Public Audit Committee

Overview of Mental Health Services

Submission from NHS Highland

General Service Description

NHS Mental Health Services are provided both by non-specialist and specialist services. General Practitioners in the NHS Highland area, as in all areas, see the largest proportion of people with mental health problems who come in to contact with the NHS. Most mental illness is seen and treated in primary care. NHS Highland is able to track some of this activity because of Local Enhanced Service contracts for depression, and through prescribing and referral information.

Specialist services in Highland are grouped around Community Mental Health Teams (CMHTs). These Teams serve specific geographical areas, and cover a number of General Practices. CMHTs are staffed mainly by psychiatric nurses. They have associated Clinical Psychologists (in the Highland Council area) and Social Workers. In the Highland Council area they are divided into teams for adults with mental health problems, and older adult teams.

In Argyll and Bute, because of the particularly large distances, in most cases one geographic team in each locality provides services for both age groups. Services for substance misuse are provided by specialist nurses linked to CMHT areas. Part of Argyll and Bute is served by a community service provided by NHS Glasgow and Clyde.

In the Highland Council area, an Out of Hours nurse telephone triage service operates through NHS24. The evening shift is provided by CPNs, and overnight by a hospital based team of senior nurses. Weekend day cover is provided by a Mental Health Liaison team based in the Accident and Emergency Department at Raigmore Hospital. This provides telephone access to specialist staff for patients who access NHS24 and are screened as requiring urgent Mental Health assistance. The staff can then make necessary arrangements for assessment, follow-up or admission as indicated.

Each of the Community Health Partnerships provides the community mental health services in its area. Hospitals are hosted by the CHP in which the hospital is geographically based. Some specialist services are provided across larger areas.

Child and Adolescent Mental Health Services (CAMHS) are provided by psychiatrists, psychologists, specialist nurses and Primary Mental Health Workers, who also have a link role with schools. Arrangements are different in Argyll and Bute where, because of its previous structure as part of Argyll and Clyde Health Board, CAMHS services are largely provided by NHS Glasgow and Clyde under a contractual agreement with NHS Highland.

There are other specialist services, including a specialist liaison service at Raigmore Hospital in Inverness, an eating disorders service, Clinical Psychology
and a Forensic Service. Arrangements for each of these are slightly different in the Highland Council and Argyll and Bute Council areas.

In-patient services are based in the main at two acute psychiatric hospitals in Inverness and Lochgilphead. The service in Lochgilphead is being restructured at present, and it is planned to re-provision the service, including a new hospital build in Lochgilphead. There are other, smaller, units for older adults in other hospitals in the NHS Highland area.

There are no secure services in the area, and NHS Highland is a partner in the development of an NHS Medium Secure service in Perth, as part of a North of Scotland Forensic Network. Patients from Argyll and Bute who need Medium Secure care are usually treated in the Glasgow and Clyde area as this is more likely to be geographically convenient for their families.

New Craigs Hospital restructured an older, off-site day hospital to a Day Hospital on the hospital site. This Day Hospital undertakes emergency assessments and is one of the factors which has contributed to reduced admissions, by offering more intensive support and identifying other community options. The Day Hospital is open 9am – 5pm Monday to Friday, and 11am – 7pm on weekends.

New Craigs Hospital has also developed an in-patient assessment unit. Individuals are admitted to this unit when an in-patient assessment is required, and a full treatment plan is developed within 72 hours which may include a longer admission, or a move to community support, which can include Day Hospital attendance where appropriate.

**Accessibility of mental health services**

**Targets for accessibility**

There are no local targets for accessibility, although the South-East Highland CHP is developing a waiting time target for psychological services. In the NHS Highland area, same day assessment in an emergency is available through duty doctors at New Craigs Hospital in Inverness, and the Argyll and Bute Hospital in Lochgilphead. In Inverness, a same day assessment service is available at the Braeside Day Hospital, with direct referral by General Practitioners, and self-referral.

Community Mental Health Teams (CMHTs) have varying arrangements, with some having a capacity for same day assessment. In practice, all CMHTs are able to see urgent referrals within one working week, and some within two working days, with the exception of islands with no resident Community Psychiatric Nurse (Colonsay, Coll and Tiree). In such a case, the patient is discussed with the GP by telephone and, in some cases, a videolink can be used for patient assessment.

The ability to see people urgently at home in rural areas within 48 hours is more limited, as staff often group their work geographically, and tend to have appointments in the same area on a particular day. Consequently, seeing someone elsewhere on a large geographical patch would mean cancelling the
other appointments. Having a separate staff member for emergencies in each rural area would be possible in some areas, but relatively inefficient as, given the low number of people, there can be no urgent referrals at all in a particular week. In practice, the individual team managers make pragmatic decisions about the urgency of referrals and decide how to allocate their available resource day to day.

A recent example of work on improved accessibility and reduced waste is the creation of joint assessment allocation meetings in Inverness. A review of referrals to Braeside Day Hospital, Clinical Psychology and Consultant Out-Patient Clinics found that, in some cases, there were multiple referrals of the same individual. There is now a weekly joint meeting to review new referrals and decide which service is most appropriate for the apparent need, and best placed to see the person in the fastest time.

Quality Measures

Many quality measures are set nationally. As part of national requirements, NHS Highland monitors readmission rates, anti-depressant prescribing and dementia prevalence from General Practice registers. There are useful for planning, but at area level this information alone is not adequate to support teams. We therefore supplement the area information as follows:

Readmissions

Colleagues at ISD provide information on the readmission target by CHP. In addition, NHS Highland uses routine hospital admission data to produce a list for each CMHT of who has been admitted from the practices they serve in the last month; how often that person has been in hospital in the last two years, and the persons cumulative hospital stay in the period. This can be provided in a more timely manner than the retrospective national data.

SPARRA MH is a risk of readmission measure, which estimates from locally held information the risk of an individual being readmitted to a psychiatric hospital. This information is provided by ISD, and an NHS Highland data analyst collates the information by CMHT area, and provides it to each Team in the way they prefer. To add value to this, the analyst also cross references the SPARRA scores, and indicates to CMHTs if individuals with high scores are on the Care Programme Approach (please see below for more information).

Care Programme Approach Use

The Care Programme Approach (CPA) is a structured approach to the care of people whose illness is particularly severe, and in whom organisational arrangements are very important. Information is collated for each area on the use of the CPA, including local rates. The service also produces, for the Highland Council area, a listing by area of use of the CPA for people on Compulsory Treatment Orders.

Anti-depressant Prescribing
A Community Health Partnership (CHP) pharmacist, on behalf of all four CHPs, produces quarterly anti-depressant prescribing information for each CMHT area. In addition, the pharmacist has created a routine analysis that can be run on PRISMS, the prescribing system, which allows practices to see their prescribing compared to the other practices in their CHP, and compared to the Highland average.

Waiting Times

Psychological Services

Psychological therapies are delivered by many staff, including psychiatric nurses. These psychological interventions are not separately recorded, but offer a range of interventions to people in their local area. Services available in particular areas include Cognitive Behavioural Therapy and EMDR. A recent initiative has made Dialectical Behaviour Therapy available, mainly as a treatment for Borderline Personality Disorder, and this has increased the range of therapies available.

Specialist Clinical Psychology services in some areas have had long waiting times. This does not mean that all people referred experience the longest waits. The waiting lists have a marked skew, with a smaller number of people having long waits, mainly relating to availability of specialist services in specific geographical areas. The Clinical Psychology department ran a waiting list initiative earlier this year, and saw and treated an additional 63 patients with the longest waits in January to March 2009.

The Clinical Psychology Department have gone on to undertake a detailed review of their administrative processes, and the ways in which individual geographical waiting lists are managed. The department has also worked with other colleagues in NHS Highland to review the nature of referrals, and the likely volume of referrals for specific problems. As a result of this, the Clinical Psychology Department is producing plans to reallocate its available resource to better match the demand.

Substance Misuse

There had been delays in access to substitute prescribing in the Inner Moray Firth area. The process is that individuals are assessed, with substitute prescribing being one possible outcome. If substitute prescribing is concluded to be an appropriate treatment option, the prescription is initiated. In the Inner Moray Firth area, this is done by the specialist service (in other areas it is usually done by GPs working with CPNs).

Once the medication is stabilised, care is transferred to a GP or specialist CPN. The issue in Inverness was that the capacity to supervise individuals once the medication was stabilised was limited. Consequently, it was not possible to commence medication without having a route for maintenance monitoring. There was no limitation of specialist assessment capacity, but rather a limit to community monitoring. The South-East Highland CHP resolved this by increasing community capacity with both increased staffing and increased clinical space. This also
provided an opportunity to review other services, and to introduce a peer support service and to bring the associated needle exchange to the same site.

The needle exchange programme in Inverness is particularly successful, with over 400 users and a 90% return rate. The service has also introduced a Heartstart UK accredited naloxone programme for users and carers, in association with the Scottish Ambulance Service, and with support from Northern Constabulary. 83 people have been trained so far, including 20 people on release from prison. In this programme, users and carers are taught to recognise the signs of an overdose, and taught to administer Cardio-Pulmonary Resuscitation and naloxone, an opiate antagonist. Scottish Ambulance Service staff consider it likely that at least two lives have been saved by this programme so far.

**Vulnerable Groups**

*Levels of Service*

Meeting all the possible demands on services is difficult. There are particular tensions in the NHS Highland area because of the difficulty in balancing local access with specialist availability. In some cases, specialist expertise is felt to outweigh local access, as in the Under 70 dementia assessment service discussed below. In other cases, such as general community mental health services, local access is particularly important and Community Mental Health Teams deliver services to their area, supported by advice and training from specialist teams. In some cases, this is supplemented by some additional dedicated local resource (e.g. Forensic Mental Health services).

*Children and Adolescents*

The main recent work on this has been integrating services in the Highland Council area, to improve the experience for young people and their families. Within the Highland Council area, Child and Adolescent Mental Health Services traditionally operated as three separate specialist services: the Department of Child and Family Psychiatry, Clinical Child Psychology Service and the Clinical Child Psychology Learning Disabilities Service.

In February 2009, a CAMHS Network Manager was appointed for a fixed term contract of one year. The main objectives were to facilitate integration of the above services, review joint working, review IT systems, implement a Choice and Partnership Approach model of working and identify changes required to deliver the service within a potential 18 week referral target.

During 2009, the three services co-located on one site and are currently in the process of amalgamating systems and clinical joint working; an integrated joint referral pathway was published on Tuesday 22nd September 2009, with integrated joint referral meetings planned to commence on 12th October 2009.

The two mental health services commenced working with a Choice and Partnership Approach model on Monday 14th September 2009; with both Services undertaking three months of concentrated work to reduce waiting lists.
Minority Ethnic Groups

The main issues are to make services accessible and culturally appropriate. The NHS Highland area has a relatively low proportion of people in minority ethnic groups and, to some extent, having a low population density of people in multiple ethnic groups spread across a large area produces some of the same challenges as rurality, balancing accessibility and specialist expertise.

NHS Highland promotes inclusion and cultural awareness with appropriate training, included in Staff Personal Development Plans. Access to translators, where necessary, has to be available quickly. A telephone translation service is available, but in the case of psychiatric hospital admissions face to face translation is often used. General information on service access is available in a number of languages from the NHS Highland website, and colleagues working in Equality and Diversity are helpful in directing staff to appropriate sources of information on support and cultural needs when people from less common ethnic groupings come in to contact with services.

Prisoners and Ex-Offenders

Within NHS Highland there are a variety of mechanisms in place to ensure support to this vulnerable group. In Argyll and Bute, there is no local prison and offenders will be transferred to a prison outwith NHS Highland. After sentencing anyone known to the local mental health service is discussed and the CMHT make a decision on on-going input, taking into account the length of sentence and individual needs of the patient.

In Argyll and Bute, due to distances of over 100 miles each way, it is unusual for local teams to retain active involvement in treatment in longer sentences. Often this means the person is discharged into the prison care services and the prison care system is asked to ensure local teams are kept informed of release dates with as much notice as possible. Consultant Psychiatrists from Argyll and Bute will try to provide a Court report on any person already known to them or the Consultant for the Forensic Team will liaise with local teams on information and advice. There is regular telephone liaison between prison health care staff and local Teams to seek advice and exchange information on the management of someone known to mental health.

Within all other parts of NHS Highland there is regular liaison between CMHTs and prison staff in Porterfield Prison in Inverness to ensure relevant information is exchanged. If the patient is on remand or has received a short sentence, visits may be undertaken as appropriate or until the patient has been transferred to New Craigs Hospital, Inverness. Patients receiving a longer sentence are transferred to a prison outwith NHS Highland. CMHTs would be informed of release dates to enable the smooth transfer of care and re introduction of care packages in a timely manner. Referrals from prison staff would be dealt with through the normal allocation process within each CMHT.

New referrals to the CMHT from prison staff are less common. In the first instance, many will go to the local forensic service. Forensic nursing services hold
a weekly clinic in the prison. They see patients for assessment, ongoing care and through care until the prisoner/patient can be supported up by other services. They identify high risk individuals coming up for release, and liaise with prison staff and local services as required. They provide training for prison nurses, including STORM training\(^1\) and ‘New To Forensics’.

There is a Substance Misuse Prison Liaison Nurse based with the prison’s addiction team in Porterfield. Referrals are accepted for individuals with an identified substance misuse problem and work is undertaken with them before and after release. The nurse has close links with the Osprey House Substance Misuse Day Care Services and will follow people up in the most appropriate community setting.

As required by individual need, there is joint working with prison social work, forensic services and area criminal justice social work services. There is also a close working relationship with the prison health centre addiction nursing and medical staff in order to maintain or initiate any substitute prescribing, maintenance, reduction or detoxification treatment programmes. Community substance misuse services will liaise with the prison to share information regarding treatment in order that care is maintained whilst the patient is in prison and on release. Any patients with severe and enduring mental health and substance misuse issues will be supported by the Dual Diagnosis Service, whilst in prison and on release. The South-East Highland CHP has commenced work on arrangements for the expected transfer of prison health services to the NHS.

**Dementia**

Current work is focussed on achieving the Government focus of earlier diagnosis. This is thought to be beneficial as it allows time for support for the person with dementia and their family, and provides them with an opportunity to make necessary decisions. This includes decisions on issues such as granting Power of Attorney, which can greatly simplify decision-making later in the course of illness, where lengthy procedures such as Guardianship can be required if earlier action has not been taken.

One recent step to improve diagnostic processes has been the introduction of a ‘one stop’ assessment service for people with suspected dementia up to the age of 70 years. Diagnosis in this age group can be particularly difficult. The service, currently offered in the Highland Council area, operates in Raigmore Hospital in Inverness. A neurologist, neuropsychologist and psychiatrist all review the referred individual in the same half day. Relevant tests, including MRI scanning, are also conducted. The person has a return appointment two weeks later at which the results of the assessments are explained to them, and any necessary action plan created.

While it would not be possible to replicate this model across all age groups, NHS Highland recently employed its first full-time memory clinic nurse. Our intention is to offer assessment by a doctor and nurse at the same memory clinic

\(^1\) ‘Specialist Training in Risk Management’, a suicide prevention skills-based course.
appointment, and to conduct necessary blood tests, to reduce unnecessary return appointments. We will assess the impact of this model, and if it is as successful as we hope, we will seek to redesign other services to provide the same facility.

Drug treatment is useful in Alzheimer’s Disease for some people, but does not affect the long-term progression of the disease. Promising work on Cognitive Stimulation techniques may offer some benefit, and we are reviewing the clinical possibilities of introducing such interventions. NHS Highland has entered into a Knowledge Transfer Partnership with the University of Stirling’s Dementia Services Development Centre. This Partnership, funded by the national Mental Health Collaborative programme, will seek to transfer existing academic knowledge into clinical practice, and we expect the use of Cognitive Stimulation techniques to be part of the work of this programme.

An example of recent joint working is a jointly funded Dementia Care Manager post in Lochaber, paid for by NHS Highland and Highland Council. The Care Manager is present at the time of diagnosis, and follows the patient and carer through the system. We are reviewing the applicability of this model for other areas.

**Delivery of Mental Health Services**

**HEAT Targets**

In summary, NHS Highland has met the readmission target ahead of schedule. We are confident of meeting the suicide prevention training target on time. The anti-depressant target and the dementia target are less under the direct control of NHS Highland as an organisation, as they both depend on influencing independent practitioners. We have seen an increase in dementia recording, however, and the anti-depressant prescribing performance has improved, and we are on trajectory to meet the target.

The figures for each target are:

*Anti-depressant prescribing:* 29.7 Defined Daily Doses per capita in the quarter January to March 2009. Target is to be no higher than 30 Defined Daily Doses per capita in the year ending March 2010. This current Highland rate is the second lowest rate among mainland NHS areas.

*Re-admissions:* The NHS Highland target is to reduce to 289 readmissions per year (within the definition). The actual figure in the period April 2008 – March 2009 was 225.

*Dementia:* Increase number of people identified as having dementia on practice registers to 2,659 by March 2011. The most recent figure was 2,108 at March 2009.

*Suicide Prevention Training:* 50% of frontline staff in specific groups to be trained by December 2010. The most recent NHS Highland figure was 1,554 staff trained at the end of July 2009 (29.4%).
Mental Health HEAT targets have been very useful in focussing attention on mental health services. The targets themselves are perhaps less important that the work that is required to underpin them, but it has been a helpful stimulus to national action.

**Suicide**

The NHS Highland area has a higher male suicide rate than the Scottish average. The causes of suicide are manifold, and many of the risk factors are not under the direct influence of the NHS. The national Choose Life programme aims to co-ordinate Scottish action, and we welcome its existence. We are aware that the national suicide prevention strategy is being reviewed at present, and we hope it will continue to exist in some form.

Most of the factors affecting suicide are common across all areas, e.g. poverty, mental illness and alcohol and other substance misuse. The factors which are, perhaps, more important in rural than urban areas include social networks, stigma and attitudes to help-seeking, rural poverty, the changing nature of some rural occupations, and availability of lethal means of self-harm.

Many of the factors affecting suicide are open to Government intervention. Other than gender, poverty is the single most important population risk factor for suicide, with young men in the most affluent groups being only half as likely to die by suicide as men in the most deprived groups. Levels of education, and coping skill teaching, are also relevant to this.

Mental illness and substance misuse services need to be responsive, and able to cope with crisis. While this is important, most people who die by suicide have not been in contact with specialist mental health services in the months before their deaths, and so wider interventions such as Breathing Space, aimed at younger people, and media campaigns promoting help seeking are of obvious potential value.

In rural areas, the work of agencies supporting farming and other rural communities is important. Firearm licensing is relevant, given the frequency of use of firearms in deaths by suicide in farmers. It would not be proportionate to limit firearm access wholesale, but ways of removing firearms from residents who are actively unwell do need to be available. The police can take such action at present, but further ways of supporting this would be useful.

**Anti-Depressants**

Recent work from the University of Aberdeen suggests that very little anti-depressant prescribing is inappropriate, in the sense that it would be inappropriate if the drugs were being prescribed for people without a depressive illness, or with an illness unlikely to respond to medication. The ‘Doing Well by People with Depression’ campaign in Scotland was based on the idea that depression is a serious illness with substantial morbidity and mortality, and that it is important that is therefore identified and treated. In that context, the increase in anti-depressant
prescribing may be a direct effect of increased recognition and increased acceptance that treatment is appropriate.

NHS Highland tries to promote the identification of depression, and its active treatment. All four CHPs in the NHS Highland area have Local Enhanced Service contracts with GPs for the identification and management of depression. This includes the promotion of standard rating scales to help gauge severity; matching of treatments to illness severity, and regular review. The Highland Joint Formulary includes guidance on which anti-depressants are preferred. Compliance is high, and is monitored by CHP pharmacy advisors.

The Scottish Intercollegiate Guideline Network recommends interventions such as information; self-help material and guided self-help for less severe illness. NHS Highland promoted a book prescribing scheme with the full support of Highland Council, and three of the four CHP areas have employed Guided Self-Help workers to support people with mild depression.

Current work on Integrated Care Pathways includes work on depression, and this should further bring together all the related strands of work on anti-depressants. The work by the Clinical Psychology department discussed above is also relevant, in that access to Cognitive Behavioural Therapy is an important option in depression treatment and increased access will be of value.

**Outcome Measures**

Our strategy is to provide information at three levels: NHS Highland, CHP and CMHT. Outcome measures, in the sense of outcomes for individual patients, are not collected other than in Clinical Psychology and CBT, where rating scales are more commonly used. The development of the new Integrated Care Pathways will incorporate more accessible information on outcomes.

At present, we monitor progress on the HEAT targets either monthly or quarterly depending on the nature of the data collection on the area. This is supplemented by information on admissions in the previous month, provided by CMHT area direct to the team. Teams receive quarterly information on SPARRA MH scores, as noted above, along with anti-depressant prescribing.

**Partnership Working**

A Mental Health Network group is held quarterly, jointly chaired by an NHS officer and a Highland Council officer. This group includes Social Work representatives from both Council areas, a Users Group, and representatives from each of the four CHPs. A monthly multi-agency group meets to address any joint issues, and to agree any necessary changes to mental health services. Other relevant groups, such as the Care Programme Approach group and the Services for Mentally Disordered Offenders Group, are also multi-agency. This works well at both strategic and operational level.

In Argyll and Bute, a full review of mental health services has been conducted recently. The redesign and public consultation process was carried out as a joint
exercise with Argyll and Bute Council, resulting in a shared view and detailed plan of mental health service provision.

**Prisons**

A detailed account of services in prisons was given above. Liaison and joint working with prison staff, and with Criminal Justice Social Work, is good.

**Educational Psychology**

Links in Argyll and Bute are to Glasgow and Clyde. In the Highland Council area, Educational Psychologists can attend a CAMHS Professional Consultation Meeting in order to discuss a particular child and CAMHS are always invited to either liaison meetings or child plan meetings. Educational Psychologists can also link through the Primary Mental Health Worker who are CHP based and attached to schools.

**Finance**

Budgets for mental health services in NHS Highland are rolled forward from year to year with any additional developments agreed by the Board. Budgets are also increased for pay inflation and the costs of staff increments. Budgets are not pooled with the Local Authorities, and there is no formal alignment, although budget statements are presented at joint meetings so that the Local Authorities are aware of NHS Highland spending and can raise any necessary issues.

Resource Transfer for Local Authorities is also assumed to be constant unless any changes have been agreed, such as a recent Learning Disability re-provision project. The Local Authorities provide statements on the spend of money which has been transferred. Budgets for community services are held in each of the CHPs which is also reported centrally. The Community Care Department analyses information for “shifting the balance”. Recent work includes a transfer of resource from in-patient older adult services to community work, with each CHP accounting to a multi-agency committee on its investment of the resource.