FIGURE 8
CONSULTANCY SERVICES LTD

2016

WEST LOTHIAN MENTAL HEALTH NEEDS ASSESSMENT

PART ONE – THE REPORT

Report prepared for West Lothian Health and Social Care Partnership

EVIDENCE INTO PRACTICE

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REPORT FORMAT

This report has been written primarily with the practice community in mind. Supplementary appendices are also available containing further data, and detail about the research methodology **(see Part 2 – Appendices Report)**. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings. **To preview this report, the researchers would recommend reading the key findings from each section followed by the final recommendations (Chapter 7 of this report).**

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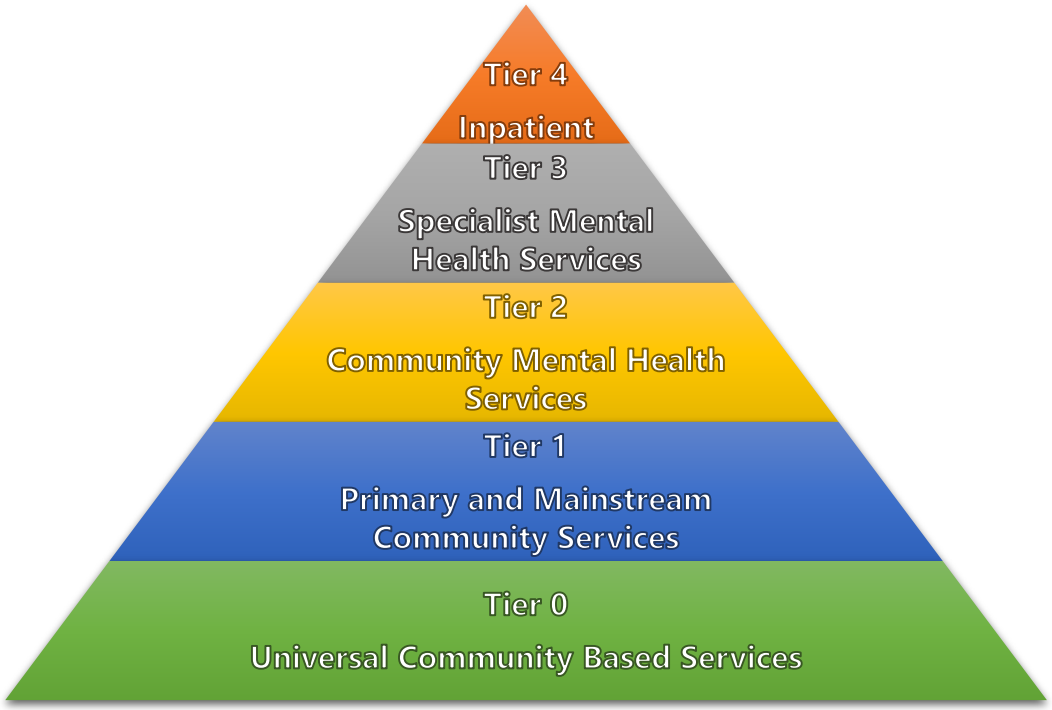
CHAPTER 1: INTRODUCTION

1.1 Introduction and background

Figure 8 Consultancy Services Ltd. was commissioned by West Lothian Health and Social Care Partnership in March 2016 to carry out a comprehensive mental health needs assessment project; and fieldwork took place between April and June 2016.

This needs assessment is a report that presents an overview and analysis of the mental health needs for adults with mental health problems (inclusive of those with early onset dementia), to mental health stakeholders across West Lothian; and will form an important and independent component to inform future mental health planning and service/support provision across Tiers 0-4:

Figure 1.1: Definition of mental health service tiers



Tier 0 Universal Community Based Services - generic services within the community to promote or improve a person's mental health and wellbeing.

Tier 1 Primary and Mainstream Community Services - comprise of GP practices as well as general medical settings and mainstream community support services available to all.

Tier 2 Community Mental Health Services - currently comprise of a range of commissioned community mental health services aimed at people living in the community.

Tier 3 Specialist Mental Health Services - currently comprise of the community mental health teams, the mental health social work team (including the mental health officer service), the community rehabilitation team and statutory day services.

Tier 4 Inpatient Services - currently include an acute psychiatric unit and mental health rehabilitation wards.

The document takes cognisance of the *Mental Health Strategy for Scotland (2012-2015)*[1] which is the successor document to *Delivering for Mental Health*[2] and *Towards a Mentally Flourishing Scotland*[3]and sets out the Scottish Government's objectives for improving mental health and treating mental illness for the period to 2015. It also takes account of the more recent *What Research Matters for Mental Health Policy in Scotland*[4] document which seeks to improve both the impact of research and the evidence base for mental health strategy in Scotland.

1.2 Defining 'mental health' and 'wellbeing'

The World Health Organisation (WHO) defines mental health as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'[5]

Alongside the WHO's definition of overall health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'; this means it is not just important to consider how to support people with mental health problems or disorders, but also how to promote and sustain good mental health in a population. This also highlights the intertwining of physical and mental wellbeing.

Aligned to WHO descriptions, the national *Mental Health Strategy*[6] identifies the importance of terminology but recognises the challenges and difficulties of clear definitions. It states: 'We use the term 'mental illness' where there is or may be a diagnosis of a particular and defined condition within a document such as *The ICD-10 Classification of Mental and Behavioural Disorders* published by the WHO; 'mental disorder' to refer to the broader category of mental illness, personality disorder or learning disability (which follows the definition in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as well as substance misuse disorders); and 'mental health problems' to refer to the more ambiguous territory which includes those with illness, but also people who may be experiencing challenges to their psychological wellbeing, but who do not have a persisting mental illness or disorder.'

For the purposes of this report we use the following terms:

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[1] Scottish Government (2012). *Mental Health Strategy for Scotland: 2012-2015*. Accessed at: http://www.scotland.gov.uk/resource/0039/00398762.pdf [20th July 2016].

[2] Scottish Executive (2006). *Delivering for Mental Health*. Accessed at: http://www.scotland.gov.uk/resource/doc/157157/0042281.pdf [20th July 2016].

[3] Scottish Government (2009). *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*. Accessed at: http://www.scotland.gov.uk/resource/doc/271822/0081031.pdf [20th July 2016].

[4] Scottish Government (2015). *What Research Matters for Mental Health Policy in Scotland.* Accessed at: http://www.gov.scot/Resource/0049/00494776.pdf [20th July 2016].

[5] http://www.who.int/features/factfiles/mental_health/en/

[6] Scottish Government (2012) op. cit.

1.2.1 Mental health problem

This is an overarching term used to refer to a wide range of diagnosable mental illnesses and disorders, including common mental health problems of low severity and long lasting severe problems.

1.2.2 Mental illness

This is generally used to describe more serious mental health problems which may require specialist services, ranging from depression and anxiety (often referred to as common mental problems) to less common problems such as schizophrenia and bipolar disorder (sometimes referred to as severe mental illness).

1.2.3 Mental Disorder

This is often used to cover a broad range of illnesses, learning disability, personality disorder and substance misuse problems. Under the 2003 Mental Health Act mental disorder was defined as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind' and was divided into a number of classifications. The 2007 Mental Health Act amended to a more general statement and removed specific classifications.

1.2.4 Wellbeing

The report examines not just mental illness or conditions, but also considers what promotes and supports mental and emotional wellbeing. The concept of 'wellbeing' has gained a wider public airing following the decision to embark on a national measurement programme developed by the Office for National Statistics (ONS), introduced in 2011. At a personal level wellbeing is "a positive physical, social and mental state" at a population, or national level, a range of indicators are being included, individual wellbeing but also the quality of the environment, equality, sustainability and the economy. Research indicates that 'wellbeing' comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity, and engagement are characteristic of someone who has a positive experience of their life. Equally important for wellbeing is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing.[7]

In a review of the evidence on how individuals can improve wellbeing, the New Economics Foundation (nef)[8] identified five actions to improve wellbeing that individuals could be encouraged to build into their lives:

[7] Huppert F (2008) *Psychological well-being: evidence regarding its causes and its consequences* (London: Foresight Mental Capital and Wellbeing Project 2008).

[8] Aked, J. and Thompson, S. (2011). *Five ways to wellbeing – new applications, new ways of thinking*. New Economics Foundation: London.

1. Connect ... With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.
2. Be active ... Go for a walk or run. Step outside, cycle, play a game, garden, or dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.
3. Take notice ... Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
4. Keep learning ... Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.
5. Give ... Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Aked et al (2009) contend that it is vital to combine consideration of the structural factors affecting the circumstances of individual's lives, together with the psychological and social aspects of their wellbeing. Only by taking this 'twin track' approach is it possible to account for the dynamic nature of wellbeing, where positive experiences ('feeling good') and outcomes ('doing well') arise through the interplay between external circumstances, inner resources, and capabilities and interactions with the surrounding world.[9]

1.3 Risks and resilience - factors impacting mental health and well being

Mental health is not just a function of an individual's characteristics or attributes, it is also affected by a wide range of social, economic and environmental factors. These have been summarised in Table 1.2 below.

- At an individual level people may be affected by biological or genetic factors or may have specific difficulties, for example communication difficulties, increasing vulnerability to mental health problems, by affecting their ability to engage, participate or understand aspects of daily living.

[9] Aked, J., Steuer, N., Lawlor, E. and Spratt, S., (2009), *Backing the Future*. See also Foresight Mental Capital and Wellbeing Project (2008), *Final Project report – Executive summary*, London: The Government Office for Science; and Thompson S, & Marks N (2008) *Measuring well-being in policy: Issues and applications,* New Economics Foundation: London.

- There are numerous socio-economic circumstances which impact mental health and wellbeing; The Marmot Review[10] highlighted the issue of employment and education; but specific events can also affect mental wellbeing including bereavement, family or relationship breakdown and exposure to violence or abuse. When considering a life course, people may be more exposed to risks at different ages; for example older people are more likely to experience bereavement of partners/friends and may become more socially isolated whereas younger adults may be more at risk of homelessness and unemployment.
- Although this needs assessment is focussed on adults, it is recognised that experience in childhood is important and resilience in adulthood may relate to the experiences and skills developed in childhood.
- At a higher level wider factors such as basic access to services, economic recession or exposure to widespread violence or insecurity also impact mental health; these factors can be considered as the prevailing environment or conditions in which people live.

Table 1.2: Risk factors and resilience

LEVEL	ADVERSE FACTORS		PROTECTIVE FACTORS
Individual attributes	Low self-esteem	⇔	Self-esteem, confidence
	Cognitive/emotional immaturity	⇔	Ability to solve problems & manage stress or adversity
	Difficulties in communicating	⇔	Communication skills
	Medical illness, substance use	⇔	Physical health, fitness
Social Circumstances	Loneliness, bereavement	⇔	Social support of family & friends
	Neglect, family conflict	⇔	Good parenting / family interaction
	Exposure to violence/abuse	⇔	Physical security and safety
	Low income and poverty	⇔	Economic security
	Difficulties or failure at school	⇔	Scholastic achievement
	Work stress, unemployment	⇔	Satisfaction and success at work
Environmental Factors	Poor access to basic services	⇔	Equality of access to basic services
	Injustice and discrimination	⇔	Social justice, tolerance, integration
	Social and gender inequalities	⇔	Social and gender equality
	Exposure to war or disaster	⇔	Physical security and safety

(Taken from Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors WHO 2012)

[10] The Marmot Review (2010). *Fair Society, Healthy Lives.* Available at: http://www.ucl.ac.uk/whitehallIII/pdf/FairSocietyHealthyLives.pdf [Accessed on 20th July 2016].

1.4 Vulnerable groups

Risks to mental health manifest themselves at all stages in life and potentially leave us all vulnerable to experiencing mental health problems. Having said this, by understanding the range of factors outlined in Table 1.2, it is possible to identify specific groups of people who have a greater risk or vulnerability to poor mental health; groups where we might expect to find greater levels of mental health need, including:

- People with long term physical illness, conditions or disabilities;
- People with substance misuse problems;
- Deprived communities, people on low incomes;
- Unemployed and people on out of work illness and disability benefits;
- People with poor education outcomes, no qualifications and low skill;
- Military veterans and people affected by conflict and war;
- People affected by violence and/or abuse, including domestic violence;
- Homeless people and people at risk of homelessness;
- Offenders, young offenders, prisoners and detainees;
- People who have suffered bereavement, and/or family breakdown including "care leavers";
- People who are socially excluded;
- People who experience barriers to accessing services and support; and
- People from black and minority ethnic groups.

Of course the relationship is complex, and risk factors may work both ways; so that people who are homeless may be at greater risk of poor mental health, and people who have mental health problems may be more at risk of being homeless. Some people fall into numerous groups; for example many people rough sleeping on the streets have "tri-morbidity", mental health problems and substance misuse problems and multiple long term health conditions or disabilities.

1.5 Purpose

The purpose of this study is to assist the West Lothian Joint Mental Health Service and its partner agencies to:

- Identify the 'bigger picture' in terms of the health and wellbeing needs and inequalities of those with mental health problems;
- Establish a process that will identify the existing and future needs of those with mental health problems;
- Map services and the way they are used; and

- Analyse and enable the prioritisation of services; and therefore inform commissioning requirements.

1.6 Objectives

The specific objectives of this project are as follows:

- To provide a comprehensive assessment and mapping of specialist and non-specialist services for those with mental health problems;
- To conduct an assessment of local need for such services;
- To identify gaps and areas of unmet need in current provision;
- To examine the current use of services, both community and inpatient;
- To examine the accessibility, appropriateness and location of current services;
- To identify any areas with over-provision;
- To provide evidence based recommendations as to how services could be extended or adapted to meet need including relationship and any overlap between agencies; and
- To suggest locality pathways for intervention and support for those with mental health problems.

1.7 Scope

This document presents the findings of the needs assessment and reports on the future requirements for mental health services/supports across West Lothian. Evidence from the Needs Assessment will assist:

- In providing evidence on the extent to which current services are meeting demand;
- In the commissioning of new services;
- In identifying gaps in existing service provision;
- In identifying areas of over provision;
- In providing evidence on the extent to which services are accessible and in the right location;
- In suggesting ways as to how West Lothian Health and Social Care Partnership and its partner agencies could extend / adapt services to meet need; and
- In providing objective comment on the re-structuring of relationships between specialist mental health services, wider health and social care services, communities, families and individuals to promote and maintain a recovery-oriented system of care across the area.

Conducting needs assessments in such a complex environment requires a great deal of understanding and flexibility on the part of the project team, and it is essential to engage as broad a range of interests as possible in the assessment process. To this end, the research team sought the

views of a wide range of different mental health and mainstream services, people who use services, families and carers; advocates and other stakeholders. The qualitative element of the study in particular aimed to consult with staff from specialist mental health services, together with a sample of the following groups which support people with mental health problems:

- Service users across the whole spectrum of mental health services;
- Carers and families;
- Advocates;
- Treatment and care providers (statutory, third, private);
- Addiction services;
- Criminal Justice services;
- Police; and
- Housing and homelessness services.

Discussions with the project steering group and key strategic planners took place at several points during the fieldwork, and this acted as a helpful 'sounding board' for the emerging findings of the study.

1.8 Data Sources

The needs assessment incorporates data from a wide variety of sources and includes evidence collated from an extensive consultation process with services users, local organisations and professionals.

The various data sources utilised in this report include:

- Audit Scotland – Overview of Mental Health Services 2009 (http://www.audit-scotland.gov.uk/docs/health/2009/nr_090514_mental_health.pdf);
- Information Services Division, part of NHS National Services Scotland (http://www.isdscotland.org/);
- National Records of Scotland – Statistics and Data[11] (http://www.nrscotland.gov.uk/statistics-and-data);
- NHS Health Scotland – Mental Health Indicators (http://www.healthscotland.com/scotlands-health/population/mental-health-indicators.aspx);
- Office for National Statistics – NOMIS Official Labour Market Statistics (https://www.nomisweb.co.uk/reports/lmp/gor/2013265931/report.aspx);

[11] The National Records of Scotland now holds the information contained on the former General Register Office for Scotland website, which is no longer being updated, as of 30/09/14 (http://www.gro-scotland.gov.uk/).

- Office for National Statistics – Personal Wellbeing in the UK 2014-15 (http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/personal-well-being-in-the-uk--2013-14/sb-personal-well-being-in-the-uk--2014-15.html);
- Scotland's Census 2011 (http://www.scotlandscensus.gov.uk/);
- Scottish Government Statistics (http://www.scotland.gov.uk/Topics/Statistics);
- Scottish Health Survey (SHeS) 2014 (http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/scottish-health-survey/Publications);
- Scottish Index of Multiple Deprivation 2012 (http://simd.scotland.gov.uk/publication-2012/);
- Scottish Parliament Information Centre (SPICe) – Mental Health in Scotland 2014 (http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_14-36.pdf);
- Scottish Public Health Observatory (ScotPHO) – Health and Wellbeing Profiles 2015 (http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool);
- Scottish Public Health Observatory (ScotPHO) – Public Health Information for Scotland (http://www.scotpho.org.uk/);
- West Lothian Intergration Joint Board – Strategic Plan 2016-2026 (http://www.westlothianchcp.org.uk/media/10225/West-Lothian-IJB-Draft-Strategic-Plan-2016-26/pdf/West-Lothian-IJB-Strategic-Plan-2016-26-Draft-Consultation.pdf);
- local data gathered from commissioned mental health services; and
- other locally gathered information and lifestyle surveys etc.

1.9 The Needs Assessment Process

This needs assessment project uses a tried and tested model for health needs assessment (which is detailed below) and is applied to both the health and social care needs of people with mental health problems across West Lothian.

In broad terms, health and social care needs assessment is the systematic approach to ensuring that the Health and Social Care Partnership uses its resources to improve the health and wellbeing of the population in the most efficient way. It involves methods to describe the health and wellbeing problems of a population, identify inequalities in health and social care (and access to services and support provisions), and determine the priorities for the most effective use of resources.

Health and social care needs assessment has become important as the costs of health and social care are rising and resources are, at the same time, limited. In addition, there is a large variation in availability and use of health and social care services and support provisions by geographical area and point of provision.

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

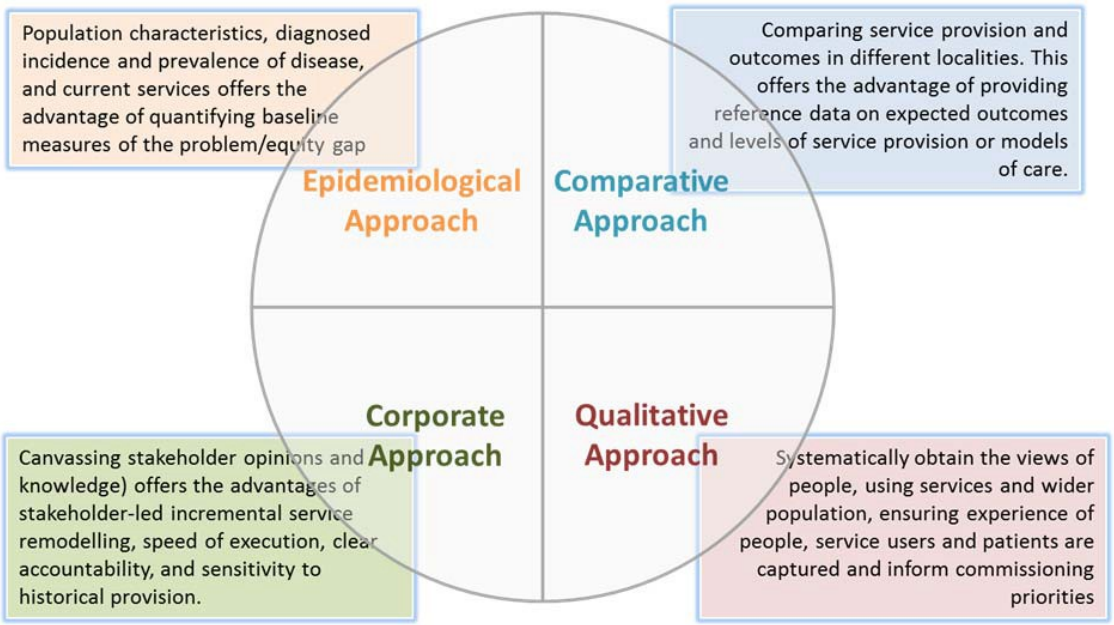
The needs assessment process has been defined, in guidance from the National Institute of Clinical Excellence (NICE), as:

> *"A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities."*[12]

The assessment process involves identifying need from four different perspectives (see Figure 1.3):

- **Epidemiological needs** – the use of health and social care information based on the population, including demographic trends, health status and risk, as well as evidence of clinical effectiveness of services and interventions.
- **Felt and expressed needs (Qualitative)** – the views of the public, from surveys, focus groups and the like, often using participatory appraisal methods.
- **Normative or expert needs (Corporate)** – as identified by professionals or experts.
- **Comparative needs** – the scope and nature of services available to the population and how these compare with services elsewhere.

Figure 1.3 Diagram of the needs assessment process



The study methods used in this needs assessment (outlined in section 1.10 below) were designed to capture each of these four different approaches/perspectives and are identified in Table 1.4 below.

[12] Cavanagh S and Chadwick K (2005), "Health needs assessment: A practical guide". London: NICE. Available at: http://www.nice.org.uk/

1.10 Summary of Study Methods

The study was conducted in four stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods and sample populations. These are set out in Table 1.4 below. All questionnaires and interview schedules were approved by commissioners prior to use.

Table 1.4: Summary of Data Collection Methods

Stage 1	**Method**		**Link to approaches / perspectives on need**
Review of Existing Datasets	Desk-based review of national and local datasets and any local specialist service data available.		• Epidemiological • Comparative
Stage 2	**Method**	**Sample**	
Quantitative Survey	Online Surveys	• Managers of all specialist mental health services • Staff in all specialist mental health services.	• Normative/Expert (Corporate) • Comparative
Stage 3	**Method**	**Sample**	
Quantitative Surveys	Online and paper-based surveys	• Service users • Non (potential) service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)
Stage 4	**Method**	**Sample**	
Stakeholder Event / Working Group / Qualitative Interviews / Focus Groups	Stakeholder Event	• All key stakeholders invited to a half-day event in relation to mental health.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Working Group	• Sample of key stakeholders recruited via approaches from the Research Steering Group, and via the stakeholder event above. The working group to meet twice to explore mental health issues.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Semi-structured interviews	• All specialist services • A range of non-specialist services • Other relevant stakeholders	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Focus Groups	• Service users • Non (potential) service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)

1.11 Terminology

When quoting individual respondents or citing literature sources we will use the terms they have chosen for accuracy of representation.

1.12 Considerations and limitations

There are a number of factors which should be taken into account when reading this report. These are:

- The views of those interviewed and surveyed were taken and reported in good faith and are their own, not necessarily those of Figure 8 Consultancy Services Ltd. or the organisations they represent. It cannot be assumed that the views of the participants in interviews, focus groups, stakeholder events or working groups are representative of all similar stakeholders.
- Making comparisons with other areas of similar population and/or geography, as well as prevalence of mental health problems, allows for a degree of 'benchmarking' to observe the relative position of West Lothian. It should be noted that there may be variations between areas in the way in which this data is collected.
- In health care, need is commonly defined as 'the capacity to benefit'. If health needs are to be identified then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available (Wright, Williams & Wilkinson, 1998).[13] The definition of need used in this study is 'the number of individuals in the general population with mental health problems who could benefit from intervention'. There are several challenges in estimating the prevalence of mental health problems in the general population involving the definition of 'problems' and the methods used to obtain the estimate.

[13] Wright, J., Williams, R., & Wilkinson, J.R. (1998). Development and Importance of Health Needs Assessment. *British Medical Journal,* 316; 1310-1313.

CHAPTER 2: EPIDEMIOLOGY

2.1 Introduction and Aims

After considering first the overall demographic make-up of West Lothian, this section is broken into a number of sub-sections. Under each of these, it examines the general research on what makes people more or less vulnerable in terms of their mental wellbeing, then at the national statistics, and then the local figures where they are available.

2.2 Method of Data Collection

Information was identified and drawn together from a range of local and national sources on prevalence and trends in the patterns of mental health problems in Scotland over the past ten years. In order to provide comparative analysis on a range of health and social indicators three local authority areas were identified from similar socioeconomic deprivation backgrounds as West Lothian[14], as well as using information from the Local Government Benchmark Framework (LGBF)[15]. The LGBF considers the many differences between local authorities that contribute to variations in performance, including: population; geography; social and economic factors; and the needs and priorities of local communities.

Falkirk, Renfrewshire and South Lanarkshire were agreed with the study commissioners and chosen as comparators as they have similar characteristics and populations as West Lothian.

2.3 Data Issues

Data relating specifically to people with mental health problems can be difficult to find and often there are problems with the data which mean that it does not give a completely accurate picture. This said, the data which is available is still useful in providing information regarding the needs of this population as long as it is interpreted with certain caveats in mind.

2.4 Demography of West Lothian

Present and future need for services and assets to address mental health needs in West Lothian depends in part on the demography of the county. In this section basic population data is therefore briefly assessed.

[14] http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/TrendSIMD

[15] http://www.scotborders.gov.uk/info/691/council_performance/1352/local_government_benchmarking_framework

2.4.1 Area Profile

West Lothian is an area of 165 square miles (428 square km) situated in the east of Scotland, positioned between Glasgow and Edinburgh, and surrounded by the council areas of Edinburgh, Falkirk, North Lanarkshire and the Scottish Borders. Livingston, Bathgate and Linlithgow are the main centres of population in this local authority.

Figure 2.1: Map of West Lothian[16]

According to National Records of Scotland, the 2015 mid-year population estimate for West Lothian was 178,550[17], an increase of 0.8% from 177,200 in 2014. This represents a 2% increase of the whole population figures reported in 2011 Census (175,118). In relation to the comparison areas, the table below shows West Lothian has a higher population than Falkirk (157,640) and Renfrewshire (174,230), and lower than South Lanarkshire (315,360). Scotland's overall population is also shown (5,347,600).

Table 2.2: Whole Population Figures for West Lothian, Scotland and Comparison Areas.[18]

	West Lothian	South Lanarkshire	Renfrewshire	Falkirk	Scotland
2015 Mid-Yr Estimate	**178,550**	316,230	174,560	158,460	5,373,000

*NRS = National Records of Scotland

[16] West Lothian Map, Google Map 2015. Available at: https://www.google.co.uk/maps/place/West+Lothian/@55.8546737,-3.7929644,10z/data=!4m2!3m1!1s0x4887c514c305f6ff:0x9f54bb6a8afceff3. [Accessed on: 22nd July 2016].

[17] National Records of Scotland.2016. *West Lothian Council Area - Demographic Factsheet. Available at:* http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf. [Accessed on: 22nd July 2016].

[18] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

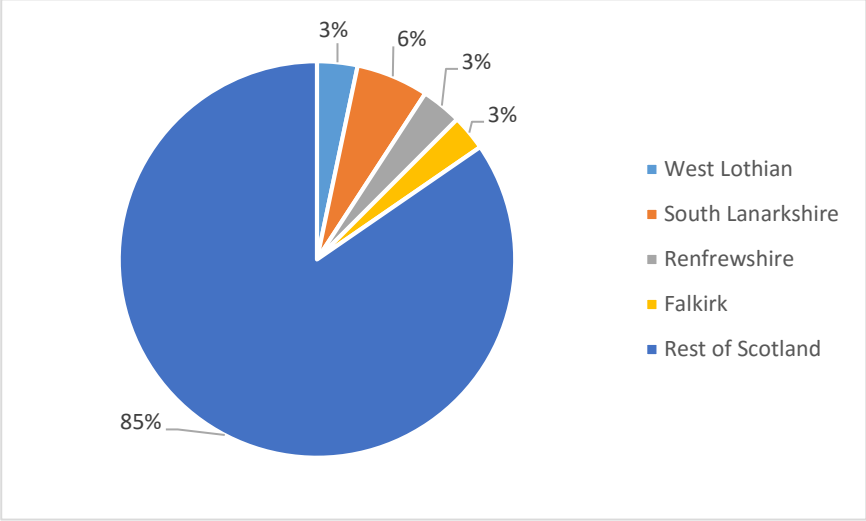
A full breakdown by age group and gender is shown in the table below:

Table 2.3 Estimated population of West Lothian, by age group and gender, 2015[19]

Age Group	Male Population	Female Population	Total	%
0-15	17,962	17,140	35,102	19.7
16-29	15,168	14,705	29,873	16.7
30-44	17,572	18,417	35,989	20.2
45-59	19,546	20,453	39,999	22.4
60-74	**12,557**	**13,806**	**26,363**	**14.8**
75+	**4,746**	**6,478**	**11,224**	**6.3**

Further analysis of the available population figures is demonstrated below which shows population percentages of West Lothian, South Lanarkshire, Renfrewshire and Falkirk compared with the rest of Scotland. The figure reveals that West Lothian, Renfrewshire and Falkirk have a similar population percentage (3%), with South Lanarkshire double this (6%). The rest of Scotland accounts for 85% of the population.

Figure 2.4: Population Breakdown of West Lothian, Comparison Areas and Rest of Scotland.[20]



[19] National Records of Scotland. 2016. Statistics and data. *Available at:* http://www.nrscotland.gov.uk/statistics-and-data. [Accessed 19 May 2016].

[20] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

2.4.2 Population: Sex

There are more females than males in West Lothian (90,999 compared to 87,551). As can be seen in the table below, there are similarities between West Lothian figures, Scottish figures and comparison areas when male and female statistics are put in percentages.

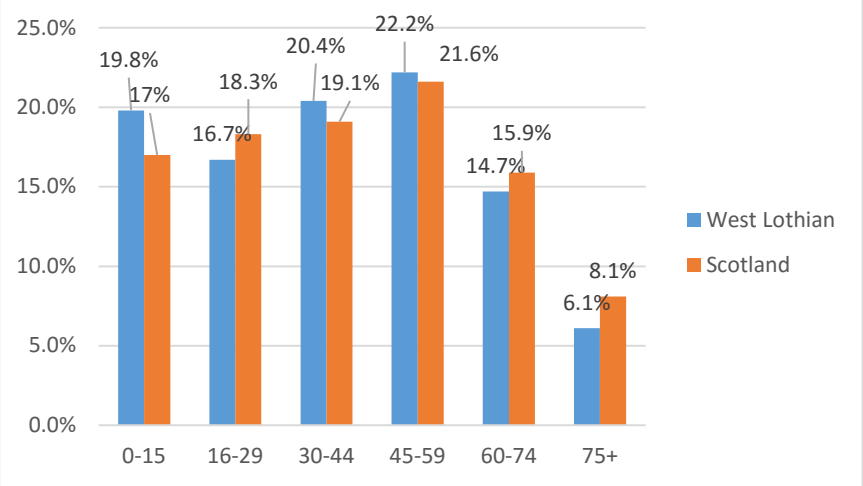
Table 2.5: Breakdown of population by Gender (for West Lothian, Scotland and Comparison Areas)[21]

	West Lothian	South Lanarkshire	Renfrewshire	Falkirk	Scotland
Male	**48.9%**	48.1%	48.1%	48.8%	48.5%
Female	**51.1%**	51.9%	51.9%	51.2%	51.5%

2.4.3 Population: Age

The population of the West Lothian is largely aged between the age brackets of 30-44 and 45-59 years of age, with 20.4% and 22.2% of people in West Lothian belonging to these age categories. This is more than the Scottish averages for these age categories (19.1% and 21.6% respectively). The graph below shows comparisons of age categories in West Lothian compared to the Scottish average.

Figure 2.6: West Lothian Population Breakdown by Age, Compared to the Scottish Average.[22]



[21] National Records of Scotland, 2011 *Census*. Available at: http://www.scotlandscensus.gov.uk/ods-web/area.html. [Accessed 22nd July 2016].

[22] National Records of Scotland. 2016. *West Lothian Council Area- Demographic Factsheet.* Available at: http://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/west-lothian-factsheet.pdf [Accessed 22nd July 2016].

2.4.4 Population: Projected Population

Current projections for West Lothian are estimating an overall population increase of 10.1 % between 2015 (n=178,550) and 2037 (n=196,664). From the table below it can be seen that the projected population of West Lothian until 2037.

Table 2.7: Projected Population in West Lothian - 2015, 2017, 2022, 2027, 2032, 2037.[23]

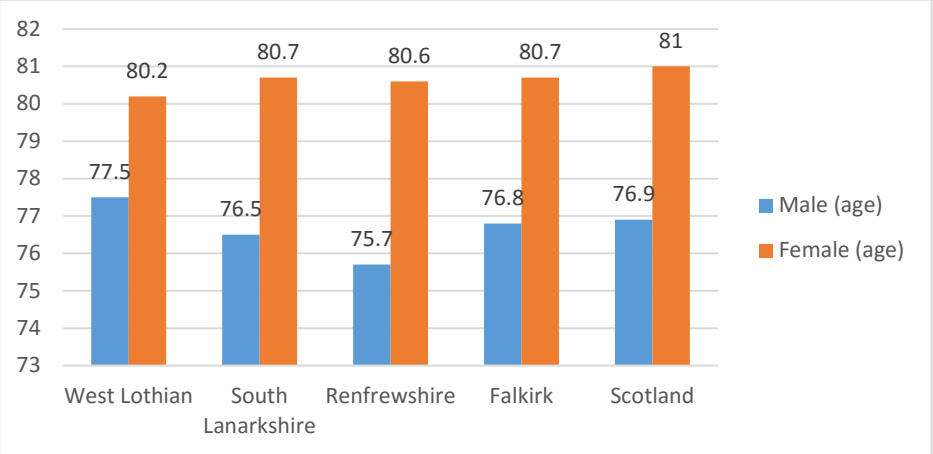
Projected years	2015	2017	2022	2027	2032	2037
Projected population	178,550	180, 252	184,774	189, 208	193,254	196,664

2.4.5 Population: Life expectancy

Female life expectancy at birth (80.5 years) is greater than male life expectancy (77.9 years) in West Lothian, with male life expectancy higher than the Scottish average (77.9 years compared to 77.1 years) and female life expectancy lower (80.5 years compared to 81.1 years). Male life expectancy at birth in West Lothian is improving more rapidly than female life expectancy.

Further analysis is revealed in the graph below and it can be seen that life expectancy at birth for males in West Lothian is higher than all other areas (South Lanarkshire 76.6 years, Renfrewshire 75.9 years and Falkirk 77.3 years). Life expectance at birth for females is slightly lower than all other areas (South Lanarkshire 80.9 years, Renfrewshire 80.6 years and Falkirk 81.0 years).

Figure 2.8: West Lothian Life Expectancy at Birth by Sex, Comparison Areas and Scotland, 2012-2014.[24]



[23] Ibid.

[24] National Records of Scotland, 2016. *Council area profiles*. Available at: http://www.nrscotland.gov.uk/statistics-and-data/statistics/stats-at-a-glance/council-area-profiles [Accessed 22nd July 2016].

2.4.6 Population: Ethnicity

The 2011 Census reveals 97.5% of the people in West Lothian consider their ethnic group to be 'white' which is higher than national figures (96.1%). Further analysis of these figures demonstrates that 87.8% of people within West Lothian consider their ethnic group to be 'White Scottish', which, again, is higher than the national average (84%), but lower than all comparison areas (South Lanarkshire 91.6%, Renfrewshire and Falkirk both 91.3%). The table below demonstrates further analysis of 2011 census data on ethnicity.

Table 2.9: Ethnicity Breakdown for West Lothian, Comparison Areas and Scotland.[25]

	West Lothian	S. Lanarkshire	Renfrewshire	Falkirk	Scotland
White- Scottish	87.8%	91.6%	91.3%	91.3%	84%
White- Other British	5.8%	3.8%	3.3%	4.5%	7.9%
White- Irish	0.7%	1%	0.9%	0.6%	1%
White-Gypsy/Traveller	-	0.1%	-	0.1%	0.1%
White-Polish	1.9%	0.4%	0.7%	0.7%	1.2%
White- Other	1.3%	0.8%	0.9%	0.9%	1.9%
Asian, Asian Scottish or Asian British	1.7%	1.6%	1.8%	1.3%	2.7%
Mixed or multiple ethnic groups	0.3%	0.2%	0.2%	0.2%	0.4%
African	0.3%	0.2%	0.5%	0.1%	0.6%
Caribbean or Black	0.1%	0.1%	0.1%	0.1%	0.1%
Other Ethnic group	0.1%	0.1%	0.2%	0.1%	0.3%

2.5 Deprivation

It is documented that individuals from deprived areas have lower overall mental well-being compared to those from more affluent areas, with national and international research demonstrating that those in deprived areas are more likely to have higher rates of hospital admissions, increased risk of premature death[26], are twice as likely to have anxiety problems than those in the least deprived areas, and also have higher rates of suicide.[27]

[25] National Records for Scotland. 2013. *2011 Census: Key Results on Population, Ethnicity, Identity, Language, Religion, Health, Housing and Accommodation in Scotland - Release 2A. Available at:* http://www.scotlandscensus.gov.uk/documents/censusresults/release2a/StatsBulletin2A.pdf [Accessed 22 July 2016].

[26] Office of the Deputy Prime Minister. 2004. *Mental health and social exclusion: Social Exclusion Unit report.* Available at: http://www.socialfirmsuk.co.uk/resources/library/mental-health-and-social-exclusion-social-exclusion-unit-report[Accessed 22 July 2016].

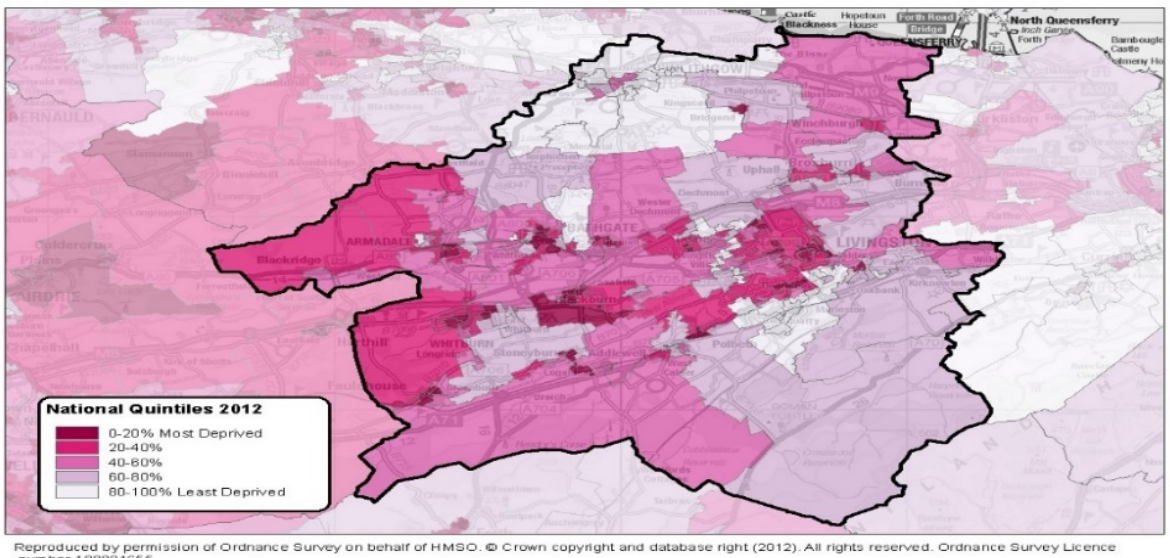
[27] Audit Scotland. 2012. *Health inequalities in Scotland.* Available at: http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf [Accessed 22 July 2016].

The Scottish Index of Multiple Deprivation (SIMD herein) is a Scottish Government tool which includes different aspects of deprivation to combine them into a single index. Specifically, the index incorporates seven domains to measure the multiple aspects of deprivation and the overall index is a weighted sum of the seven domain scores as follows: income (28%), employment (28%), health (14%), education (14%), geographic access (9%), crime (5%) and housing (2%). There are a total of 6,506 datazones (small areas) within Scotland to which the SIMD offers a relative ranking for each datazone from 1 (most deprived) to 6,506 (least deprived). The datazones contain approximately 350 households/ 800 people. Current SIMD (2012) figures for Scotland show that 742,200 people live in the 15% most deprived areas of Scotland. Figures also shows that multiple deprivation has become less clustered over time with 2004 figures highlighting approximately half of all datasets in the most deprived 10% across Scotland were in Glasgow City, whereas 2012 figures highlights that this has fallen to 35.8%. Currently Ferguslie Park, Paisley, is the most deprived area in Scotland, whereas the least deprived datazone is the Craiglockhart area of Edinburgh.[28]

2.5.1 Deprivation within West Lothian

Within West Lothian there are 211 datazones. The SIMD 2012 reveals that 13 (6.2%) of West Lothian's 211 datazones were found in the 15% most deprived datazones in Scotland, compared to 19 (9%) in 2009, 14 (6.6%) in 2006 and 9 (4.3%) in 2004. The most deprived datazone in West Lothian in the overall SIMD 2012 is S01006416, which is found in Bathgate East. It has a rank of 440, meaning that it is amongst the 10% most deprived areas in Scotland. The figure below shows the national quintiles for West Lothian.

Figure 2.10: Levels of Deprivation in West Lothian in SIMD 2012 by quintile.[29]

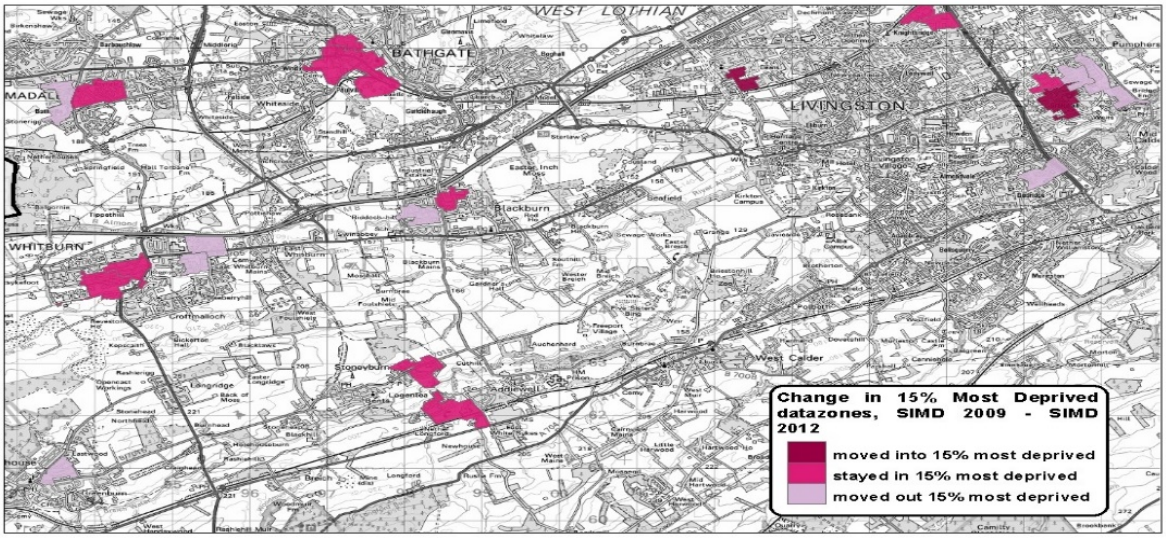


[28] Scottish Government. 2012. *SIMD 2012 Results.* Available at: http://simd.scotland.gov.uk/publication-2012/simd-2012-results/ [Accessed 22 July 2016].

[29] Ibid.

The figure below shows changes in deprivation within West Lothian with areas which have moved into the 15% most deprived, areas which have stayed in the 15% most deprived and areas which have moved out the 15% most deprived areas between SIMD 2009 and SIMD 2012.

Figure 2.11: Datazones in West Lothian Which Have Stayed in or Moved Out of the 15% Most Deprived in Scotland.[30]



SIMD mages courtesy of the Scottish Government

Further analysis of the SIMD (2012) figures is presented in the table below which shows West Lothian as having 6.2% of the 211 datazones in the 15% most deprived datazones in Scotland. This figure is lower than South Lanarkshire (13.3%), Renfrewshire (22.4) and also Falkirk (9.1%).

Table 2.12: Percentage of Most Deprived Zones in West Lothian and Comparison Areas According to SIMD 2012.[31]

West Lothian	South Lanarkshire	Renfrewshire	Falkirk
6.2% (13 out of 211)	13.3% (53 out of 398)	22.4% (48 out of 214)	9.1% (18 out of 197)

2.6 Employment (Working age)

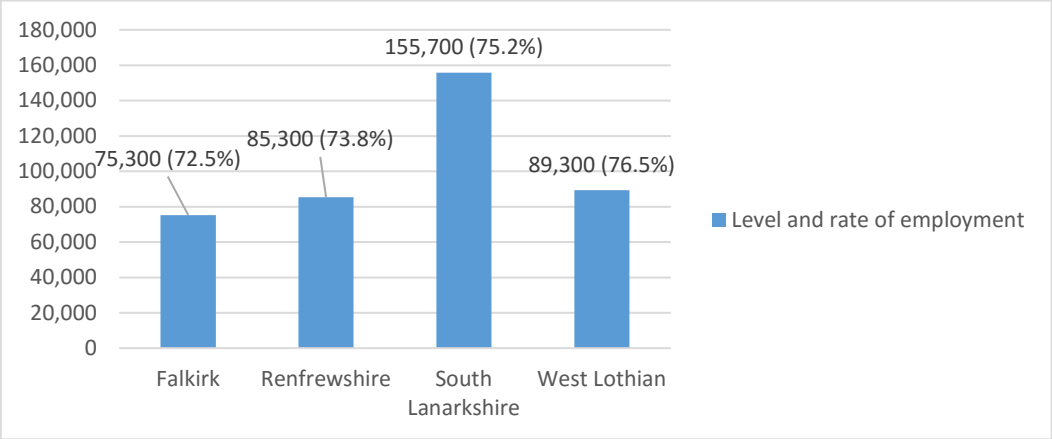
Current figures show that there are approximately 85,900 (73.3%) people employed within West Lothian. The figure below shows employment rates and levels in West Lothian and comparison areas from April 2015 - March 2016. Between 2014-15 and 2015-16 there has been a 3.2% drop (76.5% to 73.3%) in percentage rate of people employed in West Lothian, compared to a stable rate across Scotland (72.9%). In this period, West Lothian has gone from having a higher percentage rate

[30] Scottish Government. 2012. *SIMD 2012 Results.* Available at: http://simd.scotland.gov.uk/publication-2012/simd-2012-results/ [Accessed 22 July 2015].

[31] Ibid.

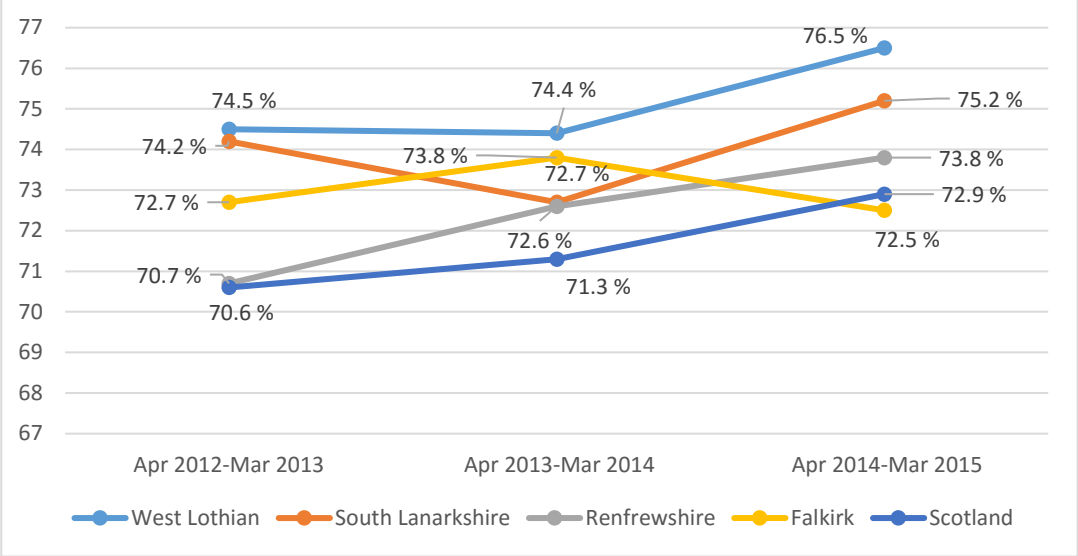
employed than all three comparison areas, to now having a lower percentage rate employed than all three comparison areas areas (Falkirk 75.3%; Renfrewshire 74.0%; South Lanarkshire 75.5%).

Table 2.13: Employment Rates and Levels in West Lothian and Comparison Areas, April 2014 - March 2015.[32]



In further detail, the figure below shows employment rates and levels in West Lothian, comparison areas and Scotland in years 2012-2013, 2013-2014, 2014-2015 and 2015-2016. The figure reveals that West Lothian is the only area to have experienced a decrease in its employment rate in the most recent period.

Figure 2.14: Percentages of Employment Rates in West Lothian, Comparison Areas and Scotland, 2012-2013, 2013-2014, 2014-2015 and 2015-2016[33]



[32] Scottish Government. 2016. *Annual population survey, results for year to March 2016 - summary tables.* Available at: http://www.gov.scot/Topics/Statistics/Browse/Labour-Market/Publications/APSAMTables [Accessed 22 July 2016].

[33] Scottish Government. 2016, op. cit.

2.7 Unemployment

Overall unemployment figures include people who are out of work and not only those claiming unemployment benefits. From the table below it can be seen that the unemployment figures in West Lothian are lower than the Scottish average (5.2% compared to 5.7%). Furthermore, West Lothian has lower unemployment figures than South Lanarkshire (5.5%), Renfrewshire (5.8%), but an equivalent rate to Falkirk (5.2%).

Table 2.15: Unemployment Figures for West Lothian, South Lanarkshire, Renfrewshire and Falkirk Compared to Scotland, April 2015-March 2016[34]

West Lothian numbers	%	Scotland
4,700	5.2%	5.7%
South Lanarkshire numbers	**%**	
9,100	5.5%	5.7%
Renfrewshire numbers	**%**	
5,2000	5.8%	5.7%
Falkirk numbers	**%**	
4,300	5.2%	5.7%

Recent labour market profile figures show the breakdown of key benefit claimants who are of working age within West Lothian and from the table it can be seen that there were a total of 15,440 working age clients claiming key benefits from April 2015-March 2016.

Table 2.16: Working-age Client Group - Key Benefit Claimants in West Lothian, April 2015-March 2016.[35]

	West Lothian numbers	(%)	Scotland %
Total claimants	15,440	13.4	13.6
Job seekers	1,670	1.5	1.7
ESA and incapacity benefits	8,970	7.8	7.9
Lone parents	1,190	1.0	1.0
Carers	1,890	1.6	1.6
Others on income related benefits	270	0.2	0.2
Disabled	1,200	1.0	1.1

[34] Office for National Statistics. 2016. *Local authority profile.* Available at: http://www.nomisweb.co.uk/reports/lmp/la/contents.aspx [Accessed 22nd July 2016].

[35] Office for National Statistics. 2016. *Local authority profile.* Available at: http://www.nomisweb.co.uk/reports/lmp/la/contents.aspx [Accessed 22nd July 2016].

Bereaved	260	0.2	0.2
Main Out-of-Work Benefits	12,090	10.5	10.7

*Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. These groups have been chosen to best represent a count of all those benefit recipients who cannot be in full-time employment as part of their condition of entitlement. Those claiming solely Bereavement Benefits or Disability Living Allowance (DLA) are not included as these are not out-of-work or income based benefits.

2.8 Welfare Sanctions

With the introduction of the new Welfare Reform Act in 2012, a new system of sanctions was implemented which has resulted in the number of unfavourable sanctions increasing for jobseekers. However, such sanctions can have negative outcomes for claimants.[36] The graph below highlights sanctions under the old regime and the higher level of sanctions since the new regime was implemented in 2012.

Figure 2.17: Annual Number of Adverse JSA Sanction Decisions in Scotland, 2001-2013[37]

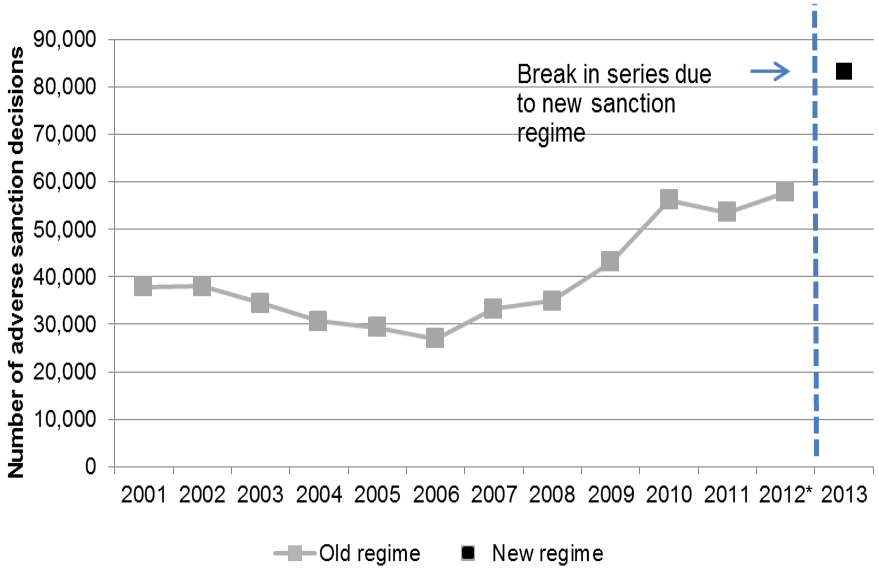


Image courtesy of the Scottish Government. 2014. Welfare Reform (Further Provision) (Scotland) Act 2012 Annual Report – 2014.

2.9 Wellbeing

Mental wellbeing is an essential part of a person's capacity to lead a satisfying life which includes the capacity to make informed choices, study, pursue leisure interests, as well the ability to form relationships with others.[38] The nation's mental health is a key priority for Scottish government

[36] Scottish Government. 2014. *Welfare Reform (Further Provision) (Scotland) Act 2012 Annual Report – 2014.* Available at: http://www.scotland.gov.uk/Resource/0045/00454504.pdf [Accessed 29 July 2015].

[37] Scottish Government. 2014, op. cit.

[38] Scottish Government. 2012. *The Scottish Health Survey*. Available at: http://www.scotland.gov.uk/resource/0043/00434590.pdf [Accessed 16 May 2016].

policy. In Scotland, mental health is measured within the Scottish Health Survey which adopts the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). This scale is made up of 14 separate statements regarding mental health and wellbeing to which respondents answer. A score is then created to determine the person's state of mental wellbeing. The maximum score is 70 and the minimum score is 14, with the higher the score the better level of mental wellbeing.[39] WEMWBS mean scores for both men and women have been relatively static since 2008, with only minor, non - significant fluctuations observed. In 2014, the average mean WEMWBS score for adults (aged 16 and over) was 50. The scores for men (50.1) and women (49.9) were not significantly different. As seen in previous years, levels of wellbeing varied across age groups. Men's wellbeing was lowest for those aged 45-54 (49.1), and highest for those aged 65-74 (51.2). Women's wellbeing showed less variation for those aged 25 and over (49.3-50.5), with lower levels seen for those aged 16-24 (48.7).

Figure 2.18: Warwick Edinburgh Mental Wellbeing Scale Mean Scores (2014) by age group and sex[40]

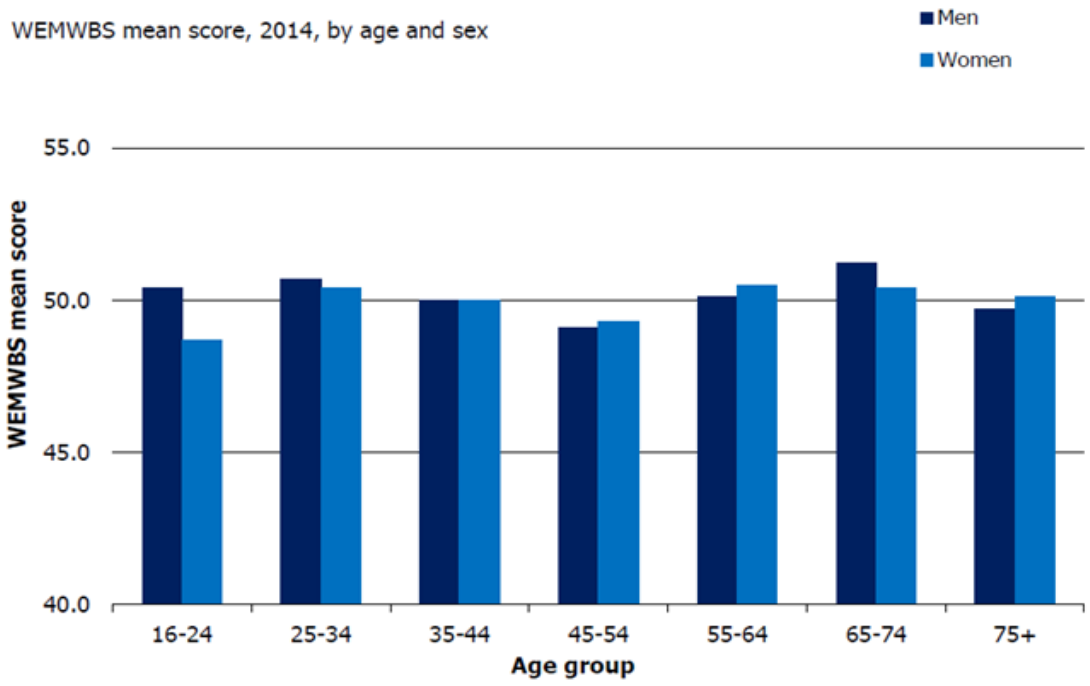


Image courtesy of the Scottish Government

Wellbeing results for each local authority are available from data in the UK Annual Population Survey.[41] To asses personal well-being in the UK the survey uses responses from approximately 165,000 people across the UK, and the publication includes the four following key questions to measure well-being which are answered on a scale from 0 to 10 with 0 the lowest and 10 highest.

[39] Scottish Government. 2015. *Health of Scotland's population-mental health.* Available at: http://www.gov.scot/Topics/Statistics/Browse/Health/TrendMentalHealth [Accessed 16 May 2016].

[40] Scottish Government. 2012, op. cit.

[41] Office for National Statistics. 2015. *Personal well-being in the UK, 2014/15.* Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23/pdf [Accessed 22 July 2016].

The questions are as follows:

- *Overall, how satisfied are you with your life nowadays?*
- *Overall, to what extent do you feel the things you do in your life are worthwhile?*
- *Overall, how happy did you feel yesterday?*
- *Overall, how anxious did you feel yesterday?*

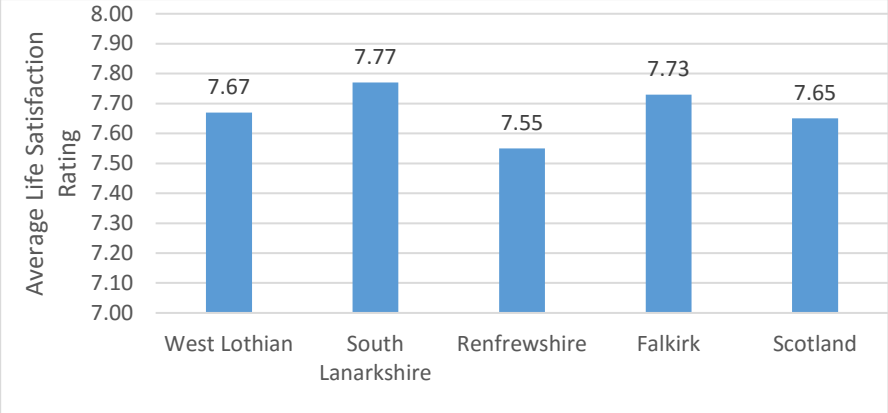
An overview of the well-being estimates is that there has been year on year improvements in reported average personal well-being ratings in the UK across each of the four measures of well-being, with the greatest gain being in the reduced anxiety levels. It should be noted that the survey should be interpreted as giving an estimate of well-being in the UK, rather than an exact measure.

There are mixed results for personal well-being in West Lothian with estimated average figures showing an increase in the reportings of 'life satisfaction' measures (2013/14=7.57; 2014/15=7.67) and 'worthwhile' measures (2013/14=7.81; 2014/15=7.9). Reporting on 'happiness' measures have slightly decreased (2013/14=7.49; 2014/15=7.44), as have ratings of 'anxiety' measures (2013/14=2.71; 2014/15=2.63). Further analyses of personal well-being ratings are presented below.

2.9.1 Life satisfaction

How satisfied a person is with their life is an important aspect of their overall well-being and from the figure below it can be seen that estimates of life satisfaction in West Lothian (7.67) are greater than Renfrewshire (7.55) and Scotland (7.65), but lower than South Lanarkshire (7.77) and Falkirk (7.73).

Figure 2.19: Estimates of Life Satisfaction From the Annual Population Survey (APS) Personal Well-being, 2014/15[42]

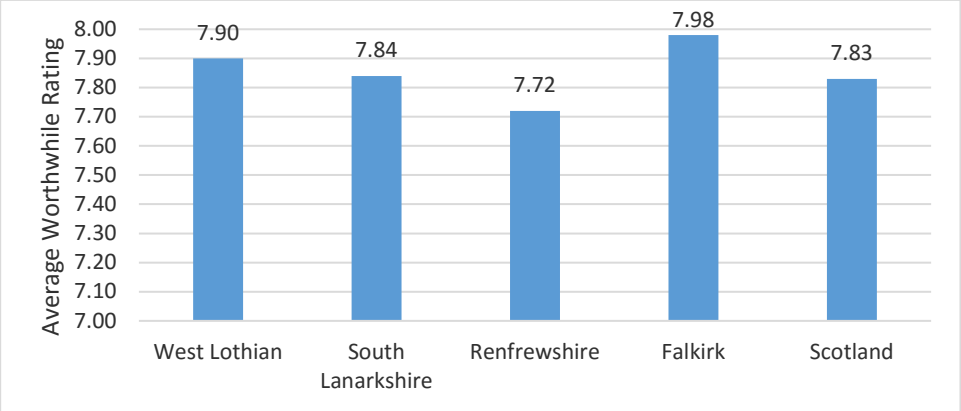


[42] Office for National Statistics. 2015. *Measuring National Well-being, Personal Well-being Across the UK, 2012/13.* Available at: http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/measuringnationalwellbeing/2015-09-23 [Accessed 18 April 2016].

2.9.2 Worthwhile

It can be seen from the figure below that worthwhile ratings in West Lothian are greater than South Lanarkshire (7.84), Renfrewshire (7.72) and Scotland (7.83), but lower than Falkirk (7.98).

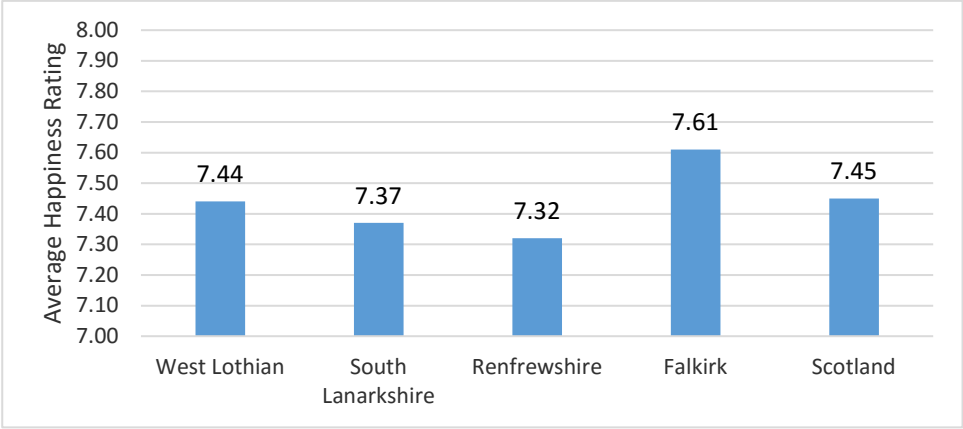
Figure 2.20: Estimates of Worthwhile From the Annual Population Survey (APS) Personal Well-being, 2014/15[43]



2.9.3 Happiness

In regards to happiness ratings it can be seen below that West Lothian (7.44) has greater happiness ratings compared with South Lanarkshire (7.37) and Renfrewshire (7.32). When compared to Falkirk (7.61) and Scotland (7.45) West Lothian's ratings are lower.

Figure 2.21: Estimates of Happiness From the Annual Population Survey (APS) Personal Well-being, 2014/15[44]



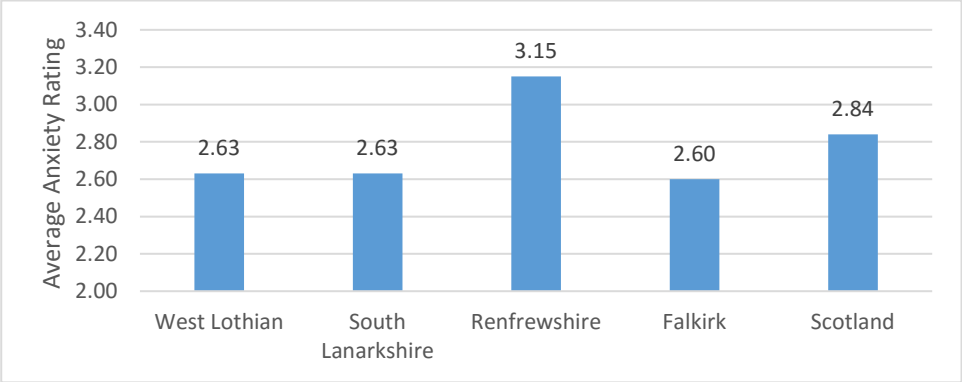
2.9.4 Anxiety

In regards to anxiety ratings, West Lothian echoes ratings from South Lanarkshire (both 2.63). This is slightly higher that Falkirk (2.6), but lower than Renfrewshire (3.15) and Scotland (2.84).

[43] Ibid.

[44] Ibid.

Figure 2.22: Estimates of Anxiety From the Annual Population Survey (APS) Personal Well-being, 2014/15[45]



[45] Ibid.

CHAPTER 3: PREVALENCE

3.1 Introduction

The issue of mental health is a primary concern for the Scottish government with statistics currently suggesting that 1 in 4 Scottish people will experience at least one diagnosable mental health problem every year.[46] Depression and anxiety are the most common; however others include eating disorders, personality disorders and schizophrenia. Further afield, estimates imply that 83 million people in Europe experience a mental health condition each year, and it is suggested that mental ill health is the primary source of chronic illness.[47] It should be noted that these figures are estimates due to the exact prevalence of mental health issues being problematic to approximate as many do not seek assistance.

A mental illness can be defined as any diagnosable illness which considerably interferes with a person's emotional, cognitive and social abilities, however the term is used interchangeably with mental health problem/ metal health issue/ mental health disorder and all terms cover various conditions and illnesses which can have different origins and symptoms and manifestations.[48]

3.2 Common Mental Health Issues

3.2.1 Depression

Depression can be described as feelings of sadness and worthlessness, a lack of energy and concentration, and/ or a loss in pleasure in activities that were previously enjoyed. In the UK, the overall prevalence in adults is 10%, and this is higher in females than males with females twice more likely to suffer from depression than males.[49] Figure 3.1 below shows the estimated number of patients in Scotland consulted for depression in the financial year 2012/13. Overall, it can be seen that females in every age group had a higher number of consultations. For both males and females the rates peaked in the 35-44 years age group.

[46] http://www.mentalhealth.org.uk/help-information/mental-health-statistics/uk-worldwide/

[47] Nowell, R. 2014. *Mental health in Scotland*. Available at: http://www.scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_14-36.pdf [Accessed 26th July 2016].

[48] Ibid.

[49] Ibid.

Figure 3.1: Estimated number of patients in Scotland consulting a GP or Practice Nurse at least once in the financial year 2012/13 per 1,000 patients registered[50]

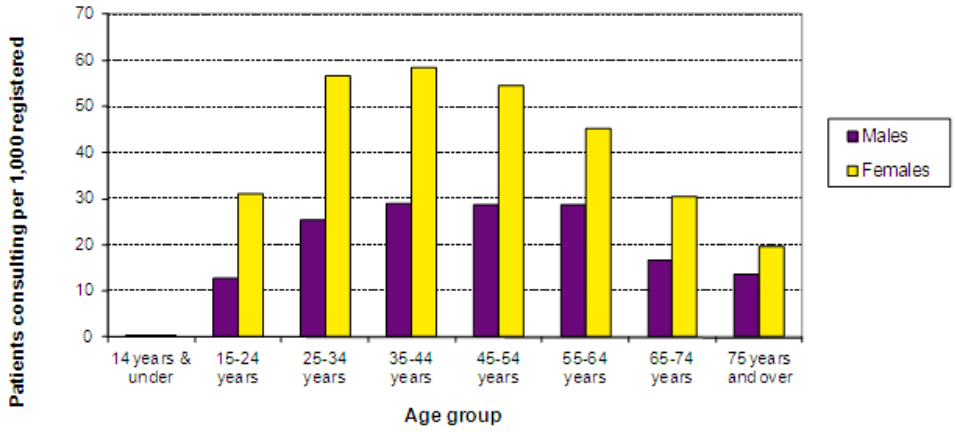
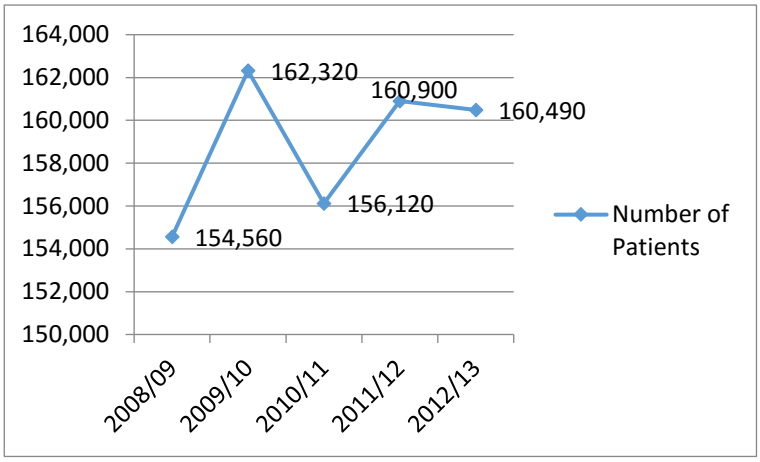


Image courtesy of ISD Scotland

Overall estimated prevalence rates in Scotland can be seen in the figure below and it can be seen that nearly 161,000 patients were seen in the year 2012/13 which is an increase from 2008/09 figures.

Figure 3.2: Estimated Number of Patients in Scotland Consulting a GP or Practice Nurse for Depression 2008/09-2012/13[51]



3.2.2 Anxiety

Anxiety can be described as an acute fear of something happening and in the UK the overall prevalence in the UK population is 9.2%.[52] Figure 3.3 below shows the estimated number of patients in Scotland consulted for anxiety and related conditions in the financial year 2012/13. Overall, it can

[50] Information Services Division Scotland. 2013a. *Health conditions-Depression.* Available at: http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/Health-Conditions/Depression/ [Accessed 26th July 2016].

[51] Ibid.

[52] Op.cit., Nowell, 2014

be seen that, similar to depression, females in every age group had a higher number of consultations. For both males and females the rates, again, peaked in the 35-44 years age group.

Figure 3.3: Estimated number of patients in Scotland consulting a GP or Practice Nurse at least once in the financial year 2012/132 for anxiety and related conditions per 1,000 Patients[53]

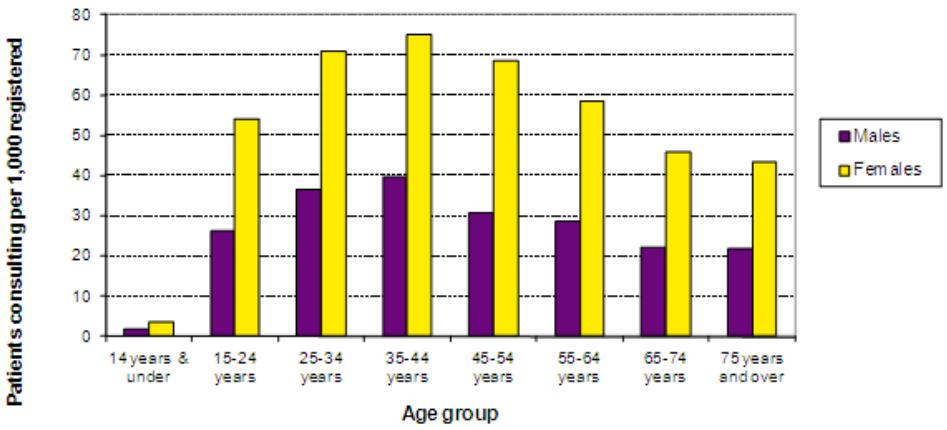
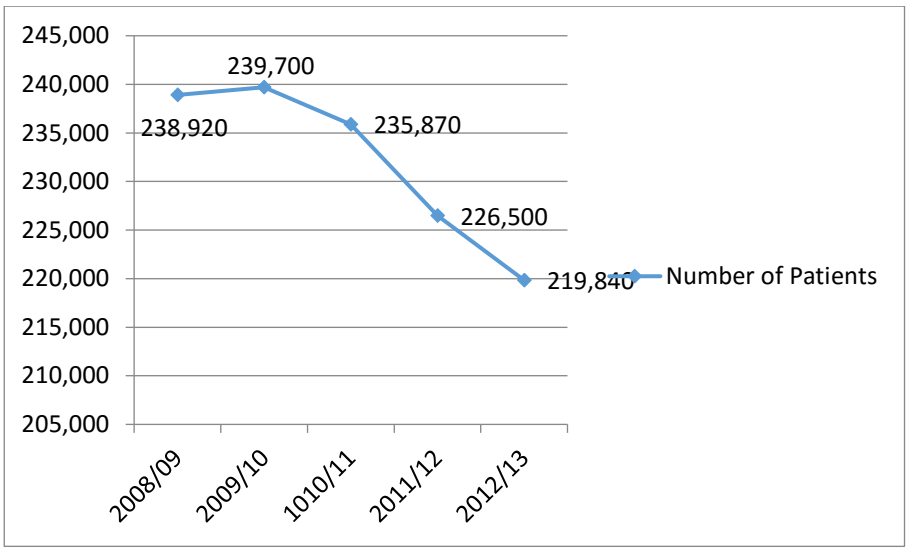


Image courtesy of ISD Scotland

Overall estimated prevalence rates in Scotland can be seen in the figure below which shows that nearly 220,000 patients were seen in the year 2012/13 which is a decrease from 2008/09 figures. The figure also shows that there has been a steady reduction from 2009/10 figures (239,700) to 2012/13 figures (219,840).

Figure 3.4: Estimated number of patients in Scotland consulting a GP or Practice Nurse for anxiety and related conditions 2008/09-2012/13[54]



[53] Information Services Division Scotland. 2013b. *Health conditions-Anxiety.* Available at: http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/Health-Conditions/Anxiety/ [Accessed 26th July 2016].

[54] Ibid.

3.2.3 Eating Disorders

Eating disorders primarily involve eating too much or too little and can involve the development of extreme associations with food resulting, at times, to anxiety and depression. Two common forms of eating disorders are Anorexia Nervosa and Bulimia Nervosa.[55] The overall prevalence of eating disorders in the UK is estimated at 2.5% of the population, of which 86% are female. Figure 3.5 below shows the estimated number of patients in Scotland consulted for eating disorders in the financial year 2012/13. It can be seen that, in contrast to depression and anxiety, there is no clear pattern in the number of consultations, however most consultations were for females in the age group of 15-24.

Figure 3.5: Estimated number of patients in Scotland consulting a GP or Practice Nurse at least once in the financial year 2012/132 for Eating Disorders per 1,000 Patients[56]

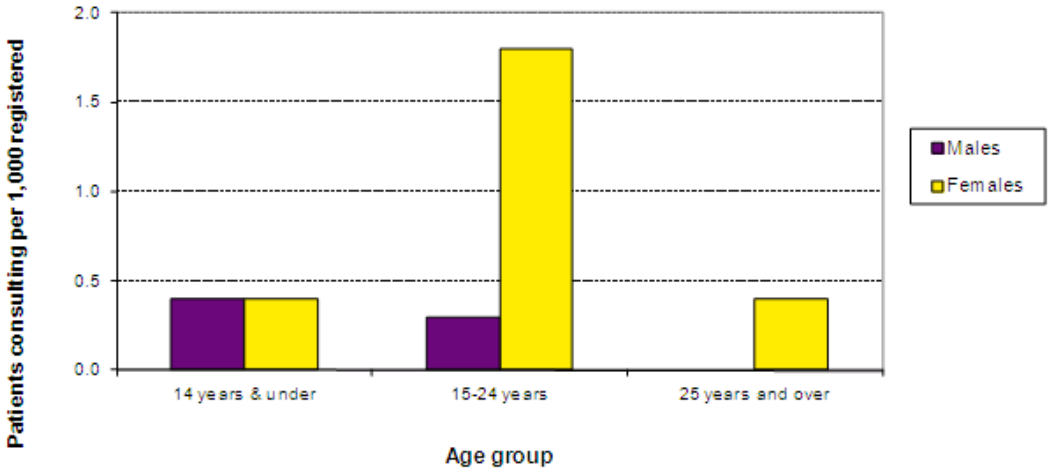


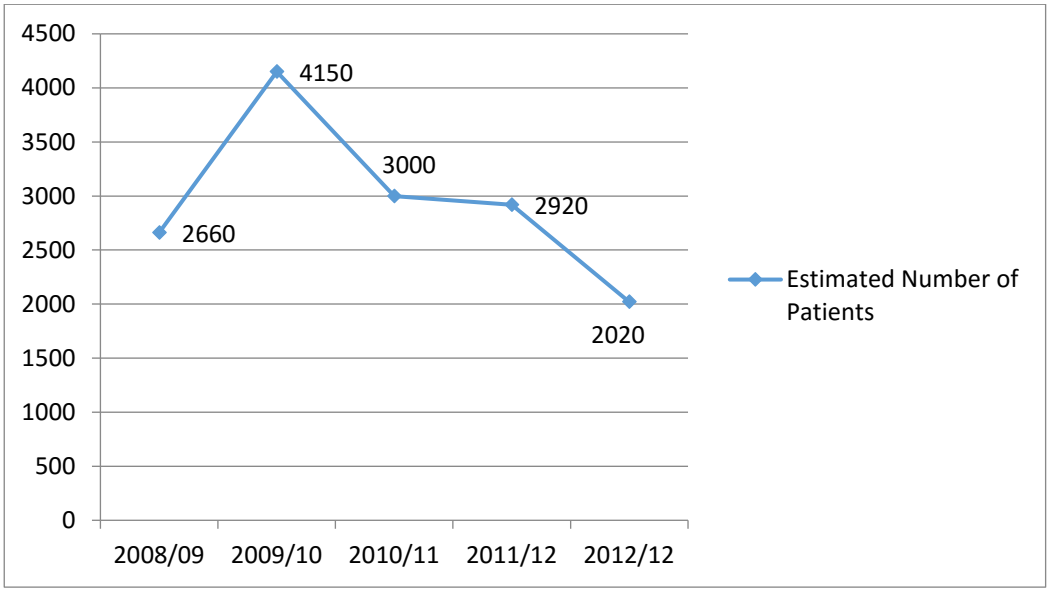
Image courtesy of ISD Scotland

Overall prevalence rates in Scotland can be seen in the figure below and it can be seen that approximately 2000 patients were seen at least once in the year 2012/13 which is a decrease from 2008/09 figures. The figure also shows that the estimated number of patients figures were highest in 2009/10 (N=4150) and since then there has been a steady reduction.

[55] Op.cit., Nowell, 2014

[56] Information Services Division Scotland. 2013c. *Health conditions-Eating Disorders.* Available at: http://www.isdscotland.org/Health-Topics/General-Practice/GP-Consultations/Health-Conditions/Eating-Disorders/ [Accessed 26th July 2016].

Figure 3.6: Estimated number of patients in Scotland consulting a GP or Practice Nurse for Eating Disorder conditions 2008/09-2012/13[57]



3.3 Medicines Prescribed to Treat Mental Health Issues

Medicines used for treating mental health problems are broken down into five general categories:

- Hypnotics and anxiolytics;
- Antipsychotics and related drugs;
- Antidepressants;
- Drugs used for Attention Deficit Hyperactivity Disorder (ADHD); and
- Drugs for dementia.

From the table below is can be seen that the most common drug used is antidepressants, both in the number of patients and the number of dispensed items.[58],[59]

[57] Ibid.

[58] Op.cit., Nowell, 2014

[59] Please note: antidepressants are also prescribed for a range of other conditions, such as migraine, chronic pain and myalgic encephalomyelitis (ME) – thus, the usage of antidepressants is unlikely to directly correspond to the number of patients with prescriptions for depression (see ISD, 2013e p 6).

Table 3.7: Prescription and usage information for drugs used in mental health treatments in Scotland, 2012/13[60]

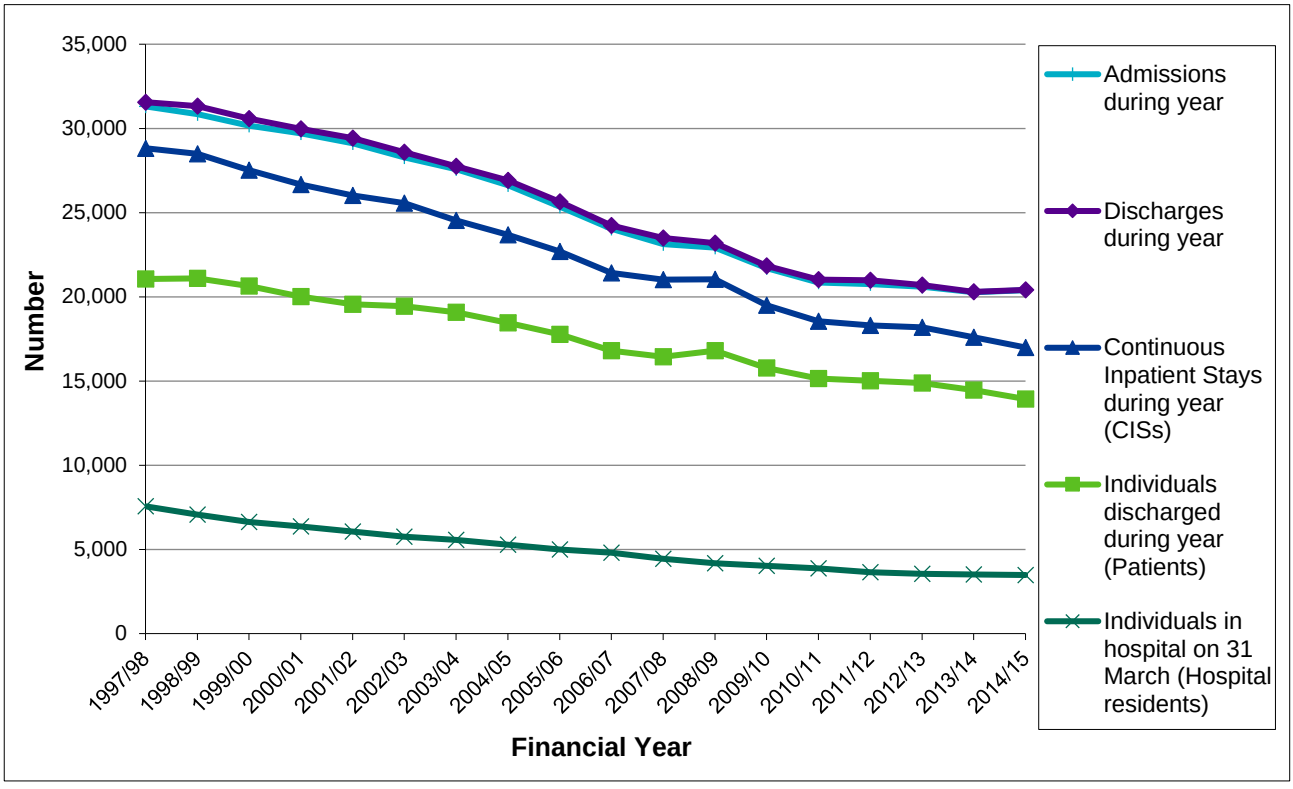
No. of dispensed items		Number of patients	Gross ingredient cost (£m)	% Change since 2003/04
Antidepressants	**5.2 million**	747,158 (67% female)	£29.5	52%
Hypnotics and anxiolytics	**2.08 million**	358,273 (64% female)	£8.8	–22%
Antipsychotics	**836,756**	80,479 (54% female)	£19.8	23%
Drugs for dementia	**183,176**	19,763 (65% female)	£10.2	229%
Drugs for ADHD and ADD	**90,885**	7,918 (19% female)	£4.3	103%

Please note: these figures are lower than figures in the graphs below; however, these figures may be an underestimate as not all prescriptions have a valid Community Health Index (CHI) attached that allows for the identification of which prescriptions have been dispensed to which patient.

3.4 Mental Health Inpatients

Information relating to mental health inpatient admissions in Scottish hospitals shows that there were a total of 20,384 inpatient admissions for the year ending 31st March 2015.

Figure 3.8: Mental health inpatient admissions in Scottish hospitals: Year ending March 2015[61]

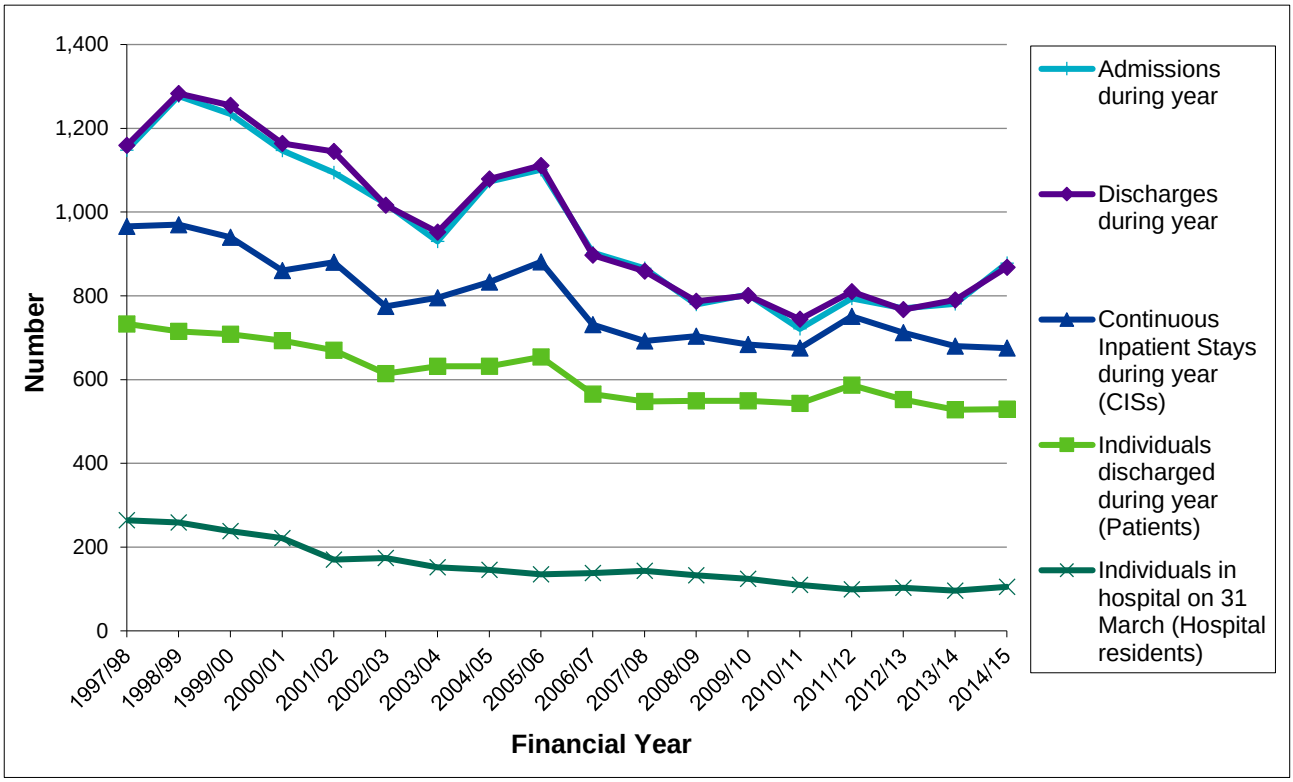


[60] Op.cit., Nowell, 2014

[61] Information Services Division Scotland. 2016. *Hospital inpatient care of people with mental health problems in Scotland: Trends up to 31 March 2015.* Available at: http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/data-tables.asp?id=1275#1275 [Accessed 26th July 2016].

Within West Lothian, there were 878 mental health inpatient admissions during 2014/15. This represents a significant increase (12.4%) from 2013/14 and the highest number since 2006-2007. The figure below shows admissions from 1997/98 to 2014/15.

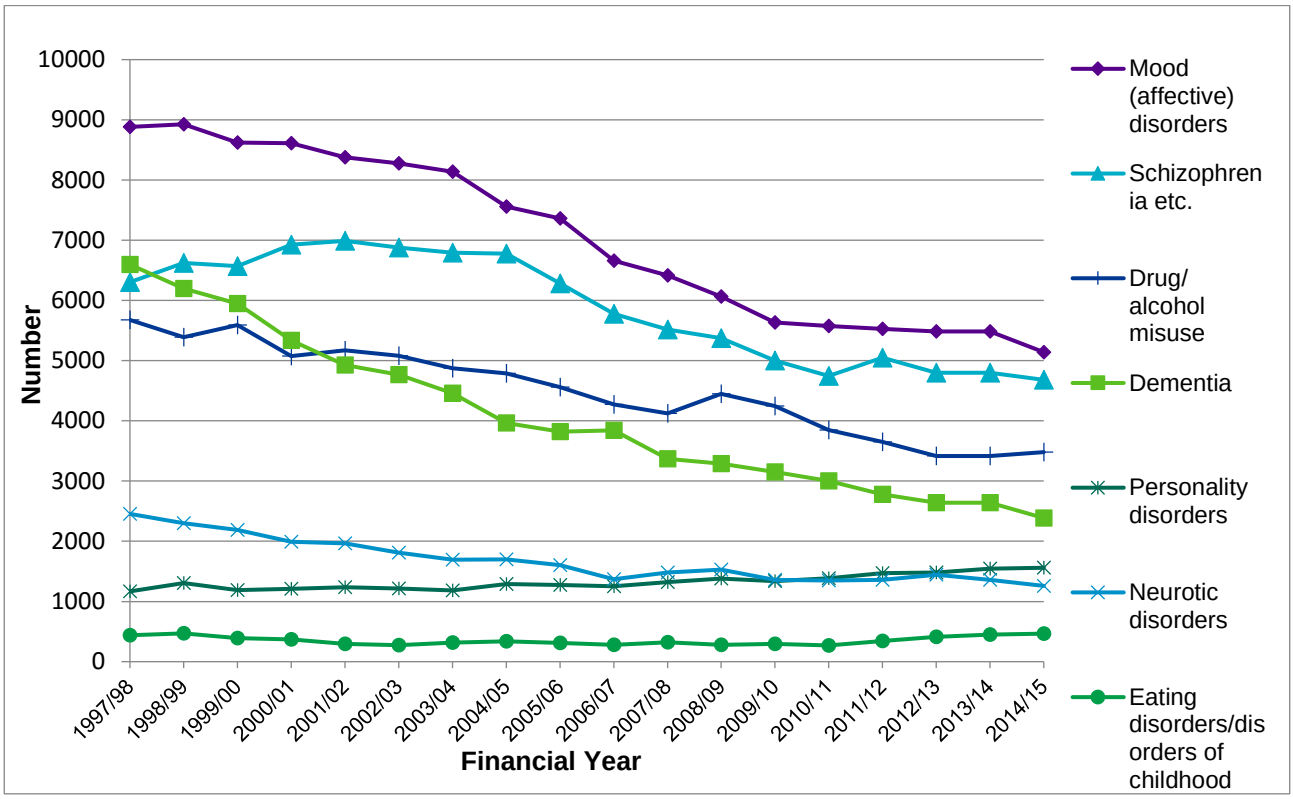
Figure 3.9: Mental health inpatients in West Lothian 1997/98-2014/15[62]



The number of mental health inpatient discharges (by principle diagnosis) from hospitals in Scotland for the year ending 31st March 2015 is shown in the figure below and it can be seen that most discharges relate to mood (affective) disorders.

[62] Ibid.

Figure 3.10: Mental health inpatient discharges by principle diagnosis: Year ending March 2015[63]



3.5 Suicide

The leading cause of death for people aged 15-34 years in Scotland is suicide[64], and preventing suicides is a major public health challenge for the Scottish Government. Since the Scottish Government rolled out the 'Choose Life' strategy in 2002, which aimed to reduce suicides by 20% by the year 2013, there has been a range of prevention methods undertaken in statutory, non-statutory and the voluntary sector which appear to have contributed towards positive results, although it is impossible to prove direct cause and effect. Since 2002 there has been an overall downward national trend in suicide rates with a reduction of 19.5% as seen in the graph below[65]; although this reducing trend has not been replicated in West Lothian over the same period.[66]

[63] Information Services Division Scotland. 2016. *Psychiatric hospital discharges by diagnosis, type of admission and gender - years ending 31 March 2010 – 2015.* Available at: http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/data-tables.asp?id=1275#1275 [Accessed 26th July 2016].

[64] Information Services Division. 2014. *The Scottish Suicide Information Database Report July 2014 Revision.* Available at: http://www.isdscotland.org/Health-Topics/Public-Health/Publications/data-tables.asp?id=1272#1272 [Accessed 04 November 2014].

[65] The Scottish Government. 2014. *Suicide reduction.* Available at: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/SuicideReduction [Accessed 27 November 2014].

[66] http://www.scotpho.org.uk/downloads/suicide/Suicide_LA_overview_2016.xlsx

Figure 3.11: Scotland level suicide rates form 2000-2013[67]

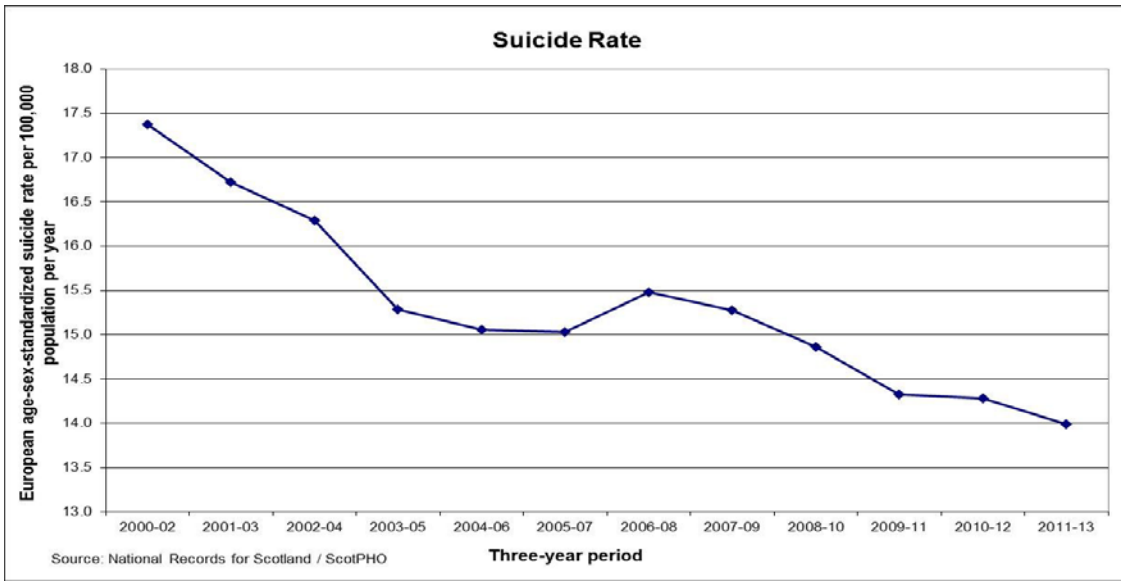


Image courtesy of the Scottish Government

More recently, figures show that between 2011 and 2015 there were a total of 3,882 deaths from 'probable suicide' (intentional self-harm and undetermined intent [UI]) in Scotland. A total of 1,847 deaths (n=47.6%) involved people aged 35-54 years old, whereas 2,831 deaths (n=72.9%) were males which suggests that men are three times more likely to die from suicide than women. As seen from the table below there were 137 deaths by probable suicide within West Lothian in this date range which amounts to 15.3 deaths per 100,000 population. A breakdown of these figures indicates that men of working age are a key risk group in West Lothian.

Table 3.12: Deaths Caused by Probable Suicide in Scotland 20011-2015[68]

Local authority	Suicide Death Self Harm		Undetermined intent [UI]		Total	
	Number	%	Number	%	Number	%
Scotland	2,802	72.2	1,080	27.8	**3,882**	100.0
Falkirk					**117**	100.0
Renfrewshire					**137**	100.0
South Lanarkshire					**203**	100.0
West Lothian					**137**	100.0

[67] Op.cit., The Scottish Government, 2014

[68] http://www.nrscotland.gov.uk/files//statistics/probable-suicides/15/suicides-table5-2015.pdf [Accessed 26th July 2016].

3.6 Psychological Therapies Waiting Times

Psychological therapies combine a variety of psychological interventions which help individuals to understand and make changes to their thinking, behaviour and relationships in order to relieve distress, and improve wellbeing.[69] In Scotland, there is a set HEAT target which requires at least 90% of Psychological Therapies patients to wait no longer than 18 weeks from the referral stage to the treatment of a psychological therapy from December 2014 onwards.[70]

The table below shows the national figures for the number of patients seen for psychological therapies within the last two quarters, and from the table it can be seen that in the quarter ending June 2014, 81.9% (n=8,090) of patients were seen within 18 weeks, whereas 81.3% (n=8,218) of patients were seen within 18 weeks in the quarter ending September 2014.

Table 3.13: Psychological Therapies Waiting Times - Number of Patients Seen in Scotland in Quarters Ending June and September 2014[71]

Quarter Ending	Type of Adjustment	Total Patients Seen	Number of Patients		% of Patients		Median Weeks
			0-18 Weeks	Over 18 Weeks	0-18 Weeks	Over 18 Weeks	
Mar-16	-	13,451	11,133	2,318	82.8	17.2	7
Dec-15	-	13,126	10,963	2,163	83.5	16.6	7
Sept-15	-	13,077	10,609	2,468	81.1	18.9	7
June-15	-	12,599	10,288	2,311	81.7	18.3	8
Mar-15	-	11,659	9,649	2,010	82.8	17.2	8
Totals	-	**63,912**	**52,642**	**11,270**	**81.6**	**18.4**	**7.4**

3.7 Dual Diagnoses

The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance misuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder.[72] This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse.[73] People with a dual diagnosis are more likely to have experienced

[69] Information Services Division. 2014. *Psychological Therapies Waiting Times in Scotland*. Available at: https://isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2014-11-25/2014-11-25-WT-PsychTherapies-Report.pdf?76824587584 [Accessed 26th July 2016].

[70] The Scottish Government. 2014. *Psychological Therapies.* Available at: http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/PsychologicalTherapies [Accessed 26th July 2016].

[71] Op.cit., ISD, 2014

[72] Lehman (1996), cited Evans, K., & Sullivan, J. M., *Dual Diagnosis: Counselling the Mentally Ill Substance Abuser,* Guilford Press, 2001 p.1.

[73] Afuwape S. A., 'Where are we with dual diagnosis (substance misuse and mental illness)? A review of the literature', November, 2003.

difficulties with education, employment, housing, personal relationships and their physical health. They are also more likely to have suffered trauma or abuse.[74]

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study of services in South London found a greater proportion of the patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics. Their analysis found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis.[75] Moreover, service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than either people with substance misuse issues or a mental illness, and in their National audit of violence, the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as a major trigger for violence in mental health services.[76]

In his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health, Professor Louis Appleby stated that "services for people with dual diagnosis - mental illness and substance misuse - are the most challenging clinical problem that we face."[77]

The term Dual Diagnoses is used interchangeable at times with co-morbidity, and there is no one single definition of the term. The World Health Organisation (2010)[78] defines the term as the '*co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder*', whereas another term refers to '*the co-occurrence of two psychiatric disorders not involving psychoactive substance use*'.[79]

Dual diagnosis or co-morbidity is often underestimated and under-diagnosed. Between 30 and 50% of psychiatric patients in Europe today have a mental illness as well as a substance use disorder, mainly with alcohol, sedatives or cannabis. In clinical prevalence samples of drug dependent patients, personality disorders (50–90%) are the most prevalent form of co-morbidity, followed by affective disorders (20–60%) and psychotic disorders (15–20%), although these syndromes interact and overlap which means a person might have more than one of these disorders in addition to drug-

[74] Banerjee, S., Clancy, C., Crome, I., *Co-existing problems of mental health and substance misuse (dual diagnosis): An Information Manual*, Royal College of Psychiatrists, 2002. Available at http://www.rcpsych.ac.uk/pdf/ddipPracManual.pdf. Accessed 04/12/2013.

[75] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2013.

[76] Ibid.

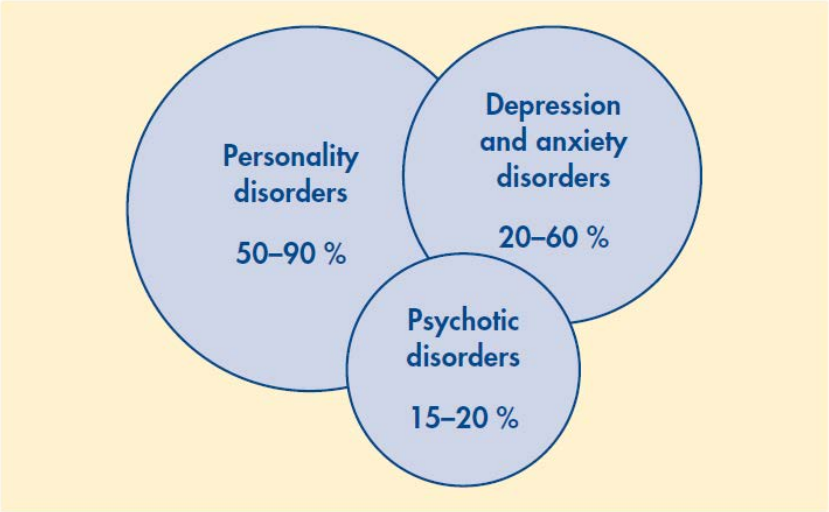
[77] The National Service Framework for Mental Health - Five Years On, Appleby L., Dept. of Health, Dec 2004.

[78] World Health Organisation. 2010. *Lexicon of alcohol and drug terms published by the World Health Organization. Available at:* www.who.int/substance_abuse/terminology/who_lexicon/en/ [Accessed 27 November 2014].

[79] European Monitoring Centre for Drugs and Drug Addiction. 2013. *Co-morbid substance use and mental disorders in Europe: a review of the data*, EMCDDA Papers, Publications Office of the European Union, Luxembourg. Available at: http://www.emcdda.europa.eu/attachements.cfm/att_220660_EN_TDAU13002ENN.pdf [Accessed 26 November 2014].

related disorders.[80]

Figure 3.14: Overlap of the three dominating diagnostic syndromes in patients with co-morbid drug-use disorders[81]



Furthermore, estimates of substance use of more than 50% are not uncommon in mental health services embedded in urban psychiatric facilities, although estimates in ruralities have been shown to be three to four times lower.[82]

The prevalence of co-occurring disorders has also been studied in community/general population samples[83] and particular links have been found between high alcohol consumption and depression

The nature of the relationship between mental health and substance misuse problems is complex, but possible mechanisms recognised by Crome et al (2009)[84] include:

- A primary psychiatric illness may precipitate or lead to substance use, misuse, harmful use, and dependent use, which may also be associated with physical illness and affect social ability.

[80] Fridell, M. And Nilson, M., *Drugs in Focus: Briefing of the European Monitoring Centre for Drugs and Drug Addiction*, 2004. Office for Official Publications of the European Communities. Available at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/dual.pdf Accessed 04/12/2013.

[81] Op. cit. Fridell & Nilson (2004).

[82] Rush, B, and Koegl, C., 'Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders within a Comprehensive Mental Health System', *La Revue Canadienne de Psychiatrie*, 2008; 53(12):810-22.

[83] For example: Reiger DA, Farmer ME, Rae DS. 'Co-morbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiological Catchment Area (ECA) study,' *JAMA*, 1990;264;2511–2518; Kessler, R., Nelson, C., McGonagle, K., Swartz, M., Blazer, D., 'Co-morbidity of DSM-III-R major depressive disorder in the general population: results from the US National Co-morbidity Survey', *British Journal of Psychiatry Supplement*, 1996; (30):17-30; Kessler R., Chiu W., Demler O, et al., 'Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey Replication.,' *Archive of General Psychiatry,* 2005;62(6):617–627; Grant B., Stinson F., Dawson D., et al. 'Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States,' *Archive of General Psychiatry,* 2004;61:361–368.

[84] Crome, I., Chambers, P., Frisher, M., Bloor, R. & Roberts, D., *The relationship between dual diagnosis: substance misuse and dealing with mental health issues*, Research Briefing 30, January 2009. Available at http://www.scie.org.uk/publications/briefings/files/briefing30.pdf. Accessed 02/12/2013. p. 4.

- Substance use, misuse, harmful use and dependent use may exacerbate a mental health problem and physical health problem, e.g. painful conditions, and any associated social functioning.
- Substance use e.g. intoxication, misuse, harmful use and dependent use may lead to psychological symptomatology not amounting to a diagnosis, and to social problems.
- Substance use, misuse, harmful use and dependent use may lead to psychiatric illnesses, physical illness, and social dysfunction.

Establishing which problem came first is often complicated and some authors warn that focussing on this issue can result in vulnerable individuals with co-morbidity being excluded from services whilst a decision about ultimate attribution is made.[85]

Co-morbidity can occur at any level of severity, and it is important to note that whilst in the UK there has been both an increased prevalence of substance misuse (particularly alcohol)[86] and an increased prevalence of dual diagnosis,[87] there is not necessarily a causal relationship between substance misuse and mental illness. Frisher et al (2005) concluded that, based on their sample of 3,969 patients with both substance misuse and psychiatric diagnosis, only a comparatively small proportion of psychiatric illness could be attributed to substance use (0.2%), whereas a more substantial proportion of substance use seems possibly attributable to psychiatric illness (14.2%).[88]

There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so do prevalence estimates. This difficulty is further compounded by an inconsistency in definition. Moreover, most studies are based on data collected from those already known to specialist services (mental health or substance misuse) and do not therefore tell us about the prevalence of dual diagnosis amongst the general population.

In line with European estimates, the charity 'Rethink Mental Illness' estimate that in the UK, a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem.[89] Studies have however shown widespread social and regional variation in the prevalence of dual diagnosis, with higher rates recorded in deprived areas than in affluent areas. That withstanding, it has been suggested that the rate is increasing more rapidly in affluent areas.[90]

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[85] Op cit. Crome et al (2009), p.3.

[86] British Medical Association Science and Education Department and BMA Board of Science (2008) Alcohol Misuse: Tackling the UK Epidemic. London, British Medical Association; NHS Information Centre (2008) Statistics on Alcohol: England 2008, London, NHS Information Centre; Murphy, R. and Roe, S. (2007) Drug Misuse Declared: Findings from the 2006/07 British Crime Survey – England and Wales, London, Home Office.

[87] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *J Epidemiology and Community Health* 2005;59:847–850; Frisher, M., Collins, J., Millson, D., Crome, I., and Croft, P. (2004) 'Prevalence of co-morbid psychiatric illness and substance misuse in primary care in England and Wales', *Journal of Epidemiology and Community Health* 2004;58:1034–1041.

[88] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *Journal of Epidemiological Community Health* 2005; 59:847–850.

[89] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.32.

[90] Op. cit., Frischer et al (2005).

Another aspect of co-morbidity relates to individuals with mental health problems having higher rates of health inequalities than the average population. Examples of higher rates of health inequalities for those with mental health issues are as follows. People with mental health problems are:[91]

- More likely to die sooner than the general population.
- Twice as likely as the general population to die from heart disease.
- More susceptible to drug and alcohol addiction.
- People with schizophrenia and psychosis die on average 15-20 years younger than the general population.
- Schizophrenics are 2-3 times more likely to develop type 2 diabetes than the general population.
- Women with schizophrenia are 42% more likely to get breast cancer than other women.
- People with schizophrenia who develop cancer are three times more likely to die than those in the general population with cancer. 61% of people with schizophrenia smoke, compared with 33% of the general population.

There are many determinants of these health inequalities and below is a brief summary of the various contributing factors to these health inequalities:[92]

- Effects of some psychiatric medications: antipsychotic medications, mood stabilisers and some antidepressants increase appetite and therefore can cause weight gain and obesity, and this can result in cardiovascular disease. (For example, it is common to have weight gain of 5-6kg within two months of first taking an antipsychotic medication and this gets worse over 12 months (Foley & Morley, 2011).
- Lifestyle factors adversely affect the physical health of people with mental health problems: poorer diets, low rates of exercise and higher prevalence of smoking than among the general population (RETHINK 2013).
- Higher rates of suicide, accidental or violent death.
- Poor monitoring of physical health.
- Misattribution of physical symptoms: seen as side effects of medication or secondary symptoms of mental health problem.
- Poorer access to physical healthcare: lack of clarity about professional roles and responsibilities can mean that when mental health service users develop physical disorders they are less likely to gain access to appropriate physical health interventions.
- Lower engagement with universal health screening and health promotion programmes.

[91] McCollam, A., and Allison, G. Mental health and health inequalities.

[92] ibid

3.7.1 The 'COSMIC' Study

In 2002, the Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC) estimated the prevalence of dual diagnosis in four inner-city areas in England (two in London, Sheffield and Nottingham). They reported that 74.5% of drug service users and 85.5% of alcohol service users experienced co-occurring mental health problems.[93] The prevalence of particular mental health problems amongst the subject group are shown in the table below:

Table 3.15: COSMIC study: Estimated prevalence of mental health problems among substance misuse patients[94]

Condition	% of drug treatment population	% alcohol treatment population
Psychiatric disorder	75	85
Non-substance induced psychosis disorders	8	19
Personality disorder	37	53
Depression &/or anxiety disorder	68	81
Severe depression	27	34
Mild depression	40	47
Severe anxiety	19	32

Similar rates of dual diagnosis were also reported in a study undertaken at the same time in the London borough of Bromley. Strathdee et al (2002) estimated that 83% of substance misuse clients had a dual diagnosis.[95]

The COSMIC study also found that 44% of the community mental health team (CMHT) patients reported problem drug use and harmful alcohol use in the preceding twelve months – the most commonly used substances being alcohol and cannabis:

Table 3.16: COSMIC study: Use of substances by CMHT patients[96]

Substance	Use in the past 12m by CMHT patients (%)
Harmful alcohol or drug use	44
Any drug use	31
Harmful alcohol use (AUDIT ≥8)	26

[93] Weaver, T., Charles, V., Madden, P., & Renton, A., 'A study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations', Drug Misuse Research Initiative/Dept. of Health, 2002. Available at http://dmri.lshtm.ac.uk/docs/weaver_es.pdf. Accessed 06/12/2013.

[94] Source: Table 2 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.33.

[95] Strathdee et al (2002), 'Dual diagnosis in a primary care group (PCG) – a step by step epidemiological needs assessment and design of a training and service response model', Department of Health/National Treatment Agency.

[96] Source: Table 3 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.34.

Cannabis	25
Dependent cannabis use	12.8
Sedatives/tranquilisers	7
Crack cocaine	6
Heroin	4
Ecstasy	4
Amphetamines	3
Cocaine	3
Opiate substitutes	1.4

The study in Bromley suggested lower levels of dual diagnosis within community mental health clients (20%), but recorded a prevalence rate of 43% for psychiatric in-patients and 56% in forensic patients.[97]

Other key findings of the COSMIC report were that around 30% of drug service users and 50% of alcohol service users had 'multiple morbidity' (i.e. complex needs); and some 38.5% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem. Also important is the conclusion drawn that the treatment population is heterogeneous, and that responding to the range and level of need is challenging.

[97] Op. cit. Strathdee et al (2002).

CHAPTER 4: KEY FINDINGS – PROFESSIONAL VIEWS

4.1 Introduction

This chapter presents a thematic analysis of the key findings of each of the mixed methods of the study that focused on the views of professionals:

- Semi-structured interviews;
- Stakeholder Events and Working Groups; and
- Professional Surveys (Service Staff, Dentists, Optometrists and Pharmacists).

The full detail of the transcribed groups and interviews, and surveys are presented in the accompanying **Part 2 Appendix Report (Appendices II, III and IV)**. These key findings have then been analysed by the research team against the original objectives of the study in order to inform the study recommendations (see **Chapter 6** below).

For maximum insight, it should be read in conjunction with Appendix III, which sets out the range of viewpoints articulated in the interviews.

To give structure, our analysis of views and what they tell us will be presented under the headings of Strengths, Weaknesses, Opportunities and Threats (SWOT).

A SWOT analysis is an examination of a system's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival.

Figure 4.1: SWOT Analysis structure

Some areas figure under more than one theme; for example, where there is evidence of both strengths and weaknesses. Similarly, it should be remembered that not all stakeholders were in

agreement, and therefore drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position.

Finally, this strand of analysis is based on subjective views and therefore must be combined with other evidence from other sources (such as service users and carers) for a fully rounded perspective.

4.2 Strengths

Traditional SWOT analysis views strengths as current factors that have prompted outstanding performance. Some examples could include: sufficient capacity across services, highly competent personnel or a focus on quality improvement. The aim here is to identify current strengths across the Mental Health sector in West Lothian as well as to identify the building blocks for developing new strengths across the sector.

What are the perceived strengths of Mental Health services in West Lothian; either directly stated or inferred from wider comments?

4.2.1 The quality and commitment of staff

Many stakeholders gave examples of where the quality and commitment of staff was a positive asset to the delivery of mental health services; such comments were made both about the staff within the stakeholder's own service but also with reference to external services. For example, individual interviewees remarked upon the personal commitment to work with patients, flexibility and willingness to do things differently.

Positive remarks were made about both statutory services (inpatient and community mental health services) as well as those working in third sector organisations.

Of course, it cannot be deduced from this that all services are universally comprised of high-quality staff and there was also evidence of staffing weaknesses in, for example, recruitment and staff absence.

4.2.2 Services for those with severe and enduring mental health problem

Services for those with severe and enduring mental health problem were identified as an area of strength by several interviewees. The Community Outreach Team were singled out for praise and there was also positive comment regarding inpatient acute care and contributions made by the specialist services based at St John's.

4.2.3 Joint Working

Interviewees cited a number of areas of good joint working, but this was not universal and others identified weaknesses.

In some areas positive joint working appeared born out of formal structural arrangements, but in others it seemed more reliant on individual relationships. In illustration, the Mental Health Well-Being Screening Group (which acts as a clearing-house for young people with mental health issues) was cited as effective at regularly bringing together a range of services to systematically triage and allocate cases. But in other cases the strength of joint working appeared more reliant on the quality of relationships between people; 'I get on well with X, we work well together'. Ultimately, a reliance on individual relationships creates vulnerability; as the quality of joint working may be diminished by staff turnover.

Some put the quality and strength of joint working down to an overarching culture; occasionally referred to as 'The West Lothian Way'. Thus some remarked upon a strong ethos of corporate working, whilst others commented on the benefits of tranches of staff working together in the same area, with shared values, over a long period of time.

There was positive comment about good working relationships between the statutory and third sectors, as well as between Council departments, e.g. in addressing wider issues of health and social inequality.

4.2.4 Service User and Carer engagement

As with joint working, this was identified as an area of both strengths and weaknesses. However, where service user or carer engagement was identified as a strength, this appeared reliant on the commitment and ethos of individual services and their staff; rather than as an embedded strength of all provision.

Examples were given of positive engagement with service users in in-patient and community mental health services; for example, in-patient wards holding weekly meetings with service users and a high level of engagement in day services run by The Community Outreach Team. There was positive comment about The Mental Health Advocacy Project and evidence that it is engaged with -a sizeable number of people with mental health issues, albeit primarily those with severe and enduring mental illness.

We heard examples of positive engagement with and support to carers, but again this appeared confined to individual services and staff members.

4.2.5 Services for people with Dementia and their carers

Strengths were identified in some aspects of services for people with Dementia and their carers. In particular, a number of interviewees commented on the positive contribution and reach into communities offered by the area's nine Dementia Cafes.

4.3 Weaknesses

Weaknesses are either system or organisational factors that will increase costs or reduce quality. Examples could include ageing facilities and a lack of continuity in care and support processes, which could lead to duplication of efforts. Weaknesses can be broken down further to identify underlying causes. For example, disruption in the continuity of care often results from poor communication. Weaknesses also breed other weaknesses. For example, poor communication disrupts the continuity of care, and then this fragmentation leads to inefficiencies across the entire system. Inefficiencies in turn, deplete financial and other resources.

The aim here is to successfully identify, explore, resolve and reduce weaknesses.

What are the perceived weaknesses of Mental Health services in West Lothian; either directly stated or inferred from wider comments?

4.3.1 The current configuration of services is not fully fit for purpose

Taking an overview of comments made, it was clear that many felt overall the current service configuration was deficient and, ultimately, not fully fit for purpose. Whilst many would have agreed that most of the necessary service elements were in place, interviewees identified issues with the scale and scope of those elements and how they were managed.

Key concerns were:

- Issues with capacity and patient flow
- Inappropriate presentations and referrals
- Inadequate or poorly functioning patient pathways
- The contribution made by psychological therapies
- Structural arrangements for management of services.

These are big issues, and we will tease out more fully areas of weakness over coming sections.

Although there were differences of emphasis and interpretation, a significant number of interviewees identified issues of capacity, capability and flow across in-patient and community mental health services. Causes suggested were: that an historic reduction in in-patient beds had gone too far; that the pace of progress into and through Rehab could be too slow; and inadequate levels of community support causing delayed discharges. We are not in a position to fully assess the validity of these individual views, but overall a sufficient number of interviewees spoke of: difficulties accessing acute inpatient beds: patients delayed in acute wards when they should be progressing into Rehab: patients delayed in Rehab because appropriate supported accommodation was not available: and of some service users requiring to be placed in out of area community services, to conclude that the current systems are not functioning optimally. A whole system view is required when it comes to capacity, capability and flow and suboptimal performance by individual elements can impact negatively on the functioning of all.

Interviewees often remarked upon inappropriate presentations and referrals and we interpret this as symptomatic of problems with service configuration. We will illustrate this more fully later, but inappropriate presentations at A&E, to CAMHS and referrals back to the GPs were a common concern.

Inappropriate presentations and referrals may well confirm claims that patient pathways can be inadequate or malfunction. We heard both positive and negative comments about patient pathways, and it is likely the quality of these will be open to variation across services and disciplines. However, the fact that we regularly heard that primary access services such as A&E, GPs and the Mental Health Assessment Team could be overloaded and unable to find appropriate, or sufficiently responsive, services onto which they could refer as confirmation of a lack efficacy in current pathways.

The role and input of psychological therapies was often a contentious topic. At a basic level there was universal agreement that waiting times for adult psychology services were far far too long; of the order of a year. The capacity of the service was recognised as an issue, but some also felt the service was not always run efficiently. Whilst there was not always agreement on the causes and extent of problems with the current service, there appeared more consensus on what the potential solutions were. Consequently, we believe there would be widespread support for an enhanced psychological therapies service, including implementation of a robust and well-resourced Stepped Model of Care; where a broader range of non-specialist staff and organisations (including the third sector) delivered psychological therapies.[98]

Finally, interviewees made a number of observations which when taken together suggest a lack of coherence to the existing management arrangements for Mental Health services. For example, some interviewees complained of disjointed or dysfunctional lines of accountability. We also heard examples of individuals appearing to wilfully not engage with fellow professionals, or who pursued their own narrow self-interest and "hobbies", to the detriment of contributing to general services. There were advocates of Mental Health services having a single manager.

4.3.2 Services for The Distressed

A common theme was the adequacy and configuration of services for those that might loosely be categorised as 'Distressed'. Whilst lumping a wide range of presenting issues - Anxiety, Depression, Substance Misuse etc. - together under the banner of 'Distress' is crude, we see merit on this occasion because progress might best be achieved through psychological interventions, Recovery based models and changes to the service users wider social circumstances (addressing homelessness, relationships, poverty and unemployment).

In contrast to perceptions of services for those with Severe and Enduring Mental Health problems, we were struck by how many interviewees thought services for people 'In Distress' were inadequate. Evidence indicated these inadequacies stem from both a lack of capacity and inappropriate service

[98] Such as advocated in 'The Matrix - A Guide to Delivering Evidence Based Psychological Therapies in Scotland', NHS Education for Scotland, 2014.

models. We heard of excessive presentations of people 'in crisis' at A&E, GPs and the Mental Health Assessment Team but for whom there was no appropriate and timely therapeutic response. Interviewees often complained of a lack of low-level, rapidly accessible services. Some went so far as to assert a lack of options was fostering a culture of risk aversion and over treatment; for example, where passing reference to suicide could trigger an automatic referral to Adult psychology, even though in practice it could be a year before such therapy was available.

Some interviewees implied that GPs were often left to carry the burden of assisting those In Distress; unsure of who to refer to or having to make do while specialist services either did not prioritise their patient or were slow to respond. Whilst this may well be true, there are surely far wider consequences if people In Distress are being let down by current arrangements. There will be negative consequences for relationships, children and families, employers, other service providers and communities.

There were mixed views about the Distress Tolerance Group, which has been discontinued relatively recently. There were positive advocates who saw it as an appropriate and cost-effective option, but others questioned its value; some went as far as suggesting the group had been dysfunctional and had amplified behaviours and distress. Whilst we cannot comment on the merits, or otherwise, of this group and approach, we would note that this is one option no longer available and some interviewees commented negatively that they now had nowhere to refer. The Distress Tolerance Group may not have been the answer, but a service remains. Going forward, it is likely that a range of options will be necessary, both from a clinical perspective and to fit with individual service user preferences.

Having already touched upon the current inadequacy of psychological services, an expanded range of services for people In Distress, based on a stepped model of care, appears appropriate.

Comments from interviewees would suggest the scale of unmet need could be significant. It is likely that further investment would be required although effective interventions may lead to savings / resources released in other areas.

4.3.3 Joint working / interdisciplinary relationships

There was evidence of poor joint working; between agencies, disciplines and individuals. Unfortunately, whilst we heard of good collaboration between individual services, this was offset by examples of unwillingness to collaborate, shallow and transient relationships and, on occasion, behaviours that appeared positively disrespectful.

It was alleged by more than one source that, historically, some psychiatrists had undermined efforts to work together; failing to attend and engage with interdisciplinary initiatives. For example, there were advocates of a single point of referral in adult services but, they observed previous efforts to establish this had faltered because of non-attendance by psychiatrists.

The presence of Locum psychiatrists was highlighted by some as detrimental to joint working; the transitory tenure meaning working relationships were not fully developed and sustained.

We heard of behaviours that appear disrespectful and high-handed; for example, regularly not replying to phone calls and emails from important partner organisations.

Whilst a more coherent management structure will not of itself be a panacea for dysfunctional personal and interdisciplinary relationships, future leadership could set clear expectations regarding the necessity for collaboration and mutual respect.

4.3.4 Patchy engagement with service users and carers

Taking the sweep of interviews as a whole, the evidence was that engagement with, and empowerment of, service users and carers was at best variable.

Some aspired to a thorough-going empowerment of service users and carers and an honesty and openness to co-production. However, it was evident that they did not expect such ambitions to be realised in the near future. More generally, there was an acceptance that more could be done to have meaningful engagement.

Finally, some implied that there was an institutional resistance to increasing service user and carer influence; noting that some vehicles for engagement, had been removed or diminished.

4.3.5 Health Inequalities

Generally, there was acceptance that health inequalities were a continuing issue. Some interviewees were of the view that there was a tokenistic up approach to tackling health inequalities, and that the NHS did not always recognise or value the contribution of partner organisations.

Some identified specific drivers of Health Inequalities - poverty and deprivation, poor public transport and out of area services. Several remarked that small rural communities were not well served by bus links and this could impact on access. One interviewee noted it was unreasonable to expect some people afflicted by anxiety to travel significant distances, including out of area to Edinburgh-based services.

4.3.6 SDS and assessment processes

Whilst often the principles of Self Directed Support were supported, there was significant concern regarding how it is currently delivered and its impact on availability of support services.

Particular weaknesses identified with SDS were: a 'failure to grow the market', its potential impact on the viability of some services and inequity between client groups. Some were also concerned about the length of time taken to conclude assessments and finalise care packages.

Some interviewees observed that whilst in theory the market should be responsive to the individual demands arising from personalisation, in reality this was not always occurring. Service users had difficulty finding providers willing to offer bespoke care packages. Providers on the other hand could struggle to deliver viable services; challenged by flexible demands from small numbers and uncertain levels of return.

Some interviewees claimed that SDS was not allocating resources equitably; for example, comment was made that whilst very significant care packages could be available for those with Learning Difficulties, other client groups might struggle to secure relatively small packages of care. One interviewee argued that current SDS arrangements actively worked against those with Severe and Enduring mental health problems; because their illness prevented them from fully understanding, or having the organisational capacity, to take full advantage of the system, consequently they were losing out to other groups.

4.3.7 Staffing - recruitment, retention and staff absence

Evidence from interviews confirmed that local NHS mental health services face challenges with recruitment and retention of staff and also high-levels of staff absence in some inpatient facilities; these issues also afflict the NHS nationally. Interviewees identified a range of damaging consequences affecting the quality of care, joint working and staff morale.

4.3.8 Well-Being

The concept and approach to Well-Being divided interviewees. Some argued its pursuit ran through everything the Community Planning Partnership did, but one derided the whole concept as meaningless and a waste of money. Whilst the latter view was rare, it was more common for people to remark that there was a lack of clarity regarding Well Being objectives and that a greater practical focus was required.

4.3.9 Support to Carers

A number of interviewees felt there was a lack of support for Carers. For example, there were positive reports regarding Post-Diagnostic Support for some people and carers with Dementia, but pressure on the service meant not all carers had benefited from this and for other carers, the support ended too early; before the most gruelling stages of the illness.

We understand that Carers of West Lothian have relatively recently increased their support to people caring for someone with a mental health problem. Time will tell if this initiative allays the concerns of those who felt the organisation was more focused on supporting carers of older people and those with physical disabilities.

4.3.10 Transitions and age-based services

Service transitions precipitated by age - from CAMHS and other Young Persons services into Adult and Adult into Older Person's services - were identified as a weakness by many interviewees.

The transition from CAMHS into Adult services was identified by some as an area of weakness because of a marked difference in the ways the two services operated; young people and families

could find the transition something of a culture shock it was also noted that planned service handovers commonly didn't happen.

It was also suggested that insufficient attention was paid to the needs of Looked After Young People; should be a strategic priority because of a higher prevalence of issues leading to poor mental health.

More than one interviewee questioned whether age boundaries remained relevant, particularly between Adult and Older Persons services. Such boundaries, it was argued, could place an artificial and inefficient barrier to delivery of some services, for example, psychology.

4.3.11 Access to specialist services

The local presence of specialist services for Eating Disorders and the Mother and Baby Parental were generally remarked upon as positives, however some also saw weaknesses in provision for other conditions; such as Autistic Spectrum Disorder and Brain Injury. In the former case, access was perceived as limited because the service for those with ASD was consultant led and based in Edinburgh.

With small numbers commenting the extent, or actuality, of such gaps in service would require further evidencing.

4.3.12 Other miscellaneous weaknesses

A number of other weaknesses were identified or inferred by interviewees, often in the passing. Often, given limited time available for interviews and focus of the study, there was insufficient time to pursue these in any detail. Thus, whilst the following may be relevant, we cannot expand on them to any extent.

- Lack of consistent approach to localities boundaries: - It was observed that there is not a consistent approach to localities boundaries in West Lothian. The Health and Social Care Partnership has two localities, but The Council may use three localities. This could cause problems for planning and data analysis.
- West Lothian's rural areas could present challenges when commissioning services. This could show itself in labour force shortages and an unwillingness from contractors to provide services.
- Some interviewees felt there was a lack of critical self-analysis amongst the primary players. These concerns appeared linked to other concerns about lack of engagement with service users and carers. There was a need to listen more and be more open to lessons from criticism.
- Although progress was credited, some clinicians made passing reference to concerns that the physical health needs of people with mental health problems were not always fully addressed.
- Some were of the view that are Medical model still held undue sway in the design and delivery of services.
- As well as noting a high prevalence of drug and alcohol issues as those In Distress, some perceived wider weakness services for these client groups.

4.4 Opportunities

Traditional SWOT analysis views opportunities as significant new initiatives available to a system. Examples could include collaboration among health and social care organisations through the development of delivery networks, community partnering to develop new care and support programmes and the introduction of protocols to improve quality and efficiency. Integrated delivery networks have an opportunity to influence health and social care policy at both local and national levels. They also have an opportunity to improve client satisfaction by increasing public involvement and ensuring client representation on boards and committees. For example, systems that are successful at using data to improve processes have lower costs and higher quality client care. The aim here is to enhance current opportunities as well as to exploit new opportunities.

This section summarises the 'opportunities' identified; either directly stated by interviewees or which can be inferred.

4.4.1 Service redesign

Whilst the appetite and ambition of interviewees varied, many saw opportunities for service redesign.

In particular, several saw a need and an opportunity to redesign services for those In Distress. There were advocates for a radical rethink, with the goals of: speeding access; enhancing the diversity and scale of psychological therapies; and making best use of existing staff resources. Some argued this could be achieved by Stepped Models of Care drawing more fully on the third sector and legitimising psychological interventions by a wider range of clinical and support staff.

Some spoke of how service redesign could bring opportunities to strengthen collaborative working; for example, through multidisciplinary teams and GP clusters.

Service redesign could also revisit the merits of age-based services, potentially sweeping away troublesome transitions and realising efficiencies.

4.4.2 Co-production

Several coupled service redesign with opportunities to build strengthened relationships with service users and carers, through co-production. Implicit in this view was that providers could learn from the experience of users and carers and that, consequently, future services models would have greater legitimacy and support.

4.4.3 A revised management structure

There's an opportunity to address perceived weaknesses in the existing management structure for mental health services. Some argued that services should be brought together under a single Mental Health Manager. Such a post could: promote a more coherent approach to service delivery and redesign; further enhance a culture of joint working and address any tensions between disciplines and individuals.

4.4.4 Recovery

Some saw opportunities to further embrace Recovery as an ethos; through the promotion of self-management, enhancing social capital and the recognition that Recovery is a journey not a destination.

4.4.5 Enablement

It was observed that Recovery was not relevant to those with a degenerative condition such as Alzheimer's. Nonetheless, there were opportunities to enhance Enablement; facilitating the fullest living of life.

4.4.6 Personalisation / SDS

In spite of perceived difficulties with the current operation SDS, generally there was support for the concept of personalisation and the opportunities it presented individual service users and carers to shape the services received.

4.4.7 Early intervention / prevention

There were those that argued for an increased focus on prevention and early intervention; or at the very least, protection of existing levels of resource allocation. There was little opportunity to discuss the precise form of future preventative activities, but we're comment was made, work with Children and Families figured most strongly.

4.4.8 Health and Social Care integration

Interviewees saw opportunities in the integration of Health and Social Care; securing sustainable services through shifting the balance of resources, clarity in priorities, efficiencies and enhanced joint working. However, it was evident that many believed there were obstacles to the achievement of these ambitions. We will touch upon these in the following Threats section.

4.5 Threats

Threats are factors that could negatively affect system performance. Examples could include: political or economic instability; and increasing pressure to reduce care and support costs.

The aim here is to avoid and thwart direct and indirect threats to the Mental Health system across West Lothian.

This section summarises Threats identified; either directly stated by interviewees or which can be inferred.

4.5.1 Unsustainable service arrangements

Many perceived current service arrangements as unsustainable in the medium to long term. Causes identified were a combination of: growing demand, unrealistic expectations and resource constraint. Some asserted these threats made the case for change, including changing models of care, reviewing priorities and potentially scaling back activities.

4.5.2 Current inefficiencies

Participants identified areas of current inefficiency that were ongoing threats; examples being: unnecessary escalation into specialist services; over treatment; inappropriate presentations and referrals; and issues with staff recruitment, retention and sickness absence.

4.5.3 Ill-informed commissioning

For a range of reasons, there was concern that inappropriate services may be commissioned. Reasons given included: failure to listen to service users and carers; unilateral action by commissioners without regard to professional advice and the evidence base; and a failure to gather and utilise performance and impact measures.

4.5.4 Personalisation and SDS

Two threats were articulated or implied. Firstly, that a drive toward bespoke delivery could undermine the viability of existing services and organisations; demand, and consequently, income could be volatile and this might result in service closures or a lack of innovation and risk aversion on the part of providers.

Secondly, individually tailored services could be more expensive because of a lack of the economies of scale achieved through group based commissioning.

4.5.5 Failure to invest in prevention and early intervention

There was concern that resource constraint would lead to further de-prioritisation of preventative activities, which would over time prove costlier.

4.5.6 Diminution of workforce, ratios and competence

Some argued that with most of service costs being staff related, continuing resource constraint would have the inevitable consequence of reducing staffing ratios, changing skill mix and reducing overall competence.

4.5.7 Lack of political support

There was concern that politicians, both locally and nationally, could not be relied upon to be consistent to take difficult decisions.

4.5.8 Vested interests

Efforts to significantly redesign services or shift the balance of resources could be opposed by supporters of the status quo.

4.5.9 Worsening Health Inequalities

Some suggested that welfare reform and increasing in work poverty would lead to an exacerbation of health inequalities. Those with mental health problems were particularly vulnerable in this regard.

4.5.10 Further centralisation of services

Concern was expressed that some local services - including in-patient beds - might be centralised in Edinburgh, with a negative impact for service users and carers.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

Ensuring good mental health within the population throughout the life course is about more than just the absence of mental disorder, and is a major contributor to wellbeing within the population. Mental health impacts on all aspects of people's lives and it is therefore the responsibility of not only the individual, but also families, friends, employers and the wider community to enable people to develop and importantly maintain good mental health.

This needs assessment has been produced to support the appropriate and efficient commissioning of mental health and wellbeing services and support provisions across West Lothian.

This chapter sets out a series of recommendations for deliberation by the West Lothian Health and Social Care Partnership. Recommendations are derived from evidence gathered and analysed from the review of data, surveys and fieldwork, including study informants.

5.2 Recommendations

The following series of recommendations have been structured around a series of key themes.

5.2.1 Joint Strategic Priorities

- **Recommendation 1:** In future, these priorities should be needs-led and not service-led.
- **Recommendation 2:** Consideration should be given to strengthening the contribution of the Third Sector; particularly in areas of lower speciality community based supports.
- **Recommendation 3:** Inclusion of 'support for carers' in future priorities.
- **Recommendation 4:** Taking cognisance of the recent NHS National Clinical Strategy and accepting issues of resource constraint and growing demand, the Integrated Joint Board to reassess the current balance of regionally and locally delivered mental health services to ensure the most beneficial and sustainable arrangements are put in place to deliver quality care as close as practicable for service users and carers; such a review to include consideration of opportunities arising from GP clusters.

5.2.2 Current Configuration of Services

- **Recommendation 5:** A comprehensive review is required, to address issues of capacity, capability and flow across the Acute, Rehab and Community Support services.
- **Recommendation 6:** A review of management arrangements for Mental Health services in light of the evidence provided in this study.

- **Recommendation 7:** A review of services for the 'Distressed' with the aim of delivering an expanded range of services and enhanced early intervention. It would seem appropriate that future services are based on a Stepped Model of Care.

5.2.3 Ethos

- **Recommendation 8:** The Integrated Joint Board to develop a statement of Vision and Values to which all Mental Health services should subscribe; this to emphasise the centrality of Recovery and the benefits of engagement and co-production with service users and carers.

5.2.4 Adult Psychology Services

- **Recommendation 9:** We would recommend consideration of developing an enhanced psychological therapies service, including implementation of a robust and well-resourced Stepped Model of Care; where a broader range of non-specialist staff and organisations (including the third sector) deliver psychological therapies (such as advocated in 'The Matrix - A Guide to Delivering Evidence Based Psychological Therapies in Scotland' NHS Education for Scotland, 2014).

5.2.5 Joint Working Arrangements

- **Recommendation 10:** Given the evidence of variable joint working between agencies and disciplines, we would recommend consideration of strengthened multidisciplinary teams across both in-patient and community settings.
- **Recommendation 11:** Consideration be given to a single point of referral for Adult services.

5.2.6 Service User and Carer Involvement

- **Recommendation 12:** Given this study has noted variable engagement with, and empowerment of, service users and carers, we would recommend consideration of developing a Service User and Carer Involvement Framework and Strategy.

5.2.7 Staffing

- **Recommendation 13:** Development of a workforce strategy for Mental Health services to address identified issues of recruitment, retention, sickness absence and an ageing workforce.

5.2.8 Transitions

- **Recommendation 14:** A review is required of transition arrangements between CAMHS and Adult Services given the evidence supplied in this study.