Scottish Needs Assessment Programme

Mental Health
Overview and Programme

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Scottish Needs Assessment Programme
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Mental Health
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SNAP Reports currently available

Total Elective Hip and Knee Replacement - a comparative assessment
Cataract Surgery
Congenital Dislocation of the Hip
Global Needs Assessment - a screening tool for determining priorities
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Breastfeeding in Scotland
Improving Gynaecological Services Within Existing Resources - A Programme Budgeting and Marginal Analysis Approach
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- Alcohol Misuse
- Tobacco
- Problem Drug Use

Acute Stroke
Teenage Pregnancy in Scotland

SNAP Reports due to be published shortly

Accidents in Scotland
Cardiac Disease
Hernia Repair

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EXECUTIVE SUMMARY

This report is intended to present an overview of relevant mental health issues, to outline a programme for future in-depth work on specific topics and to inform purchasers of health care services for mental health in Scotland.

Mental health is a central public health issue and there is evidence to suggest that the prevalence of mental health problems is growing.

- at any one time almost 30% of the adult population in Scotland suffers from a mental health problem
- an estimated 10% of the population in a year will be diagnosed by their general practitioner as having a mental health problem
- around 2% will have a significant disability as a result of a mental health problem, depression being the most common underlying reason

Mental health services are essential components of the National Health Service. They accounted for 18% of in-patient days in Scotland in 1990 and 8.3% of in-patient costs. Diagnosed mental health problems are the third most common reason for people consulting their general practitioner although undiagnosed problems leading to consultation have been estimated to be at least as common.

An overall approach to needs assessment for the purchasing of mental health problems is presented which considers the following questions:

- For whom are we purchasing services?
- What mental health problems do they have?
- What help do they want and need?
- Is purchasing care services the best way to help with the problems they have?
- What services do we currently purchase for them?
- Do current purchased services provide the help needed or wanted?
- Do the purchased services make any differences to the mental health problems they have?

A small number of users and carers groups were consulted with on issues identified. The SNAP Group prioritised the following topics for further work:

- the epidemiological monitoring of mental health problems in Scotland
- suicidal behaviour in young people
- mental health in the workplace
- the effects of changing patterns of mental health service provision and their health, social and economic implications
- the involvement of users and carers in assessing the need for, commissioning and monitoring mental health services

RECOMMENDATIONS

1 Greater priority should be given to mental health at national level.

2 A coherent uniform information data base for mental health in Scotland must be developed. The lack of sound Scottish data is a major constraint on the effective purchasing of services and the promotion of mental health. It is worth noting that OPCS is about to survey mental health in Scotland and the CRAG/SCOTMEG Sub-Group on Mental Health has a Working Group on Outcomes.

3 Appropriate and feasible mental health outcome measures should be developed using improved information.

4 Collaboration on assessing needs and communication between the different services which deal with mental health must be improved, particularly with regard to defining needs through care management and to evaluating the effects of different service interventions.

5 Further multidisciplinary, multiagency work should be carried out immediately in the priority areas identified in this report. These are:

- Epidemiological monitoring of mental health in Scotland (this links directly with recommendation 2 above)
- Mental health in the workplace
- Suicidal behaviour among young people
- Effects of the changing patterns of service provision and their health, social and economic implications
- Involvement of users and carers in assessing need for, commissioning and monitoring mental health services

KEY ISSUES FOR PURCHASERS

All health boards face a number of issues regarding the purchasing of mental health services and their wider responsibilities in promoting health and being the advocate on health for their resident population. These include:

1 The resettlement of patients who have been in long-stay hospitals

Boards are currently grappling with issues related to discharging patients to alternative services in the community: the future balance between health and social care, the pattern of community mental health services for all in the community not just those discharged and the role of National Health Service continuing care services.

2 The increasing role of community based services in delivering mental health interventions previously provided in hospital settings

A re-shaping of specialist mental health services is currently underway. The increasing decentralisation of specialist services to community settings; the creation of multi-disciplinary teams and the need for clarification of professional roles are all facets of these changes.

3 The management of mental health problems in primary care

Most patients with these problems are cared for by their general practitioner. There is a growing awareness of the need to develop alternatives to benzodiazepines, to examine the role of counsellors and their relationship to other professionals (eg clinical psychology) and the strengthening of links between self-help groups and voluntary organisations providing befriending and primary care services.

4 Improving information for purchasing decisions and developing outcome measures

Most Boards are developing service specifications, standards and contracts. However there are inadequate data on those needing and using mental health services and the type and level of care provided. Similarly, outcomes of service provision have not been defined. In the absence of these, decisions based on value for money criteria are not currently possible. Outcome measures must be developed.

5 Addressing health promotion issues

Public health professionals working in Boards have key roles in ensuring that their organisations do not simply become vehicles for purchasing direct care services. Despite the large scale impact of mental health problems, promoting mental health is currently given a low priority partly because of the lack of attention being paid to it at a national Scottish level.

6 Strengthening links with other key organisations

The NHS reforms highlighted the requirement for Boards to form "healthy alliances". Joint planning and commissioning processes are being developed to ensure the implementation of the NHS and Community Care Act. These usually involve health and social work agencies. However the promotion of mental well being and the prevention of relapse in those with established disorders involves the creation of wider opportunities in training, leisure and employment. This means strengthening links with local enterprise companies, district council leisure and recreation departments, local department of employment offices and the voluntary sector.

7 Communicating with users and carers and taking into account their perspective

The changes outlined above are taking place against a backdrop of public beliefs which are often at variance with those of professionals. There is unease about the move from institutionally based to community care, partly fuelled by media reporting. Patients and carers have their concerns compounded by these. Alienation, isolation and the infringement of civil rights impinge more on mental health services than on any other type of health care. These factors mean that Boards in their roles of assessing needs and commissioning services on behalf of these groups, must be sensitive to their expressed needs and seek to involve them in a meaningful way in purchasing decisions.

1 INTRODUCTION

The SNAP Working Group on Mental Health decided to confine the remit of the present work to those aged 16-64 years old with mental health problems excluding:

- learning disabilities
- problems related to substance misuse
- mental health in the elderly

The Group understood that the aim of national needs assessment on a Scottish basis is to aid local boards by:

- sharing public health and related expertise in focusing on specific questions
- making recommendations which will serve as reference for locally based work
- helping influence national decision-making and approaches to broader public health issues
- indicating where specific research projects could be undertaken.

The Group decided that its efforts should be focused initially on determining priorities for further work and developing a programme of needs assessment of specific topics. As background an overview was prepared of the estimated scale and nature of mental health problems in Scotland and relevant needs assessment questions were discussed.

2 THE BURDEN OF MENTAL HEALTH PROBLEMS

There is a wide spectrum of mental health problems - with a variety of adverse consequences and length of effect from distress to disease. Many are of a vague nature. In terms of the medical model they can be broadly divided into neuroses (for example, anxieties, phobias) and psychoses (for example, schizophrenia, manic depressive illness). The definitions of these overlap and the concepts on which they are based are often challenged.

There are two major diagnostic systems for categorising mental health problems:

- the International Classification of Disease - ninth revision (ICD 9). The major diagnostic chapters are presented in the Appendix.

In addition there are a variety of interview and assessment schedules designed to elicit the presence or absence of mental health problems in individuals and populations.

- the Diagnostic and Statistical Manual of Mental Disorders - third edition (DSM 3R)

These differences in concepts and classification systems lead to constraints in defining the prevalence and incidence of mental health problems in communities and interpreting studies which have attempted to do so. The following text presents a brief summary of information relevant to defining the burden of mental health problems in Scotland.

Deaths Related to Mental Health Problems

Suicide is increasingly being recognised as a major public health problem in Scotland. In 1990, 6% of years of life lost before the age of 65 years were the result of suicide, the third most important contributing cause after ischaemic heart disease and perinatal disorders.

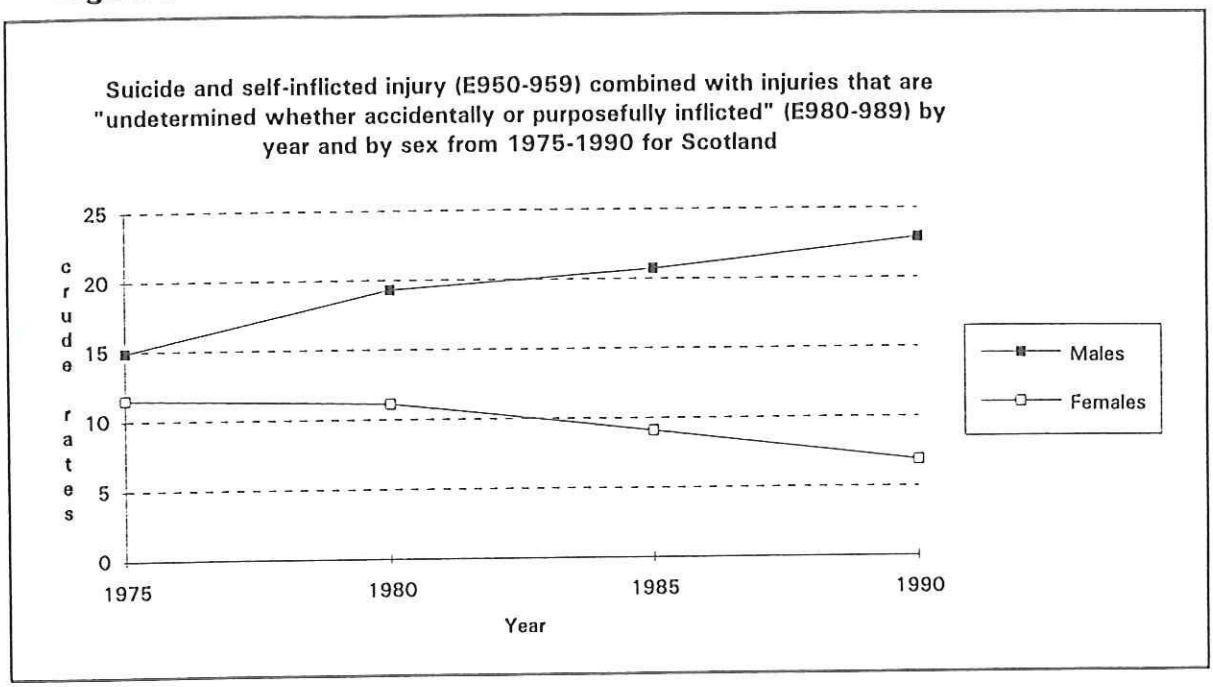
The rate of suicide is increasing in men while decreasing in women (figure 1). In males the number of annual deaths has risen from 375 to 576 in the period 1975-92. Suicide is most common in men over 75 years old although the increase is occurring in men aged less than 45 years old and particularly in the 15-24 year olds. Suicide in both males and females in Scotland is higher than in any other nation in the United Kingdom (Table 1).

Table 1
Age adjusted mortality rates (per 100 000) by country and sex for 1991 for suicide and open verdicts within the UK (using the UK as the standard population)

	UK	England	Wales	Scotland	N Ireland
Males	18	17	19	21	13
Females	6	6	5	7	6

In addition mental health problems are associated with homicides and deaths from alcohol and drugs.

Figure 1



The risk of suicide is greater in social classes I and V, the unmarried, those who are dependent on drugs and those with chronic mental or physical illness. The estimated suicide rate of 1.7 per 1000 psychiatric in-patient discharges in England and Wales[1] and the fact that up to 40% of those who commit suicide have attended their General Practitioner in the week before the event, have led to calls for health services to "identify people at risk and initiate appropriate treatment and supervision".[2]

Those suffering from schizophrenia have higher than average national mortality rates especially from suicide, heart and respiratory diseases. With regard to the two last causes, it has been postulated that smoking, poor nutrition and adverse environmental conditions all contributed to the elevated rates. Concern was expressed by carers about the physical health of their relatives during the SNAP group's consultation which is discussed later in the report.

Psychiatric Morbidity

Information on morbidity is presented according to the relevant data collection method:

i Community Surveys

It is acknowledged that the most useful data on prevalence and trends in mental health problems for public health purposes will come from large, methodologically sound community based surveys carried out on a regular basis.

The largest relevant survey of overall psychiatric morbidity with data applicable to Scotland was the Health and Lifestyle Survey carried out between 1984 and 1985[3] which used the General Health Questionnaire (GHQ). The general findings showed that morbidity levels were higher in women than men and highest in the 18-24 and 75 years and over age bands. Subsequent analysis[4] of regional differences showed that:

- the prevalence of psychiatric morbidity in Scottish residents aged 18 years or over was 28.2% compared to 31% for the United Kingdom as a whole;

- after controlling for age and sex, the standard prevalence rate was 90 (100 for England and Wales);

- the most important variables influencing differences in regional prevalence ratios were living environment and social class.

The investigators commented on the disparity between the lower Scottish psychiatric prevalence ratio and its higher overall standardised mortality ratio without offering any reasons for this.

The only recorded UK data on trends available from community surveys was through comparison of a 1977 survey using the GHQ in West London with the sample of the 1985 Health and Lifestyle Survey resident in that area.[5] This showed an increase of 8.8%, from 22.4% to 31.2%, in the prevalence of psychiatric morbidity. The investigators did not identify causes for this increase although they noted that other studies have found that unemployment in men, adverse life events and poor social support have been associated with psychiatric morbidity.

A study in Edinburgh in 1982/83[6] found that 25.2% of women aged 19-65 years were suffering from a psychiatric disorder (mainly depressive illness). Few had consulted a health care professional about their problem.

In 1982/83 Goldberg and Huxley[7] conducted a large and detailed study of mental illness in hospitals and community settings in England. This showed an "iceberg of psychiatric morbidity" with only a very small percentage of the overall number of cases being seen by specialist mental health services. It also highlighted the key role of the general practitioner in mental health in the community (Table 2).

Table 2
Iceberg of psychiatric morbidity

	Prevalence in Greater Manchester in 1982/83 (expressed as percentage of total population)
Those with mental health problems in the community	25-31.5
Those attending their general practitioner with mental health problem	23.0
Those attending general practitioner whose mental health problem is recognised	10.2
Those referred to specialist mental health services	2.1
Those admitted to psychiatric hospital	0.3

ii General Practitioner consultations

The importance of primary care services in looking after the great majority of those with mental health problems has already been noted. No Scottish-wide data are available on the incidence and prevalence of mental health problems in those seen by general practitioners. One constraint has been the applicability of diagnostic coding systems to the range of problems seen in primary care where often distress is a more appropriate defining term than disease or disorder. This has been one of the major reasons for the development of the READ coding system.

The Third National Morbidity Survey in General Practice[8] provides evidence of the high levels of psychiatric morbidity seen in primary care.

After respiratory illness and circulatory disorders, mental health conditions are the most common presenting problem to a general practitioner. The influence of mental health problems on other problems is often commented upon.

Table 3 presents data on the rate of patients consulting per 1000 population as a result of mental disorders; and for the related categories: "social, mental and family problems and maladjustment" and "symptoms, signs and ill defined conditions" which often reflect psychological problems.

Table 3
Third National Morbidity Survey 1986 Royal College of General Practitioners

	Patients consulting per 1000 on list	Consultations per 1000 on list
Mental Disorders	96.0	229.8
- severe	7.2	26.1
- intermediate	33.4	93.2
- minor	55.2	110.6
Social, marital and family problems and maladjustment	19.7	27.7
Symptoms, signs and ill-defined conditions	159.5	276.5

The statistic of 96 per 1000 patients consulting their general practitioner who are diagnosed as having a mental disorder accords well with the 10.1% of the population who have a mental health problem recognised by the general practitioner, as identified in the Goldberg survey noted earlier.

Studies have shown that of those who consult a general practitioner and are diagnosed as having a mental health disorder, 50% are still symptomatic at one year and 20-25% at three years.[9]

After standardising for age, consulting rates for mental health disorders were significantly higher in:

- social classes IV and V
- women
- the temporarily or permanently sick
- the unemployed

iii Case Registers

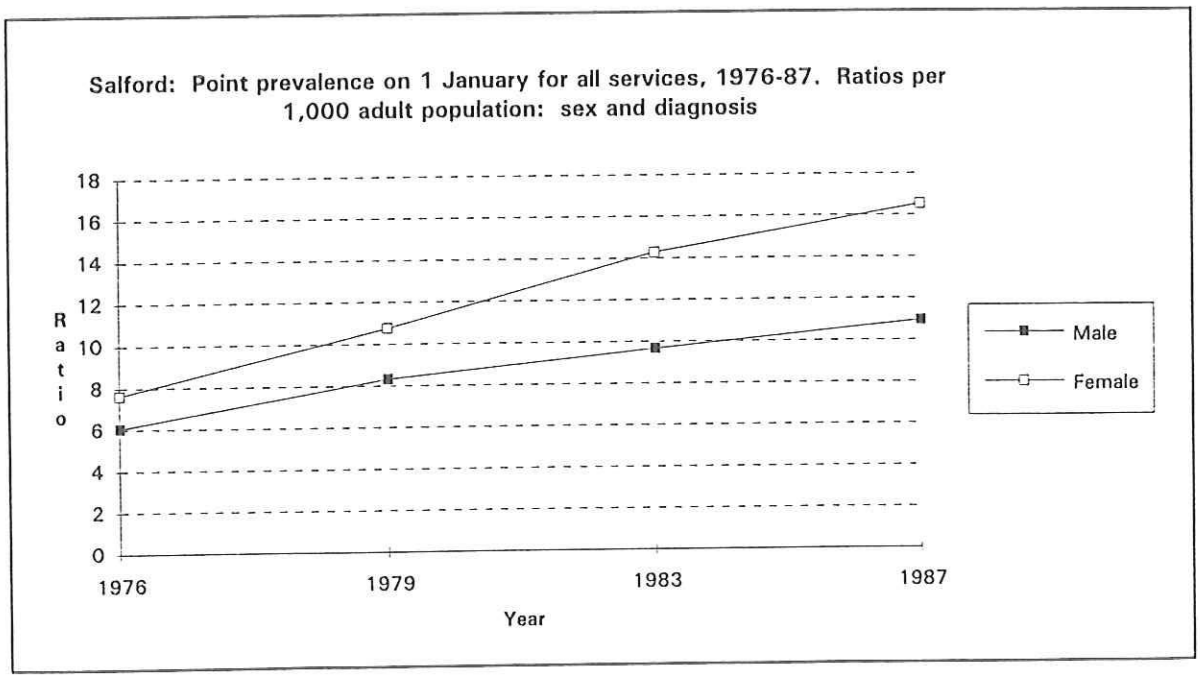
Case registers record details of those contacting specialist mental health services. A number have been functioning for many years in England. Findings from these are presented in the "Epidemiologically based Mental Health Needs Assessment" report.[10]

Data from the Salford Case Register[11] give annual prevalence ratios per 1000 total population of:

Dementia	1.6
Schizophrenia	3.0
All depressions and bi-polar	6.7
All other mental health problems	7.7

Age specific prevalence ratios were highest in the over 65s, and in contrast to the Health and Lifestyle Survey, lowest in the under 25s. Figure 2 presents point prevalence rates for male and females in the period 1976-87. The total female point prevalence rate increased by 117% and the male by 81% in the period. The major rises in both males and females were in depressions, dementias and other psychiatric illness.

Figure 2



The total annual prevalence ratio was 1.9% very close to the Goldberg statistic of 2.1% of the total population using specialist mental health services.

iv Hospital admission statistics

Data on those admitted to and discharged from psychiatric hospitals and mental health units in Scotland are recorded on the Scottish Morbidity Record Scheme form 4 (SMR 4). The pattern of use of hospital services, particularly in-patient, is changing as more community based alternatives to admission are utilised. However the scheme remains the most complete database available on mental health in Scotland.

The crude total admission rate has risen by 39.8% in the period 1970-90. First admission rates however have shown a smaller increment. Both rates have fallen in the period 1990-92 (see Table 4).

Table 4
Total and first Scottish admission rates 1970, 1990, 1992

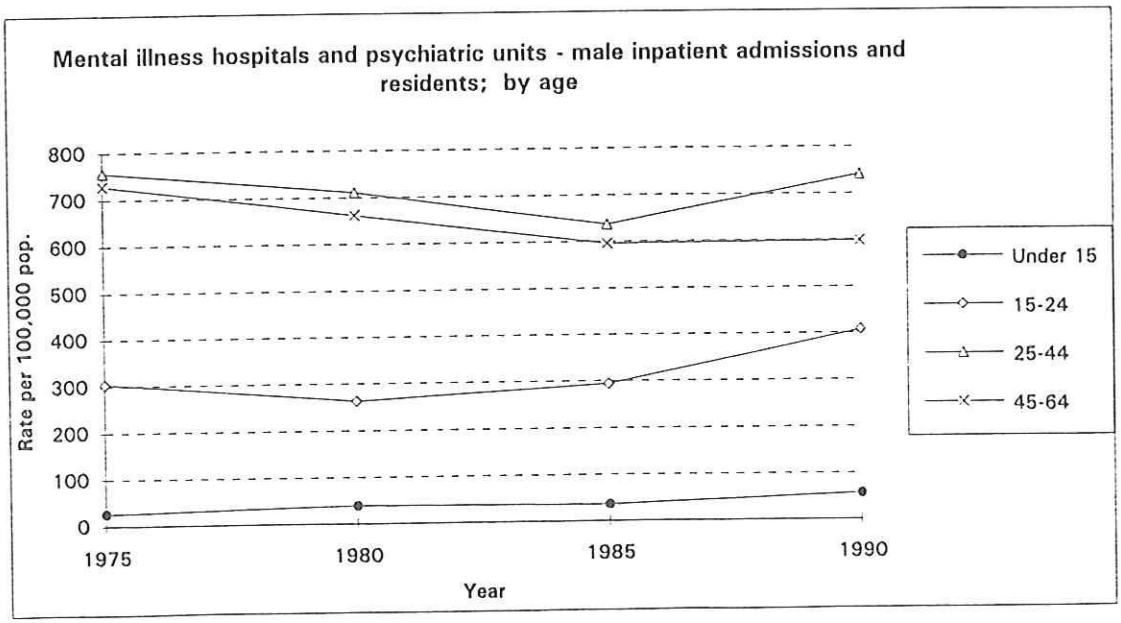
Year	Scottish total admission rate per 100 000 population	Scottish first admission rate per 1 000 000
1970	427	188
1990	597	197
1992	570	181

As can be appreciated, the major factor in the 1970-90 increase was rising numbers of re-admissions. Transfers between psychiatric hospitals also were a major factor, rising from 9 per 100 000 in 1970 to 41 in 1990.

Male admissions are more common than female in under 65 year olds with the reverse occurring after that age.

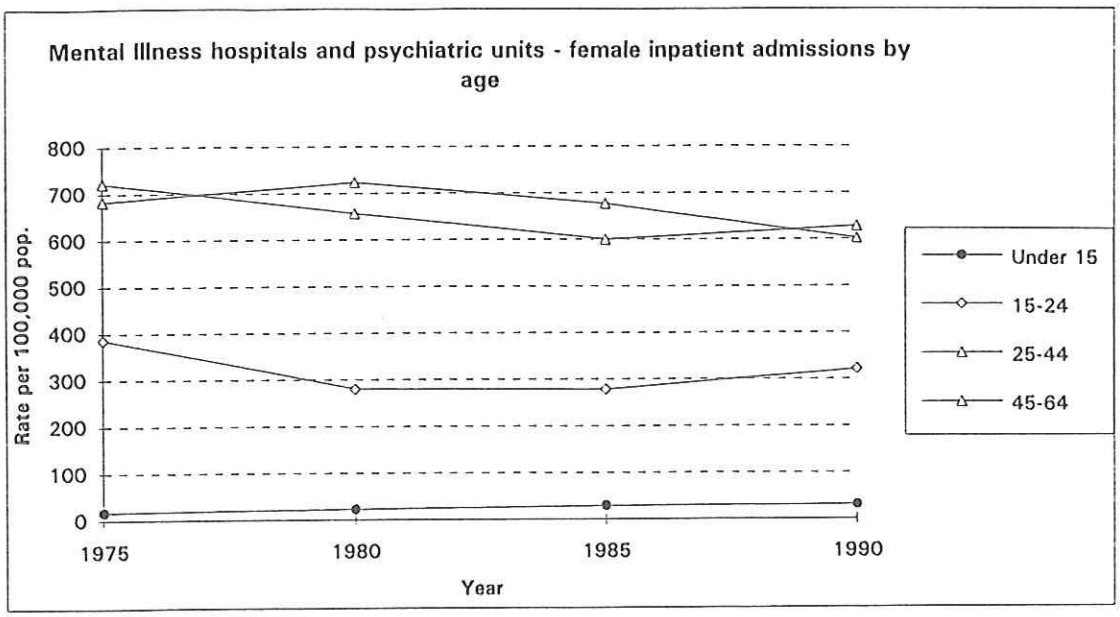
In the period 1975-90, Scottish admission rates in males aged less than 15 years and 15-24 years rose while in the 25-44 and 45-64 year bands they fell (see figure 3). At all ages under 65 years there have been significant decreases in rates since 1990.

Figure 3



In females in the same period, admission rates fell at all ages below 65 years except for those aged less than 15 (Figure 4). Paradoxically there has been a rise in the first admission rate in Scottish women aged 15-24 years since 1990. All other age groups have seen considerable decreases.

Figure 4



First admission rates by ICD diagnostic groupings show that in the period 1975-90 trends varied. Most marked were:

- a 35% decrease in the number of male first admissions due to alcohol abuse and dependency despite the fact that total admission rates for all alcohol related diseases increased substantially in the period.[12] Female first admission rates were more variable with no clear trend apparent;
- a 600% rise in male first admission rates for drug misuse and dependency and a 300% increase in females;
- an increasing rate for non-psychotic depressions in males but a more stable trend in females since 1980;
- a major decrease in the rate for females with affective psychoses;
- major falls in the first admission rates with diagnoses of neuroses in both sexes.

The situation is summarised in figures 5 and 6. Since 1990 there has been a decrease in first admission rates in most diagnostic groups.

Figure 5

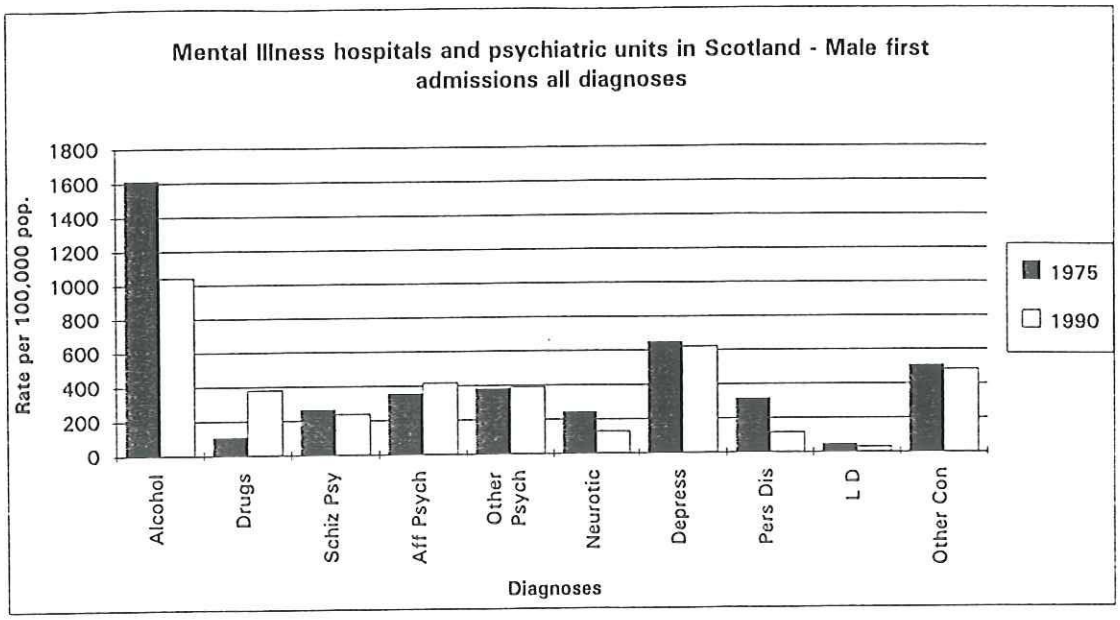
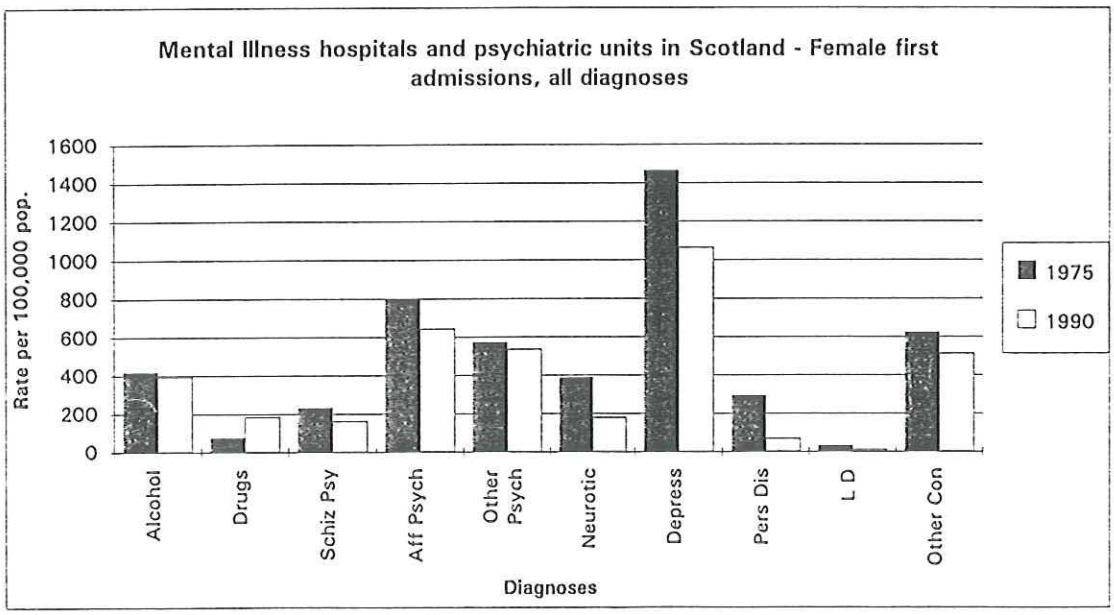


Figure 6



Key

Alcohol = Alcoholic psychoses; alcohol dependence syndrome	Neurotic = Neurotic disorders
Drugs = Drug abuse	Depress = Depressions - non psychotic
Schiz Psy = Schizophrenic psychoses	Pers dis = Personality disorders
Aff Psych = Affective psychoses	LD = Learning Disability
Other Psych = Other psychoses	Other Con = Other conditions

To what extent these trends are the result of changing morbidity or clinical practice or coding practice is unclear. A study in Edinburgh[13] noted that the apparent decline in first admission rates for schizophrenia could be due partly to changes in diagnostic criteria or the miscoding of admissions. However the noted national trends since 1990 of falling admission rates to hospital accord well with local observations on the increasing application of community based psychiatric interventions either by general practitioners or specialist mental health teams.

Psychiatric hospitals and mental health units are not the only in-patient facilities to which patients with mental health problems are admitted. Discharge rates from general hospitals recorded on the SMR 1 scheme as being due to a mental illness diagnosis, show an increase from 82 per 100 000 total population in 1970 to 172 per 100 000 population in 1991.

Mental Health Related Disability

The effects of mental health on the ability to function is a key to estimating its importance to an individual and by extension to communities and populations. A constant feature in debates about mental health is the priority which should be given to the care of those with severe disabilities compared to the far greater number who have mild to moderately severe disabilities.

The largest and most exhaustive survey on disability in the United Kingdom was carried out by the Office of Population Census and Surveys. Data extracted from two of the survey reports are presented below.[14,15] The survey used the World Health Organisation definition of disability as, "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being". Ten main areas of disability were defined. The level of disability in each area was scored and the overall severity graded on a scale of 1-10.

The prevalence of disability among adults aged over 16 years was 14.2%. The prevalence of disability wholly or partially due to mental illness (as defined in chapter 1 of ICD 10) was 2.2%. Excluding senile dementia and learning disability, the prevalence was 1.6%.

Of all those with disability wholly or partially as a result of mental illness, 82% lived in private households. However this level varied with only 60% of those with disability wholly or partially due to schizophrenia and 61% of those with senile dementia living in private households compared to 95% of those with anxiety and phobias and 94% of those with depression.

At all ages, except for 50-64 year olds, disability as a result of mental illness was markedly more common in women. Of those with disability as a result of mental illness, 11.3% were very severely disabled overall (OPCS score 9-10) of whom 48% were aged more than 75 years old. Of those with disability as a result of mental illness, 46.6% were aged 16-49 years old.

Table 5 presents the principal areas of disability caused for those living in private households with a disability partially or wholly as a result of mental illness.

Table 5
Principal area of disability of those in private households with disability totally or partially as a result of mental illness

Principal area of disability	%
Locomotion	15.9
Continence	10.1
Communication	19.0
Behaviour	96.4
Intellectual functioning	90.9

Of those with continence or communication disabilities, the majority (over 70% in each case) suffered from senile dementia or learning disability.

A profile of the mental health conditions giving rise to behavioural (motivation, problems with relationships, aggression, injury to self and others) and intellectual functioning (concentration or memory loss, confusion) disabilities in those living in private households is presented in Table 6.

Table 6
Type of mental health condition giving rise to problems of behaviour or intellectual functioning in those in private households

Type of condition	% of those in private households with behavioural disability as a result of mental illness by type of condition	% of those in private households with intellectual functioning disability as a result of mental illness by type of condition
Senile dementia	12.2	15.5
Schizophrenia	3.2	2.9
Anxiety and phobias	16.0	13.5
Depression	38.0	34.2
Learning disability	13.8	18.1
Other	23.3	22.5

Depressive illness is the most common cause of both areas of disability in those living in private households. No comparable information is presented by the OPCS on those in communal establishments.

With regard to severe behavioural difficulties (OPCS score 7.5-10.5: damage to self, others and property) as a result of mental illness, data derived from the OPCS data indicate an estimated prevalence of 1.03 cases per 1000 adults aged over 16 years old, of whom 21.4% will live in communal establishments. Excluding those due to senile dementia and learning disability, the rate falls to 0.61 per 1000 adults aged over 16 years of whom only 9.8% will live in communal establishments.

The data presented in this section highlight the importance of depression as the major cause of mental illness related disability in the community.

SPECIAL NEEDS CATEGORIES

In addition to "mainstream" mental health conditions, there is a range of less frequently occurring conditions which because of their complexity create a need for more specialist intervention. These are :

Mental disturbance in offenders

Different studies have reported varying levels of prevalence partly dependent upon the nature of the offender population and the method of case finding. A summary of UK data indicated that the overall rate varied between 9% to 66% of the total prison population with the most common forms of disturbance were personality disorder (incidence rate of between 14 and 33%), learning disability (1-45%), alcohol abuse (11-55%) and neurosis (3-12%). Psychoses are relatively uncommon and in total may be no greater than 3%.[16]

Those with learning disability and mental health problems

In up to 2% of admissions to psychiatric units and mental health hospitals, the diagnosis recorded was learning disability. In addition a small but significant proportion of those with a primary diagnosis of another mental health condition, will have a learning disability. The management of challenging behaviour in such individuals presents many problems and may require a different array of specialist interventions and support services from those with other conditions.

Those with mental health problems as a result of severe head injury

The psycho-social consequences of traumatic brain dysfunction are often severe. The combination of physical and mental disabilities mean that marital and family breakdown are not uncommon. Early psychological and other inputs at an early stage of rehabilitation can aid in learning or re-learning of appropriate behaviours.

Those with pre-senile dementia

Up to 10% of admissions in males aged between 45-64 years to Scottish psychiatric units and mental health hospitals are due to early onset dementia. As with those with head injuries the social impact of this is usually severe with the wife usually having to cope with considerable stress. Often these patients must use inappropriate mental health services for the elderly.

The Cost of Mental Health Problems

Those suffering from mental health problems are major users of specialist and primary care services. With regard to hospitals in Scotland in 1990[17]:

- patients with mental illness conditions (excluding senile dementia and learning disability) accounted for 18% of NHS in-patient bed days;
- of the twenty top diagnostic categories contributing to bed usage, 6 were mental illnesses (excluding senile dementia and learning disability);
- psychoses (schizophrenia, affective psychoses) account for 8.3% of in-patient costs.

The costs of schizophrenia to the health and social services in the United Kingdom have been estimated to be £310 million per year, drug costs accounting for 9% of the total. Indirect costs (premature mentality, early retirement, unemployment) were estimated to be £1606 million.[18]

The estimated costs to the health service of neuroses treated in primary care were £119.5 million. The estimated total of indirect and direct service costs in 1989 were £5600 million.[19] 30-40% of absences from work are caused by mental illness. In addition to the huge economic implications of this, the adverse effects on performance and quality are likely to be great although more difficult to quantify.

The enormous cost of mental health conditions reinforces their importance as public health issues.

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3 AN APPROACH TO NEEDS ASSESSMENT FOR THE PURCHASING OF MENTAL HEALTH SERVICES

Before selecting specific topics for further work the SNAP group discussed an overall approach to needs assessment.

For these purposes, needs assessment was taken to be the process of answering the following questions:

For whom are we purchasing services?

What mental health problems do they have?

What help do they want and need?

Is purchasing care services the best or only way we can help deal with the problems they have?

What services do we currently purchase for them?

Do the current purchased services provide the help needed or wanted?

Do the purchased services make any difference to the mental health problems they have?

- ***For whom are we purchasing services?***

Mental health problems can affect anybody. However Boards may wish to prioritise certain groups because mental illness occurs more often in them or as a consequence of suffering from a specific type of problem, they have needs which warrant special consideration.
These can include:

- women
- the elderly (70 years and over)
- the homeless
- those who are socially and economically deprived
- those with chronic disabling conditions who require on-going social and health care support
- those who have offended and are involved in the legal or penal processes
- young people aged 14-24 years old

What mental health problems do they have?

Basic data on the distribution and extent of psychiatric morbidity and disability in Scotland have been presented in Chapter 2. Most of the information came from English studies. There is a lack of Scottish data on the incidence and prevalence of mental health problems. This is a major constraint on the effective purchasing of services and the promotion of mental health.

Improving the quantity and quality of data on mental health should be a priority for Health Boards. Better data can come from research and local studies. To underpin local activity, there is a need for on-going data collection systems (particularly in the community) able to be applied throughout Scotland which can provide basic aggregated data to enable Boards to compare the situation in their area with others. The SNAP report puts priority on improving the national database on mental health which will facilitate studies of specific diseases and the effectiveness of service and other interventions. The extension of the OPCS survey of psychiatric morbidity to Scotland is a major advance in this area.

What help do they want and need?

Needs here are equated with a requirement for help. Health services provide different types of help (usually referred to as health care) to an individual or community. In common with other priority services, there is no guarantee that meeting or not meeting these needs will impact on the mental health problems people suffer.

With regard to obtaining information on needs at a population level, there are two key methods:

i *The collation of data from the assessment of individual needs by professionals.*

For many, particularly those with long term disabling conditions, the requirement for health care can best be considered in the context of meeting other needs e.g. for accommodation, leisure, training. There will be minimal

benefit to a person if his/her health care needs are met but others are neglected.

Since April 1994 the lead role in assessing the needs for and planning community care has been statutorily assigned to Social Work Departments. Scottish Office guidance on this care management process, defines need as:

"the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of independence or quality of life as defined by the particular care agency or authority".

Joint working in assessing the needs of people with mental health problems is essential not only for the individuals concerned but also for the wider community. Health Boards should collaborate with Social Work Departments in developing shared datasets giving aggregate measures of care needs particularly through agreeing:

- a common conceptual framework
- common definitions of types of need
- the role of health care professionals in the care management processes
- protocols on data confidentiality
- defining and quantifying unmet needs
- distinguishing need from want

ii *Consulting with the Public, Users and Carers on the needs and views on services*

The NHS reforms and the recent community care legislation emphasise the requirement on Boards to promote and facilitate the participation of users and carers in the purchasing of services.

In mental health, perhaps more than any other area of health care, involving users and carers is essential. At the same time it can be problematic due to the legal and civil rights issues related to this type of care; differing interpretations of risk by professionals and the public; the dichotomy between carers' and users' needs and the role of the media in highlighting concern with current policies. Because of these Boards must engage the wider community when taking purchasing decisions. The SNAP group identified as a priority, the development by Boards of methods of

- sampling the publics', users' and carers' views on needs
- consulting about strategic and other decisions
- establishing dialogue with voluntary and self-help groups
- where appropriate, funding in collaboration with other agencies, representative fora
- through the contracting process, placing a requirement on providers to ensure user and carer participation in decisions about services for individuals and

- facilitating the use of complaints and other procedures - for example, advocacy services

Is purchasing care services the best or only way to deal with the problems they have?

As well as purchasing care services, Health Boards have important roles in acting as an advocate for health on behalf of their resident population and in promoting health through local alliances. With mental health promotion as with similar areas of health, a long term strategy is required with programmes which attempt to:

- educate and train people in the skills necessary to cope with anxiety, stress and adverse life events
- facilitate the development of self esteem and decision making skills in young people
- promote social supports for those who may be at particular risk of developing mental health problems - for example, the bereaved
- prevent the deterioration of existing mental illness - for example, early detection and treatment of depression
- counter discrimination against those with mental health problems
- promote a more positive attitude in the general population to those with mental health problems particularly those with severe mental illness.

What services do we currently purchase?

Health care services are broadly grouped into two main areas: primary (generic) and secondary (specialist) care.

With regard to specialist services, "The Key Area Handbook on Mental Health"[1] recommends that purchasers (health and social work agencies) identify the range of service delivery options for their area. These options (Table 7) are defined by:

- the type of care (basically sub-divided into acute emergency care and rehabilitation/continuing care);
- the setting for care (basically home based, day care and residential)

Table 7
Summary of different service options

Setting	Acute/emergency care	Rehabilitation/continuing care
Home-based	Intensive home support Emergency duty teams Sector teams	Domiciliary services Key workers Care management
Day care	Day hospitals	Drop-in centres Support groups Employment schemes Day care
Residential support	Crisis accommodation Acute units Local secure units	Ordinary housing Unstaffed group homes Adult placement schemes Residential care homes Mental nursing homes 24 hour NHS accommodation Medium secure units High security units

Source: The Health of the Nation, Key Area Handbook Mental Illness

Most Boards are at the stage of developing service specifications which should reflect the range of service options required to meet the needs of their area. For this to occur, purchasers must clearly define the particular group of patients who require help from a service option, the mental health problems they suffer from and the types of help they should receive. An onus should then be placed on providers to provide data which enable purchasers to monitor their contribution to meeting needs.

Most of those with mental health problems are dealt with by primary care services. The development of a Primary Care Strategy is currently a priority for all Boards. Most Boards purchase community health services which work closely with general practitioners - for example, community psychiatric nursing and clinical psychology. In addition key objectives of many community mental health teams are to support and liaise with primary care services.

Key to specifying services in this area of growing demand is clarifying the role of the different professionals involved particularly with regard to the range and level of therapeutic interventions utilised by them. The employment of counsellors by many fundholding practices highlights the need to study this area further. Of especial interest is the development of effective alternative treatments to pharmacological interventions - for example, anxiety management, relaxation techniques and psychotherapy in primary care and guidance on which professional discipline should carry these out.

For both specialist and primary care services there is a lack of meaningful data on who receives services and the type and quantity of care provided. The development of the Scottish core community dataset will help address some of these issues although further work is needed with regard to its overlap with social work and general practice information. The SMR 4 hospital record should be reviewed particularly as it does not differentiate adequately between the different psychiatric services provided in mental health hospitals and psychiatric units.

Do the current purchased services provide the help needed or wanted?

Meeting needs is a key outcome for mental health services although some have suggested that it is only an intermediate outcome with the ultimate goal being to improve health status.[2]

As outlined above Boards should define clearly in specifications the patient group and the needs which should be met by mental health service options e.g. the types of help provided by psychiatric day hospital services could include: specialist assessment, rehabilitation, patient support, occupation and stimulation, psychotherapy, education and information.

Having clarified which need should be met by which services, indicators of unmet need could be based on:

- the proportion of those in the community identified in a population survey as requiring help who do not receive it;
- the proportion of those identified by professionals as requiring help for which there are no local services available to provide;
- the proportion of those identified by professionals as requiring help which is not available from local services;
- the proportion of those attending a service to receive help but who do not receive it or who receive inadequate amounts.

Data to measure these indicators could be collected through liaison with general practitioners, through aggregate information from care management or from community or user/carer surveys.

As indicated previously a particular group which the SNAP working Party identified as being a priority were those with chronic disabling mental health problems whose needs were partially or wholly met previously as long stay NHS patients but who are now looked after by community services. The level of met and unmet need for health care in this group should be investigated further.

Do the purchased services make any difference to mental health problems?

A role of public health medicine is to collaborate with others in identifying the effectiveness and appropriatness of health care interventions on the health status of a defined population. When an effect on health can be identified as the result of a health care process it should be called an outcome. Assessing outcomes is key to judging whether a population group can or is benefiting from a specific service or intervention.

The report "Population Health Outcome Indicators for the NHS"[3] describes the steps in assessing outcomes as:

- defining the health related objective(s) of a health care service
- selecting a measure which is relevant to this objective (health outcome indicator)

- defining and collecting data relevant to:

    a the type and volume of service activity

    b those underlying demographic, social and economic factors which underlie the risk in the population of the selected outcome indicator

- interpreting trends in the frequency of the outcome indicator through comparison with trends in service activity and in those underlying factors which influence the risk of its occurrence in the population

Dr Rachel Jenkins in two excellent articles on targets and outcome measures in mental health, featured in the two recent Department of Health reports[3,4], describes relevant health related service objectives as being:

- the reduction of incidence
- the reduction of relapse rates and readmission
- the reduction of disability and handicap
- the avoidance of mortality

In specifications, mental health service objectives should include one or more of the above.

Based on the above, for the health related objectives of a specified mental health service, one or more outcome indicators should be selected from the following categories:

- mortality (e.g. suicide)
- morbidity (e.g. parasuicide, non-psychotic depression)
- subjective health indices (e.g. the General Health Questionnaire)
- disability and/or social functioning indices

Interpreting local trends in these can best be carried out through comparison with other areas. A first step in the development of outcome indicators should be to review how the current Scottish NHS database on mental health can be improved with a view to establishing baseline data for use in determining mental health outcome indicators.

Conclusion

In order to better assess the need for mental health services, Boards should seek to develop:

- definitions of key groups who require mental health services;
- their capability to measure the extent and nature of mental health problems in their resident populations
- their means of consulting with users and carers
- mental health promotion programmes

- their service specifications particularly with regard to including definitions of the key characteristics of those who need them, the mental health problems they suffer from, the types of help they should receive, the objectives to be achieved and key outcome indicators

- their means of assessing if objectives are being achieved in terms of meeting needs and impacting on health

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4 DECISION-MAKING IN MENTAL HEALTH SERVICES: AN ECONOMIC APPROACH

Economics is the study of resource allocation decisions. In this context it can provide a framework for enabling decision-makers to address the question:

> *how can we allocate the budget so as to increase the total benefit to service users and their carers?*

There are many approaches to this "value for money" issue. This section outlines one - programme budgeting/marginal analysis - which is relevant to specifying mental health service provision.

The first stage is as far as possible disaggregating cost and activity data so as to relate to specified services

An example could be reviewing the distribution of current spending on specialist acute/emergency mental health services in achieving the objective of reducing disability resulting from specific diagnoses. The disaggregation of cost data could be by diagnosis and the specific service settings. Table 8 shows a hypothetical example.

Table 8
Percentage of Acute/Emergency Mental Health Service expenditure on Depression, Schizophrenia and Addiction by Service Setting: a hypothetical example

Service Setting	Depression	Schizophrenia	Addiction
Home based	12	10	7
Day Care	10	5	3
Residential Support	18	20	15

The second stage would be identifying whether the service is achieving its objectives by reviewing indicators of unmet need and health outcomes as outlined in the previous sections - for example, reducing the relapse rate from schizophrenia.

The third stage is assessing which changes in the balance of service options will better meet need and impact on health status. This involves:

- defining options for change
- knowing the financial framework within which decisions will be made especially with regard to whether proposed expansions in one service will be funded through development monies or offset by reductions in another services option;
- projecting the scale of benefit (in terms of meeting unmet need and impacting on heath status) from a proposed expansion in one service option through analysing local data and applying research findings from published evaluations;
- similarly projecting the scale of the costs in terms of needs and health outcomes, from reducing a specified service option;
- discussing with providers the proposed options and their assessment of the benefits and cots of switches in resource allocation;

- selecting a revised balance of service delivery options.

The fourth stage is respecifying the service(s) in the light of the amended balance of care options with a view to entering into a new contract with the provider.

Obviously this exercise cannot be carried out in a vacuum. Political considerations will always weigh heavily in resource allocation decisions. Nor can it be done annually but more probably on a basis which accords with a longer purchasing cycle, e.g. three yearly. However the approach described offers a guide on how a purchaser can help ensure step by step progress towards fulfilling strategic and service objectives through altering the balance of service delivery.

Most health boards are currently engaged in major redistribution of the balance of care for those who as a result of chronic disabling mental health problems require major on-going health and social supports. The SNAP Group considered it a priority to review the Scottish experience of the health, social and economic implications of this movement from institutional to community based forms of care with a view to developing the outlined framework.

5 PRIORITIES FOR FURTHER WORK

Given the range of issues, the scale of mental health problems and the availability of personnel to participate in the Scottish Needs Assessment Programme, it was clearly necessary to prioritise further work. The key issues as identified by the Working Group are presented below:

1 **Needs assessment methods and measures**

Priorities for first phase:

epidemiological monitoring of mental health

Priorities for second phase:

mental health service outcomes

2 **Health Promotion**

Priorities for first phase:

Mental health in the workplace

Suicidal behaviour in young people

Other key issues for future programme:

Mental health needs of the homeless

Physical health of people with chronic disabling mental health problems

Mental health of minority groups

Health and social implications of psychotropic medication

3 **Mental health services**

Priorities for first phase:

the effects of the changing patterns of service provision and their health, social and economic implications

the involvement of users and carers in assessing the need for, commissioning and monitoring mental health services

Other key issues for future programme:

the definition of needs criteria for specialist mental health and social care professionals working in the community

For each "first" phase issue, a small multidisciplinary, time-limited subgroup will be convened. These should involve user and carer representatives either as part of the group or through structured consultation. A leader for each working group has been identified. He/she will identify members and will draw up the final report.

The report will be submitted to the current Working Group and thence to the Joint Working Group on Purchasing and the Scottish Forum for Public Health Medicine.

The current SNAP Working Group will be reconvened with the following remit:

- co-ordination of the sub-groups
- forum for interchange among those involved in public health and mental health related activities in Scottish health boards
- liaison with national bodies in the development of the public health function in this field

A brief description of the topic to be considered, the remit, the speciality/discipline membership and target dates for completion of each group are presented in the following chapters.

Conclusions

Mental Health is a public health matter of concern to users, carers, the public and health professionals. The term covers a wide range of topics. It is therefore important to concentrate on a number of priority issues. These have been defined in this chapter. The next chapter suggests how this work might be taken forward.

6 PROPOSED PROGRAMME

Monitoring Mental Health in Scotland

Introduction

A key purchasing function for Health Boards is the assessment of need for mental health services. Underpinning this should be a careful appreciation of the distribution of and trends in mental illness in a Board area. The development of community care, particularly for people with long term disabilities related to chronic psychiatric morbidity, is an issue of concern for most Boards and there is a need to remedy the current dearth of information on these patients. The vast majority of those with mental health problems are looked after by primary care services, although the long term effectiveness of many interventions is often open to question.

There is, therefore, a general requirement to improve both the extent and quality of data on mental health problems and its use by public health medicine and other professionals working in assessing the need for and commissioning of services; in developing measures to promote mental well-being and as background information when investigating specific diseases or other mental health related entities or treatments.

Remit

It is proposed that a working group be established with a remit firstly, to review and make recommendations on the establishment of a mental health dataset and secondly, to develop service outcome indicators.

First phase

a Define a mental health dataset for use by Health Boards in carrying out the functions detailed above particularly with regard to:

- mortality (e.g. suicide)
- morbidity (e.g. based on ICD chapters, DSMIII categories, Reed codes)
- mental health related disability (e.g. based on WHO ICIDH definitions)
- quality of life/social adjustment/well-being indices

b Review the quality, uses and sources of currently available data on mental health especially:

- the Scottish Morbidity Record Scheme 4 (SMR 4)
- Primary Care generated data (e.g. the proposed Community dataset)
- information made available through joint social and health care procedures
- ad hoc studies

c Through comparison of the currently available with the "ideal" dataset, identify the data, their sources and collection methods required to correct any deficiencies particularly with regard to :

- national data collection
- locally based schemes

d Identify how Health Boards, Social Work Departments and other organisations can best work together at a Scottish-wide level in using the dataset.

e Present costed recommendations based on the above.

Second phase

In recent months a number of reports have described developments to measure the impact of health care. A distinction has been made between clinical outcomes (the direct end point of specific care processes) and population based measures which attempt to discern the influence service provision has on the frequency of certain health events (usually deaths). Such aggregate data can only be interpreted taking into account environmental, socio-economic and other factors which increase or diminish the risk of the condition.

a To review key issues with regard to the development of outcome indicators on:

- effectiveness of services
- impact of services on the health of patients receiving them
- contribution of mental health services

HEALTH PROMOTION

Mental Health in the Workplace

Background

An estimated 2.1 million working days are lost to the National Health Service every year as a result of certificated mental ill health of staff. Not only does this figure represent a substantial financial cost to the service, but it is also indicative of a serious level of personal distress and impaired performance at work. Furthermore, it is widely acknowledged that figures for certificated absence for mental health problems substantially underestimate the size of the problem.[1,2]

In recent years there have been an increasing number of publications highlighting the problems of mental illness and stress in health professionals.[3,4] Recent national policy documents have echoed this growing concern and emphasised the need for action to promote healthy practices in the workplace and for the National Health Service to act as an exemplar employer.[5,6,7]

Exploring the origins of such mental health disturbance and finding ways of preventing and alleviating them in the workplace setting represents a major challenge. Because the National Health Service is one of the largest employers in Scotland and because of the need to set a good example to others, this challenge is one that cannot be ignored.

Two Health Boards, namely Borders and Lothian, have already begun to investigate this issue with a view to developing a policy and taking local action. The work suggested below is designed to help and encourage other organisations in the National Health Service (and thence other employers) to do likewise, and will allow the experiences of these two Boards to be fed back, alongside those of other organisations who have taken a lead in this field.

Remit for further work

1 Literature review covering:

- prevalence and impact of mental health problems/mental illness at work
- approaches used for assessing the experience and views of staff, and for reviewing organisational practice and policies
- examples of good practice in addressing this problem

2 Development of a framework to assist organisations to develop their own 'mental health in the workplace' policy and identify action necessary.

3 Advice on arrangements for implementation and evaluation/audit of policies and action agreed.

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Suicidal Behaviour among Young Adults (15-34 Years)

Background

Although the government's policy statement, *Scotland's Health: A Challenge To Us All*, does not identify mental health or suicidal behaviour as priority areas for action in Scotland, "the rising number of deaths from suicide in young men is a particular cause for concern" (Appendix A, para. 22, p.33). Suicide trends, with special reference to youth, were considered at a meeting of the Health Monitoring Group in January 1993. More recently, the Chief Scientist Office has invited outline proposals for research on "the psychopathology of suicide with a view to improving the present position".[1]

In 1992 there were 418 recorded suicide deaths in Scotland among males aged 15+ years (a rate of 21.2 per 100 000) and 151 suicide deaths among females aged 15+ years (7.0 per 100 000). Between 1971/73 and 1990/92 the suicide rate among males aged 15+ years rose by 59%, with above average increases in the 15-24 age group (+122%), the 25-34 age group (+146%) and the 35-44 age group (+83%). Over the same time period the suicide rate among females aged 15+ years actually fell by 27%. However, increases were recorded in the 15-24 age group (+78%) and 25-34 age group (+40%). In both sexes the peak age for suicide has fallen dramatically over the past two decades: whereas 65-74 year old males and 55-64 year old females were most at risk in 1970/72, the 25-34 age group (both sexes) was most at risk in 1990/92. These same trends have been noted in other European countries but are particularly marked in Scotland.

While national (Scottish) and regional data on suicide and undetermined deaths (the majority of which are probably hidden suicides) are collected and disseminated by the General Register Office, no comparable data have been published on the incidence or characteristics of parasuicide (whether by self-poisoning, self-injury or other method). SMR1 data are being used (or under consideration) by some health boards to provide proxy indicators of "attempted suicide", but the reliability and validity of this information have yet to be assessed. In any case, hospital-treated patients form only part of the total parasuicide population (many of whom are treated solely by the general practitioner or receive no medical treatment at all). In order to assess the need for services or other types of intervention, a broad survey of the extent of parasuicide in the community, the personal and social characteristics of the parasuicide population, and the precipitating and predisposing factors in parasuicidal behaviour would have to be undertaken.

The only research centre in Scotland devoted to the intensive study of suicidal behaviour (MRC unit for epidemiological studies in psychiatry) closed down in 1990. This unit monitored trends in hospital-treated parasuicide in Edinburgh but did not collect information from elsewhere in Scotland. In 1989 (the latest year for which reliable data are available) the rate of parasuicide in Edinburgh among males aged 15+ years was 282 per 100 000, with the highest rates among those aged 15-19 years (462 per 100 000), 20-24 years (453 per 100 000) and 25-34 years (477 per 100 000). Among females aged 15+ years in the city in the same year the parasuicide rate was 315 per 100 000, with the highest rate in the 15-19 age group (838 per 100 000), rates thereafter declining with age. This level of parasuicide incidence, though very high in comparison with that reported for other European cities,[2] was lower than the peak rates recorded in the late 1970s/early 1980s. However, monitoring of parasuicide admissions to the Royal Infirmary in Edinburgh suggests that the behaviour may once again be reaching epidemic levels.

'Suicidal behaviour .... is embedded in a complex web of behavioural, emotional, interpersonal and social factors that have to be attended to concurrently at the individual, family and social level'.[3] While evidence of the aetiological significance of psychiatric illness in completed suicide is beyond doubt,[4,5] (although this is not the case in respect of parasuicide[6]), macro-economic[7] and other structural (supra-individual) influences (e.g. mass media,[8] poverty/social deprivation[9]) have also been shown to be extremely powerful.

Consequently, the problem of suicidal behaviour is best conceptualised within a public health framework. Primary prevention depends above all on the capacity of the state to create optimal conditions for healthy lifestyles and reduce the risk of self-harmful behaviour. Possible measures which could reverse the rising trend of suicidal behaviour, with special reference to youth and young adults, include:

- reducing the availability of means of self-harm, especially poisons and medicaments which are dangerous in overdose;
- implementing effective measures to tackle drug and alcohol abuse;
- controlling and reversing the growth of unemployment, especially long-term, and increasing the level of economic activity;
- providing an adequate financial and welfare safety-net for the whole population;
- combating physical disintegration and social disorganisation in inner city areas;
- seeking to alter public attitudes which increase the vulnerability of high-risk groups (e.g. victimisation and stigmatisation of the unemployed and mentally ill)[10,11]

"There is a large literature on possible measures directed at the prevention of suicide. Most of the suggestions rest on hope rather than evidence, and the issues are not straightforward".[12] Unfortunately, primary prevention of parasuicide also remains a difficult challenge, while interventions designed to prevent further episodes of parasuicide (secondary prevention) have failed to demonstrate a significant effect.[13]

Remit for further work

Literature/information search covering:

- incidence of, and temporal trends in, suicidal behaviour (suicide and parasuicide) among young adults across Scotland (at national and health board levels).
- availability and quality of SMR1 date as proxy indicator of hospital-treated parasuicide.
- review of literature on suicidal behaviour among young adults (in Scotland).
- service demand and service provision for suicidal young adults, by health board.

- strategy for containing/reversing trends in suicidal behaviour at the local health board level, especially in relation to health promotion activities aimed at young adults.

- extent and timescale of research on suicidal behaviour among young adults in Scotland (funded by research councils, SOHHD, health boards, etc).

- evidence of the effectiveness of primary and secondary prevention of suicidal behaviour (UK/elsewhere).

Design a methodology for establishing:

- the true (total population) incidence of suicidal behaviour at local (health board) and national levels.

- the extent and quality of service provision for suicidal individuals across Scottish health boards, including specification and measurement of agreed standards and outcomes.

Monitor and collate opinions and attitudes of purchasers, providers, academics, users and other relevant individuals/organisations about key issues relating to suicidal behaviour, in particular:

- extent of the problem

- adequacy of local service provision

- actual and potential role of health education/promotion at both local and national levels in reducing the incidence of suicidal behaviour.

Make recommendations to appropriate organisations/bodies, including:

- health boards

- provider units/trusts/primary health care team

- social work services

- research funding bodies

- SOHHD

- HEBS

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Future Programme: Other Issues to be considered by Subsequent Working Groups

Mental Health Needs of the Homeless

There is a noted high prevalence of mental health morbidity in the homeless although they do not form a homogenous group and suffer from a variety of disorders. Due to the nature of the population they are often a group which has difficulty in or does not want to access mainstream services. Consequently defining and meeting their health care needs requires innovation and flexibility from both purchasers and providers. It is proposed that a working group review the situation and make recommendations on the commissioning and development of appropriate services and proposes how Boards and others can influence the wider public health issues associated with mental illness in the homeless.

The physical health of people with chronic mental health problems

A concern of certain of the carers with whom SNAP members consulted was the obvious deterioration in the state of health of the person they looked after. Lack of self care, difficulties with using services such as dentistry and the side effects of medication can increase the patient's level of overall disability and handicap. Chronic mental health disorders, e.g. schizophrenia, are associated with higher levels of mortality. Indeed a proposed outcome measure for mental health services has been to reduce the number of premature deaths in people with schizophrenia. It is proposed that a group be convened to define the nature and extent of the problem and identify and assess relevant preventive measures which may be promoted by health boards.

Mental Health of Minority Groups

Data from England has suggested that mental health problems occur more frequently in certain minority groups. The manifestation of psychiatric illness is closely linked to the social and cultural milieu in which the patient lives. Little has been published on the situation in Scotland. It is proposed that a group sensitive to the needs of the different communities be established to work with their representatives in assessing the level of mental ill health in the relevant population and defining those aspects associated with it which differentiate the preventive, treatment and care response required.

Health and Social Implications of Psychotropic Medicine

Much attention has been focused on the addictive properties of certain commonly prescribed drugs. Side effects from their use can be extensive. There is a recognised overlap between the street supply of illicit drugs and the illegal availability of prescribed medicines. Most health boards have been looking at ways to reduce the number of patients prescribed benzodiazepines. However this should form only one aspect of a broad strategy to prevent or reduce ill health associated with the use of psychotropic medication. It is proposed that a group be set up to outline such a strategy.

SERVICES

Effects of the Changing Patterns of Service Provision and their Health, Social and Economic Implications

Background

In the last five years the pattern of provision of mental health services in the United Kingdom has been substantially altered. The move from institutionally to community based models of care has been especially marked in England. The debate over its effects has attained a high public profile.

In Scotland the picture has been one of more gradual change taking place against a backdrop of relatively higher levels of hospital in-patient provision. The pace of change however is increasing with particular emphasis on the reduction in long-stay continuing care beds. Since 1992 this has been accompanied by a transfer of the responsibility for commissioning most of the alternatives to hospital services to Social Work Departments along with savings accruing from the rationalisation of facilities.

Most health boards are involved in ascertaining the level of National Health Service continuing care places to be purchased by them in the short, medium and long terms. What has become apparent from this exercise is that discharges from institutions create a "ripple" effect on other mental health services, social work and other services. The level of pre-existing community infrastructure and the demands placed on it by other patients are key to the success of supporting discharged patients.

Predicting the level of mental health service provision required in the community is made more difficult because of the variety of service providers and models of delivering care. Leading commentators in England have recognised that the application of norms to help plan services is no longer viable[1]. Local needs assessment work is recommended as forming the basis for constructing purchasing policies.

To aid such work it is proposed that the consequences of planned discharge programmes from mental health institutions be studied with a view to discerning their effects on the patients' health and functional status; their pattern of use of health and social care services (particularly with regard to the expected compared to actual use) and the costs of maintaining discharged patients in the community compared to long-stay institutions. It is hoped to highlight factors which Boards should take into account in assessing the need for and commissioning services.

Remit

- to review relevant literature with a view to identifying models of good practice and problems identified with possible solutions
- to review the mental health discharge programme from long-stay hospitals to different kinds of community provision in two selected health board areas
- to review the balance of service provision, particularly with regard to:
    - i) different models of provision and their interrelationships
    - ii) the working relationship between health and social work
    - iii) the service and cost implications of the move from institutional to community based care
- to make recommendations to health boards and the ME of relevant factors which should guide purchasing decisions in this area
- to identify major areas of research need

Purpose

to look at the present position with a view to providing a base for improving purchasing and contracting in this large and complex area of health and social care

Target audience

Purchasers - in the form of Board General Managers and Directors of Public Health

Policy makers - in the form of Medical Division and Management Executive at the Scottish Office Home and Health Department

Involvement of Users and Carers in Assessing Need for, Commissioning and Monitoring Mental Health Services

Introduction

There has been a fundamental shift in the health service over recent years from a provider-driven to a purchaser-driven system, looking outwards and amenable to change. The ultimate goal of purchasing is to improve health and there is a commitment to reshaping health services. One important element in purchasing is the involvement of users of the service and of carers and real dialogue with consumers is essential. It seems obvious that where users of health services and carers participate in the planning and development of future provision, services are likely to become more relevant, more accessible and more responsive to changing need.

At a conference on the Role of the Consumer in Health Needs Assessment in 1993[1], however, the complexity of achieving meaningful participation of users and carers was emphasised. Tokenism is not enough and the process - to be effective - will take time and will require adequate resourcing.

There are three discrete groups in the new National Health Service - purchasers, providers and users - and each has a distinct role to play. Users have to tell purchasers what services they want them to purchase and to tell providers where they are going right and where what they provide is unsatisfactory. Purchasers and providers have to tell users what can and cannot be provided in a system that has never provided everything for everybody.[2]

In the context of the present report, we would like to outline four main areas to be addressed in our future programme. Firstly, we must look carefully at what we are trying to ask users and carers and why. Secondly, the various methods of doing this should be examined and this should include some consideration of training and re-training of health professionals for effective work in this field. Thirdly, there is a need for a review of current literature and ongoing projects to enable failures and successes to be shared and built on. Finally, the ultimate objective is to arrive at a general but flexible framework for consultation with users and carers which can be adapted for use with specific client groups and in differing circumstances and localities.

Remit

We would propose to start by trying to address the first question:

What are Health Boards trying to achieve in seeking participation from users and carers?

This can be split down into three main strands: i) what do Health Boards as purchasers seek to ask their users about mental health services and how do they involve them in planning?; ii) how do they ensure that user/carer participation is built into contracts with providers?; iii) how is performance on this monitored?

The proposal is to run a one day workshop in spring 1995 for a small group composed of users, carers and relevant health care professionals. The aims and objectives of the workshop would be summarised in a pre-circulated paper and a subsequent report prepared. It is envisaged that, provided funding could be secured, this would be the first of a series of such workshops tackling the whole issue of user/carer involvement. A review of published work and ongoing projects would be carried out separately.

References

1 Scottish Association of Local Health Councils. *The Role of the Consumer in Health Needs Assessment.* SAHC Conference, Perth, 1993.

2 Neuberger T. Why not ask the experts? *Health Service Journal.* 30 September 1993.

Future Programme: Other Issues to be considered by Subsequent Working Groups

Needs criteria for specialist mental health professionals in the community

Local data on the pattern of usage of mental health services shows considerable overlap in referrals from general practitioners to clinical psychologists, community psychiatric nurses and psychiatrists. A feature of the introduction of fundholding has been the introduction of counsellors into primary care to carry out some of the functions previously undertaken by these professionals. As more patients with complex needs are cared for exclusively in the community against a background of increasing pressures on scarce resources, it is incumbent that purchasers define more clearly the relevant grade and mix of specialist input required to deliver services. A first step will be defining the key skills and areas of expertise of the above professions. It is proposed that multidisciplinary working group be convened to study the relevant issues.

Appendix

Diagnosis	ICD Nos. (9th Revision)
Senile and presenile organic psychotic conditions	290
Alcoholic psychosis; alcohol dependence syndrome	291; 303
Drug abuse	292; 304; 305
Schizophrenic psychoses	295
Affective psychoses	296
Other psychoses	293; 294; 297; 298
Disorder of childhood	299; 313; 314; 315
Neurotic disorders	300 (excluding 300.4)
Depressions - non psychotic	300.4; 309.0; 309.1; 311
Personality disorders	301
Mental handicap	317; 318.0; 318.1; 318.2; 319.91; 319.99
Other conditions	All other