

Needs Assessment for a Comprehensive, Local Mental Health Service

Mental Health Reference Group



SCOTTISH EXECUTIVE

Working together for a healthy, caring Scotland

MENTAL HEALTH REFERENCE GROUP

Needs Assessment for a Comprehensive, Local Mental Health Service

March 2001

The Mental Health Reference Group evolved on 31 March 2000 to the Mental Health and Well Being Support Group. The Support Group is pleased to endorse and publish this report.

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Chairman's Introduction

The *Framework for Mental Health Services in Scotland*, launched in September 1997¹, continues to provide a relevant template against which wide partnerships including Health Boards, Primary Care Trusts, Local Authorities, voluntary agencies, service users and those who care for them, and staff at all levels can agree priorities for action to provide better care for those with a mental illness.

The Mental Health Reference Group (MHRG) was set up in 1996 to assist the (then) Scottish Office working party developing the first draft of the *Framework*. Chaired originally by my predecessor, Dr Angus MacKay OBE, the Reference Group had members from all the professions involved in mental health care, representatives of Health Boards and Trusts, local authorities and voluntary agencies, and user and carer organisations. Members came from across Scotland and also included Scottish Executive officials. The wide acceptability of the *Framework* during the consultation period, and after its launch, was greatly assisted by the ongoing advice and input of the MHRG.

After publication, it was clear that the MHRG had a continuing contribution to make. In this respect 4 sub-groups were established, one of which was charged with developing guidance for needs assessment for a comprehensive, local mental health service. (The other groups examined risk management; the interface between primary care, secondary care and social work; and outcome indicators.)

The *Framework* draws attention to the importance of services matching assessed needs with a key focus on social inclusion. This requires multi-agency agreement and understanding on approaches to local needs assessment. This report aims to provide guidance to local agencies to help achieve this.

The Scottish Needs Assessment Programme (SNAP) has published a series of papers on mental health needs as well as a “Rough Guide” to needs assessment in Primary Care². The SNAP reports show the usefulness of routine data sources in mental health needs assessment, highlighting the importance of case registers for mental health and point to appropriate indicators of health gain. This report compliments but does not replace that guidance and quite properly widens the agency interest to include all the relevant agencies.

This report provides; a broad outline of needs assessment for mental health services (Chapter 1); a process of core individual needs assessment including the key issues for information management (Chapter 2); a description of assessing mental health needs in Primary Care (Chapter 3); an outline of the basic steps in service profiling in the context of mental health needs (Chapter 4); and an approach to profiling local communities for their risk of mental health problems (Chapter 5).

¹ Framework for Mental Health Services in Scotland, The Scottish Office, 1997.

² Needs Assessment in Primary Care: a Rough Guide. Scottish Needs Assessment Programme. 1998.

Overall the report reflects the White Paper *Towards A Healthier Scotland* which highlights the importance and impact of life circumstances in the development of ill health³.

The remit and membership of the Needs assessment Sub-Group are set out in Appendix 2.

Since this report was commissioned the Mental Health Reference Group has evolved into the Mental Health and Well Being Support Group and on their behalf I commend this guidance to you.

Ian Pullen
Chairman

³ Working Together for a Healthier Scotland. The Scottish Office Department of Health. 1999.

Remit

Against the following background context, the sub-group was invited to consider best advice for an inter-agency, service user based approach to needs assessment for mental health.

A person with a mental health problem should expect his or her reasonable needs to have been foreseen and account to have been taken of them in the planning and provision of services. Forward planning requires informed prediction of needs and their relationship to demand.

In practice, there are three main sources of information need:

- Local experience and judgement. These usually reflect demand;
- Large scale epidemiological data. These usually reflect need;
- Local epidemiological studies, including case finding. These would give information on need but are almost never carried out for reasons of cost and time.

The usual source of information for strategic planning is local judgement, often supplemented in planning documents by references to national epidemiological data and national policy statements, which may represent little more than window dressing. The danger is that planning based solely on experience and judgement may simply perpetuate old faults, inequalities and unintended priorities.

There is an urgent requirement for an operational protocol, which can be used at sub-national and sub-regional levels, to enable commissioners and providers of services for people with mental health problems to assess local need in a structured and reproducible way. There is also a requirement to clarify the role of Departments of Public Health in this process and the extent to which they should be involved in needs assessment for local populations; for example, in areas to be covered by Local Healthcare Co-operatives.

1. To define the various dimensions of needs assessment, including:
 - The geographical “topography” of service needs;
 - The amount and type of provision required, including non-clinical elements such as housing, employment, socialisation and recreation;
 - Define inequalities in the type, quantity and accessibility of service provision;
 - The identification of met and unmet needs.
2. To comment on the various forms of needs assessment currently available, their relationship to demand, and their validity for local planning;
3. To comment upon the advantages and disadvantages of targeted needs assessment;

4. To clarify the Role of Departments of Public Health;
5. To make recommendations on how best to gather the valid and representative views of people who have suffered from mental health problems, and their informal carers;
6. To define ways of systematically capturing the local sources of information which already exist;
7. To make recommendations on a protocol for needs assessment which will be useful to local planners operating in a joint agency context which will take account of judgement and experience as well as epidemiological data, and which will be capable of producing an answer within a reasonable time.

Aim

To produce a note of guidance for Health Boards, NHS Trusts, and local authorities on how to collect a valid shared data set on mental health needs for a defined local population.

Executive Summary

The assessment of need for mental health services is a process which helps inform planning of care for individuals, their families and communities. It can be a powerful learning tool for local services and provides the rationale for re-designing services to better target assessed needs.

Needs assessment for mental health (and other) services has many dimensions: individual, family, community, primary care, and specialist services among others. This report concentrates on the range of needs most frequently encountered in local adult mental health services. The emphasis is on broad approaches to needs assessment, based on the “Rough Guide” concept used in the Scottish Needs Assessment Programme. A wide list of information sources is attached at appendix C for further detail.

Understandably, local agencies will be at different stages in their needs assessment but certain principles should underpin the process, including:

- Involvement of all relevant stakeholders;
- Cross reading of results to examine needs from different perspectives;
- Structure and standardisation as far as possible so that assessments and records can be shared easily; and
- Use of Information Technology to support the process.

The scope of needs assessment for mental health services is framed by the model of mental health which is used. Community development approaches to mental health needs assessment acknowledge the social influences on mental well-being. Such approaches are useful in promoting social inclusion – an issue of particular relevance for those with a mental illness and their families.

Principles

- i. All concerned must be clear **why** the needs assessment is being undertaken, **what** resources are available to undertake it, and **who** will deliver on the outcomes.
- ii. Individual needs assessment should be based on an agreed summary tool which allows comparison between individuals and within individuals over time.
 - The tool should be understood and accepted by service users and carers.
 - The Camberwell Assessment of Need for adults with mental health problems and CARE-NAPD for people with dementia are appropriate, credible tools for **specialist** mental health services.
 - **Individual** needs assessment in **primary care** may not require detailed tools but still require a standard method of recording information on mental health needs.
- iii. Capacity building is required at each level of the process for needs assessment to work successfully. “Capacity” in terms of collecting, analysing and utilising information for service planning and delivery at individual, primary care, local authority and health board levels.
- iv. Consideration should be given to the establishment of registers of people with mental health problems at LHCC level, which are able to be analysed to provide needs assessment information for local populations.

Chapter 1

Mental Health Needs Assessment

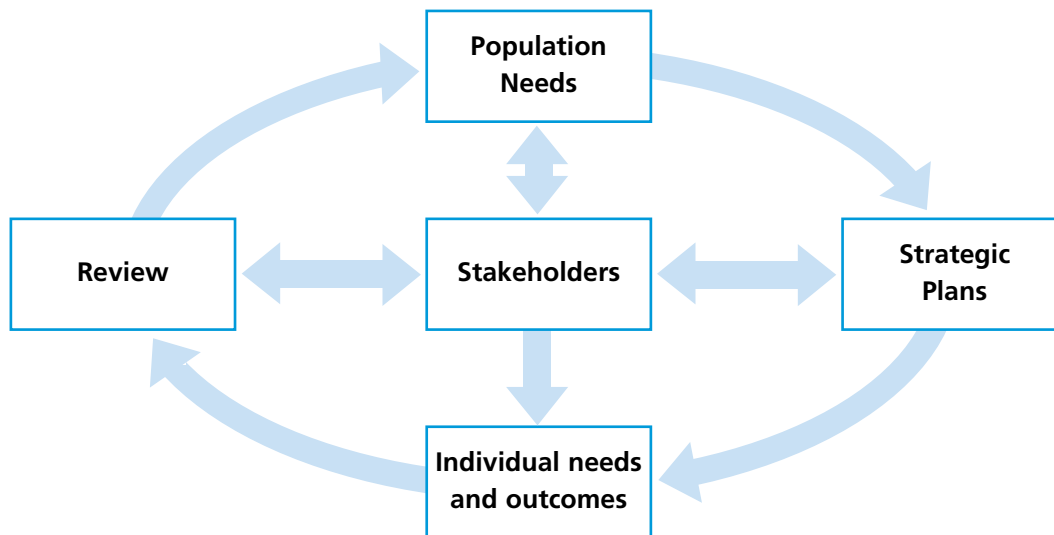
This guide outlines a generic approach to needs assessment for adults with mental health problems. It does not attempt to provide data but demonstrates how to go about finding answers to local questions. Needs assessment for specific mental health problems such as eating disorders, forensic services or child and adolescent mental health problems share a similar approach but will of course vary in detail. Where there is under-recognition of mental health problems, such as for people with neuro-developmental disorders, needs assessment can be difficult. Part of the function of good needs assessment is “horizon-scanning” which looks beyond the immediate reasonably well-known need and anticipates mental health problems emerging in the population.

Historically, developments in mental health services have been service-led. However, to be responsive to individual needs a different approach is required. To be effective this approach must be user-centred and take full account of family, community and social contexts. Assessments of needs should be continuous to take account of the changes to the needs of the individual and of the wider population over time.

Services that aspire to meet the range and complexity of needs of people with mental health problems should be designed with needs assessment and evaluation as integral features. Figure 1 summarises the process involved.

Step 1 – Getting Started

A variety of approaches have been used to undertake needs assessment for mental health services. Each has merits, with not one approach being satisfactory in isolation. For instance, postal surveys of mental health status, practice-based data or data on hospital activity have all been attempted. Community-based studies are rarer. What is needed is for all these approaches to be brought together to better integrate the service user and professional perspectives. A combination approach is more likely to reflect reality than using one method alone. This approach is sometimes referred to as **triangulation**.

Figure 1. The Process of Population Based Needs Assessment***Defining need***

Different people will necessarily be involved in assessing need; professionals, service providers, carers and people who have mental health problems. It cannot be assumed that “need” holds the same meaning for any of these groups. Different sources of information will give different pictures of need demonstrating the different ways in which the concept can be widely expressed depending on its social context.

A user-centred approach

People with mental health needs should be at the heart of the assessment process. This does not deny the part that other people play in defining need but users should be given opportunities to express their needs, individually or collectively. This approach recognises that a variety of factors affect the expression of need:

- Social circumstances and cultural traditions affect levels of tolerance of unmet needs and what is acceptable.
- Low expectations of needs being met will be a barrier to needs being recognised and reported.
- Needs may be reported only if services are known to be available to meet them.
- People may choose not to express needs for a variety of personal reasons.
- At times people may not be able to express their needs and their interests in service provision must be protected (eg through advocacy).
- Conversely, people may no longer have a need for services, but a “need” to be more independent.

The expressed needs of people who experience problems should be set alongside other sources of information on need. A triangulation approach is more likely to approximate to actual levels of need than looking only from one perspective. It is also important to see this as an on-going process and that it is used to provide a basis for monitoring outcome and assessing unmet need.

Step 2 – Choosing an Approach to Assessing Need

There are both qualitative and quantitative approaches to assessing mental health needs. They include:

- Engagement with Stakeholders: ie service users, carers, professionals, communities using the *Framework for Mental Health Services in Scotland* as a template to consider the range of needs⁴;
- Individual Assessment of Need: ie aggregated data to inform the population picture;
- Epidemiology: ie prevalence and incidence data from national and local surveys;
- Rapid Appraisal Techniques: such as those developed by Murray (see box 5 in Chapter 3)⁵; and
- Comparisons of levels and usage of provision: ie service profiling.

The merits of these approaches are summarised in Table 1.

Step 3 – Defining the population

It is best first to define the population(s) to be assessed. These can include particular groups of people with specific problems such as:

- those with severe and enduring mental illness;
- those who are homeless;
- those with drug and/or alcohol problems; and
- those with a learning disability;

Or they can be of general populations covering geographical areas such as:

- Scotland;
- a Health Board area;
- a Local Authority area or sector;
- those served by a Local Healthcare Co-operative;
- a local community (however defined); or
- those served by a single general practice

These populations can also be sub-divided by age, sex, minority ethnic group etc. There is more discussion about defining communities in Chapter 4.

Key Action Points

- Be clear why you are undertaking the needs assessment;
- Agree on the population or individuals to be assessed;
- Decide on what combination of approaches to adopt;
- Involve as many relevant service users (and carers if appropriate) as possible in the process.

⁴ As an example of how this could work see Smith H. Needs assessment in mental health services: the DISC Framework. *Journal of Public Health Medicine*. 1998; 20(2): 154-160

⁵ Murray SA, Chick J, Perry B. Mental health, alcohol and drugs: constructing a neighbourhood profile. *Primary Care Psychiatry*. 1996; 2: 237-243

Table 1

Needs Assessment Approach	Advantages	Disadvantages	Sources of information
Epidemiology	Gives ball-park figures of numbers likely to have specific problems (eg depression, anxiety, schizophrenia, dementia) Relatively quick and easy Identifies the broad range of clinical conditions and their likely prevalence	Assumes uniform prevalence, although can be weighted (crudely) for known risk factors eg deprivation Can tend toward medical rather than social needs	OPCS Surveys of psychiatric morbidity ⁶ Department of Health Epidemiological needs assessments SNAP reports Census
Comparative	Sets local service provision against national norms Good for identifying inequalities Uses existing data	Relationship unclear between provision and utilisation of services and actual need.	Accounts Commission reports Skipper (ISD) ⁷ Prescribing Data GPASS (or other computerised practice database)
Individual assessment of need	User-centred Tailored to individual	Information not always accessible or collated in such a way as to inform the big picture	Care Programme Approach Long-term care registers Community care assessments Personal housing plans
Service user views	Provides important qualitative information Participative Helps in determining where the greatest needs are – prioritising	Unclear how representative the views are – danger that those who shout loudest get heard most clearly Subjective	User surveys Conferences, questionnaires, group work Carer assessments Focus groups Community development projects
Rapid Appraisal	Good for community profiling Highly participative Good qualitative information	Does not generate statistics for planning purposes Subjective	Local informants Local information/reports

⁶ National Psychiatric Morbidity Survey, OPCS, 1996. London.

⁷ Scottish Key Indicators Package for Performance. Information and Statistics Division. NHSIS Management Executive. Scotland. 1999.

Chapter 2

Individual Needs Assessment

This chapter is written to assist professionals and service planners to develop Individual Needs Assessment for adult mental health services. The “Rough Guide” to needs assessment is relevant and should be read alongside this report⁸.

Any new system of comprehensive individual needs assessments should have regard to the following principles:

1. Service users should be involved right throughout the process and be informed of the outcome.
2. Carers have a right to their own separate needs assessment. They too should be involved meaningfully as far as possible throughout the process of individual needs assessment and informed of the outcomes (the potential for conflict with the service user view should be handled and considered sensitively).
3. The assessment measure adopted should be practical and easy to administer by staff.
4. Core elements of the assessment should be common across agencies and care sectors.
5. The measures should be sensitive enough for use for specific care groups. This means different measures will be required for groups with severe mental illness, older people with dementia, children, people with learning disability etc.
6. The measure should include sections on General Health, Mental Health, Social and Family Circumstances, Housing and ways to spend daytime in meaningful activity – eg work, training, leisure. Where appropriate, a risk assessment should be included.
7. The measures should be able to discriminate between low, medium and high needs and whether these needs are being met.
8. The assessment should contain elements which when repeated at a later date will measure change and form part of an outcome measure eg Health of the Nation Outcome Scale⁹. The Sub-Group Report on Outcome Measures should be referred to for a more detailed discussion.
9. The core elements of the assessment should be capable of being recorded electronically for ease of transfer between agencies and for collation for service audit and planning. The aim should be for all information on assessments to be captured electronically. The provisions of the Data Protection legislation **must** be complied with in every respect.

⁸ Needs Assessment in Primary Care: a Rough Guide. Scottish Needs Assessment Programme. 1998

⁹ Outcome measures are the subject of another sub-group report from the Mental Health Reference Group

Step 1 – Agree common procedures

To succeed requires practical working conditions and relationships between professionals that foster sharing of information and records. Much of this is made easier when the 2 central agencies involved, Health and Social Work, are located in the same teams with (ideally but not essentially) shared premises and shared IT systems. Professional issues around ‘confidentiality’ have to be addressed by all agencies with substantial input from local user and carer groups. It is essential that all agencies have regard to the guidance and statute affecting information sharing. Data protection legislation and other disciplines apply.

For some users access to their health records would be much improved if they held the records themselves. Patient held records are a reality in some areas of health care notably in shared Maternity Care.

Usually, there are 2 stages to needs assessment and care planning – the Pre-diagnostic phase and the Post-diagnostic phase. Both imply that in the first instance health care professionals are central to the process of assessment. Other key professionals become more involved at the point after diagnosis when the ‘care plan’ is being developed. It is therefore essential that each stage complements others to avoid unnecessary repetition for the service user/carer.

From the professionals’ view the various elements of an assessment that would give a complete picture of an individual rests in files held by different agencies. This necessitates considerable planning and effort to bring all the information together, especially when the professionals work from different bases. The Care Programme Approach demonstrates one mechanism for bringing the professionals and their assessments together with the individual user and relevant carers.

Step 2 – Agree a common core assessment form

Essential information for planning purposes can be collected through the process of individual needs assessment. However, the information has to be standardised and systematic if it is to be of value for this purpose. It also needs to be in a format that is easily retrieved, collated, or aggregated.

Data definitions for diagnosis derived from ICD(10) and Read Coding command widespread acceptance amongst hospital clinicians and general practitioners respectively¹⁰. Problems of incompatibility between the two systems, whilst real, are not insurmountable. However, universal methods of describing the needs of people with mental health problems are also needed to supplement diagnostic information. These should be pragmatic measures, applicable to a variety of care settings. Measures need to be relatively simple and describe in summary form social and psychological functioning with some indication of severity. Developing common definitions and information systems to support mental health services is the subject of a national initiative at the Information and Statistics Division (ISD) of the NHS in Scotland¹¹. A Code of Practice for joint record keeping may be one way to help professional groups overcome the confusion they have over the use of different language. Joint training may also be required.

¹⁰ ISD Scotland, Trinity Park House, Edinburgh EH5 3SQ, Scottish Clinical Coding Centre: 0131 551 8207

¹¹ For more information contact ISD Scotland, Trinity Park House Edinburgh EH5 3SQ, Customer Liaison: 0131 551 8899

Standard Definitions

Useful definitions of severe mental illness can be found in the Framework for Mental Health Services in Scotland and in the Department of Health’s Outcome Indicators for Severe Mental Illness¹².

Step 3 – Choose assessment schedules

Service Users and Carers are central to individual needs assessment. Enhancing their role will improve both process and outcomes. Not all service users and carers may want to or be able to complete such schedules without help, but many would welcome the opportunity (the role of advocacy is essential in this regard). This type of measure is best used for people with enduring mental health problems who are in contact with the statutory agencies.

There are numerous assessment schedules which have been used in different settings. Most were developed for research purposes initially but some have clinical applications for specific care groups. The following measures were considered the most promising -

The AVON Mental Health Measure (Avon Working Group, 1996)

This is a descriptive instrument designed to enable self-assessment and help service users prepare for Care Programming and Care Management and to provide information to help plan better service responses.

The questionnaire was developed in Avon by a working group of service users and carers, psychiatrists, psychologists, social workers and voluntary organisations. The measure describes options for physical health, social circumstances, behaviour, access and mental health. Patients select the description/s that are relevant and can provide further explanations if they wish to do so. They are asked if they need help to change things and are asked to identify what sort of help they need. The measure helps patients with mental health problems to build up a profile of themselves based on their abilities, needs, and aspirations. This is being considered by the sub-group on Outcome Indicators (to be published at a later date).

The Camberwell Assessment of Need (CAN)

This was designed to assist Local Authorities to assess the community services requirements of patients with severe mental illness. It has the ability to aid routine care and treatment and highlights likely areas for further assessment. The authors claim this measure can be used with other care groups.

The CARENAPD Package (Scottish Office Information and Statistics Division)

Designed to assess the needs of people with dementia and their carers in community settings. It is designed to be used as a joint Health/Social Work Assessment Measure. The same group who developed this package are working on CARENAPE for use with non-demented elderly people and their carers.

Decision on needs assessment tools will be influenced by the requirement to use outcome measures for individuals. This is being considered by the sub-group on Outcome Indicators (to be published at a later date).

Step 4 – Communication and information transfer

Individual needs assessment is part of an overall process of care, which has to be supported by the timely transfer of information. Local procedures should specify the core elements of individual needs assessment that should be available for transfer between agencies and professionals. They should specify standards for communications so that everyone who needs to know is informed appropriately (while complying in all respects to Data Protection and other requirements on information sharing).

Advances in information technology should make these processes simpler but there still need to be standard definitions and use of language if these communications are to be meaningful. This requires joint training and development of front-line staff so that information is collected and transferred in a standard way.

Step 5 – Analysis and reporting on aggregate information

Providing feedback to services on the needs of individuals helps to create a learning culture. Designated resources are needed for analysis of information returned on individuals needs and for disseminating this information to those involved in planning and delivery of services. This may include the establishment of a register of those with severe and enduring mental illness and link to administrative systems for the Care Programme Approach. It will not be possible to audit against standards set by the Clinical Standards Board for Scotland unless these systems are in place.

Good Practice: A Study of Patients with Major Mental Illness in Lanarkshire

This study was carried out in Hamilton. The case was ascertained through identifying people who had received professional attention for a psychotic illness within a set timeframe. A one in three sample were selected for interview using the cardinal needs schedule.

It was found that there were needs for care that were not being dealt with adequately. This was not so much a consequence of a lack of local services but a lack of a systematic approach to evaluation, treatment and follow-up.

An important message from this work is the need to systematically reassess patients who may not seek help. This was followed up by similar work in the Borders. They suggested a database of people with severe and enduring psychoses which could be updated every 1 or 2 years.

Key Action Points

- Bring together relevant local agencies to review existing procedures, forms, schedules and information transfer.
- Based on an understanding of local practice, systems and resources, identify ways of avoiding duplication and improving processes so that individuals' needs can be readily identified. This may include linking to administrative systems for the Care Programme Approach and developing a local register within LHCCs of people with severe and enduring mental illness.

Chapter 3

Primary Care Needs Assessment

This chapter is directed at Primary Care Teams and LHCCs and should be read in conjunction with the SNAP publication “Needs Assessment in Primary Care: A Rough Guide”².

It outlines a multi-method approach to assessing mental health need by using:

- routine practice based data;
- routine secondary care data;
- data from patients, local agencies and the general community;
- review of current service provision in Primary Care.

90% of mentally ill patients are managed in primary care (SNAP). The commonest problems (often with physical symptoms) are depression and anxiety. These symptoms can range widely in terms of their severity and the extent to which they disable.

Step 1 – Planning Phase

It is important at the outset to determine a number of parameters including the target population, the data sources and membership of the project team.

Target Population

Decisions are required on whether the study is to take place at practice level or at LHCC level. One view is that the most meaningful information for determining health responses is best developed as a result of practice-level assessment. However, if the aim is to tackle general mental health issues, which go beyond merely health services, then an LHCC approach could be more fruitful.

To avoid duplication of effort it is important to check with local public health consultants, Health Board commissioners or Primary Care Trusts whether or not anyone else has or is conducting similar needs assessment.

Data Sources

Having determined the diagnostic category codes, it is important to identify data sources. These could include;

- aggregated Diagnostic Codings from GPASS¹³. Box 1 lists the likely data available in some Scottish practices;
- prescribing data related to psychotropic medication;
- psychiatric service based activity relating to either the practice or LHCC (boxes 2 and 3 are examples of the data which the local psychiatric service or ISD Scotland may be able to supply); and
- local service user/carer focus groups.

¹³ General Practice Administrative Scheme for Scotland

If the practice chooses to study a well defined geographic area within the practice the following census parameters are useful indicators of risk from mental health problems:

- percentage residents with limiting long term illness;
- percentage unemployment rates men and women;
- percentage owner/occupiers;
- percentage lone parent households; and
- locality profiling for the practice area or LHCC area (see Chapter 4 Community Profiling for more detail).

In addition, gaining views and experiences of service users and their carers is important. This can be achieved by individual interviews or focus groups as detailed in Box 4. Rapid participatory appraisal as detailed in Box 5 is an innovative method of gaining information about a particular community which gives a balance between community profiling and individual needs assessment.

Project Team

It is important at the outset to determine the composition and leadership of the Needs Assessment Team. The following membership is suggested;

- service user or local mental health forum member;
- General Practitioner;
- practice or LHCC manager;
- psychiatrist;
- local community psychiatric nurse; and
- local social worker.

A work plan should be agreed including details of individual responsibility for tasks and a relevant timetable for action.

Step 2 – Conduct the Needs Assessment

The team members should be assigned data collection tasks to cover the data sources as detailed above. Local clinical audit data may be of relevance in informing the broader picture of service response to need. The audit may include:

- information for patients and staff;
- urgent/emergency care;
- routine care;
- primary care staff training needs in mental health;
- organisational issues; and
- interface with other agencies.

Step 3 – Analyse, interpret and implement change

Having collected all the relevant data careful analysis and interpretation will lead to the development of plans for changing or initiating services to fill identified gaps.

This should form part of an on-going needs assessment process and lead to the establishment of a register for people with mental health problems at LHCC level.

Key Action Points

- Identify a local “champion” for mental health in the practice or LHCC.
- Bring together a team to look at mental health needs using all relevant data. This may include routine data and results of ad hoc surveys eg clinical audit projects.
- Involve service users and staff in focus groups and other types of discussion to develop a clearer picture of needs and priorities.

Box 1: Data potentially available by conducting computerised searches using GPASS (General Practitioner Administration Scheme of Scotland) and comparison with national GPASS prevalences

	<i>Read 2 Codes Used for searching</i>	Practice number of patients	Practice prevalence per 100 patients	Prevalence in Scotland per 1000 patients*
Dementia	E0.. to E00z, E041			3.3
Alcohol misuse	E01.. to E01z, E23.. to E23z, E250.			7.1
Drug misuse	E02.. to E02z, E24.. to E24z, E251. to E25z			4.6
Schizophrenia	E10.. to E10z			1.2
Mood (affective) disorders	E11.. to E11z, E204., E2B., E2B0., E2B1.			51.9
- Bipolar affective disorders	E111. to E111z, E114. E11y0, E11y3, E11yz			0.5
- Depressive episode	E112. to E112z, E11z2, E204			51.0
- Recurrent depressive disorder	E113. to E113z, E118			0.4
Other psychotic disorders	E03.. to E31z, E04.. to E040., E12.. to E13z			1.3
Disorders of childhood	E14.. to E14z., E2D. to E2Dz., E2E. to E2Fz			2.6
Neurotic, stress-related & somatoform disorders	E20. to E20z., E26. to E26z., E28. to E28z., E29. to E29z			57.1
Personality disorders	E21. to E21z			0.6
Mental handicap	E3. to E3z			0.2

Notes

1. Some patients' diagnoses may not be on the computer, and thus numbers may be low.
2. It is suggested to search for groups of diagnoses eg high up in the "tree", so that no patients will be missed.
3. Standardised data input is vital within practice, and among practices if practice data is to be collated for LHCC purposes.

* Source: ISD Scotland GMP database. Data based on 51 continuous morbidity recording practices for year ending December 1999 (total population 288,433).

Box 2: New out-patient contacts by diagnosis in the most recent 3 year period n/1000/year

	<i>ICD 10 Codes</i>	Practice	LHCC	Trust/Board
Dementia	F00-F03			
Alcohol misuse	F10.1-F10.9			
Drug misuse	F11.1-F19.9			
Schizophrenia	F20			
Mood (affective) disorders	F30-F39			
- Bipolar affective disorders	F31			
- Depressive episode	F32			
- Recurrent depressive disorder	F33			
Other psychotic disorders	F04-F05,F22-F25			
Disorders of childhood	F80-F84,F88-F90, F93-F94			
Neurotic, stress-related & somatoform disorders	F40-F48			
Personality disorders	F60			
Mental handicap	F70-F79			
Total Episodes				

**Box 3: Frequency of admission by diagnosis of patients for last 3 years
n/1000/year**

<i>ICD 10 Codes</i>		Practice	LHCC	Trust/Board
Dementia	F00-F03			
Alcohol misuse	F10.1-F10.9			
Drug misuse	F11.1-F19.9			
Schizophrenia	F20			
Mood (affective) disorders	F30-F39			
- Bipolar affective disorders	F31			
- Depressive episode	F32			
- Recurrent depressive disorder	F33			
Other psychotic disorders	F04-F05,F22-F25			
Disorders of childhood	F80-F84,F88-F90, F93-F94			
Neurotic, stress-related & somatoform disorders	F40-F48			
Personality disorders	F60			
Mental handicap	F70-F79			
Total Episodes				

Notes to boxes 2 and 3

1. These data are reliable and available for individual practices and LHCCs, but may not be up to date.
2. Use of hospital services is influenced by factors other than morbidity, such as ease of access and the referral patterns of local clinicians.
3. The small numbers in any single year means it is safer to consider data over at least three years for individual practices.
4. Data are “episode based” which count number of episodes of care not number of individual patients, although this may change.
5. Generally in Scotland, out-patient diagnoses are recorded in no other speciality (a unique opportunity to use this routine data).

Box 4**Focus groups**

- Facilitated discussion groups that allow the members to express issues spontaneously
- Can give useful insights into perceived needs, quality of services and understandings of wider health issues
- Can raise issues that are important to service users and carers
- Information gained is not quantifiable
- Facilitators may need some training (particularly, but not exclusively, service users and carers)
- A variety of groups may be necessary to be representative in some situations

Practical points:

- Optimum size is 8-12 participants
- Facilitator introduces topics for discussion
- Notes are taken, preferably by another facilitator, or ideally, proceedings are recorded (where consent is given) using a tape recorder and later transcribed.

Box 5**Rapid appraisal**

A small team, ideally with a mixture of professional insights, gathers data about both needs and resources in the area under study from:

- Interviews with individuals with knowledge of the community and service users
- Available documents about the neighbourhood or community
- Observations made inside homes and in the neighbourhood

Practical points:

- Use the Framework for Mental Health Services in Scotland as an information pyramid to guide collection and analysis
- Collate the needs, priorities, and solutions perceived in the community for each box of the information pyramid
- Consider facilitating change in primary care services, commissioning of secondary care, and local advocacy to improve wider determinants of health.

Chapter 4 Service Profiling

Service Mapping and Utilisation

It is important to map existing services within the local area and relate this to local needs.

Step 1: Identify all current services for people with mental health problems

This process should identify services from all relevant agencies, statutory, voluntary, private and include leisure and social activities.

Step 2: Categorise services into functions relating to need

There are many ways to categorise these services. The Fife Joint Development Project (see box on page 27) categorised services according to:

- Somewhere to be – the range of accommodation available for people with mental health problems;
- Something to do – day services, employment schemes, training and education; and
- Someone to turn to – support groups, hospital and community services.

The template set out in the Framework for Mental Health Services in Scotland offers a more detailed range of categories and includes:

- Access and information;
- Needs for individual planning;
- Meeting needs in crisis;
- Needs for treatment and support with mental distress;
- Needs for ordinary living and long-term support; and
- Needs for personal growth and development.

Step 3: Identify location, availability, capacity, casemix, uptake and costs of services

It can be helpful to use local maps to illustrate the location of services. This can help identify gaps in provision and access problems. In these terms it is also important to determine whether services are easily accessible by public transport. Opening hours provide useful information about the availability of services and whether they are user or service-led. Services that are open Monday to Friday,

9.00 am to 5.00 pm are unlikely to always reflect local users' needs. The capacity of services needs to be offset against uptake (and waiting lists where relevant) to determine the local demand. Caseloads and casemix can be useful in demonstrating stresses and strains in the system. This can take time given existing systems are usually poorly designed to yield such information.

Each element of service should be costed separately then aggregated to determine the full resource allocation to local mental health services. This has to be done in a multi-agency context to identify the global resource invested in mental health services. Appendix B sets out a framework for this work.

Step 4: Validate findings with stakeholders

As with all aspects of needs assessment, this work requires participation of service users and their carers in interpreting the findings and drawing conclusions to inform the re-designing of local services. For instance, uptake of crisis services may be lower than expected given the need expressed by users and carers, but just knowing the service is there may offer reassurance and offset the need to utilise it.

Benchmarking

Another useful technique in service profiling is benchmarking local services against norms. These can range from staffing levels for hospital in-patient wards to ratio of spend in hospital versus community mental health services. The Accounts Commission review of mental health services contains some useful benchmarks for local services¹⁴. The Scottish Health Advisory Service also uses benchmarks to determine whether staffing levels are adequate for different settings.

Caution is needed in interpreting benchmarking exercises. Is the local population typical or does it experience relatively higher levels of mental illness because of deprivation or other factors? Different patterns of service provision may also account for variations which need to be looked at across the whole service. For instance, the lack of community mental health services is likely to lead to higher levels of staff employed in hospital settings. A further disadvantage to benchmarking is its tendency to assume average allocation or spend is appropriate.

Economic evaluation and resource allocation

Economic evaluation is a framework for comparing alternatives. It seeks to identify all of the relevant costs and benefits of different options and, wherever possible, to measure and value those effects. It tends, therefore, towards quantitative analysis. It is not sufficient to claim that having more staff must be more beneficial: the question is how much more beneficial and what else could the resources involved have been used for and what is of most relevance to the service users needs?

Resource allocation in mental health services can be measured at different levels.

¹⁴ Accounts Commission. A Shared Approach: Mental Health Services in Scotland. 1999.

A number of questions on investment can be asked.

Questions

Macro level

- What is the likely resource allocation to local services in future? The Arbutnott Report shows some areas receiving less and others more in the light of the accepted revised formula for resource allocation in the NHS.
- What is the overall spend and how does this compare with other care sectors? The average health board spend on mental health services in Scotland is 15% of overall allocation (1999). The Accounts Commission has reported on combined spend in health and social work. In future, it would be helpful and more relevant to include funding from all agencies.
- What is the per capita spend and how does this compare with other parts of Scotland?
- Is this expected given the local level of need or not? The Accounts Commission report points out a discrepancy between allocation of resources and need.
- What is the relative spend on hospital compared to community mental health services? Is this in line with strategic intentions?
- Can the cost of each programme be linked to any measure of outcome or health benefit?
- Is there evidence that taking money from one programme and shifting it to another will result in net benefit?

Micro level

- How much does each element of the service cost?

This process should be agreed by all local agencies so that the global resource available to the mental health service is assessed. Attempts should be made to appraise the benefits of these different components of the service. This begins to address the question of which types of services offer best value.

Costing services usually involves identifying resources used in hospital in-patient services, day services and community services. If there is to be a re-orientation of services to need, a fresh approach is required. Appendix B describes how costs can be apportioned to different parts of the service according to a framework based on needs of people with mental health problems. This may be difficult in the early stages of financial planning, but should be the aspiration of comprehensive mental health services. Again comparing these costs with benefits begins to address the question of best value.

Good Practice: Fife Joint Development Project

One element of this project was to profile local services using the National Framework as a template. This profile mapped services geographically and according to their availability (ie opening hours).

Gaps were particularly noticeable in daytime activities such as work, training or meeting people and in the lack of alternatives to hospital for acute crisis care.

Key Action Points

- Engage with all local services providers to establish their relative contributions to meeting the needs of people with mental health problems.
- Encourage the sharing of information on users perspectives of local services.
- Develop a shared financial framework to identify all the resources allocated to mental health services.
- Carry out appraisal of costs and benefits of all major changes in local services.

Chapter 5 Community Profiling

Socio-economic inequality has a detrimental effect on mental health: an individual's life circumstances such as employment, housing, education and environment are strong determinants of general health and well being. Needs assessment must therefore take into account community characteristics and look “upstream” to tackle the causes of mental ill health.

The ‘Rough Guide’ describes a healthy alliances approach, which can be adapted to suit local circumstances. Mapping the mental health needs of a community relies upon honesty and partnership between agencies. Promoting a common understanding will facilitate a coherent, co-ordinated and inter-agency assessment to tackle the root causes of mental health problems.

Step 1 – Identify your community. There are likely to be a number of joint working mechanisms already established and available to achieve this, eg LHCC groupings, community council areas, local council areas etc.

Step 2 – Identify the organisations. Consider those currently operating in the area with an influence on mental health. Table 5.1 lists suggested organisations, including operational and strategic personnel, who could contribute.

Step 3 – Invite organisation representatives to identify multi-agency meetings.

Step 4 – Work with agencies. Identify their concerns about the mental health of the community and the main contributory influences.

Step 5 – Prioritise concerns. Assess the concerns using a nominal group approach – as explained below.

Nominal Groups

This is a method of prioritising needs. A meeting of the people to be involved in setting priorities (eg PHCT/locality team, community group, healthy alliance group) is set up. Needs identified by participants are listed, discussed, then ranked by each participant until an agreed level of consensus is reached. This can be a structured way to use the insights which the PHCT/locality team often has into the needs of patients.

Plus points

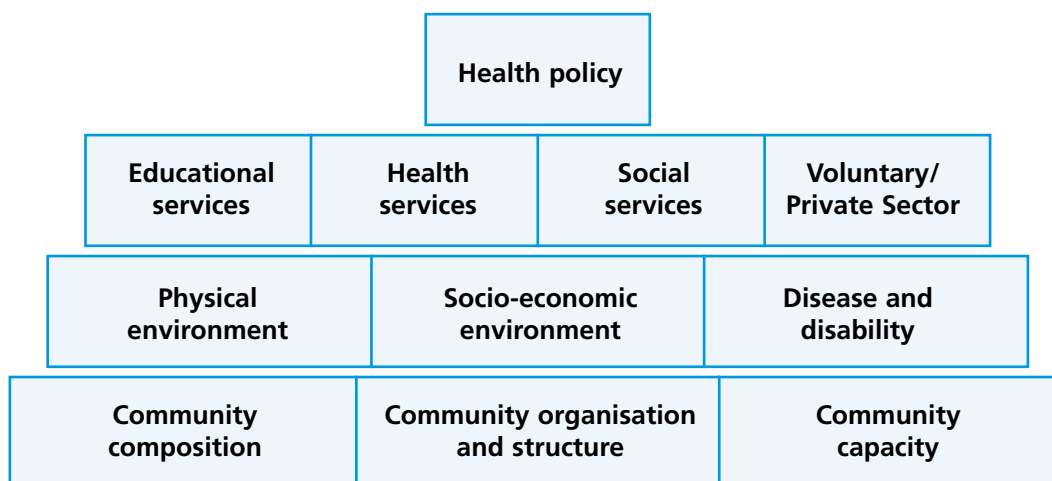
Both qualitative (the discussion) and quantitative (the rankings) data are generated. This approach encourages team-building. Relatively quick results are obtained.

Problems

Joint training is required to facilitate nominal groups.

Step 6 – Investigate areas of concern. Develop a ‘Community Characteristics Map’ or Community Profile such as an information pyramid. Table 5.2 lists sources of information which may be of relevance for promoting better mental health of communities.

Information Pyramid



Step 7 – Next Steps. To tackle areas of concern which have been identified through this process. The aim should be to agree jointly on ways to reduce the level of mental health problems and ways to tackle the underlying causes. A nominal group or ranking matrix approach may be useful here. It is also useful at this stage to identify indicators to monitor progress in achieving these tasks.

Step 8 – Implement and monitor.

Table 5.1

Strategic	Operational
Social Work Development Staff	Area Team Social Worker/Care Manager
Housing Strategy and Development Staff	Area Housing Manager(s)/Officer(s)
Health Board/Trust	Health Visitor/Community Nurse/CPN
Police - Community Involvement Branch	Community Policeman
Local Enterprise Company	Local Businesses
Environmental Health Officer	Local Schools/Head Teacher/School Nurse
Planning and Transport	Voluntary Groups
Benefits Agency	Money Advice/CAB Managers
Employment Agency	Tenant/Resident Representatives
Elected Members	Local transport companies
Council’s Research and Information Officer	Local Clergy

Table 5.2

Information to be Mapped	
Local House Condition Surveys	Health Statistics
Census Statistics	Community Facilities
Road Accident Statistics	Local Perceptions
Crime Statistics	Local Amenities
Benefit Update	Transport Links

Key Action Points

- Identify community “champions” interested in leading the discussion about mental health problems.
- Use these champions to engage with the community to find out their perceptions.
- Make explicit linkages between this work and formal planning processes such as the Community Plan to inform local priorities for action.

Appendix A

Sub-Group Membership

Membership

Dr Margaret Hannah	Consultant in Public Health Medicine, Fife Health Board (Chair)
Ms Ann Bennet	Housing Manager, Lanarkshire Housing Association
Ms Sheila Durie	Strategy & Development Manager, Forth Sector (formerly Edinburgh Communities Trust)
Dr Sandra Grant	Chief Executive, Scottish Health Advisory Service
Dr Shainool Jiwa	Counselling Service Co-ordinator, Saheliya
Professor Rex Last	Carer, nominated NSF (Scotland)
Mr Ken Laurie	Director of Mental Health Strategic Change, Fife Primary Care NHS Trust
Dr Scott Murray	Senior Lecturer in General Practice, University of Edinburgh
Mr Richard Norris	Head of Policy & Information, Scottish Association for Mental Health
Dr Pauline Robertson	Consultant Psychiatrist, Lothian Primary Care NHS Trusts/ Learning Disabilities Adviser, Scottish Executive Health Department
Mrs Elizabeth Taylor	Social Work Manager (Community Care), Aberdeenshire Council
Mr James Urquhart	Head of New Information Systems Development Unit, NHS Information & Statistics Division, Scotland
Dr Andrew Walker	Health Economist, Greater Glasgow Health Board
Dr Linda Watt	Divisional Medical Director for Mental Health, Greater Glasgow Primary Care Trust
Mr Ewen Cameron	Executive Officer, Scottish Executive Health Department

Appendix B

Framework for Profiling Mental Health Services

Service Provision and Costs (Adult Service) Elements 1 – 2

Adult Services Provision

Current Costs/Funding £000s

Service Element	Level of Provision and uptake	NHS	Soc Wk	Other	Total

Service Model

1. Access and information

Access to services

Information about need

Information about services

Prevention and education

2. Needs for individual planning

Assessment of need

Care planning

Maintaining contact

Service Provision and Costs (Adult Service) Elements 3 – 4																																																																			
<p style="text-align: center;">Adult Services Provision</p> <p style="text-align: center;">Current Costs/Funding £000s</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Service Element</th> <th style="width: 25%;">Level of Provision and uptake</th> <th style="width: 12.5%;">NHS</th> <th style="width: 12.5%;">Soc Wk</th> <th style="width: 12.5%;">Other</th> <th style="width: 12.5%;">Total</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Service Element	Level of Provision and uptake	NHS	Soc Wk	Other	Total																																																													<p style="text-align: center;">Service Model</p> <div style="border: 1px solid black; padding: 10px; margin-bottom: 10px;"> <p style="text-align: center;">3. Meeting needs in crisis</p> <p style="text-align: center;">Emergency care Physical care 'Step-Down' facilities Respite or asylum</p> </div> <div style="border: 1px solid black; padding: 10px;"> <p style="text-align: center;">4. Needs for treatment and support with mental distress</p> <p style="text-align: center;">Time-limited treatment of less severe mental health problems Specialist treatment of more serious problems</p> </div>
Service Element	Level of Provision and uptake	NHS	Soc Wk	Other	Total																																																														

Service Provision and Costs (Adult Service) Elements 5 – 6

Adult Services Provision

Current Costs/Funding £000s

Service Element	Level of Provision and uptake	NHS	Soc Wk	Other	Total

Current Costs/Funding £000s

Service Element	Level of Provision and uptake	NHS	Soc Wk	Other	Total

Service Model

5. Needs for ordinary living and long-term support

Long-term practical and emotional support in the community
 Accommodation
 Treatment of and support with long-standing symptoms
 Specialist support to people unable to use existing services

6. Needs for personal growth and development

High support setting for occupational activities
 Assessment and preparation for work
 Training or education
 Low support work setting
 Open employment
 Support in open employment
 Informal support for service users
 Leisure, recreational activities and adult education
 Support with welfare benefits
 Advocacy

Appendix C

Information Sources

1. *Framework for Mental Health Services in Scotland*. The Scottish Office Department of Health, 1997.
2. Department of Health Epidemiologically Based Health Needs Assessment for:
 - Mental Illness
 - Dementia
 - Drug abuse
 - Alcohol misuse
 - People with learning disabilities
 - Child and adolescent mental health
3. Scottish Forum for Public Health Medicine: *Scottish Needs Assessment Programme Reports* on:
 - Dementia
 - Public Health and Mental Health Gain
 - Schizophrenia
 - The Involvement of Service Users in Assessing The Need For, Commissioning and Monitoring Mental Health Services
 - Mental Health in the Workplace
 - Needs Assessment in Primary Care: a Rough Guide
4. *Health Needs Assessment in Practice*. British Medical Journal, 1998 (Wright J). Series of Articles On:
 - The Development and Importance of Needs Assessment
 - Epidemiological Issues in Health Needs Assessment
 - The Development of Practical Approaches to Health Needs Assessment
 - Needs Assessment in Primary Care I & II
 - Whose Priorities? Listening to Patients & Professionals
 - Health Needs Assessment in Developing Countries
 - Clinical and Cost Effectiveness Issues in Health Needs Assessment
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25. *Community Profiling: A Guide To Identifying Local Needs*: Bristol: SAUS Publications, 1993 (Burton P);
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28. *Community Profiling: Auditing Social Needs*: Buckingham: Open University, 1994 (Hawtin, M; Hughes, G; Percy-Smith, J);
29. *Think Big Act Small*: Health Service Journal 102 26 march 1992 (Hudson B);
30. *Assessing Health Need Using the Life Cycle Framework*: Open University Press 1993 (Pickin, C; St Ledger S);
31. *Population Needs Assessment Good Practice Guide*: London: Department of Health 1993 (Price Waterhouse);
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Exchange Information Service

The Scottish Development Centre for Mental Health (SDC) may be able to advise on how to get a hold of the references and other information sources contained in this report through their Exchange Information Service. The SDC Exchange Information Service is a free service which can supply information on literature, key contacts and practice examples of relevance to mental health service development. The SDC Exchange can be contacted at:

Exchange Information Service

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