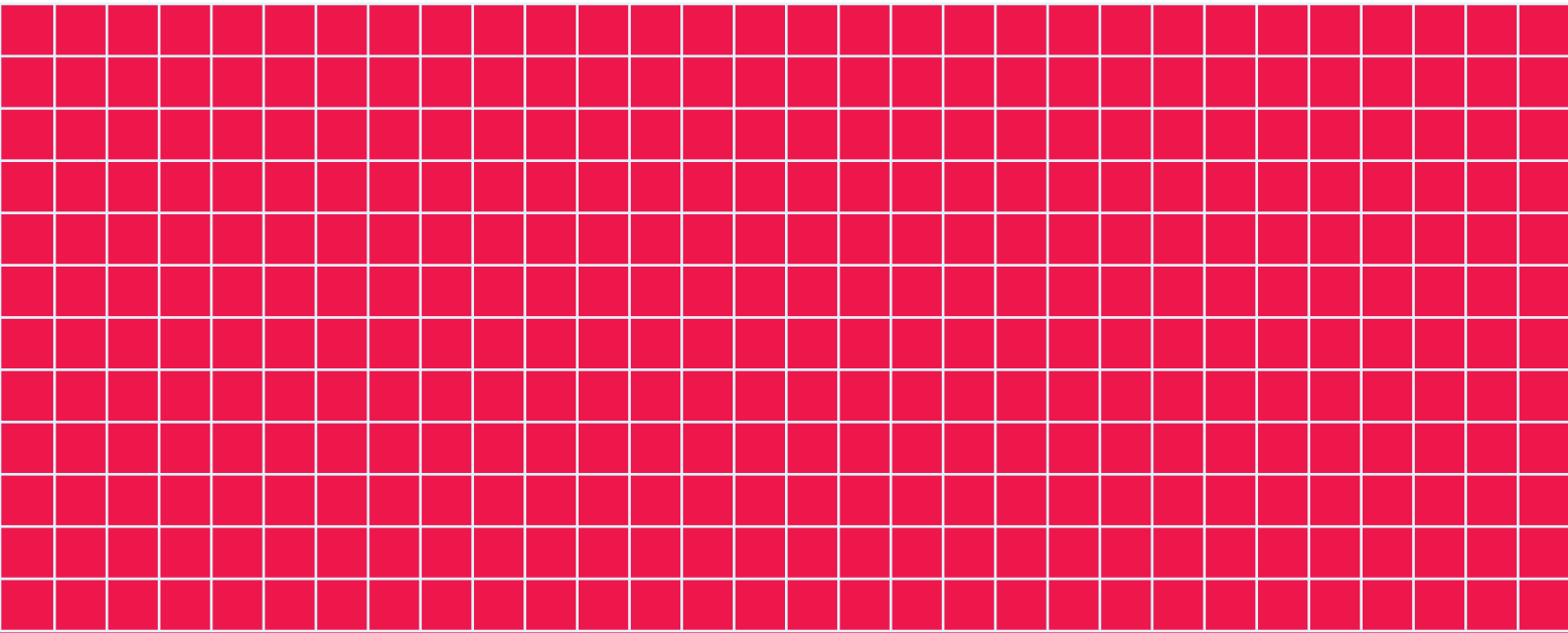
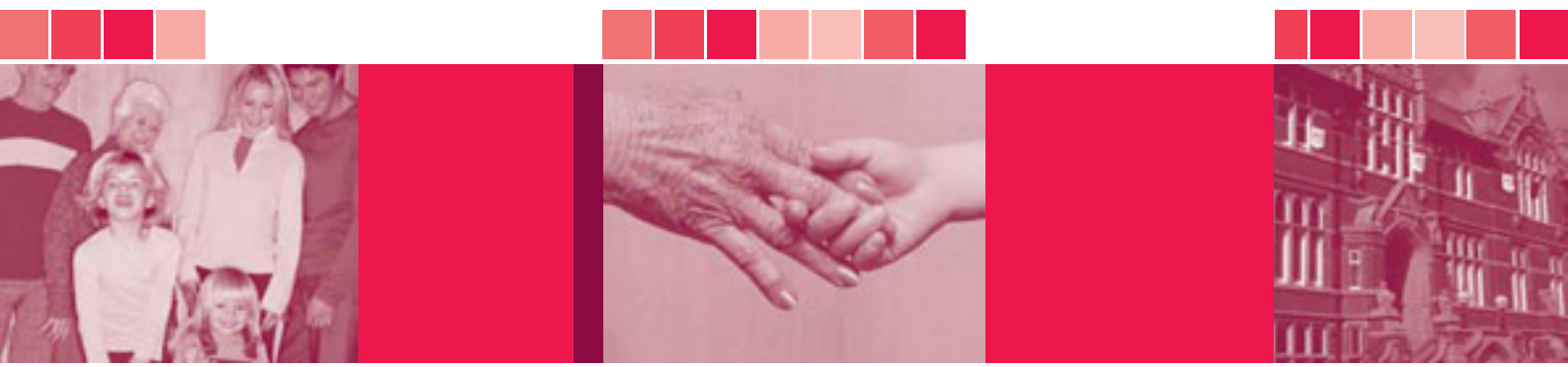


# Mental Health Benchmarking Project

November 2007

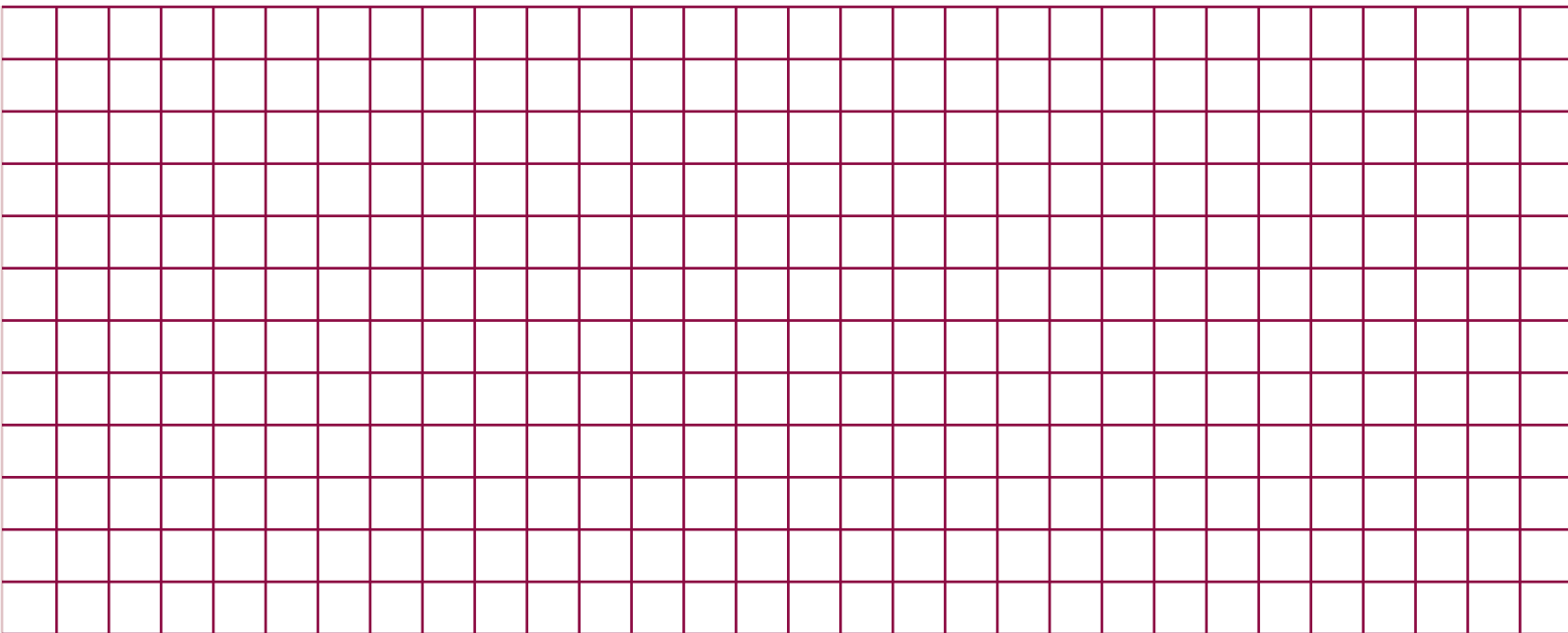
## Technical Appendix



# Mental Health Benchmarking Project

November 2007

## Technical Appendix



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## Introduction

The objective of the Mental Health Benchmarking Project is to support the improvement of mental health services to promote best practice by using benchmarking to understand, evaluate and compare services and their outcomes.

The function of this Technical Appendix is to act as a supplement to accompany the main report by providing further detail on the project work carried out and to present the project findings.

### Summary of Supporting Information

The Mental Health Benchmarking and Measurement Group in conjunction with partners involved in mental health services, agreed and undertook the following activities:

- assessment of the availability and use of mental health information
- developing a common set of mental health service definitions
- developing a balanced scorecard approach to performance
- evaluation of current mental health information system implementations
- evaluation of the role of information in joint mental health planning.

#### *Glossary and Definitions*

A draft glossary of definitions has been produced in conjunction with the Service and has undergone wide consultation with Boards and local authorities via national events and Board visits. There was broad agreement with the mental health definitions consulted on and these definitions were incorporated. Where no such agreement existed, the disagreements were categorised into minor and diverse changes for investigation by the Mental Health Benchmarking and Measurement Group (core group) and were amended if necessary and/or appropriate.

Future work will involve the development of full joint definitions with the local authorities and other partners.

The mental health glossary and definitions are contained within **Appendix A** with the mental health definitions analysis appearing in **Appendix B**.

#### *Performance Measures*

Stakeholder days were held to ascertain the performance measures necessary to manage mental health services effectively via the balanced scorecard approach. A mental health services balanced scorecard, covering both strategic and operational indicators was produced, covering key aspects of performance such as Quality, Efficiency, Cost and Future. This scorecard has been subsequently refined and further developed in collaboration with the Boards, local authorities and other partners within the service.

The latest draft balanced scorecard can be found in **Appendix C**. A subset of these indicators have been proposed as mandatory national indicators to be adopted and developed by Boards from 2008/09 onwards. These are shown in **Appendix D**, whilst **Appendix E** provides detailed definitions of the measures to be calculated.

**Appendix F** displays the tables utilised for the AVON mental health measure. **Appendix G** shows an outline reporting framework and the different users and uses of indicators.

#### *Existing Data*

Data is available at national level but this data is insufficient to demonstrate the shift from acute and other hospital-based services to community-based services within mental health services.



**Appendix H** illustrates the high level metrics which can be derived from this data; however they do not capture the whole story of a comprehensive mental health service due to information gaps.

#### *Capability Scoping*

During April to July 2007, capability scoping visits were made to all mainland Health Boards and related local authorities, with video conferencing held with one Island Board. The purpose of these visits was to:

- communicate the purpose and objectives of the Mental Health Benchmarking and Measurement Project
- seek Board input to current activities e.g. scorecard and definitions development
- assess locally available mental health information
- evaluate mental health system implementations
- evaluate the role of information in joint mental health planning.

The detailed findings from the capability scoping are contained within **Appendices I to M**.



## APPENDIX A: Mental Health Glossary and Definitions

1. Adult Mental Health	
<b>1.1 Community Services</b>	
<i>N.B. Where appropriate, some of the elements could be provided as a discrete service element within a comprehensive Community Mental Health Service (CMHS) or as a function of a Community Mental Health Team (CMHT). The model used is dependent upon the demographics of the population served.</i>	
<b>1.1.1 Community Mental Health Service</b>	Provides a community-based, multi-disciplinary (multi-agency), mental health service within a defined population/area to patients who have a severe and/or enduring mental health problem. It offers assessment, a range of interventions including individual interventions and/or group therapy in the most appropriate place for the patient including in the patients home or at a community base etc.  The focus of the service is restorative, health promoting and recovery oriented.
<b>1.1.2 Crisis Service</b>	Provides a brief intervention service to patients suffering from acute mental health distress as an alternative to hospital admission, with a maximum target response time of four hours. It offers a gatekeeping function to beds through intensive interventions to support patients in their own environment.  The service should be provided twenty-four hours a day, seven days a week. It features a multi-disciplinary (multi-agency) approach to delivering a service to its geographical area.
<b>1.1.3 Out of Hours</b>	Out of Hours offers focused mental health services that provide a crisis response to patients with mental health problems.
<b>1.1.4 Assertive Outreach Service Provision</b>	Provides a mental health service to patients who are hard to engage in mainstream services or who engage in an erratic manner. It features small caseloads ensuring staff have additional capacity to assertively follow up these patients.
<b>1.1.5 Early Intervention</b>	Provides a service to people aged between 16 years and 35 years, who have experienced a first episode of psychosis. The service is multi-disciplinary (multi-agency) and should be based in a low stigma community setting. The service offers a wide range of interventions and engagement, assertive outreach and service user and carer involvement are amongst the key principles for Early Intervention.  The focus of this service is recovery, normalisation and minimising the impact that psychosis may have on individuals and their families.



## 1. Adult Mental Health

### 1.1.6 Primary Care Mental Health Service

Provides a community-based, (normally) multi-disciplinary and multi-agency, mental health service to a defined population. The service has three functions: offering treatment and social support; supporting and advising generic primary care services; working with community partners to promote and sustain good mental health in their community. The service is for those with common (or mild to moderate) mental health problems/psychological distress. The service is characterised by rapid and easy access and by providing evidence-based brief interventions matched to patient need – from information, advice and self help approaches through psycho-educational groups to individual therapy.

**N.B.** This may include evidence-based computerised treatment programmes.

### 1.1.7 Community Forensic Service

Forensic Mental Health is a specialist tertiary service that is committed to working in a multi-disciplinary and multi-agency way to ensure safe practice.

It provides care and treatment for individuals who have a mental illness or learning disability and demonstrate serious offending behaviour or present a significant risk to others. The service offers assessment, consultation, care and treatment, which is proportionate to the situation and underpinned by risk assessment and management and treatment of offending behaviour.

Community Forensic Service should be an integral part of the wider Forensic Service and include both outpatients and Community Services; it links with other Health Services, Criminal Justice Agencies, Social Work, the Voluntary Sector, General Adult Psychiatry and Addiction Services, to ensure smooth transition to this service when appropriate.

- Forensic Outpatients are seen for specialist assessment and treatment interventions by Psychiatry, Psychology, Social Work, Occupational Therapy and Community Nursing staff
- Forensic Community Services cover patients that are: subject to Scottish Executive Restriction orders, involved with the Care Programming Approach, and considered to be in the “severely at risk” category
- Risk assessment and risk management are core functions of the Community Forensic Team, which must adapt to changing levels of risk and social circumstances on a day-to-day basis
- The community team may also provide a court diversion/court assessment.

**N.B.** In rural areas outpatient and community services may be one and the same.



## 1. Adult Mental Health

<p><b>1.1.8 Liaison Psychiatry</b></p>	<p>Liaison Psychiatry is a psychiatric specialty concerned with the provision of clinical services, teaching and research in the general hospital setting. The service aims to provide a comprehensive, accessible service to health care professionals and their patients throughout general hospitals. The service provides patients with high quality clinical care delivered through comprehensive psychosocial assessment and evidence-based interventions. The areas of clinical service provided by the Liaison Psychiatric Service are as follows:</p> <ul style="list-style-type: none"> <li>• People who attend the general hospital following an episode of self-harm or who attend threatening an episode of self-harm</li> <li>• Psychiatric emergencies in the general hospital</li> <li>• Patients with medically unexplained physical symptoms</li> <li>• Patients with co-existing physical illness and psychiatric disorder</li> <li>• Patients presenting with behavioural/psychological disturbances as a result of alcohol/drug problems</li> <li>• Patients with acute organic disorders</li> <li>• Behavioural problems</li> <li>• Specialist therapeutic interventions offered to areas of specialties, i.e. neurology, infectious diseases, transplant surgery.</li> </ul>
<p><b>1.1.9 Clinical Health Psychology</b></p>	<p>This specialty provides assessment, psychological intervention, training, consultancy, supervision and research to patients, staff and carers in both hospital and community in relation to physical health problems. As well as assessment and treatment of psychological disorders in people with physical health problems, the service also provides interventions which deal with health behaviour where mental health problems may not be the primary focus.</p>
<p><b>1.1.10 Clinical Neuropsychology</b></p>	<p>Work with patients who have acquired or are suspected of having acquired damage to their brain as a result of trauma or illness.</p>



## 1. Adult Mental Health

### 1.1.11 Perinatal

Perinatal Mental Health Community Services provide specialist services to women, their babies and families, at risk of, or affected by, mental illness during pregnancy and the first postnatal year. There is a strong emphasis on prevention of a) postnatal mental illness in high-risk women, and b) impaired development in children of women with postnatal illness. Specific roles include:

- Treatment of significant mental illness occurring in pregnancy or the postnatal period
- Preventative interventions through the early identification of antenatal women at high risk of postnatal mental illness
- Evaluation and facilitation of the mother-infant relationship to enhance recovery for the mother and prevent subsequent morbidity in the child through the promotion of good infant mental health.

Community services are organised across two areas:

- Maternity Liaison – assessment and management of women in maternity settings (antenatal and postnatal wards, hospital and community antenatal clinics) who are currently unwell or who are currently well, but at high risk of significant postnatal mental illness
- Community Outreach – assessment and management of women in outpatient and home settings referred via primary care, social services and generic mental health.

There are additional roles in teaching and disseminating best practice (e.g. through the provision of telephone advice on prescribing issues to health professionals). A network links community services to each other and to regional inpatient mother and baby services. Community services are underpinned by a perinatal integrated care pathway for the early identification and management of ill and at risk women in primary care and maternity settings.

**N.B.** Perinatal services can be provided from other services, however reporting is only for tertiary services.



## 1. Adult Mental Health

<p><b>1.1.12 Psychological Therapies</b></p>	<p>A range of essentially talking therapies used at individual, family or other group level, which may be used in conjunction with other treatments such as medication. The therapies are often time limited in nature and can be applied to a range of problems from mild to severe or complex disorders.</p> <p><b>Group 1 Behaviour therapies</b>  cognitive behaviour therapy (CBT)  cognitive analytical therapy (CAT)  behaviour therapy  dialectical behaviour therapy (DBT)  cognitive rehabilitation therapy  anger management  anxiety management  offending behaviour treatments</p> <p><b>Group 2 Psychodynamic psychotherapies</b>  psychoanalytic psychotherapy</p> <p><b>Group 3 Systemic and family therapies</b>  systems based therapies  systemic family therapies</p> <p><b>Group 4 Humanistic and integrative therapies</b>  interpersonal therapy (IPT)  psychosocial interventions  motivational interviewing  problem solving  supporting and person centred counselling  self help</p> <p><b>Group 5 Other psychological approaches</b>  eye movement desensitisation and reprocessing (EMDR)  neurolinguistic programming  neurosensory therapy</p>
<p><b>1.1.13 Co-morbidity Service</b></p>	<p>This service provides input to patients who have a dual mental health and addictions problem. It provides specialist advice to the generic mental health teams as well as inreaching to inpatient services. This can be provided as a function of CMHTs and/or Community Addiction Teams.</p> <p><i><b>N.B.</b> Requires joint working protocols to ensure that the primary problem/need drives the service input.</i></p>
<p><b>1.1.14 Other Day Services</b></p>	<p>A multi-disciplinary service that provides structured day activities with a focus on recovery for patients with severe and/or enduring mental health problems. The service focuses on assessment, supporting patients during acute episodes of illness and prevention of admission to hospital.</p>



## 1. Adult Mental Health

### 1.2 Inpatient Services

Hospital-based service that provides beds on either a formal or informal basis to provide treatment for patients who could not be safely or appropriately treated in the community.

**N.B.** Where Boards do not split their wards by function, a mechanism needs to be in place to report by function.

<b>1.2.1 Acute</b>	<p>Acute admission wards are based in both General and Psychiatric hospitals; the service is recovery focused. It provides assessment, treatment and intervention services for patients over 18 that require: short term admission for crisis or a breakdown in their current treatment plan, or significant intensive assessment that can only be carried out on an inpatient basis.</p>
<b>1.2.2 IPCU</b>	<p>The service is recovery focused; it provides intensive treatment and interventions to patients who present an increased level of clinical risk and require an increased level of observation.</p> <p>A multi-disciplinary team with specialised training; the ratio of nursing staff will be higher than a general psychiatric ward.</p>
<b>1.2.3 Rehabilitation</b>	<p>Rehabilitation delivers a recovery-based approach to ensure that the individual has all the necessary skills in self-care and social integration to be able to return to successful living in the community. Rehabilitation is provided by a multi-disciplinary service for patients whose condition requires that they undergo rehabilitation prior to discharge.</p>
<b>1.2.4 Continuing Care/Long Stay</b>	<p>For patients who require continuing hospitalisation for care that cannot be provided in the community. The philosophy of care should be based on a recovery-focused approach. Care packages will be developed in conjunction with all agencies involved to create a transition for discharge.</p>
<b>1.2.5 Perinatal</b>	<p>Mother and Baby Mental Health Units are specialist facilities which allow for the admission and appropriate care for mothers and their babies, where the baby is below one year. Multi-disciplinary staff include mental health, social work and childcare (nursery nursing, health visiting) disciplines. Specific roles include:</p> <ul style="list-style-type: none"> <li>• Treatment of significant mental illness occurring in late pregnancy or the postnatal period</li> <li>• Evaluation and facilitation of the mother-infant relationship to enhance recovery for the mother and prevent subsequent morbidity in the child through the promotion of good infant mental health.</li> </ul>



## 1. Adult Mental Health

<b>1.2.6 Forensic</b>	<p>For definition, see 1.1.7.</p> <p>For inpatients this is delivered through a progressive patient focused approach within a secure environment or assertively managed in the community in order to maximise the individual's rehabilitation potential.</p>
<b>1.2.7 Low Secure Unit</b>	<p>Low secure units include intensive care wards and forensic services such as longer term low or semi secure care. For example, forensic hostels or remand assessment beds. In addition, pre-discharge wards may be designated at this security level.</p>
<b>1.2.8 Medium Secure Unit</b>	<p>Medium secure units deliver intensive, comprehensive multi-disciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of serious mental disorder and who require the provision of security. Patients will be detained under the Mental Health Care and Treatment Act and may be restricted on legal grounds needing rehabilitation in the medium term.</p>
<b>1.2.9 Co-morbidity Service</b>	<p>For definition, see 1.1.13.</p>
<b>1.2.10 Discharge and Resettlement Service</b>	<p>An area wide co-ordinated service for inpatients bridging the gap in relation to discharge and resettlement planning and providing a rehabilitation and resettlement focus. Works in collaboration with patients, carers, other mainstream services and voluntary agencies involved in the provision of care. Prevents new and repeated homelessness by early identification of those at risk. Improves bed management and reduces the number of delayed discharges as a result of homelessness.</p>



## 2. Elderly Mental Health

### 2.1 Community Services

<p><b>2.1.1 Community Mental Health Team</b></p>	<p>Provides a community-based, multi-disciplinary (multi-agency), mental health service within a defined population/area to patients who have a severe and/or enduring mental health problem, including dementia. It offers a range of interventions including individual interventions and/or group therapy in the most appropriate place for the patient including in the patients home or at a community base etc.</p> <p>The focus of the service is to maintain patients in their local communities where appropriate by offering a range of interventions in the least restrictive environment; this includes outpatient clinics and group activities.</p>
<p><b>2.1.2 Day Services</b></p>	<p>For definition, see 1.1.14.</p>
<p><b>2.1.3 Older People's Liaison</b></p>	<p>Links with Acute Hospitals to reduce delays on discharge; a major element of the role is to work with families, assess carer's needs, work jointly with local authorities to secure appropriate accommodation, and support after discharge to minimise readmission.</p> <p>Provides domiciliary visits to nursing homes and patients' homes to conduct urgent assessments.</p>
<p><b>2.1.4 Primary Care Mental Health Service</b></p>	<p>Provides a community-based, (normally) multi-disciplinary and multi-agency, mental health service to a defined population. The team has three functions: offering treatment and social support; supporting and advising generic primary care services; working with community partners to promote and sustain good mental health in their community. The service is for those with common (or mild to moderate) mental health problems/psychological distress. The teams are characterised by rapid and easy access and by providing evidence-based brief interventions matched to patient need – from information, advice and self help approaches through psycho-educational groups to individual therapy.</p>



## 2. Elderly Mental Health

### 2.2 Inpatient Services

Hospital-based service that provides beds on either a formal or informal basis to provide treatment for patients who could not be safely or appropriately treated in the community

**N.B.** Where Boards do not split their wards by function, a mechanism needs to be in place to report by function.

#### 2.2.1 Acute

Acute admission wards are based at both General and Psychiatric hospitals and provide assessment, treatment and intervention services for patients over 65 that require short term admission for crisis or a breakdown in their current treatment plan or significant intensive assessment that can only be carried out on an inpatient basis.

#### 2.2.2 Continuing Care/Long Stay

For patients who require continuing hospitalisation for care that cannot be provided in the community. The philosophy of care should be based on a rehabilitation or recovery model. Care packages will be developed in conjunction with all agencies involved to create a transition for discharge.

## 3. Allied Health Professionals

Provides a sessional input across a range of mental health services/locations - including inpatient and community settings.

**N.B.** This section only covers services that only provide sessional input into Community Mental Health Services.

#### 3.1 Dietetics

A dietician uses the science of nutrition to devise eating plans for patients to treat medical conditions. They also work to promote good health by helping to facilitate a positive change in food choices amongst individuals, groups and communities.

#### 3.2 Physiotherapy

Physiotherapists deal with human function and movement and help people to achieve their full physical potential. They use physical approaches to promote, maintain and restore well-being.

#### 3.3 Pharmacy

A pharmacist is an expert in medicines. A pharmacist can be involved in any aspect of the preparation and use of medicines, from the discovery of their active ingredients to their use by patients. Pharmacists also monitor the effects of medicines, both for patient care and for research purposes (as defined by the Royal Pharmaceutical Society of Great Britain).



### 3. Allied Health Professionals

<b>3.4 Podiatry</b>	A chiropodist/podiatrist diagnoses and treats disorders, diseases and deformities of the feet.
<b>3.5 Speech and Language Therapy</b>	Speech and Language Therapists (SLTs) are dedicated to the needs of people with communication support needs (or impairment) and eating, drinking and swallowing difficulties (dysphagia). SLTs contribute to mental health recovery by treating directly and indirectly (through multi-disciplinary team colleagues and carers) communication difficulties, which can lead to mental illness and communication difficulties arising as a result of mental illness.
<b>3.6 Occupational Therapy</b>	Occupational therapy is integral to the working of a Community Mental Health Service.

### 4. Child & Adolescent Mental Health

#### 4.1 Inpatient Services

There are four residential psychiatric units in Scotland which cater solely for children and young people.

**N.B.** The service is provided by a multi-disciplinary and multi-agency team made up of Child and Adolescent Psychiatry, Clinical Psychology, Family Therapy, Occupational Therapy, Dietetics, Nursing, Social Work, Education, Speech and Language Therapy and Pharmacy.

<b>4.1.1 Children's Unit</b>	<p>This unit provides a residential assessment and treatment service for children with a wide range of complex mental health difficulties.</p> <p>This is a nationally commissioned service which caters for children, up to the age of 12, from all over Scotland. A small number of children receive some or all of their treatment as day-patients, but the service is provided predominantly on an inpatient basis.</p>
<b>4.1.2 Young People's Unit</b>	<p>The dedicated inpatient places for young people are in specialist units in Dundee (7), Edinburgh (12) and Glasgow (16). The number of places is to increase, from the current 35, to 57 by 2010. Each unit provides a regional service and is commissioned on that basis.</p> <p>These units admit young people, from age 12 to age 17, with severe and/or complex mental health disorders. These would usually be young people with conditions such as depression, early onset psychosis, and very low weight anorexia, who have not responded to treatment in the community or cannot be safely managed within a community setting.</p>



## 4. Child & Adolescent Mental Health

### 4.2 Community Services

#### 4.2.1 CAMHS

In most NHS Board areas across Scotland, mental health services for children and young people are provided by local multi-disciplinary Child and Adolescent Mental Health Service (CAMHS) teams.

Community CAMHS teams deliver mental health services to children and young people in their area, either via professionals working singly (tier 2) or in combinations and teams (tier 3).

The range of services offered varies considerably between NHS Boards, reflecting the different sizes of services. So, for example, the services available to island communities such as those in the Western Isles or Orkney are severely limited by the small scale of the service.

The arrangements for service delivery also vary between Boards:

- In some areas, the CAMH Service caters for up to 16 years of age, while some go up to age 18
- In some areas, services for children and services for adolescents are provided separately
- In some areas, there are separate clinical psychology services for children and young people, which usually focus on providing early intervention services.

Staffing typically includes:

child and adolescent psychiatrists, clinical psychologists, nurses, social workers, teachers, psychotherapists, family therapists, primary or community mental health workers and, less commonly, occupational therapists, speech and language therapists and dieticians (some teams only).

Multi-disciplinary CAMH Services usually provide for emergency referral during working hours, but out of hours services are currently limited to the larger centres. Within current emergency provision, some areas provide intensive, community delivered outreach services.



## 4. Child & Adolescent Mental Health

### 4.2.2 Forensic CAMHS

While advice about forensic referrals is available in a number of Board areas, only one NHS Board to date (Greater Glasgow and Clyde) has established a Forensic CAMHS team.

Such services work with young people at risk of, or involved in, offending, who also have mental health difficulties. They work closely with youth justice and social services to address young people's difficulties and provide specialist risk assessment, consultation and individual treatment.

These services would usually be staffed by:

clinical psychologists, forensic psychologists, forensic child and adolescent psychiatrists, nurses, social workers.

### 4.2.3 Liaison Services

Most services have established liaison arrangements with local general and, where these exist, paediatric hospitals. These ensure the availability of appropriate and timely mental health assessment and treatment for children and young people being cared for in those settings.

Although liaison CAMHS is not confined to this issue, all areas will have arrangements for the assessment of children and young people who have engaged in deliberate self-harm (some areas have developed dedicated *deliberate self-harm services*). These services can be provided by a number of disciplines, typically psychiatrists, nurses and psychologists, with some areas developing nurse-led services.

### 4.2.4 Early Intervention and Direct Access Services

These initiatives offer readily accessible mental health services to children and young people and their families and carers in settings such as schools, primary care and social work services.

This *primary mental health work* routinely involves providing consultation to those working in these settings and (often) time-limited treatment interventions. They, therefore, provide a suitable way of helping those children and young people with less severe or complex mental health problems.

Staffing includes:

clinical psychologists, nurses, primary mental health workers, community mental health workers, teachers, social workers.

### 4.2.5 Learning Disability Services

These services, available only in a few NHS Board areas, provide a specialist CAMH Service for children and young people with significant learning disability who are also experiencing mental health problems.

Staffing includes:

psychologists, nurses, teachers, social workers, psychiatrists (jointly trained in CAMHS and Learning Disabilities).



## 4. Child & Adolescent Mental Health

### 4.2.6 Psychological Therapies for Children, Young People and Families

As with mental health services for adults, comprehensive CAMH Services should be able to deliver the full range of psychological and psychosocial therapies for which an evidence base exists. Few areas are currently able to do this, with significant shortages of appropriately trained staff.

Where they are available, these specialist psychotherapists are often deployed within teams or services for those children and young people with particularly complex disorders, including inpatient services and “looked after” mental health teams.

### 4.2.7 Other CAMH Services

Across Scotland, CAMH Services aim to provide comprehensive mental health services for children and young people in their area. While there are few NHS Board areas where services are sufficiently well resourced to allow the full range of services, many areas have sought to develop dedicated services for children and young people with particularly complex needs. At present these include:

- “Looked after” and Accommodated services
- Neurodevelopmental services
- Early onset psychosis services
- Eating disorder services
- Drug & Alcohol services.



## 5. Specialist Other

<b>5.1 Community Eating Disorders</b>	<p>The service aims to bridge the gap between inpatient services and community. It will deliver therapeutic intervention directly to patients in addition to its consulting/training input across community services.</p>
<b>5.2 Inpatient (Partnership Beds) Adult &amp; Elderly</b>	<p>These are beds commissioned jointly by social work and health in the community to provide continuing care facilities. They may be provided by the independent sector.</p>
<b>5.3 Services for Asylum Seekers</b>	<p>These are specialist tertiary services provided to meet the particular needs of asylum seekers, refugees etc. entering the country who have significant mental health problems.</p>
<b>5.4 Services for Ethnic Minorities</b>	<p>Specialist mental health services specifically delivering interventions with black and minority ethnic (BME) individuals or communities across Scotland. (The term BME communities is currently used to describe a wide and heterogeneous group of communities – it includes Scotland’s settled minority ethnic communities, asylum seekers and refugees, gypsy/travellers and migrant workers, including white migrant workers from the Accession 8 countries within the European Union.)</p> <p>Examples include: a multi-cultural mental health team that delivers an assessment and intervention service with BME individuals experiencing mental health problems, support provided to BME individuals coming through the hospital service, provision of a mental health improvement service across the wider BME communities.</p>
<b>5.5 Mental Health Homeless Services</b>	<p>The Homeless Mental Health Service works with people with both severe and enduring mental illness, and less severe mental health problems, offering a direct access mental health service to homeless units and hostels across a population/area. This service may include nursing and medical staff, AHP services and social work. The service provides diagnosis, assessment, treatment, medication management, counselling and support.</p>
<b>5.6 Addictions Homeless Services</b>	<p>This multi-disciplinary service offers a peripatetic service to hostels and day centres. Services may consist of an integrated health and social work team working with both alcohol and drug addiction. There is medical input from both psychiatry and addictions, and a team of addiction nurses work along side the medics. Social work staff includes drug workers and a team leader. Joint assessment, cross referral, treatment, health education and support are offered to homeless people who are motivated to tackle their addiction issues.</p>



## 5. Specialist Other

### 5.7 Trauma Homeless Services

The trauma service will provide training, consultancy and clinical expertise for homeless people who have experienced multiple traumas.

### 5.8 Personality Disorder Homeless Services

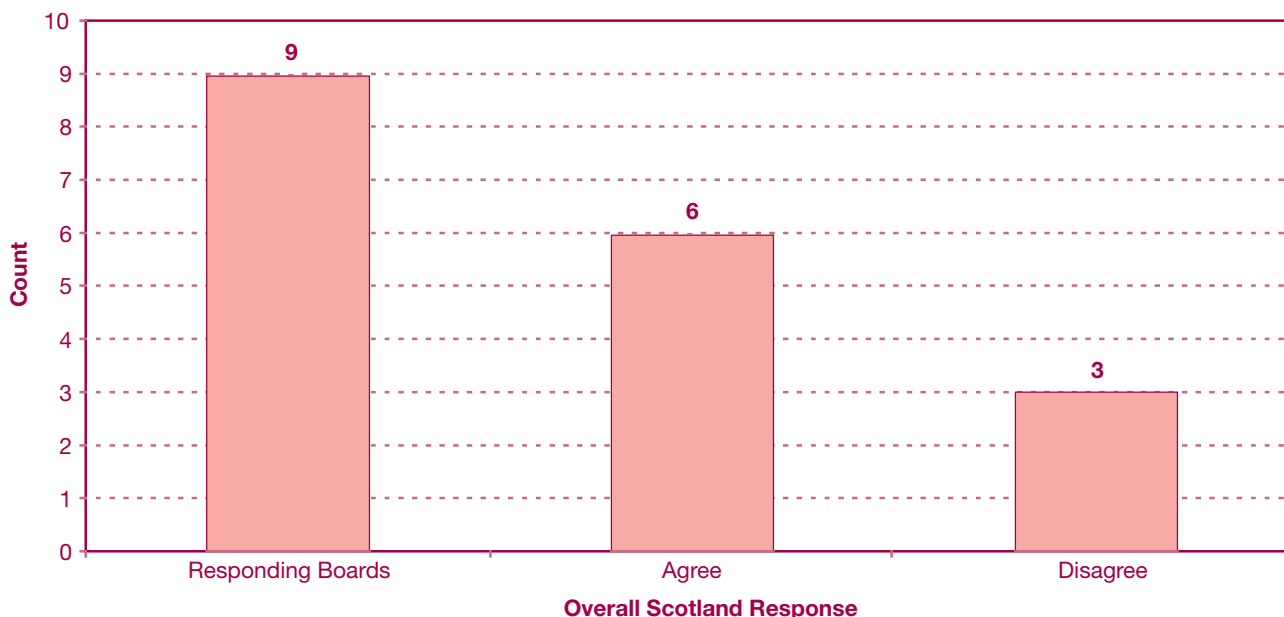
Similar remit to trauma service but focusing on supporting services across partnership agencies in managing homeless people with challenging behaviour and complex needs. It is envisaged that these two services will complement and combine in some areas of work linked around training.

This service provides a focused response to people with a personality disorder, characterised by challenging behaviour and/or mental health needs.



There was broad agreement with the mental health definitions consulted on with Boards and local authorities. Nine Boards commented on the mental health definitions, with 6 (67%) agreeing with 80% or more and the remaining 3 (33%) disagreeing with 20% or more of the definitions.

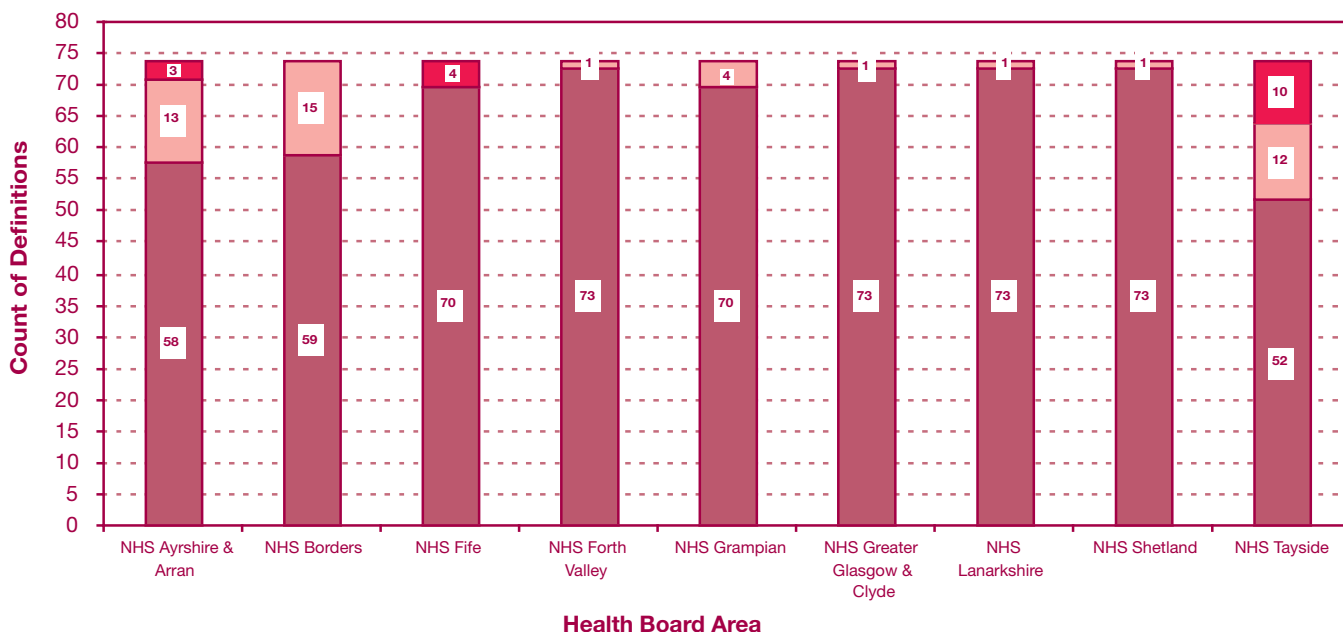
Mental Health Definitions split by response<sup>1,2</sup> for Scotland



1. Agree : agreement constitutes the Health Board agreeing with 80% or more of the definitions.
2. Disagree : disagreement constitutes the Health Board disagreeing with 20% or more of the definitions.

Disagreements were categorised into minor and diverse changes. Minor changes were simply word, sentence changes and/or minor suggestions. Diverse changes encompassed complete paragraph changes/additions or complete disagreement with the definition.

Mental Health Definitions split by change category<sup>1,2,3</sup> for each Health Board Area



1. Agree : includes no change of existing definitions, no comment i.e. blank/nil returns, not available, agreed or if the service is provided by different team/provider etc.
2. Minor Change : includes word/sentence change i.e. slight difference to existing definition or minor suggestions.
3. Diverse : includes complete change of existing definitions i.e. paragraph changes, several sentences or disagreement with definition.



Comments from the Boards/local authorities included:

- Addition of Clinical Health Psychology and Clinical Neuropsychology definitions
- Disagreement with the crisis service definition as there may be a range of crisis models depending on the structure of local services
- Disagreement that certain homeless services e.g. mental health, addictions etc. have to have teams with nursing, medical and AHP staff.

## APPENDIX C: Draft Balanced Scorecard

### Mental Health Whole System Project – Balanced Scorecard

#### Cost

##### National

- *Total spend for mental health/1,000 population*
- *% community spend/total spend*
- *Total mental health drug costs/1,000 population*
- *Persons on incapacity benefit/severe disablement allowance with a mental health diagnosis/1,000 population*

##### Local

- Unit cost for each service area
- Cost per inpatient week

#### Patient Quality

##### National

- Use of the AVON validated tool to measure patient needs and promote recovery orientated practice
- Mortality rates for severe and enduring mentally ill population/1,000 population
- % readmissions > 7 days/total admissions
- % delayed discharges
- *Suicide rates per 1,000 population*
- % carer involvement/those who have a carer
- % of voluntary inpatients/inpatients subject to compulsory treatment by Board
- % of people on community CTOs/total known to the Community Mental Health services
- Patient safety and risk management

##### Local

- Resource unavailability
- Prevalence
- Cancellations, complaints, deaths
- Positive external reports, negative external reports

#### Efficiency

##### National

- *Total psychiatric beds per 1,000 population*
- % A&E presentations with a mental health and/or substance misuse diagnosis/total A&E presentations
- Average time to assessment and time to intervention
- *Average length of stay*
- Total mental health staff numbers per 1,000 population (Arbuthnott)  
Psychiatrists/1,000 population  
AHPs/1,000 population  
Nurses/1,000 population  
Psychologists/1,000 population  
Social workers/1,000 population  
Mental Health Officers/1,000 population

##### Local

- Occupancy
- OP Did Not Attend (DNAs)
- OP new return ratios
- Community Activity
- Consultants/Doctors in Training/Nursing Trained/Untrained Ratio MI/Community Nursing
- Case-mix adjusted throughput
- Sickness absence by staff group
- LA specialist MH staff/services
- GP information Quality Outcomes Framework (QOF)
- NHS 24

#### Future

- Training/supervision index
- Information quality and capture
- Use of mental health information
- Number of accredited Integrated Care Pathways (ICP) standards implemented with 100% collection of prescribed datapoints
- Number of people receiving crisis services
- Number of people receiving CBT
- Number of drug protocols
- Development of new ways of working
- PDPs (learning/development)

##### Notes:

**Note 1** *Items in italics are currently available/readily accessible at a national level*

**Note 2** *Community Health Index (CHI) to be investigated as a potential source of community information*

**Note 3** *At a local level, indicators should be split by service type/specialty, age, gender, Community Health Partnership (CHP), Health Board, Local Authority (LA) etc. (if available)*

**Note 4** *Boards may wish to develop separate scorecards for particular mental health service areas e.g. perinatal, children's, etc.*

## APPENDIX D: Whole System Scorecard (Mandatory)

### Cost

Total spend for mental health per 1,000 population  
 % community spend/Total spend  
 Total mental health drug costs per 1,000 population  
 Persons on incapacity benefit/severe disablement allowance with a mental health diagnosis per 1,000 population

### Patient Quality

Use of the AVON validated tool to measure patient needs and promote recovery orientated practice  
 Mortality rates for severe and enduring mentally ill population per 1,000 population  
 % readmissions > 7 days/total admissions  
 % delayed discharges  
 Suicide rates per 1,000 population  
 % carer involvements/those who have a carer  
 % of voluntary inpatient/inpatients subject to compulsory treatment by Board  
 % of people on community CTOs/total known to the Community Mental Health services  
 Patient safety and risk management

### Efficiency

Total psychiatric beds per 1,000 population  
 % A&E presentations with a mental health and/or substance misuse diagnosis/total A&E presentations  
 Average time to assessment and time to intervention  
 Average length of stay  
 Total mental health staff numbers per 1,000 population by psychiatrists, AHPs, nurses, psychologists, social workers, MHOs

### Future

Training/supervision index  
 Information quality and capture  
 Use of mental health information  
 Number of accredited Integrated Care Pathway (ICP) standards implemented with 100% of prescribed datapoints

## APPENDIX E: Measure Definitions

**Note:** Measures with an asterisk require further development prior to implementation.

**Total spend for Mental Health:** health care expenditure by Board of residence (including resource transfer) for General Psychiatry Services per 1,000 population (Arbuthnott).

**Community spend as a percentage of total spend:** community health care expenditure by Board of residence (including resource transfer) for General Psychiatry Services as a percentage of total health care expenditure.

**Total Mental Health drug costs:** Gross Ingredient Cost (community prescribing only) for medicines used in mental health (British National Formulary Categories) per 1,000 population (Arbuthnott).

**Persons on incapacity benefit/severe disablement allowance with a mental health diagnosis:** the number of incapacity benefit/severe disablement allowance claimants with a mental health diagnosis per 1,000 population (Arbuthnott).

**Note:** Incapacity figures are the responsibility and control of the local authorities and are shown against Boards for information purposes only.

**Total psychiatric beds:** the number of beds for mental health specialties (adjusted for cross-boundary flow) per 1,000 population (Arbuthnott).

**\* A&E presentations with a mental health and/or substance misuse diagnosis:** the number of A&E presentations with a mental health and/or substance misuse diagnosis as a percentage of all presentations to A&E.

**\* Average time to assessment and time to intervention:** the average time taken for the client to be seen from referral to clinical assessment and the average time taken for the client to be seen from assessment to intervention.

**Average length of stay:** the total length of inpatient stay (days) for mental health specialties and principal mental health diagnosis divided by the episodes.

**\* Total staff numbers:** the total number of staff for mental health specialties (within the mental health work area) per 1,000 population (Arbuthnott).

**\* Psychiatrists:** the number of psychiatrists for mental health specialties (within the mental health work area) per 1,000 population (Arbuthnott).

**\* AHPs:** the number of allied health professionals for mental health specialties (within the mental health work area) per 1,000 population (Arbuthnott).

**Nurses:** the number of nurses (WTEs) for mental health specialties (within the mental health work area) per 1,000 population (Arbuthnott).

**Psychologists:** the number of psychologists (WTEs) for mental health specialties (within the mental health work area) per 1,000 population (Arbuthnott).

**\* Social Workers:** the number of social workers for mental health specialties (within the mental health work area) per 1,000 population (Arbuthnott).

**MHOs:** the number of mental health officers (WTEs) per 1,000 population (Arbuthnott).

**Note:** MHO figures are the responsibility and control of the local authorities and are shown against Boards for information purposes only.

**\* Patient needs and recovery orientated practice:** use of the AVON validated tool to measure patient needs and promote recovery orientated practice.

**Note:** AVON does not directly focus on patient satisfaction.

**\* Mortality rates for Severe and Enduring Mental Illness:** the number of deaths due to severe and enduring mental illness per 1,000 population (Arbuthnott).



**Readmissions as a percentage of all admissions:**

Numbers of readmissions for spells of inpatient treatment for mental health specialties (lasting 7 days or more) within 365 days of patient's discharge from a previous spell of treatment (any length of stay) as a percentage of total admissions (spells).

**Note:** The benchmarking readmission measure and the HEAT readmission target have different objectives. Benchmarking seeks to establish the size of readmissions relative to all admissions and focuses on the opportunity to prevent these readmissions. The HEAT Target is "Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days, by 10% by the end of December 2009". This focuses on this cohort of patients achieving the right mix of community services on leaving hospital and examines whether corrective action has been achieved for patients who could have been treated outwith hospital.

**Delayed discharges:** the number of discharges for mental health specialties delayed by 6 weeks or longer than scheduled per 1,000 population (Arbuthnott).

**Suicide rates:** the number of suicides (includes intentional self-harm and events of undetermined intent) per 1,000 population (Arbuthnott).

\* **Carer involvement:** the number of carer involvements as a percentage of all clients who have a carer.

\* **Voluntary inpatients to compulsory inpatients:** the percentage of voluntary inpatients compared to the percentage of inpatients subject to compulsory treatment.

\* **Community CTOs:** the number of clients on community-based compulsory treatment orders (CCTOs) as a percentage of clients known to Community Mental Health Services [total compulsory treatment orders (CTOs)].

\* **Patient safety and risk management:** measure of patient experience in relation to patient safety and risk management using the Scottish Recovery Indicator.

\* **Training and supervision:** the amount of training delivered to and supervision provided by mental health staff e.g. staff training in Care Programme Approach, self-harm and suicide, looked after children.

\* **Information Quality and Capture:** an assessment of the quality of the extraction, collation, and production of information.

\* **Mental Health Information:** an assessment of the variance and use of mental health information.

\* **Accredited ICP standards:** the number of accredited ICP standards implemented with 100% collection of prescribed datapoints.



# APPENDIX F: AVON

## Table 1: PHYSICAL

A	B	C	D	E	Letter chosen	Comments - further explanation if needed	Do you feel you need help to change things, if so what sort of help?
<b>FOOD</b> Frequently have little or no food for extended period (most of day) OR frequently abuse food	<b>FOOD</b> Almost never eat regularly	<b>FOOD</b> Often skip meals or make do with snacks	<b>FOOD</b> Almost always eat regularly	<b>FOOD</b> Always eat regularly			
<i>Abuse of food in A includes any problems with Anorexia or Bulimia. Not eating for long periods because you cannot afford to, or you are not able to prepare and/or get food should be counted as A or B</i>							
<b>SHELTER/ ACCOMMODATION</b> Roofless or night shelter	<b>SHELTER/ ACCOMMODATION</b> Short term accommodation, e.g. friend's floor, or bed-sit	<b>SHELTER/ ACCOMMODATION</b> Accommodation unsuitable or poor quality	<b>SHELTER/ ACCOMMODATION</b> Accommodation could be better	<b>SHELTER/ ACCOMMODATION</b> Good accommodation. No worries about rent or security			
<i>Quality refers to safety, warmth, lighting, sanitation etc.</i>							
<b>PHYSICAL HEALTH</b> Physical health is very poor, e.g. severe breathing/circulation problems	<b>PHYSICAL HEALTH</b> Often have physical health problems which cause regular difficulty	<b>PHYSICAL HEALTH</b> Some difficulties present most of the time	<b>PHYSICAL HEALTH</b> Occasional health problems	<b>PHYSICAL HEALTH</b> Physically fit and well			
<i>Problems may include sight, hearing, moving about, breathlessness, epilepsy, skin problems, circulation problems etc. or generally feeling under the weather and having frequent colds or other infections</i>							
<b>SELF-CARE</b> Unable to fully care for myself	<b>SELF-CARE</b> I hardly look after myself at all	<b>SELF-CARE</b> I sometimes neglect to look after myself	<b>SELF-CARE</b> I look after myself most of the time	<b>SELF-CARE</b> I always take care of myself and appearance			
<i>e.g. unable to get out of bed. Self-care refers to hygiene, being able to wash, dress, presentation etc.</i>							
<b>ILL EFFECTS OF TREATMENT</b> Severe effects which are very upsetting. May include feeling 'foggy', slowed down, or having bad physical effects such as very dry mouth, constipation	<b>ILL EFFECTS OF TREATMENT</b> Side effects are definite or marked and are sometimes upsetting	<b>ILL EFFECTS OF TREATMENT</b> Mild side effects e.g. dry mouth, but not upsetting	<b>ILL EFFECTS OF TREATMENT</b> Very occasional side effects	<b>ILL EFFECTS OF TREATMENT</b> Do not notice any unwanted side-effects			
<i>Only include side effects of treatments for mental health problems. Treatment includes medication, ECT and any talking treatment, e.g. talking about your problems may be upsetting</i>							

Table 2: SOCIAL

A	B	C	D	E	Letter chosen	Comments - further explanation if needed	Do you feel you need help to change things, if so what sort of help?
<p><b>SOCIAL SUPPORT</b> Not supported at all by contact with family or friends OR in abusive or destructive relationship with above</p>	<p><b>SOCIAL SUPPORT</b> Very little contact with family or friends – provides almost no emotional or practical support</p>	<p><b>SOCIAL SUPPORT</b> Little contact with family or friends offers some practical support only</p>	<p><b>SOCIAL SUPPORT</b> Has some contact with family or friends which provides practical and emotional support</p>	<p><b>SOCIAL SUPPORT</b> Supportive contact with family and/or friends which provides emotional and practical help</p>			
<p><b>DISCRIMINATION</b> Experience severe discrimination which has ongoing affect on daily life and/or mental health</p>	<p><b>DISCRIMINATION</b> Frequent experience which has some effect on daily life and/or mental health</p>	<p><b>DISCRIMINATION</b> Sometimes experience discrimination</p>	<p><b>DISCRIMINATION</b> Rarely experience discrimination</p>	<p><b>DISCRIMINATION</b> No discrimination experienced</p>			
<p><i>Discrimination means unfair treatment because of your illness, disability, age, religion, race or sex, sexual orientation etc.</i></p>							
<p><b>DAILY ROUTINE</b> No fulfilling day time activities, causes real discontentment</p>	<p><b>DAILY ROUTINE</b> Limited and/or unfulfilling day time activities, causes frustration</p>	<p><b>DAILY ROUTINE</b> Daytime occupation is not sufficient and is largely unfulfilling</p>	<p><b>DAILY ROUTINE</b> Daytime occupation is sufficient, but not very fulfilling</p>	<p><b>DAILY ROUTINE</b> Happy with current level of daytime activities</p>			
<p><i>Daily routine can be paid or unpaid work, daycentre or drop-in activity etc. See also back page</i></p>							
<p><b>COMMUNITY INVOLVEMENT</b> No opportunities for recreation or leisure activities outside of home</p>	<p><b>COMMUNITY INVOLVEMENT</b> Few opportunities for recreation or leisure activities outside of home</p>	<p><b>COMMUNITY INVOLVEMENT</b> Some opportunities for recreation or leisure activities outside of home</p>	<p><b>COMMUNITY INVOLVEMENT</b> Good opportunities for recreation or leisure activities outside of home</p>	<p><b>COMMUNITY INVOLVEMENT</b> Very happy with opportunities for leisure, cultural, sport and/or spiritual activities</p>			
<p>Cannot take part in cultural, sport or spiritual activities</p>	<p>Take part in very little cultural, sport or spiritual activities</p>	<p>Take part in limited number of cultural, sport or spiritual activities</p>	<p>Cannot always take part</p>	<p>Take an active part</p>			

Table 3: BEHAVIOUR

A	B	C	D	E	Letter chosen	Comments - further explanation if needed	Do you feel you need help to change things, if so what sort of help?
<p><b>SLEEP DISTURBANCE</b> Severe and long-lasting problems with sleeping</p> <p><b>RISK TO SELF</b> Often deliberately injure myself or get into dangerous situations</p>	<p><b>SLEEP DISTURBANCE</b> Experience problems a lot of the time</p> <p><b>RISK TO SELF</b> Likely to injure myself or put myself into dangerous situations either accidentally or deliberately</p>	<p><b>SLEEP DISTURBANCE</b> Causes problems some of the time</p> <p><b>RISK TO SELF</b> Occasionally take risks or put myself in a situation where I am vulnerable</p>	<p><b>SLEEP DISTURBANCE</b> Rarely causes problems</p> <p><b>RISK TO SELF</b> Rarely take risks or put myself into dangerous situations</p>	<p><b>SLEEP DISTURBANCE</b> Do not have problems with sleeping</p> <p><b>RISK TO SELF</b> I am very careful and do not get into dangerous situations where I might get injured or harmed</p>	<p>GOOD DAY</p> <p>BAD DAY</p> <p>GOOD DAY</p> <p>BAD DAY</p>		
<p><i>Risk to self includes self-harm or cutting or being likely to fall or injure yourself or taking risks with what you do e.g. drug use, unsafe sex, or being around other people who behave dangerously</i></p>							
<p><b>SUBSTANCE MISUSE</b> Dependent on non-prescription drugs or alcohol every day</p> <p><b>SUICIDE</b> Have recently* attempted to take my own life *within the last few months</p> <p><b>ANGER</b> Frequently get angry and use violence against people or property</p>	<p><b>SUBSTANCE MISUSE</b> Take drugs or drink alcohol heavily, and find it difficult to cut down when I want to</p> <p><b>SUICIDE</b> Thinking seriously about taking my own life</p> <p><b>ANGER</b> Often get angry – isolated incidents may cause damage to people or property</p>	<p><b>SUBSTANCE MISUSE</b> Drink alcohol moderately or take drugs sometimes/ most weeks. I can cut down when I want</p> <p><b>SUICIDE</b> Have been or am thinking about the possibility of taking my own life</p> <p><b>ANGER</b> Sometimes get angry and use violent language, shout or threaten people</p>	<p><b>SUBSTANCE MISUSE</b> Occasionally drink alcohol or take drugs</p> <p><b>SUICIDE</b> Occasionally think about taking my own life</p> <p><b>ANGER</b> Get angry in some circumstances – do not easily show this</p>	<p><b>SUBSTANCE MISUSE</b> Rarely or never get drunk, do not take non-prescribed drugs</p> <p><b>SUICIDE</b> I have no suicidal thoughts</p> <p><b>ANGER</b> Generally do not get angry with people or things</p>	<p>ALCOHOL</p> <p>DRUGS</p> <p>GOOD DAY</p> <p>BAD DAY</p> <p>GOOD DAY</p> <p>BAD DAY</p>		

Table 4: ACCESS

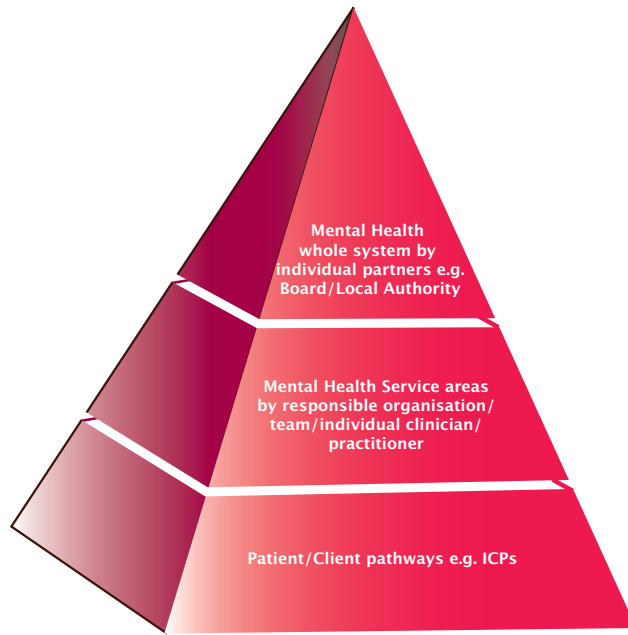
A	B	C	D	E	Letter chosen	Comments - further explanation if needed	Do you feel you need help to change things, if so what sort of help?
<b>TRANSPORT</b> No private transport is available	<b>TRANSPORT</b> Public and private transport available on some days	<b>TRANSPORT</b> Transport is generally available	<b>TRANSPORT</b> I use public or private transport	<b>TRANSPORT</b> I have my own transport	GOOD DAY BAD DAY		
I am unable to use public transport even when it is available	My use of transport is very limited because of lack of confidence or health difficulties	I can use some forms of transport	I mostly find it easy to get about	I have no problems getting about	GOOD DAY BAD DAY		
<i>Use of transport – may be limited by lack of money, need for child transport or care, mobility difficulties, geographical local etc.</i>							
<b>INFORMATION</b> Unable to get hold of any information or advice	<b>INFORMATION</b> Difficult to get hold of information or advice	<b>INFORMATION</b> Only some information is readily available	<b>INFORMATION</b> Information is mostly available	<b>INFORMATION</b> Information is readily available	GOOD DAY BAD DAY		
I am not able to understand information	I have a limited amount of understanding	I can understand a fair amount of information	I understand most information and advice	I understand most information	GOOD DAY BAD DAY		
<i>Information can be about benefits, housing, health or about your illness or what help there is available. You may need information in another language or as Braille or on tape, or need help with reading or writing</i>							
<b>COMMUNICATION</b> Hardly talk to anyone on most days	<b>COMMUNICATION</b> Usually talk to only a few people	<b>COMMUNICATION</b> Have some difficulty with talking and communicating on most days	<b>COMMUNICATION</b> I am able to talk and communicate in most situations	<b>COMMUNICATION</b> No problem talking and communicating	GOOD DAY BAD DAY		
<b>INCOME - PAID WORK ALLOWANCE OR BENEFIT</b> No regular income or benefits OR lack of income causes severe distress	<b>INCOME - PAID WORK ALLOWANCE OR BENEFIT</b> Income or benefits unclaimed or inadequate - not sufficient for all reasonable daily needs	<b>INCOME - PAID WORK ALLOWANCE OR BENEFIT</b> Income is uncertain, sometimes enough to meet needs, sometimes not	<b>INCOME - PAID WORK ALLOWANCE OR BENEFIT</b> Income is regular but only just enough to meet needs	<b>INCOME - PAID WORK ALLOWANCE OR BENEFIT</b> Secure income, sufficient to meet most needs			
<b>MANAGING MONEY</b> Daily financial affairs chaotic - require a great deal of outside help	<b>MANAGING MONEY</b> Severe difficulties coping with daily personal financial matters - need much help	<b>MANAGING MONEY</b> Able to look after personal finances with help from someone else	<b>MANAGING MONEY</b> Sometimes able to deal with personal finances on my own	<b>MANAGING MONEY</b> I am able to keep a check on my own personal finances	GOOD DAY BAD DAY		
<i>You may find that you spend money in an unpredictable or chaotic way when you are ill</i>							

Table 5: MENTAL HEALTH

A	B	C	D	E	Letter chosen	Comments - further explanation if needed	Do you feel you need help to change things, if so what sort of help?
<b>MOOD SWINGS</b> Severe, long-lasting and uncontrollable for most of the time	<b>MOOD SWINGS</b> Experience these problems a lot of the time	<b>MOOD SWINGS</b> Experience mood swings some of the time	<b>MOOD SWINGS</b> Occasionally have these problems	<b>MOOD SWINGS</b> Do not have problems with mood changes	GOOD DAY BAD DAY		
<i>Mood changes – ‘highs’ or ‘lows’, extreme elation or extreme sadness</i>							
<b>DEPRESSION</b> Severe, long-lasting and uncontrollable for most of the time	<b>DEPRESSION</b> Experience depression a lot of the time	<b>DEPRESSION</b> I am sometimes depressed	<b>DEPRESSION</b> I am rarely depressed	<b>DEPRESSION</b> Have no problems with depression	GOOD DAY BAD DAY		
<i>Depression includes feelings of sadness, feeling low, guilt, emptiness, withdrawal, low self-esteem, slowing down or inability to get going and do things</i>							
<b>UNUSUAL THOUGHTS &amp; EXPERIENCES</b> Severe, long-lasting or uncontrollable	<b>UNUSUAL THOUGHTS &amp; EXPERIENCES</b> Experience these problems a lot of the time	<b>UNUSUAL THOUGHTS &amp; EXPERIENCES</b> Sometimes are a problem	<b>UNUSUAL THOUGHTS &amp; EXPERIENCES</b> These are very rarely a problem	<b>UNUSUAL THOUGHTS &amp; EXPERIENCES</b> These are never a problem	GOOD DAY BAD DAY		
<i>This can include experiencing voices or visions, or having unusual thoughts or beliefs including feeling that people are against you</i>							
<b>ANXIETY OR FEAR</b> Uncontrollable panic OR severe, recurring anxiety and worry	<b>ANXIETY OR FEAR</b> Have bad anxiety, panic attacks or worries a lot of the time	<b>ANXIETY OR FEAR</b> I am sometimes anxious or have panic attacks	<b>ANXIETY OR FEAR</b> I rarely have these problems	<b>ANXIETY OR FEAR</b> Have no problems with anxiety or thoughts about traumatic events	GOOD DAY BAD DAY		
<i>Undue fear of everyday things or events, like going out</i>							
<b>OBSESSIVE THINKING/COMPULSIVE ACTIVITIES</b> Severe, long-lasting and uncontrollable	<b>OBSESSIVE THINKING/COMPULSIVE ACTIVITIES</b> Experience these problems a lot of the time	<b>OBSESSIVE THINKING/COMPULSIVE ACTIVITIES</b> Sometimes have these problems	<b>OBSESSIVE THINKING/COMPULSIVE ACTIVITIES</b> Rarely have these problems	<b>OBSESSIVE THINKING/COMPULSIVE ACTIVITIES</b> I have no problems like these	GOOD DAY BAD DAY		
<i>May include repeated washing, or checking, collecting or counting</i>							
<b>PROBLEMS WITH FORGETTING &amp; UNDERSTANDING</b> Unable to recognise friends or relatives OR speech confused or disorientation – not knowing where I am going to	<b>PROBLEMS WITH FORGETTING &amp; UNDERSTANDING</b> Have difficulty understanding what is going on. Sometimes have difficulty in getting people to understand me	<b>PROBLEMS WITH FORGETTING &amp; UNDERSTANDING</b> Have memory problems like losing my way or not recognising someone OR unable to grasp or remember simple things or words	<b>PROBLEMS WITH FORGETTING &amp; UNDERSTANDING</b> Have minor problems like forgetting names or where I have put things	<b>PROBLEMS WITH FORGETTING &amp; UNDERSTANDING</b> Fine – no problems in this area	GOOD DAY BAD DAY		

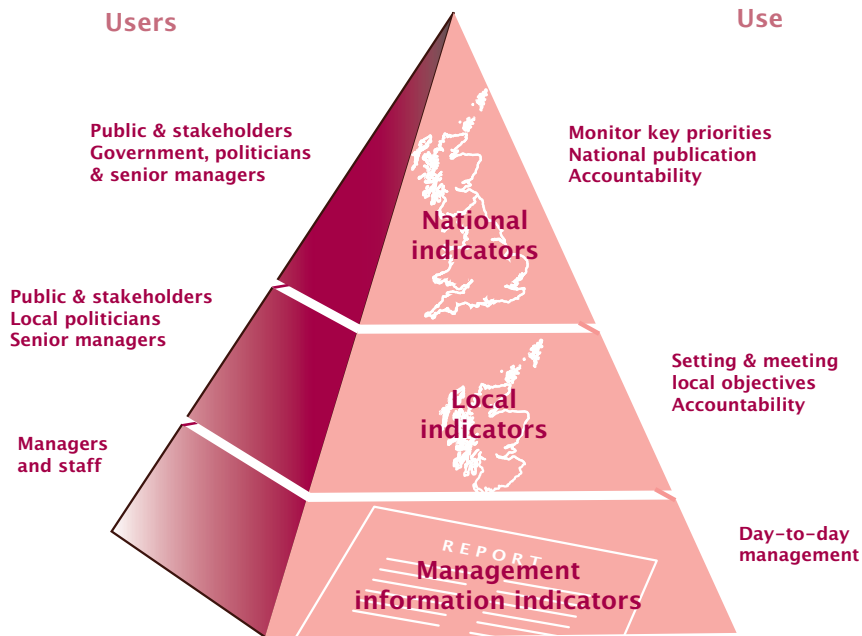
# APPENDIX G: Reporting Framework

## Reporting Framework



## The Different Users and Use of Indicators

Indicators should form a coherent set, with operational indicators supporting the publication of local and national indicators.



Source: Audit Commission





## APPENDIX I: Mental Health Resources

### Beds

Mental Health Services	Health Board	Number of beds
<b>1. Adult Mental Health</b>		
<b>1.2 Inpatient Services</b>		
<b>1.2.1 Acute</b>	NHS Ayrshire & Arran	92
	NHS Borders	30
	NHS Fife	102
	NHS Forth Valley	53
	NHS Grampian	133
	NHS Lanarkshire	144
	NHS Tayside	119
<b>1.2.2 IPCU</b>	NHS Ayrshire & Arran	7
	NHS Fife	10
	NHS Forth Valley	12
	NHS Grampian	11
	NHS Lanarkshire	80
	NHS Tayside	12
<b>1.2.3 Rehabilitation</b>	NHS Ayrshire & Arran	12
	NHS Borders	17
	NHS Fife	48
	NHS Forth Valley	14
	NHS Grampian	10
	NHS Tayside	23
<b>1.2.4 Continuing Care/Long Stay</b>	NHS Ayrshire & Arran	60
	NHS Borders	11
	NHS Fife	49
	NHS Forth Valley	81
	NHS Grampian	40
	NHS Tayside	18
<b>1.2.6 Forensic</b>	NHS Grampian	32
	NHS Lanarkshire	11
	NHS Tayside	27
<b>1.2.9 Co-morbidity Service</b>	NHS Ayrshire & Arran	12
<b>2. Elderly Mental Health</b>		
<b>2.2 Inpatient Services</b>		
<b>2.2.1 Acute</b>	NHS Ayrshire & Arran	72
	NHS Borders	24
	NHS Fife	56
	NHS Forth Valley	60
	NHS Grampian	140
	NHS Tayside	62
<b>2.2.2 Continuing Care/Long Stay</b>	NHS Ayrshire & Arran	106
	NHS Borders	52
	NHS Fife	147
	NHS Forth Valley	93
	NHS Grampian	132
	NHS Tayside	32
<b>4. Child &amp; Adolescent Mental Health</b>		
<b>4.1 Inpatient Services</b>		
<b>4.1.2 Young People's Unit</b>	NHS Tayside	7

Mental Health Services	Health Board	Number of Teams	Number of Doctors			Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered			
1. Adult Mental Health 1.1 Community Services	NHS Ayrshire & Arran	6	11 - Organised on a sector basis including inpatient and community	10		58.05	12.3			Only North Ayrshire Community Mental Health Teams have social workers as integral members of the team
	NHS Borders	4		3 Senior House Officers	2.7	12	1	2.5		
	NHS Fife	8	5.25			43.8	4.4			
	NHS Forth Valley	5	7.2			26				7.1
	NHS Grampian	18	18.4			55.6				28.3
	NHS Lanarkshire	8	4		4		140	47	32	6
	NHS Shetland	1	1				4.5			1
	NHS Tayside	10								13 (10.6 WTE)
	NHS Ayrshire & Arran	Spread across 6 Community Mental Health Teams i.e. 6					16			
	NHS Borders	1					4.75			
	NHS Forth Valley	1	1.5				8			
	NHS Ayrshire & Arran	Spread across 6 Community Mental Health Teams i.e. 6								
	NHS Grampian			Rota	Rota		3			
	NHS Tayside	1						6		
	NHS Fife	2	1				11.1	6.6		
	NHS Forth Valley	2	0.4				7.5			
	NHS Grampian			1			6	5.5		
	NHS Lanarkshire			1.5						
NHS Shetland			1.5							
NHS Ayrshire & Arran										
NHS Lanarkshire			18 Counsellors							30
NHS Shetland			5 Counsellors							
NHS Ayrshire & Arran										

12 (East Ayrshire missing)

Mental Health Services	Health Board	Number of Teams	Number of Doctors				Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered				
<b>1. Adult Mental Health</b>											
<b>1.1 Community Services</b>											
1.1.7 Community Forensic Service	NHS Ayrshire & Arran		2								
	NHS Fife		0.5	0.5			2				
	NHS Forth Valley	1	0.6	0.3			5			0.4	
	NHS Grampian	1	3								
	NHS Lanarkshire	1	2.5 (Spread over Forensic and Community)	1 (Spread over Forensic and Community)			19	11	2	1	
										0.5 SWS South Lanarkshire Council: 6 MHOs, 3 MHOs in criminal justice team, 8.5 MHOs Managerial working across several teams	
1.1.8 Liaison Psychiatry	NHS Ayrshire & Arran		1.5				7.8				
	NHS Borders	1	0.6				2				
	NHS Fife						3				
	NHS Forth Valley	1	0.6				2			2	
	NHS Grampian		1				3.6				
	NHS Lanarkshire		0.5				15.25				
	NHS Tayside	1									
1.1.12 Psychological Therapies Psychometric assessment	NHS Shetland									1	

Mental Health Services	Health Board	Number of Teams	Number of Doctors			Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered			
1. Adult Mental Health										
1.1 Community Services										
1.1.14 Other Day Services	NHS Ayrshire & Arran	2	2			8	4.6			
	NHS Borders					5.87	2.11	Included in Community Mental Health Team resource		
	NHS Fife	3				19.2				
	NHS Forth Valley	3								
	NHS Lanarkshire					7	2.8			
	NHS Tayside								Community Mental Health Team: 13 (10.6 WTE) Primary Care Mental Health settings: 28 (22 WTE)	
1.2 Inpatient Services										
1.2.1 Acute	NHS Ayrshire & Arran	4 wards	(See Community Mental Health Team)			57.94	56.08			
	NHS Borders					25.1	11.8	1		
	NHS Fife		5.25	9		78.64	29.8			
	NHS Forth Valley					37.6	21.8			
	NHS Grampian					104.5	29.8			
	NHS Lanarkshire	6	4	4		123	82	7.8		
1.2.2 ICU	NHS Ayrshire & Arran	1 ward	1			15	11			
	NHS Fife		0.5	1		18	4			
	NHS Forth Valley					17	13			
	NHS Grampian					12	6			
	NHS Lanarkshire		1.5			35	35			
1.2.3 Rehabilitation	NHS Ayrshire & Arran	1 designated ward	1	1		9.7	6			
	NHS Borders					17.5	15.3	0.35		
	NHS Fife		0.5			27.1	12.9			
	NHS Forth Valley					8.4	4.5			
	NHS Grampian					9.7	4			
	NHS Lanarkshire							3		

Mental Health Services	Health Board	Number of Teams	Number of Doctors			Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered			
1. Adult Mental Health										
1.2 Inpatient Services										
1.2.4 Continuing Care/Long Stay	NHS Ayrshire & Arran	5 wards	5			47.2	42.8			
	NHS Borders					12.3	7.6	0.35		
	NHS Fife		0.5			23	16.6			
	NHS Forth Valley					46.8	58.3			
	NHS Grampian					25	12			
1.2.6 Forensic	NHS Ayrshire & Arran		1			9	13.2			
	NHS Lanarkshire	1	2.5	1		23	13	1		
1.2.9 Co-morbidity Service	NHS Ayrshire & Arran		4			10 & 4 community	4			
	NHS Fife	1				1				2
1.2.10 Discharge and Resettlement Service	NHS Lanarkshire					3.6				

Mental Health Services	Health Board	Number of Teams	Number of Doctors			Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered			
2. Elderly Mental Health 2.1 Community Services	NHS Ayrshire & Arran	6		4						
	NHS Borders	1		1	0.5	5	1	1.38		
	NHS Fife		2.25			Included within adult Community Mental Health Team figures				
	NHS Forth Valley	2				15	4			
	NHS Grampian	8	8			25	8			8
	NHS Tayside	12: Perth & Kinross - 4 dementia, 1 functional, Angus - 3 joint NHS/SW, early stage service, Dundee - 4 teams, mixed dementia/functional								
2.1.2 Day Services	NHS Borders	3				8.3	1.87			
	NHS Fife					15	7			
	NHS Forth Valley					7.66	5.53			
	NHS Grampian					28	15			
	NHS Tayside	Perth & Kinross - 1 organic, 1 functional day hospital, 1 day/week dementia day hospital, 3 days/week dementia day hospital, Dundee - 1 organic, 1 functional day hospital, Angus - 1 functional day hospital								
2.1.3 Older People's Liaison	NHS Borders	1				1				
	NHS Fife	2	0.25			2				
	NHS Tayside		Perth & Kinross (PR) 0.2 consultant/week, Dundee (NW) as required							
2.1.4 Primary Care Mental Health Service	NHS Fife	2	0.2			6.24	4.6			

Mental Health Services	Health Board	Number of Teams	Number of Doctors			Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered			
2. Elderly Mental Health 2.2 Inpatient Services	NHS Borders	1				14.8	13			
	NHS Fife		2.5		46.88	21.95				
	NHS Forth Valley				32.22	34.7				
	NHS Tayside		2 (in total for inpatient services)							
2.2.2 Continuing Care/Long Stay	NHS Borders	3				28.7	39.6			
	NHS Fife		2.5		80.2	69.1				
	NHS Forth Valley				40.16	62.09				
	NHS Tayside		2 (in total for inpatient services)							

Mental Health Services		Health Board	Number of Teams	Number of Doctors			Number of Nurses		Number of Occupational Therapists	Number of Psychologists	Number of Social Workers
4. Child & Adolescent Mental Health	4.1 Inpatient Services			Consultants	Training	Staff Grade/Associate Specialists	Registered	Not Registered			
4.1.1 Children's Unit	NHS Tayside							OT 0.7 SLT 0.1			
4.1.2 Young People's Unit	NHS Tayside		1.5			22		OT 0.7 SLT 0.1			
4.2 Community Services											
4.2.1 CAMHS	NHS Ayrshire & Arran	2	10.8								
	NHS Borders	1.6	1	0.6	5.2		2				
	NHS Fife	2.13	1		6.2						
	NHS Grampian	8.4			21.3						
	NHS Shetland	0.15			1				0.4		
	NHS Tayside		11.5			7.5		OT 0.6 SLT 0.1	8 (6.3 WTE)		
4.2.3 Liaison Services	NHS Fife					3					
	NHS Tayside										
4.2.7 Other CAMH Services	NHS Fife					8					
5. Specialist Other											
5.1 Community Eating Disorders	NHS Fife	1		1							
	NHS Grampian	0.5			3						
	NHS Tayside	0.5		0.2	1		1.2 Dieticians		2.1		
5.5 Mental Health Homeless Services	NHS Fife	1			1						
	NHS Grampian				1						
5.6 Addictions Homeless Services	NHS Borders	1 (Community Addictions Team)		0.4 Senior Medical Officer	8						
	NHS Fife	1			3						

## Mental Health Resources: Notes and additional figures

Nine out of the twelve Health Boards visited (75%) were able to fill in the resources matrix to some extent. However, some Boards commented that it was difficult to breakdown these figures into the given categories e.g. consultant time across all the relevant headings. Therefore, some Boards sent additional notes and figures, which are detailed below:

### NHS Borders – Consultant Resources in Mental Health

Each full time consultant will have 2.5 Supporting Programmed Activities (SPAs), which are not spent in direct clinical care.

#### Adult MH Services

31.7 Direct Clinical Care Programmed Activities working across: Crisis Service, Community Mental Health Team, Day Services, Acute Inpatient Unit, Rehabilitation inpatient services and Continuing Care/Long Stay inpatient services.

#### Liaison Services

4.5 Direct Clinical Care Programmed Activities working across Liaison.

#### Older Adult MH Services

15.6 Direct Clinical Care Programmed Activities working across the following Elderly Services: Community Mental Health Team, Day Services, Older People Liaison and Primary Care Mental Health Team.

#### Substance Misuse

7.5 Direct Clinical Care Programmed Activities working with individuals with substance misuse problems including those with co-morbidities.

## NHS Forth Valley Resources (WTE)

### Selected AHPs

Specialty	Acute Services	CHP Services	Total
Dieticians	16.58	13.79	30.37
Occupational Therapy	45.14	59.10	104.24
Pharmacy	83.58	13.31	96.89
Physiotherapy	116.06	13.81	129.87
Podiatry	-	30.51	30.51
Grand Total	261.36	130.52	391.88

### CHP Consultant Psychiatrists

Specialty	Total
Child and Adolescent Psychiatry	3
Forensic Psychiatry	1.8
General Psychiatry	11.1
Old Age Psychiatry	4
Grand Total	19.9

## NHS Greater Glasgow & Clyde Resources (WTE)

Discipline	Greater Glasgow			Greater Glasgow			Inverclyde			Renfrew			Clyde Total	NHS Greater Glasgow & Clyde Total
	Adult	Elderly	Other/Community	Total	Adult	Elderly	Other/Community	Elderly	Adult	Other/Community	Elderly	Other/Community		
Consultant			102.15	102.15	7.00	1.85			8.26			3.45	20.56	122.71
Other Medical			143.14	143.14	9.20				8.34			2.50	20.04	163.18
Nursing (Trained)	307.79	221.71	372.07	901.57	51.30	36.14	25.20		125.20			30.99	268.83	1170.40
Nursing (Untrained)	197.60	205.51	92.58	495.69	33.84	48.62	7.00		98.67			13.00	201.13	696.82
Occupational Therapist			129.93	129.93	3.19	8.53	2.90		14.02			4.83	33.47	163.40
Psychologist			146.52	146.52	5.00		1.00		21.10			2.75	29.85	176.37
Management/Administration	95.70	21.62	191.00	308.32	13.66		5.00		11.95			8.40	39.01	347.33
Total	601.09	448.84	1177.39	2227.32	123.19	95.14	41.10		287.54			65.92	612.89	2840.21

## APPENDIX J: Mental Health Systems

Systems - Ease of Use, Access Issues and Reporting				
Board/Local Authority	System	Ease of Use	Access issues (Hardware/Software)	Reporting
NHS Ayrshire & Arran	FACE	Easy to use	Good access but some issues	Wide range of reports available
NHS Borders	EPEX	Easy to use but some issues	Moderately good access	Wide range of reports available
	Client Information System	Moderately easy to use but some issues	Good access	
NHS Dumfries & Galloway	TOPAS	Easy to use but some issues	Good access	Wide range of reports available
NHS Fife	PiMS	Easy to use but some issues	Good access but some issues	Wide range of reports available
NHS Forth Valley	PiMS	Moderately easy to use but some issues	Inadequate access	Wide range of reports available
	Community Care Information System		Good access	
NHS Grampian	PiMS		Inadequate access	Limited range of routine reports, often adhoc reporting
	CareFirst		Good access	
NHS Greater Glasgow & Clyde	PiMS		Good access	Wide range of reports available
	CareFirst			
NHS Highland	Local Databases	Not user-friendly	Moderately good access but some issues	Limited range of routine reports, often adhoc reporting
	PCSMR			
NHS Lanarkshire	PiMS		Inadequate access but issues will be resolved	Limited range of routine reports, often adhoc reporting. Specific information difficult to provide
	SWIS/SWIS PLUS		Good access	
NHS Lothian	PiMS	Easy to use		Wide range of reports available
	SWIFT			
NHS Shetland	MH Appointment System (OP System)	Moderately easy to use but some issues	Good access but some issues	Limited range of routine reports
	SWIFT	Easy to use		
NHS Tayside	MITRE	Moderately easy to use but some issues	Good access but some issues	Wide range of reports available
	K2 System			



## Additional Systems

A multitude of systems, including local databases and bespoke systems (other than those mentioned above) are utilised within the Health Board and local authority areas, each with differing levels of system functionality. Some of these other systems are:

- COMPAS
- COVALENT
- BLUE SKY
- HOMER
- ESCRO
- K2.

## Updating

The timeliness of updating information into these systems varies between Boards and local authorities. Common themes that have emerged relate to:

- Capacity issues
- Clinical commitments
- Lack of mobile technology
- Dual records i.e. electronic and paper based
- Individual practice and recording
- System limitations/difficulties.

## Reporting

Many Boards and local authorities are able to produce a wide range of reports, including both

standard reporting and adhoc. Reports generated include information about:

- Waited and Waiting Times
- Bed Management/Utilisation
- Admissions/Discharges
- Contacts
- Referrals
- Occupancy
- Risk Assessments
- Critical Incidents
- Team/Community Activity
- Joint Reporting – Single Shared Assessment, Joint Performance Framework
- Clinical/Staff Governance Reports.

## General Comments

The Boards and local authorities also made general comments in relation to the systems/system use, including aspects such as:

- Upgrades to existing systems e.g. ICIC datasets coded into existing system
- Move to new and improved systems in the future e.g. GCS Toolkit, OASIS, TOPAS
- Existing systems linking to CHI
- Creating a joint data warehouse accessed by health and social care
- Joint systems – to enhance integrated approach.



## APPENDIX K: Data Quality

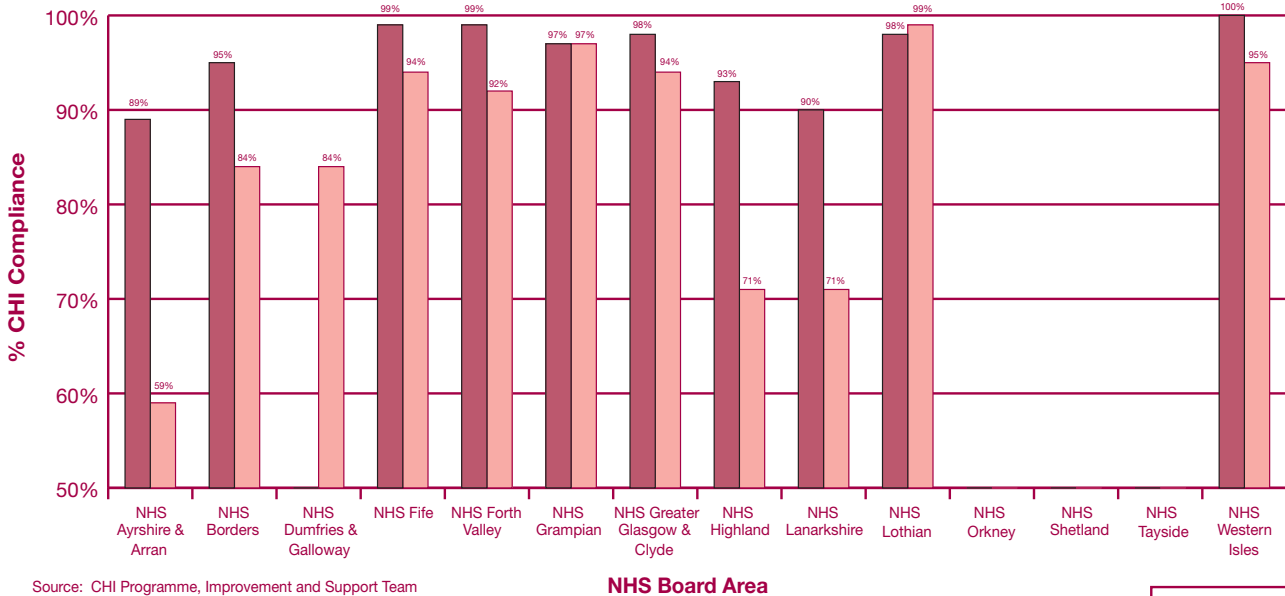
### Data Quality Issues and Potential Solutions

Data Quality Issues	Solutions
Cost Book Inconsistencies	Mental Health Outcomes based costing project
Provisional Status of SMR Returns	Improving existing systems or developing new systems in line with the National IM&T strategy Sufficient resources e.g. more staff, time, training, finance etc.
CHI Compliance	Existing or new systems facilitating an automatic link with the CHI
Data Validation	Improving existing systems or developing new systems in line with the National IM&T strategy Provide training and advice to staff utilising the system Data quality checks/exception reporting Internal audits of data Sufficient resources e.g. more staff, time, training, finance etc.
Information Sharing	Development of the National Definitions/Data Standard Sharing Framework Joint data warehouses and/or joint systems Improving existing systems or developing new systems in line with the National IM&T strategy Adopt whole system approach Sufficient resources e.g. more staff, time, training, finance etc.
Mixture of Systems	Joint data warehouses and/or joint systems Improving existing systems or developing new systems in line with the National IM&T strategy Adopt whole system approach Development of the National Definitions/Data Standard Sharing Framework
Variance of data collection and reporting	ICIC datasets coded into health and local authority systems Development of the National Definitions/Data Standard Sharing Framework Provide training and advice to staff utilising the system



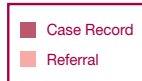
# APPENDIX L: CHI Compliance and SMR04 Completeness

Utilisation of CHI on Mental Health case records and referrals by NHS Board Area<sup>1,2</sup> as at July 2007

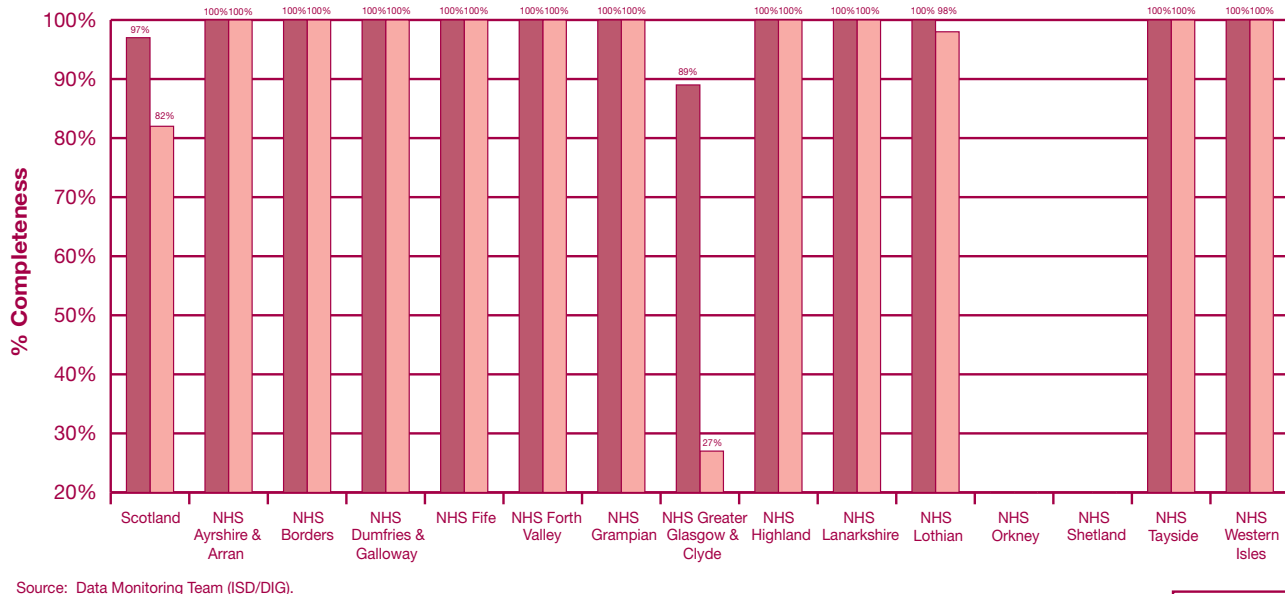


Source: CHI Programme, Improvement and Support Team  
Health Delivery Directorate, Scottish Executive

1. Due to the different configuration of Mental Health Services, returns may not cover exactly equivalent activity across boards.
2. Some boards have not yet provided data on use of CHI in Mental Health Services.



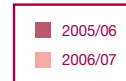
SMR04 (Mental Health Inpatients and Daycases)<sup>1</sup> Completeness Estimates by NHS Board Area<sup>2</sup> as at October 2007



Source: Data Monitoring Team (ISD/DIG).

1. Counts of discharges only.
2. Blank health boards: No SMR's expected/negligible.

NHS Board Area



## APPENDIX M: Good Practice

Below are some illustrations of good practice. These examples do not represent a comprehensive summary.

### NHS Ayrshire & Arran

- Health & local authorities use the FACE system to share information and enhance an integrated approach.
- The ICIC datasets coded into the mental health system and ready to roll out with the ICP pathways.
- Ongoing local data warehouse project to allow health and local authority to access and share information.

### NHS Borders

- Assessment letters and care planning being developed in the EPEX system.
- Utilise a workforce-planning tool.
- Data quality checks performed e.g. clinical teams review data.

### NHS Dumfries & Galloway

- Crisis Assessment & Treatment Service (CATS): system created for the data collection and evaluation of crisis services.
- Joint service e.g. CMHTs have both health and social care staff, and have joint health improvement targets.

### NHS Fife

- Clinical audits of mental health information e.g. monthly statistical reports are fed back to clinical managers.
- Management exception reports e.g. monitoring shifts in activity, outliers etc.

### NHS Forth Valley

- Qualitative work carried out on critical incidents.
- Joint team working e.g. integrated mental health teams and joint reporting e.g. Community Health Plan.

### NHS Grampian

- Datix Risk Management System used to capture incidents e.g. aggression/violence, complaints handling etc.
- Joint care approach via integrated teams/services and joint reporting e.g. single-shared assessment, joint performance plan.

### NHS Greater Glasgow & Clyde

- Critical incident process to allow clinicians and managers to learn from incidents.
- Bed management system.
- PiMS champions/super-users trained to provide advice to staff.
- Joint integrated teams/services; joint performance plan and joint reporting e.g. integrated screening services, allocations for referrals, single-shared assessment.
- MHO Activities Report detailing the breakdown of MHO activity e.g. Compulsory Treatment Orders, Carers Assessment by CHCPs.

### NHS Highland

- Joint Committee/Partnership Board – reports and issues are fed into group.
- Mental Health in Highland report. This report details a review of mental health services in Highland e.g. assessment and analysis of routinely collected data including highlighting statutory obligations, investigating external factors such as the impact of the Mental Health Act and proposing future steps to improve the service.



### NHS Lanarkshire

- Social work information system links with the health mental health system.
- Exception reports produced e.g. missing diagnosis codes, CHI etc.
- New software package being developed to create a central data warehouse of both health and community information.

### NHS Lothian

- Standard reports fed into the clinical teams.
- Exception reports produced e.g. missing diagnosis codes, CHI etc.
- Multi-disciplinary teams e.g. CMHTs and are in the process of producing charts of integrated services/joint approach to care.

### NHS Shetland

- Outpatient system links into SCI-Store.
- CHI project to address missing CHI numbers on referrals.
- Data Quality – reports fed back to mental health team for data cleansing.
- Joint Future Management model exists between health and local authority.

### NHS Tayside

- Clinical Governance Reports – look at performance indicators in relation to the Mental Health Delivery Plan.
- Internal audits to perform data quality checks.
- Producing shared definitions to enable information sharing and ensure comparability.
- Ongoing work to align systems and processes via operational policies to adopt integrated approach.





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