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**Addressing needs, finding solutions,
implementing policy: contributions to
the evidence base for modern mental
health services**

**A project submitted to Middlesex University in
partial fulfilment of the requirements for the degree
of**

Doctor of Professional Studies

Edana Louise Minghella

National Centre for Work-base Learning Partnerships

Middlesex University

December 2000

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Abstract

The National Service Framework for Mental Health (NSF) (1999) and the National Plan (2000) have stimulated a sea change in mental health care. The challenge for services is how to deliver the changes effectively to address local needs, diversity and resources. This project contributes by presenting three linked but discrete papers prepared for publication. They derive from research studies within which the author took a principal role.

The first paper analyses the needs, packages of care and clinical outcomes for people in touch with mental health services in three areas of England. It asked, what can we learn about whether, and how effectively, services match need, in different service and socio-demographic environments?

The second paper describes the implementation of two voluntary sector Assertive Outreach teams, their adherence to the Assertive Community Treatment model and outcomes for their users. It asked, how effective are voluntary sector-based Assertive Outreach teams at engaging appropriate clients and improving their clinical and social outcomes?

The third paper examines the experiences and pathways through care for young black men with severe mental illness. It asked what are the key issues affecting their pathways through care and can training GP practices improve the situation?

Taken together, three key findings emerged:

1. People with severe mental health problems receive greater than average support from modern mental health systems. However, more care for people with greater need will be more expensive if this consists mainly of inpatient care rather than alternative enhanced community based services.
2. Positive outcomes can be, and are, achieved, even for those with the most severe needs. However, services are not standardised and care pathways to and through them are not always clear, appropriate or smooth. Not adhering to clear, evidence-based models may compromise services' effectiveness.

3. Some vulnerable people still miss out on positive care, especially those who cannot, or will not, willingly engage with services. People with frequent admissions to hospital, homeless people, people with a dual diagnosis and young black men may not have equal access to the services they need, even when services are apparently set up specifically for them.

Pawson & Tilley's 'realistic evaluation' model of contexts, mechanisms and outcomes is used as a framework for critical reflection on the project as a whole. The political and professional context for the studies, and their conduct, methodologies, findings and implications for service development are explored extensively.

Acknowledgements

I owe many people a huge debt of gratitude for their inspiration, hard work and support throughout the life of this doctorate. These are only some of them.

Firstly, I would like to thank all my colleagues at the Sainsbury Centre for Mental Health. They have worked creatively and enthusiastically to support mental health services to change for the better and have been enormously influential in the mental health field and to me personally. I would particularly like to thank:

- Richard Ford and Matt Muijen for stimulating my thinking and encouraging and supporting me to undertake this doctorate
- Shirley Morrison for her patient, helpful and efficient administrative support
- Nick Gauntlett, Ganesh Sathyamoorthy, David Robertson, Colum Clinton and, especially, Heather Harper, for their energy, original thinking, invaluable research skills, humour and commitment, for supporting each other and me, and for challenging me when I got it wrong (which was frequently).
- Sarala Nicholas for her amazing way with numbers
- Lesley Warner for being there

I am immensely grateful to the service users, practitioners, managers and IT staff involved in these studies from North Birmingham, St Helens, Walton & Weybridge, Hackney, the Tulip (West) team in Haringey and the Impact team in Hammersmith. They willingly permitted our scrutiny and gave their time, ideas and thoughts, without expectation of gain or recognition.

I would like to thank everyone at the National Centre for Work-Based Learning Partnerships at Middlesex University. Kathy Doncaster has seen me through what I can only describe as this Experience, from beginning to completion, and has been solidly and firmly with me all the way. I would also like to thank Carol Baxter for her encouragement and kind words which kept me going towards the end.

My friends (especially Jane Harris, Jo Brand, Janet Cockerell, Helen Griffin and Nikolas Rose) and fantastic family have always given me boundless support. Without them, I would never have got here.

Finally and most importantly, my love and thanks to H for meticulous editing, fearless questioning, making me laugh out loud, bike rides, lovely glasses of wine at the end of the working day, and for believing in me.

Edana Minghella
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Edana Minghella
December 2000

SECTION ONE: SETTING THE SCENE

CHAPTER ONE: INTRODUCTION

BACKGROUND

This is a medium-sized project, constituting the final part of the candidate's doctorate programme. It consists of three papers prepared for publication embedded within a connecting, reflective framework. The papers report original studies within which the candidate has taken a leading role.

Aim

The overall aim of the project has been to make high quality, original contributions to mental health evaluation and service development, and more locally to the work of the Sainsbury Centre for Mental Health.

In particular, the aim has been to evaluate services in such a way that the mental health field can use the findings and/or the process constructively in the development, implementation or evaluation of services.

Objectives

- Through original research and critical evaluation, to add to the evidence concerning service provision for people with severe mental health problems, especially those who may be at risk of exclusion from services
- To support mental health services in their effective implementation of national policy by providing useful evidence around relevant, significant and emerging areas of service development
- To disseminate the findings from the studies for maximum impact to a wide and varied audience who can influence their own and/or others' service planning, service development or practice
- Through embedding the research papers within a critical framework, to reflect on the content, processes and outcomes of producing the papers for the final project

- To build on existing, and/or to develop new, evaluation methodologies
- To identify areas requiring further research and evaluation
- To demonstrate the candidate's doctoral capabilities.

MENTAL HEALTH SERVICES EVALUATION

It is important, firstly, to define briefly the professional field in which this doctorate is based, namely mental health services evaluation.

For the purposes of this project, mental health services are defined as services provided specifically for people with mental health problems. This includes a range of services and teams, provided in hospital or community, by the statutory sector (eg the NHS or Local Authorities) or the non-statutory (voluntary) sector. Like other members of society, people with mental health problems use a whole plethora of other services that are not specifically designated as mental health services (eg. Benefits Agency). These 'generic' services are excluded from the definition.

Evaluation is a form of applied research that aims to explore the value of programmes, services and/or organisations. Evaluation uses research methodology but differs from some kinds of research, in terms of its aims and its legitimate areas of enquiry. Evaluation aims primarily to discover evidence within the 'real world' to inform decision-making and planning, rather than to generate theoretical frameworks or explore abstract ideas or concepts.

Service evaluation has become more and more important politically and professionally; government policy (discussed in Chapter 2) as well as the general public (including service users themselves), increasingly require organisations to be accountable for the quality, value for money and appropriateness of the services they deliver. Evaluation is therefore not value-free and there are strong political and professional interests that need to be considered (Ford and Minghella 1998). It is a powerful tool that has been argued to "confer the power to justify decisions." (Pawson and Tilley 1997, p.xi).

Milne (1987) has described the following characteristics of service evaluation:

- Identifying and defining goals
- Analysing problems faced by the service
- Describing and standardising the service
- Measuring change
- Determining through application of research methods the extent to which change is attributable to the service
- Assessing the effectiveness of services, including modified services

In summary, mental health service evaluation operates in a political and professional environment, using applied research methods to understand and assess services for people with mental health problems. The aim is to provide evidence to support or improve those services.

THE PAPERS

Three papers have been prepared for publication. The papers are based on mental health services evaluation that colleagues and I have undertaken collaboratively. The context of the studies, including my role in the research processes, will be described extensively in Chapter Two. The full papers are presented later in the project. Here, I will provide brief descriptions of

- each paper
- the intended audiences and the journals in which they are intended to be published
- my role.

Paper 1: Needs Resources and outcomes in Three Areas in England

Authors: Edana Minghella, Heather Harper, Sarala Nicholas, Richard Ford, Colum Clinton

Brief description of the paper

This paper describes the results of a complex analysis of the mental health needs of users in contact with services in 3 areas in England, the packages of

care they went on to receive, and the subsequent clinical outcomes. The paper aimed not only to describe the findings but also to share the methodology, with the intention of enabling others to carry out needs and service assessments locally.

Proposed Journal: British Journal of Psychiatry

This paper is aimed at senior clinicians, service leaders and policy-makers. The British Journal of Psychiatry is one of the journals that is most well-respected within the professional field of mental health, particularly at a senior level. It is the official journal of the Royal College of Psychiatrists and therefore has a wide circulation. It is peer-reviewed and demands rigorous scientific standards. The word limit for the British Journal of Psychiatry is 5000 words. There are strict guidelines for publication including a prescribed structure. The paper has been prepared according to the journal's requirements, which means it is rather dry! It is to be submitted shortly.

Paper 2: Effective implementation of assertive outreach

Authors: Edana Minghella, Nick Gauntlett and Richard Ford

Assertive outreach services are intended for users with whom mental health services find it difficult to work effectively. Whilst they have complex and severe mental health needs and may be at risk to themselves or others, these users do not easily engage with community services and may end up having frequent, recurrent hospital admissions. Using evidence from our studies of two Assertive Outreach teams in London, the paper discusses the original assertive community treatment model, the expectations of this approach to service development, and the outcomes when services deviate from the model.

Proposed journal: Journal of Mental Health

This paper is aimed at practitioners, service developers and mental health academics. The Journal of Mental Health is a well-established peer-reviewed journal with a wide readership, particularly amongst practitioners of all disciplines and those who are interested in searching the literature for ideas to improve

services. Some of the key influential papers of interest to service developers have been published in this journal. It publishes a wide range of papers including discussion papers as well as research-based papers. The Assertive Outreach paper is written in the Journal of Mental Health's prescribed style, and has been submitted.

Paper 3: Pathways to care for young black men with severe mental illness

Authors: Ganesh Sathyamoorthy, Edana Minghella and David Robertson

This paper is aimed at practitioners working with ethnically diverse client groups. It is based on a study of young black men with severe mental illness in Hackney. We have developed our own qualitative and quantitative methods for interviewing users, exploring their pathways into care and interviewing General Practitioners about their role in enabling access to appropriate care for this client group. The paper presents challenging findings on black men's experiences and the aim is to encourage change in attitudes and change in practice at the 'coal-face' of service delivery.

Proposed journal: Ethnicity and Health

Ethnicity and Health is a relatively new peer-reviewed social science journal aimed at a wide professional and academic audience. This paper however is slightly different from those normally published as it forms part of a series of papers in a special edition reporting on projects delivered under the National Ethnic Health Monitoring Project. A review of that Project will be published along with a 1000-word paper from each of the local projects funded under the review, which includes our study.

My role in these studies has varied, but overall, I have been the Project Manager, taking the lead role and accountable for the successful conduct of each of the studies. Project Management constitutes a range of roles, which I will explore in subsequent chapters. I am first author of two of the papers, and second author of the last paper. Authorship is also an issue I shall be discussing later in the project.

FRAMEWORK FOR THE PROJECT

The studies reported here have focused on how to translate evidence-based ideas effectively into practice rather than 'blue-sky' intellectual, theoretical or academic research. This does not imply a lack of rigour; it does imply the need for a new paradigm for understanding and criticising the evaluation process. A suitable framework for critical analysis therefore had to be found that would reflect the intentions of this work and provide a structure within which the work could be fully considered. In their book, 'Realistic Evaluation' Pawson and Tilley (1997) challenge existing approaches and put forward a new model for undertaking this sort of evaluation. The Realistic Evaluation model has three basic foci:

- Contexts
- Mechanisms
- Outcomes

The Realistic Evaluation model

Pawson and Tilley review the history of evaluation and its various approaches and models. These are summarised as *experimental*, *pragmatic*, *naturalistic* and *pluralist*. The authors conclude that whilst some valuable lessons can be learnt from these approaches, there are also problems with all of them. For example, the authors challenge the commonly accepted idea that programmes of change are targeted at *subjects* (people), and that therefore, programme efficacy can be taken as a matter of *change in the individual subject* (person). Instead, they argue that social programmes (such as healthcare programmes) are social *systems*, involving the interplay of individual and institution, agency and structure, micro and macro social processes. Human action is not a simple matter of cause and effect. Rather, causal powers lie in social relations and organisational structures, resulting in the notion of a so-called *stratified reality*. Looking for change at the individual level is looking at only one part of this reality.

The realistic evaluation model proposes that in order to undertake effective evaluation, the *contexts* within which programmes of [social] change take place must be taken into account, and the question of outcomes must be one of identifying elements of the programme that have an effect on particular groups.

Knowledge is gained not through one study, but accumulated through revisiting findings, bringing studies together, gaining transferable lessons and reframing new questions for further investigation. This project, too, is a way of bringing studies together, revisiting the findings through critical analysis, aiming to gain transferable lessons and thinking about further evaluation.

The basic formula for realistic evaluation, according to the authors is this:

Mechanisms (M) + contexts (C) = Outcomes (O).

I shall describe what is meant by each of these elements and how they relate to the structure and content of this project.

Contexts

Pawson and Tilley argue that 'how things work' has to be *conditional and contingent*; hence the need to understand the particular historical, local and institutional contexts in which the mechanisms operate. The authors assert that lack of attention to the social conditions which pre-exist and continue through programmes is one of the great omissions of evaluation research. "Programs are ideas. Ideas have their time and place. It is this conjunction that researchers must capture with the notion of context." (p.71).

What, then, are the ideas in time and place that together comprise the context of the studies presented in this project? Current national policy is one of the most important sources and accumulation of ideas about service development. Local policy and experiences of implementation also form a contextual background. Further, the professional and institutional environments in which these studies have taken place constitute a major influence on their content, processes and outcomes. Finally, the Doctorate in Professional Studies also needs to be considered as part of the context for the project. Contexts will be explored in the next chapter, Chapter Two.

Mechanisms

According to Pawson and Tilley, interventions only and always work through the actions of *mechanisms*, through a process of "weaving resources and reasoning

together” (p.69, my italics). The question is one of understanding these resources and reasoning, the mechanisms for change that occur through programme delivery. An important issue here is the multiplicity of mechanisms and the different levels at which these mechanisms are triggered (the ‘weaving’).

The ‘programme’ under consideration here, is the programme of evaluation: the studies. Hence, for the purposes of this project, the papers themselves represent the mechanisms through which the studies have been reported and through which my evaluation of mental health services can be brought together and understood. The papers are presented in Section Two.

Outcomes

The outcomes of an evaluation constitute a consideration of what has been achieved through the programme in its context. Realist evaluation, according to Pawson & Tilley, transforms the question ‘does it work’ to ‘what is it about this programme that works for whom?’ In this project, I seek to explore what it is about this evaluation programme that has worked: how well were the aims and objectives realised in terms of rigorous research methodology and professional performance, what is the impact or potential impact, and how have the doctoral capabilities been demonstrated through this work. Therefore, following the presentation of the papers, Section Three of the project offers a critical evaluation of them, including a reflection on my own professional role, learning and development.

Of course, each study in itself could be understood within the C-M-O model. For example, taking Paper 2, the context could be regarded as including the policy context for Assertive Outreach (AO), the research evidence for implementing AO, the teams’ previous experience, voluntary sector provision and the socio-cultural and economic context of London. The mechanisms could be the teams themselves and the way in which AO is implemented by the teams. The outcomes would be the experiences of the users, their clinical benefits and the wider impact on the mental health community. All three elements within the model would create an explanation for what aspects of the intervention (AO) have worked for whom.

However, I am using Pawson & Tilley's model here as a framework for reflexive understanding and exploration of a programme of existing work. I would argue that there are various levels at which their model can be applied. Indeed they themselves use it at different levels, for example for theory generation *as part of* evaluation, as well as for an evaluation as a whole. Hence, for the purposes of this project, the three papers presented here describe the *mechanisms* for evaluating and understanding modern mental health services in *context*, and for understanding, in turn, their *outcomes*: their rigour and their actual and projected impact on practice. This project is an evaluation itself – an evaluation of the professional and political processes and outcomes of the three papers and the studies on which they are based.

ACHIEVING DOCTORAL CAPABILITIES

One of the key objectives of this project is to demonstrate my doctoral capabilities. These capabilities can be considered under the following headings:

- Knowledge, research and analysis
- Synthesis/evaluation
- Problem solving
- Self appraisal and management of learning
- Communication
- Responsibility and ethical understanding.

Table 1 shows where I intend to demonstrate my capabilities within the project. A table is necessarily schematic. In practice, I expect these headings to overlap and to highlight evidence of my capabilities throughout the project. These doctoral capabilities will be revisited at the end of the project as part of the critical self-appraisal.

Table 1: Demonstrating doctoral capabilities within the project

Doctoral capabilities	Summary of where demonstrated in this project
Knowledge, research and analysis	Section One: knowledge of current policy, evaluation theory and professional literature. Section Two: knowledge of current literature around mental health services, advanced research expertise and analytical skills. The whole project, but particularly Section Three: critical analysis of my mental health research programme, including methodological issues.
Synthesis/evaluation	Section One: synthesis and evaluation of contextual data Section Two: ability to draw informed implications from findings and generate theory within each study. Section Three: drawing together the findings, impact, strengths and weakness of all the studies and a review of conclusions and recommendations for further work.
Problem solving	Section Two: each of these are essentially a problem-solving exercise in how to implement mental health policy effectively.
Self appraisal and management of learning	Section One: description of professional role and research activity. Section Three: critical reflection on these processes and consideration of learning and development.
Communication	The project as a whole indicates my ability to communicate complex ideas effectively. The papers demonstrate my ability to communicate with different audiences within my relevant professional and academic communities.
Responsibility and ethical understanding.	My discussion of my role in Sections One and Three will demonstrate evidence of responsibility for self and others. Section Three: a full appreciation of specific ethical considerations.

HOW THE PROJECT IS STRUCTURED

The project has three sections:

- 1: Setting the scene
- 2: The papers
3. The outcomes

SECTION ONE: SETTING THE SCENE

Chapter 1: Introduction

This presents the background and aims of the project and describes the professional field. It introduces the structure of the project and the rationale for its use.

Chapter 2: contexts

This describes the context in which the studies took place. National policy, local policy and implementation issues as well as the professional contexts for the study will be explored. The context of the Sainsbury Centre for Mental Health and my role within that and with the evaluation teams are included here.

SECTION TWO: THE PAPERS

The papers

This section present the papers prepared for publication. Firstly, the Needs-Resources-Outcomes paper, secondly the Assertive Outreach paper and thirdly the paper on Young Black Men's Pathways into Care. Each is presented as a discrete self-contained paper, exactly as prepared for publication including tables and references. Please note that this is reflected in the page, table and figure numbering.

SECTION THREE: OUTCOMES

Chapter 3: reviewing the outcomes

A detailed critical evaluation of the three papers is presented. This will incorporate critical reflection on my own professional role, learning and development including how the work meets the Level 5 descriptors for the Doctorate in Professional Studies.

Chapter 4: summary and recommendations

Finally I draw conclusions about what has been achieved through this project. The initial aims and objectives of the project are revisited. Key messages from the studies are reviewed and recommendations for further work are suggested.

A note on language, abbreviations and terminology

Any professional discourse involves its own terminology; mental health services evaluation is no exception. I have tried to avoid jargon as much as possible, but it creeps in now and again. The following may need to be explained.

- SMI: Severe Mental Illness
- Users/ Service Users: people who use mental health services. Also referred to as clients
- Black: used here specifically to refer to people of Black African/Caribbean ethnicity
- Subjects: a research term for people included in a study. A term I would prefer not to use but which we did use in our Assertive Outreach paper
- Dual diagnosis: used here to refer to a diagnosis of a severe mental illness combined with a substance misuse (drugs or alcohol) diagnosis
- SCMH: Sainsbury Centre for Mental Health (to be described in chapter 2)
- DoH: Department of Health
- SMHI: Sainsbury Mental Health Initiative (to be described in chapter 2)

CHAPTER 2: CONTEXTS

“Gunpowder has within it the causal potential to explode, but whether it does so depends on it being in the right conditions.”

Pawson & Tilley (p69)

INTRODUCTION

This chapter introduces the complex contextual framework within which the three papers presented here can be understood. It discusses the national and local political and professional conditions in which the studies took place and in which the papers were written for publication. Firstly it tackles the national policy context, providing detailed summaries of the most recent key policy documents, and demonstrating their relationship to the studies. Secondly, it introduces some of the problems for implementation. Finally the section considers the professional context in which these studies were conducted and the papers were subsequently written.

THE NATIONAL MENTAL HEALTH POLICY CONTEXT ¹

Mental health services have been the subject of a major, wide-ranging governmental review. Along with coronary heart disease (CHD) and cancer, mental health is currently regarded as a priority for reform and investment.

This has resulted in a number of key government papers, most notably *Modernising Mental Health Services: Safe Sound and Supportive* (1998) and the *National Service Framework for Mental Health* (1999). Current policy has also emphasised the need for *quality* service developments, based on evidence of good models of practice (*A First Class Service*, Department of Health, 1998). The

¹ Many non-health policy initiatives are likely to have influenced, and be influenced by, mental health policy. For example, the concept of social exclusion will form part of the context for the way mental health policy is developing. However, whilst noting its importance, it is not within the scope of this project to explore other social and economic policy.

Care Programme Approach (CPA) has been revised (*Effective Care Co-ordination in Mental Health Services 1999*) and the Mental Health Act is under review. Finally, the *NHS National Plan (2000)* has again prioritised mental health. It gave further funding of another £300 million to mental health, promising particular emphasis on crisis resolution services. These developments imply a constantly changing environment where hard evidence based upon good research is vital. In particular, the National Service Framework for Mental Health and the NHS Plan have, between them, set an ambitious and challenging 10 year change agenda.

Underpinning the review of mental health services is a serious effort to modernise the system to ensure that there is safe and effective care for the severely mentally ill and to restore public confidence in services. As well as prioritising people with severe mental illness, there is a recognition that the needs of people with 'common' mental health problems who are appropriately served by primary health and social care must also be met.

The quantity and scope of government policy documents on mental health are gratifyingly large. I shall introduce the key documents, namely *Modernising Mental Health Services*, *Effective Care Co-ordination in Mental Health Services* and, in particular, the *National Service Framework for Mental Health* and the *National Plan*.

Modernising Mental Health Services: Safe Sound and Supportive (1998)

This White Paper focused on 6 areas of performance. Five of these relate to local provision (the sixth – health improvement – concerns the general health of the population at large). These 5 areas are:

- fair access : to offer fair access to health services for all, in relation to their needs.
- effective health care delivery: care should be effective, appropriate and timely
- efficiency: resources need to be used efficiently to achieve value for money
- patient/carer experience: satisfaction with services for users and their carers should be increased

- health outcomes: to achieve better clinical outcomes for users of the service.

Table 2 summarises the three key areas explored in the paper.

Table 2: Modernising Mental Health Services: Safe Sound and Supportive

SAFE	SOUND	SUPPORTIVE
Good risk management	24 hour access	Involvement of patients, service users and carers
Early Intervention	Needs assessment	Access to employment, education and housing
Enough beds	Good primary care	Working in partnership
Better outreach	Effective treatment	Better information
Integrated forensic and secure provision	Effective care processes	Promoting good mental health and reducing stigma
- - - A modern legislative framework - - -		

The National Service Framework for Mental Health (1999)

The year after *Modernising Mental Health Services* was published, the *National Service Framework for Mental Health* (NSF) fleshed out the policies announced in the White Paper. As this is probably the most important and wide ranging mental health policy document to be published in living memory, I will present it in some detail.

The NSF focuses on the mental health needs of working age adults up to 65. It was developed through an External Reference Group, which brought together health and social care professionals, service users and carers, health and social service managers, and partner agencies. This Group recommended that mental health services should:

- involve service users and their carers in planning and delivering care
- deliver high quality treatment and care which is known to be effective and appropriate, well suited to those who use them and non-discriminatory
- be accessible so that help can be obtained when and where it is needed
- promote the safety of users, carers, staff and the wider public
- offer choices which promote independence

- be well co-ordinated between all staff and agencies
- deliver continuity of care for as long as this is needed
- empower and support staff
- be properly accountable to the public, service users and carers.

The NSF sets seven standards in five areas (Table 3).

Table 3: Standards in the National Service Framework for Mental Health

AREA	STANDARD	RATIONALE
Mental Health Promotion Standard 1	Health & social services must promote mental health for all, working with individuals and communities, combat discrimination against people with mental health problems, promote their social inclusion.	Mental health problems can result from the range of adverse factors associated with social exclusion and can also be a cause of social exclusion.
Primary care and access to services Standards 2 & 3	Any service user who contacts their primary health care team with a common mental health problem should: -have their mental health needs identified and assessed -be offered effective treatments, including referral to specialist services for further assessment, treatment and care if needed. -be able to make contact with local services round the clock and receive adequate care.	Mental health problems are common. As with physical health care, the majority of mental health needs should be provided by the primary care team. With a number of points of access to mental health services, local health and social care communities need to ensure that advice and help is consistent.
Effective services for people with severe mental illness (SMI) Standards 4 & 5	All mental health service users on the Care Programme Approach (CPA) should: -receive care which optimises engagement, prevents or anticipates crisis, reduces risk; have a copy of care plan which includes action to be taken in a crisis by users, carers, care co-ordinators, advises the GP how to respond if service user needs additional help, is regularly reviewed by the care co-ordinator, and be able to access services round the clock. Each service user who needs a period of care away from home should: have timely access to an appropriate hospital or alternative bed, in the least restrictive environment consistent with the need to protect them/the public, and as close to home as possible, and have a copy of a care plan agreed on discharge, to describe care to be provided, identify care co-ordinator, and specify action to be taken in a crisis.	People with SMI are vulnerable and at risk of social isolation and discrimination. Those with SMI <i>and</i> substance misuse (dual diagnosis) have behavioural and other problems and need help from a range of services including specialist drug and alcohol services. Some individuals pose a risk to themselves. A small number can pose a risk to others, most often their carers or families.
Caring about carers Standard 6	Carers of a person on CPA should: have an assessment of their caring, physical and mental health needs, repeated at least annually and have their own written care plan.	Carers play a vital role in helping to look after service users, particularly those with severe mental health problems. Providing help and services to carers can be one of the best ways of helping users. Caring can also have an impact on carers' own mental and physical health.
Preventing suicide Standard 7	Aim to reduce the suicide rate by at least a fifth by 2101. Standards 1 to 6 will all contribute. Also services need to help prevent suicides in prison, ensure staff competency in suicide risk assessment & implement local suicide audit systems	There are over 4000 deaths from suicide in England each year. People with mental health problems, especially those with SMI are at particular risk of suicide.

Core functions for mental health services

Vital core functions that must be in place to provide comprehensive services are described in the NSF as:

- agreed protocols between primary care and specialist mental health services to ensure speedy access to primary care and specialist services
- agreed protocols to guide referrals for specialised services, such as medium secure care or eating disorder units.
- multi-professional assessment, planning and intervention through individual care packages, including home-based treatment, and assertive outreach
- early, effective interventions for people with severe mental illness
- a range of services to respond effectively to a crisis, including access to a place away from home if necessary
- adequate local treatment and care facilities, including local inpatient beds, 24 hour staffed accommodation, day and residential care.

The focus on people with severe mental health problems

The NSF argues that the first priority in many areas will be to continue to address gaps in current services for people with severe mental health problems. Such services would include 24 hour staffed accommodation, assertive outreach, home treatment and secure beds. In terms of funding, again, the NSF says that services for people with severe mental illness will continue to be given a high priority.

But once the needs of the severely mentally ill are addressed, the NSF shifts the priority to people with “common” mental health problems, such as depression and anxiety.

Implementing the National Service Framework

The NSF is described as an ambitious 10 year programme of change, which recognises that mental health services are whole systems that work effectively only when the component parts are all in place and in balance.

Some limited guidance is provided as to how to implement the national standards. Service models are included, along with examples of good practice. A

national Mental Health Implementation Group has been set up to prepare for implementation and oversee progress, with representatives from each NHS and social care region, and supported by a national Mental Health Implementation Team. Another national initiative is the development of a “toolkit” to assist with the development of local prioritised plans based on local mental health needs. This will include a review of evidence on cost-effectiveness, and comparative performance indicators on mental health services, such as benchmark data sets.

Research and Development will focus in future on evidence required to implement the NSF. Three main areas of work are identified:

- Health technology assessment, covering health promotion, prevention, treatment and rehabilitation
- Service delivery and organisation
- New and emerging applications of technology, which can improve quality, efficiency and effectiveness of health and social care

These will be supplemented by two additional areas:

- Developing methodology
- Service user involvement.

Whilst national programmes are regarded as essential, local action is also required. A number of principles for local implementation are described:

- change needs to be systematic and sustainable
- objectives must be measured both in the short-term and long-term
- the programme of service development needs to be both ambitious (in terms of standards) and realistic (in terms of local service delivery)
- action needs to be taken across agencies, including joint working and financing, and to include health improvement programmes
- there needs to be strong leadership along with a clear commitment to change from clinicians and managers
- implementation needs to be linked into the learning agenda

At a local level, leaders from the health and social care community have been required to:

- identify, engage and gain commitment from key individuals, groups and agencies
- agree arrangements for implementation
- set up a local implementation team supported by team members with sufficient seniority to commit their organisation to action
- assess mental health needs, prioritising the needs of those with severe and enduring mental illness.
- assess existing local mental health provision against the standards and service models, and prioritise a development strategy .

Service milestones are set out as part of performance monitoring. For example, Assertive outreach is expected to be in place for service users on enhanced CPA and at risk of losing contact with services by April 2002

Information systems are recognised as poorly developed and often incompatible, leading to poor communication. A draft mental health information strategy is proposed, to incorporate national work such as

- the Health of the Nation Outcome Scale (HoNOS)
- work on clinical terms and case mix
- the second National Psychiatric Morbidity Survey planned for 2000 and
- the Mental Health Minimum Data Set planned to be in use by March 2003.

All are regarded as essential for monitoring clinical and service effectiveness, particularly when working in partnership.

EFFECTIVE CARE CO-ORDINATION IN MENTAL HEALTH SERVICES – MODERNISING THE CARE PROGRAMME APPROACH (1999)

This paper followed the NSF and was published in recognition of the fact that the good intentions of the Care Programme Approach and Care Management (systems for planning and monitoring care) had not been translated uniformly into practice. The NSF provided a framework for models and service systems which could anchor a new revised approach to care co-ordination.

The main elements of this paper were:

- The CPA and Care Management to be integrated, to include a single point of referral and access to services and a joint health and social care assessment
- A lead officer to be appointed across health and social services to deliver an integrated approach
- Two levels of CPA a to be introduced:
 - Standard (eg. for those able to self manage their mental health problems or requiring low level support)
 - Enhanced (eg. for those who have multiple care needs, require more intensive support, or have dual diagnoses)
- Keyworker to be known as care co-ordinator, with responsibility for ensuring care is co-ordinated, keeping in touch with the user and ensuring the plan is reviewed as required.
- Care plans for those on enhanced CPA to include what to do in a crisis
- Care plans to reflect ethnic, cultural and sexual diversity.

THE NHS NATIONAL PLAN (2000)

The NHS National Plan sets out the new services and resources to be made available within mental health services. It pursues the theme of modernisation which has been central to health care policy. The national priority, according to the Plan, has been to ensure that people with severe mental health problems receive services that are more responsive to their needs.

The main driver of the National Plan is stated as being the issue of inequalities in health. Within this, it considers not only explicit health services but also social and economic disadvantage as a whole. For example, the Plan proposes the development of a new health poverty index that combines data about health, access to services, uptake of preventative services and opportunities to maintain good health. There is recognition, too, of the so-called 'inverse care law', where communities in greatest need are the least likely to receive required health care.

Hence work is required across government departments, and health improvement is declared to be a priority for all government departments.

The Plan reinforces the standards put forward in the NSF and specifies further services and resources. An extra annual investment of over £300 million by 2003/4 is promised for mental health. The Plan also proposes new service components which broaden the scope of the NSF:

1. To ease pressure on GP and primary care services

- 1000 new primary care mental health workers to work with GPs to help them manage common mental health problems
- 500 more community mental health staff to work in liaison with primary care, NHS Direct, and Accident & Emergency Departments

2. To help prevent initial problems, deal with crises effectively and improve outcomes for people with severe mental illness

- 50 'Early intervention in psychosis' teams
- 335 crisis resolution teams, providing an immediate response to crises
- An increase in the number of assertive outreach teams (total 220)

3. A range of other service components, including for those requiring secure accommodation

- Services for women only (day centres)
- Support for carers
- Reduction in places in high secure hospitals but more long term care and after discharge support
- Support to prisons
- Secure accommodation and rehabilitation for people with personality disorders at risk of causing harm to others

4. Improving the structure and process

- Better integration of mental health and social care provision through the establishment of a Patient Advocate and Liaison Service
- Primary Care Trusts instead of mental health trusts

- Improving and rethinking issues around recruitment and retention of staff, especially people without formal qualifications; and suggesting the need for better workforce management
- Continuing review of the Mental Health Act

SUMMARY OF RELEVANCE OF NATIONAL POLICY

In summary, national policy can be regarded as covering the following areas for service development:

- **Access** to a range of treatment and care, including early intervention and crisis services around the clock together with inpatient beds and alternative residential places
- Better **engagement** of users, with an emphasis on assertive outreach, especially in the inner cities. The expected outcome would be that people with the most severe difficulties will be engaged with the service and that this engagement would be sustained.
- The active **involvement of service users**, with particular attention to those who have been traditionally poorly served by mental health services, eg. minority ethnic groups
- **Caring for carers**, both for their own needs and to improve outcomes for service users
- **Partnerships** across primary and secondary care, across agencies and across sectors
- **Health promotion**, reducing stigma and promoting social inclusion
- **Quality** monitoring, including clinical governance, health improvement and **better information systems**
- Improved recruitment, retention and training of the **mental health workforce**

Most of these themes are central to the context of this project. Table 4 indicates the relationship between policy and the studies presented here.

Table 4: placing the studies in policy context

Study	Needs-resources-outcomes Analysis of the mental health needs of users in contact with services in 3 areas in England, the packages of care they went on to receive, and their subsequent clinical outcomes. Also aimed to share methodology for assessing local services.	Assertive Outreach A study of the effectiveness and costs of two innovative assertive outreach teams in London. The teams aimed to engage service users with severe mental health problems, at risk of losing contact with services.	Young Black men's pathways through care A study of young black men with severe mental illness in Hackney, North London. The study explores their pathways through acute inpatient care and interviews GPs about their role in enabling access to appropriate care for this client group.
Service delivery (NSF, National Plan)	Responsiveness, prioritising the SMI; once they are met, address needs of those with common mental disorders	Managing risk, engagement, responsiveness, prioritising the SMI	Responsiveness, prioritising the SMI, promote social inclusion, ease pressure on GPs, combat discrimination, fair access
Service models (Safe, Sound and Supportive, NSF, National Plan)	Needs assessment Assessment of service provision Concentrate on pressures and gaps	Policy specifies the number of AO teams that should be in place. Number and funding increased with each policy statement	Timely, appropriate and effective care in the least restrictive environment. Services for most vulnerable groups
Information systems (NSF)	The proposal of a mental health information strategy including use of Health of the Nation outcome scales (used in the NRO study). Mental Health Minimum Data set to be in place by 2003.		
Resources (Safe, Sound and Supportive and NSF)	Value for money. Using resources effectively and efficiently.		
Care Programming (Effective Care co-ordination, NSF)	Standard care plans for those with less severe needs, enhanced care for those with most severe needs. Assertive outreach for those on enhanced CPA and at risk of losing touch with services. Care plans need to reflect cultural and ethnic diversity.		
Effectiveness (Safe, Sound and Supportive, NSF)	Services need to be responsive to need and achieve better clinical outcomes. Quality and performance to be monitored.		

THE PROBLEM OF LOCAL IMPLEMENTATION

or

This is all well and good, but how do we do it and is it going to make any difference?

National policy has influenced local strategy, and indeed *requires* local strategy to be affected. Local implementation teams have been set up around the country. As a professional evaluator, I frequently receive telephone calls and letters requesting advice or professional support to implement policy. The problem for local planners, managers and practitioners is *how* to implement policy effectively. The studies in this project have taken place within the context of local services struggling with this question, and have, to a large extent, been motivated by the desire to help address it.

Carrying out a needs assessment

Experience suggests that health and social care communities are interested in local needs assessments and mapping of service availability. They are especially interested in comparing their population needs and service provision with others (benchmarking). But local services seem unclear how to undertake a meaningful needs assessment. Practitioners are used to making an assessment of an *individual's* needs, but there is less experience in carrying out an assessment of the needs of the local mental health *population*. A number of issues seem problematic, including:

- How to carry out an assessment of the needs of local mental health service users in a way that does not add undue burden to staff workloads
- How to carry out a needs assessment that uses routinely available information
- How to carry out a needs assessment that includes people not currently in touch with services
- How to carry out a needs assessment whose findings can be appropriately compared with others

The literature supports the claim that these are vexed issues for planners. Smith (1998) criticised planners' use of current service provision without a needs assessment as a basis for planning. Kisely (1998) criticised reviews of services that he considered to make inappropriate comparisons, without taking into account different socio-economic circumstances.

Implementing Assertive Outreach

The NSF and the National Plan increased the profile, priority and funding for Assertive Outreach (AO) and there are now approximately 100 AO services in England (Tom Dodd, Sainsbury Centre for Mental Health, personal communication). However, in working with services and dealing with enquiries, my colleagues and I believe there is a lack of clarity in the field. Specifically there are problems of definition, understanding, and relevance.

The following issues have emerged:

- There is a lack of understanding or knowledge of the evidence-based model of Assertive Community Treatment
- This model of care is often seen as not relevant to a particular location, especially in rural areas. Hence there has been a tendency at best to dilute the model (eg. have an assertive outreach team that is uni-disciplinary or doesn't target the appropriate users). For example, despite the fact that substance misuse services are a key feature of the established AO model, some services specifically exclude people with a dual diagnosis of mental illness with substance misuse. Another approach has been simply to appoint a single 'assertive outreach nurse' to an existing community team, with the implication that this is delivering the model.
- Service users' reactions seem to be polarised. Some are worried that Assertive Outreach is another way of implementing what they feel could be coercive practices. This is reinforced by the review of the Mental Health Act and community treatment orders. In America, legislation exists which does allow some coercive practices (eg. restricting access to benefits if users don't comply with treatment), so this worry may not be unfounded. However, in another study that I am currently undertaking, I have been working with user groups around Assertive Outreach. When informed about the model they

have been highly enthusiastic; indeed they have wanted to know why they haven't been able to access AO teams themselves.

Improving services for black and minority ethnic groups

"[There was a tendency] to postpone decisions or action when difficulty was encountered or perhaps because the patient was threatening and intimidating, and possibly because he was big and black."

The Clunis Enquiry 1994, p.107

The inequitable provision of health care to black and minority ethnic groups as well as the differential rates of specific mental disorders and suicide rates amongst black and ethnic minority groups is well known (Mental Health Foundation 1997). Young black men, in particular, are considered at high risk of dropping out of mental health services, perhaps because they find them inappropriate (Atkin and Rollings 1993). Consequently they are highly vulnerable to losing out in terms of access to timely, appropriate and effective care; instead they often come into hospital in a crisis or via the criminal justice system (Bhui 1997).

None of this is news. Those who are seeking to make changes have been challenging the way mental health services are delivered to black and minority ethnic groups for years. In 1994, for example, a Mental Health Task force was set up to explore the problems and highlight examples of good practice (*Black mental health – A dialogue for change, DOH 1994*). It noted that GPs fail to respond adequately to black clients' complaints so that service users were reluctant to approach GPs and ended up compulsorily admitted. Four years later, our Young Black Men's Pathways study was commissioned for the very same reasons. The question for change agents is, is there any reason to believe that anything will improve?

There are signs of change. Perhaps this has come about through a combination of an increasingly diverse culture (in Newham alone there are 200 different faith communities, Copsey 1997), good intentions, and fear of high profile tragedies

involving young black men who are disengaged with services (Learning the Lessons 1996). The National Plan referred to the 'inverse care law', where communities in greatest need, specifically people in minority ethnic communities, are least likely to receive the health services that they require. Developments are taking place, especially in inner cities. The London Regional Office published a review of care in 1999 (*Addressing Black and Minority Ethnic health in London* 1999). And in 2000, a London NHS Race Equality Group was established, with the aim of providing a visible focus for leadership and action to improve the health and health care for London's black and minority ethnic groups.

It does seem, then, that black and minority ethnic health has become a priority in terms of policy and practice. The time may be right for evidence-based service improvements to take hold.

THE PROFESSIONAL CONTEXT

THE SAINSBURY CENTRE FOR MENTAL HEALTH

The Sainsbury Centre for Mental Health is a registered charity, working to improve the quality of life for people with severe mental health problems. I have been working there as a Senior Researcher since October 1994.

The Sainsbury Centre aims to influence national policy and encourage good practice in mental health services, through a co-ordinated programme of research, evaluation of services and training. The Centre is affiliated to the School of Health and Life Science, Kings College London. The Centre's mission is: *Working for excellence in mental health services.*

The most recent Strategy for the Sainsbury Centre was developed in 1998 (currently under review).

Key elements of the strategy

The Strategy restates the aims of the Sainsbury Centre and then asserts that these need to be achieved by inspiring better policy and practice based on a co-

ordinated programme of research and evaluation. The products of this work programme must be actively disseminated and implemented through service and practice development.

This can be separated into the specific aims:

- identify the need and generate the evidence for best policy and practice
- identify and test existing best practice
- disseminate our knowledge and expertise
- drive implementation of best practice at national, service and individual levels.

The influence of the Sainsbury Centre

The Sainsbury Centre is undoubtedly highly influential. *Keys to Engagement* (1998), a Sainsbury Centre publication detailing the model, function and need for Assertive Outreach directly affected national policy and certainly had a strong influence on service development. The same is true for *Open All Hours* (1998) (of which I was lead author), a report of an evaluation of a home-based psychiatric emergency team, which was cited in the NSF. More recently, *Finding and Keeping* (2000) has played a major role in focusing the minds of senior managers on issues around recruitment and retention of staff, and strategies for improvement.

The strength of the Centre's influence is a key contextual factor for this project. Everything produced through the Centre tends to be high profile. Consequently, studies carried out within the Centre are generally highly relevant, methodologically robust, soundly analysed, and effectively disseminated.

THE PROFESSIONAL CONTEXT: WHERE THE STUDIES FIT IN

The Sainsbury Mental Health Initiative (Papers 1 & 2)

The Sainsbury Mental Health Initiative (SMHI) provided the Sainsbury Centre context for carrying out two of the studies reported in the papers submitted here: the Needs-Resources-Outcomes paper and the Assertive Outreach paper. Although I have referred it in previous modules, it is important to return to the

Initiative and to describe in further detail the structure, processes and outcomes of its evaluation, because of its centrality to this final project.

The Sainsbury Centre and the Department of Health launched the SMHI in 1994 by inviting bids for a total of £3 million over 3 years from service providers who wanted to establish innovative community oriented services for people with severe mental health problems. The aim was to stimulate innovation and local 'model' service developments to inform the national picture. Service development support and evaluation were integral to the Initiative. Eight sites were awarded grants, six in England and two in Wales. The funded schemes are briefly described in Table 5.

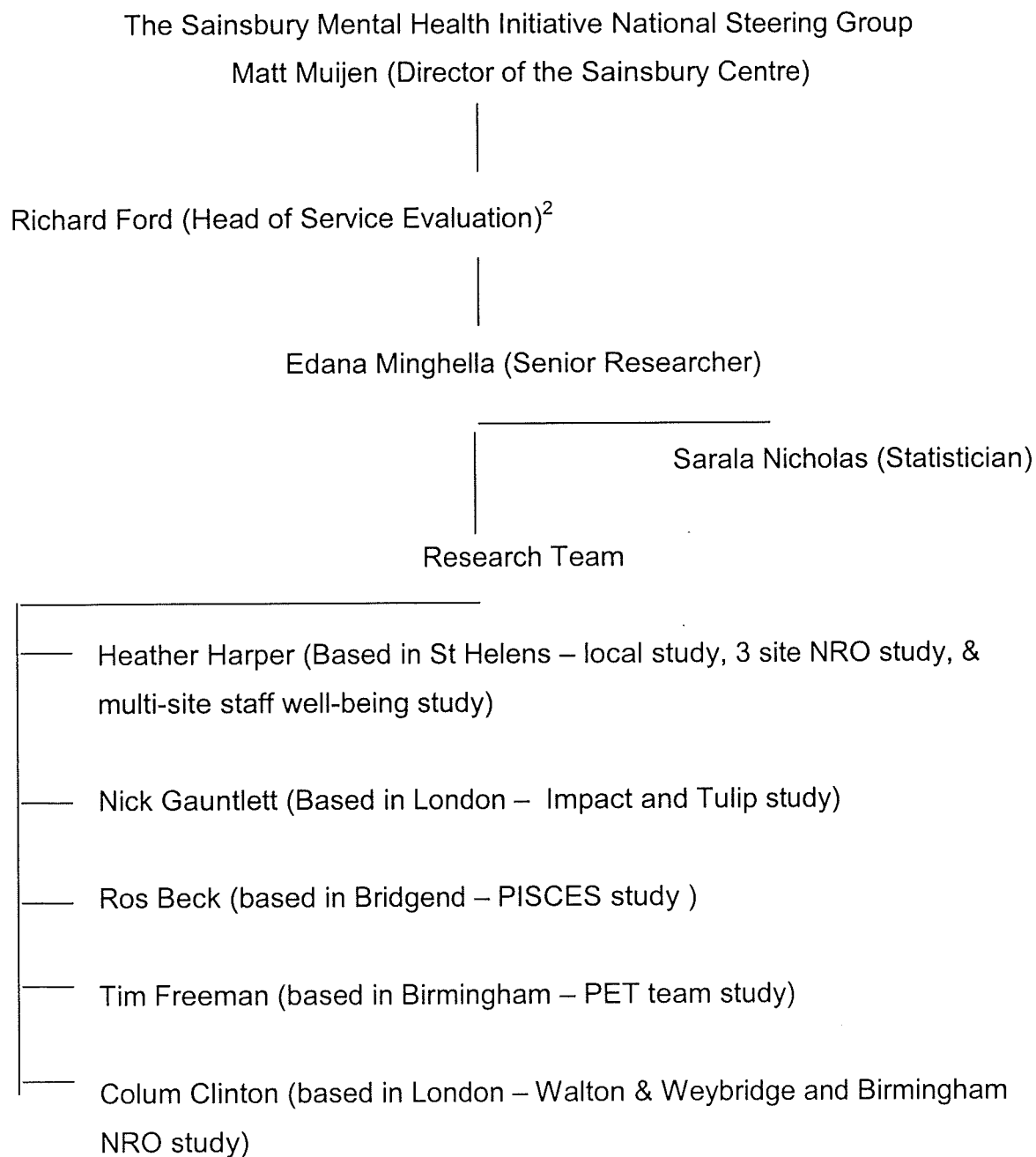
Table 5: The Sainsbury Mental Health Initiative funded services

Area	Type of team	Provided by	Other information
North Birmingham	24hr multi-disciplinary psychiatric emergency team	Health service	New team set up as a precursor to reorganising whole mental health system locally. Initiative team known (at that time) as the PET team.
Derbyshire Dales	Out of hours P/T community psychiatric nursing service	Health service	Complementing existing office hours community mental health team
St Helens	Multi-disciplinary continuing care team	Health service & Local authority	Focusing on people with most complex needs. Set up as part of re-configuring local services
Walton & Weybridge	Multi-disciplinary community mental health team	Health service & Local authority	Set up as part of re-configuring local services
West Haringey	Assertive outreach team of generic workers	Non statutory sector	Complementary to similar team within the same organisation (Tulip) in East Haringey but focusing on specific local needs (eg refugees)
Hammersmith	Assertive outreach team - multi-disciplinary	Non statutory sector	Run by MIND. SMHI team known as the IMPACT team
Bridgend	Multi-disciplinary team for carers	Health service & Local authority	Offering psychosocial intervention for families. Initiative team known as PISCES
Gwynedd	User-led bilingual advocacy service	Non statutory sector	

I was employed as the Senior Researcher with responsibility for the evaluation of the SMHI and the services funded through it. My role included recruiting and managing a team of researchers based on some of the Initiative sites. All of the researchers were employed by the Sainsbury Centre and accountable to me as their line manager. I was accountable to the Head of the Services Evaluation Section, Richard Ford, and to the Director of the Centre, Matt Muijen. I reported

to a national Steering Group which included leaders within mental health, representatives from voluntary organisations (eg. the National Schizophrenia Fellowship), user representatives and representatives from the Department of Health, the Welsh Office and the Sainsbury Centre. Figure 1 shows the lines of accountability for the Initiative evaluation.

Figure 1: Structure of accountability for the evaluation of the Sainsbury Mental Health Initiative



² Now known as Mental Health Services Research

We undertook several long-term service developments and studies through the SMHI. Many of the service developments were part of a rethink of the whole local system of mental health care delivery. The studies had therefore to deal not only with the impact for individual users of the services but also for the system as a whole. Furthermore, lessons needed to be generalisable. Studies included:

- Exploring the needs of carers of people with schizophrenia
- Rewards and pressures of working in innovative community teams
- Evaluating the effectiveness of home-based emergency treatment
- Cost consequences of home-based emergency treatment
- The needs-resources-outcomes study reported here
- The Assertive Outreach study reported here

From conception to writing up, the length of the studies ranged from 2 ½ years (Carers study) to 4 ½ years (Needs-resources-outcomes); the Assertive Outreach study took 3 years.

The Young Black Men's Pathways through Care Study (Hackney)

This study was not part of the Sainsbury Mental Health Initiative and reflects a change in my role at the Centre. As SMHI data collection was ending, I became involved with new studies (and managed new research staff), including

- assessing the need for emergency mental health services in Swindon
- evaluating dual diagnosis services in England
- Young Black Men's Pathways through Care, reported here.

By virtue of the needs of the service users involved and the models of care predominating, all dealt with the 'sharp end' of mental health care. The Young Black Men's Pathways Study was commissioned in 1998 by the London Regional Office of the Department of Health as part of a nationwide initiative aimed at improving care for people from minority ethnic groups. As the paper presented in this project was necessarily brief (due to the requirements of the Journal), I shall provide further details of the study design here. The aim of the study was to develop and evaluate an intervention at the primary care level that would help break the cycle of inappropriate admission and readmission for young black men with severe mental illness. The specific objectives were:

- To use existing evidence to develop a training package for primary care teams which would enable them to engage more effectively with young black men who are severely mentally ill;
- To review current pathways into care, interview young black male service users and interview GPs, to provide further information to inform the primary care training package;
- To pilot the training package;
- To evaluate the effectiveness of the training package

There were three stages to the study:

Stage 1: Gather baseline information using a quantitative study of pathways through acute inpatient care for young black men in Hackney; qualitative face-to-face interviews with the men; qualitative telephone interviews with GPs.

Stage 2: Use Stage 1 information to inform the GP training package. Implement a GP training package (conducted by Dr Alan Cohen, a GP affiliated to the Sainsbury Centre and Martin Davies, a mental health nurse with the National Depression Training Centre, in collaboration with staff from the local black voluntary sector).

Stage 3: Evaluate the training package by interviewing young black male service users registered with the pilot GP practices and carrying out focus groups with Practice Staff to explore their learning and transfer of learning into practice.

The study aimed to work closely with local stakeholders, deploying an iterative process of feedback and learning to create a piece of research grounded in experience. Local stakeholders included the Trust staff, local authority staff, black voluntary sector organisations and GP representation. Stakeholder meetings were held regularly throughout the duration of the study.

MY ROLE

As a Senior Researcher in the Sainsbury Centre for Mental Health, I consider my role to be to encourage good practice in mental health services and to influence policy, through managing, carrying out and disseminating sound service

evaluation and research. I shall further describe my role here specifically in relation to the studies reported in this project. Chapter Three provides a detailed critical analysis of the project, which will include a full scrutiny of my own role.

Project-managing and leading the studies

My role has been one of leading and managing a number of studies, including the three reported here. Project management in this case was not only a question of overseeing the studies (leadership role) but also of managing the evaluation teams (leadership and team-working role) and of taking an active role in the research (research role). It is a complex matrix of activities, illustrated in Figure 2.

Project management is a leadership role that encompasses a number of dimensions. Here, these included planning and managing the evaluations as a whole, as well as the specific evaluation tasks and resources, managing the performance of the staff involved, and communicating the progress and results (Institute for Employment Studies, 1998). This requires the co-ordination of time, tasks, people, and budget. As well as operational skills, interpersonal skills are also required, such as negotiation (eg. with external stakeholders, staff in the study areas), conflict resolution, and interpersonal problem solving.

As project manager with these studies, I was specifically responsible for:

- Setting up the project (including contributing to the design and protocol)
- Recruiting researchers
- Delegating tasks within a negotiated action plan and timetable
- Managing the budget
- Trouble-shooting and problem-solving
- Reporting progress to stakeholders
- Working with colleagues to produce and disseminate results

With the first two studies, I had a project management role from the outset. I took over project management of the Young Black Men's Pathways through Care study soon after it had started.

Figure 2: Project-managing the studies



Managing the teams

I worked with three teams in these studies. The team members were:

Needs Resources Outcomes (NRO) study:

- Heather Harper (HH) (Researcher, later Senior Researcher)
- Sarala Nicholas (SN) (Statistician)
- Richard Ford (RF) Head of Mental Health Services Research
- Colum Clinton (CC) (Researcher)

Assertive Outreach (AO) study:

- Nick Gauntlett (NG) (Researcher)
- Richard Ford

Young black men's pathways through care study:

- Ganesh Sathyamoorthy (GS) (Researcher)
- David Robertson (DR) (Researcher)
- John Lee (GP focus groups only) (Researcher)
- Richard Ford

I was line manager to Heather, Nick, Colum, Ganesh, David and John. Sarala worked as a statistician across the whole department and was therefore line-managed by Richard Ford. I recruited all of the researchers, apart from Ganesh. This included writing job descriptions, advertising, shortlisting and interviewing candidates.

As line manager, I was responsible for support and supervision of team members and appraisal and performance review. I generally offered monthly individual supervision. In addition, I held regular team meetings for the SMHI team because of the complex and between-site nature of the evaluations there. The team meetings were not only an occasion for bringing out-posted researchers together, monitoring progress, problem solving and project planning, but also an opportunity for the team to discuss problems and how they felt. This was particularly important because there was a risk of researchers becoming isolated in their bases away from the London office.

Ganesh, David and I also met as a team for the Young Black Men's Pathways study. Ganesh and David were based in the London office and the meetings focused on monitoring progress, problem solving and project planning.

Active role in the studies (research role)

The key stages of research can be summarised as:

- Conception
- Implementation, including data collection
- Analysis
- Synthesis
- Dissemination

Table 6: Stages and team members' roles in each of the studies

Key stage	Role	Needs-resources-outcomes study	Assertive outreach study	Young Black men's pathways through care study
CONCEPTION	Study design, methodology development & protocol writing	EM, RF, HH, HG ³	EM, RF, NG	RF, GS, DR, EM, JL
IMPLEMENTATION	Data collection including interviewing	HH, CC	NG, EM	GS, DR, JL
ANALYSIS	Statistical design and methodology	SN, RF	NG, SN, EM	N/A
	Data analysis	SN, EM	NG	GS, DR
SYNTHESIS	Bringing together the findings with new ideas	EM, HH, SN, RF	EM, NG	GS, EM, DR
DISSEMINATION	Writing papers, presenting at conferences.	EM, HH, SN, RF	EM, NG	GS, EM, DR

My role in the research studies reported in this project varied depending on the project. Table 6 describes the roles for each study and indicates which members of the team were actively involved in each stage. Initials of team members (my

³ HG Howard Goldman, Professor of Mental Health, University of Maryland & National Institute of Mental Health, USA . Acted as advisor and consultant to the Sainsbury Mental Health Initiative

own highlighted) are used for brevity. Where not already identified the initials are explained in a key underneath the table.

The table demonstrates my active role in all parts of the research process, in varying degrees with each project. My chief roles were those of

- Conception (Study design, methodology development & protocol writing)
- Synthesis (Bringing together the findings with new ideas)
- Dissemination (Writing papers, presenting at conferences)

The research team members' roles varied, although all collected primary and secondary data and had a role in data analysis. Heather (NRO study), Nick (AO study) and Ganesh (Young Black Men study) took primary roles in helping to coordinate those studies and advising other team members. Sarala Nicholas was central to deciding the statistical methodology of the NRO study, and carried out the vast majority of the complex statistical analysis in that study. She also provided expert statistical advice and support to the AO study.

MEETING THE LEVEL 5 DESCRIPTORS

This section sets the scene for how the project will meet the level 5 descriptors for doctoral capabilities, as defined in the Masters/Doctorate in Professional Studies Modules Handbook (Table 7).

Table 7: meeting the level 5 descriptors

Cognitive	
Knowledge	In this chapter, I have demonstrated a wide and in-depth knowledge of complex issues, including current, complicated policy documents, relating to mental health services.
Analysis/Synthesis	I have been able to analyse complex material and present it clearly and logically as a basis for understanding the context in which this project can be placed. I have drawn together ideas from a variety of sources to redefine the policy, service implementation and professional context
Transferable skills	
Self-appraisal/reflection on practice	I have provided evidence of working with 'critical communities', such as the national Sainsbury Mental Health Initiative steering group. I have also described the process of working with local stakeholders in the Hackney project, and developing research interventions through learning from their views and experiences. In this chapter, I have started the process of reflecting critically on my role and my own learning by describing the role in detail.
Autonomous planning and effective use of resources including other people	I have described the team structures and my team management role, and in particular described my <i>project</i> management role demonstrating autonomy and leadership (for example, in recruiting, supporting and supervising staff) within a complex set of studies, with three different research teams.
Research capability	I have signalled my research capability through an informed appreciation of the stages of research and a description of my own and colleagues' research roles in the studies to be presented in the following chapters.
Operational context	
Context	I have fully described the operational context for this project, through a studied examination of national policy, local implementation issues, the professional world of the Sainsbury Centre and my own professional role.

SUMMARY

There currently exists an unprecedented raft of policy initiatives, along with major financial backing, which is expected to have a radical effect on mental health service delivery in the UK for at least the next decade. Service models, specific functions, quality monitoring, information requirements are all key aspects of national policy. This policy context is central to the project presented here. For example, policy requires that needs must be assessed and service gaps identified (NRO study), that services must be demonstrated to be effective (NRO and AO study), that Assertive Outreach must be introduced (AO study), that there

must be equal access to appropriate care (Young Black Men Study). This chapter also highlights the potential problems for service developers in trying to implement these ideas. How can a needs assessment be undertaken locally? How should Assertive Outreach be delivered? What are the good examples of engaging with black people with severe mental illness? Indeed this section points up the focus of the whole project. National policy is now providing the imperative to match services to needs, particularly for those with the most severe problems, and/or who are likely not to engage with services; what do services still need to know to achieve these laudable aims effectively?

These studies are set in a particular professional environment. They were carried out through the Sainsbury Centre for Mental Health, a high profile, influential organisation. Thus they must be relevant, rigorous, able to bear public scrutiny and have the worth and potential for translation into practice. Further, the quality and impact of the studies are likely to be influenced by the specific circumstances of their genesis (especially the Sainsbury Mental Health Initiative) and the roles and activities of the evaluation team members, particularly my own leadership role.

At the beginning of this chapter, Pawson and Tilley set the scene for why the context for any programme of change is so important. The question remains whether the 'gunpowder' of these studies can be ignited.

SECTION TWO: THE PAPERS

**PAPER 1: NEEDS, RESOURCES,
OUTCOMES**

Needs, resources and outcomes (NRO): mental health in three areas in England

Authors: Minghella E, Harper H, Nicholas S, Ford R and Clinton C

Introduction

Users of mental health services have differing, numerous, and changing needs of varying complexity. Different areas have differing levels of resource and differing service types and configurations. For the first time, the National Service Framework (NSF) for Mental Health (DoH 1999) sets out standards and models for a responsive range of services. More than ever, it is imperative to assess the effectiveness and costs of the configuration and delivery of local services.

We examine the extent to which local resources meet local needs and how both relate to outcome. In three English localities with diverse socio-demographic and service contexts, the study aimed to describe the needs of all service users, explore whether the packages of care delivered to users match needs, and examine the relationship between severity of needs, package of care and clinical outcomes. Anticipating the forthcoming Mental Health Minimum Data Set (Glover 2000), a further aim was to develop a method that was based on routinely or commonly collected data and would produce information useful to commissioners, planners and clinicians.

Method

Study areas

An inner city area in the Midlands (Yardley/Hodge Hill in North Birmingham), a suburban area in the South (Walton & Weybridge in Surrey) and an urban/rural area in the North West (St Helens) were studied. Each was awarded three years funding under the Sainsbury Mental Health Initiative (SMHI) in 1994 to develop innovative community services (£500,000, £400,000 and £340,000 respectively). The areas are described in terms of their socio-demographic characteristics and the statutory mental health services available at the time of baseline data collection (1996/7) in Table 1.

- insert table 1 about here -

Used by the NHSE to determine resource allocation, the York Psychiatric Index (YPI) is a measure of need based on deprivation indices (Carr-Hill et al, 1994). The average score is 100, with higher and lower scores relating to higher and lower levels of identified need respectively. For comparative purposes, the YPI was used to weight the study populations.

Study populations

In Yardley/Hodge Hill and Walton & Weybridge, a one-day census was taken of working-age adults receiving statutory mental health services. People were defined as actively receiving services if they were current inpatients or residents of specialist mental health residential facilities, currently registered at day hospitals or day centres or on the active caseload of community practitioners (people receiving a one-off assessment only were excluded). Outpatients were included if they had received an appointment within the previous three months and had a future appointment pending.

In St Helens, where the recent closure of a large psychiatric hospital had left around 600 people with serious mental illness (SMI) needing community-based care, the study

population comprised only those working-age adults with SMI in touch with community mental health teams. SMI was defined as a diagnosis of any psychotic disorder using ICD-10 categories.

Data collection

For each service user, key workers or equivalent were asked to provide baseline information relating to their sociodemographics, diagnosis and contact with mental health services. Identifying information was requested in order to avoid double counting. Following training by the research team, they were also asked to complete a Health of the Nation Outcome Scale (HoNOS) version 4 (Wing et al, 1996; Wing et al 1998) for each user.

At follow up (6 months for Yardley/Hodge Hill and Walton & Weybridge and 12 months for St Helens), practitioners were asked to complete a second HoNOS to measure outcomes.

Service use

Numbers of contacts with all statutory services were collected for each user for a period of 6 months from baseline (Yardley/Hodge Hill and Walton & Weybridge) and for one year from baseline in St Helens. Contacts were defined as any face-to-face contact with a practitioner recorded in patient notes or on computer information systems. For day services, any attendance (part or whole day) was counted as one contact. For residential services, including inpatient stays, one occupied bed day was counted as one contact.

Categorising severity of need

Taking a practical and clinically relevant approach to identifying severity of need, diagnoses and HoNOS were combined to categorise baseline needs as either low, moderate or high. For each HoNOS item, a score of 2 indicates a definite problem that requires attention; a score of 3 indicates moderate problems and 4 severe or very

severe problems. In this context, therefore, it made sense to use individual item scores, rather than aggregated (total) scores. For example, a diagnosis of a psychosis *together with* any other definite clinical, social or behavioural problem (*ie* scoring 2 and above) was considered to indicate high severity of need. Table 2 outlines how all three levels of need were operationalised.

- insert Table 2 about here -

Describing packages of care

Here 'package of care' was used to refer to *all* the care delivered by *any number of* mental health services. The aim was to develop a model for systematically describing 'typical' care packages. The model was required to reflect both the type and intensity of different care packages, to be relevant to current practice, provision and policy and to be applicable to most local service configurations.

Developing this model involved 3 stages: firstly describing the *types* of single services, secondly their *combination* into different types of package of care, and thirdly, the differing *intensities* of the care provided.

Stage 1: Identifying types of service

Three levels or types of provision were identified: standard, enhanced and inpatient or equivalent. Classification of each service was calculated systematically. To calculate whether a particular community-based or practitioner-based service was of standard or enhanced type, we allocated scores for hours of availability (office hours = 1, extended hours=2, 24 hours =3) and caseload size (not applicable, eg, day centre = 0, average 1:30 or higher = 1, lower than average = 2). In other words, the longer the hours and the smaller the caseload, the higher the score. A combined score of 3 or more was classed as enhanced type. To illustrate, the emergency home treatment team in North Birmingham was classed as enhanced care because it was available 24 hours a day (score 3) and staff caseloads were smaller than average (score 2); total score = 5. The community mental health team in Walton & Weybridge was classed as standard because it operated in office hours (score 1) and had average caseloads (score 1); total score = 2.

Residential services were similarly classified. Where residential services were unstaffed or staff visiting during the day, they were classified as standard. Where there were sleep-in staff, services were classified as enhanced. Where there were 24-hour waking staff, these were classified as equivalent to inpatient type.

Stage 2: Identifying packages of care

It was expected that most clients would receive more than one service; we therefore described service contact as a 'package of care'. Packages of care were classified as *standard* if they contained only standard type services, *enhanced* if they included any enhanced type services with or without standard care, and *inpatient or equivalent inclusive* packages if they included any inpatient or equivalent type services with or without any other type of care.

Stage 3: Differentiating the intensity of the care package

The intensity of care delivered refers to the frequency of contact with services. Recent research was used to define the intensity of community- and practitioner- based services (excluding inpatient care). Following, for example, Mueser et al 1998, less than one face-to-face contact a week was considered of average intensity; frequency of one or more contacts a week was considered higher than average intensity. Frequency was based on a combination of all the individual's contacts with all services within the package of care.

Final classification of packages of care

Following this model, users might receive one of 6 packages of care:

1. inpatient (or equivalent residential) care with or without a community package
2. a standard community-based care package of average or below average intensity
3. a standard community-based care package of greater than average intensity
4. an enhanced community based care package of average or below average intensity
5. an enhanced community based care package of greater than average intensity
6. no recorded care subsequent to contact at baseline.

Outcome measures

Reflecting the intention to be relevant to practice, we followed Sharma et al (1998) to identify clinically significant change in HoNOS score at follow up as follows:

- no change (a follow up total score within 4 points of baseline)
- clinically significant improvement (a follow up total score of at least 4 points lower than baseline)
- clinically significant deterioration (a follow up total score of at least 4 points higher than baseline).

Costs data collection and analysis

The costs of care packages were calculated by applying unit costs to recorded service or practitioner contacts, using Netten and Dennett (1997). Inpatient days were costed as general psychiatric hospital days. Secure unit inpatient days were based on psychiatric intensive care unit costs, as reported in other studies (Glover et al 1999). Residential stays excluding hospital were costed according to the level of care, based on Lelliot et al's (1996) model.

Descriptive analyses were undertaken to ascertain mean costs on each site:

1. per user
2. per user by package of care
3. per user by severity
4. per user by package of care by severity.

Statistical methods

Basic descriptive statistics were used to describe the samples. For between-group comparisons of baseline ratings Pearson's chi-squared, independent sample T-tests and Mann-Whitney U /Wilcoxon Rank Sum W Test were used.

Log linear analyses for contingency tables (Bishop et al 1995, Andersen 1996) were used for the main analysis. This approach was adopted for two reasons. Firstly, following our use of clinically significant change, it allowed the use of a categorical outcome variable. Secondly, rather than explain outcomes, it permitted

examination of the complex of relationships between needs, packages of care and outcomes. Multinomial logistic regression was used in a secondary analysis to confirm the findings and to test the findings against socio-demographic variables. This is an extension to the usual logistic regression analysis of binomial data, and is used to model an outcome that is measured on a nominal categorical scale.

For each of the study sites, a series of hierarchical log-linear models was fitted. This approach starts with the simplest model, which assumes all variables are independent. Then using a stepwise procedure, the model is built up, by introducing significant first- and higher-order interaction terms, until an 'adequate' model is found. Model adequacy is judged by the value of the model deviance G^2 . The lower the value of G^2 , the better the fit of the model. A pseudo R^2 was also calculated for the final model, by subtracting the final model G^2_{final} from the null model G^2_{null} and dividing by the G^2_{null} . The statistical significance of adding new terms to a model was assessed by the use of the likelihood ratio test (LRTEST) which is based on the difference in deviance ΔG^2 between the model and the one containing the new term. For the analysis some re-coding of the variables was required. This was in order to minimise the number of zero cells and to obtain reasonable estimates and standard errors from the models.

Results

Service users

Following the inclusion criteria above, the populations of active service users in each area were as follows:

- Yardley/Hodge Hill: 670 (0.58% of population weighted by YPI)
- Walton & Weybridge: 264 (1.07% of population weighted by YPI)
- St Helens (people with SMI only): 349 (0.28% of population weighted by YPI)

To be included in the full log linear analyses, services users had to have a recorded diagnosis (including recorded as None) and a HoNOS score at baseline; they also had to have at least one further recorded contact with services *or* a completed HoNOS at follow up. In keeping with HoNOS scoring guidelines, if users meeting baseline inclusion criteria had no follow up HoNOS, their follow up HoNOS score was rated as 9 (not known) and all scores of 9 re-coded to zero. Accordingly, in all areas over 65% of the study populations were included in the statistical analyses. The final samples are described in Table 3.

- Insert table 3 about here -

Final samples in all three areas were similar in some key respects. In all areas, the largest groups of users were white, in the 31-50 year age group, unmarried, living in stable accommodation, not in paid employment and were fairly evenly split in terms of gender. Further, people with a diagnosis of a psychotic disorder constituted the largest group in all areas.

Significant differences between those included in and excluded from statistical analyses were illuminated by examining variables for which 50% or more of the data was available. The included samples were more likely to have a recorded CPA ($p < 0.010$) and in both Yardley/Hodge Hill and Walton & Weybridge, those included were more likely to have a diagnosis of psychosis (chi sq 120.08, df1, $p < 0.010$; chi sq 43.11, df1, $p < 0.010$ respectively). These differences suggest that the sampling method excluded people with less substantial mental health problems and/or who had only brief contact with services. In addition, the Yardley/Hodge Hill included sample were older (mean

age 40.72 compared with 38.15, $p=0.05$). Meaningful comparison of the two groups' needs was precluded by the high proportion (65+%) of missing baseline HoNOS data among those excluded; this was 64.91% (148 of 228) in Yardley/Hodge Hill, 73.91% (68 of 92) in Walton and Weybridge and 88.89% (88 of 99) in St Helens.

Severity of need

Table 4 shows the distribution of severity of need in each area. Users with high severity of need constituted the largest group in all three areas; they accounted for approximately 43-66% of the samples.

- insert Table 4 about here –

Packages of care

In all areas, more people received standard care that amounted to less than one contact per week than any other type of care (see Table 5). By far the most common care provided was a standard package with less than one contact a week (see Table 5). This accounted for more than half the care packages delivered in Yardley/Hodge Hill (54.75%) and Walton & Weybridge (56.98%). Where only people with SMI were sampled (in St Helens), a slightly smaller proportion (45.20%) received a standard package of average intensity.

- insert Table 5 about here

Care that included inpatient stays accounted for only 9.50% of packages in Yardley/Hodge Hill but 18.60% in Walton & Weybridge and 22.40% in St Helens.

No further care was recorded for a proportion of users (ranging from 5.20% in St Helens to 10.41% in Yardley/Hodge Hill). As all these users did have a completed HoNOS at follow-up, this may partly have been due to recording (*cf.* clinical) practices.

Outcomes

Clinical outcomes are presented in Table 6.

- insert Table 6 about here -

Three outcomes were possible: no clinically significant change, clinically significant improvement (total HoNOS reduced by 4 points or more), or clinically significant deterioration (total HoNOS increased by 4 points or more). In all areas, the largest groups of users were those who rated as having improved to a clinically significant degree. However, more than half the users in Yardley/Hodge Hill (56.34%) and in St Helens (58.80%), and 46.51% in Walton and Weybridge, either stayed the same or deteriorated.

Results of the log linear analyses

To enable the log linear analyses of relationships between needs, resources and outcomes, levels of severity were re-categorised; users with needs of moderate and of low severity were combined into a single category. That is, for the purposes of the log linear analyses, two levels of severity were considered; high and low/moderate (see Table 7).

Models were fitted, first with linear terms, then with first-order interaction terms. For all study sites, the change in deviance was highly significant from the model containing linear terms to the model containing all 3 first order interaction terms. LRTEST findings were as follows: Yardley/Hodge Hill $\Delta G^2=85.70$, $df=17$, $p<0.01$, Walton & Weybridge $\Delta G^2=38.28$, $df=11$, $p<0.01$ and St Helens $\Delta G^2=132.50$, $df=17$, $p<0.01$. For the Walton & Weybridge and St Helens data. the fitting of the second-order interaction term did not reduce the deviance significantly to warrant including this term in the model (LRTEST: Walton & Weybridge $\Delta G^2=9.00$, $df=6$, $p=0.17$; St Helens $\Delta G^2=11.20$, $df=10$, $p=0.34$). There was, though, evidence of a significant interaction between the 3 variables for Yardley/Hodge Hill (LRTEST: $\Delta G^2=19.80$, $df=10$, $p=0.03$). However, none of the individual terms in the interaction was statistically significant ($p>0.05$). Models containing

first order interactions were considered for all sites. Over 93% of the observed variation was explained by these models. (Yardley/Hodge Hill $G^2=19.80$, $df=10$, $r^2=96\%$; Walton & Weybridge $G^2=9.00$, $df=6$, $r^2=95\%$; St Helens $G^2=11.20$, $df=10$, $r^2=97\%$).

The multinomial logistic regression confirmed the results of the log linear analyses.

All associations between needs, resources and outcomes are described in Table 8.

- insert Table 8 about here -

Relationships between users' needs and packages of care

Users' needs were significantly related to the packages of care they received. Users with high severity of need were more likely to receive increased, enhanced or more complex care. The precise pattern varied across areas and reflected the services available locally (see Table 9). In all areas, people with high severe needs were more likely to receive care that included inpatient stays.

- In Yardley/Hodge Hill, users with high needs were significantly more likely than those with low/moderate severity of need to receive
 - standard packages of care with increased intensity (standardised model estimate $z=4.3$, $p<0.001$),
 - enhanced packages with increased intensity ($z=2.1$, $p=0.040$) and
 - packages of care that included inpatient stays ($z=2.6$, $p=0.009$).
- In Walton & Weybridge, users with high needs were more likely to receive packages of care that included inpatient stays ($z=3.8$, $p<0.001$).
- In St Helens, users with high needs were more likely to receive
 - enhanced packages of average intensity ($z=2.9$, $p=0.004$) and
 - packages of care that included inpatient stays ($z=4.2$, $p<0.001$).

Relationship between users' needs and outcomes

There was a significant association between severity of need at baseline and outcomes at follow up. Across all three areas, service users with high severity needs were significantly more likely to show clinically significant improvement (decreased HoNOS by 4 points or more at follow up) than those with low/moderate needs (Yardley/Hodge Hill $z=2.9$, $p=0.004$; Walton & Weybridge $z=2.7$, $p=0.007$; St Helens $z=6.5$, $p<0.001$).

Using the multinomial regression analysis, other baseline variables were significantly related to outcome, but only in one site. In Yardley/Hodge Hill only, a non psychotic diagnosis ($p=0.010$), younger age ($p=0.048$) and being female ($p=0.035$) were each related to improved outcome.

Relationship between packages of care and outcome

There were statistically significant relationships between packages of care and outcomes that varied between the three areas.

In Yardley/Hodge Hill and St Helens, greater than average care (enhanced, more intensive or care packages including inpatient stays) was associated with clinically significant deterioration at follow up (increased HoNOS by 4 points or more).

Standard packages of average intensity were more likely to be associated with improvement compared with no care at all in Yardley/Hodge Hill, and compared with packages that included inpatient stays in Walton & Weybridge.

- In Yardley/Hodge Hill:
 - users receiving enhanced care of average intensity ($z=2.0$, $p=0.042$) or of increased intensity ($z=2.8$, $p=0.004$) or care packages that included inpatient stays ($z=3.4$, $p<0.001$) were more likely to show a clinically significant deterioration than those receiving standard packages of care of average intensity.
 - Users receiving standard packages of care of average intensity were more likely to show a clinically significant improvement than those receiving no recorded care ($z=-2.7$, $p=0.008$).

- In Walton & Weybridge

- Users receiving standard packages of care of average intensity were more likely to show a clinically significant improvement compared with those receiving packages of care that included inpatient stays ($z=-2.7$, $p=0.007$).
- In St Helens
 - Users receiving enhanced care of either average intensity ($z=3.5$, $p<0.001$) or of increased intensity ($z=2.0$, $p=0.046$), or care packages that included inpatient stays ($z=2.0$, $p=0.046$), were more likely to show a clinically significant deterioration than those receiving standard packages of care of average intensity.

Costs

Costs of care packages (rounded to nearest pound) were calculated. Zero costs were excluded. As data were skewed and standard deviations high, median costs and non-parametric tests (Kruskal Wallis) were used.

Firstly costs were compared *within* areas.

In all areas, the care packages of users with high severity needs cost more than those with low/moderate severity (see Table 9).

- insert Table 9 about here -

Costs of users' care by clinical outcomes were also examined within areas. In Yardley/Hodge Hill, the costs of care packages for users who showed clinically significant deterioration were higher than for those who showed either no change or an improvement (chi square 14.275, df 2, $p=0.001$). In the other two areas there were no differences in costs according to outcomes.

Next, costs were compared *between* areas (see Table 10). Costs were annualised so that comparisons could be made across areas since Yardley/Hodge Hill and Walton & Weybridge covered 6 months service use, whilst in St Helens the study period was 1 year. Community care (standard and enhanced packages) can reasonably be regarded as continuing in the same pattern over the period of a year. However, annualising costs

of packages which include inpatient care has limitations since it presupposes that patterns of 6 months inpatient care can be doubled, which is not likely in practice. Therefore comparisons of annualised costs of packages which include inpatient care should be treated with caution.

- insert Table 10 about here -

Annualised costs were significantly different between areas for all packages of care.

Each package cost the least in St Helens.

- Standard care was significantly more expensive in Walton & Weybridge than in the other two sites (mean rank: Yardley/Hodge Hill 277.28, St Helens 234.58, Walton & Weybridge 312.50; chi-square 15.825, df 2, $p < 0.001$).
- Enhanced care was significantly more expensive in Yardley/Hodge Hill than in St Helens (not available in Walton & Weybridge) (mean rank: Yardley/Hodge Hill 67.77, St Helens 46.26; chi-square 11.641, df1, $p = 0.001$).
- Packages that included inpatient stays were significantly more expensive in Walton & Weybridge (mean rank: Yardley/Hodge Hill 63.10, St Helens 55.93, Walton & Weybridge 85.41; chi-square 12.731, df 2, $p = 0.002$).

Discussion

This study set out to discover whether services in three disparate English districts met the mental health needs of service users, and whether these needs and packages of care were related to clinical outcomes. The study also aimed to describe an approach to service description and analysis which could be generalisable to other districts and make use of the mental health minimum data set.

In no district was there a clear three-way relationship between users' needs, the care they subsequently received from mental health services, and their clinical outcome. In Yardley/Hodge Hill, a relationship was found but none of the individual fits was found to be significant. As this study may have lacked the power to detect such an effect, interpretation should be cautious. Significant two-way associations were found and are discussed below.

A model for describing packages of care

Socio-demographic and service contexts differed but many findings were remarkably similar in all areas. Using our model for describing services, we found that inpatient care and standard community based services were available in all three areas. In the two least affluent areas (Yardley/Hodge Hill and St Helens), enhanced community care - in which services were available outside normal office hours and caseloads were deliberately restricted - was also provided. Packages of care, representing these varying combinations of service types, could be defined with reference to our model.

Service responses and responsiveness

The most common care in all districts was a standard package of care of less than one contact a week. Thus, irrespective of local variations in provision, users were likely to have contact with mental health services less than once a week, only during office hours and with staff holding average or larger caseloads. Even when users were seeing more than one type of service, their frequency of contact with all services combined was normally less than once a week.

One of the key questions of this study was whether packages of care were matched to users' needs. Selection criteria ensured that people with identified mental health needs (rather than including those under assessment or with transient problems) were sampled, and service responses to these needs were explored.

At baseline, in all areas, the largest group of users had high severity of need. These users were found to receive greater input of community care, ie. more frequent, extended hours and/or restricted caseload, or inpatient care or equivalent. Thus, where severe needs were identified, services generally responded according to what they had available, whether this be greater intensity of standard services, enhanced care or inpatient care.

Outcomes

A further question concerned how clinical outcomes relate to needs. Again it seemed that clinical outcomes matched needs where users' needs were severe. In all three study sites, people with high needs were more likely to improve at follow up (decrease HoNOS score by 4 points or more) than deteriorate or stay the same. This may have been the result of statistical artefact: regression to the mean would be expected, and the higher the score at baseline, the more likely that there would be a reduction at follow up. We also tested whether there were socio-demographic differences between the people who improved and those who did not. Differences were found in only one study area, Yardley/Hodge Hill, where improved outcomes were associated with being younger, being female and having a non-psychotic diagnosis.

For people with low or moderate needs, there were no significant changes in clinical outcomes on any of the sites. In other words, care packages were not seen to help users with low or moderate needs. These findings are salutary, especially considering the large numbers in these groups.

The effectiveness of enhanced packages of care

Enhanced packages of care, and inpatient or equivalent care packages, were generally associated with poorer clinical outcomes. This is complicated by the finding that people

with severe needs were more likely to receive these packages, alongside the finding that the same group was also more likely to improve at follow up. The lack of a three-way association between needs, package of care and outcome further confounds the interpretation of these findings. While it would have been illuminating to analyse further the sub group of users who received enhanced packages of care, cell sizes were too small. This said, attempts to understand this finding reveal important lessons for the design of further research.

A causal statistical relationship between packages of care and outcome cannot be assumed. Furthermore, links between intervention and outcome can be bi-directional (Stiles and Shapiro 1989). Services may respond with enhanced care when they see that someone's mental health is getting worse; in other words, a person's deteriorating mental health leads to enhanced packages of care or inpatient stays. In this respect, the mental health minimum data set may act as a disincentive to services. By seeking simple outcome measures, responsiveness of the service to deteriorating needs could be regarded as poor performance. Since enhanced packages are now a fixture of government policy, it is important that further research is undertaken, with bigger samples in areas where enhanced care is available.

An additional question relates to the nature of the service being provided within enhanced packages and how this might relate to outcomes. Burns et al (1999) found that intensive case management (ICM) did not improve outcomes for users when compared with standard care. Intensive case management (ICM) was defined by a reduced caseload (1:10 -15). Similarly, Holloway & Carson (1998) found no clinical benefit for an experimental group receiving increased intensity of care (5.6 contacts per month) compared with a control group. As in this study, clinical interventions or actual service delivery were not investigated. Two issues emerge. Firstly, increased intensity of input or increased availability of contact with only one single service (such as an Assertive Outreach team) may not adequately describe the care actually received by the user. Secondly, without understanding the *nature* of the care provided it is difficult to know whether the only thing being compared is the number of contacts received by service users or increased availability of services, rather than qualitatively different services. If enhanced care is only a matter of increased contact (out of hours, smaller

caseloads) it may not be effective. More attention needs to be paid to the actual interventions being received (Burns et al 2000).

Costs

Costs varied enormously. Users with high needs received care of higher cost than those with low/moderate needs in all three areas. Enhanced packages cost almost four times more than standard packages in Yardley/Hodge Hill and three times more in St Helens. However, in Walton & Weybridge – with no available enhanced care - standard packages and packages that included inpatient care cost significantly more per user than in the other two study sites. The possible implication is that costs for standard and inpatient care are high when enhanced care is not available. Because inpatient care is disproportionately expensive, the apparent cost disadvantages of enhanced care are outweighed by the cost benefits of less inpatient care. Lack of supported housing in Walton & Weybridge and St Helens (Table 1) is also likely to have increased dependency on inpatient beds and resulted in higher costs for users with severe needs (Fulop et al 1996, Knapp et al 1997). Emergency home treatment as an alternative to admission and a range of supported housing facilities – effectively reducing inpatient stays at both entry and exit points - are likely to have produced cost advantages to Yardley/Hodge Hill. Costs of individual service components, such as crisis resolution or assertive outreach teams, need therefore to be seen in the context of the whole system.

Limitations of the study

Problems associated with following up such a large group of services users presented the main limitation of this study.

The use of one outcome measure at follow-up constituted a major limitation of the study. We took the pragmatic approach of training local practitioners to use the HoNOS. However, this meant relying on hard-pressed practitioners to complete the forms; furthermore, users had still to be in contact with services at follow up for a HoNOS to be completed. We made a second assumption that if a person had received further contact with services but was now no longer in contact - preventing the key worker from completing a HoNOS - this equated to no recorded problems at HoNOS (a score of zero). The approach affected the findings in that by including people without a follow up

HoNOS but with further contact with services, and allocating a score of zero, we increased the proportion of people in all sites who were rated as having a clinically significant improvement at follow up.

The HoNOS itself has limitations. Although it has been argued to have high validity (eg. Orrell et al 1999), its inter-rater reliability varies, particularly with practitioner group (Wing et al 1998). Conversely, using the HoNOS in this way is also a strength of the design, in that it is easily utilised by practitioners, is simple to apply and (as we have done here) can be used to measure clinically significant outcomes.

Secondly, cell sizes for analysis were small, which may have contributed to the lack of a three-way association. This problem was exacerbated by the missing data at follow up which excluded around half of the populations across all sites from the final analysis. However, if our approach is to be replicated, it is likely that evaluators will encounter similar problems with follow up and populations will be of similar sizes.

A third problem was that whilst we were measuring outcome, we did not start from a true baseline. 'Baseline' needs were assessed on a census date and we had no way of knowing the duration of users' mental health problems or length of time in touch with services. Users may have already improved by the time of entry into the study or, alternatively, be in crisis. Follow up periods of 6 months or even 12 months may also be too soon to see improvements, especially in the case of St Helens where only people with SMI were included in the study. Again, this will be the reality for managers using the mental health minimum data set to evaluate their services; there is no clear startpoint for measuring baseline needs and an arbitrary endpoint for measuring outcomes.

Implications of the study

This study presents a useful, generalisable model for describing and measuring the complexity of packages of care for mental health service users. The 'package of care' model, along with a standard HoNOS census for all users in touch with services, could be used to help service planners map available services and assess whether the

packages meet local needs. There are, however, resource implications for data handling and analysis.

Costs of care vary considerably between areas without any corresponding variation in outcome. Where no enhanced care is available and where there are limited alternatives to admission or residential support on discharge, costs rise because of the increased dependence on inpatient care.

Where needs are high, services respond appropriately in terms of providing more intensive support with extended hours (enhanced care). However, receiving such support is not associated with better outcomes. This, and others' findings, suggest that the nature of, and treatment provided within, enhanced care, rather than its structure, needs to be scrutinised and developed. A reliance on simple outcome measures for measuring performance in mental health may also be unhelpful because of a lack of true baseline measures and because it fails to take into account service responsiveness to increased needs.

Table 1: Service availability and sociodemographics in each study area

	Yardley and Hodge Hill	Walton and Weybridge	St Helens
Location	Midlands	South	North West
Type	Inner city urban	Suburban	Urban/rural
Population size ¹	89 842	34 081	118 311
York Psychiatric Index score (YPI)	128.86	72.34	106.41
Population weighted by YPI	115 770	24 654	125 895
Statutory community based services ²	Outpatients, day hospital, primary mental health care teams (2), day centres and employment schemes, assertive outreach team, 24 hr emergency home treatment team	Outpatients, day hospital, community mental health team (CMHT), employment schemes, out of hours crisis response service, resource centre	Outpatients, day hospital, CMHTs (3), Depot clinic, CMHN team for people with CPA level 2 needs, day centre, continuing support team for people with CPA 3 needs, community support service
Statutory inpatient and residential facilities ²	Acute inpatient unit, rehabilitation hostel, supported flats	Acute inpatient unit, nursing home	Acute inpatient unit, rehabilitation units (2), forensic unit

¹ Number of people aged 15-64 years, according to the 1991 census

² Services available during baseline data collection.

Table 2: Categorisation of the level of severity of baseline needs

Level of severity	Definition		
	Diagnosis	plus	HoNOS (incl. criterion score)
High	Psychosis	+	Any item score reflecting a moderate (=3) or a more severe problem (=4)
	Or no recorded psychosis	+	Any item score reflecting a severe or a very severe problem (=4)
Moderate	Psychosis	+	Any item score reflecting a definite problem which requires attention (=2), but none that are more severe
	Or No recorded psychosis	+	Any item score reflecting a moderate problem (=3), but none that are more severe
Low	Psychosis	+	No single item reflecting more than a mild problem (=1)
	Or no recorded psychosis	+	No single item reflecting more than a definite problem which requires attention (=2)

Table 3: Description of samples included in analyses

		Area		
		Yardley/Hodge Hill n (% of sample) unless stated otherwise	Walton and Weybridge n (% of sample) unless stated otherwise	St Helens n (% of sample) unless stated otherwise
Total number (and % of study population) [†]		442 (65.97% of N= 670)	172 (65.15% of N=264)	250 (71.63% of N =349)
Gender	Male	200 (45.25)	80 (46.51)	143 (57.20)
	Female	242 (54.75)	92 (53.49)	107 (42.80)
Mean age		40.72 (sd 12.56)*	40.71 (sd 11.79)	42.81 (sd 12.16)
Employment status	Full time	31 (7.01)	17 (9.88)	6 (2.4)
	Part time	16 (3.62)	8 (4.65)	1 (0.40)
	Not in paid employment	333 (75.34)	82 (47.67)	134 (53.60)
	Other	35 (7.92)	41 (23.84)	15 (6.00)
	Missing data	27 (6.11)	24 (13.95)	94 (37.60)
Marital status	Married	122 (27.60)	36 (20.93)	40 (16.00)
	Single	215 (48.64)	85 (49.42)	87 (34.80)
	Other (eg.divorced)	79 (17.87)	29 (16.86)	36 (14.40)
	Missing data	26 (5.88)	22 (12.79)	87 (34.80)
Ethnicity	White	349 (78.96)	94 (54.65)	250 (100)
	Black African/Caribbean	33 (7.47)	2 (1.16)	0
	Asian	39 (8.82)	3 (1.74)	0
	Other (eg. mixed race)	6 (1.36)	2 (1.16)	0
	Missing data	15 (3.39)	71 (41.28)	0
Living in stable accommodation		169 (38.24)	70 (40.70)	112 (44.80)
Primary diagnosis – Psychotic disorders		251 (56.79)*	87* (50.58)	250 (100)
Mean total HoNOS score at baseline		9.72 (sd 6.42)	12.41 (sd 7.16)	11.38 (sd 8.23)
No further contact with services after baseline		46 (10.41)*	9* (5.23)	13* (5.20)
Excluded from statistical analyses (and % of study population)		228 (34.03% of N=670)	92 (34.85% of N=264)	99 (28.37% of N=349)

* =statistically significant difference (p<0.05) between those included in analyses, compared with those excluded ; described in text.

Table 4: Distribution of needs, according to their severity, in each area

Severity of need	Area		
	Yardley/Hodge Hill	Walton and Weybridge	St Helens
	n (% of sample)	n (% of sample)	n (% of sample)
High	189 (42.76)	95 (55.23)	166 (66.40)
Moderate	169 (38.24)	48 (27.91)	42 (16.80)
Low	84 (19.00)	29 (16.86)	42 (16.80)
Total	442	172	250

Table 5: Packages of care received in each area

Type of care package	Area		
	Yardley/ Hodge Hill n (%)	Walton and Weybridge n (%)	St Helens n (%)
No care recorded beyond baseline	46 (10.41)	9 (5.23)	13 (5.20)
Standard care of average intensity	242 (54.75)	98 (56.98)	113 (45.20)
Standard care of increased intensity	46 (10.41)	33 (19.19)	19 (7.60)
Enhanced care of average intensity	23 (5.20)	0	33 (13.20)
Enhanced care of increased intensity	43 (9.73)	0	16 (6.40)
Inpatient care with/out other	42 (9.50)	32 (18.60)	56 (22.40)
TOTAL	442	172	250

Table 6 Distribution of outcomes in each area

Outcomes	Area		
	Yardley/ Hodge Hill n (%)	Walton and Weybridge n (%)	St Helens n (%)
Clinically significant improvement	193 (44)	92 (54)	104 (42)
No clinically significant change	192 (44)	52 (30)	94 (37)
Clinically significant deterioration	57 (13)	28 (16)	53 (21)
TOTAL	442	172	250

Table 7 Re-categorisation of severity of need for log linear analyses

Severity of need	Area		
	Yardley/Hodge Hill n (%)	Walton and Weybridge n (%)	St Helens n (%)
High	189 (42.76)	95 (55.23)	166 (66.40)
Moderate and low combined	253 (57.24)	77 (44.77)	84 (33.60)
Total	442	172	250

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Table 8: Description of needs in relation to both resources and outcomes in each area

				Clinically significant improvement	No change	Clinically significant deterioration	Total N	
Area	Severity	Package of care						
Yardley/ Hodge Hill	Low / moderate	None		5	24	6	35	
		Standard	average intensity	68	76	11	155	
		Standard	increased intensity	8	4	0	12	
		Enhanced	average intensity	5	6	1	12	
		Enhanced	increased intensity	5	8	7	20	
		Inpatient		2	8	9	19	
	High	None		5	5	1	11	
		Standard	average intensity	46	33	8	87	
		Standard	increased intensity	19	12	3	34	
		Enhanced	average intensity	5	2	4	11	
		Enhanced	increased intensity	17	4	2	23	
		Inpatient		8	10	5	23	
	TOTAL				193	192	57	442

				Clinically significant improvement	No change	Clinically significant deterioration	Total N
Area	Severity	Package of care					
Walton & Weybridge	Low/moderate	None		0	3	1	4
		Standard	average intensity	26	17	11	54
		Standard	increased intensity	5	6	1	12
		Inpatient		1	1	5	7
	High	None		4	1	0	5
		Standard	average intensity	32	7	5	44
		Standard	increased intensity	14	6	1	21
		Inpatient		10	11	4	25
	TOTAL			92	52	28	172
	St. Helens	Low/moderate	None		4	1	2
Standard			average intensity	37	6	11	54
Standard			increased intensity	4	0	2	6
Enhanced			average intensity	3	0	4	7
Enhanced			increased intensity	0	0	0	0
Inpatient				7	0	3	10
High		None		0	3	6	
		Standard	average intensity	15	42	2	59
		Standard	increased intensity	3	8	2	13
		Enhanced	average intensity	3	14	9	26
		Enhanced	increased intensity	2	10	4	16
		Inpatient		12	23	11	46
		TOTAL			93	104	53

Table 9: Mean cost of each users' care package in each area, according to the severity of their needs

Site	Period	Severity	Mean (sd) cost per user (£)	Statistic
Yardley/Hodge Hill	6 mths	Low/moderate (n=147)	1453.51 (2980.83)	chi-square 29.221, df 1, p<0.001
		High (n=146)	2090.46 (3551.66)	
Walton & Weybridge	6 mths	Low/moderate (n=42)	2473.73 (5599.41)	chi-square 20.620 df 1, p<0.001
		High (n=73)	5260.76 (7586.41)	
St Helens	12 mths	Low/moderate (n=63)	2199.28 (4883.89)	chi-square 13.202 df 1, p<0.001.
		High (n=129)	6291.71 (8232.31)	

Table 10 Annualised costs of care packages in each area

Area	Mean (sd) cost per service user	Median cost per service user	Mean (sd) cost per standard package of care	Mean (sd) cost per enhanced package of care	Mean (sd) cost per package of care including inpatient stays
Yardley /Hodge Hill (6 mths costs)	1520 (2996.08)	470	514 (584.62)	1928 (1774.95)	7778 (5621.03)
n	396	396	288	66	42
Walton & Weybridge (6 mths costs)	3312 (6145.87)	600	925 (1481.99)	N/a	13086 (8092.10)
n	163	163	131	-	32
St Helens (12 mths costs)	4720 (8078.14)	1065	1907 (5058.55)	2494 (3530.50)	13290 (10501.75)
n	237	237	131	50	56

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PAPER 2: ASSERTIVE OUTREACH

Assertive Outreach: does it reach expectations?

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INTRODUCTION

Assertive outreach is fast becoming a key feature of modern mental health systems. It is regarded as an essential component of mental health care within current policy and continues to be the subject of research scrutiny. Nationally the aim is for 220 teams by 2003, serving an estimated 20,000 people (DoH, 2000).

Recent government strategy for reforming mental health services outlines major proposals for ensuring safe and effective care for the mentally ill and restoring public confidence in services. *"Modernising Mental Health Services"* (DoH, 1998) asserted that people most in need of services have been failed by the current system. It proposed a continued focus on people with severe mental illness and increased and varied services which included Assertive Outreach. Subsequently, the National Service Framework (NSF) for Mental Health prescribed "vital" core functions for services, recommending that severely mentally ill users should receive care such as Assertive Outreach to optimise engagement, prevent or anticipate crisis, and reduce risk (DoH 1999).

What is Assertive Outreach?

Assertive Outreach refers to a distinct model of care, involving a multi-disciplinary team of people and with a number of specific key features, including a high staff: client ratio, 24 hour coverage, high intensity service and full range of treatment provided. These features, or critical elements, are derived from the Assertive

Community Treatment (ACT) model which originated in the USA (Stein et al, 1975; Stein & Test, 1980), and which has been comprehensively defined and incorporated in a treatment fidelity scale (Teague et al 1998).

The model is regarded as particularly effective for people with the most severe mental health problems at risk of falling out of contact with services. Two recent research reviews show that the main benefits are successful engagement of clients, reducing hospital use and improving clients' quality of life (Mueser et al, 1998; Marshall and Lockwood, 1998). However, studies also indicate that client outcomes may be related to fidelity to the ACT model. McGrew et al (1994) found that programs with higher fidelity were more effective in reducing hospital use. In a meta-analysis of 34 ACT studies, Latimer (1999) found high-fidelity programs showed 23% greater reduction in hospital days compared with lower fidelity programs at one year follow up. McHugo et al (1999) found that clients in high fidelity dual diagnosis assertive treatment programs showed greater reductions in substance misuse compared with those in low fidelity programs.

Arguably, then, the key lesson for the development and implementation of Assertive Outreach teams in the UK is that poor replication of the ACT model may hinder success and reduce the likelihood of improved outcomes (Hemming et al 1999). Given the high profile of Assertive Outreach, expectations of its success will be great. However, different stakeholders are likely to have different interests and priorities. Practitioners and providers may expect the social and clinical functioning of clients to improve, whilst purchasers and planners may expect reduced hospital use by the client group and subsequently lower costs. Service users themselves may have more diverse and conflicting expectations,

such as fear of coercion in the light of the proposed revision of the Mental Health Act.

Aims of the paper

The objective of this paper is to compare and contrast two implementations of Assertive Outreach models operating in the voluntary sector, focusing on the people who used the service, the way the service was delivered and outcomes. However, as this was not a controlled design, differences in outcomes between the two models cannot be directly compared.

The aims of the evaluation were to examine for each team:

- fidelity to the ACT model
- targeting and engagement
- clinical and social outcomes for service users
- effects on service use and costs
- service user satisfaction

DESIGN AND METHODOLOGY

The two teams were the 'Tulip'¹ team in West Haringey and the 'IMPACT' team in Hammersmith & Fulham. Both were awarded funding (£400,000 and £350,000 respectively over 3 years) from the Sainsbury Mental Health Initiative, which was

¹ Tulip also ran an outreach team in East Haringey which had already been evaluated.

set up in 1994 to encourage the development of innovative community mental health services across England and Wales. Both wanted to work with people with complex needs, using Assertive Community Treatment principles, but with important between-team differences.

The Tulip Outreach Team (West) consisted of 6 generic outreach workers including a Team Leader and Deputy. Although appointed as generic workers, in practice, two staff had clinical qualifications.

The team's stated aims were to:

- engage hard-to-reach clients
- reduce acute hospital admissions
- stabilise people in their own housing
- prevent homelessness.
- reach people of different cultures including African Caribbean, Greek and Turkish Cypriot, Asian and refugee groups.

The target caseload was 60 clients to ensure a maximum client-worker ratio of 15 to 1 enabling regular and frequent support.

In contrast, IMPACT was a multidisciplinary team consisting of a social worker, 2 community mental health nurses (CMHNs), a part-time clinical psychologist and a housing liaison worker (the Team Leader). A consultant psychiatrist post was included in the staff complement, but was vacant at the time of the study due to recruitment problems. IMPACT was part of a larger organisation (local MIND). All IMPACT workers provided a generic role as well as a specific role according to their own professional discipline. IMPACT's stated objective was to "*break the current pattern of relapse, homelessness and hospitalisation of clients currently failed by community care services*". The team planned to work with people with

long-term serious mental health problems who had a history of non-engagement with mainstream services.

Both services operated Monday-Friday, 9-5 with no out of hours service and no medical psychiatric cover at the time of the study.

Clients

Consecutive clients accepted to team caseloads were invited to give their consent to participate in the evaluation. Users were to be interviewed at baseline and at one year after acceptance. Recruitment continued within the allotted time frame to allow follow-up to take place. There were no exclusion criteria.

Measures

Treatment Fidelity

The Dartmouth Assertive Community Treatment scale (Teague et al, 1998) was used for rating overall fidelity of the teams to the ACT model. The scale consists of 27 program criterion variables grouped into three dimensions of: structure/composition (eleven items); organisational boundaries (seven items), and nature of services (nine items). One item from the latter dimension was excluded (Assertive Engagement Mechanisms) as it referred to legal mechanisms not applicable to the UK. Three items relating to dual diagnosis components of services were also excluded as neither of the teams was set up to work with this client group. Items were rated on a five-point scale with high

scores indicating high fidelity. Ratings were made by the researcher in collaboration with team managers.

Targeting

Indicators of targeting were measured by collecting demographic information from service case notes (medical, key worker and study teams), NHS Trust databases and interviews with mental health professionals. Information included psychiatric histories, accommodation status and history of untoward events (eg. violence, self-harm, trouble with the police).

Outcome measures

Clinical and social measures were obtained at baseline and at follow up 12 months later. Two measures of clinical functioning were used: the 12 item Health of the Nation Outcome Scale (HoNOS Version 4) (Wing et al, 1996; Wing et al 1998); and the 19 item Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962). Social outcome measures were the Life Skills Profile (LSP) (Rosen et al, 1989) - a 39 item scale for measuring social functioning - and the Adapted Quality of Life Interview (AQOLI) (Ford, 1995, adapted from Lehman, 1985), which includes both subjective and objective items. Clients and practitioners were also asked where they *initially expected* and then *actually observed* improvements in clients' lives over the year following the interview by saying "Yes" or "No" to expected improvements in the eleven AQOL domains at baseline, and to observed improvements at follow up.

Users' views were examined at follow up using the Likert-style Client Satisfaction Questionnaire (CSQ) (Larsen et al, 1979), supplemented with open questions .

HoNOS and LSP assessments were completed by team practitioners. BPRS, AQOLI assessments and CSQs were administered by a researcher at interview.

Service use and costs

Clients' use of health and local authority-funded mental health services during the year after contact with the teams was compared to the year before. Information was collected from case notes (medical, key worker and study teams), NHS Trust databases and interviews with mental health professionals. Case conferences, ward meetings and Section 117 meetings were excluded. Units of measurement were contacts with community staff, day services attendances and days in hospital.

Service use information was also used for cost analysis. The cost of Assertive Outreach team contacts was calculated using service expenditure and service activity data for 1997/98 and applying the figures to the number of contacts the outcome study sample received during the year after entry to the services. All costs are presented at 1997/1998 prices (Netten & Dennett 1997).

Analysis

Pearson's chi-squared was used for between-group comparisons of baseline scores. Within-group comparisons of categorical data were carried out using McNemar's Test. Comparisons over time with normally distributed continuous

data were made using paired sample t-tests. Inpatient data were not normally distributed and not corrected by transformation. Non-parametric tests (Wilcoxon matched-pairs signed-ranks test) were therefore used for comparisons over time for inpatient data. Cost data were again not normally distributed and within-group comparisons were made using the Wilcoxon matched-pairs signed-ranks test.

RESULTS

Treatment Fidelity

Both teams demonstrated fidelity to some elements of the Assertive Community Treatment model (Table 1). Both worked to the "Team Approach" philosophy of care, had small caseloads, offered a time unlimited no-close or no discharge policy, and saw clients away from the office (in-vivo). There were, however, some areas of deviation from the model. There was limited responsibility for treatment services, and limited or no control relating to hospital admission or discharge since consultant responsibility remained with the statutory sector. The CPA keyworker role also stayed in the statutory sector for Tulip clients, although IMPACT took over administrative aspects of this role for some of its clients.

There were no specialist workers in either team and there were relatively low levels of client contact compared to the model criteria, i.e. both teams visited each client less than once a week. Of a possible maximum total score of 120, Tulip scored 64 (53% of the maximum) and IMPACT 78 (65% of the maximum).

Table 1

Service users characteristics and targeting

As the teams became operational at different time points (Tulip in August 1995 and IMPACT in January 1996), baseline data were collected for different periods in each team. From the start of the service to January 1997, 42 people were recruited to Tulip and 37 to IMPACT. All users recruited to the teams were included in the study.

Table 2 shows the demographic profile of each team's clients. Numbers are small, but it seemed that the teams were targeting some vulnerable groups, such as minority ethnic groups (Tulip 76% and IMPACT 54%), people who lived alone (48% and 57% respectively), people with a diagnosis of a psychotic disorder (75% and 84%) or a dual diagnosis (24% in IMPACT only), those with previous hospital admissions (67% and 65%) and users with long-standing contact with psychiatric services (mean 8.8 yrs and 11.3 yrs).

There were some differences between the teams' caseloads. Tulip saw significantly more people from minority ethnic communities (chi-squared=5.4, $p=0.02$) and more people who had self-harmed in the year before first contact with the team (chi-squared=4.2, $p=0.04$). More IMPACT clients were diagnosed with schizophrenia (chi-squared=6.5, $p=0.01$), and more had a history of violence (chi-squared=11.4, $p<0.01$).

Table 2

Engagement

At one year follow up, 31(74%) clients were still in contact with Tulip and 32 (86%) with IMPACT. Of the eleven Tulip clients no longer in contact, three requested no further support whilst the remainder were referred on to other services. Of the five IMPACT clients no longer in contact, four were referred to other services and one died of an accidental overdose.

Clinical and Social Outcomes

Table 3 shows the significant changes in the outcome measure subscale scores between baseline and follow up. Missing data for the BPRS and the AQOLI was due mainly to clients declining to be interviewed, and for the LSP and the HoNOS due to inadequate information being available to practitioners at the time of assessment.

Table 3

Tulip clients improved significantly in four of the five social functioning (LSP) sub-scales and in overall functioning (total score). Significant improvements were also found in three of the four HoNOS sub-scales and in total scores. No significant change was found, however, in any of the BPRS items. There was also little change in clients' subjective quality of life, with significant improvement showing only in the financial domain of the AQOLI.

IMPACT clients improved significantly on the "Social Problems" subscale of the HoNOS, but not on the other three subscales or the total score. Significant positive change was found in only two items from other scales: the "Responsibility" subscale for the LSP and the "Living Situation" domain from the subjective questions of the AQOLI. No other significant change was found in any other subscales.

No significant changes were found in the objective AQOLI measures for either team's clients.

For both teams, clients and staff had consistently high initial expectations of change in clients' quality of life over the coming year. Improvements were expected by both clients and workers for most clients (50% or more) in nearly all of the AQOLI domains. For a large number (75% or more) changes were expected in quality of "*life as a whole*" (both teams), "*leisure time*" (Tulip) and "*living arrangements*" (IMPACT). For most domains, the hoped-for changes failed to materialise for clients. The expected improvements which were reported by most clients (50% or more) as actually having occurred were "*living arrangements*" and "*general health*" for both Tulip and IMPACT clients, and "*getting on with mental health services*" for IMPACT clients only.

Service use

Clients' level of contact with statutory mental health services during the years before and after recruitment to the Assertive Outreach teams are shown in Table

4. This shows the number of clients in contact with services, the number of contacts they actually had with services, and hospital use.

In the year after recruitment, more Tulip clients were in contact with nurses than in the year before ($p<0.01$). They also saw nurses ($p<0.01$) and psychiatrists ($p<0.01$) more frequently compared with the previous year. In contrast, fewer IMPACT clients had contact with social workers ($p<0.01$) in the year after recruitment than in the year before.

Table 4

Significant increases were found in both teams' clients' use of inpatient psychiatric hospital beds during the year after acceptance by the teams, compared to the year before. The number of occupied bed days (OBDs) increased for Tulip clients by 115% ($p<0.01$) and for IMPACT clients by 102% ($p=0.04$). No significant changes were found in the number of admissions, nor in the number of people admitted for either teams' client group.

Costs

The cost of Tulip clients' contacts with CMHNs and with psychiatrists significantly increased in the year after first recruitment compared to the year before (Wilcoxon matched-pairs signed ranks test: $Z=2.6$, $p<0.01$; $Z=2.6$, $p<0.01$ respectively) (see Table 5). Overall community costs (including Tulip team contacts) increased ($Z=5.3$, $p<0.01$) as did total costs ($Z=4.1$, $p<0.01$). For IMPACT clients there were significant reductions in the cost of their contact with social workers ($Z=3.5$, $p<0.01$). There were no other significant changes in

community service costs. Again, overall community costs significantly increased ($Z=5.4$, $p<0.01$) as did the total cost ($Z=5.0$, $p<0.01$).

Whilst contact with the IMPACT team appeared to be more expensive than Tulip, costs of contact with *other* services for Tulip clients effectively eliminated the difference.

Table 5

User satisfaction

Tulip clients were consistently highly satisfied with the team. Between 80% and 96% of clients rated that they were generally satisfied/very satisfied with the service. Ninety-six percent thought that Tulip was the right kind of service for them and thought it helped them to deal effectively with their problems.

IMPACT clients showed lower levels of satisfaction. Between 65% and 88% rated satisfied or very satisfied with the service in general.

In supplementary open-ended question, clients were asked to elaborate on their views and for their opinions of the "Whole Team Approach". The key areas identified by clients from each team, along with areas for improvement, are summarised in Figure 1. The value of practical help was commonly mentioned amongst both teams' clients. Staff attitudes were also welcomed, and compared favourably with statutory sector staff. Perceptions of favourable attitudes seemed often to be linked with availability:

"I like the way they are: friendly and polite and cheerful. They come round every week and are supportive which has cheered me up. I like the talking and the company, the spending time on a one-to-one. They're very responsive – more than the CPN, and escort me to outpatients." (Tulip client)

Conversely, the few negative comments were often related to the *lack of availability* of the teams outside of office hours, especially weekends. Clients wanted more of the service: more visits, more workers and more activities.

The Team Approach was generally acceptable, with the elements of choice, variety and stability of service contact particularly welcomed.

"When one is ill, another can stand in. There was a gap if the social worker I used to have went away." (IMPACT client)

"It does work. In a sense, it's nice to see a different face. The variety brings you out as a person." (IMPACT client)

Where clients were dissatisfied with the Team Approach, though, it was with the lack of continuity and potential for confusion.

"I found [the Team Approach] confusing. There was no continuity. There's no follow up from the previous visit as one worker does a piece of work and you may not see them again for a while. You have to start all over again." (Tulip client).

Figure 1

DISCUSSION

Assertive Outreach is a model of care for supporting people with severe mental health problems with complex needs. The teams in this study aimed to achieve engagement with, and effective care of, people with such needs using Assertive Community Treatment principles. Our evaluation suggests that they had mixed success.

Our study was limited primarily by a follow up period of only one year. However, other studies have found improvements (including decrease in hospital bed use) after only one year (see Latimer 1999). Secondly, important contextual issues are not explored here. For example, the Assertive Outreach teams' functions may have overlapped with existing service provision, such as homelessness teams. Indeed, contextual issues have crucial implications for the effectiveness and development of services. Alongside an assessment of local need (see below), developers need to carry out a 'mapping' of local services to check out gaps and overlaps before deciding the functions they need to provide or improve on within the locality. Notwithstanding these limitations, our evaluation has produced findings with important repercussions for developing Assertive Outreach services.

Both teams in this study were seeing people who meet known criteria for

Assertive Outreach. There were high levels of psychotic disorder, a high level of

social isolation, and a large proportion of clients with histories of self-harm or violence. Over half the clients were from minority ethnic communities. The IMPACT client group had more severe and complex mental health problems; a higher proportion had a psychotic disorder, more had histories of violence, and on average they had experienced longer contact with mental health services. However, other vulnerability factors were not strongly represented in either team. For example, neither team had large proportions of clients who were homeless or in unstable accommodation (26% and 24%), people with recent untoward events or multiple admissions to hospital. Furthermore, without a needs assessment, the teams' success in targeting from the local population who might be in need of the service cannot be measured. The issue of effective targeting and how it may relate to outcome is addressed further later in the discussion.

Engagement with clients was reasonably effective. At the end of the 1 year study period a high proportion of clients were still in contact with both teams. However, over a quarter of Tulip clients dropped out of contact and were made inactive during the follow-up period. One possible reason for this was an early enthusiasm for ensuring rapid referral uptake and a lack of experience with assessment procedures. This may have led to accepted referrals eventually turning out to be inappropriate for long-term intensive support. Given the limited caseload size, a new team must be able to gatekeep successfully to ensure that the right people get the support they need and that potential clients are not excluded because the caseload is full. It would be a waste of a valuable resource and a team would not be sustainable if it focused on people who did not need the kind of support offered by Assertive Outreach. Thus an important lesson for service developers is to ensure referral criteria are clear to referring agents

and to the team itself, and to ensure that the team does not feel pressurised into taking on inappropriate clients in order to appear successful and active. A slow intake would be more appropriate and expectations in the long term are more likely to be met.

Clients did not perceive positive change in their quality of life. However, there were some measurable changes. Tulip clients showed significant improvements on a number of HoNOS and LSP items and some improvement in AQOLI scores. Very little significant change was found for IMPACT clients. Team comparisons are open to interpretation as the evaluation was not designed as a controlled study. One possible reason for the differences in outcome is that IMPACT seemed to be working with a more severely disabled client group and this may have made it more difficult to achieve desired outcomes. In addition, the increased engagement of Tulip clients with statutory services, as well as Tulip's input, may have contributed to their clients' positive results.

We used the AQOLI domains here as a simple tool for identifying staff's and users' hopes and expectations for change. This approach may have practical, as well as research, application. The clinical use of outcome measures such as the HoNOS and the LSP could also help practitioners to focus on need and use a problem-solving approach to achieve desired outcomes.

The majority of ACT studies have found a reduction in hospital use. This finding was not replicated by the teams in this study. One explanation is that it is perhaps unrealistic and over-optimistic to expect an immediate impact on hospital use, especially in teams just starting up, and an effective service would expect to

see reductions in the long-term. However, the studies mentioned earlier demonstrate a reduction in bed use in the first year, which is then greater in the second year.

It is becoming clearer that setting up Assertive Outreach teams improves client outcomes and satisfaction "*if correctly targeted on high users of inpatient care.*" (Marshall & Lockwood 1998, p2, our italics). Just one controlled study has reported a negative effect on hospitalisation following contact with an Assertive Outreach team; this study involved only people who were not already high users of hospital, with only 38% having a diagnosis of schizophrenia (Curtis et al 1992). In our study, fewer than a fifth of the teams' clients had had more than one admission in the year before contact with the teams. The research team identified high users of local inpatient beds in the two years spanning intake into the study. We found 26 people in Haringey, and 49 people in Hammersmith & Fulham, who were admitted three or more times in either year. Only four of these people from each site were referred to the respective Assertive Outreach teams. A further problem is raised by this finding: what happens to the remaining local service users who don't get Assertive Outreach, but need it?

Another possible explanation for some of the disappointing outcomes from this study is the teams' level of fidelity to the ACT model. Both teams intended to adhere to key ACT principles and to achieve outcomes relevant to the model. Although they conformed to the model in important ways - in particular they both used the Team Approach - it is possible that the lack of specialist, especially psychiatric, input to the teams would have affected outcomes. Without a psychiatrist on the team, there is little likelihood of preventing admission or

facilitating discharge, shown to be effective in impacting on hospital use (Muijen et al, 1992). Equally, where teams lose control of admission and discharge, hospital bed use can increase (Audini et al 1994). Neither team in this study had adequate control around admission and discharge to hospital or responsibility for crisis provision out of hours (although IMPACT did subsequently implement a round-the-clock helpline). Furthermore, medical or other specialist assessment and treatment would necessarily take place in isolation from the Assertive Outreach intervention, resulting in possible communication problems and discontinuity of care. And time spent in liaison, travelling and accompanying clients to other services, is time spent away from direct interventions.

There was also limited ability to provide services to meet the full range of client needs. Providing Assertive Outreach outside the statutory sector may well have advantages (e.g., fewer bureaucratic structures resulting in more flexible working, not associated with authority so that users are less suspicious). However, non-statutory working could also exacerbate problems associated with the inability to affect hospitalisation or to provide some essential mental health services. These issues overlap with the human resources elements. Numbers of staff were not as high as recommended by the model, and given the potential number of clients who might be in need of care, this will also have reduced the impact at the service level. According to *Keys to Engagement* (Sainsbury Centre 1998), an inner city deprived area might yield 200 people per 100,000 of the adult population in need of the service. Haringey (Tulip) has an adult population of 80,479 (1991 census), which could mean a potential client group of 161. Hammersmith and Fulham (IMPACT) has an adult population of 106,286 which

could mean a potential 212 clients. A year after the study began, the active caseload of each team was still only 69 and 53 respectively.

The teams provided care at home or in ordinary community settings, such as cafes, and rarely discharged clients. However, the frequency of client contact was less than the model dictates although probably higher than standard community services. Other UK studies with disappointing outcomes for case management or intensive community treatment services have reported intensity of input of similarly low levels (see for example McCrone et al's 1998 report on the PRISM study which described an average contact frequency of 1 per fortnight).

However, frequency of input is necessary but not sufficient to affect outcomes. In these teams, there was little work with the client's social network, such as evidence-based psychosocial interventions with families (Tarrier et al 1994). It is not only the structure and organisation of teams, but their interventions that will affect outcomes. A recent RCT, for example, found no difference in outcomes for users of an intensive case management (ICM) team compared with a control group under the care of the CMHT (Burns et al 2000). Whilst there was higher contact frequency for the ICM group, there was no difference in the specific mental health interventions provided to the two groups. A model of care is not an intervention but a vehicle for its delivery and more research is needed into the actual interventions provided within innovative service models.

Significantly, service users felt positively about the teams. They were particularly happy with staff attitudes and the practical support received. Views on the "Team

Approach" were mixed and although some clients liked the accessibility and continuity of this approach, and the variety and skill mix of different practitioners, some also found it confusing and disorientating. Suggestions for improvement included the need for weekend and evening support and for an on-call psychiatrist, adding weight to the argument for medical cover and round-the-clock support outlined above. However, in general, service users highly valued the different sort of service they were receiving from these two teams and this has to be balanced against some of the other, less encouraging findings of the study.

CONCLUSION

Given the current high profile of Assertive Outreach, expectations of its success will be high. Furthermore, the ongoing critical eye of the media and the public will closely monitor attempts to improve mental health services, and any perceived failure to do so will be powerfully highlighted. This study supports the suggestion that, whilst UK opinion may be divided as to how or indeed if ACT will work here, high-fidelity approaches are likely to be most effective (Marshall & Creed 2000).

In our study, service users valued the service provided but there were some disappointing outcomes. Although the AO teams conformed to the ACT model in some ways, they also departed from it in others. In addition, there was a lack of effective targeting, particularly of those who use hospital beds the most. The findings suggest that new outreach services need to consider all the critical elements that make up the AO model, and to be aware of the potential consequences when these elements are not followed closely. It is the responsibility of these new services to ensure that they meet the needs of users who require Assertive Outreach and maximise the chances of success.

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We would like to thank the staff and users of the IMPACT and Tulip teams for their invaluable contributions. Please note that this study took place in the early stages of both teams' development; some practices and structures have subsequently changed.

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Table 1. Treatment Fidelity scores for Tulip and IMPACT

CRITERION	Team Ratings	
	Tulip	IMPACT
Human Resources: Structure & Composition		
Small Caseload	5	5
Team Approach	5	5
Program Meeting	3	3
Practising Supervisor	4	4
Continuity of Staffing	1	5
Staff Capacity	5	4
Psychiatrist on Staff	1	1
Nurse on Staff	1	4
Substance Abuse Specialist	1	1
Vocational Specialist on Staff	1	1
Program Size	3	3
Total	30	36
Organizational Boundaries		
Explicit Admission Criteria	4	4
Intake Rate	5	5
Full Responsibility for Treatment Services	3	3
Responsibility for Crisis Services	1	3
Responsibility for Hospital Admissions	1	3
Responsibility for Hospital Discharge Planning	1	3
Time-Unlimited Services	5	5
Total	20	26
Nature of Services		
In-vivo Services	5	5
No Dropout Policy	4	4
Assertive Engagement Mechanisms	N/A	N/A
Intensity of Services	3	3
Frequency of Contact	1	1
Work with Support System	1	1
Total	14	14

1 - low fidelity; 5 - high fidelity

Table 2. Characteristics of samples

	Tulip (n=42)	IMPACT (n=37)
	n (%) unless otherwise specified	
GENDER		
Male	28 (67)	29 (78)
Female	14 (33)	8 (22)
AGE (years)		
Mean (SD)	37 (11)	38 (9.5)
ETHNICITY		
Black & Minority Ethnic Communities	32 (76)	20 (54)
White	10 (24)	17 (46)
ACCOMMODATION		
Living alone	20 (48)	21 (57)
Homeless/temporary housing	11 (26)	9 (24)
DIAGNOSIS		
Schizophrenia	20 (48)	28 (76)
Affective Psychosis	24 (10)	-
Other Psychosis	7 (17)	3 (8)
Other Diagnosis	8 (18)	6 (16)
No Diagnosis	3 (7)	-
Dual Diagnosis	-	9 (24)
HISTORY OF VIOLENCE		
Ever	1 (2)	11 (30)
In year before 1 st contact	1 (2)	4 (11)
HISTORY OF SELF-HARM		
Ever	14 (33)	8 (22)
In year before 1 st contact	9 (21)	2 (5)
CONTACT WITH MENTAL HEALTH SERVICES BEFORE 1ST CONTACT WITH TEAMS		
Any admission in year before	22 (52)	19 (51)
More than 1 admission in year before	8 (19)	6 (16)
Any admission within last 5 years	28 (67)	24 (65)
Contact with community mental health service in year before	29 (69)	27 (73)
IN HOSPITAL AT FIRST CONTACT WITH TEAMS	13 (31)	5 (13)
LENGTH OF CONTACT WITH MENTAL HEALTH SERVICES (Years)		
Mean (SD)	8.8 (7.5)	11.3 (8.6)

Table 3. Outcome measures ²

HoNOS subscales reduced scores = reduced symptoms	Tulip			IMPACT		
	T1 mean (sd)	T2 mean (sd)	mean change	T1 mean (sd)	T2 mean (sd)	mean change
(Response rate: n, %)	(38, 90%)	(32, 76%)		(37, 100%)	(32, 86%)	
Behavioural	1.7 (1.7)	1.5 (2.1)	-0.3	2.5 (2.3)	1.6 (1.9)	-0.8
Physical Impairment	2.4 (1.7)	1.4 (1.6)	-1.1**	1.5 (1.6)	1.9 (1.7)	0.5
Symptoms	5.5 (2.7)	4.1 (3)	-1.5*	4.4 (2.6)	3.9 (2.6)	-0.6
Social problems	8.5 (3.4)	4.9 (3.6)	-3.8*	8.4 (3.3)	6.7 (4)	-1.9**
Total	18.1 (7.2)	11.9 (8.2)	-6.6*	16.8 (6.1)	14.2 (7.4)	-2.7
BPRS reduced scores = reduced symptoms						
(Response rate: n, %)	(39, 71%)	(25, 62%)		(24, 65%)	(16, 43%)	
Total	11.5 (6.6)	10 (5.9)	-0.5	14.4 (7.5)	12.6 (5.6)	-0.6
LSP subscales Increased scores = improved functioning						
(Response rate: n, %)	(38, 90%)	(32, 76%)		(37, 100%)	(32, 86%)	
Non-turbulence	38.3 (5.6)	41.9 (5.8)	4*	36.4 (7.6)	38.8 (7.1)	1.9
Responsibility	15.8 (3)	16.9 (3)	1.4*	13.6 (2.3)	15.2 (2.7)	1.5**
Self-care	29.1 (6.8)	31.8 (7.1)	3.4**	28.7 (5.7)	29 (6.1)	0.3
Social Contact	13.5 (3.7)	14.9 (4.1)	1.9*	12.4 (3.3)	12.9 (3.9)	0.7
Communication	18.8 (4.1)	20.4 (4)	1.5	18.7 (3.5)	18.7 (3.7)	0.3
Total	115.5 (18.6)	125.9 (20.7)	12.1**	109.8 (15.2)	114.7 (16.6)	4.6
QOL subscales Increased scores = improved satisfaction						
(Response rate: n, %)	(30, 71%)	(25, 59%)		(24, 65%)	(17, 43%)	
Living situation	3.5 (1.4)	4.2 (1)	0.6	3.3 (1.1)	3.8 (0.9)	0.6*
Family relationships	3.4 (1.5)	3.1 (1.3)	-0.3	2.8 (1.4)	3.4 (1.4)	0.5
Social relationships	3.3 (1.1)	3.2 (1.2)	0.1	3.4 (1.2)	3.2 (1.7)	-0.05
Leisure	2.5 (1.5)	3 (1.7)	0.5	3.2 (1.6)	3.7 (1.4)	0.3
Religion	4.1 (1.3)	3.5 (1.6)	-0.4	3.7 (1.2)	3.7 (1.3)	-0.3
Work	1.6 (1.6)	2.1 (1.4)	0.6 *	2.1 (1.8)	2.3 (1.3)	0.1
Finances	2.5 (1.4)	3.2 (1.6)	0.6 *	2.8 (1.7)	2.9 (1.6)	0.1
Personal safety	2.6 (1.7)	2.8 (1.4)	-0.08	3.5 (1.4)	3.7 (1.6)	0.3
General Health	2.7 (1.6)	2.8 (1.3)	0.05	3 (1.2)	3.2 (1)	0.5
Mental Health services	4 (1)	3.6 (1.4)	-0.2	3.3 (1.4)	3.7 (1.2)	0.4
Gen. QoL Satisfaction	2.5 (1.1)	2.7 (1.1)	0.3	3.1 (1)	3.1 (1.2)	-0.8
Total	3 (0.8)	3.1 (0.8)	0.1	3.1 (0.8)	3.3 (0.8)	0.1

² significance levels for paired t-test (all improvements): * p<0.05, ** p<0.01

Table 4. Contact with statutory mental health services

		Tulip (n=42)			IMPACT (n=37)		
Number of clients in contact (%)							
Service	Year before	Year after	Sig.	Year before	Year after	Sig.	
CMHN	14 (33)	22 (52)	++	7 (19)	4 (11)		
Social Worker	16 (38)	19 (45)		16 (43)	8 (22)	--	
Psychiatrists	24 (57)	31 (74)		18 (49)	21 (57)		
Daycare	6 (14)	13 (31)		0 (0)	3 (8)		
In-patient	22 (52)	22 (52)		19 (51)	23 (52)		
Total number of client contacts with services							
Service	Year before	Year after	Sig.	Year before	Year after	Sig.	
CMHN	232	319	++	59	27		
Social Worker	82	108		88	10	--	
Psychiatrists	63	117	+	58	66		
Daycare	440	635		0	133		
Inpatient (Occupied bed days)	1448	3115	++	1360	2825	+	
Hospital use							
No. admissions	32	28		29	28		
No. people admitted (%)	22 (52)	17 (40)		19 (51)	19 (51)		
No. people in hospital (%)	22 (52)	22 (52)		19 (51)	23 (62)		
Occupied Bed Days	1448	3115	++	1360	2825	+	
Mean Length of Stay per client (sd)	34.5 (53.5)	74.2 (90.3)	n/a	36.8 (103.5)	76.4 (103.5)	n/a	
Median occupied bed days per client	4.5	21	n/a	5	30	n/a	

+ significance level p<=0.05 (increase)

++ significance level p<=0.01 (increase)

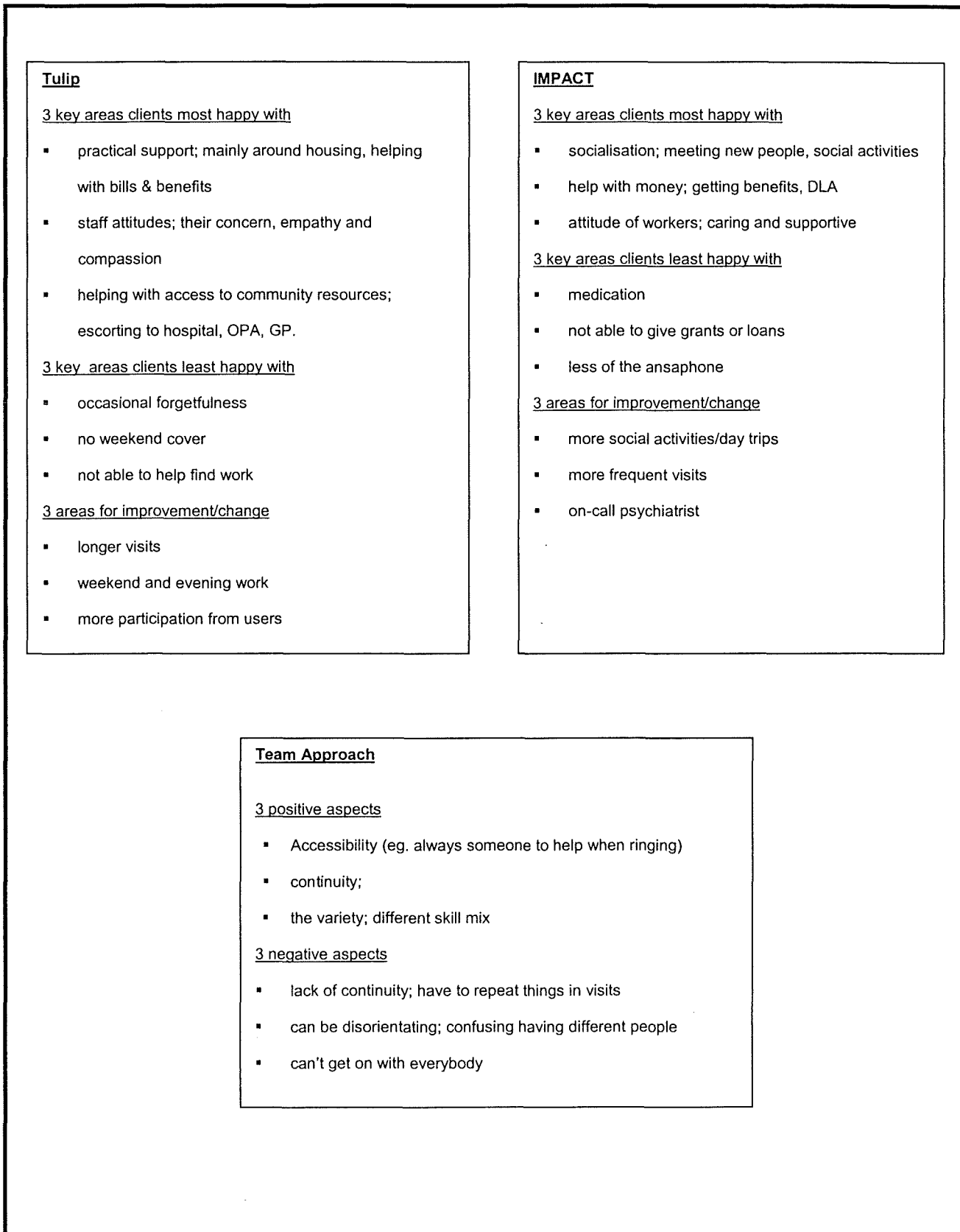
- significance level p<=0.05 (decrease)

-- significance level p<=0.01 (decrease)

Table 5. Costs of Mental Health Service use

Service	Unit	Tulip (n=42)		IMPACT (n=37)	
		Mean cost (£) per client (sd)		Mean cost (£) per client (sd)	
		Year before entry	Year after entry	Year before entry	Year after entry
CMHN	Contact	239 (444)	329 (437)	69 (193)	32 (139)
Social Worker	Contact	79 (160)	104 (154)	96 (182)	11 (23)
Psychiatrists	Contact	136 (168)	253 (228)	143 (220)	162 (197)
Daycare	Attendance	487 (1615)	657 (1574)	0	126 (579)
AO Team	Contact	-	3817 (1714)	-	6259 (3444)
In-patient care	Day	4492 (6964)	9662 (11759)	4789 (7547)	9947 (13481)
Total Community Costs (including SMHI team)		942 (1710)	5161 (2679)	308 (42)	6590 (3603)
Total Costs		5433 (7621)	14823 (12565)	5097 (7588)	16337 (13217)

Figure 1



**PAPER 3: YOUNG BLACK MEN'S
PATHWAYS THROUGH CARE**

Pathways to Mental Health Care for Young Black Men: Implications for Primary Health Care.

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Research has consistently shown that mental health services are not adequately meeting the needs of young black¹ men with serious mental illness. Mental health outcomes for young black men are far worse than for young white UK men (Cochrane and Sashidharan 1996), both in terms of their use of, and satisfaction with, psychiatric services (Parkman et al 1997). Young black men are more likely to be admitted to hospital under a section of the Mental Health Act (Davies et al 1996) and are more likely to be frequently readmitted than their white counterparts (Birchwood et al 1992). Furthermore, mental health and primary care services have been demonstrated to be ineffective at detecting mental illness in its early stages (Commander et al 1997a), and engaging with or gaining the confidence of this client group (Bhui 1997). Consequently, young black men often come into contact with mental health services via the criminal justice system or are admitted compulsorily (Bhui 1997).

The Sainsbury Centre for Mental Health undertook a research and development project in Hackney with the aim of improving young black men's access to appropriate mental health services. Initial research data was generated to describe the pathways of young black men through acute psychiatric services. This contributed to the development of a training pack to enable primary care teams to engage more effectively with the client group.

The training package was then piloted and evaluated in two local GP practices. The expected positive outcomes were that primary care teams would be able to detect severe mental health problems at an earlier stage and then refer on to appropriate community based services. The overall aim was to improve mental health outcomes for the client group.

The project was carried out in the London borough of Hackney, a deprived inner city area with a Jarman (1993) score² of +43. A third of the population are from minority ethnic communities; African Caribbean, African and 'black other' groups make up 11%, 7% and 4% respectively of the total population (London Borough of Hackney 1996a).

Research Method

A sample group was selected of 50 young black men (aged 18-40 and from the Black - African, African Caribbean or mixed race ethnic groups) who were consecutively discharged from psychiatric hospital in City & Hackney Community NHS Trust between June and October 1998. Their hospital case notes and the Trust's computerised database were analysed. Interviews were attempted with all the service users in the sample and their GP's. Service users from the initial sample were reluctant to be interviewed, so a second sample group of young black male users of Hackney's mental health service was also selected. Users in the second sample were required to have had at least one hospital admission in the past year. Twenty-two service users were

¹ The term black is used in this study to describe people of African origin and descent: people commonly referred to as African or African/Caribbean; and black people of mixed parentage.

² The Jarman Index is a measure of social deprivation, a score of zero indicates that an area has the national average level of deprivation for England and Wales, while a positive score indicates the degree to which the locality is deprived compared to the national average, a negative score indicates relative affluence.

interviewed, 13 from the first and nine from the second sample group. The 50 service users in the first sample group were registered with 35 different GPs, of whom 16 agreed to be interviewed.

Findings from the research data: Pathways study

Although most users had some contact with the secondary mental health services before their admission to hospital, a sizeable minority, roughly a third, did not. Of the 37 service users who had previously been admitted, 25 had a care plan when they were discharged at that time. However, at the point of the admission under investigation, only a fifth still had a care plan in operation³. Just under a third (n=12) of users who had been previously admitted were discharged at that time without a care plan being put in place (see table 1). And 30% of users with a previous admission had not been in contact with any mental health service in the three months prior to the admission under investigation.

Table 1 Care following last admission (n=37)

	Had care plan on previous discharge (n=37)	Care plan still in place at point of admission (n=13)
Yes	25	5
No	5	N/A
Not recorded	8	6

For seven of the 50 service users in the sample, their first contact with any mental health service was through admission to an acute psychiatric ward.

The Police made nearly a quarter of referrals (23%) of these young black men to the wards.

³ A care plan was defined as not operating if important elements of the care which were supposed to be provided were not being delivered to the user

Following discharge from the admission under investigation, 28% of users were not seen by any mental health service within the first month of discharge.

In summary, care before admission was very patchy, with many users out of contact with services despite previous hospital admissions. Admission often took place via the police. Contact after discharge was equally worrying, with more than a quarter of people not in touch with services during the first month after discharge.

Service user interviews

Some users perceived services, especially inpatient services, as punitive and coercive. Users said they wanted empowerment and affirmation, but their inpatient experience was one of containment rather than a therapeutic environment. Whilst users said they had too much inpatient care and drug therapy, there were some services they would have liked that were simply not on offer to them, such as counselling and alternative/complementary medicine. Users felt that GPs were generally not well informed about mental health issues. They lacked specific information about medication and community resources, particularly for black people with mental health problems. Many users felt that this lack of knowledge was associated with a lack of concern and interest about them in general.

GP Interviews

For their part, many GPs felt that young black men with severe mental illness had multiple problems in accessing primary care services by virtue of falling into a number of categories: men, young people, severely mentally ill and

black people. GPs believed that primary care services were viewed as part of the 'establishment', which was perceived to be hostile to young black men with mental illness.

Poor communication between GPs and secondary mental health services was highlighted. For example, GPs were often unsure whether their patients were currently inpatients, AWOL, on leave or discharged.

Service developments

Training was delivered to two GP practices by the primary care training team, which included staff from the Nile Centre, a local black voluntary organisation. Evaluation of the training suggested there had been some benefits. Training provided an opportunity to focus on specific issues pertaining to young black men, which otherwise practice staff would have little time to reflect on.

Additionally, the joint training that had taken place with the locality mental health teams was perceived to improve working relationship with these teams.

However the long-term impact of such training without any related service development in either the primary care or specialist mental health services must be questioned. In Hackney an assertive outreach team has been developed which it is hoped will address some of the issues of young black men falling out of contact with psychiatric services. Across the local health authority a full-time development worker has been recruited to lead the development of services to more effectively meet the needs of young black men. The findings from this project have contributed to the development worker's agenda, which includes the possibility of setting up two primary care liaison positions to improve services for this client group.

Our findings support earlier work which highlights problems within existing mental health and primary care provision for young black men with mental illness. An effective strategy to deal with these problems is likely to encompass specialised initiatives which aim to improve engagement, enhance joint working between secondary and primary care so that users are quickly linked into appropriate services, and facilitate seamless care across hospital and community services. Primary care training may be a necessary part of this strategy but is not sufficient on its own.

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SECTION THREE: OUTCOMES

CHAPTER 3: WHAT HAS BEEN ACHIEVED?

INTRODUCTION

What has been achieved in this project? This question is addressed here. This Section revisits the project's contexts (Section One) and its mechanisms (Section Two) to evaluate its outcomes.

Firstly, the scene is set with a summary of the key findings from the studies. Secondly, the papers are subject to critical evaluation, which will include assessments of the actual and likely impact of the studies. I will also reflect critically on my role in the process, and on my own professional development. At the end of this chapter, I shall be refer back to the Doctorate Programme and demonstrate how the project meets the Level 5 descriptors. Chapter Four summarises and concludes the project.

KEY FINDINGS FROM THE STUDIES

The papers presented in the previous three chapters each reported from studies of contemporary mental health services. Key findings are summarised here as reported in the papers. Additional details are provided for the third paper, Pathways through Care for Young Black Men, since the limitations of the publication guidelines did not allow for a full description of the findings. These limitations and their effects will be explored later in the chapter.

Box 1: Key findings from Study 1: Needs, Resources, Outcomes

A picture of needs and resources could be described. The most common package of care received by users of mental health services is a standard package with less than one service contact per week. The largest group of service users had high severity of need at baseline.

Resources, in the form of service delivery, matched need: the individuals with high severity of need received greater input of community care.

Clinical outcomes matched needs where users' needs were severe. People with high needs were more likely to improve at follow up. However, for people with low or moderate needs, there were no significant clinical outcome changes on any of the sites. Services did not demonstrate an ability to help people with low or moderate needs.

Resources, in the form of service delivery, did not match outcomes: enhanced packages of care, and inpatient or equivalent care packages, were generally associated with poorer clinical outcomes.

Resources in the form of costs matched needs and packages of care: costs were highest for service users with severe needs. But costs for standard and inpatient care were higher where no enhanced care was available.

Box 2: Key findings from Study 2: Assertive Outreach

The Assertive Outreach teams in this study saw people with severe and complex mental health problems, but not those who used inpatient care most frequently or who were vulnerable for other reasons, such as homelessness. Only a tiny minority of local service users with multiple admissions to hospital were in contact with the AO teams.

The teams were able to engage effectively with most service users.

A year after clients' first contact with the teams, outcomes were varied. Some improvements were shown in mental health needs and social functioning in one team's clients, but not in the other. There was little improvement in the quality of life for either of the team's clients. Inpatient bed use increased for both teams' clients; the number of admissions stayed the same but length of stay increased. Service use costs increased because of the high use of inpatient beds.

Clients especially appreciated the AO staff attitudes and the practical help they provided.

The teams adhered to some parts of the Assertive Community Treatment model but deviated from it in critical ways. Neither team had adequate control around hospital admission and discharge, or responsibility for out-of-hours crisis provision, medical or other specialist input such as vocational or dual diagnosis workers. Time spent in liaison, travelling and accompanying clients to other services not available within the team, reduced the amount of time in therapeutic contact.

Box 3: Key Findings from Study 3: Pathways into Care for Young Black Men

Many of the young men in the sample could not be interviewed despite the persistence of researchers. Most did not respond or keep appointments. Others were at risk of homelessness or harm to self or others.

Most (n=37, 75%) had been in hospital before. Twenty-five had been given a care-plan following discharge from a previous hospital admission, but only 5 of these were still in place in the period leading to the admission under investigation. So, of the 37 people with previous admissions, only 5 (13.5%) had a working care plan in place before they were re-admitted.

Pathways into acute inpatient care often involved coercion and/or potential trauma; 46% (n=23) of service users were admitted under a section of the Mental Health Act and 10 people (20%) had been brought to hospital by the police. For a substantial minority (n=7, 14%) their first contact with any mental health service was through admission to an acute psychiatric ward.

Pathways *out* of acute care were not smooth either. More than a quarter of the sample (28%, n=14) had not been seen by any mental health service within a month of being discharged. Within six months of the discharge under investigation, over a third (36% n=18) of service users had been re-admitted, 3 of whom were admitted twice.

Service user interviews produced a number of key themes. The picture was fairly bleak, but there were some good experiences and users indicated how things could be better.

- Most said they could speak to GPs about physical health but not mental health problems.
- GPs were seen as poorly informed about mental health, medication or community based resources, particularly for black people with mental health problems. Many users felt that this lack of knowledge reflected a general unconcern about them.
- Just under half felt their GP understood their experiences as a black man, but a third did not. GPs' understanding was demonstrated through attentiveness, listening and practical help.
- Users felt that they were subject to discrimination and prejudice in primary care not only because of their ethnicity, but also because of having a mental health problem.
- For most of these service users, their first ever contact with mental health services was a disturbing experience which frequently (for almost half) involved the police.
- Mental health services, especially hospital, were seen by some users as punitive and coercive. They wanted empowerment, affirmation and greater access to counselling and alternative/complementary medicine.
- They felt that they were subject to discrimination and prejudice in varying degrees in their contact with mental health services. For many, this was experienced as being denied access to services or affecting the way they were treated on the ward (eg. 'over-medicated'). A small minority reported serious allegations of assault.

CRITICAL REFLECTION ON THE THREE PAPERS

The project as a whole is constructed around the connecting, reflective framework of Contexts, Mechanisms and Outcomes. However, in order specifically to explore *outcomes*, it is necessary to separate out a critical reflection of the research studies and the reported papers themselves. For this purpose, I will use the guidelines for the assessment of evaluation issued by the US Joint Committee on Standards for Educational Evaluation (summarised by Shufflebeam 1980, cited by Pawson and Tilley 1997). To reflect critically on the studies, I sought a professionally credible system that would enable discursive consideration of their quality. I was also concerned that the system should not prevent a 'whole picture' being created (eg. by inhibiting creativity or by distracting with details). The US Joint Committee on Standards for Educational Evaluation met these criteria. They focus on four areas:

- Utility
- Feasibility
- Propriety
- Accuracy

The rationale is

1. that an evaluation should not be done at all if there is no prospect for its being useful to some audience (*utility*).
2. that an evaluation should not be done if it is not feasible to conduct (eg. practically or cost effectively). (*feasibility*)
3. that an evaluation must be done in a way that's demonstrably fair and ethical (*propriety*)
4. that the evaluation must be considered for technical adequacy (*accuracy*)

UTILITY

The fundamental purpose of evaluation is to feed into improvements in policy and practice. Thus, utility could be seen as combining notions of 'impact' and 'practicality'. To make a comprehensive estimation of their utility, both the actual and potential utility of the studies will be considered.

The utility of the studies to date is summarised in Table 8.

In the professional mental health field, more direct impacts now depend on publication. The journals to which the papers have been submitted have been chosen for maximum influence (see Chapter 1). Furthermore, we plan to submit a fuller paper representing the Young Black Men's Pathways study in more detail, with the intention of disseminating both more information and to a broader audience. Peer-reviewed publications are not the only way to deliver useful knowledge to influential audiences. Other effective methods include the use of so-called 'trade' journals. These publish journalistic articles presenting principal findings and implications to managers and practitioners of different disciplines. Notable trade journals include the Health Service Journal (HSJ) and Nursing Times. Such journals may be interested in our studies and we will certainly pursue these as possibilities. They reach a very wide audience, particularly people who have little time to absorb complex material and need information that is timely, relevant to current policy and practice, and simply presented.

Table 8a: Actual utility of the studies to date (NRO)

Study	Achievements so far
Needs Resources Outcomes	<p>This strongly influenced the Department of Health and West Midlands Regional Office in commissioning us to do a large and nationally important study, which I am leading jointly. The study aims to evaluate the implementation of the National Service Framework in the West Midlands, and whether service models in different socio-demographic areas (inner city, urban and rural) are meeting local users' needs. We are using the same baseline measurement methodology as the NRO.</p> <p>The study is highlighted in the Sainsbury Centre briefing paper (A First Class Mental Health Service, Briefing No 6, 1998) as a methodology to assist with quality assurance.</p>

Table 8b: Actual utility of the studies to date (AO)

Assertive Outreach	<p>A recent Health Select Committee on Mental Health noted key Sainsbury Centre learning about priorities when setting up assertive outreach teams (Health Select Committee 2000). The Government responded by recommending a review of current research on assertive outreach (DoH 2000). The data provided by the Sainsbury Centre came from this AO study.</p> <p>I presented early findings from the AO study at a national conference organised by the Sainsbury Centre in 1999. This was a participatory conference attended by around 200 professionals involved in the planning and implementation of AO services.</p>
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Table 8c: Actual utility of the studies to date (Young black men's pathways)

<p>Young black men's pathways through care</p>	<p>Our study has been cited as an example of innovation in the London Mental Health Strategy (<i>Mental Health in London: A Strategy for Action</i>. NHSE 2000). The Strategy subsequently highlighted six areas for action and development around black and minority ethnic health, including reviewing how well mental health services reflect local ethnic and cultural needs, developing anti-racist and cultural awareness training and promoting new ways of serving dispersed communities.</p> <p>Locally in Hackney, the study findings have been very influential. An AO team has been developed partly in response to the findings. The Health Action Zone responded by appointing a development worker to improve services for young black men. This worker has organised mental health awareness days for black men and hopes to set up two new primary care liaison positions for this group. Additionally, an audit of how the CPA process works or not for young black men is to be carried out.</p> <p>A further influence has been on our own products and methodologies. The experience and findings of this study enabled us to improve interview schedules we were developing into a Culturally Sensitive Audit Tool (CAT) (GS, DR and EM). We aim to publish the CAT in late Spring 2001.</p> <p>Finally, this study has influenced the initiation of a major piece of work into black mental health currently being conducted by the Sainsbury Centre. Called '<i>Breaking the Circles of Fear</i>', this high profile project is a nationwide solution-focused exploration of, on the one hand, the experiences of black mental health service users and their families/carers, and, on the other, the experiences of working with them.</p>
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It is also important to value the methodological impacts of the project. A major expectation of the NRO study was that we would be able to design a suitable methodology for monitoring service response to need. To this end, our work has succeeded in providing:

1. A straightforward method for measuring 'severity of mental health need' by combining diagnostic category and the simple measure of the HoNOS. Although there have been recent advances in this area (see Huxley 2000),

previous methods have either been too complicated for services to apply themselves or too crude (eg. using diagnosis alone)

2. A method for describing and categorising combined packages of care delivered to service users. To our knowledge this has not previously been attempted.

Given policy imperatives to carry out needs assessments and to evaluate the effectiveness of service provision in meeting identified local needs, these methods hold significant potential utility for mental health services.

With the Young Black Men's Pathways study, I originally created the Pathways tool, using it in earlier studies (see Minghella and Ford 1997). Subsequently, we have supported a number of services in using the tool themselves to conduct Pathways Studies. For the Hackney study, we worked as a team to adapt the tool to be able to point up ethnicity issues. Again the tool could be used by services themselves. As with the NRO methodology, the Pathways methodology has been promoted by the Sainsbury Centre (Briefing 6).

To summarise, to an extent, the full impact of these studies is yet to be realised. However, there are a number of concrete indications of the studies' impacts and practicality, and of their considerable potential for more. Regarding the question of *impact*, results have been taken up and responded to by senior level policy makers. They have also been received by a large number of practitioners involved in different ways in implementing and developing mental health services. In the form of national conference papers and local presentations, dissemination has begun and the papers are expected to be published in appropriate, influential journals.

And, considering the question about their *practicality*, the Young Black Men's Pathways study has already had major local influence, whilst methodologies from this and the NRO paper have influenced evaluation practice. New methodological approaches are themselves likely to have important practical application for mental health services.

FEASIBILITY

The feasibility of these projects perhaps cannot be challenged; not only *could* they take place, they did take place. However, I shall consider some of the practical and professional constraints which may have affected the process of conducting these studies, and their outcomes, and which have produced lessons about how to conduct similar studies differently in future. (Note that I will consider methodology *per se* when I critique the accuracy of the evaluation).

Studies at a distance: relationships with researchers

Conducting studies at a distance created both practical and professional constraints. The NRO study took place in three different parts of the country: St Helens on Merseyside, North Birmingham and Surrey. One of the researchers in that study (the more senior) was based in St Helens. The other was based in London. Both had to travel extensively to all three sites to collect data. The researcher based in St Helens also had to make a long journey to meet with other research team members and to receive supervision. The Assertive Outreach study took place in two different London boroughs and the AO researcher was based half time with each. For the Young Black Men's Pathways study, the researchers were both based in the London office of the Sainsbury Centre and travelled to Hackney to undertake the study.

The researchers could and did feel isolated at times. Even if they had an established base on the site, they were not part of the actual service and therefore had no immediate peers. If they were *not* based on the site they could feel like demanding interlopers. For example, one researcher was dubbed 'the Sainsbury spy'.

Despite regular visits to most sites, I could not have the amount of contact with either the sites or the researchers that I would have liked. I could not fully appreciate what was happening at the site or have a feel for local issues and pressures that would affect the study and the researcher. On-site researchers were issued with laptop computers with internal modems. We used email a great deal to communicate and this certainly helped, especially when it became

possible to attach documents to emails. But this did not ensure, for example, that I would know how to contact the researcher quickly when necessary.

Most importantly, it was hard to keep track of progress and to support researchers through the inevitable peaks and troughs of the research process and correspondingly variable motivation levels. It was difficult, too, to monitor their workload and time management. I was concerned that one researcher was not putting in the quantity and quality of work required to complete the study successfully and on time. Conversely, there was another researcher who, it emerged, had an unrealistic timetable, was pulled in many different directions, was over-committed and over-loaded, and I did not realise it. I had thought that the systems I had put into place (monthly individual supervision, regular team meetings) would have made it possible to manage such situations effectively. But they didn't. One of the consequences was that both studies concerned took longer than expected, in one case because the researcher's motivation was low, and in the other because the expectations themselves were unrealistic. I have learnt from the experience and changed my practice.

Key lessons:

- Work with the researchers from the earliest possible stage in a study (preferably conception).
- Make sure study proposals contain realistic timescales.
- Negotiate with the researchers and clarify our roles, responsibilities and accountabilities, an agreed timetable and milestones. Review this frequently.
- Aim to build an open and trusting relationship with individual researchers and encourage them to let me know if things are not working out.
- Ask questions! The day to day manager is the conduit for the relationship between the individual employee and the organisation (Barber and Bevan 1999) so it's important to ask about the task, the study, themselves, senior management and other aspects of the organisation.
- Make my expectations clear from the start and encourage the researchers to do the same.

- Ensure researchers let me and the team administrator know of their planned whereabouts and contact details a week in advance, and of changes as early as possible.

These lessons were learnt through invaluable feedback from the researchers I have worked with, through reflecting on my own performance, and through undergoing a Project Management Training Course with the Industrial Society earlier this year. Other Senior Researchers and I had requested this course because of our concerns about how effectively we were managing teams and studies. I have also inevitably become more confident and more knowledgeable about managing people, and about managing research tasks. For example, I know how many stakeholder interviews can reasonably and effectively be undertaken by one researcher in one day. Interestingly, the lessons apply regardless of whether the researcher is based in the London office or on the research site. Having said this, these lessons become critical when colleagues are *not* working in the same location and do not have access to the day-to-day contact on which we rely for picking up issues informally.

Studies at a distance: relationships with the study areas

A further problem with carrying out studies at a distance was that of building good-enough relationships with local staff, including IT staff, to facilitate access to medical notes, records, IT systems and service users themselves. This presented a challenge in all three studies. In two of the studies (NRO and AO), we also needed practitioners (keyworkers) to complete HoNOS and other assessments.

Where researchers were based on site, they were more effective at managing these problems. They made the effort to foster relationships with staff and worked out strategies to encourage them to participate. However, sometimes this in itself could cause problems. For example, one researcher would offer help with local practitioners' academic work as a way of giving, as well as expecting, co-operation. This inhibited the progress of the researcher's own work at times. The researcher insisted that such mutual co-operation paid off but it seemed high risk.

Where researchers were not based on site it was often very difficult to get the required co-operation and information, especially when we were asking to access sets of information twice (baseline and follow up) as in the NRO study. In one site, we had to resort to offering a prize to the first keyworker to complete all their follow up HoNOS assessments. The number of HoNOS assessments increased, but this site had the lowest response rate. The study area was undergoing constant organisational change, staff felt demoralised and they saw no reason to co-operate with an external evaluation they felt no ownership of.

Key lessons:

- Need a site-based 'champion', with some seniority but not too removed from operational work, who will encourage participation
- Need to work with the study areas at both team level and stakeholder level to help create a sense of ownership, eg. discuss the study's aims and objectives, agree feedback strategies, take on board ideas about the structure and content of research instruments
- Need to timetable regular feedback to local staff so that they can see the results of their efforts
- Constantly monitor the cumulative mass of problems and assess ('risk assessment') whether it is worth pursuing the study. Recognise that the decision to pull out may be necessary.

Reaching service users who are reluctant to engage with services

For two studies we sought to interview service users who were not *currently* well engaged with services and (evidence suggested) were also likely to be *reluctant* to engage with services. In the Assertive Outreach study the problem was less pronounced because generally the service users were at least in touch with the AO team. In the Young Black Men's Pathways study, though, this was not the case. The young men had been hospitalised but had had little subsequent contact with any services. This group proved very difficult to reach for research interviews. That is, the very reasons why it was important to conduct the research (to understand their limited and reluctant contact with services) was

reflected to some extent in their relationships with the research, and challenged familiar research procedures and expectations.

Fifty people were in the original pathways sample. The inclusion criteria were: aged 18-40, Black African Caribbean, male and recently discharged from acute hospital in Hackney. Contrary to our hospital sources, we discovered that one person was not Black African Caribbean. Of the 49 people remaining in the sample, 36 either did not respond to invitations to be interviewed, refused, agreed but did not attend interviews, were too ill to be interviewed or had moved. We managed this problem in several ways. Firstly, we had already decided to pay service users for their time; we decided to increase payment from £5 to £10. (I discuss the ethical question of paying service users to participate in research in the 'Propriety' section). Secondly, we notified the study funders of what had happened, and sought their advice. Thirdly, after discussion with the funders, we selected a second sample of service users who were not among those sampled initially but had experienced at least one hospital admission in the previous year. Finally, we used our research experience in struggling to gain access to the young black men as a 'process finding', to demonstrate how difficult it is to engage with this client group, despite persistence, funds, time and it being in our interests to do so.

My management of this study demonstrates a more systematic and effective approach to problem-solving. I came to the study with the experience gained from the Sainsbury Mental Health Initiative (SMHI) studies. I was able to use that experience to recognise and pre-empt problems, deal with them by sharing responsibility both with the team and with the study stakeholders, and be flexible and creative in doing so.

Key lessons:

- Calculate the risk of not being able to access service users in specific client groups and build constructive strategies into the protocol
- Always notify the study funders if there are problems as they may have good alternative ideas; this involves them in the process, and they will share the responsibility for taking difficult decisions.

- Be flexible. In real world, realistic evaluations, the study methods may need to be changed.

Writing papers and the question of authorship

Previous sections have indicated some of the many and difficult issues in managing research teams; writing up the research for publication presents more. Inclusion of participants as authors was not a problem with any of the papers, but the actual writing of the papers and the order of authors were.

Following considerable debate, the British Medical Journal issued guidelines around authorship (available on their website: www.bmj.com). They state that authorship credit should be based only on *substantial* contribution to

- conception and design, or analysis and interpretation of data
- writing the article or revising it critically for important intellectual content
- making the final approval of the version to be published.

All of these conditions need to be met for contributors to be included as authors. On their own, acquiring funding or data collection are not regarded as justifying authorship.

These guidelines do not take into account the political nature of research. As Scott (1997) has argued, authorship is a political problem that involves territorial rights, colonisation, and empire building. The order of authorship is also important; it matters because first authorship has greater status. To illustrate: in making a citation in a book or paper, the convention is to refer only to the first author in the main body of the text, or both authors if there are only two. Authors whose names appear later in a list of three or more are only mentioned in the references.

The power relations in conducting research, alongside the junior researcher role, mean that it is not always easy for junior staff to take the lead in writing a paper. I encouraged and attempted to support two junior researchers to take the lead

role in writing two of the papers in this project. Neither had a track history or substantial experience of writing papers for publication and I wanted to help and coach them. At the same time, I was involved in setting up new studies and managing other teams. My time was extremely limited. Two problems arose, one with each of the papers.

One problem related to the order of authorship: the researcher's contributions did not match the criteria for first authorship. The researcher had made modest contributions to the design of the study and to making sense of the findings, and was relatively inactive in sustaining the momentum of writing the paper itself. The researcher made use of material I had written that synthesised the findings and drew out implications for practice. The parts of the paper written by the researcher needed repeated editing and re-editing; progress was inordinately slow such that the paper was long overdue for submission. For the final draft, it was agreed that I should take over the writing. My manager was also a co-author. We both felt that, as a function of the *type* of contributions I had made to *both* the study and the paper, I should be first author. Conversely, the researcher argued to retain first authorship, as a function of the *amount* of time and effort the researcher had put into the *paper*. While these statements over-simplify the relationship between the type and amount of our contributions (eg. to some extent they are necessarily inter-dependent), they serve to illustrate our polarised positions. After considerable debate, these were only negotiated by resorting to another (similar) set of written guidelines for authorship found by the researcher.

The second problem, involving the Young Black Men's Pathways paper, was the final quality of the paper to be submitted for publication. The researcher's inexperience of writing for publication was exacerbated by some confusing and limiting guidelines for writing the paper. There was also an unrealistic timetable for submission, as it was part of a special issue of the journal. I was able to spend some time editing the paper, but not to my satisfaction and the timetable precluded more. As well as credit, authorship confers accountability (Smith 1997) and as one of those accountable, I was unhappy. Senior colleagues' review of the paper confirmed my estimation of its flaws. As a result, the paper has some characteristics of a journalistic article and some of a short academic report, but does not meet the criteria of either.

Key lessons:

- Authorship must be discussed and agreed with the evaluation team as soon as a potential paper is envisaged. It, and individuals' contributions, are usefully reviewed at key points (whether or not problems are looming).
- Potential authors need to be aware of the conventions for qualifying as authors
- The order of authorship may need to be reviewed; the conditions under which this might happen should be discussed early on
- More junior researchers, or those without much experience of writing papers, need coaching. Senior colleagues and/or peers may be able to help; it is not my role alone but the responsibility of the department to help develop researchers' skills in this area.
- Be cautious about submitting papers under more restricted conditions than normal; it may mean extra work and a less effective method of dissemination.

PROPRIETY

All studies were approved by local research ethics committees. The Royal College of Psychiatrists (RCP) recently issued guidelines for ethics committees and researchers regarding the ethical conduct of mental health research (Royal College of Psychiatrists 2000). I shall refer to this extensively while assessing the propriety of these studies.

Funding

Study funding can be a problem if funders seek to control access to the findings of the study and their dissemination, or if there is a conflict of interests which could bias the results. The Sainsbury Mental health Initiative (SMHI) funded the first two studies. The London Regional Office funded the third study. In no case was there a veto over the findings or constraints on publication. However, the SMHI also made a large contribution to the funding of some of the services involved in the studies, and it was a requirement of that funding that the areas participated in our evaluations. It was assumed that the funding may increase their co-operation with the evaluation (eg. tracing case notes). Whether this assumption was valid and realised is open to question.

The Young Black Men's Pathways study was part of a wider national initiative on minority ethnic health. Its funding has affected our dissemination, in that the paper presented here was submitted to Ethnicity and Health in its current format as part of the dissemination of the national initiative through the London Regional Office. The effect on the paper is that it is not as substantial as we would have liked and provides a limited picture of the study and its findings. We can submit a more detailed paper for publication elsewhere at a later date, so this does not constitute a major negative constraint on our achievements.

The involvement of service users in the studies

The RCP guidelines note that a person's care should not be affected by their decision about whether or not to participate in a study and they should not be required to justify their decision. Where service users were involved in our studies, we ensured that they were given and understood an information sheet that emphasised this point. We advised service users that they could stop an

interview at any time. Once familiar with the aims and procedures of the study, they were asked to sign a consent form confirming their agreement to take part.

What, though, constitutes 'involvement'? I have used the term here to mean the involvement of service users in research interviews, to seek their views and experiences and/or to assess their needs. We reported the findings from user interviews in the AO study and in the Young Black Men's Pathways study.

The NRO study was different, using local databases and clinical records to identify people in touch with services and measure their service contacts. It could be argued that this is also a form of user involvement requiring the same ethical principles as those applied to user interviews. However, consent to access records was not obtained, and service users were not contacted. Data was stored anonymously and was only used in aggregated form. To contact everybody in touch with services and seek their consent would have been completely impractical and, I would argue, unnecessary. The RCP guidelines reflect this view. They say that perusal of clinical records does not need consent where data is analysed in group form and anonymously.

A different question is whether service users' views *should* have been included in the NRO study. In fact, we did interview a sample of service users in St Helens, and we carried out two focus groups with users in Yardley/Hodge Hill. The interviews in St Helens sought to discover users' experiences of how well services were assessing and meeting their individual needs. The focus groups explored users' satisfaction with local services. The findings from the user interviews and focus groups were not included in the paper. Would their inclusion have enriched the NRO paper and enhanced the propriety of the study? On the one hand, users' experiences of services must be a central part of the equation when measuring the quality of care. On the other hand, the paper attempts an already very complex task. Including users' experiences, views or user-based measures of need and outcome would have added yet another layer of complexity to this already complicated paper. In conclusion, I think that, *ethically*, we were right to explore users' experiences, views and understandings of their own needs, and should report these separately in the context of a

simplified version of the NRO findings. *Methodologically*, the issues are slightly different and will be explored in the section on Accuracy.

The question of providing payment to service users to take part in research is also a vexed one. Some would argue that payment confers a sense of obligation bordering on coercion. On the other hand, when staff are interviewed, they are usually in their work situation and are therefore being paid whilst the interview takes place. This is rarely the case for service users, many of whom are not even in work.

The RCP guidelines point out that the difference between an innovative service and a research study, is that the intention of the service is to benefit the individual, whereas in research, service users *in general* may benefit but the individual may or may not benefit. Therefore there is no intrinsic reason why an individual user should agree to take part in research, especially without proper remuneration. Furthermore, payment demonstrates the value of users' contributions. This view has recently been supported by the Consumer in the NHS Research Unit (Hanley et al 2000). The RCP guidelines also state that it is reasonable for participants in research to be reimbursed for their time, expenses and inconvenience.

We knew that, by definition, the Assertive Outreach sample could be difficult to reach and anticipated that this may also be the case with the young black men in Hackney. We paid service users up to £10 for their time and expenses. It is likely that this did help in reaching some of the people who would otherwise have had little direct incentive to take part in the studies.

Confidentiality/anonymity

The Sainsbury Centre is licensed under the Data Protection Act to deal with research data. We kept confidential, computerised records, accessible by password. No one is identifiable in any of our reports. I am determined that confidentiality and anonymity of individuals should be maintained, and confident that it was. This is ethically sound practice. It is also pragmatic practice. Our ignoring or flouting these standards, or being seen to, is likely to discourage participation and co-operation in future evaluations.

Risk to researchers

Ethical practice does not only apply to protecting the rights of people being researched; it must also be concerned with those carrying out the research. The RCP guidelines note that there must be agreed procedures for minimising risk to researchers. People with mental health problems are no more likely to be dangerous than anyone else. However, for the AO and the Young Black Men's Pathways studies, we were particularly aware of potential risk because of the specific nature of the services and the client groups. The service users in the samples were people who were not closely in touch with services, little may have been known about them, their risk of harm to others may not have been recently assessed, and their likelihood of having complex needs including a forensic history was high. Agreement to be interviewed was difficult to obtain; therefore we were reluctant to inconvenience users by asking them to meet us on our terms. This meant seeing most of the users in their own homes ie. in physically isolated and unknown environments. With the AO study, it was a question of gradually developing ways of managing this issue. We had not thoroughly thought it through. The researcher and I tried to resolve the situation as and when risks were raised (which they were). This was time consuming, not satisfactory and did not properly protect the researcher.

I learnt from this experience, and by the time of the Hackney study, the team and I were able to work out a more systematic protocol, including providing the researcher with a mobile phone. The protocol was agreed as follows:

- before carrying out an interview, the researcher should attempt to find out from practitioners whether there is any known risk associated with the service user
- where a serious risk is identified or if the researcher has any reservations, the researcher should discuss whether and how to proceed with the Project Manager. (One interview did not take place for this reason)
- where a possible risk is identified, the researcher should suggest meeting the user in a neutral, more public location (eg café) or with the person's keyworker

- when carrying out an interview at home, the researcher should inform the Project Manager of the name and address of the interviewee and time of interview, and report back on completion.

This protocol did not always prove effective. Having attempted in vain to interview one service user by visiting him at his flat several times, the researcher went back to the keyworker to try to explore other ways of engaging with the person. It was only at this point that the keyworker warned the researcher that the flat was dangerous to enter. The service user had booby-trapped his flat because he feared the interference of the 'authorities'. This shows that such protocols are only effective if information is accessible and shared appropriately.

In summary, these studies were all subjected to ethical scrutiny through local research ethics committees. They conformed to standard conventions of ethical propriety. Areas of ethical debate and learning have included consideration of the involvement of service users and managing risk to researchers.

ACCURACY

Accuracy is concerned with the technical adequacy of a study, ie. the *appropriateness* and *effectiveness* of its design and methodology. Design and methodology are related aspects of the research process and their credibility has a bearing on the potential impact of the papers.

The question here is, do the design and methodology of our studies lead to valid and generalisable findings?

Quantitative and qualitative design and methodology

Quantitative and qualitative methods, and a range of study designs, were used. For the NRO study, only quantitative methods were used. For the AO study, the methods were mainly quantitative with some qualitative aspects. In both studies, inferential statistics were used to analyse the quantitative data. For the Young Black Men's Pathways study, qualitative and quantitative methods were used, although descriptive statistics only were used to analyse the quantitative data.

The randomised controlled trial (RCT) remains almost incontrovertibly the 'gold standard' for medical (sic) research design. The RCT design presupposes quantitative methodology and statistical analysis. Yet Greenhalgh (1997) points out that even RCTs are subject to the risk of systematic bias, that is, anything that erroneously influences conclusions about groups and distorts comparisons (Rose & Barker 1994). For example, different and varying care may be provided to individuals aside from the care being evaluated and the design is insensitive to whether it is the former, latter or both affecting outcomes. However, the elevated status of the RCT in particular, and quantitative research in general, are maintained and bolstered by their favoured inclusion in the top medical journals. A recent survey of original papers published in medical journals over 5 years, found that only 2% reported qualitative studies (Boulton, Fitzpatrick & Swinburn 1996).

As Patton (1987) has suggested, numbers convey a sense of accuracy and precision. Quantitative methodology is often implicitly accepted as likely to

produce valid and accurate findings, as long as the statistical analysis is appropriate. The debates over whether (and how) qualitative design and methodology are similarly capable of producing valid findings, and whether a combination of quantitative and qualitative methods might indeed *enhance* evaluation findings continue.

Recently, the National Research and Development Directorate conducted an exercise to consider different ideas about how to conduct health research and - of particular relevance to realistic evaluation - health *research and development* (Fulop & Allen 2000). Two issues stood out. Firstly, the report advocated the use of a variety of research methods, including 'non-traditional' methods like action research, 'realistic evaluation' and reviews. Secondly, the report supported the need to identify reasons for the gap between research and implementation. Overall, the report reflects a growing understanding that the interests of policy and service development stakeholders, along with pressure from them, may suppress some of the traditional tensions and antagonisms between qualitative and quantitative methods (Hurley 1999). In mental health research specifically, it has been argued that many of those at the sharp end of policy and practice would like closer links with researchers, especially to help with early indications of problems and successes in implementation (Richardson et al 2000). The authors suggest a variety of methods, from qualitative approaches and action research (aspects of which feature in the Hackney study), to the use of routine databases (as in the Needs-Resources-Outcomes study).

In conclusion, then, the issue is perhaps no longer one of quantitative or qualitative methods, randomised controlled trials or single case studies. As Patton (1999) has argued, there is a growing consensus in social science evaluation and research for the need to match appropriate methods to evaluation questions and issues, not to advocate universally any single methodological approach for all evaluation situations.

Strengths and weaknesses of the design and methodology of the studies

Having introduced the debate over the implicit validity and acceptability of quantitative and qualitative methods in health services research in general, there

remains the question of the particular methodological strengths and weaknesses of the studies presented here. The point is to explore whether the methods were appropriate for producing accurate findings corresponding with the study aims. There is not the scope within this project to critically appraise the full methodology of all three studies. Indeed, some of the methodological considerations have already been raised in the papers themselves. Instead I will summarise the central design and methodological issues, and the strengths and weaknesses of each in addressing our evaluation questions.

Table 9: NRO: a summary of 'Accuracy'.

Summarised central question	What can we learn about whether and how effectively services match need, in different service and socio-demographic environments?
Summary of design	Survey of needs of everyone in touch with services; prospective quantitative description of service use; repeat measure of need after 6 months or 1 year.
Summary of methods	Health of the Nation Outcome scale (HoNOS) and socio-demographic profile for everyone in the care of local mental health services at baseline and follow up. Use of medical records and local databases to collect service use. Standardised costs applied to service contacts. Log linear analysis used to statistically analyse the relationships between needs, resources and outcomes.
Methodological/ design strengths (addressed our aims & leads to generalisable findings)	<p>Able to assess and quantify severity of need simply</p> <p>Able to measure and categorise packages of care delivered by three different mental health services.</p> <p>Able to demonstrate whether packages of care matched users' needs, whether their clinical outcomes were related to baseline need, and how care related to outcomes.</p> <p>Able to demonstrate how service costs change when enhanced community care is not available</p>
Methodological/ design weaknesses (didn't address our aims and/or leads to finding that can't be generalised)	<p>Because the study was evaluating what actually happened in practice, could not predict or influence sample sizes; insufficient statistical power is likely to have affected the ability adequately to test the relationship between the three variables.</p> <p>HoNOS alone is a limited measure for evaluating outcomes.</p> <p>Not reporting service users' views about their needs or how services matched them</p> <p>Know only about the service structures, not about the nature of the interventions</p>
Comments	The creation of a relevant, generalisable methodology was itself one of the aims of this paper.

Table 10: Assertive Outreach: a summary of 'Accuracy'

Summarised central question	How effective are voluntary sector-based Assertive Outreach teams in terms of engaging appropriate clients and improving clinical and social outcomes for clients?
Summary of design	Recruit all new users of the AO teams, assess needs and previous service use at baseline and at one year follow up.
Summary of methods	Interviews with users and keyworker ratings for HoNOS, Brief Psychiatric Rating Scale (BPRS), Adapted Quality of Life interview (AQOL), Life Skills Profile, socio-demographic profile at baseline and follow up. Use of medical records and local Trust IT databases to collect service use. Follow up interview added Client Satisfaction Questionnaire and qualitative questions. Standardised costs applied to service contacts. Dartford Assertive Community Treatment scale to measure fidelity to the ACT model. Parametric and nonparametric statistics used to test differences between baseline and outcome measures. Content analysis used to analyse the qualitative data from follow up interview.
Methodological/ design strengths (addressed our aims & leads to generalisable findings)	Assessment of clinical and social effectiveness achieved through standardised quantitative measures which permitted valid and reliable statistical comparisons between baseline and follow up. Use of the ACT model helped elucidate why the teams were effective or not Qualitative data from user interviews illuminated reasons for users' satisfaction and dissatisfaction with AO teams Past and prospective service use data enabled comparison of previous engagement with services with success of AO teams in engaging users Use of hospital IT systems identified people with multiple admissions who were not on the teams' caseloads
Methodological/ design weaknesses (didn't address our aims and/or leads to finding that can't be generalised)	Follow up period may have been too short to observe change adequately Small sample sizes due to slow recruitment to the AO teams
Comments	An RCT could have been used to assess whether AO was more effective than 'standard' care for this client group. Issues for consideration would include how to measure and control 'standard' care and how to ensure that the comparison sample has the same characteristics as the treatment group. The ethics of 'denying' AO to people in need of it (through randomisation) could be a problem.

Table 11: Young black men's pathways through care: a summary of 'Accuracy'

Summarised central question	What are the key issues affecting pathways through primary care and acute mental health care for young black men and can training GP practices improve the situation?
Summary of design	Examine the pathways through care of a sample of 50 young black men consecutively discharged from hospital. Interview them about their experiences. Telephone GPs for their opinions. Use the interview, pathways and GP data to inform a primary care training package. Pilot and evaluate the training package in 2 GP practices. Interview young black male mental health service users registered with those practices to see if their experiences are different from those in the first sample (nb. Final stage not reported here).
Summary of methods	Hospital IT system to obtain admission data for identifying sample. Pathways data collection form designed to facilitate collection and organisation of quantitative and qualitative data on admissions pathways from medical notes. User interviews using semi-structured interview with interviewer of same ethnicity. Descriptive statistics used to analyse the Pathways data. Content analysis used to analyse the qualitative interview data.
Methodological/ design strengths (addressed our aims & leads to generalisable findings)	Pathways data highlighted significant problem areas for young black men's pathways through acute care. User interviews provided detailed insight into their experiences and why they may not be inclined to seek out primary care for mental health problems or willingly engage with mental health services
Methodological/ design weaknesses (didn't address our aims and/or leads to finding that can't be generalised)	Use of medical notes alone may have produced misleading or incomplete findings about pathways due to the limitations of using only what has been recorded in the notes. Difficulties encountered in interviewing users meant numbers were small. The use of a second sample meeting amended criteria may have confounded the findings.
Comments	It has been argued that using ethnically matched interviewers in mental health produces more reliable data (Nazroo 1997).

In summary, quantitative and qualitative methods have been used in evaluating mental health services for this project. Whilst the first paper presented here is completely quantitative in design and methodology, the second two have used a combination of methods. It is gradually becoming more acceptable within health

services evaluation to utilise a variety of methodologies with the proviso that the methods need to be appropriate for the evaluation questions. There are methodological and design weaknesses in all three of the studies. Nevertheless, the strengths are important, relevant and robust enough to ensure that many of the findings are valid and generalisable.

MEETING THE LEVEL 5 DESCRIPTORS

With reference to the three papers and this section, Table 12 demonstrates how the project meets the Level 5 descriptors for doctoral capabilities.

Table 12: How the project meets the level 5 descriptors

Cognitive	
Knowledge	The project demonstrates my wide knowledge of a number of complex ideas and issues. These include extensive knowledge of mental health services and systems, different approaches to care, awareness of health and inequality issues, advanced level quantitative and qualitative research methodology.
Analysis/Synthesis	As project manager on all three studies, I have had a lead role in data analysis and in the broader formulation of the political, professional and practical implications of the studies. I have demonstrated my ability to use a range of analytical methods. I have synthesised the findings from these studies both within the papers, and – in this chapter - <i>between</i> the papers, to draw wide-ranging implications for service development, and for the development of evaluation approaches. Through the studies I have developed new approaches (for example, new methodologies) and produced findings that add new dimensions to existing knowledge around service implementation.
Evaluation	I have independently evaluated the studies and assessed them comprehensively, using highly regarded evaluation criteria. Through this process I have been able to indicate and justify arguments about how to improve research practice.
Transferable skills	
Self-appraisal/reflection	Throughout this chapter I have demonstrated the ability to critically appraise my role and my practice. I have highlighted where and how my practice has changed and indicated key (and sometimes painful) lessons learnt.
Autonomous planning, effective use of resources incl other people	The conduct of these studies demonstrates my ability to plan work effectively, in complicated and multilayered situations. For example, managing multi-site studies, managing researchers based away from the office, planning and managing several studies and teams simultaneously. My abilities to plan effectively and manage the team effectively has developed and improved, as I have demonstrated throughout this chapter.
Research capability	The papers demonstrate my research capability in the various stages of research (conception, design and methodology, analysis, interpretation and writing up). I have shown research skills in, for example, quantitative and qualitative data analysis and the ability to draw out major implications from a range of findings. I have also shown my abilities to critically assess the appropriateness of methodologies and to draw conclusions from the current arguments for and against different approaches.
Problem-solving	The studies presented several problems in terms of project management, team operation, ethics and methodology. I have highlighted the main problems and shown the abilities to creatively consider potential or deliver actual solutions.
Communication/presentation	As lead author in two of the papers, second author in the third, and throughout the presentation of this project, I have established my abilities to present complex material clearly and for different audiences, including those who are not mental health professionals.
Operational context	
Context	Chapter 2 exemplified my ability to understand and interpret comprehensive policy and professional contextual issues. Within the papers I demonstrated my understanding of the background contexts and also the context for implementation. In this chapter I have explored contextual issues further, including how the potential impact of the studies is dependent on their context.
Responsibility and ethical understanding	I have provided evidence of my understanding of ethical issues including controversial issues, such as the involvement of service users. I have applied ethical principles to the conduct of the studies and they have all been scrutinised and approved by local research ethics committees.

CHAPTER 4: SUMMARY AND CONCLUSIONS

This chapter summarises and reviews the project against the original aims, highlights the main messages, and makes suggestions for future implementation of the findings for services and for research.

The complete picture is represented in Figure 3 which acts a backdrop for this chapter. Each of the bubbles represents a key aim of the project. The figure indicates the ways in which the aims have been achieved and how they relate to each other. The theme is one of a continuous research and service development loop, influenced by and influencing the Sainsbury Centre for Mental Health and national policy. Underpinning the project have been my critical reflection and doctoral capabilities, as demonstrated throughout.

THE RESEARCH

The project has presented three papers prepared for publication based on original research studies. Each study had its own context, rationale, aims and objectives and methodology. At the same time, they are due to report within an overall policy and service development context. Policy, in particular, has had a major influence on the studies. Through increased funding as well as political principles, The National Service Framework for Mental Health (NSF) (1999) and the National Plan (2000) have stimulated a sea change in the way mental health services will be delivered in the future. The challenge for services is how to deliver the changes effectively in ways that address local needs, diversity and resources. The challenge for the Sainsbury Centre, and for us as mental health services researchers, is to provide good quality, relevant programmes of work to support implementation and continue the process of improvement. These studies are therefore embedded within an exciting and challenging political context.

The studies have been conducted collaboratively within research teams, rigorously and ethically. I have described the variety of designs, research methods and methods for data analysis. As with all research, there are methodological weaknesses and these have been highlighted in the previous chapter. The two main weaknesses were small sample sizes (even in the NRO

study) and limited follow-up periods which may have affected the outcomes. But there have also been methodological strengths. These include the use of routinely available data sources in varying degrees for all three studies, robust, replicable methods of analysis, and the development of new methodologies for data collection and organisation.

Three excellent and challenging research teams worked with me on these studies. As a result, the studies produced valuable quantitative and qualitative evidence in relevant, emerging areas of mental health service development, such as Assertive Outreach. All of the studies have particular application for services for people with the most severe problems, who may also include those at risk of exclusion from services, such as young black men.

I summarised the findings of each study in the last chapter. But what do they tell us together? Three key findings have emerged; they relate to:

- services and resources
- clinical outcomes, and
- access to care.

Services and resources

People with severe mental health problems receive greater than average support from modern mental health systems. However, more care for people with greater need will be more expensive if this consists mainly of inpatient care rather than alternative enhanced community based services.

Outcomes

Positive outcomes can be, and are, achieved, even for those with the most severe needs. However, services are not standardised and care pathways to and through them are not always clear, appropriate or smooth. Where clear, evidence-based models exist, if services do not adhere to them they may not be effective.

Access to care

Some vulnerable people still miss out on positive care, especially those who cannot, or will not, willingly engage with services. People with frequent admissions to hospital, homeless people, people with a dual

diagnosis and young black men may not have equal access to the services they need, even when services are apparently set up specifically for them.

IMPLEMENTATION

The key findings from the studies point up a number of recommendations for implementing effective mental health services. Three main areas for the implementation of effective change can be identified.

The big picture

The NSF requires services to assess needs and identify gaps in service provision, with which the NRO should prove useful. Its methodology provides a framework for categorising a whole service's packages of care in line with policy and describes a simple way of assessing users' needs through a census. The statistical analysis of needs, resources and outcomes is likely to be too complex for services to use themselves. But the basic methodology for describing services and needs uses routine data and the Health of the Nation Outcome Scale, which is also likely to *become* routine. Through our explication of the methodology, the NRO paper discusses practical issues regarding handling the data, such as how definitions of a census population might be applied and how problems such as double-counting can be avoided.

These descriptions hold considerable potential for planners and managers. They permit inequities and mismatches to be identified. Refining the process would enable comparisons between different localities to be made. Planners would be able to use the findings to make informed decisions about where to develop new services and what they should be. In addition they will have indications of the nature, resource implications, time and staffing needs of the developments.

In summary, the NRO provides help with identifying and making sense of the 'big picture'. It provides information for the first time about how the whole service system can be categorised, measured, costed and matched against service users' needs.

The smaller picture

Exploring the big picture in line with policy will uncover gaps. Currently, gaps are most likely to be found in enhanced community services for service users with severe mental illness and complex problems. The NSF requires these gaps to be addressed as a priority, through implementing Assertive Outreach and other enhanced services. The needs assessment will have helped identify the need for Assertive Outreach locally, including numbers of people who might be eligible. The AO paper specifies common pitfalls and practical lessons through highlighting which elements of the ACT model and its implementation are critical in ensuring an effective service. The paper describes, for example, how to target effectively and how to ensure the service has adequate control over hospital admission and discharge by being available round the clock and having medical input. It also provides guidance about the interventions required, especially which interventions are valued by service users. Service users' appreciation of practical help in particular, has operational implications both for interventions and staffing of AO services. This has been a repeated finding the significance of which may not be obvious. Practical help is immediate, understandable and meaningful; it can form the foundation for developing trusting, working relationships (Repper et al 1994).

The even smaller picture (or is this the bigger picture?)

Service users, then, have important things to say about services and their effectiveness. The NSF exhorts services to involve service users and their carers in planning and delivery of care. In our Hackney study, we were able to derive detailed material from young black men with severe mental illness, people who are often excluded both from services and from research. They provided invaluable insights into why they are not inclined to engage with mental health services, why they feel let down by primary health care, and what services could do to make them feel valued, included and supported.

This leads to a key implementation message. If, as the NSF and National Plan insist, inequalities of access and of service provision are to be addressed,

services must listen to users, and not just those who are active in local user groups, but those who do not easily engage with services. While difficult to carry out, our study provided lessons for services wishing to consult users, including seeing them on their home ground and matching the ethnicity of practitioners or investigators with that of the service users.

IMPLICATIONS FOR FURTHER RESEARCH

Back to the future

Realistically, how is research expected to answer practical and policy questions? Rather than a single uniform answer to a given question, we can expect a 'family of answers', related by principles that emerge only over the course of much research (Cook et al 1992). Thus, it is essential to accumulate and reflect on results from high quality work.

Pawson and Tilley (1997) talk of going back to consider and reconsider findings and then forward to attend to the new puzzles that emerge. There is a need to go back and 'puzzle' again over the findings of all of these studies. For example, why was enhanced care associated with poor outcomes in the NRO study? Did the establishment of AO teams in the voluntary sector exacerbate the problems caused by not strictly adhering to the ACT model, or was it an advantage? What kind of improvements at primary care level would ameliorate young black men's access to appropriate mental health care?

The NRO study in particular provides a complex analysis of needs, packages of care and outcomes, using sophisticated statistical analysis. It needs to be tested further, preferably with populations sufficient to ensure statistical power.

Interventions

At the same time, the interventions provided by services need to be examined. The NRO looked at the packages of care but not at the interventions delivered within the packages; this is a gap that, as we noted in the paper, appears in other studies too. It is an area that poses particular problems for researchers. For

example, observing practitioners is labour-intensive (and therefore costly) and observation tools are difficult to standardise especially when observing a range of disciplines. However the results are rewarding. In a recent multi-site study on the work of dual diagnosis teams, for which I was the project manager, we developed an observation tool for identifying typical interventions and carried out non-participant observation of staff-client sessions. Through involving the staff member in the process we were able to agree joint understanding of the nature of the intervention. The results generated insights into the differences in service delivery across the sites, factors illuminating the variability of their effectiveness, and training implications. Further, in terms of methodology the study achieved and demonstrated the benefits of a positive move towards a closer working relationship between researchers and practitioners, as recommended in the National Listening Exercise (Fulop & Allen 2000).

Pathways through care

Pathways through care, especially for those who do not remain in contact with services or for whom inpatient admissions are frequent, merit further investigation. We know from the Hackney study, as well as other research, that young black men are disadvantaged, but are there factors within other groups that influence their pathways into care and their administrative outcomes? Are there factors in the practitioners and services (eg. attitudes, procedures) which affect how they deal with individuals or groups so that those peoples' pathways into care are less effective than they should be?

Acting on the design suggestions proposed in the National Listening Exercise, I would want to carry out a research *and development* study around pathways into and through acute care. An extensive study such as this would involve three stages:

- Stage 1: an initial investigation into the process of care from breakdown in the community through acute interventions through to discharge and beyond, the views and experiences of service users and carers, and the attitudes, experiences and training needs of staff.

- Stage 2: using the findings to help services change, through the use of feedback loops, involving all the key stakeholders including service users, and providing training and service development support
- Stage 3: assess improvements by repeating the initial investigation.

As Richardson et al (2000) pointed out, there is a need for “more than more research”; it also needs to be different. More collaboration between researchers and service stakeholders is needed to advance implementation. So, a study such as the one outlined here could provide:

- a model for how to help indicate problems in service delivery
- an evidence base for improvement and
- support effective change.

CONCLUSIONS

This project has presented three papers prepared for publication, based on evaluations of contemporary mental health services. Through using a framework of ‘contexts-mechanisms-outcomes’, I have considered in detail the political and professional relevance of the studies, their likely impact, strengths, limitations and implications. Throughout, I have reflected on my own practice, areas of learning and professional development and demonstrated my doctoral capacity with explicit reference to the level 5 descriptors.

The studies are the core of this project. Through creative, pragmatic and effective research, they have been able to deliver practical messages to key audiences around relevant and significant questions. The findings reveal a mixed picture of modern mental health services in a time of unprecedented change. In some instances, care is being delivered appropriately, effectively and with efficient use of resources so that some people with severe needs receive the services they need. But services are not consistent nationally, access to them is not equitable and relevant evidence is not uniformly translated into practice.

In mental health services research, we know we could always do better. We need to develop formative realistic evaluations that include our partners – the people

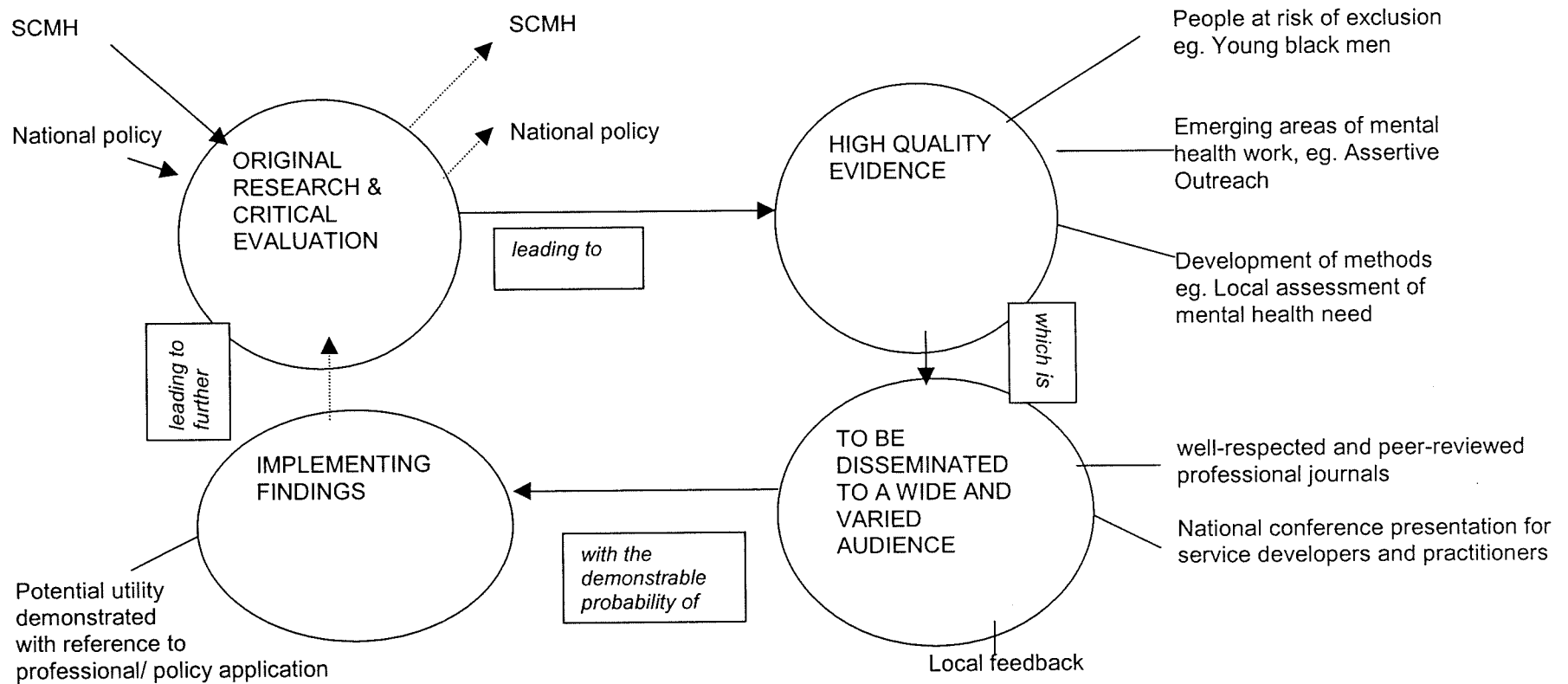
who use, deliver and formulate policy about services. We need to sustain a dialogue with service developers and trainers to enhance assimilation of findings into everyday practice. And we need to keep challenging: not only the world of mental health services, but ourselves, our own skills and methods, our messages.

So much is happening in mental health services. My colleagues and I live in exciting times. At last there is a central commitment to improving quality and equity, new ideas for organising care, a growing recognition of the strengths and weakness of the system, and unfamiliar levels of funding: in short, a move away from complacency, towards action.

From a personal perspective, this project is embedded in a connecting framework that has enabled me to reflect in detail on my work, my role, my professional relationships, my mistakes and my achievements. There is a lot here and a lot necessarily left out. The opportunity for thoughtful, critical reflection is all too rare, and I feel privileged to have had it. It is a necessary activity; without it, we are destined not to *learn* from experience but to repeat it.

Figure 3: Summary and achievements of the project

Critical reflection



Doctoral capabilities

FULL REFERENCE LIST

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