A MENTAL HEALTH STRATEGY FOR GREATER GLASGOW

GREATER GLASGOW JOINT MENTAL HEALTH STRATEGY

ISSUED BY GREATER GLASGOW HEALTH BOARD IN PARTNERSHIP WITH:

GLASGOW CITY COUNCIL
EAST DUNBARTONSHIRE COUNCIL
WEST DUNBARTONSHIRE COUNCIL
EAST RENFREWSHIRE COUNCIL
SOUTH LANARKSHIRE COUNCIL
NORTH LANARKSHIRE COUNCIL
GREATER GLASGOW PRIMARY CARE NHS TRUST
YORKHILL NHS TRUST

MAY 1999
A MENTAL HEALTH STRATEGY FOR GREATER GLASGOW

CHAPTER 1: INTRODUCTION AND STRATEGIC CONTEXT

- National Policy Context
- Vision
- Objectives
- Strategic Background
- Developing the Joint Strategy in Greater Glasgow
- Strengths and Development Needs in the Present Services

CHAPTER 2: NEEDS ASSESSMENT AND CURRENT PATTERN OF SERVICES

- Needs Assessment
- Demographic and Area Profiles
- Mental Health in Greater Glasgow: Key Findings
- Mental Health in the Community, the Health Centre and the Hospital
- Suicide and Self-Poisoning (Para-Suicide)
- Children and Young People
- Drug Misuse and Dependence in Greater Glasgow
- People with Personality Disorders
- Wernicke-Korsakoff’s Syndrome and Alcohol Related Brain Damage
- Mental Health Problems of Older People
- Dementia
- Early Onset Dementia
- Acquired Brain Injury
- Mental Health Needs of Ethnic Minority Communities
- Services for Women
- Mentally Disordered Offenders
- People Detained Under Sections of the Mental Health Act
- Mental Health Inequalities and Deprivation
- Current Pattern and Resourcing of Services

CHAPTER 3: CHILDREN AND YOUNG PEOPLE

- Current Services and Resources
- Current Service Delivery
- Service Users and Carers Perspectives
- Future Service Development
- Priorities for Future Development

CHAPTER 4: ADULT MENTAL HEALTH SERVICES

- Current Services
- Resources
- Service Users and Carers Perspectives
- Problems and Issues for Current Services
- Tiers of Service
• Priorities for Future Action
• Post-Natal Depression
• Drug and Alcohol Services
• Homelessness and Mental Health
• Resource Implications

CHAPTER 5: SERVICES FOR MENTALLY DISORDERED OFFENDERS
• Current Services and Resources
• Issues
• Future Services
• Advocacy
• Resource Implications

CHAPTER 6: SERVICES FOR PEOPLE WITH LEARNING DISABILITIES
• Current Services and Resources
• User and Carer Perspectives
• Problems and Issues for Current Services
• Future Services
• Tiers of Service and Priorities
• Resource Implications

CHAPTER 7: MENTAL HEALTH SERVICES FOR OLDER PEOPLE
• Current Services
• Resources
• Service User and Carer Perspectives
• Problems and Issues for Current Services
• Tiers of Service
• Priorities for Action
• Resource Implications

CHAPTER 8A: SERVICES FOR OLDER PEOPLE WITH DEMENTIA
• Current Services and Resources
• Resources
• Service User/Carer Perspectives
• Problems and Issues for Current Services
• Tiers of Service
• Alcohol Related Brain Damage
• Priorities for Action

CHAPTER 8B: SERVICES FOR YOUNGER PEOPLE WITH DEMENTIA
• Current Services and Resources
• Service User/Carer Perspectives
• Problems and Issues for Current Services
• Tiers of Service
• Resource Implications
CHAPTER 9: MENTAL HEALTH THERAPIES

• Therapies for People with Mild to Moderate Mental Health Problems (Anxiety and Depression)
• Therapies for people with Moderate to Severe Mental Health Problems
• Priorities for Action

CHAPTER 10: THEMES AND ISSUES

• Promoting Social Inclusion
• Health Promotion
• Care Pathways
• Staff Partnership and Organisational Development
• Housing
• Employment and Training
• Social Support Networks
• Services for Ethnic Minority Groups
• Outcomes
• Links with Academic Institutions

CHAPTER 11: JOINT PLANNING AND REVIEW

• Introduction
• Local Authority Joint Commissioning Bodies
• Monitoring the Implementation of the Joint Strategy
• Information
• Clinical/Professional Audit
• Priorities for Action

CHAPTER 12: FINANCIAL OVERVIEW

• Current Resources
• Financial Implication of Client Group Priorities
• Development of Financial and Management Information Systems
CHAPTER 1: INTRODUCTION AND STRATEGIC CONTEXT

THIS CHAPTER

- sets out the vision and objectives of the Joint Strategy;
- describes the strategic background;
- describes the process for developing the Joint Strategy across Greater Glasgow;
- analyses the strengths and weaknesses of current services.

INTRODUCTION

Mental Health is a national priority for the NHS in Scotland and a continuing priority for local authorities in terms of care in the community. The Joint Strategy provides an opportunity to review provision and to ensure the development of mental health and dementia services which will:

- prioritise the needs of people with severe and enduring mental illness;
- meet the needs of people with mental health problems who can be safely managed and cared for in the community, with primary health and social care support;
- provide effective and safe care for people during periods of acute illness and for those with severe and enduring problems;
- promote mental health and wellbeing in the population and build supportive communities;
- build public confidence in mental health services and reduce stigmatisation and social exclusion of those with mental health problems.

A major theme of the Joint Strategy is the promotion of social inclusion which links closely with the multi-agency programmes being developed by the Glasgow Alliance to tackle the wider social policy agenda.

NATIONAL POLICY CONTEXT

The Joint Mental Health Strategy has been prepared as a local response to the Framework for Mental Health Services in Scotland. The Framework was issued by the Scottish Office in September 1997 setting out the core components of a comprehensive mental health service and providing a useful template for health boards and their planning partners to review current service provision. The Framework represents an essential reference point for the development and the implementation of the Greater Glasgow Joint Mental Health Strategy against which progress can be readily measured.

The development of the Framework in Greater Glasgow has taken place against the backdrop of a number of Government policy initiatives which will have a major impact on the future shape and direction of mental health services. These include:

The White Paper “Designed to Care” set out the Government’s vision for the NHS in Scotland. This reinforced the central role of the Health Improvement Programme as the vehicle to ensure the achievement of 5 key strategic aims:

- improving health;
- tackling inequalities;
- developing primary care;
• developing community care;
• reshaping hospital services.

The establishment of Primary Care Trusts as a direct consequence of the White Paper bringing together primary care and mental health services in a single organisation will promote the development of integrated services influenced by Local Health Care Cooperatives.

The White Paper “Aiming for Excellence” sets out an agenda to modernise Social Work services in Scotland. Following the Modernising Community Care Action Plan, the White Paper sets out proposals to ensure:

• better/quicker decision making;
• people to be cared for at home where possible;
• new emphasis on working better in localities;
• setting standards for care;
• ensuring agencies achieve best value.

These themes are entirely consistent with the Mental Health Framework and provide an essential policy context for developing local mental health provision.

The White Paper “Towards a Healthier Scotland”. The Government’s white paper on public health sets out a new national strategy for improving Scotland’s health and acknowledges the relationship between health and the environment in which we live. The strategy involves linked action at three levels:

• life circumstances;
• lifestyles;
• direct work on a number of health topics.

The overarching aim at all levels is tackling inequalities. The crucial role of action by local authorities and other agencies is emphasised, as is the need to ensure that community views are reflected and local people are actively involved in decision making and new initiatives.

The recent Scottish Office Acute Services Review contains a number of important themes which have a resonance for future mental health provision.

These include:

• a multi-disciplinary approach to health gain;
• managed clinical networks;
• quality assurance and accreditation;
• optimum use of staff resources;
• research and development;
• information management and technology.

VISION

The Joint Strategy has five main themes which together create the vision for future mental health services in Greater Glasgow:
i) The dignity of the individual, recognising in the importance of the client/patient throughout with greater emphasis being given to user input in the planning and delivery of services.

ii) Integration of services around the needs of clients to ensure a complimentary pattern of service and the delivery of care between the statutory agencies.

iii) Normalisation. The recognition that individuals with mental health problems have the right to basic needs such as adequate housing, employment and social support.

iv) Early intervention and promotion of positive mental health.

v) Delivery of effective care and treatment to people with mental health problems in our community.

OBJECTIVES

The Joint Strategy has a number of objectives which inform the detailed proposals set out in individual care group sections and are reflected in the targets contained in the Implementation Plan.

- equity of service provision across the Health Board area based on agreed indicators of need;
- the establishment of joint commissioning arrangements involving all key partners to develop the strategic mental health agenda;
- continuing over the period of the Joint Strategy the shift in emphasis from hospital based to locally based community services rooted in primary care;
- the provision at a local level of a comprehensive and complimentary network of community based and hospital in-patient services, based on inter-agency protocols;
- the availability of appropriate supports to primary care based on shared care arrangements;
- the development of more specialist services for offenders, people who abuse drugs and alcohol and services which are more responsive to the needs of women and people from ethnic minority communities;
- the provision of dedicated services for people with early onset dementia;
- ensuring the provision of adequate housing and employment/training opportunities for people with severe and enduring mental health problems to promote independent living;
- ensuring accessible effective and responsive crisis services to people experiencing a mental health crisis;
- promoting evidence based practice and best value through a consistent focus on clinical and cost effectiveness with an emphasis on outcomes;
- involvement of clinical and professional staff in commissioning and evaluating services;
- involving service users and their carers in service planning and monitoring quality and ensuring the availability of independent advocacy services;

The Joint Strategy also recognises the need to address public education and awareness in order to promote and foster communities which care and support vulnerable groups and individuals in their midst. A key element of the Strategy involves education to overcome the negative stereotypes and stigma too often directed towards people with mental ill health. To do this effectively there is a need to give the public reassurance on public safety and engage positively with the media on mental health issues.
STRATEGIC BACKGROUND

In 1993 the Board issued its Mental Health Strategy covering the period up to the year 2000. The Strategy signalled a reconfiguration of mental health and dementia services with a move from Victorian institutions to a network of more locally based community health services and the development of supported accommodation and nursing homes. In addition, the Board has recently consulted and agreed proposals to develop a local network of services for mentally disordered offenders.

This change of policy towards community based services was endorsed in the Greater Glasgow Joint Community Care Plan of 1995. This resulted in a joint implementation process between health and local authorities to close Gartloch and Woodilee hospitals and to develop alternative community based health and social care services for the North and East sectors. It is significant, however, that the JCCP was based on agreement for only the North and East sectors. As a result, the services in the South and West have developed at a much slower rate and without multi-agency agreement and to continue to have a lower expenditure per head than the North and East. The Strategy still reflects work in progress and key structural issues around overall balances of care and future in-patient reconfiguration will be completed during 1999/2000.

This was reflected in the Greater Glasgow Joint Planning Statement of December 1997 and in subsequent Joint Community Care Plans. The critical need to address imbalances in care across GGHB to ensure a consistent approach to service provision remains one of the major challenges for the Mental Health Strategy. The recent Community Care Implementation Unit (CCIU) review of joint planning issues across Greater Glasgow similarly highlighted the need for planning partners to redress outstanding balance of care and investment issues.

It is important to recognise that in recent years considerable progress has been made in developing joint work between health and social work staff, particularly around hospital resettlement programmes. More recently the implementation of the Care Programme Approach has helped to foster a culture of joint working at an individual client level between agencies including housing. Whilst undoubted progress has been made in this area, improving joint working remains a strategic priority and the recent progress needs to be encouraged and become the standard consistently applied in the delivery of services for people with serious mental health problems or with dementia.

DEVELOPING THE JOINT STRATEGY IN GREATER GLASGOW

The Joint Strategy has been developed in an inclusive manner with the emphasis throughout on a partnership approach between health, primary care, social work, housing and users and carers. A multi-agency Greater Glasgow Mental Health Steering Group with representatives of the Health Board, the Greater Glasgow Community and Mental Health Services NHS Trust, each of the six local authorities in the Greater Glasgow area, housing agencies, the GP Sub-Committee and trade union representation has overseen the production of the Greater Glasgow Joint Strategy and ensured that it links into wider health and local authority strategic agendas.

The process involved the following:

i) Local Authorities

The establishment of multi-agency Local Authority Mental Health Groups to prepare local mental health strategies, consistent with Joint Community Care Plans and to inform the Greater Glasgow Joint Strategy. The local authority processes also
included extensive consultation with users and carers as part of the Joint Community Care Planning process. A digest of the key issues and priorities emerging from each of the local authority groups is attached at Annex 1.

ii) **Stakeholders**

Stakeholder conferences were organised by the Local Authority Groups to elicit key issues, concerns, priorities for a range of groups and individuals involved with mental health services. These conferences involved users, carers, representatives from the voluntary sector, GPs, mental health professionals, the Health Council. A number of well attended user specific events were organised as part of the JCCP and Framework Consultation. These highlighted a number of key concerns for service users and informed the priority setting within the Strategy.

iii) **Primary Care**

As well as GP involvement in the Local Authority and Stakeholder conferences, two seminars on mental health and primary care were organised. These allowed GPs to discuss mental health from a primary care perspective and the key issues have been incorporated into the various care groups sections of the Joint Strategy.

iv) **Clinical and Professional Staff**

To reflect clinical and professional engagement in developing the Framework, individual workshops with psychiatrists, psychologists, nursing staff, social work staff, occupational therapists and managers of services were held. The aim was to ensure ownership from the professional groups and that the implementation facilitates clinical and practitioner leadership and enhances relationships between professional groups.

v) **Specialist Services**

A number of services have been developed on a Greater Glasgow basis, reflecting the specialist nature and/or smaller numbers of people affected. Specialist services included:

- Child and Adolescent Mental Health Services
- Services for Mentally Disordered Offenders
- Drug and Alcohol Services
- Eating Disorders

Multi-agency working groups on these services were established to develop plans for these services and to consult with stakeholders.

**STRENGTHS AND DEVELOPMENT NEEDS IN THE PRESENT SERVICES**

The development process for the Joint Strategy identified many strengths in services. In particular:

- a well developed range of community mental health and social care services established as part of the Gartloch and Woodilee hospital reprovision programme;
- progress made toward joint working between health and social work services in delivering mental health care;
• the successful implementation of the Care Programme Approach across Greater Glasgow;
• a history of genuine multi-agency planning of mental health services;
• many excellent and highly committed clinical and practitioner staff;

However, it was also recognised that services are operating under considerable pressure and that there are a number of areas where service could be improved:

The Joint Strategy found that our services need:

• to be better organised as a whole system, with the different services and agencies working together better to organise care around the individual;
• to extend the work of the Community Mental Health Teams and ensure complementary service provision to meet people’s needs;
• to be able to offer better 24 hour support in crisis;
• to be able to work better with people with very high needs, especially those who are reluctant to keep in touch and become vulnerable or, in some cases, present a risk to others;
• to be able to provide more specialist services for a number of groups, including early onset dementia, eating disorders and women with post-natal depression;
• to be able to give more practical help and support to service users with their needs for employment, housing and social inclusion in the community;
• to make more advocacy available to service users;
• to work more closely and effectively with GPs and Primary Care Teams;
• to deliver more sensitive and responsive services for women and people from ethnic minority communities;
• to network in the community to promote the acceptance and inclusion of people with severe mental illness.

Many of these issues relate to the historic pattern and range of our services, the current balance of resourcing towards hospital based provision and pressure on our overstretched staff in a number of areas. These issues were again highlighted in the recent CCIU report.

The Joint Strategy seeks to build on the considerable strengths in current service provision and the dedication and commitment of staff. There is no doubting, however, that in a number of critical areas current services need to be realigned and more focused towards tackling needs of people with mental health problems. This will involve addressing issues concerning the current balance of resources between hospital and community based services, the degree to which professional groups and agencies work together and the role of users and carers in the mental health system.
CHAPTER 2: NEEDS ASSESSMENT AND CURRENT PATTERN OF SERVICES

THIS CHAPTER

- notes the expected changes in the size and structure of the population of Greater Glasgow and the implications of this for mental health services;
- sets out the key findings of a detailed needs assessment;
- describes the factors contributing to mental ill-health in Greater Glasgow;
- highlights the correlation between mental ill-health and deprivation;
- describes the current pattern and uptake of mental health services across the Greater Glasgow area.

NEEDS ASSESSMENT

There is no single measure of the mental health of an individual nor of a population. A comprehensive description of mental health requires information from several different sources. This section uses data from community surveys, estimates of general practice work, deliberate self-poisoning admissions, psychiatric and general hospital admissions and suicide rates for the population of the Greater Glasgow area. Much of the available data reflect service usage which may not give a true indication of unmet need. The analysis has shown that there is a lack of accurate measures of the number of people with particular mental health problems living in Greater Glasgow and of the severity of those problems.

DEMOGRAPHIC AND AREA PROFILES

Greater Glasgow Health Board covers a population of just over 900,000 spread across six local authority areas. A map showing the Health Board area and local authority boundaries is shown below.

The population of Greater Glasgow is expected to decline by just over 5% by 2006. The 1996 population and projected population by the year 2006 are shown below.

Table 1: Population and Projected Population

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Whole Population 1996</th>
<th>Year 2006</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>60,383</td>
<td>52,127</td>
<td>-8,256 (-13.4%)</td>
</tr>
<tr>
<td>5-14</td>
<td>113,447</td>
<td>111,567</td>
<td>-1,880 (-1.7%)</td>
</tr>
<tr>
<td>15-44</td>
<td>400,303</td>
<td>356,390</td>
<td>-44,013 (-11.0%)</td>
</tr>
<tr>
<td>45-64</td>
<td>193,957</td>
<td>207,696</td>
<td>+13,739 (+7.1%)</td>
</tr>
<tr>
<td>65-74</td>
<td>80,277</td>
<td>70,558</td>
<td>-9,719 (-12.1%)</td>
</tr>
<tr>
<td>75-84</td>
<td>45,229</td>
<td>45,590</td>
<td>+361 (+0.8%)</td>
</tr>
<tr>
<td>85+</td>
<td>13,363</td>
<td>14,459</td>
<td>+1,096 (+8.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>906,959</td>
<td>858,287</td>
<td>-48,677 (-5.4%)</td>
</tr>
</tbody>
</table>

(Source: Scottish Health Statistics 1996 (Dec 1996))
The population of the Health Board is split across the six local authority areas as follows:

**Figure 1: 1996 GGHB Population by Local Authority Area**

<table>
<thead>
<tr>
<th>Local Authority Area</th>
<th>Population</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow City</td>
<td>616430</td>
<td>(67.8%)</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>110750</td>
<td>(12.2%)</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>46580</td>
<td>(5.1%)</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>63250</td>
<td>(6.9%)</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>56190</td>
<td>(6.2%)</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>16400</td>
<td>(1.8%)</td>
</tr>
</tbody>
</table>
MENTAL HEALTH IN GREATER GLASGOW: KEY FINDINGS

- Compared with men, women more commonly report mental health problems and have higher GP consultation rates for mental illness.
- Most types of serious mental health problems are more common in the most deprived parts of Greater Glasgow.
- Hospital admissions for self-poisoning continue to rise.
- Suicide rates among younger men have been rising slowly in recent years.
- The large number of children and adolescents with mental health problems and disorders suggests a need for both increased health services and greater working between health, education and social work.
- People with learning disabilities have particular needs for physical and mental health services - current use and provision of services by this group need to be better understood.
- Dementia is the most common of the mental health problems which affect older people.
- Significant numbers of younger people are affected by a range of dementia and associated conditions.

MENTAL HEALTH IN THE COMMUNITY, THE HEALTH CENTRE AND THE HOSPITAL

- Among people living in the community neurotic disorders (anxiety, depression, panic attacks, etc.) are about 40 times more common than psychotic disorders (schizophrenia, bi-polar disorders) - 160 per thousand versus 4 per thousand.
- Among people attending GPs, neurotic disorders are about 25 times more common than psychotic disorders. Depression and anxiety account for 73% of all consultations for mental health problems in general practice in Greater Glasgow.
- Reflecting their greater severity, psychotic disorders are about twice as commonly the reason for admission to psychiatric hospital in Greater Glasgow than neurotic disorders.

Overall psychiatric hospital admission rates in Greater Glasgow are identical for males and females (Figure 1). However, women are more likely to suffer from dementia and depression and to be admitted for self-poisoning. Men have much higher rates of admission for schizophrenia and mental illness associated with drug and alcohol related problems and they are 3.5 times more likely to commit suicide.

Figure 2: Mental Health Prevalence Related to Gender
SUICIDE AND SELF-POISONING (PARASUICIDE)

Suicide remains a relatively rare event with around 100 cases each year in Glasgow of whom three-quarters are male. Suicide rates are about three times more common in the most deprived areas compared with the most affluent. In the early 1990’s there was an increase in suicides among young men across Scotland but it is unclear whether this trend is continuing. Only around one-third of people who commit suicide suffer from a mental disorder, although a considerable proportion of the remainder have drug or alcohol misuse problems.

Self-poisoning, sometimes referred to as parasuicide or attempted suicide, is far more common, with around 2,500 admissions in Greater Glasgow in 1995 and rising numbers each year since 1989. 60% of cases are female and rates are 4/5 times higher for people living in the most deprived areas compared with the most affluent. The majority of cases have taken an overdose of paracetamol. There is no current consensus on the best way of addressing the mental distress that usually precipitates the episode. It is significant that a proportion of those who self-poison repeat this within one year with a sizeable minority eventually taking their own life. Current psychiatric support to acute hospitals is patchy and it is recognised that a major review of this service area needs to be undertaken during 1999/2000 to determine the future levels and nature of this component of liaison psychiatry.

CHILDREN AND YOUNG PEOPLE

Using the established national prevalence rates of 7-10% of children and adolescents having either moderate or severe mental disorders would mean that around 15,000 children and young people in Greater Glasgow would have a significant mental health problem.

A recent report, “Mental Health and Illness in Greater Glasgow”, highlights that mental health problems are more likely to occur in children or adolescents exposed to certain stresses or disadvantages. In particular, it mentions abuse, special needs and those children in alternative care to the family home. Numbers of children with mental health disorders are identified as around 5,000 under 12 years of age and around 10,000 between 13-17 years of age. Major disorders suggested in this group are depressive disorder, eating disorder, psychotic disorder, hyperkinetic disorder, autism spectrum disorders and obsessive compulsive disorders.

It is important that young people in treatment, particularly those with continuing problems, either psychiatric or neurodevelopmental, are linked into adult services as they reach adulthood. It is likely that these are underestimates as it is known that depression and other illnesses in young people are under-recognised.

Meeting the needs of children and young people requires that the context within which they lead their lives is fully understood by professional staff as many young people feel alienated from conventional mental health services. There is no doubt that social factors such as ethnic background, deprivation, unemployment, poor housing, educational difficulties influence the mental health of young people. Tackling the mental health problem alone will not necessarily bring about improvement, there will need to be a co-ordinated care approach across agencies that tackles underlying social factors.
DRUG MISUSE AND DEPENDENCE IN GREATER GLASGOW

- In the Greater Glasgow area there are an estimated 210,000 smokers, 33,000 people drinking more than twice the recommended upper limit and 7-10,000 serious drug users with heavy drinking and drug injecting more common among men.
- Rates of all hospital admission for alcohol or drug misuse related problems are 10 times and 33 times more common respectively among people living in the most deprived parts of Greater Glasgow compared with the most affluent.
- Problem drinking and drug misuse are a frequent cause of severe mental distress, not only for users but also for their families and the wider community.

Figure 2: Not One Problem but Many

There is considerable overlap between mental illness and drug and alcohol misuse and dependence. A high proportion of people in prison or who are homeless have drug or alcohol problems and some have additional mental health problems.

PEOPLE WITH PERSONALITY DISORDERS

Individuals with personality disorders pose major difficulties for agencies involved in the provision of mental health services. It is difficult to quantify the extent of people with personality disorders in Greater Glasgow. There is a tendency for some elements of services to distance themselves from this group considering them as “untreatable”. There is, however, a need to develop consistent service responses to some of the needs and challenges posed by this group.

WERNICKE-KORSAKOFF’S SYNDROME AND ALCOHOL RELATED BRAIN DAMAGE

Until recently little was known about the impact of Wernicke-Korsakoff’s Syndrome in Greater Glasgow. A recent study in the east end demonstrated that between 1990 and 1995, 47 patients were assigned a diagnosis of Korsakoff’s psychosis. An audit of mental health in-patients in Greater Glasgow in June 1998 identified 62 patients with alcohol related brain damage. Local authorities in the Greater Glasgow area currently fund around 80 places for people with Wernicke-Korsakoff’s syndrome or alcohol related brain damage. It is estimated that 30% of residents in homeless hostels in Greater Glasgow have problems with alcohol abuse.
MENTAL HEALTH PROBLEMS OF OLDER PEOPLE

Older people with mental health problems comprise:

- those who develop a functional mental illness, such as depression, schizophrenia and other psychoses later in life;
- people with dementia or allied brain diseases;
- older people who have had a mental health problem since early or middle age;
- relatives or friends who care for someone in these groups.

A significant number of older people will have a combination of these groupings - for example, dementia and depression.

Old age mental health services have responsibility for people with dementia and for older people who develop a severe mental health problem later in life. Those with enduring mental health problems who have been under the care of a general psychiatrist within the adult service remain there unless their needs change and warrant a transfer to a specialist team. Older people with mental health problems may present with a physical illness or disability. Services for older people with mental health problems should, therefore, incorporate ways of meeting physical health needs as well as mental health, social and practical needs.

For the Greater Glasgow population of 900,000 there will be in the region of 144,000 people over the age of 65 years of whom about:

- 15,000 have a moderate depressive illness;
- 4,200 have a major depressive illness;
- 14,000 have significant anxiety levels;
- 2,200 have a psychotic illness.

DEMENTIA

The tables below present information on the current and projected needs of Glasgow’s population with dementia.

Table 4: Estimate of Numbers of People with Dementia

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30-59</td>
<td>287</td>
<td>310</td>
<td>313</td>
<td>8.0</td>
<td>9.1</td>
</tr>
<tr>
<td>60+</td>
<td>7087</td>
<td>6688</td>
<td>6422</td>
<td>-5.6</td>
<td>-9.4</td>
</tr>
<tr>
<td>75+</td>
<td>5182</td>
<td>5037</td>
<td>4907</td>
<td>-2.8</td>
<td>-5.3</td>
</tr>
<tr>
<td>85+</td>
<td>2336</td>
<td>2403</td>
<td>2323</td>
<td>2.9</td>
<td>-0.6</td>
</tr>
<tr>
<td>90+</td>
<td>873</td>
<td>963</td>
<td>1023</td>
<td>10.3</td>
<td>17.2</td>
</tr>
<tr>
<td>Total</td>
<td>15765</td>
<td>15401</td>
<td>14988</td>
<td>-2.3</td>
<td>-4.9</td>
</tr>
</tbody>
</table>

(Source: Base and Projection Glasgow City Planning Department, Eurodem Prevalence Rates)
The issues that are of particular significant for health and social care planning are:

- Population estimates showing increases or decreases between 1995/2005 as follows:
  - 4.9% reduction in the overall number of people with dementia
  - 9.1% increase in the 30-59 years dementia population
  - 5.3% reduction in the 75+ dementia population
  - 17.2% increase in the 90+ dementia population
- The likelihood of dementia increases with age. Around 1:4 people over 85 are affected, compared with 1:8 over the age of 75. This is significant given the high dependency, physical frailty and vulnerability of this group and because they are often less likely to have a carer living with them.
- Although Glasgow’s black and ethnic minority population represents around 3.5% of the total population, a projected increase in the number of elderly people within this section of the population will have implications for the planning of appropriate dementia services, particularly in localities where the population is concentrated.
- Recent research indicates a sharp increase in the number of people with Korsakoff’s Syndrome.

A more detailed needs assessment on dementia will be commissioned with the Dementia Services Development Centre, University of Stirling as part of the implementation of the Joint Strategy and will be carried out during 1999/2000.

**EARLY ONSET DEMENTIA**

The main types of early onset dementia (under the age of 65) are Alzheimer’s Disease and vascular dementia. Other causes include Huntingdon’s Disease, tumour, normal pressure hydrocephalus, frontal dementias, CJD and HIV. Very small numbers of people have symptoms that are treatable. Correct diagnosis is vital. Within GGHB there are probably around 400 people with early onset dementia. The progression of the disease varies according to the cause and survival may be up to 15-20 years or longer. The needs of people in their 40s and 50s are considerably different from those of older people.

Timely and accurate diagnosis is essential and can be achieved with improved diagnostic techniques and if diagnosed early enough may help an adjustment to lifestyle. Individuals have a right to information about their diagnosis and to have an explanation of their symptoms.

The estimated prevalence of early onset dementia in the Greater Glasgow population is set out in the Table below.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia of Alzheimer’s type</td>
<td>70</td>
</tr>
<tr>
<td>Other degenerative dementias</td>
<td>60</td>
</tr>
<tr>
<td>Dementia due to brain damage (mainly alcohol)</td>
<td>200</td>
</tr>
<tr>
<td>Huntingdon’s Disease</td>
<td>90</td>
</tr>
</tbody>
</table>

The needs of carers of people with early onset dementia are significant with considerable other family responsibilities continuing to be assumed by the carers.
ACQUIRED BRAIN INJURY

A recent survey has been conducted of 3000 people who had sustained a head injury in Greater Glasgow over one year. It was found that, even among those with a relatively mild injury, disabling mental health problems were still common one year after the injury. Few had sought or obtained help from health or social work services for these problems. It is estimated that around 500 people suffer a traumatic brain injury each year in Greater Glasgow, with a further 400 who are seriously affected following a stroke. Work on developing a strategy for people who are physically disabled will address these and related issues.

MENTAL HEALTH NEEDS OF ETHNIC MINORITY COMMUNITIES

Around 3.5% of people in Greater Glasgow are from an ethnic minority background, with significant Pakistani, Indian and Chinese communities. Smaller numbers of residents originate in other parts of the world and students come from many countries. There are no reliable data to indicate whether or not mental health problems are more common among ethnic minorities than the general population in Greater Glasgow. A recent survey of a sample of users and carers from the Pakistani, Chinese and Indian communities revealed large differences in perceptions of mental illness. Differences in communication with service providers because of language and cultural differences were frequently reported.

A theme emerging in the development of the Joint Strategy is that there is a need to improve the sensitivity and effectiveness of mainstream services to people from ethnic minority communities. This entails working to ensure that staff in the statutory sector are trained in working sensitively with members of these communities. It also means working with specialist ethnic services in the non-statutory sector. A major concern relates to working with NHS Trusts, local authorities and the voluntary sector to combat any unwitting racism in the provision of mental health services. This needs to involve antiracist/cultural awareness training for the statutory sector as well as campaigns amongst the general public. A key focus for this work will be the work of the Glasgow Anti-Racist Alliance funded as a Social Inclusion Partnership.

SERVICES FOR WOMEN

Mental Health has been identified by women as a priority area for service development. A recent GGHB report on mental health problems in women (February 1998) identified the following:

- 14% of the adult population living in the community have significant mental health problems;
- there are significant differences in the types of mental health problems experienced by men and by women;
- the 3 key areas identified for service development are in relation to post-natal depression, eating disorders and services to help and support women who have mental health problems as a result of violence against women.

Women need services which recognise their need for safety and freedom from harassment. It is known that many women experience sexual abuse and domestic violence and that these experiences contribute to depressive disorders, substance misuse and alcohol abuse. The differences in psychiatric morbidity amongst women need to be taken into account in service delivery a wider range of psychological therapies and counselling for women need to be available.
A study of post-natal depression among women giving birth in Greater Glasgow in 1997 reported that 26% of women had evidence of post-natal depression. There is, however, still a lack of recognition of post-natal depression with a fear of stigmatisation on the part of sufferers. Unrecognised post-natal depression has a serious detrimental effect on the psychological, social and educational developments of the child. There is, therefore, a clear need to improve the identification and treatment of post-natal depression in a family context by maximising the input of health visitors and primary care.

MENTALLY DISORDERED OFFENDERS

The Scottish Office policy document on Mentally Disordered Offenders (January 1999) set out the basis for developing services for this group. The policy indicated that a national needs assessment would be undertaken to assist future planning of services. The Board as part of its 1997 Strategy for Offenders identified a significant level of psychiatric morbidity amongst offenders and people in the criminal justice system. At present there are 80 Greater Glasgow residents in the State Hospital Carstairs and at any one time there are about 100 mentally disordered offenders being treated within psychiatric hospitals in Greater Glasgow. The need for specialist in-patient services in Greater Glasgow for mentally disordered offenders was highlighted in the Mental Welfare Commission’s Report (1996/97) citing evidence of patient entrapment in the State Hospital, the inappropriate use of admission beds and the inappropriate use of prison facilities currently taking place to care for this group.

Compared with the general population, a high proportion of people charged or convicted of criminal offences have mental illness, learning disability or drug or alcohol dependence. A prevalence of psychosis of up to 5% has been recorded in several surveys of prisoners. Greater Glasgow Health Board is now implementing a comprehensive strategy designed substantially to improve the local treatment and services for mentally disordered offenders whilst ensuring public safety.

PEOPLE DETAINED UNDER SECTIONS OF THE MENTAL HEALTH ACT

People detained under the Mental Health Act are usually those with the most acute needs and whose care requires the most intense interventions and co-ordination across agencies. Information from the Mental Welfare Commission Report for 1996/97, shows that 1404 detentions under sections of the Mental Health Act were carried out. This represents a ratio of 156 per 100,000 population compared to a Scottish average of 137 per 100,000 population. Such patients often require intensive nursing care and low stimulation areas/rooms to reduce anxieties. The need for sufficient IPCU beds with separate space for such patients needs to be recognised.

MENTAL HEALTH INEQUALITIES AND DEPRIVATION

A large proportion of the most deprived neighbourhoods in Scotland lie in Glasgow City. In Glasgow City, 77% of the population live in the most deprived areas (depcats 5 to 7) and only 4% in the most affluent (depcats 1 and 2). In contrast, the part of East Renfrewshire within Greater Glasgow includes none of the most deprived areas, with 91% of its population living in the most affluent areas.

A variety of indicators have been used to examine the link between mental health and deprivation. These include standardised rates for suicide (1991-95); admissions for self-poisoning (1995); mental hospital admissions for various diagnoses (1993-95); and emergency admissions for alcohol or drug misuse related problems (1991-95). These have
then been used to calculate the relative proportions of people with a particular mental health problem in each of the 144 postcode sectors deprivation category. By comparing each of the other six depcats with depcat 1, the relationship with increasing deprivation can be examined. The results are shown in Figure 4.

For most mental health problems in Greater Glasgow there is a strong link with deprivation. Compared with people living in the most affluent areas, people living in the most deprived areas are 2.7 times more likely to be admitted for depression, 3 times more likely to commit suicide, 4.5 times more likely to be admitted for self-poisoning, 6 times more likely to be admitted with schizophrenia, 10 times more likely to be admitted for an alcohol related problem and 33 times more likely to be admitted for a drug misuse related problem.

A deprivation model for Greater Glasgow has been developed. The model assumes that for a given level of mental health need of people in the most affluent areas (depcats 1-2) those of people living in depcats 3-4, 5-6 and 7 are twice, three-times and four-times greater respectively. The results of this show that Glasgow City has 68% of the population but would require 78% of available resources to address the level of need predicted by the model. On the other hand, East Dunbartonshire and East Renfrewshire require a smaller proportion of available resources than their population sizes would suggest. The other local authorities are relatively unaffected by the weighting.

**Figure 4: Mental Health and Deprivation**

The results of the application of this model are shown in Table 6 below.
Table 6: Mental Health Need in each Local Authority as a Proportion of the Greater Glasgow Total when Adjusted for Deprivation (1-4 Model)

<table>
<thead>
<tr>
<th>Authority</th>
<th>Population</th>
<th>Unweighted % of GGHB area</th>
<th>Adjusted % 1-4 model</th>
<th>Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow City</td>
<td>616430</td>
<td>67.8</td>
<td>78.3</td>
<td>+10.5</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>110750</td>
<td>12.2</td>
<td>6.3</td>
<td>-5.9</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>46850</td>
<td>5.1</td>
<td>5.2</td>
<td>-0.1</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>63250</td>
<td>6.9</td>
<td>2.7</td>
<td>-4.2</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>56190</td>
<td>6.1</td>
<td>5.6</td>
<td>-0.5</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>16400</td>
<td>1.8</td>
<td>1.7</td>
<td>-0.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>909870</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of expenditure on mental health by the NHS in 1997/98 revealed that there was a reasonably close correlation between actual spend and the Needs Model outlined above. The results were as follows:

Table 7: NHS Mental Health Expenditure Related to Deprivation Model

<table>
<thead>
<tr>
<th>Authority</th>
<th>Unweighted % of GGHB area</th>
<th>Adjusted % 1-4 model</th>
<th>Actual NHS Spend</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow City</td>
<td>67.8</td>
<td>78.3</td>
<td>76.3</td>
<td>-2.0</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>12.2</td>
<td>6.4</td>
<td>7.9</td>
<td>+1.5</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>5.1</td>
<td>5.2</td>
<td>4.8</td>
<td>-0.4</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>6.9</td>
<td>2.8</td>
<td>4.1</td>
<td>+1.3</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>6.1</td>
<td>5.6</td>
<td>5.3</td>
<td>-0.3</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>1.8</td>
<td>1.7</td>
<td>1.6</td>
<td>-0.1</td>
</tr>
</tbody>
</table>

During 1999/2000 further work will be carried out on developing a needs led resource allocation model to establish an agreed system for future allocation of health resources to locality Community Mental Health Teams and other mental health services. This will result in an agreed financial framework across GGHB which will ensure over the period of the Strategy equity of service provision linked to need both across local authority areas and within each local authority. This will mean agreeing with Glasgow City Council, in particular, a resource allocation model at locality/area team level to reflect relative need. This work will pick up key balance of care issues between the North/East and South/West sectors which have arisen out of the differential development of mental health services associated with hospital closure programmes.

**CURRENT PATTERN OF SERVICES**

Greater Glasgow is characterised by high levels of mental health need. This is reflected in high rates of hospital admission, with an increasing co-morbidity between mental ill-health and drug and alcohol misuse. Current occupancy rates for both acute and elderly admission beds are between 92 and 95% and increased numbers of people are being treated in the community by adult and elderly mental health teams.

Service users, carers, staff and voluntary organisations have told us about problems with the way services are currently organised. The pressure on hospital beds remains high and needs more effective management, crisis services need to be more responsive, genuine alternatives to hospital admission need to be developed, the capacity of services to work
with people with very high levels of need who tend to lose touch with services is limited and services need to be better organised as a whole system.

The pattern of psychiatric morbidity reflected in new referrals/contacts to adult mental health services in 1997/98 is presented in the diagram below.

**Figure 5: Psychiatric Morbidity - Adult Mental Health 1997/98**

A similar pattern is evident in services for the elderly mentally ill and people with dementia.

**Figure 6: Psychiatric Morbidity - Elderly Mental Health (including Dementia) 1997/98**
In 1997/98 a total of £137M was spent by health and local authority services on mental health and dementia provision. The breakdown of this spend was as follows:

**Table 8: Total Mental Health Spend 1997/98**

<table>
<thead>
<tr>
<th></th>
<th>£k</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Spend</td>
<td>86693</td>
<td>63.3</td>
</tr>
<tr>
<td>Total Local Authority spend</td>
<td>50301</td>
<td>36.7</td>
</tr>
<tr>
<td>Total Mental Health Spend</td>
<td>136994</td>
<td>100</td>
</tr>
</tbody>
</table>

Expenditure by local authority area is as follows.

**Figure 7: Local Authority Mental Health Spend 1997/98 (£K)**

Detailed figures are not available from North Lanarkshire Council but a provision has been included to project the total local authority mental health spend within Greater Glasgow.

The spend by both health and local authority by care groups is set out in Table 9 below.

**Table 9: Mental Health Spend by Care Group 1997/98**

<table>
<thead>
<tr>
<th>Care Group</th>
<th>Health (£M)</th>
<th>Local Authority (£M)</th>
<th>Total (£M)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>16.6</td>
<td>33.6</td>
<td>50.2</td>
<td>36.6</td>
</tr>
<tr>
<td>Elderly</td>
<td>16.0</td>
<td></td>
<td>16.0</td>
<td>11.7</td>
</tr>
<tr>
<td>Adult</td>
<td>37.9</td>
<td>13.1</td>
<td>51.0</td>
<td>37.2</td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>4.1</td>
<td>2.6</td>
<td>6.7</td>
<td>4.9</td>
</tr>
<tr>
<td>Addictions</td>
<td>9.3</td>
<td>0.2</td>
<td>9.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Mentally Disordered Offenders</td>
<td>2.5</td>
<td>0.2</td>
<td>2.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Homeless</td>
<td>0.3</td>
<td>0.6</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86.7</strong></td>
<td><strong>50.3</strong></td>
<td><strong>137.0</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
The local authority expenditure presented in Table 9 and Figure 8 above for Addictions and Mentally Disordered Offenders reflects only specific mental health spend and does not take account of a range of generic social work input to these groups.

One of the major themes of the Joint Strategy relates to the balance between in-patient and community based expenditure in health care. The pattern of expenditure by the NHS between these two areas is presented in Figure 9.

**Figure 9: Current NHS Expenditure In-patient/Community Based Services**
The data presented in Figure 8 demonstrates the continued preponderance of mental health expenditure in the NHS towards hospital based care. Overall, of the £87M spent by the health service on mental health in Greater Glasgow in 1997/98 65% was directed to hospital services. The implications of this continued emphasis on in-patient expenditure were reflected in the recent CCIU report.

The current pattern of service provision and expenditure reflects a shift from health to social work over the period since 1993. Since this time a total of £10.7M has been resource transferred to develop a range of social supports and community infrastructure for people with mental health problems and/or dementia. Based on current agreements resource transfer will increase to £14M by 2000/2001. This is broken down by local authority area as follows.

Table 11: Resource Transfer by Local Authority

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow</td>
<td>8420</td>
<td>10277</td>
<td>10727</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>1420</td>
<td>1805</td>
<td>1895</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>310</td>
<td>420</td>
<td>420</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>11</td>
<td>121</td>
<td>121</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>227</td>
<td>407</td>
<td>407</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td>319</td>
<td>411</td>
<td>433</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10718</strong></td>
<td><strong>13441</strong></td>
<td><strong>14004</strong></td>
</tr>
</tbody>
</table>
CHAPTER 3: CHILDREN AND YOUNG PEOPLE

THIS CHAPTER

- acknowledges the importance of promoting mental health in children and adolescents and of tackling morbidity present as soon as possible
- sets out the pattern of current service provision
- highlights issues identified by service users and their carers
- identifies problems and deficits within current services
- describes a model for future services, taking into account the public health and social policy considerations
- identifies priorities for future developments

INTRODUCTION

The mental health and well being of children and young people is influenced by many factors: their family, their health status, and the community in which they live. It requires a comprehensive, co-ordinated response by a wide range of agencies to respond to identified needs. Services need to be developed which take account of both health and social policy and the contributions that can be made by both statutory and voluntary agencies. In whatever way the services are configured, they require to place the child or the young person at the centre, listening and taking account of their views and those of their parents and carers.

CURRENT SERVICES AND RESOURCES

In keeping with earlier policy statements, a Handbook on Child and Adolescent Mental Health and Together we Stand, the Health Board and its planning partners accept the need for a multi-tier service. Such a service would aim to match the level of provision to identified needs, aiming to achieve effective and efficient use of resources from both statutory and voluntary agencies.

Current specialist mental health services are provided by Yorkhill NHS Trust, Greater Glasgow Primary Care Trust and Nôtre Dame clinics.

Yorkhill NHS Trust

Child Psychiatry Services

The Directorate currently has a budget of £1.5m to provide services for children and families. Of this £140k contributes to the Academic Department of Child and Adolescent Psychiatry which benefits both children and young people. Services include a 7-day in-patient unit with 8 beds, 2 specialised day service programmes and 4 community teams.

From 2000 the in-patient unit will be the only 7-day psychiatric provision for children (up to the age of 12) in Scotland. The clinical teams also offer a limited paediatric liaison service to the main hospital for children and adolescents who present with neuropsychiatric, psychosomatic, and psychiatric disorders complicated by a physical disorder.
The Scottish Centre for Autism

This centre offers an assessment and treatment programme to children who suffer from severe forms of autism.

Department of Clinical Psychology

This Department supports services in the main areas

- in acute paediatric teams and specialities for ill and disabled children attending the hospital
- in Community Child Health where an early intervention facility is available to GPs and child development centres by direct referral
- psychologists working within child and family psychiatry teams

Essential principles in services are an enhanced understanding of the whole child – physical, psychological and social health being indivisible throughout childhood and adolescence. Outreach and linkage with other service providers are vital components of the service.

Greater Glasgow Primary Care Trust

Adolescent Psychiatry Services

Specialist services to adolescents and their families are provided from age 12 through to 17 years of age. Those suffering from moderate or severe mental health disorders are seen at one of the four community bases, which offer assessment and treatment.

More complex or severe disorders requiring in-patient or day programmes are treated within the in-patient unit at Gartnavel Royal Hospital. This service is available for adolescents up to 16 years (but up to 17 if still in secondary education). This unit also provides an in-patient service on a regional basis i.e. West and Central Scotland.

The current budget is £1.3m.

Psychotherapy Resource Group

This is a shared resource which spans both the Child and Adolescent Psychiatry Directorates. It is a small group utilising a pooled expertise to offer consultation, limited assessment and treatment response to individuals for whom such treatment is indicated. Resource pressures in this speciality results in the service not being able to provide treatment for everyone who might benefit.

University of Glasgow Department of Child and Adolescent Psychiatry

The Department has 3 prime responsibilities: research, teaching and provision of a clinical service. It is responsible for taking a lead in research. Current themes include the neurobiological aspects of hyperactivity, psychological trauma and parent training. The main teaching responsibility is to the undergraduate curriculum. This Department has the only Chair in Child and Adolescent Psychiatry in Scotland. The position is currently vacant although efforts
to recruit suitable candidates are ongoing. An early appointment would assist in strengthening the links between academic research and clinical practice.

The clinical services span both child and adolescent mental health and provide a number of specialist, integrated services including the hyperkinetic clinic, psychological trauma consultation group and a neuropsychiatry clinic.

**Voluntary Organisations**

**Nôtre Dame Centre**

This centre provides therapeutic intervention for emotionally distressed children, young people and their families. Access to the service has been via GPs, health visitors and hospital clinicians although the referral mechanism is currently being reviewed.

Greater Glasgow Health Board currently invests £78k in this service resource. Additionally the centre is supported by a combined £200k investment annually from social work and education.

Other Agencies in the voluntary sector which contribute to care delivery within the Greater Glasgow Health Board area are Aberlour Trust, Barnardos, NCH, Children First and Sense.

**SERVICES TO CHILDREN AND FAMILIES OFFERED BY SOCIAL WORK AND EDUCATION DEPARTMENTS**

Many children and young people with mental health problems receive Social Work services. Special needs services are provided through

- child development centres;
- joint assessment teams in schools;
- needs assessment and record of needs;
- special needs registers;
- Children's Review and Children’s Hearings.

Education also provides services for special needs children and young people in particular

- within school support such as special educational needs auxiliary support;
- external support for schools from psychological services;
- day placements;
- residential placements;
- education provision in hospitals.

Both services offer support for children with significant emotional and behavioural difficulties in residential and day care environments.

It will be important to ensure that within the current initiative of developing full-service community schools issues related to mental health are given full consideration. Further discussion will be required with project leaders to ensure the most effective use of the mental health resources available.
CURRENT SERVICE DELIVERY

The current service provision involves active networking across both statutory and voluntary agencies. However, with recent social policy initiatives such as social inclusion, community schools and the provision of childcare, links between health, education and social work will become increasingly important. Statutory agencies are required to work within a legislative framework which encompasses the Children’s Act, the Mental Health Act, Social Work Act and the Education Act. It is vital that there is collaboration between agencies to achieve the best outcome of care for children and young people.

Other mainstream services are directly or indirectly involved in the care of children and young people e.g. child health services, primary care workers such as GPs, health visitors, accident and emergency services, schools, residential homes etc.

STRENGTHS OF CURRENT SERVICES

- High level of expertise and commitment within the specialist services.
- Devolved management structures offering flexibility.
- A well established core group of senior staff.
- A developing group of professions allied to medicine involved in care delivery.
- Success in recruiting experienced staff to the developing service.
- A strong ethos of education and training for staff supported by clinical supervision and performance development.
- Well developed inter-agency links with clinical services.
- An established joint commissioning group.

WEAKNESSES OF CURRENT SERVICE

There are a number of difficulties and concerns with current services and the processes for care delivery. The resources available for specialist mental health services are stretched to meet all the needs of the client group. The community teams in the city remain small and there continue to be gaps in both skills and clinical disciplines which constrain the service that can be provided. Inter-agency collaboration is put under pressure, particularly when agencies experience a diminution of their own resources. Frontline staff such as teachers, school nurses, health visitors and GPs often lack the skills and knowledge to effect early interventions for children and young people resulting in an increased demand on specialist services.

Specific pressures within current services can be grouped into 4 areas: lack of focus on early intervention; issues around the existence of specific and specialist services for some client groups; in-patient units, and training and development issues.

Early Intervention Gaps

- Clinical psychology clinics based in child health.
- Shared care models with GP’s, Health Visitors, and Community Child Health.
- Structured preventative work with health promotion colleagues.
- Clear understanding of referral protocols and the appropriateness of referrals to all agencies.
- Parenting initiatives with community staff.
Specific Service Gaps

- Limited resources within existing community teams.
- Provision of services for learning disabled children and young people.
- Provision of services for “looked after” children with mental health problems.
- Provision of specialist forensic child and young people’s psychiatric service.
- Limited liaison services, currently some paediatric provision at Yorkhill but no comprehensive service city-wide.
- No specialist day provision for young people with chronic/complex psychotic disorders.
- Reduction of direct Social Work support to each community team.
- Limitations within the University Department for support of teaching and research.
- Lack of clinical psychology support for the wider services.

In-patient Issues

- Closure of the Ladyfield In-patient unit in 2000, leaving Yorkhill as the only existing 7-day in-patient service in Scotland, this will no doubt result in an increase of referrals.
- It is also anticipated that the Adolescent Unit in Dumfries will close within the next 18 months causing similar problems for the In-patient Unit at Gartnavel Royal Hospital.
- Discussions on future provision for both child and adolescent services are ongoing within the West of Scotland General Manager’s forum to decide the way forward for the in-patient services.

Training and Development

- Failure to exploit fully opportunities for training and development, particularly on a joint agency basis.
- No development of joint protocols between agencies for referrals.
- Training and education for all service providers, especially in relation to shared care models.
- The provision of preventative work with health promotion colleagues.

SERVICE USERS AND CARERS PERSPECTIVES

Children and young people and their parents expressed the following views on the services:

- the in-patient and day programmes were rated highly;
- input from clinical staff was seen as helpful and supportive;
- the keyworker system was effective and welcome.

Areas for improvement were identified as:

- the need to improve facilities and physical environments;
- more one-to-one sessions with each young person;
- support for families and siblings;
- better recognition of the needs of parents as carers;
- an individual approach to the handover between children and adolescent services.
In particular, they sought a reduction in the need for hospitalisation and to lessen the effects of labelling through:

- a greater emphasis on primary prevention;
- a proactive strategy for health promotion;
- a broader provision of community services through innovations in schools and primary care;
- the development of home-based treatments;
- more support for parents dealing with children and young people with mental health problems.

FUTURE SERVICE DEVELOPMENT

The 4 tier service suggested by the HAS document, “Together We Stand” should form the basis for future commissioning of services.

*Figure 1:*

It is suggested that future development is steered by the Joint Commissioning Group already established to implement proposals from the Children’s Plan related to mental health incorporating the implementation of developments agreed within the Mental Health Framework into its work programme. A priority for the group is to establish a managed care network across health, social work and voluntary agencies that will enable a fully co-ordinated approach to care for those who access the services.
Developments and the actions required to improve services have been categorised within the Tier 1-4 structure rather than as a list of priorities. Developments in different tiers can happen simultaneously, and the detailed phasing of developments and their resourcing is set out in Chapter 12 Financial Framework. The approach to future investment priorities recognises the pressure currently experienced by specialist community teams and seeks to augment them as soon as possible. However, it also seeks to develop the wider range of services and support for children and young people and to promote early intervention in mental health problems, which may in turn reduce pressure on more specialist services.

**Tier 1**
- Facilitate multi-disciplinary training for frontline staff i.e. teachers, health visitors etc which increases awareness of problems, gives some basic strategies for handling, strategies for health promotion and information about more specialist services.
- Review the available literature on the treatment of conduct disorders and implement training programmes based on effective interventions for teachers, social workers and primary care workers.
- Develop a joint assessment tool for Tier 1 agencies as part of basic screening.
- Work with the school health service to develop an enhanced role in relation to the mental health of pupils.
- Participate in the development of mental health inputs to the new community schools
- Pilot the role of primary care resource worker in 2 LHCCs linked to community health teams for children and young people and the Primary Care Team. The rationale of this development would be to assist in the early identification of mental health problems. The worker would also provide advice, support and some therapeutic interventions for the client group at the “frontline” e.g. in schools, health centres, doctors’ surgeries.
- Review the literature on early intervention strategies to select and implement those recommended as most effective.

**Tier 2**
- Improve collaboration between agencies through “shared care” models of intervention linked to the keyworker principle.
- Enhance the provision of clinical psychologists for both children and young people for improvement of early interventions and targeting of vulnerable groups as well as community teams based on a robust service plan with phased implementation of additional resources.
- Formulate a service plan that will meet the needs of looked after children and their families and support education and training needs of staff.
- Develop, through the Joint Commissioning Group, a fully costed proposal for a range of multi-agency day care opportunities.

**Tier 3**
- Identify and cost the additional resources required by community teams and agree an implementation timetable within the resources available for the Mental Health Framework.
• Develop the concepts of a managed care network for children and young people’s mental health with all key players.
• Develop psychiatric liaison services for children and young people in the context of a review of service provision for adolescents within acute services.
• Formulate a plan for a multi-disciplinary service for children and young people with learning disabilities and mental health disorders.
• Link with the Drug Action Team to undertake a needs assessment to identify the extent of drug and alcohol misuse amongst children and young people and devise an effective service response.
• Undertake a planning exercise to assess the further resources required to develop an effective psychotherapy service.

Tier 4

• Develop a specialist service for children and young people with mental health problems who offend within the current Forensic Strategy.
• Identify the resources required to develop services for adolescents with autism and Aspergers Syndrome.
• Undertake a review of current resources within mental health services for eating disorders in order to develop during the Strategy period an improved service for children and young people.
• To assess the need for specialist mental health programmes offering highly specialised assessment and treatment.

Some associated developments need further consideration with adult services:

• further development of psychology and psychiatric services for “stressed” parents of severely ill children;
• services for parents with mental health problems that impact upon child development and family life.

Chair of Child and Family Psychiatry

The Academic Department of Child and Adolescent Psychiatry has a crucial role in providing professional leadership and in informing strategy with evidence from research. The Board will work closely with the University of Glasgow to ensure a successful appointment to the vacant Chair of Child and Adolescent Psychiatry. It is anticipated that there may be opportunities to share with the University the funding of academic staff to support the new professor.

Nôtre Dame

Discussions are underway between the NHS departments, GPs and Nôtre Dame on the most appropriate role for the Nôtre Dame Centre in the overall configuration of service. The Board will pilot a new approach to prioritising referrals to the Centre during 1999/2000 and will also progress discussions with the City Council Departments of Social Work and Education about joint commissioning of the service. In year one of the Strategy an additional £20,000 will be made available to Nôtre Dame to deal with priorities referrals.
Additionally, there is a need for a Scottish-wide debate on the strategy for specialist services for children and young people to ensure best use of the scarce available resources.

**PRIORITIES FOR DEVELOPMENT**

**1999/00**

- Develop the concept of a managed care network for all services.
- Enhance community teams in order to facilitate:
  - multi-disciplinary training for frontline staff;
  - work with the school health service to develop an enhanced role in respect of mental health;
  - participate in the development of mental health inputs into the new community schools.
- Resources to support training materials and to facilitate:
  - review of the literature on conduct disorders in order to support training programmes with effective strategies;
  - review of the literature on early intervention strategies to select the most effective for implementation.
- As a result of funding from the Mental Health Development Fund begin to implement proposals to meet the needs of “looked after” children and develop a more detailed service plan consistent with the overall Mental Health Strategy.
- Develop a joint assessment tool.
- Formulate a plan for a multi-disciplinary service for children and young people with learning disabilities and mental health problems.

**2000/01**

- Pilot the role of a primary care resource worker.
- Develop a costed proposal for a range of multi-agency day care opportunities.
- Link with the Drug Action Team to undertake a needs assessment to identify the extent of drug and alcohol misuse and devise an effective service response.
- Link with the Child Health Strategy to consider psychiatric liaison service developments for adolescents.
- Develop a specialist service for children and young people who offend within the current forensic strategy.
- During 2000/01 development work on the detail of establishing, as part of the overall implementation of the Strategy for Mentally Disordered Offenders, a service to meet the particular needs of young people with mental health problems who become involved in the Criminal Justice System.

Priorities have only been identified for years 1 and 2. Additional funding of £400,000 has been allocated to develop services for children and young people in these years. The priority in years one and two will be to enhance specialist community teams which will enhance the range of service availability and enable them to improve support to primary care. Further work in this period will take place to formulate plans for future service development in those areas where gaps have been identified. This will culminate in a proposal for a phased financial framework providing the resources to move to implementation. The prioritisation of issues in the later years of the framework will depend upon the continued ability to invest in service development.
CHAPTER 4: ADULT MENTAL HEALTH SERVICES

THIS CHAPTER

- describes current services and resources for adults with mental health problems;
- sets out user and carer views on adult services;
- highlights areas of concern with current service provision;
- sets out proposals for the future configuration of adult mental health services and priorities for action;
- describes current drug and alcohol services and future priorities;
- describes services for homeless people and future priorities;
- sets out the potential resource implications of the priorities identified for adult services, drug and alcohol services and services for homeless people.

INTRODUCTION

A wide range of services need to be in place to ensure good and high quality mental health and social care services for adults. This section sets out the current service components of services for adults with acute and seriously enduring mental health problems and mental health services for people with drug and alcohol problems, people who are homeless and the changes that need to be implemented to improve service delivery.

CURRENT SERVICES

Over the last five years, the Board has commissioned 12 adult Community Mental Health Teams (CMHTs) (covering 85% of the population) to support in-patient and continuing care services. These Teams have been developed in a phased way over this period with a remit to target services at people who have:

- severe and enduring mental illness;
- acute distress as a result of mental health problems;
- significant impairment in level of functioning due to a mental health problem.

CMHTs should provide a range of clinical services, functional support and recreational opportunities to people who are mentally ill within a defined locality.

As well as CMHTs, five day hospitals for adults with mental health problems provide support, treatment and a continuity of care between hospital discharge and community care.

In addition to the network of community mental health services, there are 665 adult mental health in-patient beds available across Greater Glasgow. A breakdown of beds by function is shown below:
Adult mental health in-patient beds are provided on 7 hospital sites as set out below:

In the continuum of care acute in-patient beds provide a high level of intensive intervention and support to people experiencing severe breakdown and disturbance. Acute in-patient treatment provides a protective environment for people who pose a significant risk to themselves or others. They provide:

- stabilisation of patient illness;
- intensive and skilled treatment and investigation;
- sanctuary for vulnerable patients;
- crisis respite.

Acute beds should be used to treat people too severely ill to be managed in a less supportive setting and who need intensive medical and nursing support, usually for a limited period of time.
SOCIAL CARE SERVICES

Social Work and Housing departments contribute significantly to supporting people with mental health problems in both community and hospital based settings. This is done directly or by commissioning and arranging for appropriate services to be provided by a wide range of voluntary and independent organisations.

Social Work departments provide directly an assessment and care management service by staff located in a range of settings.

- Social Work Department Area Teams;
- Hospitals (Assessment);
- Community Mental Health Resource Centres; and,
- Specialist Projects.

Services provided directly by Social Work departments can be accessed in a wide range of settings - hospital units, community mental health resource centres, child and adolescent psychiatry units, court and prison units, local area teams, health centres and project bases. They include a range of services to meet statutory actions under mental health and community care legislation, services to support providers develop new services, inspection and registration services, services to support service users/carers and communities. These are more fully described in Chapter 10 and include access to an out of hours service through Social Work Standby which has a Freephone number. In particular, Social Work has been active successfully completing the resettlement programmes for Gartloch and Woodilee hospitals through commissioning 90 supported accommodation places attracting £2 million capital from Scottish Homes and developing home support and day services, including a number of Clubhouse projects.

The main provider of social care services in mental health, however, is the voluntary sector with around 75% of services commissioned by local authorities.

Mental Health Officers (specially trained social workers) will provide the statutory responses by providing a range of reports, both in relation to hospital detention and in relation to community based orders such as Guardianship and Community Care Orders for the small but growing number of individuals who require this.

RESOURCES

A total of £51 million is spent by health and local authorities on adult mental health services. The split between health and local authority spend for adults with mental health problems in 1997/98 is set out below.

*Figure 4: Split between Health and Local Authority Spend for Adults with Mental Health Problems*
Of the £37.9 million spent on adult mental health services, two-thirds or £25.5 million, was spent on hospital in-patient services. A profile of the NHS spend on adult mental health services is set out below:

**Figure 5: NHS Adult Mental Health Spend**

The Social Work spend on mental health is set out below:

**Figure 6: Social Work Spend on Mental Health**

**SERVICE USERS AND CARERS PERSPECTIVES**

The needs of mental health users and their carers are well documented. The stakeholders events organised as part of the development of the Joint Strategy and a number of specific user events raised the following issues for adult mental health services:
• the need for easily accessible and responsive crisis services to be available 24 hours a day;
• improved care management and co-ordination between professional staff and between agencies;
• increased user and carer involvement in service planning, development and review;
• improved information on the nature of the mental illness and the side effects of any prescribed medication;
• the need for increased availability of psychological or talking therapies;
• the development of an enhanced range of local services to reduce the need for admission to hospital;
• the availability of more sensitive and responsive services for women and people from ethnic minority backgrounds;
• the need for more respite care facilities

Local authority consultation on Community Care Plans for 1998-2001 also raised these concerns along with:

• the impact of poor housing and environments on mental health;
• the need to develop employment opportunities and/or day services/opportunities;
• the need to have effective rehabilitation services;
• the need to address stigma by campaigns/projects in schools and through influencing the media.

PROBLEMS AND ISSUES FOR CURRENT SERVICES

Whilst the network of mental health services for adults has developed significantly from the traditional model of in-patient, out-patient and day hospital services, nevertheless, there are still gaps in the range of services/interventions available to care for and support people with mental health problems in their own homes and in their communities.

The following issues have emerged during the preparation of the Strategy:

• easily accessible “out of hours” crisis services and the lack of integration of crisis services between agencies with day-time services;
• absence of intermediate services between community health and acute in-patient services;
• lack of consistency in the services available and approaches across CMHTs;
• co-ordination of care is not always well integrated across disciplines and agencies;
• support for GPs and primary care needs to be strengthened;
• absence of specialist services for people with particular needs, including people with Korsakoff’s, women with post-natal depression and people with serious eating disorders;
• patient mix in in-patient facilities, including mixed sex wards;
• increasing levels of co-morbidity between mental illness and drug and alcohol problems;
• the management of people with personality disorders.

TIERS OF SERVICE

The hierarchy of tiered responses for the identification, assessment and management of adults with mental health problems in a single care continuum is set out in the Figure 7 below:
The future pattern of services for adults with mental health problems will be based on consistent standards and the delivery of core components. These will be based on a clear structure of service responses forming a care continuum reflecting agreed care pathways and treatment protocols.

PRIORITIES FOR FUTURE ACTION

i) Primary Care

The Joint Strategy recognises the central importance of GPs and primary care in preliminary diagnosis and treatment of many of the individuals with mental health problems in the community. Consistent support to primary from secondary care is, therefore, an important priority for the Strategy.

It is proposed that during the first year of implementation of the Joint Strategy that:

- each CMHT should identify liaison staff to work with GPs in their local area;
- local referral criteria, care pathways and shared care protocols for the management of and treatment of psychiatric illnesses should be agreed;
- supervised specialist counselling and advice services be available within primary care;
- processes to ensure the identification of people within GP practices with serious mental health problems and appropriate sharing information between agencies involved in their care.
The advent of the Primary Care Trust presents an excellent opportunity to look at the development of primary care mental health services for individuals who have mental health problems which are not categorised as severe and enduring.

ii) Community Mental Health Teams (CMHTs)

CMHTs involving health and social work services will be the focal point for the care of people with severe and enduring mental health problems within a locality. There is an imperative to complete the network of adult community mental health teams and it is proposed to do this during 1999/2000 by commissioning four new teams to cover:

- Drumchapel/Bearsden;
- Pollok/Darnley;
- Castlemilk/King’s Park;
- Pollokshaws/Shawlands.

It is important that CMHTs deliver consistent standards of service. In order to ensure this during 1999/2000 a number of pieces of development work will be carried out. This will include:

- specification of the core functions to be delivered by CMHTs;
- agreeing the relationship between CMHTs and social work and housing services;
- ensuring the development of consistent links between CMHTs and primary care;
- developing information systems for the identification of seriously mentally ill people within localities;
- agreeing a protocol with clinicians on roles and responsibilities for patients with drug and alcohol problems;
- agreeing and implementing a protocol for assertive outreach to ensure consistent follow-up to people who have difficulties engaging with services.

In addition, it is expected that during 1999/2000 CMHTs should assume responsibility for management of acute in-patient beds and manage bed availability. Linking CMHTs with acute in-patient services will be important in creating a continuum between community based and in-patient services with rotational staff deployment between in-patients in community based services.

A core function of CMHTs will involve close liaison with housing agencies to access, support and maintain people with mental health problems in their own tenancies and housing. In addition, teams will provide input into social care supported accommodation projects to ensure effective and integrated care with care and housing providers.

iii) Crisis Services

A critical component of a comprehensive mental health service is the provision of easily accessible crisis/out of hours services. Such services need to be available to all people with mental health problems from children and young people to elderly people, including those with dementia.

People in crisis are currently dealt with by mainstream Mental Health and Social Work services during “office hours”. Social Work Standby deal with many emergencies out
of hours. Out of hours mental health nursing staff rotate to provide an on-call rota. This responds only to people known to CMHTs, although a recent pilot in one area linking with the Glasgow Emergency Medical Services (GEMS) opened referrals to anyone assessed by the GEMS service and felt to be in need of a psychiatric response. In 1997/98 a total of 271 people used the Trust’s crisis services. It is frequently stated by users and carers that the way in which current out of hours services are organised inhibits many people from accessing and using the services. Current service usage may not, therefore, be considered as an accurate reflection of need.

A central component of a comprehensive mental health service is the provision of a 24 hour, 7 day a week community based crisis response service. The crisis services needs to cover all people with mental health crisis, including people with dementia and young people.

During 1999/2000 we will deliver crisis services which include:

- Referral to the services will be open with well-defined links to social work standby and the GEMS service to ensure the crisis is dealt with comprehensively and rapidly.
- A single referral/contact telephone number.
- Procedures for rapid, next day follow-up by CMHTs, if appropriate.
- Information regarding access to the service and service standards, including response times, should be clearly stated and widely publicised.
- Community services will provide a consistent service to deal with crisis and emergencies between 9.00 am and 9.00 pm.
- A dedicated team covering the Greater Glasgow area will operate for out of hours crisis and emergencies. The team will comprise multi-professional and agency staff able to access a range of services.

An important function of the crisis service is to minimise the need for hospital admission. During the first year of operation of the new crisis arrangements a review of the effectiveness of the service will be conducted. On the basis of this review, recommendations on the further development and the extension of crisis services will be made.

iv) Services for People with Personality Disorders

There is a need for the agencies involved in planning and delivering mental health services to agree a consistent service response for people with personality disorders. It is known that the Scottish Office is establishing a Working Group to look at issues surrounding the care of people with personality disorders as part of the development work on the national strategy on Care for Mentally Disordered Offenders.

In the interim, a local short-life working group has been established to develop a protocol clarifying roles and responsibilities for professional staff and agencies in the care of people with personality disorders. This will guide future local service response for this group of individuals who currently fall between individual agencies.

v) Day Services

Day services and support are an integral part of a comprehensive mental health network. Four types of day services need to be in place. These are:
• **Treatment/Rehabilitation Services** provided in day hospitals with therapy and rehabilitation for acutely ill and seriously disturbed clients with attendance being time limited. In addition, a limited number of day hospital places will be available for individuals with longer term needs.

• **Occupational/Training Services** including services to support/maintain people with mental health problems back into employment with close links to rehabilitation services and with the education sector.

• **Support Groups and Social Activities** of mental health users providing leisure and social activities in each locality. An important element in this type of day provision is the provision of creative arts activity/therapy and the availability of complementary therapies for mental health users.

• **Day Care** for adults requiring longer term support. This will be provided as part of social care provision with health input from locality based community mental health teams, following consultation with the client’s GP.

During year one of the Strategy, day hospitals and services will be reviewed to ensure that this range of day services are available in an equitable manner across Greater Glasgow.

**vi) Future Configuration of In-patient Services**

A major review of the future level of adult in-patient services and the number of sites is being carried out with a view to preparing a detailed consultation paper by late summer 1999. Future in-patient services should reflect a split between the north and the south of the river with IPCU, acute admission and rehabilitation services serving each area:

The review of adult mental health in-patient services will take into account a number of factors:

• balance of care between health and social care and relative investment between these components;
• the current spread of in-patient services across a multiplicity of sites;
• the link between community mental health teams and in-patient services;
• the development of enhanced community facilities, eg, crisis houses, to prevent hospitalisation;
• the inappropriate patient mix in a number of current services;
• the need to introduce smaller ward sizes;
• the need to improve facilities for women with, particularly post-natal depression and their child;
• provision for a number of specialist services, including eating disorders and people with acute drug/alcohol abuse;
• the requirement for more community based active and effective rehabilitation;
• the poor and unsatisfactory accommodation currently available on a number of sites, eg, Southern General Hospital and Parkhead Hospital.

An important component of the review will involve the issues around the quality of acute in-patient care and therapeutic interventions arising out of the recent Sainsbury Centre Report “Acute Problems” (1998). It is known that current in-patient services are under considerable staffing pressure with high levels of observation and limited therapeutic interventions. These issues need to be given a high priority in the in-
patient review and proposals to increase active therapy and rehabilitation in wards developed

The review will consider the possibility of developing a number of alternatives to admission and that these services may reduce the need for in-patient beds over time. The review, however, will maintain a focus on shifting the balance of care from institutional to flexible home care and community-based services.

vii) Liaison Psychiatry

A key component of a comprehensive mental health service involves liaison psychiatry. This consists of services for people who have a mental health problem along with a co-existing physical illness who present to a general hospital. This includes people who self-harm.

Current Services

At present this element of service is not consistently developed across Greater Glasgow. In East Glasgow, a liaison and parasuicide assessment service has been developed to support the Glasgow Royal Infirmary, whilst a nurse-led parasuicide assessment service has been developed for North Glasgow around Stobhill. There is a limited medical and nursing parasuicide and liaison service at the Victoria Infirmary and Southern General hospitals in South Glasgow, whilst there is virtually no specialist Consultant service for West and North Glasgow. A recent pilot of attaching CPNs to A&E departments at both the GRI and the Western Infirmary proved successful in providing a psychiatric assessment to vulnerable individuals presenting through A&E.

Future Service Requirements

The need to develop a consistent liaison psychiatric service into acute hospitals is recognised. This service should:

- provide a rapid psychiatric assessment to patients in A&E departments, in wards and in out-patient clinics;
- provide advice and support to ward nursing and medical staff in the recognition of mental health problems in patients;
- support medical services in the detection and management of alcohol problems;
- provide training and support to general trained nurses and junior medical staff to manage less complex mental health conditions.

Future Service Provision

During the course of the Mental Health Strategy, liaison psychiatric services will be developed on the basis of the following approaches:

- provision of a Consultant psychiatric and psychological liaison service into general wards and specialist clinical areas, including cardiac, neurological rehabilitation, gastrointestinal disorders, oncology and plastic surgery;
- the attachment of CPNs to A&E departments to provide psychiatric assessments;
• the development of a specialist role in parasuicide assessment amongst a number of CPNs within CMHTs linked to acute hospitals and led by Consultant Psychiatrists.

During 1999/2000 the above approaches will be developed into a detailed implementation plan consistent with the overall financial framework. This review will also address the needs of mental health patients who require input from acute services whilst in mental health hospitals.

viii) Anti-Psychotic Drugs

Recent developments in anti-psychotic drug therapies offer significant improvements both in terms of outcomes and reduction of side effects. The development of Clozapine for resistant schizophrenia and newer atypical neuroleptics following approvals from the Board’s Drug and Therapeutic Committee are being introduced on the basis of agreed protocols. A Drugs in Psychiatry Strategy Group has been set up between the Board and the Trust to co-ordinate and oversee the introduction of newer drug therapies and to ensure consistent application in line with strategic developments and the overall mental health financial framework.

ix) Supported Accommodation

There is a current imbalance in supported accommodation across Greater Glasgow reflecting the development of social care services arising out of the Gartloch and Woodilee hospital closure programmes in the North and East sectors.

In order to establish equity of provision in supported accommodation provision it is proposed:

• to carry out an audit of existing supported accommodation projects addressing balance of care issues across GGHB;
• to develop an Accommodation Strategy in conjunction with the review of in-patient services;
• to develop in the interim a further 50 supported accommodation places targeted towards areas where current shortages have been identified.

SERVICES FOR WOMEN

A number of major issues need to be addressed in respect of mental health services for women.

Post-Natal Depression (PND)

It is estimated that post-natal depression can affect up to 26% of women in Greater Glasgow. If left undiagnosed and untreated the condition may persist for a long period, whereas with proper treatment it can be reduced to around 6 weeks.

To provide a dedicated service for women with PND the following is required:

• a multi-disciplinary team including midwives, members of the primary health care team and mental health staff. In addition, staff from social work and the voluntary organisations provide counselling for women during the postpartum period and beyond;
• post-natal support groups should be provided across the city by health visitors working in conjunction with CPNs;
• a community, day patient and in-patient psychiatric service is required for the 300-500 women requiring care in the community and the 40 women requiring in-patient services. A 4 bedded unit with a nursery area, a day area, a kitchen area, a separate laundry and toilet facilities should be developed.

As 10% of women in the post partum period develop a major depressive illness a full range of psychiatric care needs to be targeted to this group. An integrated care pathway involving all levels of mental health services from primary care through community support to acute in-patient care with provision for the baby, based on auditable standards will be developed in 1999/2000 as part of the clinical effectiveness agenda.

**Violence Against Women**

During 1999/2000 with Mental Health Development funding a detailed review of current service responses for victims of domestic violence, an assessment of health needs and the development of effective mental health service responses for this vulnerable group will be carried out. It is estimated that around 30,000 women in Greater Glasgow may experience domestic violence in any year and over 100,000 at some point during their lives.

In addition, many women have been the victims of sexual abuse during childhood which is linked with depression, anxiety, eating disorders and sexual dysfunction in adulthood.

In order to build on work already undertaken by a Women’s Health Policy Working Group it is proposed that a strategic approach to future service provision for women who suffer from domestic violence and/or have been subject to sexual abuse be developed. This should involve a broad range of service providers from primary care, acute services, mental health and social work.

**Eating Disorders**

Eating disorders, particularly amongst young women, are associated with considerable morbidity and mortality and at present there is no dedicated service in Greater Glasgow. The Board currently spends around £400,000 on external referrals for patients with eating disorders requiring in-patient care.

It is proposed to develop a local service involving community based support in addition to dedicated in-patient provision during the period of the Strategy. In addition to the current ECR expenditure, £350,000 has been identified to develop this service by the end of the Strategy. Discussions will also be pursued with other West of Scotland health boards to ascertain the feasibility of developing such a service on a West of Scotland basis.

**ALCOHOL AND DRUG SERVICES**

The co-existence of substance misuse and mental illness is now one of the commonest challenges faced by mental health, social care, criminal justice and housing services. The successful treatment of severe Alcohol or Drug Dependence and its attendant health and social problems, required careful multi-agency assessment and appropriate and effective use of a range of forms of treatment and support.
Current Services

i) Primary Care and General Hospitals

For a large number of people with substance misuse the sole or main point of contact will be the GP. GPs refer patients with significant substance misuse problems to specialist clinical services. Acutely disturbed patients may first present in A&E departments. Patients with alcohol related brain damage may be admitted and first diagnosed in general hospital wards.

ii) Mental Health Services

Community Mental Health Teams and hospital based services encounter a high proportion of patients whose mental health problems involve substance misuse. This patient group access significant number of general psychiatric hospital beds - 562 admissions in 1998.

iii) Specialist Clinical Services

The Alcohol and Drug Directorate in the Primary Care Trust has four consultant-led teams based in the north, east, south-east and south-west sectors. There are significant differences in the types of service model and the balance between alcohol and other drug work in the four teams. Addiction psychiatry services are coterminous with general adult psychiatry and accept referrals from primary care, acute services, general adult psychiatry and other psychiatric disciplines including forensic psychiatry.

During 1998/99 the Directorate’s workload was:

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Out-patients</th>
<th>Day-patients</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>432 (Alcohol)</td>
<td>1446</td>
<td>1569</td>
<td>2396</td>
</tr>
<tr>
<td>44 (Substance Misuse)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Due to limited resources Addiction Psychiatry provides a more comprehensive service for alcohol related problems. In relation to non-alcohol related substance misuse, a specific service is provided for assessment, detoxification (opiate and non-opiate) and treatment of co-morbidity, where this follows primary substance abuse.

The Glasgow Drug Problem Service in the Community and Mental Health Services NHS Trust started in 1994. It accepts referrals from GPs of opiate dependent patients. Assessment by a medical and nursing team often leads to initiation of prescribed methadone which is usually continued by the GP once stabilisation is achieved. The service currently sees around 1500 referrals per year.

iv) Specialist Social Care Services

Community based addiction services: Local authorities operate a range of services providing practical advice and support for people with drug or alcohol problems. In Glasgow City 12 Social work projects supported 3,700 in 1997/98 with around 1,000 being supported in shared care with the GP Drug Misuse Clinic Scheme.

Residential services: A number of residential units offer a range of rehabilitation programmes for people with severe dependency on alcohol or other drugs. These
include Phoenix House, Red Tower, Victoria View, Rainbow House and Castle Craig. Two establishments managed by the Aberlour Trust provide support to women and children.

_Glasgow Drug Crisis Centre:_ This service provides round-the-clock walk-in access and a 12-bedded residential unit for drug users in crisis, many of whom present with mental health disturbance.

_Alcohol-related brain damage (ARBD):_ The Community and Mental Health Services NHS Trust currently has around 60 beds occupied by patients with ARBD, accommodated in a wide variety of ward settings. There are three nursing homes outwith Glasgow City registered to take people with Korsakoff’s psychosis. Four other nursing homes have one place each. Some people with ARBD live in hostels and other residential homes or supported accommodation.

There are a number of issues relating to current service provision, including:

- a dispersed clinical service over 10 sites;
- the increasing prevalence of co-morbidity involving alcohol or drug misuse and serious mental illness;
- the reluctance of many Primary Care, Generic Mental Health Services and Social Care Services to work with people with substance misuse problems;
- the challenging behaviour and disruption to general services often occasioned by people with substance misuse problems;
- the absence of a consistent response to the mental health problems for substance abusers across GGHB.

**Future Service Provision**

It will be important in developing future mental health services for people who have drug problems to ensure a consistent and co-ordinated approach with parallel work being developed under the auspices of the Drug Action Team Strategy. This will include agreeing funding between the mental health and drug services for the development of enhanced treatment and support for people with co-morbidity.

There is a need to rationalise in-patient and day patient services on a hospital based site and to merge existing health service resources to establish two community based Alcohol and Drug teams linking with existing social work services and specialist services in the voluntary and independent sector.

The main functions of the teams would be:

- assessment and management of severe alcohol or drug dependence;
- assessment and management of alcohol or drug related co-morbidity;
- assessment and management of alcohol related brain damage;
- partnership with the Glasgow Drug Problem Service and liaison with the Glasgow Drug Crisis Centre and Link-up;
- liaison with Prison Services, the Police, Homeless Mental Health Team, the Forensic Directorate in the management of mentally disordered offenders and homeless people with substance misuse problems;
- liaison with primary care, general psychiatry and general hospitals, social work and voluntary agencies to develop agreed protocols;
- agreement of models of care with performance management targets;
• develop specialist ongoing training for Directorate staff;
• provision of appropriate ongoing training aimed at improving the attitudes and knowledge of non-specialist mental health staff in relation to substance misuse problems;
• encouragement of ongoing service evaluation and high quality research;
• development of computerised patient information systems that facilitate individual patient care and yield useful process and outcome data.

The needs of young drug misusers have been recognised by the Joint Strategy Group for Children and Young People, including increasing difficulties in residential children’s services. A needs assessment on this set of problems will be carried out to inform future service developments.

Pressure on acute mental health in-patient beds as a result of admissions of individuals who have a dual diagnosis of mental illness and drug or alcohol misuse is becoming more pronounced. The need to develop enhanced in-patient services for this group during the strategic period is recognised and as an interim pending the final review of in-patient services £420,000 has been allocated to redress these pressures.

It is important that joint working arrangements to include clear protocols are developed between specialist drug and alcohol services and general mental health services, including social work and voluntary sector providers.

Future service provision for people with alcohol related brain damage is described in Chapter 8b on Services for Younger People with Dementia.

HOMELESSNESS AND MENTAL HEALTH

People become homeless for a variety of reasons which are often linked. These may include the breakdown of family or other relationships, unemployment or violence. Mental health problems including severe alcohol or drug dependence are common. In addition, the state of homelessness itself can have a negative effect on mental health, causing depression and anxiety and potentially worsening pre-existing mental health problems. Addressing mental health problems can be a critical factor in enabling a homeless person to recover from their predicament. On the other hand, being homeless can make it more difficult to access both specialist mental health services and agencies able to address other problems. Two key principles of service provision for the homeless are therefore:

• enabling access to services;
• taking a comprehensive approach.

Current Services

CPN Hostel Service
The Trust provide a community psychiatric nursing service to mentally ill clients in all hostels across Glasgow. This has 3 qualified RMHs and 3 health support workers. They liaise with a consultant psychiatrist with a specialist homeless remit for one and a half days per week.

Drug and Alcohol Problems
Homeless people with drug problems can access the Drug Crisis Centre where general medical and nursing care is provided but specialist psychiatric input is currently not available. Some people with alcohol problems may be referred to an addiction psychiatrist through the CPN Hostel Service.
Primary Care Services
Dedicated primary care services are provided by the CMHS NHS Trust in conjunction with the City Mission and CCI and by GP practices in conjunction with the Talbot Association. The extent to which these services can address problems is variable but usually limited.

Social Care Services
A wide range of support services for homeless people is provided by Glasgow City Council and several independent agencies. During 1998 a large number of short-term projects have been initiated under the Rough Sleeping Initiative. Mental health services generally refer homeless people with complex substance misuse problems to the relevant sector service. The Link-up Project is a city centre service currently being established by Turning Point providing short-term accommodation for disturbed homeless people, many of whom will have chronic alcohol dependency and alcohol related brain injury. The social work homeless team has close links with the social work addictions service.

FUTURE SERVICE PROVISION
- There is a need for mental health services to link more closely with a range of initiatives for homeless people, particularly the Rough Sleepers Initiative.
- There is current uncertainty about the level of unmet need among homeless people with mental health problems.
- There is an apparent rise in the proportion of homeless people in Greater Glasgow with severe drug dependency particularly among young single homeless.
- There is a lack of service provision for the assessment and subsequent management of homeless people with drug alcohol dependency of co-existing alcohol or drug abuse and mental ill health.
- There is concern that people with mental health problems are being discharged from prisons or hospitals into hostels without adequate liaison.

This suggests the following priorities for action:
- Complete a survey of mental and physical health problems among homeless people with support from the Mental Health Development Fund.
- Establish links between the Drugs and Alcohol Directorate and the Drug Crisis Centre, the Turning Point Link-up Project, the CPN hostel service and the Social Work Homeless Team.
- Develop primary care provision to hostels provided by GPS to manage mental health problems including drug and alcohol dependency.
- Review discharge arrangements from hospitals and prisons to ensure co-ordinated care is available to people discharged to hostels.
- Agree a development programme to enhance mental health support to homeless persons with other agencies involved in the Rough Sleepers and other initiatives.

RESOURCE IMPLICATIONS
A number of priorities for investment in adult mental health services during the period of the Strategy have been identified:
- complete the network of Community Mental Health Teams;
- increased supported accommodation;
- increase in Employment/Training schemes;
- develop assertive outreach;
- improved crisis services;
increased support to primary care;

- enhance day services and opportunities;
- create a number of specialist in-patient units targeted towards women with post-natal depression and people with a dual diagnosis involving mental illness and drug/alcohol problems;
- increase staffing levels on wards;
- social care including respite care and care management;
- develop Community Drug and Alcohol Teams and more effective links between CMHTs and specialist drug/alcohol services;
- improve co-ordination of services for homeless people with mental health problems.

The notional costs for the identified priorities are as follows:

<table>
<thead>
<tr>
<th>Proposed Development</th>
<th>Total £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Network CMHTs (4 Teams)</td>
<td>1400</td>
</tr>
<tr>
<td>Improved Crisis Services</td>
<td>270</td>
</tr>
<tr>
<td>Enhanced/Specialist In-patient Units</td>
<td></td>
</tr>
<tr>
<td>Post-natal (4 beds)</td>
<td>580</td>
</tr>
<tr>
<td>Alcohol/drug (20 beds)</td>
<td></td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td>200</td>
</tr>
<tr>
<td>Supported Accommodation (50 places)</td>
<td>1500</td>
</tr>
<tr>
<td>(including CET)</td>
<td></td>
</tr>
<tr>
<td>Respite Care (8 places)</td>
<td>200</td>
</tr>
<tr>
<td>Day Services/Employment Services</td>
<td>500</td>
</tr>
<tr>
<td>Home Support/Day Care</td>
<td>250</td>
</tr>
<tr>
<td>Drug and Alcohol Teams</td>
<td>800</td>
</tr>
<tr>
<td><strong>Resource Requirement</strong></td>
<td><strong>5700</strong></td>
</tr>
<tr>
<td>Realignment of Existing Community Services</td>
<td>(800)</td>
</tr>
<tr>
<td><strong>Total Resource Requirement</strong></td>
<td><strong>4900</strong></td>
</tr>
</tbody>
</table>

The enhanced network of services for adults with mental health problems has a potential additional cost of £5.7 million. It is expected that around £800,000 will be available from reconfiguring existing community mental health services including day hospitals. This leaves a balance of £4.9 million to meet recurrently. The detail of these costs and phasing is set out in Chapter 12 on the Financial Framework. As the Strategy is developed it will be important to link developments to a range of potential funding sources, including Social Inclusion Partnerships, the Drug Action Team Strategy, the Rough Sleepers and other Homeless initiatives.
CHAPTER 5: SERVICES FOR MENTALLY DISORDERED OFFENDERS

THIS CHAPTER

• describes current services and resources allocated to mentally disordered offenders;
• identifies problems and issues resulting from current services;
• sets out the future strategic direction for services for offenders;
• describes the future structures of service provision;
• sets out the priorities for implementation and resource implications.

CURRENT SERVICES AND RESOURCES

During 1998 the Scottish Office consulted on Health, Social Work and Related Services for Mentally Disordered and published a policy document on these services in January 1999. This policy aims to ensure the co-ordination of care and support for the benefit of the individual and to ensure public safety.

In a similar vein, in December 1997 the Board adopted a Strategy on the Development of Services for Offenders with Mental Health Problems and/or Learning Disabilities which is consistent with the national policy. The Strategy was developed and is being implemented by a multi-agency Steering Group with the key objective of ensuring balance between the individual needs of offenders and public safety.

Health care for mentally disordered offenders is provided mainly by the Community and Mental Health Services NHS Trust and the State Hospital, Carstairs. Social care and support are provided by the community care and criminal justice services of the Social Work Departments of the six local authorities in the Greater Glasgow area.

The current health services are based on the following configuration:

The State Hospital, Carstairs, accommodates MDOs who are considered needing high levels of security. At present, there are 80 Greater Glasgow residents in the State Hospital.

The Clinical Directorate of Forensic Services provides a range of specialist services to the prisons and courts. Out-patient assessment and treatment is provided for patients with long-term problems. In 1997/98, over 350 people received out-patient services. Specialist advice and support is given to general psychiatrists treating mentally disordered offenders.

In-patient services are currently provided in general psychiatric, intensive psychiatric wards, and acute in-patient beds, or in a specialist interim unit for long-stay patients at Leverndale Hospital.

Offenders with learning disabilities are supported in the community by Community Learning Disability Teams. On the Lennox Castle site there are two units for people requiring close supervision providing nine places.

A small number of Greater Glasgow residents are transferred to out of Health Board placements through Extra Contractual Referrals. In 1997/98, a total of £400,000 was spent on ECRs for MDOs.
The social work criminal justice services of all the local authorities work closely with mentally disordered offenders with the aim of preventing reoffending through supervision and support. In addition, social services provide appropriate accommodation and support for those able to live in the community and assistance in addressing financial, legal, marital, child care and other problems.

In the City of Glasgow a number of specialist social care services are also in place. The Access Project is an initiative to help people with mental disorder who come into contact with the police and provide diversion, assessment and consultancy. The Turnaround Project is a recently funded initiative designed to assist female offenders with serious drug problems to be diverted from custody into appropriate treatment where possible and to be given improved access to treatment in Cornton Vale Prison if a custodial sentence is required. The Open Door initiative at Barlinnie Prison, through individual counselling and client support groups, assists prisoners with current difficulties both within and outside the prison whilst they serve their term of imprisonment. It is designed to prepare mentally disordered prisoners for their return into the community and thus aid prevention of their re-entry into the criminal justice system.

Glasgow City Council has recently committed £60,000 to improve staffing in bail hostels and bail supported accommodation to enable placement of higher needs residents in these facilities who have a criminal justice background, some of whom may also have mental health problems. Community psychiatric nurses and community learning disability nurses work with social workers to provide the appropriate support and treatment for individuals on bail.

The spend on services for offenders is presented in Figure 1 below.

*Figure 1: Current Expenditure on Services for Mentally Disordered Offenders*

![Figure 1](image)

**ISSUES**

As the Board’s Strategy for Offenders recognised, current services are under major pressure and are not adequate to meet the levels of need. The major areas of concern are:

- the absence of suitable, local in-patient services both in terms of medium secure beds and accommodation for people with longer term needs;
- the frequent inability to resettle patients in appropriate accommodation in Greater Glasgow from the State Hospital resulting in patient entrapment;
- direct discharges from the State Hospital to the community;
• increasing pressure within the criminal justice system with significant numbers of MDOs in police custody, courts and persons requiring early diversion or specialist services;
• dual diagnosis issues surrounding co-morbidity with drug/alcohol misuse;
• appropriate services for people with major behavioural disturbances and/or personality disorders;
• shortage of suitable housing/accommodation for MDOs in the community;
• lack of co-ordinated community support and systems to support MDOs in the community;
• absence of services for adolescent offenders;
• lack of common client data systems;
• lack of clarity around potential resource release from the State Hospital to local services as and when State Hospital places reduce.

FUTURE SERVICES

The Strategy for MDOs adopted by the Board is consistent with the recent Scottish Office Consultation on Services for Mentally Disordered Offenders (January 1999). The principles for developing the Greater Glasgow service follow this and the earlier Reed Report of 1992, emphasising that mentally disordered offenders should be dealt with:

• proper attention to quality of care and the needs of individuals;
• as far as possible in the community rather than in institutional settings;
• under conditions of no greater security than is justified by the degree of danger they present to themselves and others;
• in such a way as to maximise rehabilitation as near as possible to their own homes and families.

In pursuing these principles the Strategy highlights the following:

• that the service is jointly planned and commissioned;
• the importance of diverting appropriate offenders from criminal justice to health and social work services as early as possible;
• the need for commissioning agencies to ensure the network of health and social care services to respond to the needs of offenders and to ensure services for the resettlement of patients from the State Hospital as appropriate;
• specialist services are well-integrated with general mental health services
• underpinning care arrangements through the Care Programme Approach and the recognition at all stages of the need to ensure the highest possible levels of public safety.

This represents a profound change for care of mentally disordered offenders. The emphasis on the need to develop integrated processes across the range of agencies involved in the care of mentally disordered offenders will be a priority. This “whole system” approach to mentally disordered offenders will have implications on service provision and resources. In addition, the attitudinal and cultural changes required are not minimised and effective and multi-agency training programmes will be key to ensuring effective implementation. The configuration of services set out envisages four tiers of service provision represented in diagrammatic form below:
Figure 2:

i) Patients requiring specialist care in the high security setting offered by the State Hospital.

ii) Mentally disordered offenders who require care/treatment in a local medium secure unit. The Board is currently working with the Greater Glasgow Primary Care Trust to commission a 32-bed unit for people with mental health illness and four beds for those with learning disabilities.

iii) Services for offenders requiring low levels of security on a long-term basis. This accommodation will be available through a combination of NHS in-patient facilities and accommodation with support in the community. Forty in-patient residential places will be available for long-term care with capacity for between 15 to 18 new supported residential places commissioned in the community.

The special needs of young men and women and people from ethnic minority groups are recognised. Within the secure accommodation being commissioned, suitable and separate accommodation for women will be available. The needs of young people with mental health problems who come into contact with the criminal justice system will also be a focus for services. Accommodation and follow-up services tailored to the needs of young people will be included in service design.

It is the intention to develop the proposed in-patient services for offenders requiring medium security and for those requiring lower levels of security on a single site. The two components of in-patient services will be differentiated by internal design.

iv) Mentally disordered offenders requiring care in the community. A multi-agency outreach team will be established to ensure effective care management and supervision. Specialist services to promote diversion from police custody, the courts and prisons will form part of the network of services.
The community based outreach team will provide the co-ordinating focus for the new services and work in a complementary fashion with existing social work and voluntary sector services. The outreach team will co-ordinate services and provide a single entry point for new health referrals. It will provide assessment, treatment and support to both in-patients in the new service and to people living in the community and/or in the criminal justice system. The team will provide help and advice in times of crisis and operate around the clock with the aim of diverting appropriate individuals from the Criminal Justice System as early as possible. The team will be staffed by clinicians and practitioners from both health and social work with skills and experience with offenders. All MDOs receiving care from the new service will be on Care Programming arrangements.

A significant proportion of the activity of the service will involve statutory cases and require close co-ordination with probation, parole, prison, hospital and aftercare services.

A central component of the proposals revolves around services for early diversion from the criminal justice system. Within the Outreach Team, a diversion team will operate consisting of CPNs, Social Workers, Housing Officers with psychiatric input to deliver rapid assessment and referral services to people in police custody, in the courts or in prison.

Community supported housing offering support and supervision will be developed along with employment projects offering activities and educational opportunities.

**IMPLEMENTATION AND RESOURCE IMPLICATIONS**

The Board committed £5.7 million new revenue funding for developments for MDOs during the period of the Strategy. The implementation of the agreed programme has been delayed due to difficulties in agreeing a site for the in-patient unit. The Primary Care Trust has recently submitted a business case/option appraisal with a preferred site and it is hoped that this will allow the site to be agreed finally. It is not now expected that the new in-patient unit will be operational before 2002.

The resource implications of the system of care envisaged are significant. The establishment of the spectrum of services ranging from medium secure in-patient facilities through supported hostel accommodation, integrated community infrastructure and enhanced psychiatric support to the police, courts and prison services is predicated on substantial additional investment in services for offenders.

For the in-patient services set out in this paper a capital investment of around £12.5 million will be required with a recurrent revenue commitment of £8.96 million for the extended network of services. Further capital of around £600,000 is committed in order to provide the supported accommodation and other accommodation needs for offenders in the community.

In 1999/2000 a second interim secure unit to deal with continuing pressure to resettle patients from the State Hospital and patients referred from the criminal justice system will be commissioned. The second unit will contain a number of beds for people in the acute phase of illness and again this will assist in preventing inappropriate referrals to the State Hospital. In addition, the community outreach team, care programme co-ordination, supported accommodation, employment projects, information systems and advocacy/user/carer support will be developed.

Expenditure in subsequent years will be directed towards developing the in-patient services in the purpose-built secure facilities required for this care group.
The projected financial profile of the new service is as follows:

**Table 1: Mentally Disordered Offenders Financial Profile - (end point of Strategy)**

<table>
<thead>
<tr>
<th>Services</th>
<th>£k</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Team</td>
<td>750</td>
<td></td>
</tr>
<tr>
<td>MH Acute/Long Stay Accommodation</td>
<td>6200</td>
<td></td>
</tr>
<tr>
<td>LD Acute Accommodation</td>
<td>500</td>
<td>6700</td>
</tr>
<tr>
<td>LD Long Stay Accommodation</td>
<td></td>
<td>748</td>
</tr>
<tr>
<td>Supported Accommodation</td>
<td></td>
<td>600</td>
</tr>
<tr>
<td>Day Services</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Advocacy Services</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td></td>
<td>8958</td>
</tr>
</tbody>
</table>


CHAPTER 6: SERVICES FOR PEOPLE WITH LEARNING DISABILITIES

THIS CHAPTER

- sets out current service provision and resourcing of services for people with learning disabilities and with a concurrent mental illness and/or challenging behaviour;
- highlights service users and their carers perspective;
- identifies problems and issues;
- identifies priorities for future service delivery and resource implications.

INTRODUCTION

This section must be seen in the context of the developing Learning Disability Strategy which will in turn reflect any recommendations emerging from the Scottish Office Review of Learning Disability Services due to be completed in December 1999.

Many people with a learning disability live in the community with other family members. They and their families should be able to access mental health services within the community that they know, have grown up in and in which they have existing relationships.

People with a learning disability have a higher rate of psychiatric illness than the general population. The Welsh Health Survey (1995) suggested that 32.2% of people with learning disabilities also have mental health problems. This is three times higher than in the general population. There are a number of potential risks associated with learning disability including those associated with specific causes of learning disability, for example the strong association between early onset dementia and Down’s Syndrome. Depression has also been associated with Down’s Syndrome and with Autism. People with learning disabilities brought up in institutions are particularly vulnerable to emotional and behavioural problems.

Historically, services for people with learning disabilities, including mental health services, were provided in large long-stay institutions. The long-stay hospital serving the Greater Glasgow area is Lennox Castle, however large numbers of men and women with learning disabilities originating from Greater Glasgow live in other institutions across Scotland. The Secretary of State has recently agreed to the closure of Lennox Castle Hospital by 2002. As a result of this around 500 people will be resettled from Lennox Castle and other hospitals back into their local communities by the year 2002. Some of them will have existing mental and major physical health problems and require particular expertise as part of their ongoing care. In addition, people already living in the community may have or develop mental health problems and need access to mental health promotion, screening, treatment and ongoing support.

CURRENT SERVICES AND RESOURCES

The current profile of health services for people with learning disabilities, including services to meet mental health needs are set out in the tables below.
Table 1: Health Service Provision

<table>
<thead>
<tr>
<th>In-Patient Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission/Assessment/Respite</td>
<td>22 beds</td>
</tr>
<tr>
<td>Continuing Care (Lennox)</td>
<td>300 beds (March 1999)</td>
</tr>
<tr>
<td>Continuing Care (other hospitals)</td>
<td>201 beds</td>
</tr>
<tr>
<td>Close Supervision Unit</td>
<td>7 beds</td>
</tr>
<tr>
<td>CLDT x3 and Additional Support Team</td>
<td>1,780 caseload</td>
</tr>
</tbody>
</table>

Community Learning Disability Teams offer services to people with learning disabilities. Those with a dual diagnosis may require input from specialist mental health services.

Social Care Services

It is estimated that there are around 5,000 people with learning disabilities living in the community across Greater Glasgow. Most of these people live at home with their families and receive a range of support services.

In addition, local authorities commission 550 accommodation places with support across Greater Glasgow for people in need of enhanced support. In order to support carers around 100 respite places are available for people with learning disabilities. A network of adult day centres, sheltered work places and community education places are commissioned. A total of 1,500 places are available in day services. Social work provide a range of assessment and care management including mental health officer support for people in the community. In addition, a number of specialist care managers have been appointed to support people being discharged from long-stay care.

Local authority social work departments spend approximately £32 million on learning disability services.

Health

As follows: Services at Lennox Castle £16.7
Community Services £2.7
Services at Other Long-stay Institutions £7.2
Total £26.6 M

Social Work

Nursing Home and Residential Care £16.2
Day Care £15.3
Total £31.5 M

USER AND CARER PERSPECTIVES

A recent Mental Health Foundation report on the views of service users and carers concluded that people with a learning disability seek:

- recognition that they are individuals, with their own strengths and weaknesses, which may change over time
- opportunities to develop their abilities and interests and to contribute to others
- a place to live of their own choice, including the choice of whom to live with
- good health, appropriate to their particular needs and circumstances
- a wide variety of relationships and a recognition or their importance
- the right to participate in all decisions which affect their daily lives.
The findings of this work are supported by a 1997 study commissioned by the Health Board through the National Development Team.

**PROBLEMS AND ISSUES FOR CURRENT SERVICES**

**Training Issues**

- The extent of mental health problems amongst people with a learning disability is not well understood outwith specialist services.
- Very few nurses are trained in learning disability and mental health which can lead to difficulties in providing the best quality care in learning disability and general mental health in-patient settings and community resource teams.
- Mental health, general practice and social work staff providing out of hours/crisis response do not always have access to specialist knowledge of the issues in learning disability or available services. This can result in inappropriate admissions to hospital or a poor service response to service users and carers and others, eg, police.

**Co-ordination of Services**

- Lack of explicit pathways from learning disability services to other relevant mental health services including specialisms, eg, alcohol and drugs, forensic, adolescent.
- Inability of the system to be sufficiently flexible to support individuals across settings.
- Lack of comprehensive multi-agency response to out of hours crisis.
- Need for more comprehensive and proactive outreach to support community placements.

**Special Issues**

- Autistic Spectrum Disorders - particular recommendations need to be agreed across disciplines on the assessment, throughcare and management of this group including how they transfer from childrens and adult services.
- Dementia - specific service responses for individuals with Downs Syndrome and early onset dementia require to be developed.
- Protocols for providing treatment and care to people exhibiting bizarre or challenging behaviour who do not have clear mental health or learning disability diagnosis are needed.
- A Needs Assessment is required to assess numbers and types of clients on current CMHT caseloads and to look at demographic and diagnostic features, service use.
To deliver this tiered approach we need:

- a person centred approach to planning and delivering services
- services that promote emotional wellbeing and personal growth;
- services which can screen, assess, support and treat people with mental health problems in the community;
- sensitive and appropriate services for older people linked to Elderly Mental Health Teams;
- care management that can lead to flexible, individualised support packages;
- to build on the success of the Additional Support Team which offers innovative, flexible support and make a real impact on diverting admissions to beds;
- effective liaison arrangements between the Community Learning Disability Teams and Community Mental Health Teams, including the capacity for flexible working across Trust Divisional boundaries;
- effective integrated arrangements for providing a responsive out of hours/crisis service;
- in-patient services for short-term assessment and treatment of people who cannot be treated in the community. These services will be provided within the Assessment and Treatment beds being commissioned as part of the learning disabilities programme;
- forensic services that meet the needs of mentally disordered offenders, offering the appropriate level of security. These are integral components of the proposals for mentally disordered offenders;
- a small number of continuing NHS care places for those people requiring high levels of specialist NHS support on a long-term basis;
• to increase numbers of dual general mental health and learning disability psychiatrists and nurses;
• aftercare arrangements for planning and supervision using statutory procedures appropriately.

The priorities set out above will be delivered during the first two years of implementation of the Strategy.

RESOURCE IMPLICATIONS

The network of services to be commissioned as part of the learning disability programme to replace Lennox Castle and other hospitals will include a range of mental health and psychological support services for people with a dual diagnosis of learning disability and mental illness. Similarly, a core function of the network of Community Mental Health Teams will be to establish effective liaison arrangements with Community Learning Disability Teams and agree joint care packages to ensure the mental health needs of people with learning disabilities in the community are met.

People with learning disabilities with acute mental health problems requiring hospital admission will normally be admitted to the assessment/treatment beds commissioned as part of the learning disability programme but there may be occasions when an admission to an acute mental illness bed is required. What is needed to support this is better communication and clear protocols, neither of which will require significant additional resources. Training and awareness raising may require some investment.
CHAPTER 7: MENTAL HEALTH SERVICES FOR OLDER PEOPLE

THIS CHAPTER

- describes the current services and resources for older people who have mental health problems;
- sets out user and carer perspectives on these services;
- highlights areas of concern with current service provision;
- describes future arrangements for mental health services for older people, priorities for action and the resource implications.

INTRODUCTION

Older people have many mental health needs. The prevalence of conditions such as depression and anxiety are high and are common reasons for contacting a GP. Hospital admission rates for psychiatric and non-psychotic depression are as high among the over 65s as in younger age groups. Problem drinking and misuse or dependence upon tranquillisers or sleeping pills continues with advancing years.

For some elderly people, life is characterised by loneliness and isolation, boredom and inactivity, relative poverty and increasing physical disability and discomfort. It is not surprising, therefore, that anxiety and depression should be particularly prevalent among older people.

The present chapter is concerned with older people with functional mental illness. People with dementia are considered in Chapter 8.

CURRENT SERVICES

GPs and primary care services provide a great deal of treatment, care and support for elderly people with mental health problems. Secondary services for older people with mental health problems are provided in the main by the Mental Health Division of the Primary Care Trust. Services comprise a range of in-patient, day hospital and community mental health facilities. Clinical services for older people with mental health problems are currently linked with dementia services, in a single Clinical Directorate.

Community mental health services are provided by 10 specialist elderly mental health teams. These teams comprise a range of health professionals and provide comprehensive assessment of need and treatment, liaising with primary care, social work, housing and other agencies to deliver specialist packages of care and support to people in their own homes. The Elderly Mental Health Teams also provide outreach services to nursing and residential homes and other locations providing care and support for elderly people in the community. In 1997/98 a total of 900 older people with mental health problems were referred to Elderly Teams.

The Elderly Teams also link closely with 9 day hospitals for elderly people with mental health problems, providing 71 places. Day hospitals provide a range of detailed assessment, therapeutic care, functional and social support to assist people to remain in their own homes. In 1997/98, there were 730 new referrals of older people with mental health problems to day hospitals.
Community mental health services for older people with mental health problems are supported by acute assessment in-patient beds and NHS continuing care beds. There are assessment beds provided on five sites and 310 NHS continuing care beds. Many of the current residents in the continuing care beds are people who have “grown old” in hospital and continue to be under the care of adult general psychiatrists. For the future these beds will be largely replaced by community facilities.

SOCIAL WORK SERVICES

Social work provide a range of services for this client group. A considerable element of home care and day care services are allocated to older people with mental health difficulties. This includes a range of social care supports, lunch-clubs, recreational and leisure services and advice. A number of elderly people with mental health problems receive care and support in social work commissioned supported accommodation projects. In addition, a considerable number of elderly people in both residential and nursing homes will have mental health problems. It is not possible to quantify the exact levels of social work input into care and support for older people with mental health problems due to the current social work recording systems and resource allocation systems of local authorities.

RESOURCES

As it is not possible to quantify social work expenditure precisely to older people with mental health problems, the profile expenditure presented below reflects only NHS spend. In 1997/98 a total of £15,960,000 was spent on mental health services for older people (excluding expenditure on services for people with dementia). The breakdown of this expenditure was as follows:

Figure 2: NHS Expenditure on Mental Health for Older People

From the above, it can be seen that 84% of health expenditure on services for older people with mental health problems is directed towards hospital in-patient services. It is envisaged this pattern will change in the future.
The absence of detail on social work expenditure for this client group does not denote a lack of service. Again, given the ageing population in the continuing care beds it is expected that over time the proportion of expenditure committed to long-stay hospital care will decline to be replaced by more community based alternatives.

SERVICE USER AND CARER PERSPECTIVES

From the stakeholder events service users and carers identified a number of issues for the future provision of services for older people with mental health problems. The main issues were:

• poor co-ordination of care across agencies and disciplines;
• lack of respite care facilities;
• more home and practical support needed;
• too great a reliance by professionals on drug therapies;
• inadequate or inaccessible information to users and their carers about the condition and help from voluntary and other organisations;
• difficulties in obtaining help and support for “out of hours” crises.

PROBLEMS AND ISSUES FOR CURRENT SERVICES

The main issues to be addressed by the Joint Strategy are:

i) **Equity**

The need to ensure services are distributed fairly across Greater Glasgow based on need addressing the issues arising out of the imbalance of service provision between the North and East and the South and West.

ii) **Diagnosis, Assessment and Co-ordination of Services**

As with other aspects of mental health services there is a need to improve the co-ordination of care between agencies. In particular:

• early diagnosis and information to users and carers to allow future planning for the individual and his/her family;
• agreed and co-ordinated assessment and care management processes.

iii) **Day Services**

These require complete review as signalled in the local authority Joint Community Care Plans to establish closer working between day services and day hospitals.

iv) **Therapies**

Drug therapies prescribed to older people need to be reviewed and consideration given to making available more talking and psychological therapies and enhancing social support networks to improve social functioning.

v) **Community and Home Based Care and Support**

As highlighted above, the overwhelming balance of NHS care at present is directed towards hospital care. There is a need to improve the range and quality of home care
to enable older people with mental health problems to remain at home as long as practical.

vi) **Culturally Sensitive Services**

The need to ensure that services for older people are culturally sensitive and responsive to the needs of ethnic minority groups.

vii) **In-patient Services**

It is recognised that there is a need to review in-patient provision and to consider reducing the number of beds and to develop alternative community based services. This review will be carried out in conjunction with reviews of adult mental health in-patient services and in-patient services for people with dementia.

viii) **Organisation of Services**

At present, there is an incompatibility in the way in which health and local authorities plan and arrange care for older people with mental health problems. Local authority social work organise around adult care and services for dementia, whilst health arrange services around adults and elderly people with mental health problems including dementia. There is a need to get a greater consistency of approach across agencies. It will be helpful to more clearly identify specific resources dedicated to this care group.

ix) **Older People with Long Standing Mental Health Problems**

There is a large group of people in hospital and in the community who have suffered long standing mental health problems and are now over 65. Mental health services do not respond in a consistent way to this population, some of whom remain with general adult psychiatry and some being transferred to psychiatry of old age. Audit and research on appropriate models of care is needed for this population and an agreed approach to the future care needs of this group implemented between the Board, the Trust and local authorities.

x) **Medicine for the Elderly**

Mental health problems are common among patients referred to medical services for older people. In particular, neurological conditions such as strokes and Parkinson’s disease carry high risks of mental health problems. More needs to be done to integrate medical and mental health services for this population.

**TIERS OF SERVICE**

The hierarchy of structured service provision for the identification, assessment, care management and support of older people with mental health problems is set out below.
Future services for older people with mental health problems need to be based on:

- shared care protocols with GPs;
- shared care protocols with medicine for the elderly;
- comprehensive home and community assessment;
- community services as alternative to residential or NHS continuing care;
- increased home based care and support;
- closer working between NHS day hospitals and local authority day services;
- intensive in-patient treatment and rehabilitation of acutely ill people;
- specialist in-patient provision for people with challenging and volatile behaviours requiring long stay care.

**PRIORITIES FOR ACTION**

The following priorities for future service provision for older people with mental health problems have been agreed during the work on the Joint Strategy:

- develop and implement agreed assessment and care management processes between health and social work;
- enhance community and home support services through the development of a range of social care and community services;
- develop primary care support workers, linked to elderly mental health teams;
- improve crisis response services, particularly “out of hours” as part of the general enhancement of crisis services;
- improve co-ordination of care in the community by better links between day hospitals and day services and liaison between Elderly CMHTs and local social work;
- review the current organisational arrangements for older people with mental health problems and for people with dementia to ensure more effective planning and commissioning mechanisms;
• review in-patient provision for older people with mental health problems and agree future levels of services and resourcing.

RESOURCE IMPLICATIONS

As it is not possible at present to identify local authority spend on services for older people with mental health problems, the analysis of resource implications of the proposed network of services is based purely on NHS spend.

The major resource requirement of the proposals relate to enhanced home care services and support to primary care provided through a range of community based health and social care services. It is envisaged that within each elderly mental health team there would be a team of health and social care workers to provide home support, day services, respite care and support for people in nursing and residential care. The specific needs of people from ethnic minority groups will be addressed in this development. In addition, primary care support workers would be employed. It is proposed that these enhanced community based teams would be developed over the period of the Strategy, funded from a reduction in NHS continuing care beds with resources released as the population who have “grown old” in hospital declines.

The other priorities for action relate primarily to improved organisational or joint working and are largely cost neutral. The finance for the improved crisis service is contained within the proposals for adult mental health services.
CHAPTER 8(A): SERVICES FOR OLDER PEOPLE WITH DEMENTIA

THIS CHAPTER

• describes the current range of services and resources for people with dementia;
• outlines issues arising out of stakeholder events;
• identifies problems with current services;
• describes the basis for the future provision of services;
• sets out the priorities for action and their resource implications.

CURRENT SERVICES AND RESOURCES

In recent years there has been a shift in the balance of care from institutional based health care to community care, although there remains across Greater Glasgow a high level of both residential and hospital based care.

Health Care

Table 1: Current Health Provision

<table>
<thead>
<tr>
<th>Service</th>
<th>No of Beds/Places</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Care</td>
<td>305</td>
</tr>
<tr>
<td>Acute</td>
<td>126</td>
</tr>
<tr>
<td>Elderly Mental Health Teams x 10</td>
<td>1,350 new referrals per annum</td>
</tr>
<tr>
<td>Day Hospital Places</td>
<td>106</td>
</tr>
</tbody>
</table>

Between 1994 and 1997 there has been a reduction in the number of dementia in-patient beds. These have been replaced by the commissioning of 152 nursing home places and 30 places in dementia care units within the independent sector. During this period a number of other services have been developed to enable more people to live in their own homes. These include:

• the development of 21 projects providing community support services including home support, day care and carers support services in the North and East Sectors as replacement services for the closure of Gartloch and Woodilee hospitals;
• the establishment of 10 Elderly Mental Health Resource Centres to support people with dementia in the community;
• day hospitals services in 10 locations across the city but the take up rate varies.

Table 2: Social Care Provision and Expenditure

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Activity</th>
<th>Expenditure (£K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>3200 users</td>
<td>3100</td>
</tr>
<tr>
<td>Home Care Respite</td>
<td>272 users</td>
<td>265</td>
</tr>
<tr>
<td>Carer Support Projects</td>
<td>N/A</td>
<td>150</td>
</tr>
<tr>
<td>Day Activities</td>
<td>980 places</td>
<td>2000</td>
</tr>
<tr>
<td>LA Residential Homes</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>LA Residential Respite</td>
<td>38 places</td>
<td>600</td>
</tr>
<tr>
<td>Private/Voluntary Residential Homes</td>
<td>440 places</td>
<td>1875</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>1900 places</td>
<td>11700</td>
</tr>
<tr>
<td>Other</td>
<td>N/A</td>
<td>240</td>
</tr>
<tr>
<td>Resource Centre Staff</td>
<td>18 FTE</td>
<td>925</td>
</tr>
</tbody>
</table>
At this point, within local authority residential homes, the truest reflection for residents with dementia could be gained from the dementia screening score of the survey, ie, 40%. Those assessed as likely to have dementia (38%) and those medically diagnosed (35%) are both likely to be slight undercounts. The score for mental confusion was 52%.

[*Homes for Elderly People Survey 1998 Glasgow City Council Social Work Department*]

- Around 60% of all nursing home places are estimated to be for people with dementia with most places in the North and East sectors.
- Specialist home care is often provided as an additional service operating alongside the main home care service. It is usually provided with staff specifically trained in dementia care. They work with people with dementia and/or carers in practical and personal assistance, and also provide home based programmes of therapeutic social care.
- Specialist day care for people with dementia is provided from a range of settings, with a concentration of provision within local authority residential homes for elderly people. The distribution of this service is not spread evenly across the Greater Glasgow area.
- Within Glasgow City local authority residential homes 3% of bedspaces were specifically designated as respite for people with dementia - 28 places.
- Networks of community based services, including carers support, information and advice and advocacy projects have been developed in partnership with the voluntary sector to support people with dementia and their carers.
- Within medicine for the frail elderly in acute hospitals a significant proportion of admissions will involve a dementia component. Similarly, amongst the population in NHS continuing care frail elderly beds significant numbers will in addition to physical incapacity have dementia related symptoms.

**RESOURCES**

In 1997/98 a total of £50.2M was spent by health and local authorities on dementia/elderly mental illness services. This was split - 67% spend by local authorities, 33% by the NHS.

Of the £16.6M spent by health on dementia/elderly services 80% was spent on in-patient services with the remaining 20% on community based services, including day hospitals. Within the spend on in-patient services, 68% was focused on continuing care with the balance on acute/assessment provision.

**SERVICE USER/ CARER PERSPECTIVE**

Recent stakeholders events have highlighted the following issue for services:

- the need for dementia friendly mainstream services;
- the need for services which:
  - support people in their own home with practical personal assistance;
  - support carers through respite and education;
  - provide respite for the individual;
  - provide day hospital/day care;
  - provide accommodation and support;
  - provide appropriate models of long-stay care;
- the need for earlier diagnosis and a complementary range of responses from key agencies which:
ensures co-operation amongst key agencies, significantly in assessment and care co-ordination arrangements;
- outlines clear pathways to care for people with dementia and their carers;
- develops awareness and education of public, key agencies and carers;
- develops opportunities for the voice of people with dementia to be heard through the development of advocacy services.

PROBLEMS AND ISSUES FOR CURRENT SERVICES

The main issues to be addressed are:

i) **Equity**

- the need to ensure services are distributed fairly across the Greater Glasgow area according to need addressing issues arising out of the imbalance of service provision between the North and East and the South and West;
- the need to ensure that care services are designed and delivered in appropriate ways which take account of the age and life stage of the individuals;
- the need to ensure that services are culturally sensitive and meet the needs and aspirations of the black and ethnic minority community.

ii) **Diagnosis, Assessment and Co-ordination**

- early diagnosis to allow individuals to make decisions about their legal and financial affairs and to plan the future with their families and friends;
- improved, co-ordinated assessment procedures;
- the provision of information, emotional support and practical help for people with dementia and their carers from the point of diagnosis to the terminal stages of the illness;
- availability of appropriate, flexible levels of care in relation to the individuals own pathway through the illness.

iii) **Day Services**

These require a complete review as signalled in local authority Joint Community Care Plan with the aim of establishing closer working between day services and day hospitals.

iv) **Drug Therapies**

Recently, two new drugs to improve memory function in people with dementia have been introduced and more are on the way. Treatments available at present temporarily improve function to a variable and unpredictable extent. Further evaluation of the place of these therapies is ongoing.

v) **Management of Psychological and Behavioural Aspects of Dementia**

Recent SIGN guidelines have been introduced in this area. The implementation and monitoring of these guidelines which include a variety of drug and non-drug approaches is needed.
vi) Community and Home Based Care and Support

There is a continuing need to improve the quality and range of services to meet the complex and changing needs of people with dementia and their carers and to design services to meet future need. Recent changes in in-patient services in North and South sectors will facilitate further opportunities to explore and extend care options to enable yet more people to receive care at home and support local decisions in care planning.

vii) Residential and Nursing Home Care

An appropriate range and balance of care options will continue to be developed. Long-stay care will aim to achieve a dementia friendly environment for all residents together with a smaller number of discrete facilities catering for those with more complex needs which can not be met in mainstream settings.

viii) Design of Dementia Care

The 1999 City of Architecture Project “Just Another Disability - Making Design Dementia Friendly” will make a valuable contribution to the design of dementia facilities through its advice, customisation, design brief, audit tool and publication.

ix) Culturally Sensitive Services

The need to ensure that services are culturally sensitive and meet the needs and aspirations of the black and ethnic minority community.

x) In-patient Services

In-patient services are currently provided on five sites across Greater Glasgow.

a) Assessment

The purpose of these places is to assess and manage major behavioural disturbance in people with dementia. 91 places are provided on four sites across Glasgow. It is recommended that this should reduce to three sites which should provide high quality accommodation where people with dementia and “functional” illness can be managed separately. These units should be on or adjacent to a general hospital site and must have access to appropriate ongoing care.

b) Continuing Care

NHS continuing care remains necessary for people with severe, unstable or unpredictable conditions. There are 305 such places at present. Units should be placed to allow local access and do not require to be on a hospital site. The number of places required will be reviewed along with the need for dementia residential and nursing home places. There may be a need for a specialised unit for the management of people with dementia with major behavioural problems.
xi) Crisis Services

An integrated approach to supporting people with dementia and their carers during periods of crisis and out of hours will be developed in 1999/2000. This will involve linking Social Work Standby, the GEMS service and a dedicated specialist mental health team contactable via a single referral system/telephone number. This will be part of the general crisis service outlined in Chapter 4 but recognising the particular needs of people with dementia.

TIERS OF SERVICE

The hierarchy of tiered responses for the identification, assessment, care management and support of people with dementia is set out in the diagram below. When needs assessment becomes more refined it should be possible to identify numbers of people within the tiers to assist in the future planning and development of services.

Figure 1: Proposed Structure for Dementia Services

![Diagram of tiered services for dementia]

It is important, however, to recognise the unpredictability and variety in the development of dementia requires a flexible response, operating across a range of tiers and agencies to ensure the delivery of an integrated service. There follows a basic outline of the tiers of service.

**Tier 1**

People experiencing problems interfering with normal function but still able to manage independently. Also includes people worried about the possibility of becoming ill, especially those in high risk groups.

Service responses include public information and education, screening populations at risk, assessment and diagnosis in primary health care, referral to specialist services when diagnosis is in doubt, treatment via agreed
guidelines, support via mainstream services, eg, home care with specialist advice, information, education for patient and caregivers.

**Tier 2**
Includes people whose symptoms result in the need for support to maintain independent living and those in care establishments whose mental function deteriorates to the extent that care becomes compromised.

Service responses include agreed and complementary assessment process and care pathways, full community care assessment and care management if deterioration is likely to be permanent or irreversible, specialist assessment and monitoring to support primary health care and mainstream social care and/pr periods of assessment and treatment in specialist care settings.

**Tier 3**
Includes people unable to maintain independent function without intensive support and people in care establishments whose care needs are in danger of being unmet due to mental health problems.

Service responses include community care assessment, co-ordinated car packages involving specialist services, possibly including care programming. Periods of in-patient mental health assessment and treatment may be required. Specialist support for care establishments or transfer to specialist units for continuing care may be recommended.

**Tier 4**
Includes people who present unstable and unpredictable difficulties, people who need ongoing intensive specialist monitoring and people whose conditions may be terminal.

Service responses include continued health care under Consultant supervision or in establishments where such expertise is easily accessible, treatment in accordance with clinical guidelines (eg, SIGN) and review of care needs if difficulties resolve.

**Note:** People in high need tiers will also need the service responses provided to those in other tiers. For example, people with severe illness need education, diagnosis, etc.

Future dementia services will:

- create a complementary pattern of care to provide health and social care services for people with dementia to help them in their own homes, or provide appropriate long-stay care in smaller units in a homely or domestic setting;
- promote integrated models of care, dementia units attached to homes for elderly people and in home based services by a combination of specialist and general services and including carer support services;
- improve co-ordination of care to achieve the “best fit” between needs and resources;
- establish mechanisms for effective professional collaboration and multi-agency working at local levels (eg, CPA, Area Resource Groups, CARD).

**PRIORITIES FOR ACTION**

These are the priorities for older people with dementia. Priorities for the carers of people with dementia are identified in Chapter 9.
General:

- develop tool to audit mainstream services to ensure dementia friendly access and accommodation;
- provide consistent access points to the network of services with specialist interventions/treatments to maximise functioning and maintain health and wellbeing including drug treatments, memory assessments, risk assessments, challenging behaviour;
- ensure access to advocacy for people with dementia;
- improve early diagnosis and information for people with dementia;
- develop advocacy services for people with dementia.

Home and Community Based Services:

- establish equitable distribution of dementia services across Greater Glasgow and agree main service components;
- ensure availability of 24 hour support to include appropriate crisis services;
- explore the feasibility of alarm services and housing services to maintain and sustain people with dementia;
- jointly review the role and function of day hospitals and day services and clarify functions and responsibilities;
- develop jointly agreed pathways between primary, secondary and social care services, supported by multi-agency protocols and procedures;
- evaluate the clinical and therapeutic effectiveness of new drug therapies for people with dementia.

NHS In-patient Services and Residential and Nursing Home Care:

- review in-patient provision and develop costed proposals for future levels/configuration of services;
- set and monitor consistent standards of care for people in dementia care placements;
- develop long-stay care towards the provision of smaller, more domestic dementia care facilities;
- develop training and skills programmes to enhance areas of expertise and competencies including assessment, management of challenging behaviour, creative therapies.

RESOURCE IMPLICATIONS

A major priority for all dementia services is to develop a robust financial framework that takes account of all current services and charts future changes.

The major resource changes for future services for people with dementia need to flow from the review of in-patient services. The review will address the balance of care between community and residential care, specialist in-patient and generic services, health and social care, acute treatment and long-term support, older people with dementia and young people with dementia.

In the interim, a funding package of £100,000 has been identified to facilitate the resourcing of advocacy services. A further £400,000 has been earmarked in future revenue projections to develop further social care services for older people with dementia.
CHAPTER 8(B): SERVICES FOR YOUNGER PEOPLE WITH DEMENTIA

THIS CHAPTER

• describes the current range of services and resources for younger people with dementia;
• outlines issues arising out of stakeholder events;
• identifies problems with current services;
• describes the basis for the future provision of services;
• sets out the priorities for action and their resource implications.

CURRENT SERVICES AND RESOURCES

In recent years there has been an increasing recognition of the particular needs of younger people with dementia and this “sub” chapter is a step towards refining a response. Issues for carers are dealt with in Chapter 8B although it will be important to note the particular needs of younger families (with perhaps closer parallels with carers issues for the adult mental health group). In addition, there are very particular issues for families where there is an established genetic basis, for example, in Huntingdon’s Disease.

The specific service and resource issues for people with Down’s Syndrome who develop dementia should be addressed within Chapter 6 on learning disability.

The focus of a strategic review for Acquired Brain Deficiency services remains to be determined - most likely within physical disability services.

Health Care

The present NHS provision is arranged as follows:

• GP services;
• specialist neurological services;
• alcohol and drug services;
• genetic services;
• old age psychiatry;
• general psychiatry;
• general medicine (including accident and emergency services).

Currently there is no single or clear route to service, nor is it possible to identify precise numbers receiving or in need of service from the different elements of the NHS family.

There is no specific acute or continuing care provision for younger people with dementia.

Social Care

Similarly it is not possible to identify discrete provision and resource distribution from within the range of social care services. People will receive social care services through a number of access points or service types:
• hospital based social work teams;
• area based social work teams;
• social work prison services;
• social work alcohol and drug services;

Social care:

• general home care services;
• general day services;
• general residential and nursing home services;
• specifically registered nursing home services (eg, Korsakoff’s).

There is one discrete younger persons community based service purchased by social work services through Mental Illness Specific Grant funding and community care monies allocated to social work area teams. This service provides:

• information and advice and education;
• counselling;
• home support;
• day care;
• carers support (including respite - short breaks).

The service is provided by Alzheimer’s Scotland Action on Dementia.

RESOURCES

Further work would require to be undertaken to separate out the amounts of monies used by younger people with dementia receiving discrete and mainstream services.

SERVICE USER/ CARER PERSPECTIVE

Stakeholder events have highlighted the following issues for services:

• the need for age and stage appropriate services;
• the need for services to be sensitised to the particular needs of some service users, eg, people with Huntington’s disease;
• the need for education and awareness for service users, carers and families, professionals;
• the need for early diagnosis, the right to know and support services, eg, financial and legal management;
• getting the balance right between mainstream and discrete services;
• the need for a range of particular age appropriate services to meet the needs of younger people with dementia, including Huntington’s disease, especially providing meaningful and appropriate day opportunities;
• the need to develop services for people with alcohol related brain damage, including Wernicke-Korsakoff’s Syndrome, comprising:
  • preventative services;
  • accurate and comprehensive assessments;
  • rehabilitation programmes;
  • day care opportunities;
  • supported housing with support;
  • reduction in use of nursing home provision.
**PROBLEMS AND ISSUES**

- There is a shortage of services for younger people with dementia.
- There is therefore a lack of alternatives in long-stay care for people with early onset dementia, Huntingdon's disease and alcohol related brain damage including Korsakoff's Syndrome, who are in the main cared for in long-stay psychiatric or general nursing homes.
- There is a lack of clarity in the pathways to diagnosis and routes to services.
- As there is no specific or continuing care provision for younger people with dementia. This will need to be given particular consideration in the review of NHS in-patient services.
- There is insufficient refinement in local needs assessment.
- The identification of issues and the development of appropriate service responses is at an early stage.
- The groups concerned are numerically small but intensive in need.
- Need to ensure services are culturally sensitive and meet the needs of people from the black and ethnic minority community.

**TIERS OF SERVICE**

Future dementia services will address the needs of people with early onset dementia and people with alcohol related brain damage including Korsakoff's Syndrome. Given the distinctive needs of these varied groups, further work will be undertaken in both needs assessment and care pathways through a joint review group.

a) **Priorities for Young People with Dementia**

*General:*

- establish a Joint Commissioning Group to develop specific and costed proposals of future care for younger people with dementia.

*Home and community based services:*

- develop housing needs assessment and support profile;
- link to day hospital/day service review to ensure sensitive and appropriate services for younger people;
- ensure age and condition that recognises the specific needs of younger people for home care and community based staff.

*NHS in-patient services and residential care:*

- establish coaching team to support residential care staff and to develop day opportunities;
- develop specialist assessment capacity for of individuals with early onset dementia, Huntingdon's disease and alcohol related brain damage.

b) **Priorities for Alcohol Related Brain Damage Services**

Proposals for future service provision for people with alcohol related brain damage, including Korsakoff's Syndrome, have been developed by a working group during the preparation of the Joint Strategy. The key elements of the proposals are:
an accurate and comprehensive assessment in designated specialist beds;
- following assessment, many patients will be transferred for up to six months to one or two specialist rehabilitation developments each with eight continuing care and two respite beds;
- day care facilities would be developed to link into each core unit;
- continued use will be made of existing nursing home provision but it is expected that this will diminish over time as more appropriate provision is developed;
- other supported accommodation will be accessed ranging from various sheltered housing projects to scatter flats.

These developments and their relationship with existing services are summarised in the diagram below.

**Figure 2: Proposed Model of Treatment, Rehabilitation and Care**

**RESOURCE IMPLICATIONS**

A major priority for all dementia services is to develop a robust financial framework that takes account of all current services and charts future changes.

The major resource changes for future services for people with dementia need to flow from the review of in-patient services. The review will address the balance of care between community and residential care, specialist in-patient and generic services, health and social care and acute treatment and long-term support of older people with dementia and younger people with dementia. A major emphasis in the review will be to reconfigure existing services to enable the development of specialist services for early onset dementia and alcohol related brain damage. This will involve the close identification of current expenditure
by both health and social work on these services and agreement on how this money can be
restructured to help support an enhanced service.

An immediate funding priority will be to resource a coaching support team and enhance
available services for this group. Funding of £200,000 has been allocated in year one
implementation for these developments.
CHAPTER 9: MENTAL HEALTH THERAPIES

THIS CHAPTER

- Sets out therapeutic approaches for people with mild to moderate mental health problems;
- Describes therapies for people with moderate to severe mental illness;
- Identifies priorities for action.

INTRODUCTION

The effectiveness of different treatment interventions will have a critical effect on commissioning decisions. It is of importance, not only that effective interventions are used but that these are provided from integrated services. A range of effective treatment methods which take account of users’ choices, needs and wishes should be available. Services should be culturally competent and respectful of the beliefs of those who use them.

The approach to mental health therapies to be developed as part of the Mental Health Strategy will be based on:

- a range of psychological therapies and supports;
- support for voluntary organisations running groups in the community;
- simple time limited therapies in the primary care setting;
- an integrated specialist psychological therapies services, with filters in the shape of shared protocols for referral to component parts of the service; and,
- information about availability and robust mechanisms for audit, quality assurance, supervision and evaluation of therapies.

Psychological and other therapeutic approaches will complement the use of medication and other interventions, such as ECT. The key criteria determining the availability and development of a range of mental health therapies and treatments must be a clear demonstration of effectiveness and a firm evidence base.

THE VIEWS OF SERVICE USERS

Service users generally appreciate the benefits of the mental health service particularly in an acute episode and when needing hospitalisation and intensive therapy. However, service users often ask for other therapies which would allow them to increase their chance of a successful recovery or to help them maintain an acceptable quality of life particularly where they face living with a chronic illness perhaps for many years. Little information on the range of therapies exist therefore some register of therapies available to people throughout the area is desirable.
THERAPIES FOR PEOPLE WITH MILD TO MODERATE MENTAL HEALTH PROBLEMS

Service users often feel current services are limited in assisting them in dealing with a number of mental health problems that may be perceived as not requiring specialist mental health services input but are nonetheless very distressing to the person concerned, eg, life crisis or relationship difficulties.

Mild psychological morbidity affects 30% of the population each year. The number of people presenting to primary care with symptoms of depression and anxiety is known to be only a fraction of those with symptoms. This hidden morbidity probably includes a huge range of problems such as addictions, social isolation, marital and family breakdown, bereavement and undisclosed anxiety and depression. Many people will establish their own support networks to enable them to cope or choose to access independent counselling services or complementary therapies.

Community Mental Health Teams deal with a large number of service users referred with minor to moderate problems who may benefit from alternative sources of help and support at least in the first instance.

There is a need within primary care to offer in non-stigmatised settings, interventions that are effective and brief and which involve both individual and group therapies. The development of initiatives within the context of Healthy Living Centres may help to achieve a balance of appropriate care.

Examples of therapies that may be provided in primary care or community include:

- psychological treatments;
- counselling;
- psychodynamic therapies;
- self-help;
- medication;
- therapeutic activity;
- creative therapies and applied arts;
- complementary medicine;
- psychosocial therapies.

Service users with more persistent or severe disorders may require to be referred to the Community Mental Health Team, who offer access to a wider range of therapies and more specialist interventions.

The range of therapies described below is not exhaustive nor necessarily provided by mental health services but provides a degree of choice to the service user. Advice and support in selecting a therapy should be provided following assessment by the primary care team or if more specialised advice is required by the Community Mental Health Teams.
Psychological Treatments

Effective psychological interventions make an essential contribution to the mental health of adults, the elderly and adolescents. These interventions are also used with adults who have learning disabilities but are less well established in terms of effectiveness. Clinical research has demonstrated the efficacy of Cognitive Behaviour Therapy (CBT) and Interpersonal Psychotherapy (IPT) in a wide number of psychiatric disorders. These interventions are structured, time limited and readily understandable to service users.

Recent reports evaluating the efficacy of psychological interventions (American Psychological Association, 1993; Roth and Fonagy, 1995) list depression, somatic problems, sexual dysfunction, eating disorders, obsessive–compulsive disorder (OCD), generalised anxiety disorders, panic disorder with and without agoraphobia, specific phobias, post-traumatic stress disorder (PTSD), schizophrenia (in combination with medication) as being treated effectively with structured brief psychological treatments. Both reports used stringent criteria before determining that an effective treatment exists. All psychotherapies are not equally effective: Psychological therapies, mainly CBT and IPT, are not only better than no treatment but, as good as or better than effective drug treatments, at reducing relapse rates in moderately severe depression. CBT and behavioural treatment are as good as or better than drug and other psychological interventions in the treatment of obsessive–compulsive disorder, panic disorder, with and without agoraphobia, other anxiety disorders and bulimia nervosa. Recent evidence suggests that Eye Movement Desensitisation Re-processing (EMDR) and cognitive restructuring are superior to drug based interventions in the treatment of post-traumatic stress disorder.

Psychological interventions are delivered by all mental health professionals, particularly by Clinical Psychologists, trained in cognitive and behavioural psychotherapies, to Primary Care patients and to out-patients through referral to local departments of Clinical Psychology and to appropriately trained staff in Community Mental Health Teams. The main reason why psychological treatments are still not widely accepted is not one of effectiveness. The problem is one of accessibility, expertise, public perception and dissemination (Barlow and Hoffman, 1997). Although the cost of psychological therapies may be relatively higher than medical based interventions, progress has been made in designing brief therapies which include an element of self-administration on the part of the service user.

Counselling

Counselling services complement existing mental health services for the group of service users for whom psychiatric care is inappropriate. Service users and GPs have highlighted that they have found counselling to be beneficial. This is clearly in line with their continued request for more talking therapies. A recent Scottish Office report (National Medical Advisory Committee, 1998) indicated that approximately one quarter of GP practices surveyed had a practice counsellor but less than 10% of these were accredited by a professional organisation. GPs with a practice based counsellor tended to refer service users with stress-related family or marital problems. A wide range of counselling approaches were offered. To date, there is little evidence to conclude that counselling, delivered by practice based counsellors or by members of the Primary Care Team, is clinically effective. Guidelines about which problems are appropriate for counselling and clear treatment objectives should be developed and systems for accreditation and supervision introduced.
Psychodynamic Therapy ("Psychotherapy")

Psychodynamic psychotherapy is a treatment valuable for a proportion of service users with complex problems unresponsive to treatment in general practice or psychiatric services. It is based on understanding human personality and relationships and aims to enable people to take constructive charge of their lives.

Symptoms, distress, difficulties in relationships and recurring patterns of behaviour are explored within the therapeutic situation. The process relies upon the development of a therapeutic relationship in which the therapist pays attention to what is being communicated and how it might cast light upon problematic internal states of mind or feelings, desires or other forms of inner conflict often expressed as disturbed relationship patterns.

A specialist psychotherapy service operates in two ways: through direct treatment of service users which may be on an individual basis, in a group or as part of a couple or family, and through indirect services, involving psychotherapy supervision of other staff involved in mental health services or through consultation to individuals or teams delivering psychiatric or general medical/surgical care.

Service users treated in the psychotherapy services are predominantly those with personality disorders, multiple neurotic problems, post-traumatic stress disorders and mood disorders. They have often had previous treatment episodes, including in-patient admission and suffer from substantial impairment of their functioning.

Specialist treatments are available for some specific service user groups such as for those who have suffered sexual abuse, for service users with eating disorders and for service users with sexual problems.

The service is led by Consultant Psychotherapists who provide specialist assessment of service users as the basis for treatment planning. Most service users are seen for varying periods of up to 6-9 months’ weekly attendance although some require substantially longer term psychotherapy, either individually or in a group.

Intensive group psychotherapy is available for service users with personality disorders who require more containment than once weekly therapy would provide. A range of group psychotherapeutic programmes is provided across the Sectors with varying degrees of intensiveness to accommodate different types of service users.

Psychotherapists are involved in liaison work to general medical/surgical clinics for service users with, for example, chronic pain or irritable bowel syndrome. In recent years there has been a high (and increasing) demand for psychotherapy services both from general practitioners and from service users themselves.

There is evidence for the effectiveness for psychodynamic psychotherapy both from randomed control trials (RCTs) and from other forms of appraisal. A recent study of service users with borderline personality disorder randomly allocated to a maximum of 18 months’ treatment in a psychoanalytically informed partial hospitalisation programme has shown significant improvement on all outcome measures compared with the control group who received routine psychiatric care.
**Self Help**

Extensive literature including books, audio and video tapes are now available on the subject of self-help. Within Greater Glasgow there is a growing network of self-help and social support groups available. These are offered by CMHTs, Social Work Services and community agencies such as, Glasgow Association For Mental Health and the Manic Depression Fellowship. These groups are designed to offer help related to a specific issue such as anxiety management and relaxation or to provide social, educational and recreational activities to enable service users to improve their quality of life, to build meaningful relationships and to reduce loneliness and isolation. The promotion of self-help programmes is useful for mental health service users, to encourage their participation in health and social care and to promote optimum levels of independence and self-sufficiency.

**Medication**

Psychotropic medications, particularly anti-depressants, are useful in the treatment of mild to moderate mental disorders. They are often effective adjunctive therapies in the treatment of panic disorder, phobic illnesses and milder depression / anxiety states. Care has to be exercised where the drugs are potentially dependency forming such as Benzodiazepine tranquillisers and hypnotics. For such medication, prescriptions should be limited to a few weeks to deal with a crisis or to assist a service user in participating in non-drug treatments such as psychological interventions.

**Therapeutic Activity**

Therapeutic activity is a tool that is used to bring about a change in function. Occupational Therapists and other health care professionals involve service users in therapeutic activity. Results from some studies comparing Occupational Therapy activity groups with traditional verbal groups suggest that activity-focused groups tend to get a better response from and are preferred by service users than do primarily verbal groups.

By encouraging service users to become involved in activities which give meaning to life by determining roles, values, habits and routine vital components which contribute to a sense of well being are established. Groups exploring social skills, anxiety management and activities of daily living provide both an assessment tool for therapists and are used as a treatment media which influence change in service users function. Opportunities should be available to involve service users in therapeutic activity and for therapists to undertake research studies to prove scientifically the clinical effectiveness of this treatment.

**Supportive Psychotherapy**

Clinicians in the course of implementing specific treatments often provide considerable support to the user of service and at times this may be more important than the specific intervention. The high demand for individual appointments reflects the usefulness of this service.
Creative Therapies And Applied Arts

Recognition is continually growing that for many people with mental health problems, creative therapies become a visual language to express and explore feelings that may be difficult to communicate verbally. They have a role in amplifying diagnosis, effecting treatment and assisting the healing process. Art Therapy is a form of therapy in which the making of visual images in the presence of a qualified Art Therapist contributes towards externalisation of thoughts and feelings that may otherwise remain unexpressed. Music Therapy and Drama Therapy are growing professions whose practitioners aim to help their service users discover an outlet for often complex and confusing emotions and to foster within them self-awareness and growth. Drama, creative writing and art have long been recognised by Occupational Therapists as providing a focus for individuals and groups who have problems engaging in therapy and are currently widely used as a treatment media within day and rehabilitation services.

Good practice and collaborative working in the application of the arts in health settings already exist in the work of clinical staff and professional organisations such as Project Ability and the East Glasgow Alcohol Services, Living Arts and the Elderly Directorate, Trongate Studio, EDICT (East Dunbartonshire Initiative for Creative Therapy), Art In Hospital, Survivors Poetry Scotland and the Council for Music in Hospitals. These initiatives should be reviewed and consolidated within mental health provision, in order to identify scope for development.

Complementary Medicine

Complementary Medicine, with its emphasis on the restoration of health rather than the removal of illness is found useful by some users of service. The major therapeutic systems of Naturopathy, Homeopathy, Chinese and Ayurvedic Medicine such as Acupuncture and Herbalism are systems of medicine in their own right, with fundamental theory which may be based in alternative understandings of nature and human functioning.

Many mental health service users seek alternative options to the pharmacological treatments currently prescribed. A significant percentage of NHS clinical practitioners have some training in complementary therapies and wish to use these skills within their own practice or to be able to refer to a properly accredited practitioner. The new Glasgow Homeopathic Hospital will offer a range of therapies including Homeopathy, Acupuncture and Arts Therapies to create a holistic approach to healing. At present there is little evidence for the efficacy of such treatments but practitioners are keen to audit and evaluate their practice to demonstrate the value of their interventions.

THERAPIES FOR PEOPLE WITH MODERATE TO SEVERE MENTAL HEALTH PROBLEMS

Moderate Disorders

These are conditions where the mental health problems although not meeting the criteria for severe and enduring mental health disorder, significantly affect daily life by rendering the individual unable to work or live independently. Examples include depressive disorder, anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, eating disorders and personality disorder. The severity of the disorder is such that it is unable to be met by a primary care based intervention. The preceding therapy modalities delivered by skilled practitioners can be most effective.
Severe Disorders

In addition to medication and other forms of treatment described previously, long-term support is necessary for those with severe enduring mental health needs. In this group of disorders marked social disability can persist even when symptoms are well controlled. Thus interventions need to address both the symptoms and social disability. The individuals, often because of ongoing psychosisis, are unable to articulate their needs so that there has been a tendency for services to ‘drift’ to the moderate end of the spectrum.

These disorders include severe depression, bi-polar disorder, schizophrenia, severe phobic and obsessional disorders, alcohol and drug dependence and their long term consequences, organic disorders and other psychotic disorders.

Medication

Medication is available to treat psychoses (anti-psychotic drugs), clinically significant depressions (antidepressants), to prevent relapse in major mood disorder (mood stabilisers) and to reduce craving and withdrawal phenomena in the addictions. In the psychoses and major mood disorders, long term treatment geared towards relapse prevention often follows treatment of the acute episode. The most successful treatment regimes employ the minimum effective dose to reduce side effects and the potential for drug to drug interactions.

Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) involves the application of an electrical stimulus under anaesthetic in order to induce an epileptic seizure which is modified by a muscle relaxant. It is most useful in severe depression but can be used for other conditions. Despite advances in order forms of therapy, it still has a major role in modern mental health practice. However it is important to note that this treatment is provided to relatively few people.

Within the Glasgow area there are currently four NHS sites for the administration of ECT. A named consultant is responsible for each of these areas.

ECT is administered under the care and supervision of expert medical and nursing staff in accordance with the recommendations of the CRAG Good Practice Statement and is subjected to rigorous internal and external audit. Glasgow ECT clinics are major participants in the Scottish National Audit of ECT, which audits both the process and outcome of ECT. Glasgow is also in the forefront of the development of the role of the nurse in ECT.

ECT has proven effectiveness, not just in clinical trials in selected populations, but also in routine clinical practice. National data suggests that over 70% of people who receive ECT will benefit substantially. Few, if any, treatments in the field of mental health can claim or demonstrate that degree of clinical effectiveness.
Psychosocial Therapies

A wide range of psychosocial interventions exist which contribute to the management of the acute, stabilisation and stable phases of severe and enduring mental illness. The only evaluations of these interventions have been carried out whilst the service user has been on appropriate medication. Psychosocial interventions should not be seen as alternative to drug treatment but as adjunct therapies.

Early interventions (1960s) were focused on the negative impact of under-stimulation, institutionalisation and burden and are now part of the standard management of severe mental illness. They have not been subject to the intense outcome evaluation that more specialised, specific therapies have undergone in recent years. Nevertheless they are considered essential components of good practice. They are relatively cheap, easy to provide and make a considerable difference to the quality of the individual’s life. Such therapies include:

- Activities of daily living – structuring the day
- Social skills training – improving relationships and communication
- Vocational rehabilitation
- Improving social networks.

Often known as Rehabilitation or Recreational therapies they consist of core components that perhaps need to be ‘reframed’ in today’s mental health services.

Recent interventions (1970s/80s) have been more stringently evaluated and evidence exists for their effectiveness. Mostly, they are highly specialised, expensive interventions for selected service user groups. These interventions may be delivered by suitably trained health or social work professionals. However research shows that using an unskilled therapist renders them valueless even harmful. Such interventions include:

**Education Programmes** – for service users and families. Such programmes extend beyond simple information – giving information on the course, management of the illness and importance of medication compliance. They provide an educational approach to skills training or problem solving aimed at preventing relapse and reducing stress.

**Family Interventions** – are aimed at the reduction of frequency of relapse, burden of care and improvement in compliance with medication. They include an educational component. Family interventions derived from a number of theoretical background have been shown to be effective. Several practice guides have been published to describe the techniques.

**Cognitive Therapy** – There is evidence for the effectiveness of Cognitive Therapy in modifying symptoms such as hallucinations and delusions or the consequences of the symptoms (cognitive, emotional, physiological, behavioural). The treatment programmes are intense and require a highly trained therapist. The reduction of symptoms has not been shown to lead to significant social or lifestyles improvements.

A number of techniques exist which are just a refinement of good practice but using a more systematic approach, such as Early Intervention Therapy aimed at identifying prodromal symptoms or ‘relapse signature’ and Compliance Therapy aimed at improving medication taking. A fuller description of the above interventions are contained in the SIGN Guideline Psychosocial Interventions in the Management of Schizophrenia (October 1998).
PRIORITY FOR ACTION

There should be explicit pathways through the complex network of services available for people with mental health needs. At present service users usually are left to find their own way and often fail.

1. Services for which there is a satisfactory evidence base should be extended. Whereas others for which there is little evidence of effectiveness should gradually be withdrawn. New services should be evaluated prior to introduction or piloted to allow investigation of their clinical effectiveness.

2. There is a need for a reasonable distribution of mental health resources for people with all severities of mental illness. Early recognition and treatment of mild mental disorder may well prevent subsequent severe illness or relapse prevention or reduction will reduce the burden of severe illness on users and their families.

3. The most effective use of Psychiatrists’ time is in the treatment of severe mental illness such as schizophrenia, depression, bi-polar organic and eating disorders. It is important as far as is possible to manage less serious disorder in Primary Care so that Psychiatrists can be deployed to achieving the greatest possible effect.

4. Adequate training and resources are required by the Primary Care Team to enable it to support and treat the great majority of service users with mainly mild or moderate illness who do not require the services of a Mental Health Team. Some specialist resources in the community such as Community Psychiatric Nurses, Psychology and Counsellors should be linked to Primary Care.

5. All therapies should be subjected to rigorous assessment and evaluation, with the teams involved in the delivery of services being responsible for the delivery of outcome measures. A programme for audit is urgently required in the use of Neuroleptics, Non-specific Counselling, Psychodynamic Therapy and Alternative Therapies. These will therefore be the priority for future clinical audit programmes in the Greater Glasgow, Primary Care NHS Trust.

6. There is a need for the development and continued updating of protocols in the use of Psychotropic drugs.

7. Introduce structured programmes of arts and other therapies to complement more traditional therapeutic approaches, with in-built audit and evaluation programmes of clinical effectiveness.

8. Training programmes require to be introduced to ensure staff in CMHTs have the appropriate levels of expertise to deliver a number of therapeutic interventions (eg, psychosocial interventions, CBT, etc).
CHAPTER 10: THEMES AND ISSUES

During the preparation of the Joint Strategy there were a number of recurring themes and issues which are central to the provision of a comprehensive mental health service. This chapter sets out the means to:

- link the mental health issues into the wider social inclusion work across Greater Glasgow;
- set out a consistent approach and key themes in developing the mental health promotion agenda;
- establish clear care pathways and effective co-ordination of care arrangements across professional and agency boundaries;
- ensure staff partnership, organisational development and human resources issues that need to underpin the Joint Strategy;
- develop housing and the importance of a safe and secure home for people with mental health problems;
- promote employment and training and the need to ensure that mental health systems promote and support people in employment and provide skills and training to help people back into employment;
- foster social networks and support to break down the debilitating sense of social isolation and alienation experienced by many people with mental health problems;
- recognised and respond to the particular needs of people from ethnic minority communities experiencing mental health problems;
- develop outcome measures based on effectiveness and best value;
- develop and promote agreed programmes of academic research in partnership with universities in Glasgow.

PROMOTING SOCIAL INCLUSION

Social Inclusion is a major strand of government policy aimed at breaking the cycle of deprivation, exclusion, alienated young people and anti-poverty action by coherent multi-agency initiatives. The Glasgow Alliance Strategy (March 1999) highlighted action to improve mental health as a key objective. The Strategy recognises the critical importance of co-ordinated inter-agency support for people with chronic and debilitating mental illness, strategies to reduce stigma, preventing domestic violence and supporting mental health initiatives in community schools.

The establishment of a number of geographic Social Inclusion Partnership (SIP) areas in Greater Glasgow and three issue based initiatives concerned with prostitution, young people leaving care and ethnic minorities offers real opportunities to develop co-ordinated responses to tackling the huge issues associated with poverty, deprivation, exclusion and mental health.

A great many people with mental health problems are amongst the most excluded and vulnerable in our communities. There is a pressing need to ensure that the needs of mentally ill people, including people suffering from drug and alcohol abuse, the long-term unemployed, the homeless, children and women in abusive relationships, ethnic minorities and people encountering discrimination on the basis of gender or sexual orientation are addressed in the SIPs.
HEALTH PROMOTION

While the focus of A Framework for Mental Health Services in Scotland is directed to those with severe and/or enduring mental health problems, there is a recognised need to “promote mental health and engage actively in health promotion, including action to de-stigmatised mental illness”. Moving away from an ill-health perspective and broadening the definition of mental health to encompass emotional well-being, health promotion can play a pivotal role through enhancing citizenship, social integration and emotional resilience.

In developing the Joint Strategy, attempts have been made to integrate this health promotion perspective. This section restates some health promotion activity set out in previous chapters and highlights areas and opportunities for health promotion work to contribute to the wider mental health agenda. It is important to recognise that work with a health promotion focus is not exclusively the province of health promotion specialists and for many initiatives positive outcomes will depend on involvement of a range of professionals working in mental health.

The Mental Health Promotion Perspective

Health promotion programmes will be developed and delivered in relation to four strategic aims:

i) The reduction of stigma/discrimination

A major action area is to reduce stigma and discrimination associated with mental health problems. Negative attitudes cause distress to people experiencing mental health problems as well as creating barriers to help seeking behaviours. The Joint Strategy will target the information and education needs of key stakeholder groups whose understanding of and support for the implementation of the Mental Health Strategy will be critical for its success.

- MPs, MSPs, Local Authority and Health Board Members;
- community and business leaders, local media and high profile personalities.

In addition, a programme to redress the media portrayal of mental illness will be developed involving:

- encouraging balanced and sensitive portrayals of people with mental illness (looking to HIV or gay rights movement for approaches);
- responding to articles/adverts which exploit mental illness for humour or sensationalism;
- promoting accuracy in the use of medical terms association with psychiatric conditions;

ii) Improving the health and quality of life of people with mental health problems

This will focus on the promotion of positive mental health with attention being paid to major life events when people experience particular stress, for example, birth, move from primary to secondary school, changing jobs, unemployment, retirement, bereavement.
iii) Prevention

This will include interventions targeting the public in the population whose psychological, social or physical status confers a higher risk of developing a mental health problem and those already displaying mental health difficulties. Interventions range from primary prevention linked to primary care through to services for people with severe mental health problems.

iv) Promoting Positive Mental Health

The development and maintenance of positive mental health/emotional well-being through creating healthy social, economic and cultural structures, promoting citizenship and social integration and through nurturing emotional resilience is a central component of the health promotion agenda. Mental health is essential to overall health and well-being and should reflect social, economic and cultural factors which influence beliefs and impact on the way in which communities, families and individuals respond to mental ill health.

The Role of Health Promotion

The Board’s Health Promotion Directorate will work at strategic and operational levels to ensure that a health promotion perspective is integrated into key developments around mental health and which translate into practice locally. Consistent with the Board’s Health Improvement Programme, inter-agency activity will be developed through a four-tier approach to enable a health promotion agenda to be progressed. Individual initiatives will often operate at more than one of these levels.

i) Strengthening Individuals

• work with local partners to support the implementation of the Government’s New Deal Welfare to Work programme;
• tackling stress in the workplace through Scotland’s Health at Work Award Scheme;
• supporting/rolling out programmes of evidence-based practice in on a variety of issues (eg, post-natal support both within the community and in primary care; Choices Clinic - a primary care based initiative offering a listening support and advice on local services);
• developing new resources targeted to the needs of specific groups, including young people and adults with mild learning disabilities, and for particular issues, for example, exam stress and stress at work;
• on the basis of identified needs, delivering health education/promotion programmes to various client groups.

ii) Strengthening Communities

• supporting Social Inclusion Partnerships (SIPs). This work will include involvement with the geographical SIPs and the three thematic SIPs: young people in/coming out of care, prostitution and ethnic minorities;
• contributing to plans to ensure stronger community-based networks;
• contributing to programmes of action on preventing domestic violence, supporting its victims and streamlining services for women experiencing such abuse.
iii) **Improved Services and Facilities**

- supporting the introduction and development of Healthy Living Centres which will involve, in part, working with local communities to develop new types of facilities;
- progressing mental health promotion activity in schools by contributing to the development of Community Schools, supporting the implementation of mental health policies and rolling out Health Promoting Schools Initiatives;
- supporting primary care in managing mental health problems through information dissemination, resource production, training, etc.

iv) **Encouraging Economic and Cultural Change**

- co-ordinating a 5 year inter-agency programme to address stigma associated with discrimination;
- developing inequalities in health initiatives, with a focus on ethnic minority health and in deprived communities;
- contributing to Scotland-wide developments through national agencies such as the Health Education Board for Scotland and through inter-agency fora;

Central to all four themes will be joint training, needs assessment and research between health and social care services.

Training will be delivered on a range of issues including:

- health promotion practice for mental health workers;
- reducing workplace stress at source for managers;
- peer support on bullying for pupils and staff across regeneration schools;
- health promotion for workers with the homeless.

The Health Promotion contribution to needs assessment and research will develop to the knowledge base in prevention and promotion and will inform practical initiatives. Specific activities include:

- developing health profiles;
- conducting process and outcome evaluation;
- identifying the mental health needs of vulnerable groups such as young carers;
- exploring factors associated with teenage girls’ body image and self-esteem.

**CARE PATHWAYS**

A wide range of services need to be co-ordinated to ensure high quality mental health and dementia services. This section sets out the care pathways that need to be in place to provide a cohesive system of care from primary care through to specialist services for people with severe and enduring mental health problems.

**Primary Care**

Primary care services provide a focal point for patients and their carers to access a network of health and social care services. This can be represented diagrammatically as follows.
GPs and other members of the primary care team provide the first tier of mental health and dementia services, and for many people all their mental health needs can be met within primary care.

GPs and primary care services provide the main focus for:

- screening processes (e.g., 75+);
- early identification of people at risk of developing mental health problems;
- early diagnosis;
- a number of treatments/therapeutic interventions for the majority of patients able to be managed in primary care;
- referral to secondary mental health services and/or social care services.

Primary care therefore needs to be supported by:

- the development and availability of multi-agency training modules in mental health/dementia issues and diagnosis;
- the establishment between primary care, secondary mental health, social care and housing services of clear care pathways based on agreed:
  - referral criteria;
  - identification of seriously mentally ill in the practice;
  - shared care protocols;
  - shared patient information protocols;
  - standards for communication on onward referral/discharge of patient from specialist services.
  - process for resolving complex cases/disputes
- the restructuring of secondary services to ensure that dedicated staff are allocated to primary care liaison;
- access to support staff, including skilled counsellors, welfare rights/benefits advisors to primary care;
- development of information packs/on-line materials for general practices, including information about diagnosis, sources of help, support and advice.

The establishment of the Greater Glasgow Primary Care Trust bringing together primary care and mental health services in a single organisation gives new opportunities to strengthen links and joint working arrangements between primary care and local mental health services.
Community Mental Health Services

In Adult and Elderly Community Mental Health Teams should co-ordinate care across both the community based services and acute in-patient beds within a single continuum. The Teams will act as the gatekeeper of acute admission beds in the majority of cases and the planning and co-ordination of discharge and aftercare from hospital will be merged within a single team.

Community Mental Health Teams will be the focal point for secondary care management arrangements for people with mental health problems within a given locality. A multi-agency system of care management will be applied, including the Care Programme Approach for people with serious and enduring mental health problems. It is envisaged that the CPA will apply to a minority of individuals who will be subject to a detailed risk assessment to determine an agreed care plan between all the agencies involved to minimise risk to themselves and others.

Good care management is vital to effective care and support for people in the community. The process is based on regular reviews and the tailoring of services to promote independence and the wellbeing of the individual.

Figure 2: Care Management Process

- Publishing information about services and how to get them
- Deciding the level of assessment - user and/or carer, who will co-ordinate it, who is it for, eg, individual, court
- Assessing needs of individual/carer with their participation (including advocacy if appropriate) and in consultation with relevant others
- Reviewing changes in wellbeing, appropriateness of service, level of interventions
- Monitoring wellbeing, quality of care, consequences of unmet needs
- Implementation of care plans through a keyworker, funding arrangements, agreements with service providers
- Care planning - matching needs with supports and highlighting gaps in services
Social Care Services

Social Work involvement is vital to the effective functioning of the Community Mental Health Teams. The key functions of Social Work as part of the network of mental health services include:

**Fieldwork Services**

- local intake/reception - services open to all and able to provide a crisis response;
- assessment and continuous review of support needs of service users and carers;
- care management and continuous review of individual care arrangements;
- case management of individual packages of care;
- advice/representation on welfare benefits, debt, housing issues;
- support of user/carer groups, voluntary and community organisations;
- specialist assessment and care management by mental health officers including statutory interventions;
- counselling in relation to drug/alcohol addiction, person centred counselling and special counselling services for women;
- dedicated out of hours service.

**Residential and Home Support Services (Public and Independent Sector)**

- assistance with practical domestic and personal care tasks;
- practical and emotional support to encourage independent living skills;
- befriending;
- drop-ins for information and advice and informal support;
- day care to promote social inclusion and provide structured activities plus supports into education/employment;
- respite services for relief from a situation, from caring or parenting;
- long-stay care including supported accommodation, residential and nursing homes.

**Organisational Services**

- registration of independent service providers;
- inspection of long-stay facilities;
- monitoring, reviewing and evaluation for quality, relevancy and best value of mental health social care of services;
- commissioning new services;
- strategic joint working for consulting on, agreeing and implementing the agenda for community care plans and joint mental health framework, etc.

Complementary working with specialist mental health services needs to be based on clarity about responsibilities, agreement on levels of service to be provided and effective liaison with local social work staff.

**STAFF PARTNERSHIP AND ORGANISATIONAL DEVELOPMENT**

**Staff Partnership**

The NHS in Scotland has produced a Human Resource Strategy based on “Partnership” and “Collaboration” for delivering sustainable change. The Strategy states that partnership “will
be based on agreement that the staff affected by change will be properly involved and allowed to influence the shape and implementation of decisions which affect their work”.

This partnership approach will be taken forward through the newly constituted Mental Health Partnership Forum. This forum involves senior lay and full-time officials of the trade unions who represent staff in the Primary Care Trust together with mental health managers and the Health Board. This will provide a forum to discuss the proposals in the Joint Strategy and to consider how best to take forward the plan.

A total of nearly 2500 staff are employed by the Trust to provide mental health services. The profile of the Trust mental health staff is presented in Figure 3.

**Figure 3: Profile of Mental Health Staff**

![Profile of Mental Health Staff](image)

Major personnel issues for the Trust include:

- reviewing the balance of the current 70 consultant psychiatrist posts and to agree future priorities/specialty areas;
- the range of disciplines and support posts employed within Community Mental Health Teams;
- the continuing process of transferring staff from hospital to community locations during the period of the Joint Strategy;
- establishing realistic targets to increase the number of bilingual staff and staff from ethnic minority backgrounds.

The Trust has developed redeployment principles in agreement with the staff trade unions.

The partnership approach will focus on training and support to staff. New learning partnerships and work towards the Investors in People award have already started to address this important issue.

**Organisational Development**

In 1997 the Sainsbury Centre report on roles and training of mental health staff urged the development of shared competencies for staff and the establishment of distinctive competencies for each profession. These competencies should be developed through shared learning and separate professional development. This joint approach to staff
development would ensure that resources are used to best effect and that staff regardless of their employer or profession are appropriately trained to deliver the agreed aims and priorities.

This approach is endorsed and the need to underpin the Joint Strategy with work which engages with Health, Social Work and Housing professionals is recognised. The Joint Strategy needs the ownership and commitment from the professionals involved in delivering services and ensuring implementation facilitates the growth of clinical and practitioner leadership and the enhancement of relationships between the professional groups across Health, Social Work and Housing boundaries.

The translation of the Joint Strategy from a strategic document to a dynamic process for achieving sustained improvements in care places a premium on good and effective clinical, professional and managerial leadership. The organisational development process will seek to nurture an organic and sustainable cadre of leaders of mental health services.

At the core of the future delivery of mental health and dementia services is the concept of local managed care networks. The concept of team that needs to be developed should not be reliant on a building or a slavish adherence to a particular model. Teams are about relationship and an extended network of services which need to be rooted in common soil of the needs of service users. The team building work to take place as an integral part of the implementation of the Joint Strategy needs to address issues around:

- flexible working;
- breaking down insularity and looking outwards to enhance the wider social inclusion agenda;
- authority and power sharing without losing control;
- accountability;
- recognising the interdependence of professional groups;
- containment of anxieties and offering psychological support.

Fundamental to this approach is the need for staff in teams to respect and value each others professional responsibilities and accepting diversity as a means to create a synergy to enable users to benefit from genuine partnership working.

### HOUSING

**Introduction**

A permanent, affordable and comfortable home is fundamental for good mental health. Users of mental health services cite an appropriate place to live as a core need. The provision of homes for people with mental health problems should include providing support to maintain people in their own homes, a choice of housing with support appropriate to their need and support to people who have become homeless to allow them to have a home of their own.

**Current Housing Services**

Over recent years, 285 social care supported accommodation places have been commissioned by Social Work with a recurring value of £8.4 million based on a number of models: group homes, core and cluster, dispersed units - with levels of care to reflect the range and changing needs of people. The majority of these places were set up originally as part of the major hospital resettlement programmes.
At present, local authority housing departments and housing associations provide a range of services and support for people with dementia and mental health problems. These include:

- a range of services to support people in tenancies:
- community alarm services
- concierge services in multi-storey flats
- support services including close clearing and garden maintenance
- sheltered housing
- housing management programmes, including contributions to care programme approach.

**The Approach**

The provision of housing support should be tailored to meet the needs of individual service users within a wider support network of services. The proposed levels of support are:

- support to maintain own homes;
- accommodation with specialist mental health support;
- support to homeless people.

**Figure 3: Proposed Structure of Housing Support for People with Mental Health Problems**

A key question in relation to the future approach to the housing needs of people with mental health problems concerns the balance of provision. This involves considering:

- choice and user preference;
- flexibility and ability to adapt to changing needs including long-term and crisis;
- social inclusion - ability to integrate into local community and access local facilities.
The joint planning partners will commission an audit of housing needs for people with mental health problems and address the issue of the balance between supported accommodation and accommodation with support.

It will be necessary continually to review models of care to ensure they remain consistent with the developing needs of people with mental health problems. The ongoing work on social care supported accommodation will be linked to the review of in-patient beds to ensure a balance of provision across GGHB and that a co-ordinated approach to housing linked to other services is developed.

As an interim, it is proposed to commission up to 50 new supported accommodation places for the South and West sectors. The funding implications for this provision are identified in Chapter 4 on Adult Services.

**Issues**

Individual local authority groups have identified a range of issues associated with housing and support:

- The majority of local authorities in Greater Glasgow have limited public sector housing. This has implications for:
  - individual service users’ opportunity to exercise choice
  - ability of people to stay within their own local authority area and support networks
  - success of hospital discharge arrangements
- Imminent changes to housing benefits and special needs grant funding coupled with the need for local authorities to demonstrate best value has implications for:
  - support services provided by housing
  - development of new schemes
  - funding of support packages
- The need to increase the role of housing providers in mental health planning, support and discharge arrangements building on the success of the care programme approach.
- The need for more appropriate models of housing for older people including:
  - dementia “friendly” housing
  - very sheltered accommodation

**Priorities for Action**

Action is required to strengthen and develop housing support in the following areas:

- Establish working group to assess impact of benefits/funding reviews and develop a multi-agency strategy.
- Ensure policies, procedures and protocols maximise individuals right to resources
- Develop agreed sharing of void rent to protect tenancies during acute admission.
- Develop local multi-agency planning and training initiatives building on success of CPA.
- Revise assessment and discharge protocols to include housing element.
- Establish working group to analyse current provision and review against local needs, user preferences and future priorities.
- Comprehensive needs assessment of homeless population (including needs of particular groups, eg, those fleeing domestic violence).
EMPLOYMENT AND TRAINING

Introduction

Negative attitudes towards people employing people with a history of mental health problems were identified at both stakeholder events and seen as one of the biggest barriers to be overcome. In addition, the current benefits system is often regarded as restrictive and a disincentive to people gaining employment.

Current Employment Services

At present, around 300 mental health users are in some form of training or transitional employment schemes. The detail of this is set out in the table below.

Table 1: Current Mental Health Employment Projects

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Project</th>
<th>Total No of People</th>
<th>No of Males</th>
<th>No of Females</th>
<th>Age 25-40</th>
<th>Age 40-50</th>
<th>Age 50-60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charlie Reid Centre (NSF)</td>
<td>Café. Trained to SVQ Levels 1 &amp; 2 FH.</td>
<td>17</td>
<td>5</td>
<td>12</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clubhouse (GAMH)</td>
<td>7 transitional employment (cleaning, admin, catering, retail).</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Richmond Fellowship</td>
<td>Vocational training schemes, horticulture, business admin, personal level. Job search.</td>
<td>25</td>
<td>19</td>
<td>4</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust/SAMH</td>
<td>Range: woodwork, horticulture, computers, office skills, catering, painting and decorating, graphic design, printing, arts, literacy.</td>
<td>North: 59</td>
<td>42</td>
<td>17</td>
<td>26</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>South: 92</td>
<td>64</td>
<td>28</td>
<td>51</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>East: 24</td>
<td>14</td>
<td>9</td>
<td>11</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>West: 66</td>
<td>55</td>
<td>11</td>
<td>34</td>
<td>16</td>
<td>6</td>
</tr>
</tbody>
</table>

Action on employment should:

- address assessed needs of those with mental health problems giving priority to those with severe and enduring problems;
- be sensitive to/compatible with local labour market analysis;
- ameliorate financial poverty and/or poverty of opportunity.

The Approach

Three key elements are outlined below:

i) The Employment Continuum

The Strategy builds on current innovations in employment related activity for people with mental health problems distinguishing those in work, those who are job ready and those who are not job ready.
In Work | Individuals in employment who require additional assistance in entering/returning to the employment market including those who have recently received acute service supports; individuals in employment who require assistance in maintaining their employment as a consequence of mental health issues.

Job Ready | Supported/not supported (including those who have been out of employment as a consequence, directly or indirectly, of mental health issues)

Not Job Ready | Training/activity (including those who have been out of employment as a consequence, directly or indirectly, of mental health issues: ability)

ii) **Levels of Intervention**

The employment related aspects of service should relate to where individual service users lie within the “employment continuum”. The role of the components of the service in assisting individuals to move on at different points within the continuum should be defined.

The proposed levels of intervention are: prevention; first contact; ongoing support; and intensive support.

*Figure 4: Proposed Structure for Employment Training Opportunities*
iii) Range of Responses

Understanding the strengths of different approaches to employment will assist in matching the individual to the scheme best suited to him or her. Similarly, an analysis of need will help identify services required to fill these gaps.

There is, therefore, a need to audit existing service models, and to identify employment outcomes in respect of:

- productive/therapeutic programmes
- integrated/segregated programmes
- permanent/transitional programmes

Thereafter there is a need to develop a range of services for those:

- in work
- job ready
- not job ready

Priorities for Action

Action on three key areas is required:

- the need for increased co-ordination of effort;
- the need to identify interventions which can prevent social exclusion;
- the need to develop (or expand) innovative approaches.

This is consistent with the work of the Glasgow City Joint Community Care Employment Group which has recently established a Joint Employment Unit to promote and co-ordinate employment and training opportunities for community care client groups. A key action for 1999/2000 will be to develop and link a mental health component to the Joint Employment Unit.

The Need for Increased Co-ordination of Effort

- A national policy perspective from the Scottish Office with a lead responsibility identified for developing a strategy for Scotland.
- The need to align mental health activity with social & economic regeneration strategies and agencies.
- Needs assessment and resource analysis.
- Assessment and care management processes - employment needs will be incorporated into care management practice.
- Clarifying funding eligibility criteria and impact on benefits- resource guide for users to be produced.
- Policy co-ordination between housing, benefits, employment (national policy context).
- Link to an employment task-force.

The Need to Identify Interventions which can Prevent Social Exclusion

- Early assessment to determine where an individual's needs lie and appropriate package of employment/training agreed.
- Public/Employer/Union - information awareness campaign.
- “Your Rights To and In Employment” Guide.
- Resource Directory and Access Pack
• Interventions and advice to maximise the uptake of benefit entitlements.

The Need to Develop or Expand Innovative Process

Actions as above and:
• Audit of existing service models.
• Development of services through partnership approaches for those:
  • in work
  • job ready
  • not job ready
• The Clubhouse model has been developed in East Dunbartonshire and part of Glasgow City. It is proposed that during the period of the Joint Strategy two further employment related projects are commissioned for the South and West sectors.

SOCIAL SUPPORT NETWORKS

Many people with mental health problems live alone and addressing social isolation is a key issue in the provision of mental health services and support. For users living with their families/carers the need for social support and respite is important. In all of this, programmes to reduce stigma are vital to allow more integration of people with mental health problems in a wider community.

The Joint Strategy sets out to ensure:

• practical help, social contact and support groups and activities for people living alone;
• support to family/carer and the availability of temporary placements outside the home to relieve stress and allow family/carers a break;

Information

Users and carers need to understand the nature of the illness, the effects of various treatments/behaviours on the condition and the choices/options available. Mental health users and their carers need to be provided with a range of information including:

• access to support, self-help groups and advocacy services;
• availability of different therapies and the nature and impact of any medication prescribed;
• services from primary care mental health teams, from social work, housing, other agencies and hospitals;
• assessment, care management, review mechanisms, role of keyworkers.

The role of the voluntary sector in providing information to service users and co-ordinating access to information through a variety of media should be explored.
Mental Health Charter

Mental health users and their carers should have a clear statement of intent outlining standards that can be expected. An early task for the proposed joint commissioning groups within each local authority are should be to develop local charters.

Advocacy

The range of advocacy services available to mental health users should be based on the SHAS/Scottish Office publication “Advocacy: A Guide to Good Practice”.

A key principle of the Joint Strategy will be to seek to ensure the availability of independent advocacy for individuals who have no-one to represent their views. The need for specific advocacy projects for mentally disordered offenders and for people with dementia is recognised and there will be early developments in this area. It will be important to build on the existing networks of mental health advocacy around the Glasgow Advocacy Network, Speak Your Mind and Alzheimer’s Scotland Action on Dementia.

Approaches to advocacy from self-advocacy through citizen advocacy to professional advocacy will be developed. Easily accessible information to users/carers on how to access an advocate will be available and policies on user rights to and the status of advocacy will be in place.

Carers

Many people - relatives, friends, neighbours - provide substantial amounts of care and support to individuals with mental health problems. Carers can often be subjected to discrimination and stigma along with service users in consequence of having a mental health problem/illness or caring for someone who does. Services can also discriminate against carers by making assumptions about their role based on gender, culture or status.

Objectives

The main objectives for mental health service staff in working with carers are:

- to promote and sustain carers own mental health well-being;
- to enable carers to access quickly and easily services for themselves and the people they care for;
- to ensure an equal distribution and development of support services for carers;
- to ensure services are flexible and responsive to the needs of carers;
- to involve carers in planning, monitoring, evaluating and developing services;
- to work to reduce stigma and eradicate discrimination experienced by carers.

Resources

Most existing services target users but provide support to their carers through reducing the users dependence or providing relief from caring tasks, eg, home care, day care opportunities. Respite care and carer support groups offer more direct benefits to carers including information sharing and education opportunities, emotional support and reduction of isolation.
Priorities

The following priorities for carer support have been identified:

- developing appropriate and acceptable respite provision;
- addressing the needs of young carers and carers of young carers and carers of younger people with dementia;
- ensuring carers receive a Community Care Assessment to record their needs where appropriate;
- producing good quality public information easily available to carers;
- availability of advocacy services;
- regular dialogue with carers through stakeholder events;
- consultation with carers in the planning and development of services through a range of means to identify and record the views of carers.

Service User Participation

The Joint Strategy proposes mechanisms by which service users can be involved at all levels of planning, commissioning, monitoring and evaluating the services which they receive.

Throughout the summer and autumn of 1998 stakeholder events took place across Greater Glasgow involving service users, carers, voluntary organisations and statutory agencies and including GPs. In February 1999 a user consultation day took place in which approximately 140 mental health service users participated in workshops organised around issues previously highlighted at the above stakeholder events. Many of the issues raised regarding gaps in current mental health services and future development options are referred to throughout this Strategy.

Plans to address the issues will be facilitated by various means:

- At local authority level mental health service user groups will be established to work with joint commissioning structures. This will allow representatives of all groups of service users including people suffering from dementia to contribute directly to the commissioning of services.
- Service user representatives will be involved in deciding future mental health policies alongside statutory agencies.
- Service users will be involved in service planning and delivery and in monitoring the effectiveness of all services provided by statutory and voluntary agencies.
- Service users can expect to be effectively involved in policy and service development.
- Mechanisms will be put in place to ensure that the above aims are realised with opportunities for users to be involved in a series of forums within which they will receive training and support to contribute their knowledge of what would produce effective mental health services for Greater Glasgow.
- Systems of communication will be developed to ensure that users are fully informed of the potential range of service developments in their area.
- Regular meetings will take place throughout Greater Glasgow in which users, voluntary organisations, statutory organisations can participate in the dialogue necessary to ensure future services reflect peoples needs.
- A further meeting of service user representatives will be co-ordinated to agree the above plans and implement a representative and sustainable process for effective user involvement.
**Voluntary Sector and Mental Health Provision**

People who become emotionally or mentally ill should expect to have access at a local level to services appropriate to their need for assistance, care and treatment. This implies a diversity of services ranging from clinical care to very informal befriending and social support. Elements of the whole range are needed by different organisations. It is in this context that the voluntary sector has increasingly provided community services of various kinds.

There are several areas in which voluntary organisations make an important contribution to mental health services in Scotland:

- as a direct provider of home, day, employment and social care services;
- campaigning for the rights of mentally ill people;
- educating the public about mental illness;
- providing mental health information services;
- providing a forum for the public, users of services and professionals to express their opinions of mental health services;
- offering people with mental illness and their families a chance to support each other and to campaign for better services.

**Issues**

It can be difficult for the voluntary sector to be treated as legitimate providers of mental health services and they certainly still have the least amount of resource and staff, despite often working with most challenging clients, particularly in the case of those users who refuse to use mainstream services. Often these vital services are kept at the margins, through year-on-year funding and a continuation of a “project ideology” which prevents integration of the service being offered into the mainstream. Whilst many purchasers and providers recognise that statutory services are not always appropriate or easily accessible, the development of a range of alternatives needs to be embedded in the fabric of mainstream health and social care services, including primary care.

Many organisations are providing multiple services to meet the holistic needs of their users. Mental health problems are not seen in isolation from the wider social and economic situation and this has meant that users often also receive welfare advice, housing advice, skills training as well as recreational activities.

**SERVICES FOR ETHNIC MINORITY GROUPS**

Work on the Joint Strategy has revealed that we should work to improve the sensitivity and effectiveness of our services to people from ethnic minority communities. This means working to ensure that mental health staff are trained and supported in working with the needs of members of these communities. It also means working with representatives of specialist ethnic services in the non-statutory sector to develop services further.

**Communication and Understanding**

Lack of bilingual staff and accessible information for service users and carers are major barriers to accessing services. Use of skilled interpreters and advocacy services are necessary because people cannot always communicate for themselves and clear information is essential for understanding what is possible and exercising choice. Mental health staff require training and support which ensure they are culturally aware, which extends their knowledge and understanding of concepts of mental health beyond a western biomedical
model and which equips them to deliver services in ways which will increase service uptake by individuals in need but unable to benefit from current services.

**Primary Care**

Primary care has a central role, whether in terms of better information about health, health gain, providing primary care services, referring to secondary and specialist services, treatment and improving pathways to care. Practices and therapies which are rooted in eastern and western traditions should be encouraged to complement each other and offered as an option where appropriate. It is particularly important that Primary care adopts a holistic approach to health, building on the success of “one-stop clinics”. Particular attention should be given to the needs of carers to ensure assumptions are not made about the extent of care they are providing or can be expected to provide.

Safe environments with support for child care are essential to improve access and positive local action on poverty, violence and racism is likely to improve the overall effectiveness of services.

**Crisis Services**

Literature has shown that people from ethnic minority communities are more likely to be in touch with services in a crisis. There is a need to ensure that crisis services are provided in a way that does not discriminate on the basis of colour, nationality or ethnic origins. Where appropriate the crisis team should have access to multi-skilled, multi-racial and multi-lingual staff with a mental health background. The availability of home treatments is often of particular relevant in trying to meet the needs of individuals from ethnic minority backgrounds.

**Elderly**

The older population within the black and ethnic minority community is expected to double over the next seven years. Access to local and specialist services, whether in health, housing, social care or voluntary sector needs to be improved. The dementia needs of this group have not been fully acknowledged and addressed. There needs to be further development of sensitive assessment methods, appropriate and accessible information and support for sufferers and carers, ethnic monitoring and advocacy.

**Priorities**

The following priorities for action have been identified:

**Communication** - the availability of interpreting, translating and advocacy services for people from ethnic minority communities and the need to increase the numbers of bilingual staff working in mental health services. All providers of mental health services should have communications policies in operation that can be audited for effectiveness.

**Consultation** - ethnic minority service users and their carers need to be involved in service planning and monitoring in order that developments in services can be more inclusive and barriers to service uptake removed.

**Information** - improved availability of reliable information about mental health issues, services, patient rights and complaints procedures.
Equity of services - flexibility of service responses to meet needs of ethnic minority groups and sensitivity to the cultural, religious, hygienic and dietary needs along with proactive management interventions to tackle any unwitting institutional racism.

OUTCOMES

The Joint Strategy recognises the need for development work in outcome measures to reflect the work of CRAG/SCOTMEG groups on mental health and based on the following:

- User Involvement
- User Wellbeing
- User Satisfaction

Existing outcome measures relating to suicide rates, mortality/suicide within a year of hospital discharge are of little use as they do not relate to the vast majority of people with mental health problems or address quality/satisfaction with service issues.

A Best Value approach to developing outcomes should adopt SMART criteria, in that they must be Specific, Measurable, Action-orientated, Realistic and Timeous.

Outcome measures based on assessing outcomes across a range of indicators, both clinical and social will be developed. These include:

- The User Generated Scale - based on measuring progress on a 3 point scale that can be linked into the CPA and related to:
  - clinical outcome
  - functional outcome
  - satisfaction with process
  - consequences of types of interaction
- Health of the Nation Outcome Scale (HONOS) measures 12 elements of acute mental health problems and can be used by a range of professional staff on a multi-agency basis.
- Avon Mental Health Measure - a user generated measure looking at individual functioning against a number of aspects of everyday life.
- Dementia Functional Rating Scales - a number of scales exist, including REPDS and the CARE system to assess individual functioning.
- Joint work on Best Value delivering care that matches cost and quality based on individual needs.

The work on outcomes relates closely to the need to develop effective quality assurance and accreditation progress in mental health across both health and social work services. The development of outcome and performance management systems is a key component of developing a performance culture in mental health services with an imperative to establish processes around improved efficiency and effectiveness.

LINKS WITH ACADEMIC INSTITUTIONS

The Greater Glasgow area has several universities who have Health and Social Studies Departments. Links with these would be important in the ongoing work on developing, delivering and evaluating services and new models of care in mental health.

While there are numerous departments, a starting point for collaboration would be with the University of Glasgow’s Department of Psychological Medicine. Staff of this Department are
working on developing “The Glasgow Institute of Psychosocial Interventions in Mental Health”. This aims to deliver training, research and supervision for all professionals working in the mental health field around such psychosocial interventions as cognitive behavioural therapy, family therapy and interpersonal therapies for individuals with the whole range of mental health problems. Staff of GIPSI would supervise fieldwork staff while they are working with a user and their families to promote improvement in the skills base of staff and hence the effectiveness of treatment. The staff would also provide some direct treatment services. Fieldwork staff would come from any professional background in Health or Social Work initially.

Links with Departments of Nursing, Social Work and Occupational Therapy will be forged over the course of the next few years to ensure that Undergraduate and Postgraduate training is relevant and useful to the model of service which is being developed through the Framework process. To this end a liaison group will be set up between the Framework Steering Group and the relevant academic departments to explore the links.
INTRODUCTION

Recent government policy initiatives in both health and social work have placed a premium on the development of effective joint commissioning and joint working between agencies. Both the NHS White Paper “Designed to Care” and “Modernising Community Care” highlighted the need to put in place joint structures which would promote a joint delivery of services to individuals.

The Joint Strategy similarly places considerable emphasis on the need for partner agencies to evolve effective joint commissioning arrangements for mental health services. It is important to recognise that joint commissioning is not simply about pooling resources. In its broadest form, joint commissioning involves creating a pattern of care based on:

- complementary services;
- collaborative working;
- co-ordinated care;
- commissioning arrangements.

This involves:

- assessment of population needs;
- assessment of individual needs;
- agreement on strategy/policy;
- service planning;
- commissioning of services;
- monitoring and evaluation.

A number of the building blocks for joint commissioning have been put in place. These include:

- developing a joint needs assessment process and criteria for the basis of a future model for resource allocation;
- identifying and sharing the current spend by each partner agency in mental health services;
- agreement from the partner agencies that their resource allocation will mirror the Mental Health Framework Implementation Plan;
- recognition of the need for and processes to agree eligibility criteria and responsibility for the provision of services and mechanisms to monitor service performance;
- joint strategy for engaging with all stakeholders in the mental health system.

Joint planning structures with each local authority have established Strategy Groups covering Community Care, Children and Families and Criminal Justice services. Membership includes Social Work, Housing, GGHB, Health Trusts and Strathclyde Police. The Groups have responsibility for joint work, with a particular focus on producing the three-year joint plans required by statute. Whilst Social Work has lead role, all the planning partners are committed to the successful development and implementation of the plans. Each plan has a section on mental health needs with an associated programme of action for improving and developing services.
It is proposed that the following structures to develop joint commissioning will be established:

**LOCAL AUTHORITY JOINT COMMISSIONING BODIES**

Each local authority within the Greater Glasgow Health Board area will establish a mental health joint planning and implementation group. Membership of the Group will be drawn from Social Work, Housing, the Health Board, the Primary Care Trust, Scottish Homes as well as service users and carers, representatives from the voluntary section, the police and education. The joint commissioning arrangements for South and North Lanarkshire will be developed in conjunction with Lanarkshire Health Board whilst those for West Dunbartonshire and East Renfrewshire will involve Argyll and Clyde Health Board.

The main function of the Joint Planning and Implementation Groups will be to determine local priorities consistent with the agreed financial framework and monitor the implementation of the Joint Strategy for Mental Health and Dementia within the local authority area. The groups will be the lead joint planning body with responsibility for community care planning and the mental health and dementia components of Joint Community Care Plans.

The remit for the local authority groups will include:

- updating needs assessments for the local population;
- determining priorities for the local authority area within an agreed resource envelope;
- defining and reviewing roles and responsibilities for service provision;
- allocating resources for a comprehensive mental health service across the local authority area;
- ensuring equity in the provision of mental health services;
- defining key operational policies and procedures, including the Care Programme Approach, discharge planning arrangements;
- monitoring the implementation of the Joint Strategy in the local authority area;
- monitoring services against a series of key outcome measures;
- ensuring involvement of users, carers, the voluntary sector and primary care in planning, delivery and evaluation of local mental health services;

A number of services will be commissioned jointly on a Greater Glasgow basis involving the Board, the Primary Care Trust and local authorities. The services which will be commissioned across Greater Glasgow are:

- Services for Children and Young People (also with the Yorkhill NHS Trust)
- Mentally Disordered Offenders

**MONITORING THE IMPLEMENTATION OF THE JOINT STRATEGY**

A consistent approach to monitoring the implementation of the Joint Strategy will be developed. Each year the central focus of implementation will begin with the Joint Commissioning structures agreeing a Monitoring Plan to check progress in the implementation of the Joint Strategy. The Joint Commissioning structures will prepare an annual progress report that will be reported to the statutory agencies represented on the Joint Planning Groups.

**INFORMATION**

There are serious deficits in information to plan, monitor and review services. A priority for the implementation plan and the joint commissioning arrangements will be to agree an
approach to developing a consistent recording and reporting client based information for people with mental health problems and dementia. A basic requirement will be for information systems that collect information on:

- Care Programme Approach
- Simple Local Care Records
- Routine Outcome Measures
- Care co-ordinated across both agencies and specialist and generalist services

A critical issue to be resolved relates to sharing patient/client information across professional groupings and agencies. A piece of work is underway on developing protocols for sharing information as part of the Strategy for Mentally Disordered Offenders. The results of this work will be developed into a series of shared protocols through the joint commissioning structures involving all professional groupings to ensure a consistent approach to sharing information relevant to the care of individuals based on the principle of duty of care.

Particular emphasis will be placed on the establishment of information systems which can aggregate individual needs assessments to allow a picture of met and unmet needs to be presented to assist in the future reshaping of services.

**CLINICAL/PROFESSIONAL AUDIT**

Multi-disciplinary clinical audit will be an important part of the monitoring and review process. The joint commissioning structures will agree an annual programme for clinical audit with service providers and use the results to inform future commissioning arrangements.

**PRIORITIES FOR ACTION**

- Establish Joint Mental Health Planning and Implementation Groups for each local authority with agreed remits.
- Establish Greater Glasgow Joint Commissioning Groups for Child and Adolescent Services, Mentally Disordered Offenders and Early Onset Dementia.
- Agree through Joint Commissioning arrangements annual monitoring process for Joint Strategy Implementation Plan.
- Agree Clinical Effectiveness Audit Programme for mental health services with Trusts and local authorities.
- Establish as part of Joint Commissioning a working group to review information systems and to record future approaches to reporting information for mental health and dementia services.
- Agree protocols for sharing information on people with mental health problems and dementia between agencies and professional groups.
- Develop a specification for the work of the Community Mental Health Teams.
- Clarify the level and nature of involvement with people with personality disorders.
CHAPTER 12: FINANCIAL OVERVIEW

THIS CHAPTER

- outlines the resource currently invested in mental health services across Greater Glasgow;
- summarises the financial implications of the priorities within the client group sections;
- proposes developments to financial and management information systems.

CURRENT RESOURCES

Between the NHS and the six local authorities across Greater Glasgow, a total of £137M is invested in mental health and dementia services. The organisations invested the following during 1997/98:

Table 1: Total Resources 1997/98

<table>
<thead>
<tr>
<th>Organisation</th>
<th>£M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Glasgow Health Board</td>
<td>86.7</td>
</tr>
<tr>
<td>Glasgow City Council Social Work</td>
<td>41.5</td>
</tr>
<tr>
<td>East Dunbartonshire Council Social Work</td>
<td>2.5</td>
</tr>
<tr>
<td>West Dunbartonshire Council Social Work</td>
<td>2.0</td>
</tr>
<tr>
<td>East Renfrewshire Council Social Work</td>
<td>1.9</td>
</tr>
<tr>
<td>South Lanarkshire Council Social Work</td>
<td>1.7</td>
</tr>
<tr>
<td>North Lanarkshire Council Social Work</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>137.0</td>
</tr>
</tbody>
</table>

The total resource can be presented by client group as follows:

Figure 1: Total Resource by Client Group

The investment by the six local authorities is heavily biased towards delivering services for people suffering from dementia with 67% of social work spend being directed to this client group. Health service spend by care group is shown graphically below.
Within each of the care sections priorities for action have been identified that emerged during the work on the Joint Strategy. In many cases such actions involved a reassessment and improvement of an existing service and resource, the proposal would therefore be cost neutral. Within some care sections the recommendations include for a major review of service that may result in significant reconfiguration. An integral component of such an appraisal would be the construction of a financial framework to support the decision making process. However, priorities have been identified that have a financial implication and this has been incorporated within each of the care sections. The current projected costs of developments by care group have been established and phased over the life of the programme as follows:

<table>
<thead>
<tr>
<th>Proposed Developments</th>
<th>&lt;-------------- Programme Year --------------&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 £k</td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>20</td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>300</td>
</tr>
<tr>
<td>Adult Mental Health Services</td>
<td>1,217</td>
</tr>
<tr>
<td>(including Drug &amp; Alcohol and Homeless Services)</td>
<td></td>
</tr>
<tr>
<td>Services for Mentally Disordered Offenders</td>
<td>2,725</td>
</tr>
<tr>
<td>Services for People with Learning Disabilities</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health Services for Older People</td>
<td>650</td>
</tr>
<tr>
<td>Themes and Issues</td>
<td>90</td>
</tr>
<tr>
<td>Total Annual Developments</td>
<td>5,002</td>
</tr>
</tbody>
</table>
The detail of the development expenditure is set out in the relevant chapter of the Strategy and summarised at the end of this section.

Table 3 outlines the various funding sources being applied to finance the developments identified above. The different methods of generating funding include the recycling of existing mental health resources within Glasgow through the reshaping of current service, releasing funds from contracts with providers outwith Glasgow and finally by applying new monies including the Boards commitment to Services for Mentally Disordered Offenders, the recent commitment within the Health Improvement Plan to finance Mental Health developments and Glasgow City Social Work– Modernising Community Care funds.

**Table 3: Programme Sources of Funds**

<table>
<thead>
<tr>
<th>Realignment of Existing Resource</th>
<th>Programme Year</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 £k</td>
<td>2 £k</td>
<td>3 £k</td>
<td>4 £k</td>
<td>5 £k</td>
<td>6 £k</td>
</tr>
<tr>
<td>Existing Adult Community Services</td>
<td>-325</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
</tr>
<tr>
<td>Day Hospital Reconfiguration - Phase 1</td>
<td>-176</td>
<td>-176</td>
<td>-176</td>
<td>-176</td>
<td>-176</td>
<td>-176</td>
</tr>
<tr>
<td>Day Hospital Reconfiguration - Auchinlea</td>
<td>-60</td>
<td>-121</td>
<td>-121</td>
<td>-121</td>
<td>-121</td>
<td>-121</td>
</tr>
<tr>
<td>Existing MDO Service Funding (Incl ECR's)</td>
<td>-458</td>
<td>-478</td>
<td>-528</td>
<td>-3,258</td>
<td>-3,258</td>
<td>-3,258</td>
</tr>
<tr>
<td>XBF Retraction Renfrewshire HC</td>
<td>-400</td>
<td>-550</td>
<td>-550</td>
<td>-600</td>
<td>-600</td>
<td>-650</td>
</tr>
<tr>
<td>Other XBF/ECR Savings</td>
<td>-50</td>
<td>-200</td>
<td>-250</td>
<td>-300</td>
<td>-350</td>
<td>-400</td>
</tr>
<tr>
<td>HIP Elderly Bed Reduction</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
<td>-500</td>
</tr>
<tr>
<td>JCCP Capital Finance Provision</td>
<td>-200</td>
<td>-200</td>
<td>-200</td>
<td>-200</td>
<td>-200</td>
<td>-200</td>
</tr>
<tr>
<td>Realignment of In-patient Services - Health</td>
<td>-40</td>
<td>-160</td>
<td>-160</td>
<td>-160</td>
<td>-160</td>
<td>-160</td>
</tr>
<tr>
<td>Realignment of In-patient Services - S.A.</td>
<td>-312</td>
<td>-625</td>
<td>-937</td>
<td>-1,250</td>
<td>-1,250</td>
<td>-1,250</td>
</tr>
<tr>
<td><strong>Total Release of Existing Resource</strong></td>
<td>-2,169</td>
<td>-2,765</td>
<td>-3,297</td>
<td>-6,440</td>
<td>-6,802</td>
<td>-7,215</td>
</tr>
<tr>
<td><strong>Additional Funding Identified</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDO Development Funding Requirement</td>
<td>-2,168</td>
<td>-2,922</td>
<td>-3,102</td>
<td>-5,700</td>
<td>-5,700</td>
<td>-5,700</td>
</tr>
<tr>
<td>Modernising Community Care - SW</td>
<td>-100</td>
<td>-100</td>
<td>-100</td>
<td>-100</td>
<td>-100</td>
<td>-100</td>
</tr>
<tr>
<td>HIP Mental Health Development Provision</td>
<td>-565</td>
<td>-1,000</td>
<td>-2,000</td>
<td>-3,000</td>
<td>-4,000</td>
<td>-4,000</td>
</tr>
<tr>
<td><strong>Total New Mental Health Funding</strong></td>
<td>-2,833</td>
<td>-4,022</td>
<td>-5,202</td>
<td>-8,800</td>
<td>-9,800</td>
<td>-9,800</td>
</tr>
<tr>
<td><strong>Total Available Resource</strong></td>
<td>-5,002</td>
<td>-6,787</td>
<td>-8,499</td>
<td>-15,240</td>
<td>-16,602</td>
<td>-17,015</td>
</tr>
</tbody>
</table>

Table 4 demonstrates the current state of development of the affordability within the financial framework over the life of the programme and shows a balanced position for years one and two.
Further work is still required regarding the phasing of developments and sources of funds to bring the programme back into balance in later years. The envelope of finance currently identified at the end point would appear to fund the proposals identified within the individual care groups. This will require to be continually reviewed, particularly in light of the outturn in years one and two. Clearly, even if the assumption underlying the financial model hold up years three and four require to be revisited in order to achieve balance.

To this end the financial framework needs to be a fluid document that can be used by management to advise the decision making process and ensure the viability of the development programme in the longer term. Further refinement of the financial framework, particularly in years three to six, will need to consider the following:

- The ongoing mental health in-patient review for north and south Glasgow will have a major impact on the later years of the programme. The financial analysis associated with this review has not yet established the recurring financial impact for the options being considered. The framework has necessarily assumed a cost neutral position, which will inevitably change as a result of this piece of work. Irrespective of the end point impact there will be a need for non-recurring funding to facilitate any strategic change process.

- The detail of social care provision, including supported accommodation, as a result of any changes in in-patient services will require further consideration by local authorities in conjunction with the Board and Trust.

- Assumptions contained within the existing framework about the pace of retraction from existing services will need to closely monitored and changes reflected in later years.

- The need to address balance of care and investment issues indicated in the CCIU report.

- The development programme has primarily been financed by recycled existing Health spend or new Health commitments. There is a continued need for all the planning partners to review existing spend and identify new recurring or one off monies to finance the programme as it develops.

**DEVELOPMENT OF FINANCIAL AND MANAGEMENT INFORMATION SYSTEMS**

Agencies involved in the development of the Joint Strategy have encountered difficulties in generating reliable information on activity and financial commitment by individual client group. Examples being:

<table>
<thead>
<tr>
<th>Programme Year</th>
<th>1 £k</th>
<th>2 £k</th>
<th>3 £k</th>
<th>4 £k</th>
<th>5 £k</th>
<th>6 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Annual Developments</td>
<td>5002</td>
<td>6787</td>
<td>8883</td>
<td>16324</td>
<td>16624</td>
<td>17004</td>
</tr>
<tr>
<td>Total Available Resource</td>
<td>-5002</td>
<td>-6787</td>
<td>-8499</td>
<td>-15240</td>
<td>-16602</td>
<td>-17015</td>
</tr>
<tr>
<td>Funding Balance</td>
<td>0</td>
<td>0</td>
<td>384</td>
<td>1084</td>
<td>22</td>
<td>-11</td>
</tr>
</tbody>
</table>
i) Current health activity and financial monitoring systems do not readily provide information on dementia services. Existing systems have an adult/elderly division.

ii) When identifying the cost of social work services specialist client group figures were included plus an estimate for generic services used by people with mental health problems. For example, when identifying the cost of services for people with dementia a figure was included for elderly and generic social work services.

iii) The varying ability of organisations to provide reliable data makes comparison difficult particularly in relation to activity.

The existence of reliable information is of paramount importance to allow the agencies involved make well-informed decisions. The need to track the movement of resource and activity over time plus the development of joint commissioning arrangements will rely on sound and robust information flows. A priority must, therefore, be:

- the development of financial and management information systems within the health service that will facilitate reporting by specific client group. In particular, dementia, services for people with alcohol related brain damage, people with addictions and services for women;
- a detailed review of local authority data supplied to date to ensure consistency and completeness;
- an appraisal of local authority social work financial and management information systems to consider the feasibility of mental health care group resource accounting and activity monitoring.
<table>
<thead>
<tr>
<th>Details</th>
<th>1 £k</th>
<th>2 £k</th>
<th>3 £k</th>
<th>4 £k</th>
<th>5 £k</th>
<th>6 £k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Needs Assessment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detailed needs assessment of dementia</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children &amp; Young People</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish integrated clinical service</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Specialist services for offenders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced crisis/emergency service</td>
<td>115</td>
<td>150</td>
<td>150</td>
<td>150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison service with acute hospitals</td>
<td>50</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhance community teams</td>
<td>230</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
</tr>
<tr>
<td>Improved eating disorder service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>350</td>
</tr>
<tr>
<td>Notre Dame Funding Pressure</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Developments</strong></td>
<td>300</td>
<td>400</td>
<td>515</td>
<td>740</td>
<td>790</td>
<td>1140</td>
</tr>
<tr>
<td><strong>Adult Mental Health Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete network of community teams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team No.1</td>
<td>220</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
</tr>
<tr>
<td>Team No.2</td>
<td>220</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
</tr>
<tr>
<td>Team No.3</td>
<td>220</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
</tr>
<tr>
<td>Team No.4</td>
<td>220</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
<td>350</td>
</tr>
<tr>
<td><strong>Total Developments</strong></td>
<td>880</td>
<td>1400</td>
<td>1400</td>
<td>1400</td>
<td>1400</td>
<td>1400</td>
</tr>
<tr>
<td>Improved crisis service</td>
<td>67</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
<td>270</td>
</tr>
<tr>
<td>Development of specialist in-patient units</td>
<td>40</td>
<td>373</td>
<td>586</td>
<td>586</td>
<td>586</td>
<td></td>
</tr>
<tr>
<td>Community drug &amp; alcohol teams</td>
<td>400</td>
<td>800</td>
<td>800</td>
<td>800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td>100</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced day services</td>
<td>250</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Support &amp; Day Care</td>
<td>125</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional supported accom. places</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurring Costs</td>
<td>125</td>
<td>250</td>
<td>500</td>
<td>1000</td>
<td>1250</td>
<td>1500</td>
</tr>
<tr>
<td>Transitional Funding</td>
<td>95</td>
<td>100</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td>50</td>
<td>70</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Locally accessible respite services</td>
<td>25</td>
<td>100</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td><strong>Total Developments</strong></td>
<td>1217</td>
<td>2155</td>
<td>3738</td>
<td>5426</td>
<td>5676</td>
<td>5706</td>
</tr>
<tr>
<td><strong>Services for Mentally Disordered Offenders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish outreach team</td>
<td>750</td>
<td>750</td>
<td>750</td>
<td>750</td>
<td>750</td>
<td>750</td>
</tr>
<tr>
<td>A range of accommodation options</td>
<td>320</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>Advocacy services</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Employment opportunities</td>
<td>200</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Establish medium and low secure unit</td>
<td>570</td>
<td>800</td>
<td>7308</td>
<td>7308</td>
<td>7308</td>
<td></td>
</tr>
<tr>
<td>Establish second interim secure unit</td>
<td>1395</td>
<td>1180</td>
<td>1180</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Developments</strong></td>
<td>2,725</td>
<td>3,260</td>
<td>3,490</td>
<td>8,818</td>
<td>8,818</td>
<td>8,818</td>
</tr>
<tr>
<td><strong>Services for People with Dementia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older People Needs &amp; Model Assessment</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop advocacy services</td>
<td>50</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Services for younger people with dementia</td>
<td>100</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Alternative Health Services - HIP Beds</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Alternative SW Services - HIP Beds</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
<td>250</td>
</tr>
<tr>
<td>Older People with Dementia - Social Care Services</td>
<td>200</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td>400</td>
<td>400</td>
</tr>
<tr>
<td>Alzheimer’s Bid</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total Developments</strong></td>
<td>650</td>
<td>872</td>
<td>1040</td>
<td>1240</td>
<td>1240</td>
<td>1240</td>
</tr>
<tr>
<td><strong>Themes and Issues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved multi-agency working</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote user/carer involvement</td>
<td>60</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total Developments</strong></td>
<td>90</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
DEVELOPING THE GREATER GLASGOW JOINT MENTAL HEALTH STRATEGY

LOCAL AUTHORITY MENTAL HEALTH STRATEGY GROUPS

A key element of the process for developing the Greater Glasgow Joint Mental Health Strategy involved establishing Mental Health Strategy Groups in each of the six local authority areas in Greater Glasgow.

The Groups involved a broad range of stakeholders and identified key issues and priorities for the future development of mental health and dementia services for the local authority area.

This annex sets out the conclusion of these groups which are fully reflected in the priorities and plans within this strategy.

GLASGOW CITY COUNCIL

Glasgow City Council has a population of 616,000 and is characterised by high levels of deprivation and ill-health.

Glasgow City is faced with particular challenges for its mental health services. The concentration of homeless people, including many young people and hostel dwellers in the centre and east; the significant, increasing and changing population from Ethnic Minority communities; growing numbers of young adults with Alcohol Related Brain Damage and general high levels of alcohol/drug abuse; the high numbers of individuals to be resettled from long-stay hospitals all converge with the general poverty and disadvantage recognised to exist in the city to create substantial and complex need.

The size of the area and its population, the plurality of health and social work service delivery points and the diversity of independent providers create a demand for a cohesive, co-ordinated infrastructure for the planning, delivering, managing and financing of the spectrum of care services for people with severe and enduring mental health problems.

<table>
<thead>
<tr>
<th>Service Issues</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td>• Agree balance of care and development of joint commissioning programme for South/West Glasgow.</td>
</tr>
<tr>
<td>Significant variation in the level of services available in different parts of the city.</td>
<td>• Establish effective care management arrangements and agreed pathways.</td>
</tr>
<tr>
<td></td>
<td>• Develop new in-patient unit for the North of the City at Stobhill Hospital.</td>
</tr>
<tr>
<td></td>
<td>• Review and implement crisis/emergency services.</td>
</tr>
<tr>
<td>Service Issues</td>
<td>Actions</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Responding effectively to users needs in the community.                      | • Audit and review day opportunities including review of future levels and function of in-patient and community mental health services.  
  • Complete supported accommodation and community infrastructure proposals for North East Glasgow.                                                                                                                                                                                                                                                                  |
| Service user and carer involvement in planning and service delivery.          | • Develop joint advocacy services.  
  • Establish and support structure for users and carers involvement.                                                                                                                                                                                                                                                                                                                                                                         |
| Lack of employment opportunities and support for people wishing to take up and maintain employment. | • Review and develop employment projects in conjunction with the Joint Employment Unit.                                                                                                                                                                                                                                                                                                                                                                                                       |
| In creasing incidence of mental disorder amongst people in criminal justice system. | • Implement comprehensive network of services for mentally disordered offenders.                                                                                                                                                                                                                                                                                                                                                                                                            |
| Dementia                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Significant variation in the level of services available in different parts of the City. | • Agree balance of care and develop joint commissioning programme for South/West Glasgow.  
  • Complete dementia care unit programme and community infrastructure for North East Glasgow.                                                                                                                                                                                                                                                                                                                                                       |
| Effective and quick responses to people with dementia and their carers.       | • Establish effective assessment care management arrangements and agreed pathways.  
  • Develop information/training packages and care pathways for GPs and other primary care staff to ensure improved and earlier diagnosis and effective intervention and treatment.  
  • Develop joint advocacy strategy.                                                                                                                                                                                                                                                                                                                                                                                                  |
| Responding effectively to users needs in the community.                      | • Develop service proposals for younger people with dementia.  
  • Replacement services in North and South Glasgow (home support, residential and nursing, community health services).                                                                                                                                                                                                                                                                                                                                                                             |
| Supporting carers.                                                            | • Develop network of carers support groups.                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Effective co-ordination of services.                                         | • Jointly review role/function of day hospitals/day services.                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Improving the physical design of accommodation for people with dementia.     | • As part of Year of Architecture, review physical design of accommodation (in-patient care, nursing, residential, day services and people’s own homes) and develop audit tool for wider application.                                                                                                                                                                                                                                                                                                                                                     |
WEST DUNBARTONSHIRE (CLYDEBANK)

The population of West Dunbartonshire is 95,760, of which 47,000 live in the Clydebank area within GGHB. The population of Dumbarton relates to Argyll and Clyde Health Board for health care.

Many of the foundations of a comprehensive integrated mental health service for Clydebank are already in place:

- the involvement of Primary Care in mental health service planning and development;
- the adoption of a community based approach to psychiatric service delivery;
- integration of social work and mental health services;
- collaboration with voluntary sector providers;
- user and carer representation and active involvement in service planning via the Mental Health Forum;
- support of and development work with local communities;
- substantial provision of home based care;
- employment initiatives including job coaching.

Service gaps and issues have been agreed locally as:

<table>
<thead>
<tr>
<th>Service Issues</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>Monitoring of Care Programme Approach</td>
<td>Framework Group to oversee Care Programming (Year 1)</td>
</tr>
<tr>
<td>Home care for people with mental health problems</td>
<td>Establish sub-group to develop issues (Year 1)</td>
</tr>
</tbody>
</table>
| Support for families | Parenting skills for people with mental health problems  
| | Support for children of people with mental health problems  
| | Panel of advisors for Young Persons Sub-Group of Mental Health Forum |
| Employment/day opportunities Support in the community | Monitor/evaluate Job Coaching Scheme (Year 1)  
| | Directory of services  
| | Multi-agency Working Group to address stigma  
| | Development of collaborative work with Clydebank Community Support Project  
| | Further development of Stepping Stones and supported accommodation projects |
| Develop Mental Health Officer role in care teams and in delivering aftercare services | Recruitment, training and ongoing support to Mental Health Officers |
| Older People |         |
| Improve home supports | Increase local day care provision  
| | Social Work attachment to elderly mentally ill (Year 1)  
| | Joint assessments |
| Improve residential/nursing home service | Mental health input into homes  
| | Link with PAMS team |
Service Issues | Actions
--- | ---
Child and Adolescent Services | Input to Greater Glasgow Strategy for:
Addiction services | • Child and Adolescent Services
Forensic services | • Mentally Disordered Offenders
 | • Addiction Services
 | • Homelessness
 | Input to Local Health Care Co-ops

Service Users and Carers | Joint Information Directory (Year 1)
Communication of information to service users | Implement hospital discharge protocol
Inter-agency communication | Continue destigmatisation work
Education of public | Enhance and further develop user/carer involvement (Year 1)
Service user involvement | Link to GGHB crisis service (Year 1)
Out of hours support | 

Organisational | Establish Joint Commissioning Group to implement and develop local joint strategy
Develop joint planning, commissioning and review | 

EAST DUNBARTONSHIRE (STRATHKELVIN, BEARSDEN AND MILNGAVIE)

The population of East Dunbartonshire is 110,750. The whole of East Dunbartonshire lies within the Greater Glasgow Health Board area.

The East Dunbartonshire area divides into two district areas. In the east there is the Strathkelvin area served by multidisciplinary/agency resource centres for adult and elderly linked to admission units at Woodilee Hospital. In the west there are small Community Psychiatric Nurse teams covering adult and elderly and hospital based Consultant Psychiatric linking to Gartnavel Royal Hospital.

Spanning the entire area is the East Dunbartonshire Social Work team. A number of voluntary organisations and housing agencies exist within the district, mainly at the Strathkelvin end.

Service Issues | Action
--- | ---
General | Strategy Group working on a directory of service with possible employment of a service user to update.
Lack of structured information on services available within the area. | IT links. Monitoring and evaluation of effectiveness of CPA.
More effective communication between agencies. | 

Service Issues | Action
--- | ---
**Adult**
Establish CMHT for Bearsden/Milngavie area.
Previous research identified the benefits of assertive outreach.
Problems with mode of access/intervention for people in crisis.
Poor transport links for clients attending services (Strathkelvin).
Lack of day services within the area.
Lack of Social Work provision dedicated to Mental Health for Bearsden and Milngavie area.

To be developed during first year of Joint Strategy.
To be developed/ incorporated into the function of the CMHTs.
GGHB approach to a comprehensive crisis intervention service will be developed.
Potential for services to be located more centrally.
Priority for the provision of comprehensive day services across the L.A. area.
Provision of Social Work in Mental Health setting to be addressed by the Area Team.

**Elderly Services, including Dementia**
Establish CMHT for Bearsden area.
Lack of Co-ordination/ development of respite services.
Little/no joint assessment process between agencies.
Lack of day services for people suffering from functional illness and challenging behaviour.
Further develop home based care.
Ensure early diagnosis of illness particularly dementia.

To be established during year 2 of the Joint Strategy.
Develop a protocol between agencies for access and service pattern for respite care.
Develop a joint assessment tool and associated protocol between agencies.
Agree a model of care with a “one stop” access point. Develop referral criteria.
Extend home based care to deal with personal hygiene and social activities.
Develop links: Primary care to ensure a method and procedure for early diagnosis.
Specialist training for Primary Care workers.

**Key Themes**
Lack of local needs assessment.
Housing stock in public sector is small.
Shortage of supported accommodation.

Comprehensive local needs assessment is required.
A joint approach to develop a range of housing provision. Encourage housing associations to promote initiatives related to Mental Health.
Develop joint accommodation strategy between relevant partners.

**Employment and Training**
Lack of support to employers on Mental health issues.
Lack of opportunities locally for employment/employment placements.

Develop an employer’s forum with agencies and service users.
Develop highly supported model of employment provision via Clubhouse.

The above services issues and action points have been summarised from the local authorities Mental Health Strategy Group report.

**EAST RENFREWSHIRE (EASTWOOD)**

East Renfrewshire is located to the South of Glasgow with the Greater Glasgow Health Board area covering Eastwood District.

The population of East Renfrewshire is 87,220 of whom 1,997 of the population were of black and ethnic minority origin and an estimated 5-7% of the rest of the population were of Jewish origin. The elderly population is predicted to rise from 12,335 to 13,836 between 1994 and 2001.
East Renfrewshire relates to three health boards:

Greater Glasgow Health Board (GGHB) area  61,600 (70%)
Argyll and Clyde Health Board (ACHB) area  24,830 (28%)
Lanarkshire Health Board (LHB) area  1,650 (2%)

Health Service Provision

The Eastwood service provides a locally based adult and elderly comprehensive and responsive multi-disciplinary approach. The service is delivered through a combination of home visiting, out-patient clinics and locally based groups. In-patient services are provided by multi-disciplinary ward based teams at Leverndale Hospital. A number of gaps have been identified during the development of this document as follows:

- advocacy services;
- employment/vocational/educational services;
- services for people from ethnic minorities;
- services for homeless people’
- user involvement in the development of information;
- inter-agency working/better communication;
- development of specialist services, ie, child/adolescent, drug/alcohol, eating disorders, sexual abuse, dementia services;
- development of joint quality initiatives and outcome measures.

Six Year Vision

- to gain a thorough understanding of the needs of the various communities in the Eastwood area;
- develop joined-up services and the structures to support them;
- establish an effective and flexible joint commissioning and review mechanism.

First Year Implementation Plan

i) Information

- initiate ethnic minority research;
- develop housing needs review;
- establish joint information group.

ii) Joint Commissioning

- develop protocols (roles and responsibilities)
- clarify funding and review mechanisms.

iii) Involvement

- enhance, improve and develop user/carer involvement.

iv) Joined-up Working

- establish group let by senior clinicians to develop a proposal for a joined-up service.
v) Review

- commission and undertake an evaluation of the effectiveness and value of services within the Eastwood area.

Following the review on the effectiveness of current services, implementation plans for subsequent years will be jointly developed.

SOUTH LANARKSHIRE (RUTHERGLEN AND CAMBUSLANG)

The Rutherglen/Cambuslang locality of South Lanarkshire is within the Greater Glasgow area. The population of Rutherglen/Cambuslang is around 56,000. Health care for the other parts of South Lanarkshire are commissioned by Lanarkshire Health Board.

Both adult and elderly community mental health teams operate in the Rutherglen/Cambuslang area. South Lanarkshire Social Work has agreed to develop social care services within the teams for resource transfer. This will:

- Augment the social work component of the existing adult community mental health team.
- Establish a flexibility budget within the team to support joint working.
- Extend the provision of Home Support and Day Activity Services including support, befriending and respite.
- Contract for a specific local Mental Health Advocacy Services.
- Employ a jobcoach to establish employment training opportunities.
- Augment existing supplementation availability – enabling flexible local purchasing of respite and residential care.

As a result of stakeholder and joint planning work the following short-term priorities and action plan emerged from the framework process are as follows:

<table>
<thead>
<tr>
<th>Service Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration of new social work service</td>
<td>Develop operational policies</td>
</tr>
<tr>
<td></td>
<td>Joint information for users</td>
</tr>
<tr>
<td></td>
<td>Integrated database</td>
</tr>
<tr>
<td></td>
<td>Out of hours agreements</td>
</tr>
<tr>
<td>Local accessible services</td>
<td>Review potential for local delivery of services</td>
</tr>
<tr>
<td>User/carer involvement</td>
<td>Develop user forum</td>
</tr>
<tr>
<td></td>
<td>Involve users in</td>
</tr>
<tr>
<td></td>
<td>Review of service information</td>
</tr>
<tr>
<td></td>
<td>Local Planning meetings</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Establish working links between Glasgow Advocacy Network and local advocacy projects</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>Develop mechanism for all members of continuing care team to be known to each severe and enduring client</td>
</tr>
<tr>
<td>Primary care interface</td>
<td>Actively pursue links with developing Local Health Care Co-operatives</td>
</tr>
</tbody>
</table>
In the longer term the priorities which emerged from the framework process are as follows:

<table>
<thead>
<tr>
<th>Service Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>Establish planning links with housing to implement Accommodation Strategy</td>
</tr>
<tr>
<td>Joint Commissioning</td>
<td>Collaborate with Lanarkshire Health Board/South Lanarkshire Council in development of local vision and priorities Develop Rutherglen/Cambuslang locality joint commissioning implementation group Review new service after six months and then annually</td>
</tr>
<tr>
<td>Monitoring and Review</td>
<td>Implement best value review of joint teams (year 4/5)</td>
</tr>
</tbody>
</table>

**NORTH LANARKSHIRE (CHRYSTON/STEPPS)**

The population of North Lanarkshire within GGHB is 16,400. The area is rural in make up with particular needs in relation to accessing services elsewhere and the availability of transport to facilitate the take-up of services.

Specific gaps in services have been identified as:

- befriending;
- advocacy;
- daycare;
- employment and education/training opportunities;
- respite and support for carers;
- good public information on resources.

<table>
<thead>
<tr>
<th>Service Issues</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of locally based services for daycare, groupwork, etc</td>
<td>Explore usage of community premises to develop local drop-in or other support programmes</td>
</tr>
<tr>
<td>Lack of training/education and employment opportunities</td>
<td>Link into other initiatives developing supported employment</td>
</tr>
<tr>
<td>Services appear fragmented and are not well understood</td>
<td>Produce information booklet on local and nearby services Identify outlets for publicity material Develop mechanisms for updating information</td>
</tr>
<tr>
<td>Improve joint working</td>
<td>Small scale localised joint training programme Build on success of partnership work with Richmond Fellowship</td>
</tr>
<tr>
<td>Problems accessing services outwith the area</td>
<td>Clarify funding for cross boundary services Improved joint working</td>
</tr>
<tr>
<td>Inadequate transport</td>
<td>Improve co-ordination and use of existing transport resources and budgets of service providers</td>
</tr>
</tbody>
</table>