Abstract  Background  Service planning based on aggregated needs assessment is rarely practised. There is a lack of research into how population-based needs assessment approaches can be translated into routine clinical settings.  Aims  This study aimed to ascertain the 2-month period prevalence of psychosis in Gloucester City, to investigate the level of need among those in contact with mental health services, and to identify the compromises which are involved in routine collection of data to inform services, compared with specifically funded research studies.  Method  People with ICD-10 diagnosis of functional psychosis were identified by searching General Practice and mental health service records in Gloucester City. The needs of the sub-sample in touch with mental health services were assessed using the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS).  Results  Four hundred and seventy-four cases were identified, including 403 in contact with mental health services. Staff CANSAS data were collected for 225 patients, with a mean rating of 7.0 met and 3.6 unmet needs per patient. Unmet need was higher in the non-Caucasian group.  Conclusions  In this locality, patients with functional psychosis were largely in contact with mental health services, were in employment, were disproportionately looked after by a few City centre General Practitioners, and high levels were in supported accommodation. Higher levels of need were found than previously demonstrated. Systematic assessment of needs with research instruments to contribute to locality service planning is possible without a major research grant, but involves compromises on established research designs.

Key words  local mental health services – assessment

Introduction

The planning, provision and evaluation of local mental health services should be based on evidence. Three types of evidence have been proposed for assessing the needs of the catchment area population: current service use, population-based morbidity, and local needs assessment (Slade and Glover 2000).

The advantages of considering current service use are that data are normally relatively easily available, with a nation-wide coverage. This availability makes it suitable for national use in constructing needs indices. Service activity data can be supplemented with additional questions to provide relevant data for some questions. For example, repeatedly gathering data about the pressure on in-patient mental health services in London produced evidence which kept mental health services in London, England, high on the political agenda (Audini et al. 1995). The problem with this approach is that it is very influenced by the power of the individuals and organisations involved, and inevitably leads to an inequitable and non-evidence based distribution of resources.

A perspective which is independent of service activity is provided by epidemiological surveys of population-based morbidity, such as the Epidemiologic Catchment Area study in the USA (Regier et al. 1984) and the national Psychiatric Morbidity Study in the United Kingdom.
Kingdom (Jenkins et al. 1997a). These give precise estimates of the overall prevalence of the more common mental disorders, but are inefficient for investigating more severe mental disorders, partly because of low baseline prevalence, and partly because the socially marginal life associated with some mental health problems makes systematic under-representation likely. This can be addressed through the use of ‘Booster’ samples, by including all patients in contact with mental health services (Jenkins et al. 1997b), or the use of more sophisticated sampling approaches such as capture-recapture methods (Hay and McKeganey 1996).

The third type of data involves aggregating data from the catchment population. This can take two forms – either using existing local and national data to estimate the mental health needs of the population, or by directly surveying the views of the relevant population subgroup. Examples of the former include the Jarman deprivation index, developed on the basis of consensus between General Practitioners about patient characteristics associated with high use of primary care services (Jarman 1983), and statistical models quantifying the relationship between social variables measured in censuses and service use (Glover et al. 1998). The second approach involves identifying the views of local people, and using these data in aggregated form to inform service planning (Smith 1998). This approach is least researched, but may be most in line with the social and political focus on consumerism, flexible local configurations of services, and individualised mental health care.

The actual prevalence of mental disorders in apparently similar catchment areas will always differ from any estimate based on broader populations, due to local factors such as resettlement programmes and hostel distribution, voluntary sector services, the history of services in the area, etc. Furthermore, the needs of people with any individual mental disorder may be very diverse, so a prevalence estimate is inadequate for service planning. Therefore, at a local level the ideal approach would be to identify all people with a specific mental health disorder, systematically survey their needs, and aggregate the results. The difficulty is that this is potentially an expensive and time-consuming endeavour. Using the methods of well-funded national research studies would maximise the quality of data, but compromises are necessary if needs assessment is to be feasible at a local level.

The Gloucester Caseload Project (GCP) involved a local needs assessment, which integrated the rigour of research with the realities of resource-limited routine practice. The objective of the GCP was to translate the methods of well-funded epidemiological studies into a form suitable for local use, where minimal extra resourcing is available. The three specific aims were to ascertain the 2-month period prevalence of psychosis in a defined catchment area, to assess the needs of current service users, and to identify the compromises which are involved in routine collection of data to inform services, when compared with specifically funded research studies.

Subjects and methods

Setting

The investigation was carried out in the Gloucester and South Tewkesbury Primary Care Group, which includes the city of Gloucester and its environment. The total population in 2000 was 145,501. Historically, the two main county asylums were based in Gloucester City, and many long-stay patients were rehoused locally in the large supported lodgings scheme run by Social Services (total 245 places). Current psychiatric services include a 22-bedded acute ward for the locality, with 12 rehabilitation beds and 34 hostel beds serving Gloucester and the two other localities within the Trust. A psychiatric day hospital, a Clubhouse, a sheltered employment unit and a range of Social Services and charitable day centres operate within the city. At the time of this study, locality community health services included two consultant-led community mental health teams and a community rehabilitation team.

Resources

This study was a partial replication of the PRISM Psychosis Study, a well-resourced study involving total case ascertainment for two South London Boroughs (Thornicroft et al. 1998). Limited resources were formally designated to the GCP. These included the salary and costs of the project manager, who was line-managed by the Trust Development Manager, and based in the locality day hospital with the locality services manager (RH). There was some (< £ 2,500) funding for data entry, and information technology costs, and the Trust made available limited additional resources and finances to the locality team managers to reflect overtime and additional staffing needs resulting directly from keyworker participation. The GCP was managed by a steering group, which included user and carer input, staff from Health and Social Services and local non-statutory mental health groups.

Sample

Patients were aged 18–65 years, and had an address in the locality between July and August 2000. Diagnostic criteria were taken from the PRISM Psychosis Study (Davies et al. 1996): lifetime diagnosis of functional psychosis, including ICD-10 codes for schizophrenia, schizoaffective disorder, delusional disorder, manic depressive disorder, psychotic depression, but excluding depression without psychotic symptoms. Unlike the PRISM Psychosis Study, clinical diagnoses were not confirmed by research diagnoses. In-patients and hostel patients were included. People with learning disability and psychotic illness were also included, but results were considered separately and are not reported here.

Case identification

Potential subjects were identified by direct approach to all Health, Social Services and other specialist mental health workers in the locality, including staff in Social Services and charitable day centres, and day hospital staff. The project manager contacted all 21 General Practitioner (GP) practices in the locality, and working in conjunction with practice managers and interested General Practitioners, used primary care electronic record systems and a structured search routine considering diagnosis and treatment, to identify all cases of psychosis in contact with primary care services. The number of cases known to primary care services, but not receiving specialist mental health care was thus recorded, but there was no direct contact with such cases, and patient details were not removed from individual practices.