



Executive Summary

Scotland-wide consistent data are already available on:

- Available psychiatric beds
- Diagnoses of those being cared for as psychiatric inpatients
- Those admitted to general hospitals after episodes of self-harm
- Aggregate activity (headcounts) for outpatients, daypatients and community contacts
- Prescription drugs associated with mental health dispensed in the community
- Frequency of visits to GPs for mental health reasons
- The workforce available to deliver mental health care
- Cause of death (including suicide)

Headline points from the report

- Available general psychiatry beds in Scotland have reduced three fold since 1980. This is in line with the change in emphasis towards community care.
- ...but the number of consultant psychiatrists and psychologists has risen since 1990
- 40% more per head is spent on prescriptions for anti-depressants in Scotland than in England
- ...but surveys suggest that people in Scotland are no more prone to depression. (Perhaps proportionately more Scots visit their doctor, and receive more modern medications?)
- Depression was the commonest contributing diagnosis for Scots visiting their GP in 2000
- Schizophrenia in those aged 16-65 on 31 December 2000 showed a 20 year prevalence rate of 4.3 per 1000 (5.4 for men, 3.2 for women)
- Suicide was the leading cause of death among young men in 2000, and the numbers appear to be rising. The male suicide rate for Scotland in 1998 (26 per 100 000) was more than double the UK average (12 per 100 000)
- Ritalin (methylphenidate) prescribing per young person shows a seven-fold variation across Scottish NHS boards

Areas we need to explore further

- **We need to have fuller information on the care being delivered in community settings.** This applies not only to mental health, and is particularly important in allowing the delivery of **complete and integrated packages of care** where different types of interventions are delivered by different members of a multi-disciplinary, multi-agency team. Although the care recipient/ service user is a key member of the care team they should not have to coordinate communication among other team members. The Improving Mental Health Information Project team have already embarked on a series of endeavours to improve information sharing among care providers. These include the development of a **draft information core for integrated care (ICIC)**, intended to provide the basic shared description of encounters and interventions that care providers will need in order to deliver 'joined-up care'.
- **We also require better information on the quality of care.** At present we do not have good measures of outcomes, and in any case have poor knowledge of interventions being delivered in the community. It is often therefore very challenging to know whether the correct care is being delivered. The core information gathered by the ICIC can also be used to deliver consistent data for quality improvement, service planning and management.
- We need to document more fully the **mental health problems of those primarily in contact with services for physical problems.** We believe that the current data stream from general hospitals (SMR01) considerably under-records the mental health problems of their patients.
- Confidentiality and security are important. In all cases personal information must only be procured and processed in full compliance with the Human Rights Act, Data Protection Act and CSAGS guidance.

Alastair Valentine Philp (alastair.philp@isd.scot.nhs.uk), 1st July 2002