

**Mental Health Needs Assessment  
in the Glenrothes Area**

**Glenrothes and North East Fife  
Community Health Partnership  
Local Mental Health Partnership Forum**

**Final report  
September 2009**

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## Contents

Executive Summary .....	i
1. Introduction .....	1
2. Methodology .....	3
3. Desk Research .....	9
4. E-Survey .....	36
5. Telephone Interviews .....	53
6. Focus Groups with Services Users and Carers .....	72
7. Key Themes .....	89
8. Conclusions and Recommendations.....	92

## Appendices

Appendix 1 – E-Survey

Appendix 2 – Discussion Guide - Telephone Interviews

Appendix 3 – Discussion Guide - Focus Groups with Service Users and Carers

## List of Tables

Table 2.1	Service Providers Interviewed
Table 3.1	Indication of pressures on prevalence of neurotic and psychotic disorders – Glenrothes
Table 3.2	Estimated prevalence of neurotic symptoms in Glenrothes
Table 3.3	Estimated prevalence of personality disorder symptoms in Glenrothes
Table 3.4	Estimated prevalence of psychotic disorder symptoms in Glenrothes
Table 4.1	Respondents by sector
Table 4.2	Respondents by role
Table 4.3	Respondents by service location and delivery
Table 4.4	Respondents by type of mental health assessment
Table 4.5	Presence and length of waiting list
Table 4.6	Frequency of treatment or support sessions
Table 4.7	Duration of treatment or support sessions
Table 4.8	Adequacy of frequency and duration of treatment or support sessions
Table 4.9	Progress towards delivering for mental health
Table 4.10	Assessing service quality
Table 4.11	Assessing service availability
Table 4.12	Additional training needs identified
Table 4.13	Plans for service improvements

## List of Figures

Figure 1	Exhibit 12 – Taken from an Overview of Mental Health Services – Audit Scotland
Figure 2	Exhibit 13 – Taken from an Overview of Mental Health Services – Audit Scotland
Figure 3	Exhibit 8 – Taken from an Overview of Mental Health Services – Audit Scotland
Figure 4	Average rate (1/100,000) of inpatient treatment by condition, 2003/04-2007/08
Figure 5	Rates of inpatient treatment for drug misuse, 2003/04-2007/08
Figure 6	Rates of inpatient treatment for alcohol misuse, 2003/04-2007/08
Figure 7	Rates of inpatient treatment for schizophrenia, 2003/04-2007/08
Figure 8	Rates of inpatient treatment for mood (affective) disorders, 2003/04-2007/08
Figure 9	Rates of inpatient treatment for personality disorders, 2003/04-2007/08
Figure 10	Rates of inpatient treatment for neurotic, stress related & somato form disorders, 2003/04-2007/08
Figure 11	Average proportions admissions to inpatient specialist services, 2003/04-2007/08
Figure 12	Trend in Gender by inpatient admission and area, 2003/04-2007/08
Figure 13	Length of stay – cumulative percentage, 2003/04-2007/08
Figure 14	Trends in aftercare arrangements, 2003/04-2007/08
Figure 15	Aftercare arrangements for young people

## Executive Summary

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### Introduction

Glenrothes and North East Fife's Local Mental Health Partnership Forum (LMHPPF) commissioned ODS Consulting, in partnership with Kinbank Social Research Consultancy, to undertake this work between March and August 2009. The research findings will help to:

- identify what the needs of those with mental health problems are; and
- prioritise areas for service development.

### Methodology

This research was both quantitative and qualitative. It involved:

- desk research - obtaining statistical information on demographics and prevalence of mental health problems;
- e-survey - with mental health practitioners (42 responses were received – of which 20 were partial);
- telephone interviews - with NHS and other service providers (16 respondents) ; and
- focus groups - with service users and carers (eight service users and three carers).

### Main Findings

#### Prevalence of conditions in Glenrothes

- The number of people affected by neurotic disorders in the study area is likely to be high - but services are likely to be in touch with only a small proportion of them at any one time.
- The number of adults with currently active psychotic conditions is likely to be lower and they are more likely to be known to services and to be receiving treatment than those with neurotic disorders. However, this may mask important differences between sub groups, for example those with dual diagnosis.
- In respect of certain conditions, the rates of inpatient care for residents of Glenrothes are significantly above those for Fife as a whole. There may be a variety of reasons for this including higher levels of illness, fewer options for care in the community or more active local services appropriately identifying and admitting the chronically unwell.
- The most common mental health conditions being treated by respondents of the e-survey were depression and anxiety.

### Availability of services

- Just under a third (31%) of service providers felt that the availability of mental health services was adequate; while a further third (31%) said that availability was poor. Only one in five (19%) stated the availability of services was good.<sup>1</sup>
- A lack of day care provision was identified as a particular weakness of the current service provision.

### Capacity issues

- Capacity issues were identified in psychology and in services dealing with patients at the “crisis” stage of their care – the Fife Intensive Outreach Team was mentioned as one specific service which tended to take on more service users, but rarely discharge anyone.
- The service providers felt that they were currently operating at capacity and those who said they were not currently working to capacity stated this was because of staff shortages and vacancies.
- Patients with co-morbidity issues (substance misuse problems as well as mental health problems) were identified as a group who were not currently well served by service provision.
- Service providers also identified that more could be done to work with older people, those with personality disorders and those with “mild to moderate” mental health problems.

### Awareness of services

- Service providers felt that awareness of services among the general public was poor, and that those newly diagnosed would not know where to go for help. This was compounded by a lack of awareness among GPs – who it was felt (by other service providers, service users and carers) often referred patients inappropriately.
- The service users recognised their lack of knowledge of what services were available and commented they had only found out about relevant groups and services by chance. Word of mouth appeared to have played an important role in awareness and take up of local groups and services.

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<sup>1</sup> Based on 16 responses

### **Expectations of services**

- Service users wanted services to address long term causes of mental health problems, not just provide short term solutions. It was also expected that services should offer understanding, practical and emotional support and the ability to refer proactively to other relevant services.

### **Communication with service users**

- Service providers did have channels in place to communicate with service users – but it was acknowledged that often services rely on a small group of ‘keen’ representatives, rather than trying to encourage response from a wider group.

### **Impact on carers**

- Carers were affected by a number of issues such as isolation, stress and financial implications such as a very low income. They valued services specific to their needs as carers.

### **Quality of service**

- When asked to self-assess the quality of their own service; 18% of service providers commented that they provide a high quality service (and a further 18% stated their service was *very high quality*). The majority (59%) said the service they provide was satisfactory.<sup>2</sup>
- Service users’ views on the quality of services varied and were often strongly affected by their personal experience. Service users rated mental health services in Glenrothes between ‘good’ and ‘very poor’.

### **Barriers to accessing services**

- Service providers perceived the location of the service to be a barrier for some service users. There was a view that the public expect services to be “on their doorstep” and this was compounded by the poor public transport links in the area. Stigma was also mentioned as a barrier to accessing services.
- Service users agreed that accessibility and location of services could be a barrier, as could waiting lists and personal experience of the service – often a negative first impression leads to service users not continuing their care.

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<sup>2</sup> Based on 17 responses

## Recommendations

The final section of the report contains a number of recommendations in the following areas:

- increasing the focus on community based services;
- broadening the engagement of service users;
- reviewing strategic planning and joint working arrangements;
- raising awareness of available services
- improving the accessibility of services; and
- reviewing the management and delivery arrangements for the Local Mental Health Forum, including improved involvement of GPs.

## 1. Introduction

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### 1.1 About this report

This report sets out findings from research exploring whether those with mental health problems in the Glenrothes area have unmet needs. The study area includes Glenrothes and its immediate surroundings - including Leslie and Markinch.

Glenrothes and North East Fife's Local Mental Health Partnership Forum (LMHPF) commissioned ODS Consulting, in partnership with Kinbank Social Research Consultancy, to undertake this work between March and August 2009. The research findings will help to:

- identify what the needs of those with mental health problems are; and
- prioritise areas for service development.

### 1.2 Research context

'Delivering for Mental Health'<sup>3</sup>, the mental health delivery plan for Scotland, recognises the importance of good mental health for the Scottish population and the need to promote positive mental health. The focus of 'Delivering for Mental Health' is on treating and preventing severe and enduring mental illness. But it also takes into account a wider range of disorders and illnesses, including depression and anxiety, which affect mental health and wellbeing.

The Delivery Plan of Fife's Mental Health Strategy Implementation Group sets out the actions being taken in Fife to meet the targets and commitments outlined in 'Delivering for Mental Health'. The LMHPF is in the process of developing a local action plan for mental health.

The LMHPF acts as a collaborative planning group for mental health services within the Glenrothes and North East Fife Community Health Partnership. The remit of the LMHPF includes:

- promoting the integration of statutory and voluntary agencies to meet the Mental Health agenda;
- shaping and informing mental health strategy at a Fife-wide level;
- agreeing on the delivery of strategy at a local level;

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<sup>3</sup> Delivering for Mental Health, Scottish Executive, 2006

- monitoring the health and well-being agenda to allow local evaluation of the effectiveness of local mental health services; and
- identifying local mental health needs and priorities for development.

### **1.3 Research aims and objectives**

The aim of the research was to identify the needs of those with mental health problems and identify whether there were any gaps in the current service provision. This involved:

- a quantitative exploration of relevant statistical data including prevalence information;
- a survey of mental health practitioners in the statutory and voluntary sectors and in GP practices;
- qualitative research conducted through telephone interviews with key stakeholders and service providers in the local area; and
- focus groups with service users and carers to understand the experiences that they had of the service.

### **1.4 Project management**

We worked closely with the project manager for the research (the chair of the LMHPF). We provided progress updates and a presentation of the draft final report to the forum.

This report details the key findings of this study in the following sections:

Section 2	Methodology
Section 3	Desk research
Section 4	E-survey
Section 5	Telephone interviews
Section 6	Focus groups with service users and carers
Section 7	Key themes
Section 8	Conclusions and recommendations

## 2. Methodology

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### 2.1 Research Ethics

At the start of the research, a research protocol was prepared. Advice was sought from the East of Scotland Research Ethics Service on whether there was a requirement for a full ethical review under the terms of the Governance Arrangements for Research Ethics Committees in the UK. This was considered by the Research Ethics Co-ordinators and they gave advice that there was no requirement for ethical review. This was because the work was a service evaluation – with recruiting of service users through voluntary organisations.

### 2.2 Introduction

This research was both quantitative and qualitative. It involved:

- desk research - obtaining statistical information on demographics and prevalence;
- e-survey - with mental health practitioners;
- telephone interviews - with NHS and other service providers; and
- focus groups - with service users and carers.

### 2.3 Desk Research

Statistical information on the demographics of the study area were sourced from the Scottish Census (2001), Scottish Neighbourhood Statistics and the Scottish Index of Multiple Deprivation (2006). Study area level information was available on population, households, health, education and employment. Where appropriate, this was compared with data for Fife and Scotland.

The prevalence rates for a range of mental health conditions were sourced from the National Statistics report<sup>4</sup>. This extensive study was conducted by the survey division of the Office for National Statistics on behalf of the Department of Health, The Scottish Executive and the National Assembly for Wales.

NHS Fife's Information Services Division provided statistical information on:

- use of in-patient services by residents of Glenrothes Local Management Unit; and
- GP services.

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<sup>4</sup> Psychiatric morbidity amongst adults living in private households, Office for National Statistics, London: The Stationery Office, 2001.

The mapping exercise conducted by Glenrothes and North East Fife Mental Health Partnership Group was reviewed and used as a primary source of contact details for local services.

Information on the use of compulsory treatment in Fife and elsewhere in Scotland was sourced from the Mental Welfare Commission's Annual Report for 2007 – 08<sup>5</sup>. In addition, the Mental Welfare Commission was contacted for data on the use of compulsory treatment in the Glenrothes area. However, they advised that they do not normally produce small area statistics of this kind and that a special request would be required. They advised that even if such a request were accepted it would take until the autumn before it could be fulfilled. Consequently the team did not proceed with this request.

Finally the recently published Audit Commission report 'Overview of Mental Health Services'<sup>6</sup> was studied for comparative information on resource allocation between different Health Boards and Local Authorities.

## **2.4 E-survey**

### **Target audience**

The e-survey was designed specifically with the target audience in mind. We wanted to capture the views of GPs, mental health care professionals and relevant voluntary/private sector organisations. All of these professionals are extremely busy, and so we had to make it as easy as possible to capture their views. The survey was designed to be completed online and to be as convenient for this target group as possible.

### **Design of the e-survey**

The e-survey was designed using Survey Monkey (an online tool that allows the researcher to tailor the questionnaire to their own specification). The tool allows progress to be tracked, so researchers can see, at any time, how many surveys have been completed and the survey responses.

A key aspect of designing a survey of any kind is to ensure that it is not too long and laborious for people to complete. The survey focused on a number of key topics, including:

- estimates of prevalence of specified conditions within workloads;

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<sup>5</sup> Our Overview of Mental Welfare in Scotland 2007 – 08, The Mental Welfare Commission for Scotland, 2008.

<sup>6</sup> Overview of Mental Health Services, Audit Scotland, May 2009

- views on the availability of relevant services (like counselling and day care); and
- local progress against 'Delivering for Mental Health' commitments and targets.

The e-survey was designed to route respondents through questions relevant to their role and exclude topics out-with their experience or competence. We estimated it would take approximately 10- 15 minutes to complete, depending on the responses given. The survey is at Appendix 1.

### **Piloting**

Before we published the online survey, we tested the questions with two practitioners. This was to test the length and clarity of the questions and to take advice on any additions or omissions. Generally, responses were good – although the opportunity was taken to remove some questions and to amend some wording.

### **Recruitment**

The LMHPF provided a database which included the names and contact details of approximately 30 practitioners as well as a separate list of eight GP practice managers.

We extended the list of contacts to include those appearing from the mapping exercise by the Mental Health Partnership Group. In addition, the Advisory Group forwarded the survey to those they thought would be relevant respondents.

### **Distribution and promotion of the survey**

A flyer was produced to raise awareness of the e-survey among GPs. The flyer outlined the research, and offered GPs the opportunity to volunteer for further discussions over the telephone. It was agreed that the most effective way of engaging GPs was through their Practice Managers, so the flyer was sent by email to the eight practice managers across Glenrothes and NE Fife.

An email, containing a link to the survey was sent to over 75 mental health care professionals and relevant voluntary and private sector organisations (including those working in drugs and alcohol; supported accommodation and homeless person's services). This contained a brief explanation of the research and encouraged recipients to respond.

We are confident that the online survey offered the opportunity to participate to a very wide range of stakeholders.

## **Timescales**

We initially allowed two weeks for completion of the survey, from 8 to 22 May. The initial response to the survey was slow, and so it was agreed to extend the deadline by a week to 29 May. A reminder email was sent to those who had not yet responded.

## **Analysis**

We tracked the responses – and whether they were GPs, clinicians or from other parts of the voluntary or statutory sectors. This was useful, as it became clear that some respondents were “dropping out” of the survey without completing it. We found that some questions were not being answered – specifically those relating to prevalence, capacity and unmet needs.

We reviewed the survey after a few days of it being ‘live’ and amended the language. We encouraged people to make appropriate estimates where necessary, and stressed that responses were ‘in your opinion’. We also stressed that if respondents felt unable to answer a particular question they should skip it and move on.

In the end 42 people responded. Of these, just over half (22) completed the bulk of the questionnaire. The remainder completed only some of the questionnaire. The response from GPs was disappointing. Four responded – none of them completed the majority of questions.

## **2.5 Telephone interviews**

Telephone interviews were conducted with 14 representatives from a range of NHS, council and voluntary sector service providers. The aim of the telephone interviews was to explore perspectives on local services directly with those delivering these services.

## **Discussion guide**

We designed a topic guide for use in these interviews. It was semi- structured to enable the researchers to follow up on interesting points made during the interview, rather than being a prescriptive document. The discussion guide covered the following main topics:

- services in the wider area;
- strategic planning; and
- communicating and engaging with stakeholders

The discussion guide is attached at Appendix 2.

## Recruitment

We worked with the LMHPF to identify appropriate interviewees. From the 19 contact names or organisations, we successfully interviewed 14 service providers. Table 2.1 outlines the job titles of those with whom interviews were successfully conducted.

Service providers
Programme Manager – Mental Health collaborative
Manager of Mental Health Services
Locality Mental Health Team Manager
Clinical Services Manager (Mental Health)
Nurse Practitioner
Lead Occupational Therapist – Fife Mental Health Service
Consultant Psychiatrist
Clinical Psychologist
Carer
Service provider – employability
Service provider – addictions
Social Work mental health officer
Choose Life co-ordinator
Mental Health Nurse Specialist

**Table 2.1: Service Providers Interviewed**

## Analysis

Interviews typically lasted half an hour, although some were longer. On completing the interviews, the researcher prepared a written note of the conversation – complete with verbatim quotes where appropriate. Once all 14 interviews were complete, the researchers discussed the key themes and points emerging from the interviews.

### 2.6 Focus groups with mental health service users and their carers

A total of 11 people participated in this element of the research - eight service users and three carers. The sessions proved very useful and informative.

## Recruitment

Flyers were designed to recruit participants. These contained both text and images and separate designs were put together for service users and carers.

These were distributed to 20 local service user and carers groups in the area, identified through the mapping exercise. Key groups were then contacted by telephone to explain the research further.

In order to maximise recruitment, general publicity materials were also sent to GP surgeries in the area and to Nurse Practitioners. This was to ensure that we did not only target those with 'severe and enduring' mental health problems – but extended the research to those with mild or moderate conditions too.

Recruitment of the groups took place in June and early July 2009.

### **Venues**

Discussions took place at the Exit Community Centre in Glenrothes – selected for its ease of access and familiarity to the participants. It was important to ensure that participants were comfortable and at ease to discuss their own experiences.

### **Mixed methodology**

To ensure that participants were willing to take part, they were given the option of participating in a group session, or if they preferred a one to one interview with a researcher. Six people wished to have face to face interviews (3 service users and 3 carers).

Two focus groups were organised – one with members of Fife Hearing Voices Network and the other with users of SAFE Group.

### **Discussion guides**

A separate discussion guide was designed for use with the service users and the carers. .  
The discussion guides are at Appendix 3.

### **Participant profile**

Eleven participants in total were consulted for this research. More had indicated that they would take part, but on the day of the groups some participants had to drop out, either due to ill health or child care responsibilities. The poor weather on the day may also have had an impact on numbers.

All participants were women. The majority were in the age range 40 – 60, but two or three were estimated as aged between sixty and seventy five. It is not known if the lack of male participants was a reflection on the profile of those attending local self help groups, or a more general indicator of men's unwillingness to discuss their mental health.

Following each of the focus groups and interviews with service users and carers, the researchers prepared a note of the discussion, complete with quotes.

### 3. Desk Research

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The desk research gathered demographic information on prevalence of mental health problems. It also aimed to compare the capacity of services and the demand in the Glenrothes area.

We also analysed statistical information on how services and resources are currently targeted in the NHS Fife area, when compared to other parts of Scotland. This bigger picture for Fife gives an important context to service delivery in the Glenrothes area.

#### 3.1 Mental Health services and indicators for Fife

A recent report by Audit Scotland<sup>7</sup> gives a useful starting point for understanding key issues for mental health service delivery in Scotland as a whole and Fife specifically. A number of its conclusions are considered especially relevant to the study.

Key findings included:

- Mental health problems can affect anyone, but those living in deprived areas or from socially excluded groups are more likely to be affected.
- Scotland's incidence of mental health problems is comparable with England and Wales, but the suicide rate in Scotland is higher
- Joint working between statutory and voluntary sector organisations is very important to the effective delivery of services, but at this time there are insufficient means of establishing if this is occurring or not
- Unpaid carers are estimated to save Scottish society £375M each year.

#### Deprivation and social exclusion

In spite of there being an established link between deprivation and mental ill health the Audit Scotland report found that the amount spent in Health Board areas on mental health services were **not** related to levels of deprivation.

Figure 1 is Exhibit 12 from Audit Scotland's report. It shows that although Fife is one of the Health Boards with a higher than average level of deprivation, its per capita expenditure in

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<sup>7</sup> Overview of Mental Health Services, Audit Scotland, May 2009

2007/08 on mental health was lower than the Scottish average. Fife had less funding per head than several Boards in less deprived areas (like Borders and Dumfries and Galloway) and those with similar levels of deprivation (like Tayside).

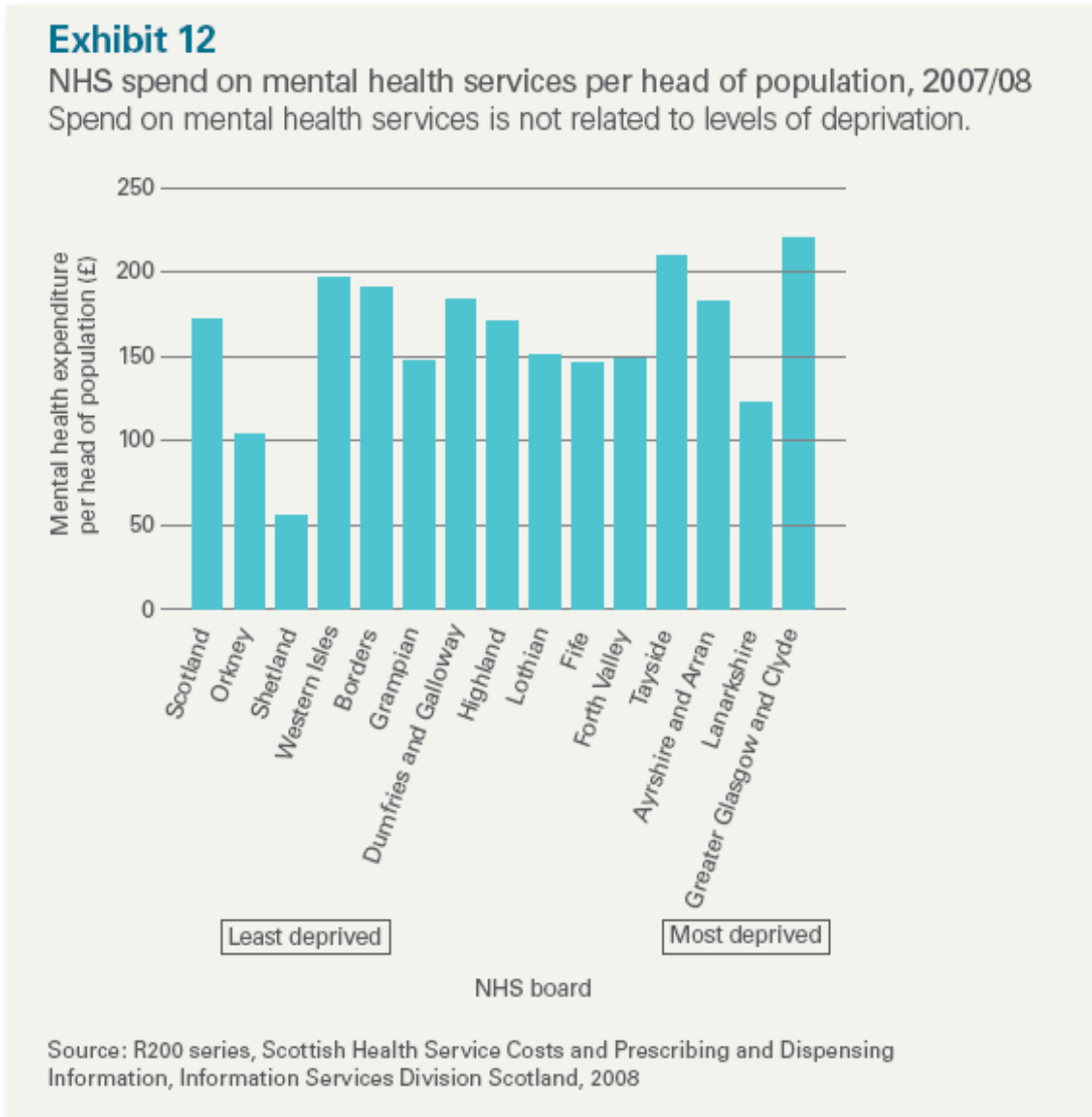


Figure 1: Exhibit 12 - Taken from Overview of Mental Health Services – Audit Scotland

### Spending on psychiatric services

Figure 2 is Exhibit 13 from Audit Scotland's report. It shows that Fife spends proportionately more (60%) of its mental health budget on inpatient care than any other Health Board area with the exception of the Western Isles

The figure also shows that Fife has the lowest proportion of resources committed to Community Psychiatric Teams of any Health Board area. However, it should be noted that Audit Scotland reported difficulty in establishing true levels of spend on community based mental health services - because of a lack of standardised recording and benchmarking.

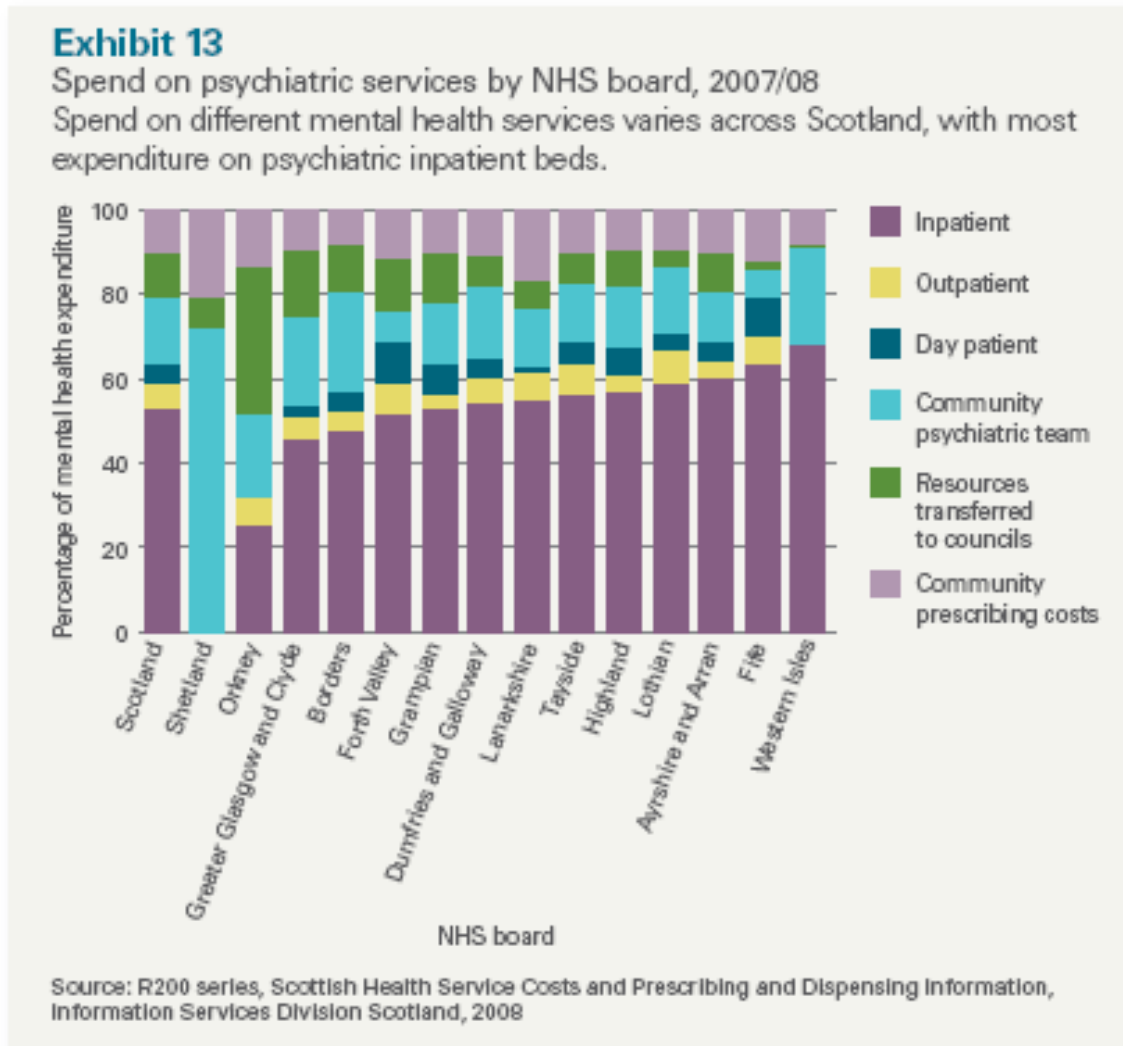


Figure 2: Exhibit 13 - Taken from Overview of Mental Health Services – Audit Scotland

Fife has one of the highest proportions of inpatient psychiatric beds (1.2 per 1000 of population) – exceeded only by the Western Isles and Greater Glasgow and Clyde.<sup>8</sup>

<sup>8</sup> Source: Inpatient facilities by NHS Board and Speciality, Information Services Division Scotland, 2009

In Scotland, there has been a programme of transferring resources from health boards to councils as inpatient services were closed and community services were expanded. The current emphasis on inpatient care would go some way to explain why levels of resource transfer from Fife Health Board to Fife Council to support community mental health services was very low in 2007 / 08. The average level of resource transfer for Scotland as a whole was £17.56 per head, in Fife this was only £2.72.

Although Fife has significant levels of deprivation (it has the 12<sup>th</sup> highest concentration of deprived datazones of the 32 councils in Scotland<sup>9</sup>), the spend by Fife Council on mental health services is significantly below average - £22 per head compared to £28 nationally<sup>10</sup>.

Fife may be able to make savings through changes in levels of inpatient care and more efficient deployment of resources. Figure 3 shows that Fife has one of the lowest bed occupancy rates in Scotland – and is operating below the ‘recommended occupancy rate’.

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<sup>9</sup> Source: General Report, Scottish Index of Multiple Deprivation, 2006.

<sup>10</sup> Source: Overview of Mental Health services, Audit Scotland, Exhibit 15, p32

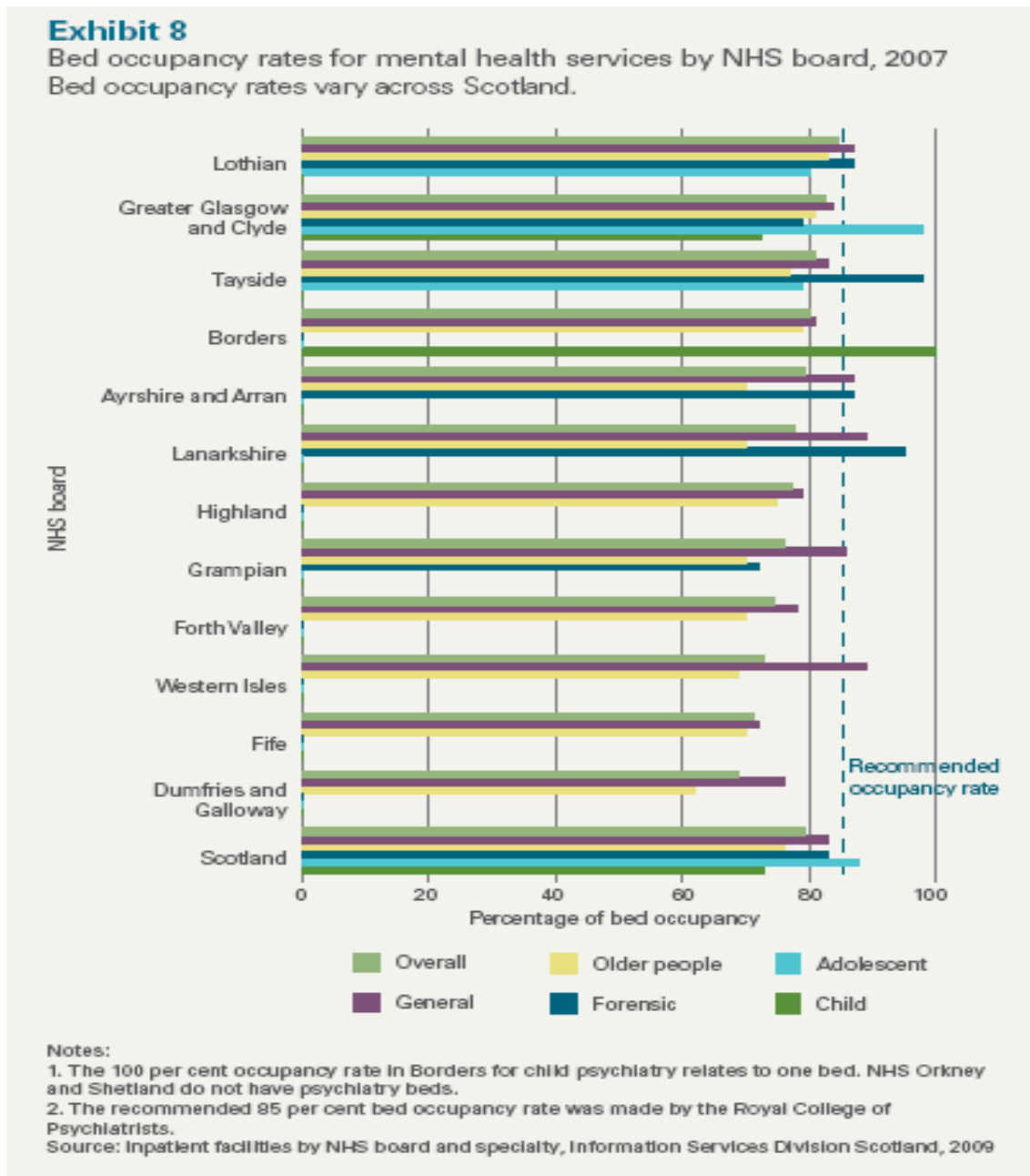


Figure 3: Exhibit 8 - Taken from Overview of Mental Health Services – Audit Scotland

We understand that NHS Fife is working to address the challenges presented by historically high levels of inpatient services by consolidating provision. Inpatient services will move from three sites to two through a phased closure of beds at Whyteman’s Brae, Kirkcaldy. The speed at which this occurs and the levels of savings achieved will be highly significant in terms of the pace and scale at which alternative community based provision can be supported.

The lower than average commitment of resources to mental health services in Fife, when combined with the relatively high level of resources committed to in-patient care, is constraining the ability to resource community based services in Fife

### **Use of Compulsory Treatment Measures**

Fife makes high usage of Compulsory Treatment Orders (CTOs)<sup>11</sup>. In 2008, 27 CTOs were granted per 100,000 people in Fife, second only to Highland (28 per 100,000).

The total number of people on Compulsory Treatment Orders is a function of numbers granted and their duration. A snapshot on 2 January 2008 found that 54 people per 100,000 of population were on CTOs in Fife, second only to Lothian (56 per 100,000).

Taken together these figures suggest that not only are higher numbers of CTOs sought in Fife, but also that average time on a CTO is longer than in many other areas.

The Mental Health Welfare Tribunal's report did not draw firm conclusions, but it suggested that patterns of CTOs such as that in Fife might be linked to resources and the availability of services. It went on:

“Areas with a high use of the 2003 Act may have a culture of legal intervention, perhaps more than is necessary.”

### **3.2 Prevalence rates and their application to Glenrothes**

Prevalence rates can be useful as broad indicators when considering what services are required. However, they should be treated with caution as rates can change over time and be affected by a range of factors, including the extent to which identified 'at risk' groups are present in a specific community.

In considering prevalence rates it is important to remember that:

- rates for particular services and types of treatment will reflect the local supply as well as the level of demand for services;
- local emphasis on particular disciplines (like psychiatry or psychology) can impact on rates; and
- accessibility of services; the length of waiting lists and 'word of mouth' views also have an impact.

<sup>11</sup> Source: Mental Health Tribunal for Scotland (MHTS) quoted in MWC Annual Report

There is also a need to be cautious in respect of some specific conditions – for example dual diagnosis for mental health problems and alcohol dependence. There is broad agreement that levels of alcohol dependence in Scotland have been on a rising trend for a least the last decade and there have been recent concerns that alcohol related mortality rates may be double those previously estimated<sup>12</sup>. But the extent to which this has fed through into increased levels of mental ill health has not been established.

There are similar concerns regarding changing patterns of drug misuse – arising both from changes in the extent of usage and of the impact of particular drugs. For example, there is much speculation about links between ‘skunk’ (strong cannabis) and schizophrenia, but insufficient information to assess any impact on the prevalence of mental ill health. For these reasons it has been concluded that to apply the prevalence rates for alcohol or drug dependence from the psychiatric morbidity study could be misleading – and therefore we have not done this.

The Office of National Statistics report<sup>13</sup> is the most recent and comprehensive report of its kind for the United Kingdom. It includes a prevalence analysis for Scotland – and is one of the source documents for the Audit Scotland report. This report is used extensively here to provide estimated numbers of people experiencing specific conditions in the Glenrothes area and to give an indication of levels of take up of services. However, it is stressed that these are estimates.

The psychiatric morbidity report identifies a number of ‘at risk’ groups whose presence, or lack of presence, could affect the numbers of people affected by mental health problems in a community. It found that those with a neurotic disorder were **more** likely to be:

- Women (who made up 59% of those with a disorder compared to 48% of those without a disorder)
- Aged between 35 and 54 (who made up 45% of the group with a disorder compared to 38% of those without a disorder)
- Separated or divorced (who made up 14% of the group with a disorder compared to 7% of those without a disorder)

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<sup>12</sup> Alcohol attributable mortality and morbidity: alcohol population attributable fractions for Scotland, Scottish Government (statistical publication), June 2009.

<sup>13</sup> Psychiatric morbidity among adults living in private households, Office for National Statistics, 2000

- Living as a one person household (who made up 20% of the group with a disorder compared to 16% of those without a disorder)
- Living as a lone parent (who made up 9% of the group with a disorder compared to 4% of those without a disorder)
- Be economically inactive (who made up 39% of the group with a disorder compared to 28% of those without a disorder)
- Be tenants of Local Authority Housing or a Housing Association (who made up 26% of the group with a disorder compared to 15% of those without a disorder).

Those with a probable psychotic disorder were more likely to be:

- Separated or divorced (who made up 29% of the group with a disorder compared to 8%)
- Living in a one person household (who made up 43% of the group with a disorder compared to 16% of those without a disorder)
- Have longstanding physical health problems (who made up 62% of the group with a disorder compared to 42% of those without a disorder)
- Have low educational qualifications (who made up 84% of the group with a disorder compared to 63% of those without a disorder)
- Be economically inactive (who made up 70% of the group with a disorder compared to 30% of those without a disorder)
- Live in accommodation rented from a local authority or housing association (who made up 49% of the group with a disorder compared to 17% of those without a disorder)
- Live in an urban area (who made up 88% of the group with a disorder compared to 66% of those without a disorder).

Therefore communities where there are significantly higher levels of any or all of these risks groups should anticipate higher numbers of people with mental health problems.

It is most appropriate for this report to consider Glenrothes' needs and services in comparison with the rest of Fife. This is the level at which strategic decisions are made, including what level of resources are allocated down to 'Local Management Units', such as the Glenrothes area. We have compared the proportions of the population of Fife and the Glenrothes area in the higher risk groups for which data are available. Much of the data used comes from the 2001 Census, and there may have been changes since then. But this

analysis can give useful guidance as to which groups in a specific area might be particularly worth targeting.

### **Prevalence of women**

Census figures show there was no significant difference in the proportion of women in the study area when compared to Fife as a whole (52% in both instances). Therefore the local gender balance should not affect the numbers with neurotic disorder in Glenrothes, when compared to Fife.

### **Prevalence of those aged 35 to 54**

The Census used a broader age banding than the Psychiatric Morbidity report, therefore exact comparison was not possible– the Census bandings were 30 – 44 and 45 – 59. Glenrothes settlement area had slightly higher proportions of population in both Census bandings than Fife as a whole – 23% compared to 22.4% for the 30 – 44 age group and 42.9% compared to 42.3% for the 45 – 59 banding. This could be putting upward pressure on the number of people affected by a neurotic disorder in Glenrothes area when compared to Fife.

### **Prevalence of single person households**

In 2001, Fife had a higher proportion of single person households than the study area – 31.1% compared to 28.6%. This may put downward pressure on the numbers of people with neurotic or psychotic disorders in the Glenrothes area, compared to Fife.

### **Prevalence of those separated or divorced**

In 2001, the Glenrothes area had a higher proportion of adults who were separated or divorced – 12.5% compared to 11.2% for Fife. This could put upward pressure on numbers affected by neurotic disorders or psychosis.

### **Prevalence of lone parent households**

In 2001, the study area had a higher proportion of lone parent households (11.2% compared to 10.0%), than Fife. This may put upward pressure on numbers with neurotic disorders in Glenrothes area, when compared with Fife.

### Prevalence of economically inactive<sup>14</sup> adults

In 2001, the Glenrothes area had a lower proportion of economically inactive adults – 32.3% compared to 34.3% for Fife. This was as a result of fewer retired people (13.5% compared to 14.6%) and fewer students (3.2% compared to 4.5%). This could put downward pressure on numbers with neurotic disorders or psychosis in the Glenrothes area, compared to Fife.

### Prevalence of Local Authority and RSL accommodation

In 2001, the Glenrothes settlement area had a higher proportion of households living in accommodation rented from the Local Authority or a Housing Association – 28.9% compared to 26.4% for Fife. This could put upward pressure on numbers affected by neurotic disorders or psychosis.

### Prevalence of low educational attainment

In 2001, the Glenrothes settlement area had a marginally higher proportion of adults who had no qualifications – 33.3% compared to 32.2% for Fife. This could put upward pressure on numbers affected by psychosis.

### In summary

The upward arrows indicate upward pressure on numbers. The downward arrows indicate downward pressure on numbers. There are significantly more upward than downward pressures on numbers in Glenrothes when compared to the whole of Fife.













Indicator	Neurotic Disorders	Psychosis
Women		
Aged 35-54		
Single Person Households		
Separated/ Divorced		
Lone Parents		
Economic Activity		
Social Housing		
Low Educational Attainment		

Table 3.1: Indication of pressures on prevalence of neurotic and psychotic disorders: Glenrothes compared to Fife

<sup>14</sup> The Census classifications for economically inactive are retired, student, looking after home / family, permanently sick or disabled and other. Those that are unemployed are categorised as economically active

### 3.3 Estimating prevalence and numbers for neurotic disorders in Glenrothes

Neurotic disorders were found by the psychiatric morbidity study to be the most common form of mental health problem experienced by adults in Britain, with 1 in 6 adults estimated as being affected by moderate to severe symptoms<sup>15</sup> of a neurotic disorder in the previous week.

Table 3.2 takes the prevalence rates for neurotic disorder for Scotland and applies them to the 2001 Census' population figures for Glenrothes, Markinch and Leslie to give an estimate of the numbers who have experienced such a disorder in the past week. The figures have not been adjusted for other factors which might increase or decrease prevalence, which have been noted in earlier paragraphs. This would be a very complex task, and with the data being old it could generate inaccurate results and encourage a false sense of certainty.

Estimated unadjusted prevalence of Neurotic Symptoms in Glenrothes					
	Women		Men		Total number
Aged over 16 in Glenrothes Area	18,360		16,596		34,956
	Estimated %	No	Estimated %	No	
Sleep problems	28%	5,141	23%	3,817	<b>8,958</b>
Fatigue	29%	5,324	20%	3,319	<b>8,644</b>
Irritability	22%	4,039	16%	2,655	<b>6,695</b>
Worry	20%	3,672	17%	2,821	<b>6,493</b>
Depression	10%	1,836	9%	1,494	<b>3,330</b>
Concentration and forgetfulness	10%	1,836	7%	1,162	<b>2,998</b>
Depressive ideas	9%	1,652	7%	1,162	<b>2,814</b>
Anxiety	8%	1,469	6%	996	<b>2,465</b>
Somatic symptoms	8%	1,469	4%	664	<b>2,133</b>
Worry - physical health	6%	1,102	5%	830	<b>1,931</b>
Obsession	6%	1,102	2%	332	<b>1,434</b>
Phobias	5%	918	3%	498	<b>1,416</b>
Compulsions	3%	551	1%	166	<b>717</b>
Panic	3%	551	3%	498	<b>1,049</b>

**Table 3.2: Estimated prevalence of neurotic symptoms in Glenrothes**

Source of prevalence rates - Psychiatric morbidity report, Table 2.3

When considering these figures it should be noted that some people will have more than one neurotic disorder – therefore the total number of people suffering from neurotic disorders is **not** the sum of the estimated numbers for each disorder.

<sup>15</sup> The instrument used by the researchers to measure neurotic disorder was the revised Clinical Interview Schedule (CIS – R).

### 3.4 Estimating prevalence and numbers for personality disorders in Glenrothes

The psychiatric morbidity research established prevalences for personality disorders by taking a sub sample of participants and undertaking a second stage semi structured clinical interview.

The study used the following definition:

*“...an enduring pattern of inner experience and behaviour that deviates markedly from the expectation of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”*

By definition a person has a personality disorder for life. Because the sample size was smaller (626 interviews) the research only broke prevalence down into categories, by sex and age.

The prevalence rate for any personality disorder was found to be 54 per 1,000 men and 34 per 1,000 women. Obsessive-compulsive personality disorder had the highest prevalence of any category of personality disorder and was more common among men than women. These rates are applied to the population of the study area in Table 3.3 – for some disorders there is a marked increase in prevalence amongst certain age ranges and these are highlighted.

Estimated prevalence of Personality Disorder in Glenrothes											
	Women					Men					Totals
No over 16 in Glenrothes Area	18360					16596					34956
Age	16-34	35-54	55-74	All %	Estimated No	16-34	35-54	55-74	All %	Estimated No	Total
Obsessive Compulsive		8%	<b>37%</b>	13%	2387	22%	26%	30%	26%	4315	<b>6702</b>
Avoidant	2%	15%	2%	7%	1285	9%	<b>17%</b>		10%	1660	<b>2945</b>
Schizoid	6%		<b>22%</b>	8%	1469	8%	2%	<b>21%</b>	9%	1494	<b>2962</b>
Paranoid	3%	5%		3%	551	9%	<b>21%</b>	2%	12%	1992	<b>2542</b>
Borderline	5%	7%		4%	734	2%	<b>24%</b>		10%	1660	<b>2394</b>
Antisocial	5%	0%		2%	367	8%	<b>17%</b>		10%	1660	<b>2027</b>
Dependent			1%	0%	0	5%			2%	332	<b>332</b>
Schizotypal	1%	1%	1%	1%	184		0%			0	<b>184</b>

**Table 3.3: Estimated prevalence of personality disorder symptoms in Glenrothes**  
 Source of prevalence rates - Psychiatric morbidity report, Table 2.10

In the national research sample the prevalence of dependent and schizotypal personality disorder was very low, only 1 per 1,000 cases, while no case of histrionic or narcissistic personality disorder was found.

### 3.5 Estimating prevalence and numbers for psychotic disorders in Glenrothes

To establish the prevalence of psychosis the psychiatric morbidity research study used a two stage process, an initial structured interview followed by a second stage semi structured clinical interview<sup>16</sup>. We have applied the national rates to the Glenrothes population aged over 16 and the estimates are contained in Table 3.4.

<b>Estimated unadjusted prevalence of probable psychotic disorder in Glenrothes (amongst age range 16 - 74)</b>					
	<b>Women</b>		<b>Men</b>		<b>Total</b>
Aged over 16 in Glenrothes	18360		16596		34956
	Estimated %	Estimated No	Estimated %	Estimated No	
Probable psychotic disorder	5%	<b>918</b>	6%	<b>996</b>	<b>1914</b>

**Table 3.4: Estimated prevalence of psychotic disorder symptoms in Glenrothes**  
 Source of prevalence rates - Psychiatric morbidity report, Table 2.11

### 3.6 Co-occurrence of disorders

The psychiatric morbidity study also produced indicators for the co-occurrence of disorders – such as neurosis with psychosis; or psychosis with alcohol or drug dependence. Seventy seven percent of the adult population were found to have no disorder, 19% a single disorder, a further 3% were assessed as having two disorders, with 1% having more than two.

If these figures are applied to the study area it gives the following numbers for all adults in the Glenrothes area – total population 34,956.

- No disorder – 26,916 (77%)
- 1 disorder – 6,642 (19%)
- 2 disorders – 1,049 (3%)
- 3 or more disorders – 350 (1%)

These figures include those assessed as having an alcohol or drug dependence and there may be doubts about whether the study reflects current (presumed higher) prevalence rates.

<sup>16</sup> The instrument used for assessing psychosis was SCAN (Schedules for Clinical Assessment in Neuropsychiatry) (Wing et al, 1990; World Health Organisation, 1999). Full details of the methods used are given in chapter 1 of Psychiatric morbidity among adult living in private households, 2000. Office of National Statistics 2001.

### 3.7 Estimating the numbers receiving treatment and engaging with services

#### Neurotic disorder

The psychiatric morbidity study of the UK found that 24% of people assessed as having a neurotic disorder were receiving treatment of some kind at the time of interview. Twenty percent of those with a neurotic disorder were taking psychoactive medication, with 9% having counselling or therapy. Some would be receiving both.

Those who had more than one disorder were more likely to be receiving treatment – 54% of those with two or more disorders were receiving treatment compared to 19% of those with only one disorder. 47% of those with two or more disorders were receiving medication, compared to 24% receiving counselling or therapy. This reflects the general pattern that medication is the primary form of treatment. Again, some would be receiving both.

Anti depressants were the most common psychoactive medication being used – being received by 16% of those with a neurotic disorder.

Of those being treated with counselling or therapy this was most common as a treatment method amongst those with phobias (27%), obsessive compulsive disorder (20%) and depressive episode (17%). Those with mixed anxiety and depressive disorder were least likely to be receiving counselling or therapy (5%).<sup>17</sup>

However, such historic prevalences should be set against any changes in working practices and resourcing. By way of example, the study found that only 1% of people with neurotic disorders were receiving Cognitive Behavioural Therapy (CBT). Given 'Delivering Mental Health' has placed a considerable emphasis on increasing access to talking therapies it is likely that the use of CBT in Scotland has increased in recent times; albeit the evidence for this occurring in Glenrothes appears to be mixed. The study found that 39% of all those with a neurotic disorder had spoken with their GP about a mental health or emotional problem within the last year. This rose to 69% for those with two or more disorders. This gives further confirmation that those with more complex conditions were more likely to be engaged with services and in treatment.

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<sup>17</sup> All figures quoted in respect of levels of treatment taken from Section 5.1 of Psychiatric Morbidity among adults living in private households, 2000.

GPs, rather than specialist services, are most likely to be in contact with those with neurotic disorders. Only 1% of those with a neurotic disorder had been in contact with an outpatients department in the last quarter, rising to 12% for those with two or more disorders.

Sixteen percent of those with a neurotic disorder reported they had used one or more community care services in the last year. This prevalence will be affected by local service delivery.

### **Probable psychotic disorder**

Levels of treatment and engagement with services were significantly higher for those with psychotic disorders.

The study found that 85% of those with a probable psychotic disorder were having treatment at the time of interview. Fifty six percent were receiving anti psychotic medication but this was often in combination with other medication. Eighty four percent of those with a probable psychotic disorder were receiving medication of some description.

Forty percent were receiving counselling or therapy.

Seventy one percent of those judged to have a probable psychotic condition had spoken to their GP in the last year about a mental health or emotional problem.

Twenty eight percent of those with a probable psychotic condition had made one or more visits to an outpatient department in the last quarter; 19% having attended a psychiatric out patient clinic.

Over half (51%) had used one or more community care services in the last year, of which the most commonly used were community psychiatric nursing services (30% had used these in the last year).

### **3.8 Key issues arising from application of prevalence rates**

Accepting that the application of prevalence rates is a crude tool, nonetheless four issues emerge that are important to a strategic assessment of how future services are to be designed and delivered.

Firstly, the evidence is that there will be large numbers of people in the Glenrothes area affected by mental health conditions - particularly neurotic disorders and personality disorders - and that large numbers of them will either not have been diagnosed or will not be receiving treatment at this time.

Secondly, there is limited capacity and no prospect of service growth that would meet **all** unmet needs. Determining the strategic priorities and objectives of services is particularly important.

Thirdly, there are needs both from those with severe and enduring conditions in resource allocation between these needs.

These are Fife wide issues as much as they are local issues. They should primarily be addressed through Fife wide strategic planning mechanisms. Nonetheless, our research suggests that historic patterns of geographic commissioning within Fife mean that there can be significant differences in service provision from one area to another.

This leads to a fourth issue, does the Glenrothes area receive an equitable share of resources dedicated to mental health?

### **3.9 Evidence from local data**

Contact was made with NHS Fife's Information Services Department and they were extremely helpful in furnishing useful comparative data for the Glenrothes Local Management Unit (LMU) and Fife, drawn primarily from the SMR04 dataset.

Most of the information available was in respect of inpatient services, with the most up-to-date information being for the period 2003/4 – 2007/8.<sup>18</sup>

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<sup>18</sup> Study of data from the Quality and Outcomes Framework (QoF) revealed some apparent discrepancies that could not be explained. For this reason the QoF data is not presented here. Figures for several different data sets were precisely the same, suggesting an erroneous copying of figures. Information Services advised that these elements of the data had been provided by an external source.

The SMR04 dataset records a main diagnosis and up to a further three diagnoses on admission. Up to five diagnoses can be recorded at discharge. The information presented here is based on the main diagnosis as described at the time of admission to hospital.

### **Inpatient admissions rates by condition**

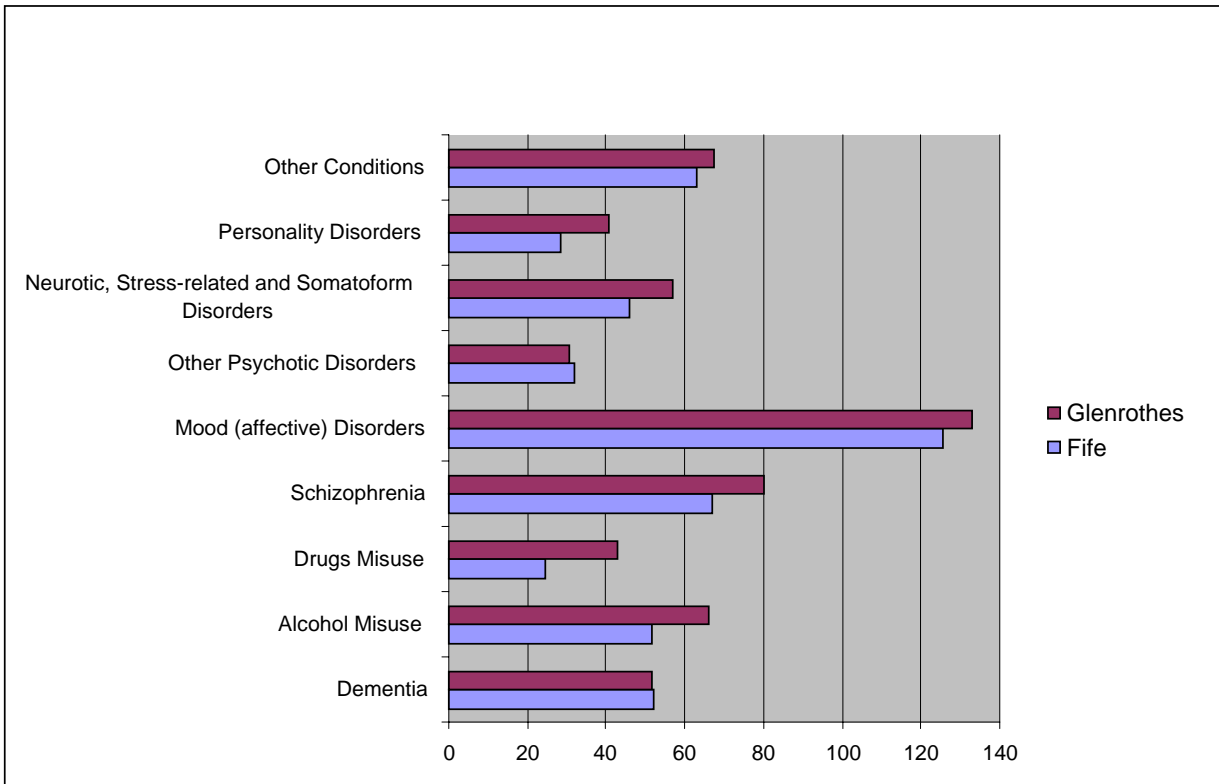
Figure 4 shows that, with the exception of dementia and 'Other Psychotic Conditions', the averaged rates of inpatient treatment over 2003/4 – 2007/8 were higher for Glenrothes than for Fife as a whole. (The figures include young people under 18 and we analyse these separately at the end of this section.) In some cases the differences were very marked – particularly for drug misuse, alcohol misuse, personality disorder, schizophrenia and neurotic disorders.

There may be a variety of reasons for this including:

- higher levels of illness;
- fewer options for care in the community; or,
- proactive local services appropriately identifying and admitting the chronically unwell who are being overlooked in other parts of Fife.

We cannot reach firm conclusions on these trends without further information on how local services are delivered and information on perceived gaps.

When considering the following tables it should be borne in mind that rates are per 100,000. As the Glenrothes LMU has a population of approximately 35,000, apparently significant fluctuations in rate may result from a handful of admissions. This is especially important in respect of volatility in year to year rates.



**Figure 4: Average rate (1/100,000) of inpatient treatment by condition 2003/04-2007/08**

### Trends by specific conditions

Admissions for some conditions showed some potentially significant differences between Glenrothes and Fife as a whole.

### Mental and behavioural disorders arising from drug misuse

Figure 5 shows that, in contrast to the rest of Fife, inpatient treatment for drug misuse in Glenrothes showed a strong upward trend throughout 2003/4 – 2006/7. This is followed by a sharp fall, mirrored to a lesser degree for Fife inpatients. The reasons for the drop in rate in the final year is not clear, but as rates of alcohol misuse are not likely to have reduced by such a significant degree, if maintained this might signal a change in admissions practice or the availability of alternative means of treatment in the community.

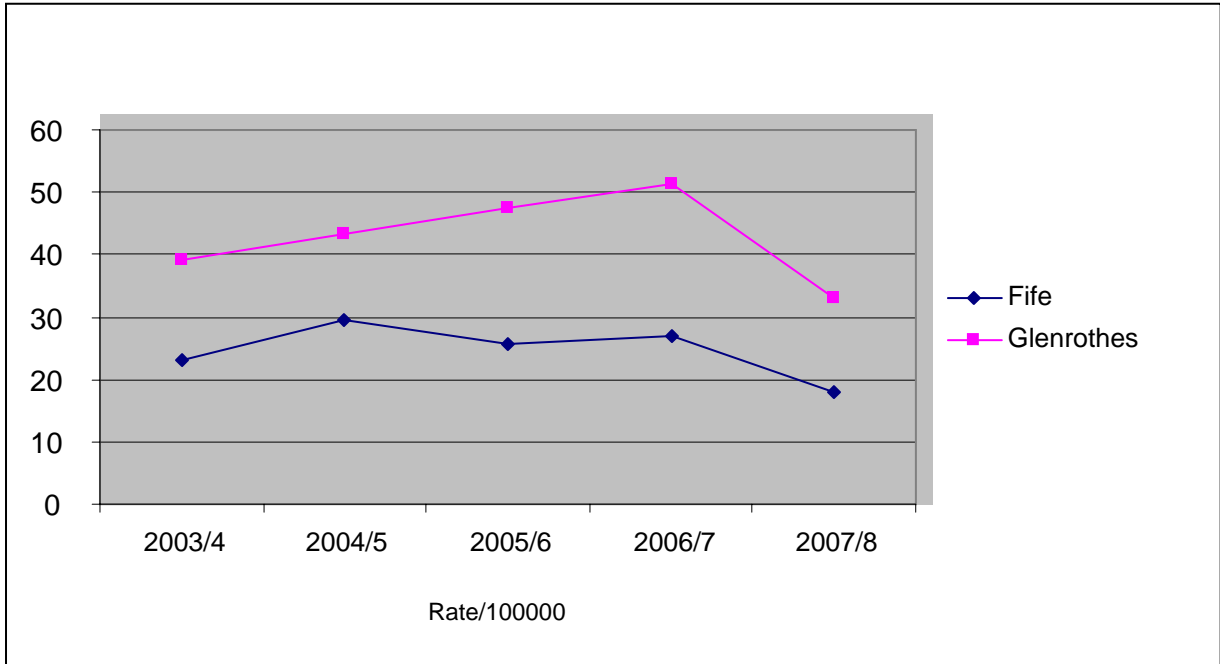


Figure 5: Rates of inpatient treatment for drug misuse 2003/04-2007/08

**Mental and behavioural disorders arising from Alcohol misuse**

Figure 6 shows rising trends in inpatient treatment for alcohol misuse in Glenrothes are mirrored by Fife as a whole, but at a lower level.

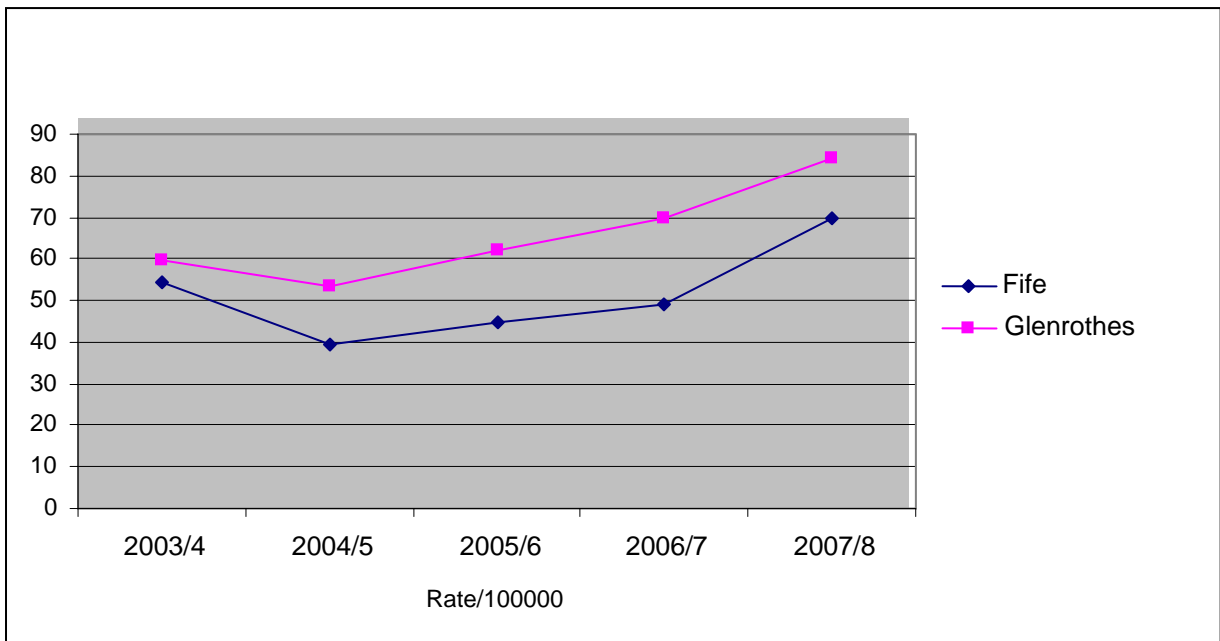


Figure 6: Rates of inpatient treatment for alcohol misuse 2003/04-2007/08

## Schizophrenia

Figure 7 shows that rates of treatment for schizophrenia were generally higher and more volatile for Glenrothes.

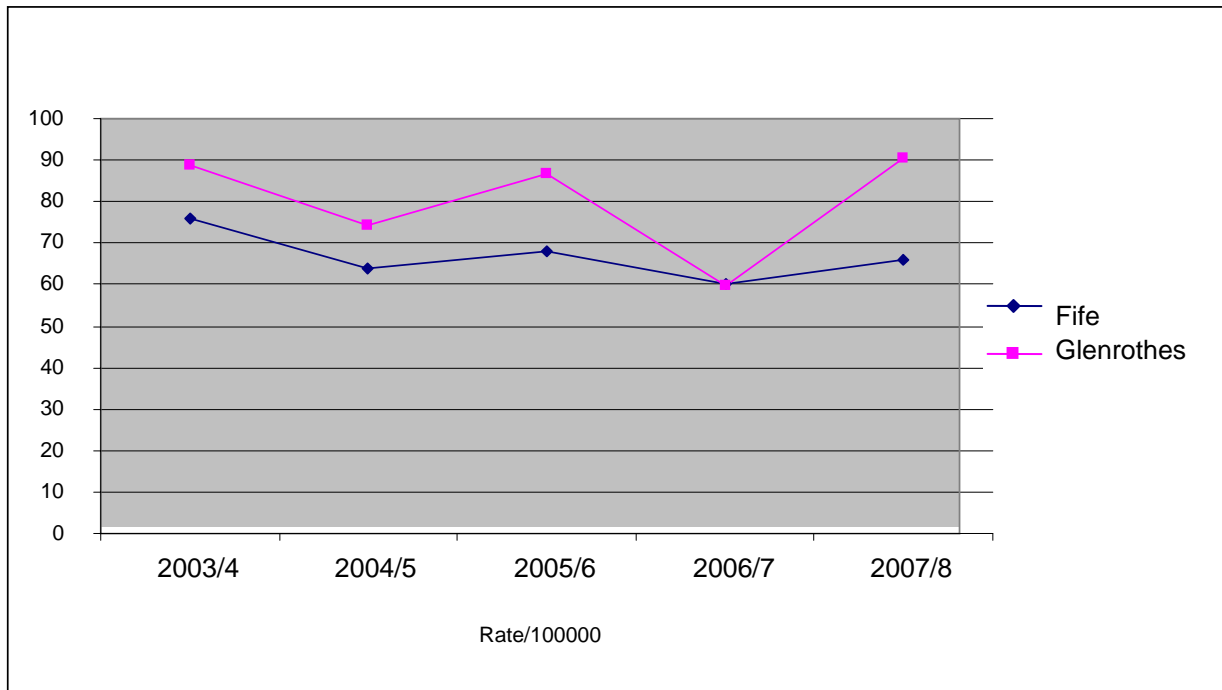


Figure 7: Rates of inpatient treatment for schizophrenia 2003/04-2007/08

## Mood Disorders (Bi Polar, single or recurrent Depressive episodes)

Figure 8 shows there was a dramatic downward trend in those treated for Mood Disorders over the five year period – particularly in Glenrothes. Possible explanations might be changes in admissions practice, the availability of alternative community support to prevent admission and changes in recording and diagnosis. In the latter case, it is possible that the growth in numbers for those treated for Alcohol Misuse might represent re-categorisation of some whose primary diagnosis might previously have been another condition such as Depression - there being established links between the two.

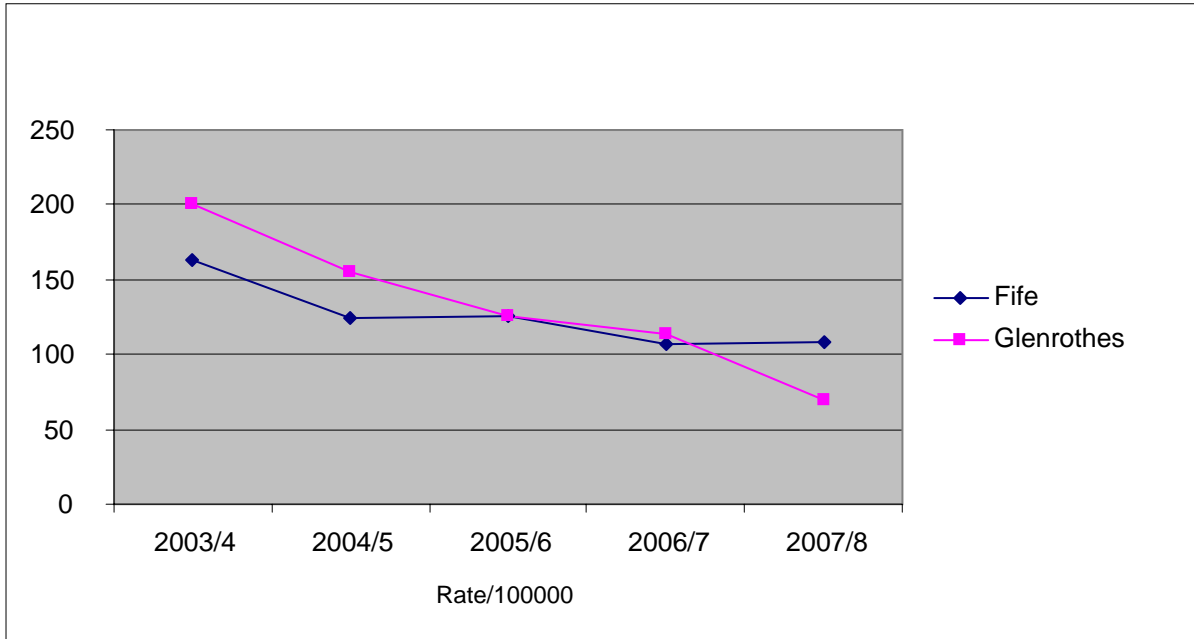


Figure 8: Rates of inpatient treatment for Mood (affective) disorders 2003/04-2007/08

**Personality Disorder**

Figure 9 shows that with the exception of a marked peak in 2003/4 a flat trend inpatient treatment rates above those for Fife.

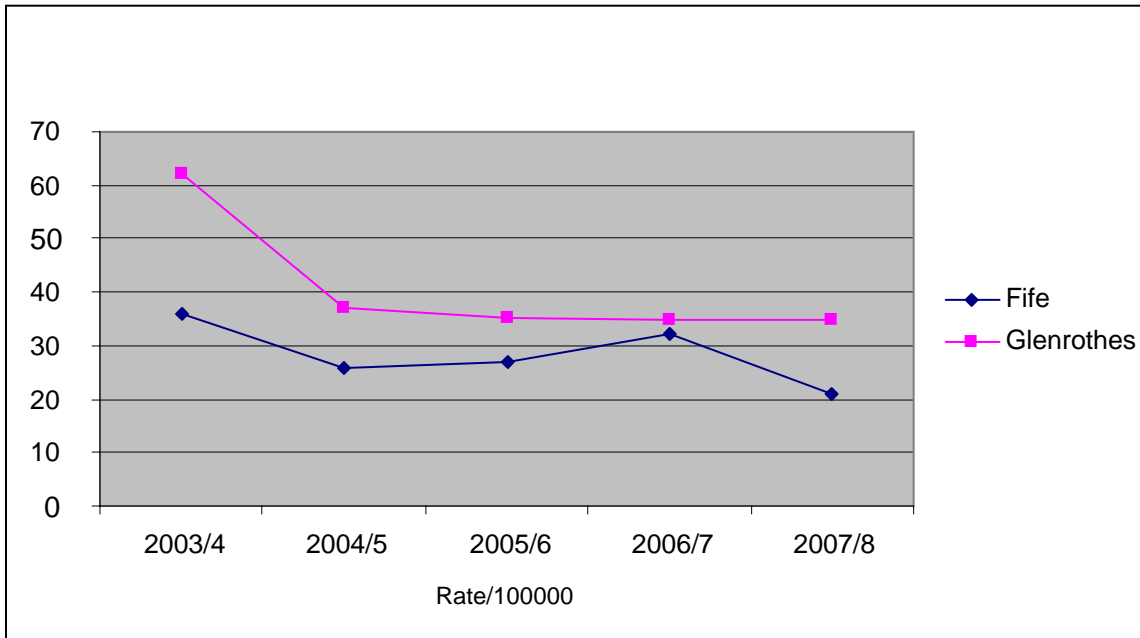
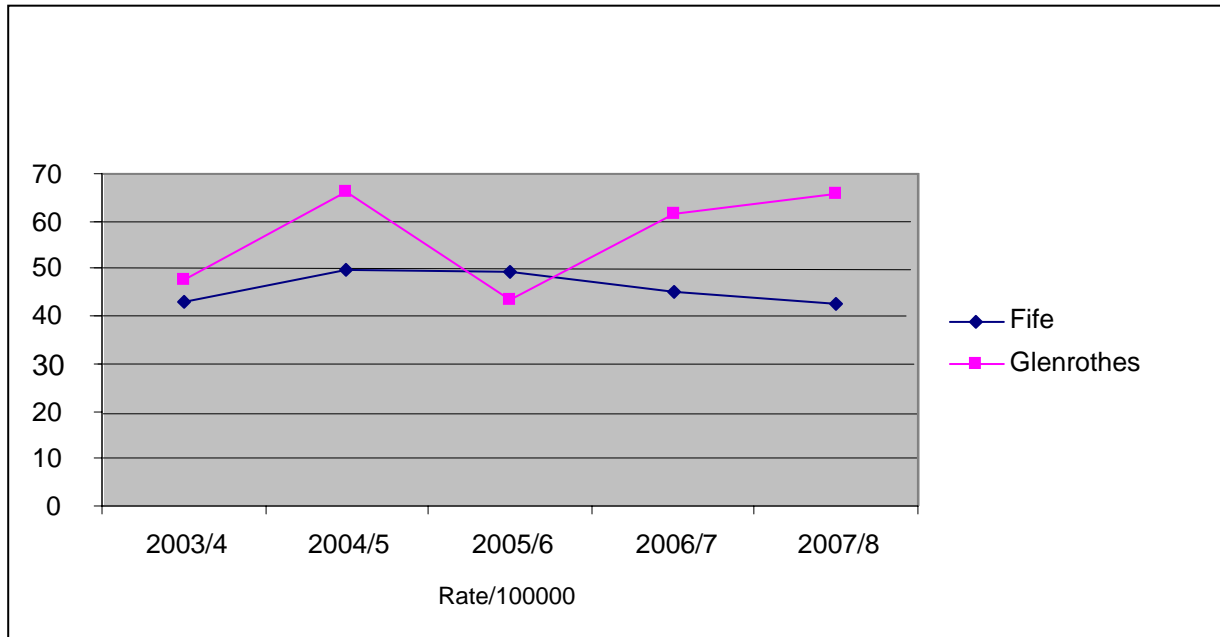


Figure 9: Rates of inpatient treatment for personality disorders 2003/04-2007/08

### Neurotic disorders

Figure 10 shows that whilst ordinarily above the rates of treatment for Fife, there were marked fluctuations in the rates of treatment for Glenrothes from year to year.



**Figure 10: Rates of inpatient treatment for neurotic, stress related and somato form disorders 2003/04-2007/08**

### Allocation within inpatient services

Given the profile of inpatients from Glenrothes it is unsurprising that Figure 11 shows that inpatients from the area were slightly more likely to be treated in general psychiatry wards than the average for Fife, with fewer being treated by old age psychiatry. Only a very small number of inpatients were treated by other specialist inpatient services – for example adolescents, forensic psychiatry or learning disabilities.

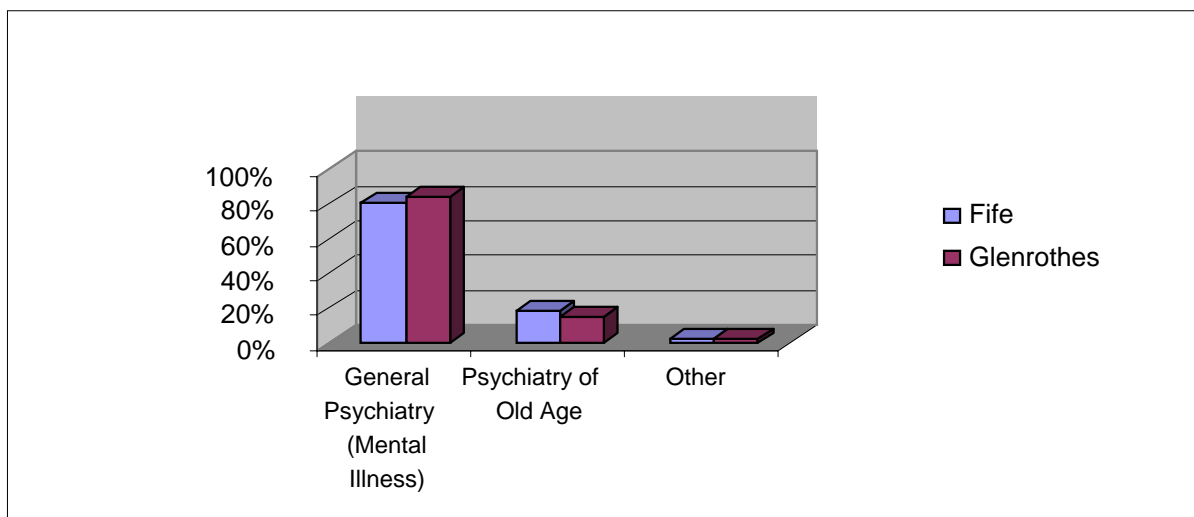


Figure 11: Average proportions admissions to inpatient specialist services 2003/4-2007/8

### In patient profile by gender and area

Figure 12 shows whilst there has been a narrowing of margins in recent years in respect of male admissions to psychiatric bed, levels of admissions from Glenrothes have historically been above those from Fife, for both sexes.

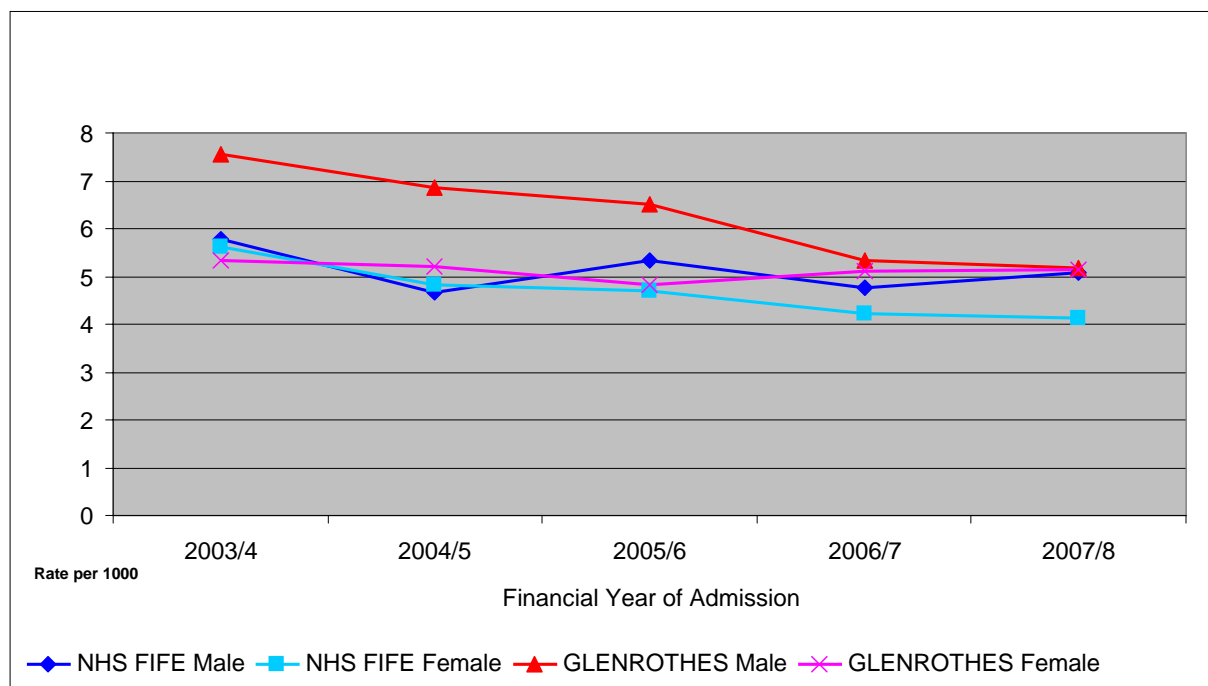


Figure 12: Trends in gender by inpatient admission and area

### Rates of formal detention

Study of rates of use of formal measures showed no significant differences between the two areas in respect of the proportions of inpatients detained.

### Length of inpatient stay

As Figure 13 shows, inpatients from Glenrothes area were slightly more likely to remain in hospital beyond 30 days – 32% for Fife and 36% for Glenrothes. There could be a number of explanations for this including a greater severity of the condition from those presenting from Glenrothes or slower discharge because of reduced options for care in the community by relatives and friends or services.

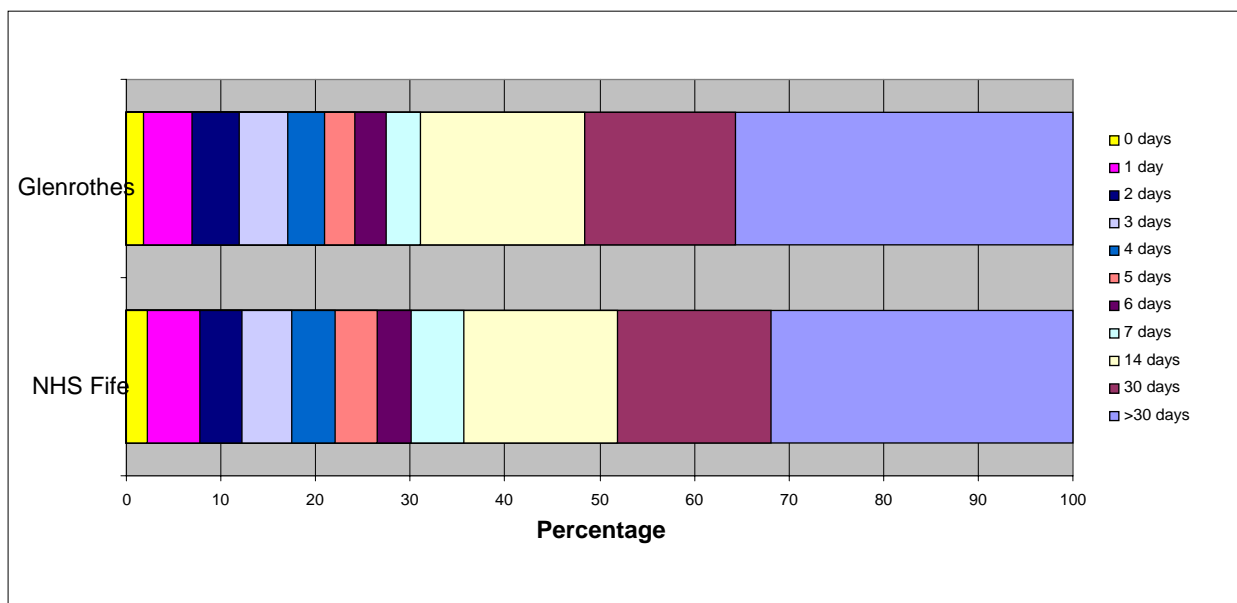
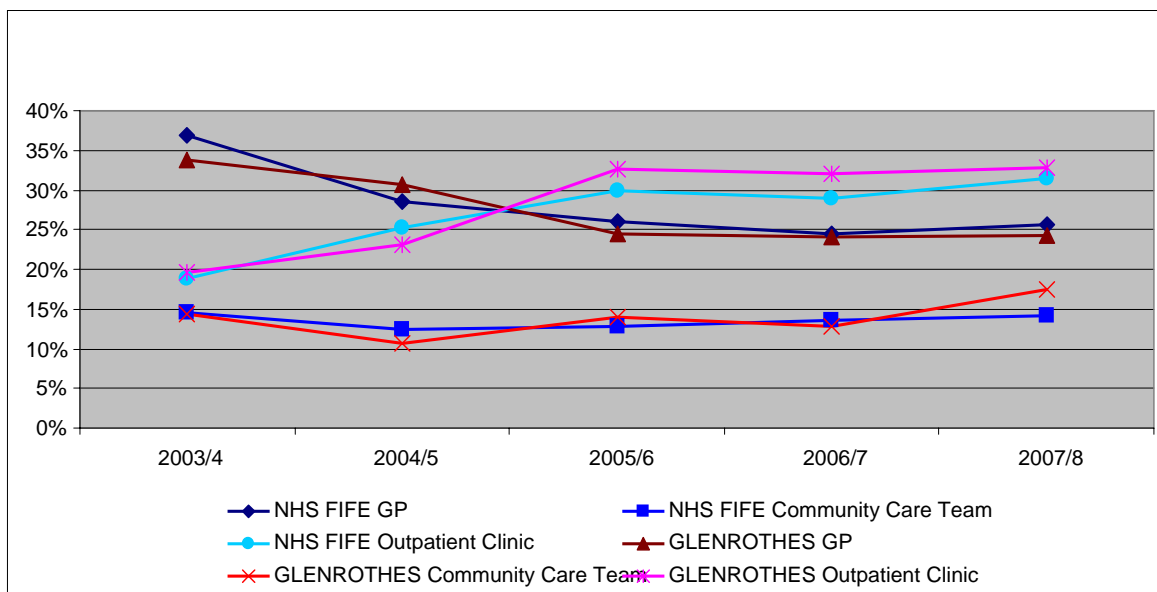


Figure 13: Length of stay cumulative percentage 2003/4 – 2007/8

### Aftercare arrangements

Figure 14 shows what appears to be a Fife wide trend, mirrored in Glenrothes, of more patients being referred to outpatient clinics on discharge, instead of to GPs. Whilst this arrangement may be positive, the research has established that the location of some outpatient services out with the Glenrothes area is a problem for some service users. Therefore, for some this trend in aftercare may be unsatisfactory.



**Figure 14: Trends in aftercare arrangements**

**Inpatients – 18 and Under**

Over the period 2003/4 – 2007/8, 36 people aged 18 or under from Glenrothes were recorded as inpatients. As numbers were small the findings should be treated with caution, however the following can be noted.

Significantly more young women (22) were admitted than men (14). In both cases the rate of admission was above that for Fife as a whole – 0.8 per thousand for young women from Glenrothes compared to 0.4 for Fife and 0.5 per thousand for young men compared to 0.3 for Fife.

Young people from Glenrothes were less likely to be inpatients of General Psychiatry than those from Fife – 69% from Glenrothes were registered with General Psychiatry compared with 84% for Fife as a whole. Thirty one percent of those from Glenrothes were recorded as being treated by ‘Other’, more specialist inpatient teams.

Young People from Glenrothes were less likely to be detained under the provisions of the Mental Health Acts – 14% compared to 18% for Fife.

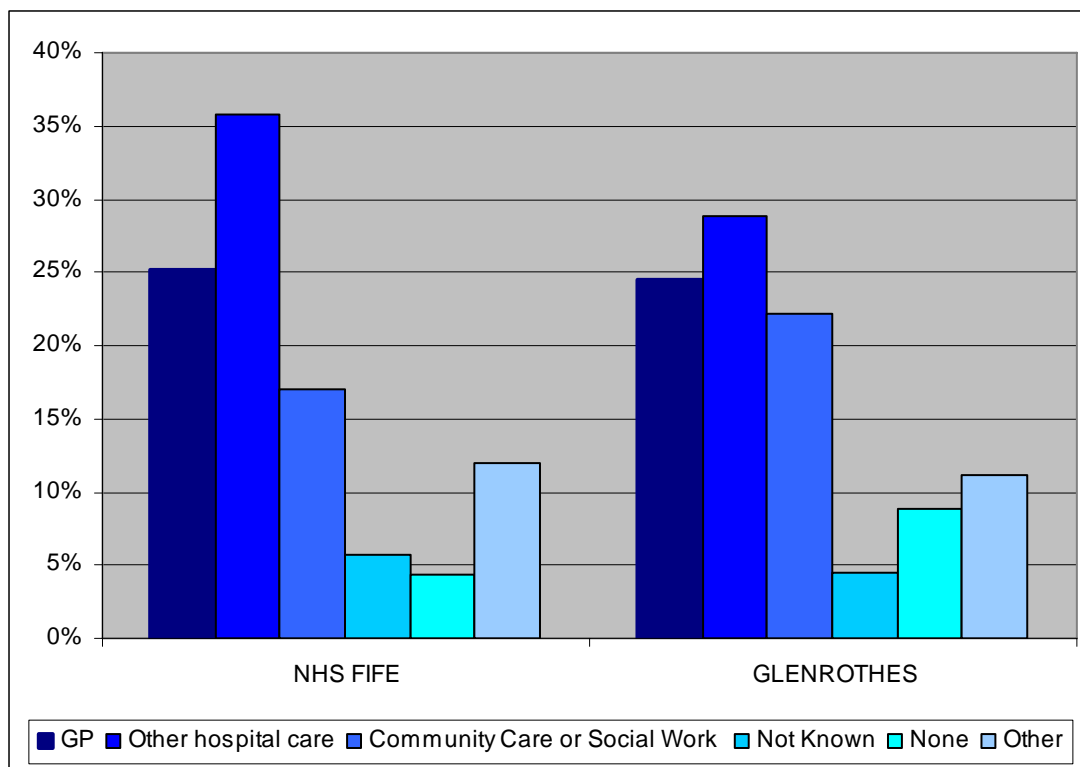
However, a higher proportion of young inpatients from Glenrothes were readmissions following a break from inpatient care – 39% compared to 31% for Fife. For half of



those from Glenrothes this was their first experience of inpatient care, whereas this figure rose to 56% for all young people from Fife.<sup>19</sup>

With numbers being small NHS Fife's analytical division withheld statistics on the prevalence of particular conditions amongst young inpatient from Glenrothes. The exception to this was in respect of Neurotic, Stress-related and Somato form Disorders – the diagnosis of 12 (33%) of all those admitted from Glenrothes. It is noteworthy that this gives a rate of 20.9 per thousand compared to 6.5 per thousand for young inpatients from Fife as a whole.

The following table shows the aftercare arrangements for young people from Glenrothes compared to Fife.



**Figure 15: Aftercare arrangements for young people**

For all young people, but less so those from Glenrothes, the most common aftercare category was ‘Other hospital care’ – which can cover Psychiatric Day Hospital, Outpatient Clinic and transfer to other psychiatric inpatient.

<sup>19</sup> In 11% of cases it was unknown or unclear whether this was a repeat admission.

Referral rates to GPs for aftercare were similar for both Glenrothes and Fife. But higher proportions of young inpatients from Glenrothes were referred to Community Care or Social Work as the lead agents in aftercare.

### **3.10 Key issues arising from application of prevalence rates and study of local data**

The key issues that emerge from consideration of prevalence rates and local data are as follows:

- The number of people affected by neurotic disorders in the study area is likely to be high - but services are likely to be in touch with only a small proportion of them at any one time, perhaps 25%.
- If the numbers to be treated are to be driven up, the most obvious method would be a proactive approach by GPs and surgeries – firstly because of primary care’s screening function but also because some 40% of sufferers are predicted as having discussed a mental health or emotional problem with their GP in the last year.
- The number of adults with currently active psychotic conditions is likely to be lower and they are more likely to be known to services and to be receiving treatment than those with neurotic disorders. However, this may mask important differences between sub groups, for example those with dual diagnosis.
- In respect of certain conditions, the rates of inpatient care for residents of Glenrothes are significantly above those for Fife as a whole. There may be a variety of reasons for this including higher levels of illness, fewer options for care in the community or, conversely, more proactive local services appropriately identifying and admitting the chronically unwell.
- Fife has one of the lowest bed occupancy rates in Scotland (for mental health) and is operating below the ‘recommended occupancy’ rate.
- Fife makes a high use of Compulsory Treatment Orders compared to other Health Board areas.
- Adapting national figures, we would expect that about 8,000 people in Glenrothes would have a mental health disorder.

## 4. E-Survey

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The e-survey was designed to seek the views of mental health practitioners and service providers on the following:

- estimates of prevalence of specified conditions within workloads;
- views on the availability of relevant services (like counselling and day care);  
and
- local progress against Delivering for Mental Health commitments and targets.

In total, 42 people responded. Of these, just over half (22) completed the bulk of the questionnaire. The remainder completed only some of the questionnaire. The response from GPs was disappointing. Four responded – none of them completed the majority of questions.

The questionnaire routed respondents through questions that were relevant for them. As a result of partial completion and the routing used, response for each question varies from the maximum of 42. In many of the questions, there are only a small number of respondents; therefore caution should be applied when interpreting this data.

This chapter of the report details the survey responses and includes verbatim qualifying comments where appropriate. The survey was designed in consultation with the Advisory Group and is appended at Annex 1.

### 4.1 Respondent profile

Respondents were asked whether their service operates in the statutory, voluntary or private sector. The majority of the respondents were working in the statutory sector – although nearly a third of respondents were from the voluntary sector.

Sector	% of respondents	No. of respondents
Statutory sector	66%	27
Voluntary sector	32%	13
Private sector	2%	1
Total	100	41

**Table 4.1: Respondents by sector**

*\*one respondent chose not to answer*

A good range of responses was received, as shown in Table 4.2. There were fewer GPs than other types of service providers.

Role	% of respondents	No. of respondents
Locality Mental Health Team member	14%	6
GP	10%	4
Other specialist NHS Mental Health or related practitioner	17%	7
Other specialist provider of mental health services	21%	9
Other relevant support provider	19%	8
Other	19%	8
Total	100%	42

**Table 4.2: Respondents by role**

## 4.2 Capacity of services

This section of the survey was intended to gather information about the capacity of services, including:

- the number of service users their service could cope with (n=14); and
- views on whether their service was currently operating at capacity (n=22).

Respondents found it difficult to estimate the capacity of their service – even as an ‘educated guess’. Just one third of respondents answered this question. Those responding indicated the maximum number of clients their service could sustain. Caseloads varied from 45 for a voluntary counselling service, to 180 for a statutory service and to a maximum of 300 for a community based voluntary service offering self help and recreational activities.

More respondents (22 people) responded to the question on whether their service was currently operating at capacity. Almost two thirds (64%) of those responding said that their service was currently operating at capacity (14 respondents) while just over a quarter (27%, 6 respondents) stated they were not operating at capacity. Some of the organisations which stated that they were not operating at full capacity (three in the statutory and three in the voluntary sector) qualified this, commenting on job vacancies or a general lack of resources.

“The service is very busy but being statutory we are not in a position to say we are full. We do however operate waiting times but these are different for different parts of the service.”

Statutory service provider

“We have a number of posts vacant.”

Voluntary service provider

### 4.3 Prevalence by condition

We asked respondents to give detail on clients' needs by estimating the numbers of service users with particular conditions using the service. Respondents were presented with a list of conditions, such as depression, anxiety, dementia, drug and alcohol dependencies and personality disorders. We asked respondents to estimate in percentage terms the prevalence of their service users with these conditions.

Respondents struggled to answer this question, with some stating that they could not give an accurate percentage, and left their response blank. Fourteen responses were received.

The main conditions that were being dealt with by the services that responded were depression, anxiety and psychotic disorders. To give a fuller flavour of the responses, we have selected two examples which we have presented as case studies below.

#### Case study 1 Statutory organisation

This statutory service offers specialist psychological support to mental health patients within the NHS. All of their service users are thought to come from the Glenrothes area. This service can cope with up to 75 patients at capacity, but felt that they were not currently operating at this level because of vacancies and staff shortages. In terms of prevalence, this service estimated that 35% of its patients were suffering from depression, while a further 40% suffered from anxiety. This service indicated that up to a quarter (25%) of its service users were suffering from a personality disorder. Alcohol and drug dependencies were not common characteristics among these patients. The service estimated that less than 5% of its clients were suffering from either condition.

### Case study 2 Voluntary organisation

This voluntary service is a specialist provider of mental health services. It offers support such as self help and leisure and recreation as its primary functions. This service can have 300 patients when working to capacity, but currently felt that this was not the case due to a lack of funding and resources. Less than 10% of its service users are believed to come from the Glenrothes area. Service users were likely to be suffering from depression or anxiety (40% respectively). Approximately 2% suffered from alcohol or drug dependencies. This service estimated that half of its users had experienced a psychotic disorder (such as schizophrenia or bi-polar disorder) in the last year.

#### 4.4 Mental health and your service

The survey asked respondents to confirm whether they were directly providing treatment and support to people with mental health problems. Just over half of all respondents (22 respondents) indicated their service was treating and supporting patients. Therefore the following two tables are based on these 22 potential respondents.

Of the services offering support and treatment to mental health patients; the majority described themselves as “community based” (57%, 12 respondents).

Service location	% of respondents	No. of respondents
Primarily Community based	57%	12
Primarily hospital/In patient based	10%	2
Equally split between community and In-patients	14%	3
Other	19%	4
Total	100%	21*

**Table 4.3: Respondents by service location and delivery**

*\*one respondent chose not to answer*

Service providers were also asked to indicate the assessment process that is undertaken in their organisation. Overall, 58% (11 respondents) stated they conduct their own, in-depth mental health needs assessments on all service users.

Assessment	% of respondents	No. of respondents
This service conducts its own in-depth mental health assessment on ALL service users	58%	11
This service undertakes a mental health assessment on service users, but only when concerns are identified	11%	2
This service DOES NOT undertake any mental health assessments but we may receive such assessments from other appropriate services	16%	3
No mental health assessments are conducted here and is not undertaken on our behalf by others	16%	3
Total	100%	19*

**Table 4.4: Respondents by type of mental health assessment**

*\*three respondents chose not to answer*

In some cases, joint assessments are carried out between two service providers to ensure all service users are properly assessed.

“Joint assessment is carried out in certain cases where service users have impaired judgement.”

Statutory service provider

“We work alongside other agencies to ensure all service users are assessed appropriately.”

Statutory service provider

#### 4.5 Unmet needs

The survey sought to identify levels of unmet needs in respect of the individual service providers. All the respondents providing direct treatment and support (n=22) were asked to give estimates of the proportion of their clients who are experiencing particular mental health problems which are not being treated or supported by the respondents’ service. Ten people answered this question - six from the statutory sector and four from the voluntary sector. Case study examples highlight these service providers’ views on unmet needs.

### Case study 3 Voluntary service provider

This specialist NHS mental health practitioner offers psychotherapy and professional counselling to service users. At capacity, this service can accommodate 45 patients but current staff shortages mean that it is not operating at capacity. Approximately two thirds (65%) of service users come from the Glenrothes area. This community based service conducts its own mental health assessments on all of its service users. Some of its service users were suffering from mental health problems that were not being treated by the respondent's service. This was particularly in relation to alcohol and drug dependencies, as well as personality disorders. For example, the table below shows the estimated prevalence of each condition among service users, and the percentage who are not receiving help for this condition from this service.

Condition	Prevalence	Not being treated by service
Depression	30%	10%
Anxiety	30%	10%
Dementia	0%	0%
Alcohol dependency	2%	100%
Drug dependency	2%	100%
Personality disorders	5%	100%
Psychotic episodes	2%	100%

#### Case study 4 Statutory service unmet need

This statutory service has a capacity of 180 clients, but is not running at capacity because of less demand for the service as other teams take on clients. This service is community based and conducts its own mental health assessments on all its clients. It has identified alcohol and drug dependencies as areas of unmet need.

Condition	Prevalence	Not being treated by service
Depression	25%	0%
Anxiety	20%	0%
Dementia	0%	0%
Alcohol dependency	15%	30%
Drug dependency	10%	100%
Personality disorders	20%	No response
Psychotic episodes	10%	0%

“Clients with drug dependency problems are dealt with primarily in the Addictions service, however there is now no dual diagnosis team in central Fife and there is definitely an identified need to deal with these clients who often need intensive and sustained intervention in order to keep them engaged in services.”

Statutory service provider

#### Barriers to unmet needs

The 22 respondents providing direct support and treatment were asked to indicate the reasons for some service users with mental health problems not using the respondents' service. Thirteen respondents answered this question

Lack of capacity within the service was highlighted as a barrier, as were issues with the service users themselves, such as the client not following a treatment programme or not maintaining contact with the service.

Other reasons for clients not accessing services were that services were only appropriate to treat certain people and that some people access services because they are linked to detention orders, as part of rehabilitation.

“This service only works with people being treated under mental health legislation.”  
 Statutory service provider

“The majority of service users are subject to detention and therefore have no choice about engagement. Support services for inclusion, diversity and socialisation are limited because of a lack of funds. Specialist input, such as anger management therapy is often not resourced.”  
 Statutory service provider

### Waiting lists

The 22 respondents were asked whether their service operated a waiting list for those whose mental health needs were not currently being met by their service. There were 18 responses. Of these, seven (39%) indicated they operated a waiting list. Six of these respondents estimated the length of the waiting list as a proportion of the capacity of their service. Half of these respondents (3 respondents) indicated that their waiting list was less than 10% of the capacity of the service, while a third (2 respondents – both from the statutory sector) said their waiting lists were more than 100% of the capacity of the service.

Waiting list	% of respondents	No. of respondents
Yes	39%	7
No	61%	11
Total	100%	18*
Length of waiting list	% of respondents	No. of respondents
Waiting list is less than 10% of the capacity of service	50%	3
Less than 25% of the capacity of the service	17%	1
Less than 50% of the capacity of the service	0	0
Less than 75% of the capacity of the service	0	0
Less than 100% of the capacity of the service	0	0
More than 100% of the capacity of the service	33%	2
Total	100%	6**

**Table 4.5: Presence and length of waiting lists**

\*4 respondents chose not to answer

\*\*1 respondent with a waiting list did not answer this question

#### 4.6 Frequency, duration and adequacy of engagement

Those providing treatment and support services to clients (n=22) were asked the 'typical' frequency and duration of support or treatment sessions. They were also asked to rate the adequacy of this frequency and duration.

##### Frequency of treatment session.

Sixteen respondents (out of the total 22 providing treatment) indicated the typical frequency of treatment or support sessions. Over a third (38%) of respondents saw their clients weekly, while a quarter (25%) saw clients every two weeks. Just under a fifth (19%) stated they saw their clients on a daily basis; this included two statutory organisations and one voluntary organisation.

Frequency	%	No.
Daily	19%	3
Weekly	38%	6
Every 2 weeks	25%	4
Monthly	6%	1
Not applicable	13%	2
Total	100%	16*

**Table 4.6: Frequency of treatment or support sessions**

\* 6 respondents chose not to answer

##### Duration of treatment session.

Fourteen respondents indicated the typical length of time they would spend with a service user during a treatment or support session. The table below indicates that almost two-thirds (64%) of respondents would spend one hour with a client in a typical session.

Duration	%	No.
Up to 30 minutes	7%	1
1 hour	64%	9
1 -2 hours	14%	2
Not applicable	14%	2

**Table 4.7: Duration of treatment or support sessions**

\* 8 respondents chose not to answer

### Adequacy of frequency and duration of sessions

Service providers were then asked to rate the adequacy of the time spent with service users and the frequency of these sessions.

Adequacy of frequency and duration	% of respondents	No. of respondents
Excellent	31%	5
More than adequate	31%	5
Adequate	25%	4
Inadequate	6%	1
Very inadequate	6%	1
Total	100%	16*

**Table 4.8: Adequacy of frequency and duration of treatment or support sessions**

\* 6 respondents chose not to answer

### Referral to services

Respondents who provided treatment (n=22) were asked about how clients were referred to their service. Fifteen service providers answered this question (n=15). There was a wide variety of approaches. For example, a voluntary service, offering support to families of those with substance misuse addictions, received 80% of its clients through self-referral. However, psychiatry services have no clients self-referring - all came through referrals from specialist mental health services. Some other statutory services receive the majority (up to 90%) of their clients from GP referrals.

### 4.7 Methods of treatment and support

Those providing treatment and support directly to those with mental health problems (n=22), were asked to rank the primary methods used by their service to treat patients. Sixteen respondents answered this question.

The most common primary method of treatment was 'social care support' while medication, counselling and psychological therapies were also used as the primary method of treatment. Secondary methods included access to leisure activities.

### 4.8 Progress on 'Delivering for Mental Health'

'Delivering for Mental Health' (2006) sets out the Scottish Government's strategic vision for Mental Health services. As part of tackling depression, anxiety and stress, one of the commitments of 'Delivering for Mental Health' is "We will increase the availability of evidenced based therapies for all age groups in a range of settings and

through a range of providers.” We asked those respondents providing support and treatment (n=22) to describe their overall progress towards this target since 2006.

Progress towards Delivering for Mental Health	% of respondents	No. of respondents
Very good progress	0%	0
Good progress	40%	6
No progress	40%	6
There is less access to psychological therapies	13%	2
There is markedly less access to psychological therapies	7%	1
Total	100%	15*

**Table 4.9: Progress towards Delivering for Mental Health**

*\*7 respondents chose not to answer*

An equal number of respondents stated they had made ‘no progress’ as indicated they had made ‘good progress’. Some statements highlighted why some service providers felt they had made progress, and why others felt they had not.

“We offer a variety of therapies through the CPN service but also work in collaboration with O.T, day hospital and psychology to provide appropriate therapies.”

Statutory service provider

“There is a distinct lack of referrals from all professionals perhaps they are unaware of the free help that is available to their clients/patients.”

Voluntary service provider

## 4.9 Service quality and availability

### Rating service quality

When asked to self-assess the quality of their own service to the people of Glenrothes, 18% commented that they provide a high quality service (and a further 18% stated their service was very high quality). The majority (59%) said the service they provide was satisfactory.

Service quality	% of respondents	No. of respondents
Very high quality	18%	3
High quality	18%	3
Satisfactory	59%	10
Poor	0	0
Very poor	0	0
Don't know	6%	1
Total	100%	17*

**Table 4.10: Assessing service quality**

*\*\* 5 respondents chose not to answer*

Comments included:

“What we have is high quality but there are deficits such as high waiting times for psychology, and the mixed acute wards where clients with a primary diagnosis of drug/alcohol addiction are in with those with just mental health issues.”

Statutory service provider

“Because of the range of services we offer it is difficult to tick just one box. For example, I believe we offer high quality service to our in-patients but the community services are poor; not because we don't have good people working in the community but because there are not enough of them and they do not have adequate places to work.”

Statutory service provider

“Motivation and a lack of public transport and local accessible support, makes involvement problematic. Glenrothes lacks identity and the population has been drawn from outlying areas so community involvement is fragmented. It has high incidence of drugs/alcohol problems which impact on mental health referrals.”

Statutory service provider

### Rating service availability

Sixteen respondents (out of the total of 42) rated the availability of mental health services to the people of Glenrothes. An equal number of respondents indicated the availability of services was “adequate” as was “poor” – 31% (5 respondents respectively).

Service quality	% of respondents	No. of respondents
Availability of relevant services is very good	6%	1
Availability of relevant services is good	19%	3
Availability of relevant services is adequate	31%	5
Availability of relevant services is poor	31%	5
Availability of relevant services is very poor	13%	2
Total	100%	16*

**Table 4.11: Assessing service availability**

\*\* 26 respondents chose not to answer

The availability of relevant services was rated relatively negatively by the service providers. This is perhaps linked to the existence of 'barriers' to accessing these services. Over 80% of those responding to this question (13 people) indicated that barriers do exist, stopping people from Glenrothes accessing mental health services. The most significant barriers were thought to be a lack of capacity, the location of services and stigma or prejudice.

#### 4.10 Training needs

Respondents were asked whether their service had any additional training needs. Five respondents stated they did have further training requirements.

Additional training needs	% of respondents	No. of respondents
Yes	29%	5
No	41%	7
Don't know	12%	2
Not applicable	18%	3
Total	100%	17*

**Table 4.12: Additional training needs identified**

\*\* 25 respondents chose not to answer

Comments from those whose service had training needs were varied:

"Staff need ongoing training on mental health issue and in appropriate ways to engage effectively with service users."

Voluntary service provider

“Currently our service is actively discouraging face to face contact with client group. Administrative role has taken over and systems have replaced people. This has resulted in reduced monitoring/contact and diluted quality of the service. I need to be properly trained in IT systems if this is the new face of delivering support services.”  
 Statutory service provider

#### 4.11 Service improvement

Respondents were asked whether there were any plans to improve their service in Glenrothes. Almost half of those responding (47%, 8 respondents) indicated they did have plans to improve.

Plans for service improvement	% of respondents	No. of respondents
Yes	47%	8
No	29%	5
Don't know	24%	4

**Table 4.13: Plans for service improvements**

*\*\* 25 respondents chose not to answer*

Improvement plans included moving into new areas of support for specific groups (such as older people). Others hoped to increase the capacity of their service by filling vacant posts.

“When funding becomes available we will look to introduce an intensive assessment support and treatment team for older people.”  
 Statutory service provider

#### Further improvements to your service

Comments were made on improvements that could be made to existing mental health services to make them more efficient. Extra staff who are more specially trained, as well as better and bigger facilities were common areas for improvement.

“Better facilities and shared bases for multidisciplinary teams. Increased staffing and increase in mental health staff providing care in GP practices.”  
 Statutory service provider

“Appropriate accommodation to allow our community teams to do all of their business within the local area and would allow us to provide some day hospital services in the locale.”

Statutory service provider

“Extra staff would be a bonus and would reduce waiting lists and also free up time for more in-depth therapies and also allow more time for staff training.”

Statutory service provider

### **Service improvements external providers should prioritise for Glenrothes**

Finally, all 42 respondents were asked to detail any improvements that external providers could prioritise for the people of Glenrothes. Providing alternative to hospital admissions, either through better day care or befriending projects as well as more resources for staff and accommodation were seen as beneficial.

“Mental health services in Fife are significantly underfunded by comparison to other health boards. Resources are not necessarily targeted to the most needy areas. This is a highly deprived area but does not have the level of resource needed to meet the mental health needs of the population.”

Statutory service provider

“Need for better co-ordination of services between health, local authority, voluntary sector and private sector at a strategic level.”

Statutory service provider

“Alternatives to hospital admission - Day care community support workers are needed.”

Statutory service provider

### **4.12 Summary of key points from e-survey**

There are relatively small numbers of respondents for some questions, and so caution has to be employed when interpreting the data.

- The breakdown of respondents was two thirds statutory and one third voluntary, with one from the private sector. Four GPs responded – but none were complete responses.

- In terms of capacity, those responding indicated the maximum number of clients their service could sustain. Caseloads varied from 45 for a voluntary counselling service, to 180 for a statutory service and to a maximum of 300 for a community based voluntary service offering self help and recreational activities.
- Most said that they were operating at capacity. Those not operating at capacity commonly stated this was due to vacant positions within their service or a general lack of resources.
- Those treating patients (52% of respondents) would typically see patients weekly (38%) or every two weeks (25%) for about an hour (64%) although some would spend up to 2 hours with a patient (14%). Two thirds (62%) felt this was more than adequate.<sup>20</sup>
- When asked to self-assess the quality of their own service; 18% commented that they provide a high quality service (and a further 18% stated their service was very high quality). The majority (59%) said the service they provide was satisfactory.<sup>21</sup>
- Just under a third (31%) of respondents felt that the availability of mental health services was adequate; while a further third (31%) said that availability was poor. Only one in five (19%) stated the availability of services was good.<sup>22</sup>
- 80% said that barriers existed to accessing services. The most significant barrier was thought to be a lack of capacity.
- Just over a quarter of respondents (29%) stated that they did have training needs in regards to mental health – these were in relation to mental health first aid, engaging with service users and general training to keep people up to date with new developments in treatment or support<sup>23</sup>.

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<sup>20</sup> Based on 16 responses.

<sup>21</sup> Based on 17 responses.

<sup>22</sup> Based on 16 responses.

<sup>23</sup> Based on 17 responses

- Almost half (47%) of respondents indicated that they did have plans to improve their service in relation to mental health patients.<sup>24</sup> Examples include more joint working with other services, increasing capacity by filling vacancies and introducing treatment and support for older people.

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<sup>24</sup> Based on 17 responses

## 5. Telephone Interviews

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### 5.1 Introduction

Depth telephone interviews took place with 14 service providers. These included statutory NHS services such as clinical psychology and consultant psychiatry services as well as voluntary service providers such as Fife Employability Access Trust (FEAT). Typically these lasted approximately thirty minutes, although some lasted over an hour. A semi-structured discussion guide was used and this is attached at Annex 2.

### 5.2 Services in the wider area

Respondents were asked to comment what they felt were the strengths and weaknesses of the current provision of mental health services in Glenrothes and NE Fife.

#### **Strengths of current services**

##### **Commitment to deliver mental health services**

A number of the respondents indicated that one of the strengths of the current service was the commitment of service providers to work together to deliver a comprehensive service. One respondent praised the current services for extending Fife-wide – providing a more consistent service. Linked to this, was multi-agency working, where different service providers come together to discuss cases and share information. The strength was the commitment of each of these practitioners, such as Community Psychiatric Nurses (CPNs), social workers and substance misuse practitioners. Often information can be shared in this situation, providing an opportunity to discover an alternative to hospitalisation for patients.

##### **Nurse Practitioner Services**

The Nurse Practitioner Service operating in GP surgeries was identified by respondents as being a particularly useful service. The nurses can work more intensively with patients than GPs – who are under significant time pressures. By involving the nurse practitioner, patients can receive a faster service, usually within their own GP practice – stopping the need to be referred to a specialist service and ultimately cutting down waiting times. This was seen as particularly useful when patients were in need of psychology services where the current waiting time is estimated at one year.

These nurses are also able to secure some patients direct access to day hospitals, by-passing the need for waiting lists. There was a particular example cited, where patients had been referred to group work activities at Dunniker Day Hospital. These were patients with milder conditions, which GP surgeries had not been able to address consistently. This was a positive example of a Nurse Practitioner referral.

This early intervention can also prevent the escalation of illness for some patients.

“Patients can be seen quickly and in their local practice – which they appreciate and prefer. Surgeries are not considered to be stigmatised in the same way as a specialist in-patient services.”

Service Provider

### **Voluntary services**

Some service providers praised the work of the voluntary services who, it was felt, were “filling a gap” in service provision, not covered by statutory services. The voluntary sector, it was felt, could build strong relations with the service users.

“Voluntary services fill the gaps because they can react quickly to need...they can be more ‘hands on’ and they can offer things that the public sector can’t – for example, buddying, one-to-one support, and drop-ins.”

Service provider

### **Other strengths of service**

Other strengths that were mentioned (normally by one of the respondents) included:

- the development of the new ‘Unscheduled Care Team’ which will replace the 24 hour on-call assessment team;
- the high number of in-patient beds was praised, so that those who need admission could be looked after;
- the good working relations between the psychologists and psychiatrists delivering community services; and
- the day hospital in Cupar being developed as a ‘treatment centre’ which has resulted in the numbers of users increasing and the quality of care improving.

## **Weaknesses of current service provision**

Respondents also indicated what they considered to be the weaknesses of the current provision of mental health services.

### **Locality Mental Health Team**

Several interviewees identified issues around the Locality Mental Health Team (LMHT). Not all respondents identified the same issues. But overall, the comments related to the structure and management of the service, the lack of consistency within the team, the failure to fully engage with other community services and the poor accommodation from which the LMHT operates.

#### ***Structure and management***

Some respondents observed that the LMHT did not achieve the synergy of health and social care functions that would normally be expected of a fully functioning Community Mental Health Team.

“The team is fractured in its delivery. It is unfortunate that it is not a consultant led service as it does not truly function as a Community Mental Health Team.”

Service provider

In contrast to those respondents who felt multi-agency working was a key strength of the service provision, it was observed by some that there was some insularity within disciplines. For example, some respondents indicated that CPNs tended to work amongst themselves and the same was true of the other LMHT specialities – although it was noted that the team were trying to build closer working relations between specialities.

#### ***Poor accommodation***

A few respondents did comment that the LMHT’s premises were “*woefully inadequate*” to the service it was expected to provide.

### **Day services**

There was concern over the perceived lack of day care provision which offers social support to those with mental health needs. Some of the voluntary groups (like the Express Group) were acknowledged as providing this service – but some respondents

felt this type of provision was not always suitable for their patients – particularly those at the “top end” of enduring mental illness who are perhaps being discharged from hospital after long stays.

Others felt that provision for those with mild or moderate mental health conditions were underdeveloped and that more should be done to use group based approaches and to deliver stress management classes.

### **Lack of available information about services**

There was a view among some respondents that it was difficult to identify what services were available in Glenrothes as there was no one central point of contact to go to for information. The ‘Living in Fife’ directory had listed all the available support and treatment services up until 2007, when it lost its funding. Since then, no website or directory exists listing available service provision.

“If you were newly diagnosed in Glenrothes, with a mental health problem you would have no idea where to go for help.”

Service provider

### **Other weaknesses of services**

Other weaknesses that were mentioned (normally by one of the respondents) included:

- the traditional opening hours of services (between 9am – 5pm) denied those in employment the opportunity to engage in regular sessions;
- there was a lack of access to appropriate accommodation for services in Glenrothes;
- the remit of the Nurse Practitioners was too limited; neither Nurse worked with patients with addictions or with clients with psychosis; and
- one nurse practitioner covered 5 GP practices alone – an example of spreading a good resource too thin.

### **5.3 Capacity of current services**

Respondents commented on the situation within their own service in terms of capacity and their perceptions of how other services are dealing with increasing numbers of patients.

## **Psychology services**

Specific services such as psychology were highlighted as operating a particularly long waiting list. Some respondents felt that psychology services were poorly resourced in comparison to other parts of Fife - having half the staff per head of population in comparison with West Fife, for example.

## **Social Work**

The Fife Intensive Outreach Team work with patients at “crisis stage” – they have severe and enduring mental ill health and are also suffering from substance misuse problems. This team’s remit is to offer support to dual diagnosis patients. This is often for the ‘long term’. There are examples of patients being treated for longer than 5 years - which can lead to capacity issues.

“The difficulty is that these patients require support for the long term – there are patients who could be on the books for up to 6 years. It is not a quick turnover and very seldom are people discharged.”

Service provider

## **Overstretched voluntary services**

While some of the respondents indicated the benefits of the voluntary sector, ‘filling a gap’ in service delivery because of its flexible nature, others indicated a problem with the consistency of the care provided by these services. For example, referring a patient to a voluntary-led service may only guarantee the patient a one-off session. Patients have to be continually referred to ensure continued care. This was seen as a capacity issue.

“There is no continuity. There is also a limit to how many people can be using the service at any one time.”

Service provider

Representatives from the voluntary sector however felt that their flexibility was a real plus to providing a continuing service. For example at FEAT, clients are seen within a fortnight and can be accessing employment training within one month.

There was concern that voluntary sector services were patchy – in that there was not a flow through the service. People become service users and rarely move on. There

was a call to have more of a joined up approach, so that people can access different types of voluntary support without being moved around.

“From the client point of view there is a lot of passing from pillar to post. There is a need for more of a joined up approach. Patients are moved from one agency to another and they should be able to access support without being moved around.”

Service provider

“The voluntary sector is patchy. There is not a flow through of services – for a lot of people, they become a case-load but don’t get discharged and so the service waiting list is perpetuated by clients who will not leave. There should be more for non-medical services – for example structured social services.”

Service provider

To help relieve capacity issues, one stakeholder suggested more joined up working, which they felt would negate the need for waiting lists. This would take the form of a “one stop shop” where different services could be accessed under one roof. If a service took on a client who had more complex needs than they could provide, that service would negotiate with other services.

“Services just create waiting lists by passing clients onto other services.”

Service provider

#### **5.4 Client groups not well served**

##### **Dual diagnosis**

Respondents were asked to indicate whether they felt there were any particular groups of people (or people with specific mental health conditions) that were not being adequately served by the current service provision. The consensus was that those with a dual-diagnosis (of mental health and substance misuse problems) were falling through the net – often because their complex needs mean they do not fit neatly into a particular care programme.

“Those with dual diagnosis need help with basic tasks, such as managing money...so for example, I have a patient who has his mental health needs under control, but who makes poor decisions and does not manage his money – well, what can Social Work

do for him? All I can do is create pathways to employment, education and help empower people”

Service provider

“Those with co-morbidity issues, and with alcohol related brain injuries – but these people do not fit neatly into any categories – for example, those with brain injuries can be linked to dementia and they tend to need to be in care homes but they don’t fit in with the model as they could be young – but still need care home care.”

Service provider

A further concern raised by one respondent about this particular client group was their “chaotic” lifestyle, which can mean that patients miss appointments and therefore services can be reluctant to take them on board.

### **Mild to moderate mental health problems**

There was also concern among the respondents that those who were described as the “worried well” who would suffer from, mild to moderate mental health conditions may be missing out on services.

“(Who is not well served?) ....Those who are described as being “mild to moderate” in terms of their mental health problems – as there is not enough to help early diagnosis. There should be more support for people with mental health problems who are in work, and the support should be targeted at keeping them in employment.”

Service provider

“We don’t serve mild and common mental health problems well.”

Service provider

### **Older people**

Two of the respondents indicated their concerns over services specifically for older people in relation to dementia. These were not felt to be adequate. This was a concern as it was felt that demand in this area would grow, in accordance with the ageing Scottish population.

### **Personality disorders**

Some respondents indicated that those patients with personality disorders are not well served. The perception was that this patient group were “a drain on resources”. It was

suggested that more needs to be done to provide staff with appropriate training to deal with personality disorder patients.

“More needs to be done to think about how to develop services, and provide better treatment. More training should be provided to service providers about dealing with patients with personality disorders and that the service provision should match this with more focus to be put on meeting their needs.”

Service provider

### 5.5 Other gaps in service provision

In addition to inadequate provision for particular groups (like those with co-morbidity needs, older people with dementia and those with personality disorders), respondents identified more general gaps in service provision. These included improving the availability of day care services and counselling. There was also the concern over a lack of ‘out of hours care’ which needs to be more specialised, rather than dealt with by A&E.

“There is a lack of out of hour’s crisis services – at the moment this is dealt with by A&E, GPs and other wards, but there needs to be more specialist care.”

Service provider

#### Day care services

Some respondents felt that more informal services were needed, offering social support to those with mental health needs.

“There is no day centre or day hospital where people could use as a drop-in, to have a cup of coffee or play pool. There is a need for more informal support.”

Service provider

One respondent suggested that the local authorities should be taking on more of a role to provide suitable day-care accommodation and resources. The view of some respondents was that day care had been ‘handed over’ to the voluntary sector, and in some cases, this had not been adequately supported and had ceased to exist.

## The role of GPs

Also identified was a gap in the service provided by GPs. Often when people first feel unwell they would visit their GP. The respondents perceived the issue to be that GPs are then automatically referring patients on to other services, without adequately assessing their health. It could be that those with ‘mild and moderate’ needs could be dealt with by the GP. It was acknowledged that more training and resources would need to be provided to allow the GP to perform this task – but this could reduce the ‘automatic’ referral to other services.

“You often hear GPs say, ‘50% of those who come to see me have mental health problems’ and they think this is someone else’s problem. It is evident that practices need to gear up and recognise that mental health is a big problem. There is a need for support and to put in services for “common” mental health problems.”

Service provider

## 5.6 Barriers to accessing services

Barriers such as the location of services and the poor public transport system in Glenrothes were identified by respondents. In addition, a concern over the issue of ‘stigma’ attached to accessing mental health services was also identified as a barrier to service use.

### Location of services

Some respondents felt that Glenrothes is perceived as being poorly developed in terms of services. Respondents commented that there is a “territorial” issue. People want services, to be on their doorstep – otherwise the view is that the provision is poor. The concern was more to do with transport, rather than distance.

“Public transport is an issue across Fife. Glenrothes is a good base in which to have mental health services but there are access issues for people trying to get into the area.”

Service provider

## Stigma

Respondents acknowledged that for some people, the issue of stigma and the perceived repercussions of being seen to be using a mental health service were significant barriers. One respondent stated that they had done some work into

addressing education around mental health, but more needed to be done to combat the issue of stigma.

“There is more than likely some issues of stigma and whether mental health problems are publicly acceptable which has an impact on whether people use the service.”

Service provider

“Stigma still exists as a barrier to accessing services, they try to link in with existing campaigns such as See Me, but she said that people do not want to be seen accessing services – they want to remain anonymous and they particularly don’t want to be seen accessing mental health services as “they don’t like the label”.”

Service provider

### **Recent changes to improve accessibility**

The availability of appropriate accommodation in Glenrothes was identified as a major constraint to service development. It had been hoped that the recent redevelopment of one of the GP practices would have allowed for increased accessible and non-stigmatised accommodation, but in reality this has not happened.

### **5.7 Examples of good practice**

A number of examples of good practice among current service provision were identified, including:

- The Addictions team have a good relationship with Fife Intensive Rehabilitation and Substance Misuse Team (FIRST) which provides a Fife wide rehabilitation service to individuals with substance misuse problems, via one to one interviews, groups and volunteer support;
- ENerGI – a registered charity offering support and information for people with mental health problems and their carers through a drop in and other complimentary therapies;
- The Community Outreach Team have several support workers and work with nurses to deal with mental health patients;
- FEAT are seen to be doing a good job and the community teams were also working well, linking in with education;
- Penumbra Fife early response project;
- Moodcafe; and
- Hands-on Scotland.

## 5.8 Strategic planning

We explored with the service providers their involvement in strategic planning and joint working partnerships. We also explored awareness and use of “Delivering for Mental Health” – the Scottish Government document which sets targets and commitments for improving patient and carer experiences of mental health services.

### Describing Strategic planning arrangements

The service providers we spoke to tended to describe themselves as “on the periphery” of strategic planning. Their perceptions however, were that plans were not well developed. While there was an acknowledgement that more joined up working was taking place, this was not seen to be encompassing mental health services.

“The strategic planning arrangements for mental health services in Glenrothes are more joined up, but there needs to be more attention paid to mental health services, as sometimes they feel they are on the bottom rung of the ladder - in terms of services and finance.”

Service provider

“We are terrible at strategic planning. The NHS is generally poor at planning and delivery. It doesn’t pull together and do the tough stuff – too much is based on vested interests.”

Service provider

One respondent commented that while there were strategic plans in place for new buildings and hospitals, the future of the services as a whole was not being well planned.

### Aims and objectives of strategic planning arrangements

Respondents generally felt that there was no coherent strategic framework for mental health services in Fife. While providers felt informed, to an extent, about developments in services, they were not aware of a strategic plan that was available to guide their actions.

One respondent observed that strategic objectives are delegated from the Mental Health Strategic Implementation Group and that they should be clear – such as HEAT targets. But this was not felt to be the case.

“Increased access to talking therapies sounds fine – but what does it mean in practice? There is no whole system approach, which isn’t helped by the historic baggage in this area.”

Service provider

“There is a lack of cohesion to overall objectives and approaches. At the coalface some decisions seem strange; for example relocating beds to Stratheden. It isn’t clear that resources have moved from in-patient services to enhance community services.”

Service provider

Several service providers shared the view that there was a lack of clarity surrounding the aims and objectives and this was ultimately linked to funding. Only one respondent stated positively that strategic aims and objectives for mental health services were clear.

### **Strategic plans responding to local needs**

There were mixed views among respondents as to whether current strategic planning arrangements could respond properly to local needs. Some felt that current plans were not capable of doing this. Others felt the structures were in place to offer a consistent service – if resource issues could be addressed.

“No, not capable...In Glenrothes there are consultants doing different things – referring to different places and the social work team is not aligned well with them. People do not know where to go.”

Service provider

“Yes, the structures don’t need to change if the resource issues can be addressed and we have appropriate plans and goals.”

Service provider

### **Examples of joint working**

There were also mixed views on joint working. Most of the respondents had experience of working in partnership with another organisation; but had found varying degrees of success.

For example, some service providers found it difficult to engage with GPs – particularly as there is no Forum in which to do this.

This was felt to be a particular issue by one respondent who spoke of new assessment systems being applied by some GPs which would have an effect on specialist services by potentially increasing demand. However, the lack of joint working between specialist services and GPs meant this process of assessment had not been discussed prior to implementation.

Others commented on the lack of consistent joint working between the NHS and its main partner – the Council. Fife Council was described as being in “*a constant state of reorganisation*” resulting in a decline in joint working practices in recent times.

### **Delivering for Mental Health**

Delivering for Mental Health includes targets and commitments for improving patient and carer experiences. There are fourteen commitments and three targets in total. We explored with service providers the progress they felt their organisation had made towards meeting these.

Overall, there were examples of progress being made towards a number of the commitments. Three commitments were mentioned by most respondents as being well underway:

- Commitment 5 - improving the physical health of those with severe and enduring mental illness through physical health assessments at least every 15 months;
- Commitment 7 – training key staff in using suicide assessment tools and prevention training programmes – with 50% of staff trained by 2010; and
- Commitment 8 – managing and caring for people in the community; avoiding inappropriate admissions and achieving crisis standards by 2009.

Others felt that the onus had been on targets, as this was perceived as the focus of the Government. The targets set out in the document were as follows:

**Target 1:** Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.

**Target 2:** Reduce Suicides in Scotland by 20% by 2013.

**Target 3:** 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

Some service providers reported positively that they had already met Target 3 by reducing the rate of re-admissions.

Others expressed concerns about the targets; specifically Target 1, which involves the reduction of defined daily dose of antidepressants. Service providers felt this was an unrealistic target without the introduction of additional resources such as talking therapies.

“We can’t achieve zero growth in anti-depressant prescribing without additional resources into talking therapies.”

Service provider

“GPs are under pressure to give patients something, but they need to change their prescribing approaches.”

Service provider

One respondent raised future difficulties with staffing. According to this respondent, there has been a 40% decline in the numbers of nurses and psychologists currently in training in Scotland, which will lead to serious long term issues about recruitment and service delivery.

## 5.9 Communicating with service users

We discussed general awareness of the services that were available and the opportunities that existed for patients and service users to get their views heard by service providers.

### Awareness of services

There was a consensus among service providers that GPs varied in their awareness of relevant mental health services and in their interest to find out what was available. Acknowledged as the first point of contact for most patients, GPs were thought to be ill-informed about the range of services and, it was felt, often referred inappropriately.

“They often do not know who to refer to, so they refer to the CPN, who then has to refer to someone else – taking up the amount of time taken to successfully refer the patient.”

Service provider

Others stated that GPs were often encouraged to signpost mental health patients to other services rather than prescribe medication – yet it was recognised that there was a “big gap” in their knowledge of available and relevant services that could benefit their patients.

“It is those who first present at a GP who are not too unwell that we don’t know about – it depends on the GP, but some do not refer appropriately.”

Service provider

Patients themselves were not aware of where to go for treatment and support. Some felt this was because of the diverse range of services that are available – and that often patients can be passed from “pillar to post” without receiving the right treatment – and as a result, can give up seeking treatment altogether.

“There is a gap where people are seeking help but they are not sure where to go.”

Service provider

“There is such a range of services the public are confused. What’s the difference between voluntary and public services? And if you get passed onto another organisation who turns out not to be best placed to help, then you’d give up.”

Service provider

There was agreement that there should be a greater publicity of services, but often (despite the road-shows or conferences), there were still examples of people who were unaware of service provision. There was a suggestion to create a ‘one stop shop’ approach to service delivery. This would not be labelled as a mental health service, but should have a generic title, such as “support and advice” and could work on a drop-in basis, where staff could have direct links into other services and could signpost clients as appropriate.

### **Communication with service users**

Service providers tended to believe they communicated well with their own service users, but it was felt this was not consistent across the whole of the mental health service provision.

“We communicate really quite poorly in Glenrothes – especially with the mild and moderate service users.”

Service provider

Others agreed that their approach to gathering feedback or views was not consistent.

“We’re not good at collecting feedback –it can be difficult and depends on how unwell the patient is and knowing when to approach them.”

Service provider

### **Opportunities for communication with service users**

Patient forums and representative groups were in existence – but it was acknowledged that patients may not know about these, or how to go about getting involved. These types of groups tend to be frequented by the “usual suspects” – the dedicated few who want to get their views across. But they may not be representative of patient views more generally. It was recognised that more should be done to capture the views of a wider range of people.

“There are mental health partnerships which have broadened awareness and knowledge – but the service is guilty of having relied on the same group of service users and carers to act as sounding boards. We do need to broaden our contact with people.”

Service provider

However, some service providers felt that opportunities to engage with service users were purely tokenistic and that service users had no real say in the future of service delivery.

“There are stakeholder events but these are often window dressing.”

Service provider

“Questionable if services users have or will influence the shape of services – but it may be different for in-patients under compulsory care.”

Service provider

Others were more optimistic and felt that there were positive examples of service users shaping the service. For example, within the Addictions team there was an example of a service users group made up of existing patients, ex-patients and carers who meet regularly and feed their views directly to staff.

There was a concern however, that by promoting service user involvement, services would receive information and suggestions which they could do nothing about.

“(We’re) scared to promote service user involvement too much in case we are inundated with information that we can’t do anything about.”

Service provider

There was a general view that service user views need to become more deeply imbedded into service delivery culture, and that more has to be done to make efforts to engage those ‘hidden voices’ rather than relying on a few keen patients to be representative.

One way of expanding the numbers of patients and service users giving their views, would be to ensure that language, format and other equalities issues are not acting as barriers to involvement. For example, one service provider had recently had documents and materials translated into Polish.

However, despite the acknowledgement that materials can be produced in other languages, service providers did not feel confident at delivering their services to those whose first language was not English. There were other cultural difficulties identified by some respondents, such as engaging with Muslim women, for whom social contact can be an issue.

“Delivering talking therapies to those for whom English is not their first language is always going to be a challenge.”

Service provider

“We are not geared up to working with all ethnic minority patients in a diverse way - for example, Muslim women who stay at home and are hard to engage with. Social contact for them can be an issue.”

Service provider

### 5.10 Summary points from telephone interviews

- The strengths of the current service provision were thought to be the commitment to partnership working and providing a consistent service across Fife. The contribution the Nurse Practitioner Service gives to mental health service provision and the gaps filled by the voluntary sector were identified as specific strengths.
- Weaknesses include the lack of day care provision, the structure and management of the Local Mental Health Team and also the general lack of information about available mental health services.
- Capacity issues were identified in psychology and in services dealing with patients at the “crisis” stage of their care – the Fife Intensive Outreach Team was mentioned as one specific service which tended to take on more service users, but rarely discharge anyone.
- Patients with co-morbidity issues (substance misuse problems as well as mental health problems) were identified as a group who were not currently well served. Service providers also identified that more could be done to work with older people, those with personality disorders and those with “mild to moderate” mental health problems.
- A common barrier to accessing services was perceived to be the location of the service. There was a view among service providers that the public expect services to be “on their doorstep” and this is compounded by the poor public transport links in the area. Stigma was also mentioned as a barrier to accessing services.
- In terms of strategic planning, few of our respondents had been heavily involved. But it was felt that the current strategic direction was not clear.

- Service providers felt that awareness of services among the general public was poor, and that those newly diagnosed would not know where to go for help. This was compounded by a lack of awareness among GPs – who it was felt often referred patients inappropriately.
- Service providers did have channels in place to communicate with service users – but it was acknowledged that often services rely on a small group of ‘keen’ representatives, rather than trying to encourage responses from a wider group.

## 6. Focus Groups with Service Users and Carers

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This section sets out the findings from the service user and carer interviews and focus groups. A total of eleven people participated in this element of the research - eight service users and three carers.

Six individual interviews took place and two discussion groups – organised by the Fife Hearing Voices Network and the SAFE Group.

This section of the report discusses the key findings from the consultations with service users and carers. This focuses on the areas outlined in the discussion guides (Annex 3).

Service users and Carers' views are reported separately.

### 6.1 Views of Service Users

#### Background and context

We had some difficulty in recruiting service users and it would appear that service user groups are weakly developed and vulnerable. In our view this contributed to the difficulties in recruiting for these sessions.

There are a number of possible reasons why self help groups for service users are not as strong as they might be at this time, including:

- changes in the funding and roles of organisations providing support and advocacy to service users;
- the lack of a history of vibrant service user groups within the Glenrothes area;
- the lack of a local facility that acts as a focal point; and
- a view (expressed by some service providers) that service user groups have been poorly supported and resourced by commissioners and that their contribution has not always been valued.

Nonetheless, the interviews and focus groups did provide useful information for the study.

## **Expectation of services**

The term 'services' will be widely used as it was clear that some service users valued peer support organisations and less formally delivered services more than those on offer from statutory provision. The reasons for this were, on occasion, complex. But there may be opportunities for those delivering statutory and other services that might be described as 'mainstream' to learn from the activities of some peer support or informal organisations.

Although each individual had their own expectations of services a number of core expectations emerged:

- That treatment and support services should help individuals address long term causes of mental health problems, not just short term symptoms and episodes;
- that service users should be offered understanding and respect and not be judged;
- that services provide emotional and practical support;
- that those delivering services should have appropriate training, knowledge and skills;
- that services should be accessible, delivered fairly and in a manner that avoids stigma; and
- that providers were aware of other relevant services and publicised these and referred to them.

## **Addressing long term needs**

Service users placed the greatest value on services that helped them to understand the underlying causes of their mental health problems, to come to terms with these and in some cases to change their patterns of thinking.

A number had positive experience of either counselling or listening based peer support. They emphasised the value of the individual feeling fully engaged in their treatment, rather than being a passive recipient.

For these service users, medication – primarily anti depressants – appeared to be seen in addition to other, more valuable, interventions.

“The counselling is the major thing. Satisfies everything and is working for me. My episodes have reduced”.

Service user

“I have been on anti-depressants all my life...but these masked my emotions and I neither moved forward nor back. Whereas attending the group (Peer Support) I have moved forward leaps and bounds. (I have put the past behind me and ...) I now know who I am and what my values are”.

Service user

The general point emerging from these comments and others made by other service users in the focus groups was that they wanted assistance to take the long view on their condition, its causes and treatment and to understand the options available to them.

### **Understanding, empathetic, respectful and non judgemental service**

Respondents emphasised how important it was to service users that individuals delivering services offered understanding, empathy, and respect and did so in a non-judgemental manner.

For many, the extent to which they valued the service they had received (and indeed their very willingness to use a particular service) was heavily influenced by the approach and attitudes of those delivering the service and the quality of relationships they built with service users. Positive attitudes and behaviours were valued, including those from self help groups:

“My CPN is good to talk to. They listen and are sensitive to my needs. They return my phone calls”.

Service user

“Listening is so important for helping people to open up. Telling people what to do is the worst”.

Service user

There were examples of negative attitudes and behaviours:

“One of my GPs laughed at me”

Service user

“I disagreed with one of the nurses at Whyteman’s Brae, so they withdrew the service”

Service user

“I didn’t like the attitude of two (out of 4) of my GPs. (...The other two were much better)”.

Service user

“My views wouldn’t be respected by my GP, but would be by others”.

Service user

### **Emotional and practical support**

Some service users referred to “positive emotional support” offered by service providers, such as CPNs. Professional practical support was also valued for example in securing appropriate benefits or being able to assist some people who had mobility problems. However, discussion of emotional support was most common in relation to the value of peer support - from others who shared similar experiences. This offers an endorsement of the potential of thriving community based self help groups.

“I would be totally lost without this (peer support) group. You are accepted, made welcome, and feel safe”.

Service user

“The Drop In has helped keep me out of hospital.”

Service user

### **Appropriate training, knowledge and skills**

It was clear that staff or volunteers should be expected to have appropriate training, knowledge and skills. To illustrate this, there were both positive and negative comments about GPs. Their training and professional competence was not questioned. But inter-personal skills had been an issue:

“I don’t discuss my Mental Health with my GP. I think it embarrasses him. I just wouldn’t go there.”

Service user

Some participants noted that while they valued the efforts of volunteers they did not always have the training and skills to deal effectively and appropriately with group members:

“Some people in groups can be over-powering and judgemental. A lack of paid staff means that untrained volunteers have to deal with this and they may not have the skills to do so and can be vulnerable because of their own ill health”.

Service user

### **Accessible, non stigmatised and fairly delivered services**

The accessibility of services was a major issue for some of the service user participants. Particular issues referred to were travelling to out of area services, waiting lists, catchment areas and turnover of staff undermining continuity.

Travel to out of area services, such as day services at Whyteman’s Brae, was commonly described as inconvenient, time consuming and expensive for those on low income. Additionally two service users felt unable to travel on public transport alone, because of feelings of paranoia. Unless accompanied by others, they were unable to access services that involved any unassisted travel.

However, another remarked positively that travelling by public transport gave a sense of independence.

“I like catching the bus out of town, it makes me get up and go somewhere and be more independent”.

Service user

One participant considered that the current geographic arrangement of services resulted in a “postcode lottery” and there were other issues with psychiatry services in her locality. As a resident of Glenrothes North their inpatient hospital was Stratheden, whereas for others in Glenrothes it was Rothes Ward at Whyteman’s Brae.

Participants felt uneasy being in a ward with people who lived locally and who they might “*stand next to at the bus stop*”. Furthermore their care had been disrupted by not having a settled psychiatrist – “*I get a different locum every six or seven weeks*”.

### **Stigma**

Some commented on the stigma associated with being a user of mental health services. For many the increased delivery of psychiatric and psychological services through GP surgeries was considered positive. Several made positive remarks in respect of services received from the two Nurse Practitioners based in surgeries.

But one person did not want to access mental health services through their surgery. This may be because they did not feel able to discuss their mental health with their GP.

One service user felt that mental health services were not properly understood or valued by others in the NHS. They illustrated this by describing a slow response to ensuring they had appropriate medication available to them whilst an inpatient of a general ward.

### **Knowledgeable and proactive in respect of complimentary services / self help groups**

Several participants said they wanted services to provide them with more information and guidance on what was available and to be more active in recommending or referring to complimentary services. Some felt that key staff, such as GPs, were not always knowledgeable of, or up-to-date with, the services that were available in their area. For example, a long term user of services said:

“Nothing was said (about other services) or given (re contact details etc)”

Service user

Another said:

“The first I heard about these other services was from you. I would have gone along to them if I’d known they were available”<sup>25</sup>

Service user

<sup>25</sup> Referring to service contact details provided to all participants in the interviews / focus groups.

### **Service users awareness of services**

Many service users complained of a lack of knowledge of what services were available and how they had only found out about relevant groups and services by chance. Word of mouth appeared to have played an important role in awareness and take up of local groups and services.

“Nobody signposted me at all. I didn’t receive any local contact details and the only adverts you see are for ‘See Me’. This is a lonely illness and I don’t know where to look.”

Service user

The facilitator had information containing contact details for a range of services available in Glenrothes. These were distributed at the focus group discussions to participants. This resulted in a number of participants indicating their lack of awareness of services relevant to them.

A number of those involved with self help or peer support groups observed that a lack of promotion of, and awareness of, services such as the ones they were using could have a negative impact on viability.

“Services don’t always pass information on (about our group)... (that means) not enough people are going to make the group work.”

Service user

### **Service users views on the quality of services**

Views on the quality of services varied and were often strongly affected by personal experience. The three service users interviewed were asked to rank Mental Health Services in Glenrothes on a five point scale from ‘very good’ to ‘very poor’ – one described them as ‘good’, one as ‘very poor’ and one had no clear view.

The rating exercise was not attempted with the focus group participants. However, the comments suggest that service users tend to equate the quality of the services with the extent to which they delivered on their core expectations. In particular when reflecting on what was good about services, comments were almost always focussed on:

- **how** services were delivered **by individuals**; and
- **who** delivered the service?

How the service was delivered seemed at least as important as the type of service being delivered.

### **Barriers to accessing mental health services**

Service users identified a number of barriers to using mental health services in Glenrothes.

#### **Access issues**

The need to travel to services was an issue for some with cost, time, inconvenience and exacerbation of paranoia and anxiety all being mentioned. The travel issue was most commonly mentioned about services outwith Glenrothes. However, two services users needed to take two buses across Glenrothes to access some services and for them this was a barrier.

Some participants observed that opening times of services could be a barrier – specifically lack of evening services for those who were working or who were otherwise unable to attend during the day.

#### **Location of services**

Certain locations were also a barrier. Most people thought that delivering mental health services through GP surgeries was positive - but one disagreed and said they would not use such services. Again, whilst some favoured increased use of Glenrothes Day Hospital for delivering localised services, a smaller number were unsure if this was appropriate or not.

#### **Waiting lists**

Waiting Lists were seen as a barrier, with the waiting list for psychology services being most commonly mentioned. One service user had been put off pursuing Cognitive Behavioural therapy by the long waiting list. Another had not been referred to psychology because of the waiting list.

### Personal reasons for not accessing services

A number of personal reasons for not accessing services were mentioned - and there were important themes running through comments made.

For example, a significant number of participants had looked elsewhere for help, **beyond 'medical' services**, such as delivered by their GP, because they felt their needs were not being met. For some, seeking alternatives was also linked to past negative experiences.

“For a long time I didn't seek medical assistance (in spite of past in patient care and a regular pattern of depressive episodes). I had a fear of medical services and there was a strong culture in our family that you didn't go to the Doctor. (Later) Counselling made me willing to consider other things”.

Service user

Once again, the importance of the **manner** in which key Practitioners engage with those with mental health problems was evident.

“The GP at my last practice was good. But haven't found one at my new practice with whom I can have the same relationship”.

Service user

Issues of **self esteem** were also an important factor for some, affecting the choices they made about what, if any, treatment they participated in:

“My GP was keen that I take anti –depressants but I refused to accept it was a mental health problem (had experienced physical pain). I felt I was letting myself down if I acknowledged mental health problems”.

Service user

One person identified that the service they were offered was not willing to accept her perspective.

“One of the barriers is that I’m not compliant. The nurse wanted me to forget the past. From day one I was told that I should do what normal people do. When I pushed for an alternative nurse the service discharged me”.

Service user

## Equalities issues

The primary equalities issues that emerged related to:

- access to services for those on low income that had to travel;
- inability to access services for those who had to be accompanied when travelling;
- general issues of stigma of those affected by mental health problems; and
- general health services not taking appropriate account of the needs of those with mental health problems.

There were no participants from ethnic minorities, men or younger age groups.

## Treatment preferences

Participants were commonly receiving a number of different forms of treatment: medication, emotional support to tackle stress, counselling, and CBT. It was not possible to draw firm conclusion about treatment preferences.

However, the range of treatments being accepted by individuals confirmed that most were willing to engage with a number of methods and could differentiate between them in respect of their purpose and efficacy.

## Areas for improvement

Participants identified a number of areas for improvement.

## Service improvements

Many participants felt there was a need to address the stigma of those affected by mental health problems. For example;

- how other people responded to them as mental health service users;
- how well services were resourced and located; and
- the type of image they had (for example, institutionalised or informal).

Several felt there was a need for a 'resource centre' or similar in Glenrothes that could act as a focal point for those affected by mental health problems. Comparisons were drawn with Cupar having 'The Cottage' and Kirkcaldy the 'Contact Point'. It was felt that having such a resource centre would stimulate self help activity and make it more viable, leading to the potential for stronger groups and the possible development of evening and weekend activities.

There were also suggestions to improve the availability of some services, particularly group work through evening sessions.

Some felt that there should be more support to the families of those affected by mental health issues. One participant felt that there should be more referral to those peer support groups that placed an emphasis on listening in a non judgemental manner – *"what's needed is inside of them."* Another felt that services should do more about 'looking to the future' with them and challenging them to move forward.

### **Increased awareness**

There was wide agreement that raising awareness of existing services should be a priority.

### **Engagement in the wider community**

Some participants felt that more could be done to help them engage in mainstream activities and be better integrated into the wider community. They wanted help to get learning and volunteering opportunities and greater opportunities for social contact.

## **6.2 The Views of Carers**

Three carers participated in one to one interviews. All had been longstanding carers of people with enduring conditions. One of them was a carer to two adults, each with differing but challenging mental health conditions.

It was clear from the interviews that the job of being a carer had been extremely demanding for all participants. All had made significant sacrifices to fulfil their role as carers and in some cases this had been at high personal cost in terms of a different life they might otherwise have had. The key issues raised, were isolation, stress and lack of information.

## Isolation

All participants had experienced isolation as a direct result of being a carer. One suggested that their role was undervalued - as a single parent this carer had been unable to pursue work and a career because of the heavy burden of caring. Amongst other things this had narrowed their social horizons.

One commented that being the primary carer had created tensions in relationships with other family members. It could be difficult managing a caring relationship whilst also looking after others.

“(Those not directly involved) just don’t see it, (they get) bored. I don’t have the option of distancing myself.”

Carer

A participant described how different their situation was when the person they cared for was growing up. One participant knew their son had difficulties, but stated that it took a ‘long time’ for him to be assessed and once this occurred, there were no additional services available to them. This participant commented that there were fewer services available when her son was younger.

## Lack of information and knowledge

A lack of information, knowledge and, for some, confidence undermined their ability to negotiate with professional staff:

“Until they were diagnosed it was a very difficult time. It’s the scariest thing when the medical profession say they’re much better and you’re not convinced”.

Carer

“I never knew what to expect. I didn’t get any help in the 70s – 90s, but I didn’t know what the issues were. ”

Carer

Two carers stated they had spent long periods concerned that something significant was wrong but were unable get answers from professionals. They felt that if the professionals been more responsive there would have been earlier and more effective intervention. This would have led to an improvement in the quality of life of their dependents. One participant said;

“Some professionals don’t want to give you a diagnosis – they think they’re doing you a favour. But his symptoms were obvious.”

Carer

One participant commented that they now had a better understanding of their dependent’s condition and as they had been a carer for some time, now felt more confident at negotiating with services and individual staff.

### **Stress and worry**

All three carers reported they suffered from stress and worry as a consequence of being a carer. For example, there were worries about what would happen in the future, especially when they were no longer able to care for their dependent.

“I was keen to get things settled. As you get older you wonder what’s going to happen to them.”

Carer

“I don’t plan, because I’ve been given a huge streak of pessimism. This has had a depressive effect. I can’t expect the grandchildren to fulfil my role”.

Carer

There was also the stress of managing inter-personal relations – with those cared for and also other members of the family.

“If my daughter could put more on to me, she would.”

Carer

“They were bullied. This worried me”.

Carer

### **Low income**

Another key issue for carers was the significant financial impact of being a carer.

“I’m really poor...I get £53 per week Carers Allowance. I would have had a job if I wasn’t a carer. I don’t own anything and have no savings”.

Carer

### **Variability in personnel and services**

All three carers had experienced difficulties with particular professional staff.

“Social Work involvement was very patchy. Very much an issue of who you got. The psychiatrists have been variable too”.

Carer

“A doctor who didn’t know my daughter was too upbeat in her assessment of her current health. But I challenged this and ultimately the outcome was successful”.

Carer

However, each also had very positive comments about services received from other professional services.

### **Support received as carers**

All three had received support from Fife Families Support Project and were very positive about this service, while one had also been in contact with Fife Carers Centre and praised this for its availability and for the focus being on the carer.

“The social worker (from FFSP) never let me down. Always came once a month and helped as much as they could.”

Carer

“It was good knowing someone was there at the end of the phone, or that someone would visit. (It was important) knowing that the service was for **me**, that it’s separate.”

Carer

### **Views on current services**

Two of the participants indicated their satisfaction with the service their dependents' received, while the third carer had had a less satisfactory experience.

One described how the supported accommodation their son was living in was a major improvement from previous arrangements:

"(Compared to previous arrangements) it's a hundred times better - I can't believe it's true. The Support Workers are super; I can't fault them at all. I can see an improvement, they're so much happier; they get involved in things and are encouraged to go out and about."

Carer

While other positive comments included:

"They have been well supported by the Team. There is a positive sense that recovery is part of the agenda. The Team has also helped unlock other services. And they do 'the difficult stuff' (reference to negotiating with dependent) – taking this away from the family has been valuable."

Carer

However, one carer did not have such positive comments on their experience.

"It's been very mixed. Some (people and services) have been very good but others a disappointment. Budget cuts mean there's been a lack of staff. Psychiatric care has been withdrawn and not replaced."

Carer

### **Carer involvement with Care Planning**

The two participants with the longest experience as carers reported considerable difficulty getting information from, or engaging with, professional staff in previous times. For one there had been significant improvements, but for the other there were still regular struggles to get the services they felt were needed. Comments included:

"I get invited to the Care Planning meeting. I listen and am quite happy."

Carer

“When I’ve approached them with concerns they have listened and taken action. Support has been upped when needed.”

Carer

### Areas for improvement

There was a reasonable level of satisfaction with the services that were currently received. But suggestions did include reducing the length of time before seeing a consultant; staffing issues; and that more should be done to address the stigma surrounding mental health.

“Speed up the contact with consultants – you have to wait too long.”

Carer

“The media’s portrayal of schizophrenia is unfair – it’s an illness”.

Carer

“(Address) the lack of staff. I think there should be at least one mental health professional involved – I’m not a professional.”

Carer

### 6.3 Summary of key points from service users and carers consultations

- Service users and carers expected services to address long term causes of mental health problems, not just provide short term solutions. Services were also expected to offer understanding, practical and emotional support and also the ability to refer proactively to other relevant services.
- Many service users complained of a lack of awareness of what services were available. Many said that they had only found out about relevant groups and services by chance. Word of mouth appeared to have played an important role in awareness and take up of local groups and services.
- Views on the quality of services varied and were often strongly affected by personal experience. Service users rated Mental Health Services in Glenrothes between ‘good’ and ‘very poor’.

- Service users identified that accessibility and location of services can be a barrier, as can the waiting list and personal experience of the service – often a negative first impression leads to service users not continuing their care.
- Carers were affected by a number of issues such as isolation, stress and financial implications such as a very low income. Services such as the Fife Family Support Project and the Fife Carers Centre were praised for offering help and support.

## 7. Key Themes

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The key themes from this research are outlined below.

### 7.1 Prevalence of conditions in Glenrothes

- The number of people affected by neurotic disorders in the study area is likely to be high - but services are likely to be in touch with only a small proportion of them at any one time.
- The number of adults with currently active psychotic conditions is likely to be lower and they are more likely to be known to services and to be receiving treatment than those with neurotic disorders. However, this may mask important differences between sub groups, for example those with dual diagnosis.
- In respect of certain conditions, the rates of inpatient care for residents of Glenrothes are significantly above those for Fife as a whole. There may be a variety of reasons for this including higher levels of illness, fewer options for care in the community or more active local services appropriately identifying and admitting the chronically unwell.
- The most common mental health conditions being treated by respondents of the e-survey were depression and anxiety.

### 7.2 Availability of services

- Just under a third (31%) of service providers felt that the availability of mental health services was adequate; while a further third (31%) said that availability was poor. Only one in five (19%) stated the availability of services was good.<sup>26</sup>
- A lack of day care provision was identified as a particular weakness of the current service provision.

### 7.3 Capacity issues

- Capacity issues were identified in psychology and in services dealing with patients at the “crisis” stage of their care – the Fife Intensive Outreach

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<sup>26</sup> Based on 16 responses.

Team was mentioned as one specific service which tended to take on more service users, but rarely discharge anyone.

- The service providers felt that they were currently operating at capacity and those who said they were not currently working to capacity stated this was because of staff shortages and vacancies.
- Patients with co-morbidity issues (substance misuse problems as well as mental health problems) were identified as a group who were not currently well served by service provision.
- Service providers also identified that more could be done to work with older people, those with personality disorders and those with “mild to moderate” mental health problems.

#### **7.4 Awareness of services**

- Service providers felt that awareness of services among the general public was poor, and that those newly diagnosed would not know where to go for help. This was compounded by a lack of awareness among GPs – who it was felt (by other service providers, service users and carers) often referred patients inappropriately.
- The service users recognised their lack of knowledge of what services were available and commented they had only found out about relevant groups and services by chance. Word of mouth appeared to have played an important role in awareness and take up of local groups and services.

#### **7.5 Expectations of services**

- Service users wanted services to address long term causes of mental health problems, not just provide short term solutions. It was also expected that services should offer understanding, practical and emotional support and the ability to refer proactively to other relevant services.

#### **7.6 Communication with service users**

- Service providers did have channels in place to communicate with service users – but it was acknowledged that often services rely on a small group of ‘keen’ representatives, rather than trying to encourage response from a wider group.

### 7.7 Impact on carers

- Carers were affected by a number of issues such as isolation, stress and financial implications such as a very low income. They valued services specific to their needs as carers.

### 7.8 Quality of service

- When asked to self-assess the quality of their own service; 18% of service providers commented that they provide a high quality service (and a further 18% stated their service was *very high quality*). The majority (59%) said the service they provide was satisfactory.<sup>27</sup>
- Service users' views on the quality of services varied and were often strongly affected by their personal experience. Service users rated mental health services in Glenrothes between 'good' and 'very poor'.

### 7.9 Barriers to accessing services

- Service providers perceived the location of the service to be a barrier for some service users. There was a view that the public expect services to be "on their doorstep" and this was compounded by the poor public transport links in the area. Stigma was also mentioned as a barrier to accessing services.
- Service users agreed that accessibility and location of services could be a barrier, as could waiting lists and personal experience of the service – often a negative first impression leads to service users not continuing their care.

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<sup>27</sup> Based on 17 responses.

## 8. Conclusions and Recommendations

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### Introduction

Fife generally has a relatively low level of resources for mental health when deprivation is taken into account. It also has a particularly high proportion of its budget on inpatient care – and less on community psychiatric teams.

Glenrothes is more deprived than some parts of Fife, but not the most deprived. However, rates of inpatient care from the area appear to be higher than might otherwise be expected. This may reflect a lack of alternative services in the community to prevent admission. The high level of inpatients would imply a need for above average services in the community, to care for inpatients with high level needs on their discharge.

### Increased focus on community based services

The current resourcing of mental health services and the heavy emphasis on in patient services makes changing to more community based services difficult. The pace and scale of resource transfer will affect what services can be developed in Glenrothes in the short to medium term. More generally there may be a need for NHS Fife to look at the proportion of its budget spent on mental health services if it is to achieve wider goals in health improvement. Mental health issues may well be holding back improvements in physical health – such as motivation to exercise, reduce drinking or smoking.

The likelihood is that services will, relatively speaking, be far more engaged with those with psychotic conditions than with the far larger numbers who suffer from neurotic disorders and personality disorders. To meet the needs of those with neurotic and personality disorders is likely to require a significant change in how services are delivered and a reallocation of resources away from inpatient services and towards broader community services focussing on the well being of the population as a whole.

GPs generally were not engaged fully in mental health issues (when compared to physical health) – although the development of Nurse Practitioners within general practices is seen as a very useful development. This was particularly effective when

the Nurse Practitioner operates in one practice – rather than being spread across a number of practices.

#### **Recommendation 1**

The local delivery of day care services, group work and other outpatient services should be increased as resources allow. This could also be assisted by better use of the Glenrothes Day Hospital and other community resources.

#### **Recommendation 2**

A Glenrothes based resource centre (similar to those in Cupar and Kirkcaldy) should be developed to provide a focal point for service users and carers groups. It could be possible for this type of centre to be shared with other relevant services, such as employability services and advocacy.

#### **Recommendation 3**

Improve the primary care response for mild to moderate mental health conditions (like anxiety and depression) by enhancing the Nurse Practitioners' Service. This can help reduce some of the burden on GPs; make sure that there is a mental health resource available through GPs' surgeries; and, potentially, reduce the number of referrals to more specialist services.

#### **Recommendation 4**

As more community based services are provided, monitor the levels of referral to specialist services (particularly Psychology) to assess what adjustments are needed to meet any changes in demand.

#### **Other service improvements**

The telephone interviews and on line survey of service users identified a number of potential areas for service improvement. These included:

- developing new services;

- enlarging the capacity of some existing services;
- addressing the needs of groups that were less likely to be well engaged with services (such as those with dual diagnosis); and
- strengthening user involvement and the role of the voluntary sector provision:  
and
- improving strategic planning and joint working.

#### **Recommendation 5**

Review the current methods and resourcing of user involvement to broaden the opportunity for service users to influence services.

#### **Recommendation 6**

Review the current arrangements for strategic planning and joint working with the aim of engaging all relevant organisations more effectively and review the processes for identifying outcomes and the activities and resources required to deliver these.

#### **Awareness of services**

There was clear evidence of a lack of awareness of the range of services available amongst service users. In addition, there appeared to be a lack of an overall awareness of all available services amongst some of the providers – with GPs mentioned in this respect.

#### **Recommendation 7**

The LMPHF should agree the key messages and target audiences for an awareness raising strategy. It should identify the resources and methods which should be used to deliver the strategy. This is likely to include contact details and a 'pen picture' of each mental health service that is available to people in Glenrothes – together with guidance on who the service would suit. This should be produced in a format that is easy to update – perhaps online, with simply produced paper copies. And a specific person or organisation should have the responsibility for keeping the information up to date and reviewing the impact of the strategy.

### **Access to services**

Individual service users could be very positive about the services received from individual practitioners. But they identified broader concerns about issues such as access to services (like travel and waiting lists); stigma; provider and public awareness of what was available locally and the lack of a focal point for self help groups. Carers had experienced isolation, stress and worry. They valued support that was targeted solely on them. Having sufficient, information, knowledge and confidence to negotiate with professional staff had been an issue.

#### **Recommendation 8**

In developing strategic planning and joint working, care should be taken to make sure that services are as accessible as reasonably possible for the service users and carers of Glenrothes. This should cover all aspects of access – not only geographical location.

#### **Recommendation 9**

The policies and practices for engaging those with dual diagnosis should be reviewed, in the light of the access issues that have been identified.

### **Structure of LMHT**

A number of service providers felt that the structure and management of the Locality Mental Health Team could be improved. This could, in turn, improve the awareness and integration of mental health services.

#### **Recommendation 9**

The management and delivery arrangements for the Locality Mental Health Team should be reviewed, with a view to ensuring its caseload and services are more coherently delivered across disciplines. Consideration should be given to having a consultant led service.

**Recommendation 10**

Alternative premises for the Locality Mental Health Team should be identified.

**Next steps**

It is important that the findings of this research and its recommendations are fully considered and an action plan prepared which takes account of the resources available.

**Recommendation 11**

The Local Mental Health Partnership Forum should discuss and agree which of the service gaps identified by this research should be prioritised for the local area in the short to medium term and to advocate for these improvements to NHS Fife Mental Health Strategic Improvements Group.

**Recommendation 12**

The Local Mental Health Partnership Forum should consider how best to engage with GP surgeries to develop a shared understanding of aims and objectives and how these can be achieved. If regular attendance at the Forum by GPs cannot be secured, alternative engagement methods may be required.

## Appendices

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- Appendix 1 E-survey
- Appendix 2 Telephone interview discussion guide
- Appendix 3 Focus groups with service users and carers discussion guide

**Appendix 1**  
**E-survey**

## Introduction

Glenrothes and North East Fife Community Health Partnership have commissioned ODS Consulting to conduct a Mental Health Needs Assessment of the Glenrothes area. The aim is to identify with service users, carers and other stakeholders how local mental health provision can be strengthened. We greatly value your opinion as a local stakeholder and would ask you to answer this online survey; depending on your role this should take no more than 10 - 15 minutes.

If you are unable to answer some questions click NEXT at the bottom of the page, proceeding through to the end.

You will NOT be asked to pass on any confidential medical information. The local research ethics office have confirmed this survey does not require ethical review.

Please complete the survey by 29th May 2009

### CONFIDENTIALITY

All returns are confidential and, unless you volunteer for a telephone interview, will also be anonymous.

Navigate by using the NEXT and PREV buttons at the bottom of each page. On some pages, you may require to scroll down to see these. Questions with an asterisk require an answer to progress.

When asked to state proportions etc, enter numbers only. Do not add % signs etc.

For the purpose of this survey Glenrothes includes Markinch and Leslie

### What sector does your service operate in

Statutory (including GPs)

Voluntary

Private

### \* Which of the following best describes your role in respect of mental health service provision?

Locality Mental Health Team Member

Other specialist provider of mental health services

GP

Other relevant support provider (e.g. social care, housing etc)

Other specialist NHS Mental Health or related practitioner

Other

Other (please specify)

## Other NHS staff

### What is your specialist area?

Psychiatry

Occupational Therapy

Psychology

Other

Other (please specify)

## Other specialist providers

## Please tick the PRIMARY functions of your service

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Day care services                      | <input type="checkbox"/> Carer support | <input type="checkbox"/> Leisure and recreation |
| <input type="checkbox"/> Visiting Social Care / Housing Support | <input type="checkbox"/> Self Help     | <input type="checkbox"/> Befriending            |
| <input type="checkbox"/> Employment and training services       | <input type="checkbox"/> Advocacy      |   |

## Other relevant providers

### Which of the following best describes the primary function of your service?

- |  |   |
|--|---|
| <input type="checkbox"/> Children and Families Social Work | <input type="checkbox"/> Carer support services               |
| <input type="checkbox"/> Older Persons Social Work         | <input type="checkbox"/> Addiction services                   |
| <input type="checkbox"/> Criminal Justice                  | <input type="checkbox"/> Housing or Homeless Persons Services |
| <input type="checkbox"/> Other Social Care                 | <input type="checkbox"/> Other                                |

Other (please specify)

## Other providers

Please describe your role

## Capacity of your service

This section gathers information about the mental health needs of people using your service

If you can, please give a figure for the capacity of your service, i.e the maximum caseload / number of clients the service can sustain when fully staffed. EXCLUDE THOSE WHO ARE ON A WAITING LIST.

Enter a number here

If you can, please estimate what proportion of service users are drawn from the Glenrothes area?

%

Would you say the service of which you are part is currently running at capacity?

- Yes  No  Don't know

## Not operating at capacity

Please describe why your service is not operating to capacity. For example its a new service, or posts are vacant etc.

## Prevalence by condition

This section gathers important detailed information about client needs. Please give answers where you can, but if you are unable to answer proceed to the bottom of the page and click NEXT.

IF YOU CAN Please estimate the percentage of those enrolled with your service who experience the following mental health related problems (include those who are not being supported / treated for this condition by your service). If none, enter 0 where applicable

IF YOU FEEL YOU CANNOT ANSWER THESE QUESTIONS, SKIP BY CLICKING NEXT AT THE BOTTOM

% of service users estimated as experiencing an episode of Depression in the last week

% of service users estimated as experiencing an episode of Anxiety or other neurotic disorder (inc phobias etc) in the past week

% That experience Dementia

% That experience Alcohol dependency

% That experience Drug dependency

% That have a Personality Disorder

% That experienced an episode of a Psychotic disorder (schizophrenia, bi-polar disorder etc) in the past year

## Mental Health and your service

\* TO ROUTE YOU APPROPRIATELY THROUGH THE SURVEY PLEASE ANSWER THE FOLLOWING QUESTION. Not all those being surveyed are service providers.

Does your service provide treatment or support to people with mental health problems?

Yes

No

## Service location and delivery

Please choose the most relevant description

The service I am part of delivering is primarily community based

The service I am part of delivering is equally split between the community and In Patients

The service I am part of delivering is primarily Hospital / In Patient based

Other

Other - please describe

## Assessment process

## Please choose a statement that best describes how you assess the mental health needs of clients

This service conducts its own in depth mental health assessment on ALL service users

This service undertakes a mental health assessment of service users, but only as and when concerns are identified

This service does not undertake any mental health assessments, but we may receive such assessments from other appropriate services (e.g. through internal NHS referral etc)

No mental health assessments are conducted by this service and this function is not undertaken on our behalf by others

Comments

## Unmet needs

This section seeks to identify levels of unmet needs IN RESPECT OF YOUR SERVICE.

Please give estimates where you can, but if you are unable to answer some or all proceed to the bottom of the page and click NEXT.

Please estimate the proportion of clients of your service who experience DEPRESSION but are NOT, for whatever reason, being treated / supported for this problem by your service

%

Please estimate the proportion of clients of your service who experience ANXIETY OR OTHER NEUROTIC DISORDERS but are NOT, for whatever reason, being treated / supported for this problem by your service

%

Please estimate the proportion of clients of your service who experience DEMENTIA but are NOT, for whatever reason, being treated / supported for this problem by your service

%

Please estimate the proportion of clients of your service who experience ALCOHOL DEPENDENCY but are NOT, for whatever reason, being treated / supported for this problem by your service

%

Please estimate the proportion of clients of your service who experience DRUG DEPENDENCY but are NOT, for whatever reason, being treated / supported for this problem by your service

%

Please estimate the proportion of clients of your service who experience PERSONALITY DISORDER but are NOT, for whatever reason, being treated / supported for this problem by your service

%

Please estimate the proportion of clients of your service who experience PSYCHOTIC DISORDERS but are NOT, for whatever reason, being treated / supported for this problem by your service

%

## Barriers to meeting needs

There can be many reasons why needs are not met.

Please rank the primary reasons (up to 4) why some service users with mental health problems are NOT being assisted by your service

	Primary reason	2nd reason	3rd reason	4th reason
Mental Health is not the remit of our service	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Enduring lack of capacity within the service	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Temporary lack of capacity within the service	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Lack of appropriate expertise	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Service users has not sought / does not want assistance	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Service user has not followed treatment / support plan (lack of insight etc)	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Mental Health problem undiagnosed	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Inability to maintain contact with services	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Other access issues	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Service user excluded for other reasons	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>
Other	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>	<input type="text" value="jñ"/>

Other (please specify)

## Waiting lists

Do you have a formal Waiting List for those whose mental health needs are not currently being met by your service?

Yes

No

## Length of Waiting List

Please choose which best describes the length of Waiting List, as a proportion of the capacity of the service

The Waiting List is less than 10% of the capacity of the service

Less than 75% of the capacity of the service

Less than 25% of the capacity of the service

Less than 100% of the capacity of the service

Less than 50% of the capacity of the service

More than 100% of the capacity of the service

## Engagement with services

Whilst there will be variations between cases and types of condition, what would be a typical FREQUENCY of treatment / support offered by your service to people with mental health problem?

Daily

Monthly

Less than yearly

2 - 3 times a week

Quarterly

Not applicable

Weekly

Six monthly

Every 2 weeks

Yearly

What would be the typical DURATION of assistance offered at an individual mental health treatment / support session

Under 10 minutes

2- 4 hours

Between 10 minutes and half an hour

Over 4 hours

1 hour

Not applicable

1 - 2 hours

Please rate the ADEQUACY of the frequency and duration of engagement that your service is able to offer to people with mental health problems

Excellent

Inadequate

More than adequate

Very inadequate

Adequate

## Referral

Please estimate the proportions of people with mental health problems who access your service by the following routes.

% Self referral

% Referral from a specialist mental health service

% GP referral

% Other agency referral

% Other

## Services offered

Please rank the primary methods (Up to 4) used by your service when assisting people with mental health problems

	Primary method	2nd method	3rd method	4th method
Medication	jn	jn	jn	jn
Counselling	jn	jn	jn	jn
Social Care support	jn	jn	jn	jn
General Health promotion	jn	jn	jn	jn
Psychological therapies (CBT etc)	jn	jn	jn	jn
Alternative / holistic therapies	jn	jn	jn	jn
Assistance to access employment and training	jn	jn	jn	jn
Assistance to access leisure activities	jn	jn	jn	jn
Self Help	jn	jn	jn	jn
Suicide prevention	jn	jn	jn	jn
Other	jn	jn	jn	jn

Other (please specify)

Please describe any other services offered that you believe have a positive impact on mental health

## Progress on 'Delivering for Mental Health'

'Delivering for Mental Health'(2006) sets out the Scottish Government's strategic vision for Mental Health Services.

### PSYCHOLOGICAL THERAPIES

As part of tackling depression, anxiety and stress one of the Commitments of 'Delivering for Mental Health' is:

'We will increase the availability of evidenced based therapies for all age groups in a range of settings and through a range of providers'

In respect of access to psychological therapies for people in Glenrothes, how would you describe overall progress towards this target since 2006 (either through your service or external providers)

Very good progress

There is less access to psychological therapies

Good progress

There is markedly less access to psychological therapies

No progress

Feel free to add any observation here

To route you to the relevant section please choose between the following.

I am a GP

I am NOT a GP

GPs only

Delivering for Mental Health makes the following commitment:

"We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient where possible and appropriate has a physical health assessment at least once every 15 months"

How would you rate progress on this commitment within your own service

Strong progress

Some progress

No progress

There has been a decline in availability of physical health assessments

There has been a marked decline in availability of physical health assessments

Add comments as necessary

A key target of 'Delivering for Mental Health' is:

'Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10'.

Please rate your own service against this target.

Significantly exceeding target

Exceeding target

On target

Behind target

Well behind target

Add comments as necessary

## Service quality

Accepting that there may be limiting factors, how would you assess the quality of your mental health services to people from the Glenrothes area?

Very high quality

High quality

Satisfactory

Poor

Very poor

Don't know

Add comments here as appropriate

## Assessment Processes - Non Mental Health Services

Although your service is not involved in the provision of mental health treatment or support, there may be times when you need to assess if a client has a mental health problem, e.g. in respect of referral to external services.

Which of the following best describes how your service arranges assessment of mental health problems amongst service users?

Mental Health is a topic in our standard internal client assessment processes

Clients are referred externally for mental health assessment, as and when required

Assessment is undertaken by this service as and when required

We do not assess clients' mental health and would not refer them for external assessment either

Comments

## Availability of relevant services

Please estimate what proportion of your service users with a mental health problem require assistance from EXTERNAL mental health services?

%

Overall, how would you describe the availability of mental health services to the people of Glenrothes

The availability of relevant services is very good

The availability of relevant services is poor

The availability of relevant services is good

The availability of relevant services is very poor

The availability of relevant services is adequate

## Barriers

Do you think there are any BARRIERS to people from the Glenrothes area accessing appropriate mental health services?

There are barriers

There are no barriers

## About the barriers

Please rank (up to 4) the primary barriers to people from Glenrothes accessing appropriate services for their mental health problems

	Most significant barrier	2nd most	3rd most	4th most
Location of services	jn	jn	jn	jn
Lack of specialist services	jn	jn	jn	jn
Lack of capacity	jn	jn	jn	jn
Unsuitable opening hours	jn	jn	jn	jn
Appointment only services	jn	jn	jn	jn
Stigma / prejudice	jn	jn	jn	jn
Lack of awareness of services	jn	jn	jn	jn
Cultural barriers (e.g. gender / ethnicity of staff)	jn	jn	jn	jn
Referral processes	jn	jn	jn	jn
'Zero tolerance' policies	jn	jn	jn	jn
Don't know	jn	jn	jn	jn
Other	jn	jn	jn	jn
Other (please specify)	<input type="text"/>			

## Training needs

Do you have any additional training needs to fulfil the mental health role required by your service

Yes

Don't know

No

Not applicable

## Your training needs continued

Please describe any training needs you have in respect of mental health

## Good practice

Please describe any examples of good practice from your service in respect of mental health

## Service improvement

Does your service have any plans to improve mental health services to the people of Glenrothes?

Yes

No

Don't know

## Planned service improvements

Please describe planned service improvements

### Other improvements to your service

Please describe any other improvements that COULD be made to YOUR service for people with mental health problems in Glenrothes

### Service improvements by others

Please describe any service improvements / new services you think EXTERNAL providers should PRIORITISE for the people of Glenrothes

### Any other comments

Use this section to make any other, final, comments

### Participating in telephone interviews

As part of our research we will be undertaking some telephone interviews with service providers. If you would be willing to participate in a telephone interview, lasting approximately 30 minutes, please give your contact details below and we may contact you.

Please give your name, job title, organisation, tel number and email address below

## Appendix 2

# Telephone and Interview Discussion Guide

### Mental Health Needs Assessment in the Glenrothes Area

#### Glenrothes and North East Fife CHP

#### Telephone interviews with NHS and voluntary sector service providers

<b>Introduction and warm up</b>
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- Introduce interviewer and ODS Consulting
- Explain the purpose of the research and how views will be used
- Explain that:
  - ODS will not attribute comments to individuals
  - Your comments will remain anonymous

Ask respondent to give job title – what does your day to day role entail?

<b>Services in the wider area</b>
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What do you think are the strengths of the current provision of mental health services to people in Glenrothes?

What do you think are the weaknesses of current provision of mental health services to people in Glenrothes?

Are there any capacity issues for existing services?

Are there any client groups with mental health problems that are not well served by current arrangements?

Are there any accessibility issues with the delivery of current services to people in Glenrothes – e.g. Fife wide services, opening hours etc

- Are there any gaps in service provision? What are these?
- What, if any, barriers exist to accessing mental health services in Glenrothes? What can be done to overcome these barriers?
- Are there any services you think are particularly good?  
Which ones and why?

<b>Strategic planning</b>
---------------------------

- How would you describe strategic planning arrangements for mental health services in Glenrothes and, more widely, Fife?
- Are aims / objectives for service delivery and development clear? If not, why not
- Are you involved in joint working in service planning and delivery? How would you describe this? (probe for effectiveness, quality of working relationships, organisational tension etc)
- Are current arrangements capable of responding appropriately to local needs (Glenrothes)? What issues arise?

“Delivering for Mental Health” was a paper put together by the Scottish Government. In this paper, the Government set targets and commitments for improving patient and carer experiences of mental health services

- What progress do you think your organisation/service has made towards meeting these commitments?
- In what sense – can you give me an example?

### **Communicating and engaging with service users**

- How well do you think mental health services communicate with service users?
- Are there any equalities / diversity issues (in presentation of materials, language, ethnicity etc)
- Are all those that could benefit from existing services aware of them? If not, why not?
- What opportunities exist for patients to have a say in the way services are delivered? Is there a patient user group/forum/etc?
- Are the views of service users / carers appropriately respected? Can you give any examples where they have positively shaped services?
- What else could your organisation do to promote service user involvement?

Any other comments?

Thank and close

## Appendix 3

# Focus Groups with Service Users and Carers

## Discussion Guide

### Mental Health Needs Assessment in the Glenrothes Area

#### Glenrothes and North East Fife CHP Carers' Focus Group Discussion guide

#### Introduction

- Introduce moderator and ODS Consulting
- Explain the purpose of the research and how views will be used
- Explain that:
  - ODS will not attribute comments to individuals
  - Your comments will remain anonymous
  - Participation is voluntary
- Explain how views will be recorded
- Check happy to be audio-recorded
- Carer introductions – Name, how long been a carer for.

#### Warm up

- What would you say is the best thing about being a Carer? – get group to shout out positives? – write on flip chart
- What would you say is the worst thing about being a Carer? – get group to make suggestions – write all on flip chart.
- Ask group to rank the worst things – what is the biggest issue facing Carers' of patients with mental health conditions? Try to get group to come to a consensus.

#### Expectations of services

- What would the ideal service look like?
- What does it have to include?

Moderator to make 2 lists on flip chart paper – “Must-haves” and “Nice to have”  
– get group to make suggestions about mental health services.

- Are these reasonable expectations? Why do you say that?
- Should services for mental health patients differ in any way from mainstream health services? Why/Why not?

### **What do services expect from carers**

- What do services expect from Carers?
- What should they expect?

Moderator to write on flip chart paper – “what services expect” and “what they should expect”.

- Is there a difference?
- Is it a reasonable expectation?

### **Local services**

- General perceptions of local services
- Discussion of positive experiences – what made them positive?
- Discussion of negative experiences – what made them negative?

Moderator refer group back to first flipchart with list of ‘negative issues about being a carer’

- Do local services address these concerns/negative aspects?

Moderator refer group back to flipchart list of “must haves” and “nice to haves”.....

- Do local services fulfil your expectations?
- What was your initial expectation when you first used this service and has it met that expectation?
- Have any services exceeded your expectations? In what way?
- How do local services in Glenrothes and NE Fife compare to other areas? Anyone able to comment? What is your perception of how well GNEF services compare to other areas – do you think they are better, worse or average? – Why?
- Is there a gap in local services? Is there a particular service or treatment that is not available? (probe what and where it is available).
- What about waiting lists? – Have these affected you? – probe for positive and negative experiences of waiting lists.

- Are there any areas of local service delivery that you think could be improved? What are they? What should be done differently?

### **Planning and Influencing services**

Refer back to earlier discussions – has anyone mentioned engagement/consultation?

- Are there any examples of engaging with local services? How was it done? Was this effective? Why/Why not?
- Is it important to be able to engage with local services? Why/Why not? – what is the value?
- What are the ways in which Carers can engage with local services? – list on flip chart.
- On what sort of issues would you like to be able to have a say?
- Is there anything you wouldn't want to be consulted or asked about?

Any other comments?  
Thank and close.

## **Mental Health Needs Assessment in the Glenrothes Area**

### **Glenrothes and North East Fife CHP Service Users' Focus Group Discussion guide**

#### **Introduction**

- Introduce moderator and ODS Consulting
- Explain the purpose of the research and how views will be used
- Explain that:
  - ODS will not attribute comments to individuals
  - Your comments will remain anonymous
  - Participation is voluntary
- Explain how views will be recorded
- Check happy to be audio-recorded
- Carer introductions – Name, where they live, occupation, type of mental illness if wish to disclose?

#### **Warm up**

In order to get the group comfortable about speaking out in front of others, start the discussion with some easy – warm up questions.....

- What would you say is the best thing about living in Glenrothes and North East Fife? – get group to shout out positives? – write on flip chart
- What would you say is the worst thing about living in this area? – get group to make suggestions – write all on flip chart.

#### **Impact of engagement with services**

- Why do some patients who suffer from, or who are at risk of mental ill-health seek treatment at services?
- What are the benefits of seeking treatment at a service?
- What impact do you think this has on their health/attitude?
- Are there any negative aspects of seeking treatment from services? What are they?

## **Barriers**

- How did you feel before your first visit to the service? (or if not attending a service for treatment, how do you think you would feel before your first meeting?)
- If not attending a service – why not? What is stopping you?
- What barriers do you think exist for people attending mental health services? – list on flipchart. Can the group come to consensus about which are the biggest barriers (rank?)

(suggestions for discussion: location, gender and ethnicity of staff, types of treatment, opening hours, awareness of service).

- How much of a barrier is stigma to accessing services?

## **Treatment preferences**

- Would you say you were currently receiving your preferred treatment? If not, why not?
- Would anyone say they were receiving “alternative treatment”? – Thoughts on this? What does this include? Is this type of treatment as effective as traditional methods?
- What about ‘personal fitness programmes’ – how do these compare to treatment like medication or counselling?

## **Expectations of services**

- What would the ideal service dealing with mental illness look like?
- What does it have to include?

(probe equalities issues if not mentioned already, such as gender and ethnicity of staff, translation, interpretation services, format of information – Braille, other languages, etc).

- Are these reasonable expectations? Why do you say that?
- Should services for mental health patients differ in any way from mainstream health services? Why/Why not?

### **Awareness of services**

- How many people in the group are using local services?
- How did you first find out about the service?
- What do you think about the way local services are advertised? Could more be done to publicise? Explore fully.

### **Local services**

- General perceptions of local services
- Discussion of positive experiences – what made them positive? Any good practice examples?
- Discussion of negative experiences – what made them negative?

### **Planning and Influencing services**

Refer back to earlier discussions – has anyone mentioned engagement/consultation?

- Are there any examples of engaging with local services? How was it done? Was this effective? Why/Why not?
- Is it important to be able to engage with local services? Why/Why not? – what is the value?
- What are the ways in which service users' could engage with local services? – list on flip chart.
- On what sort of issues would you like to be able to have a say?
- Is there anything you wouldn't want to be consulted or asked about?

**Any other comments?**

**Thank and close.**