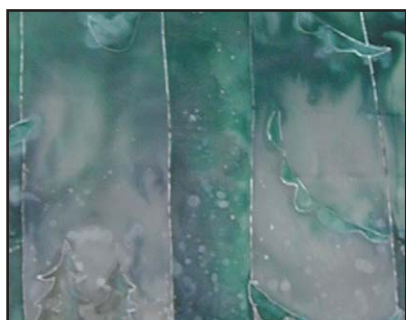


*National Institute for
Mental Health in England*

Cases for Change

Emerging Areas of Service Provision



Cases for Change

Mental health services in England are experiencing a period of unprecedented change. The pace of this change is potentially matched only by the pace at which information about both effective and less effective practice in mental health care is emerging. Over the past five years an incredible wealth of published literature has continued to remind all those engaged in developing mental health services of the reasons why fundamental change is necessary and of how services might be improved to better meet the needs of service users.

In addition to the evidence emerging from the research literature, it is important to recognise the role that publications appearing beyond the peer-reviewed journals have also had in informing the many cases for change that exist in adult mental health care today. These include publications reporting non-research based service reviews and the expert opinion of groups and organisations representing the interests of mental health service users, carers and professionals.

For those engaged daily in supporting change in local mental health services it can be difficult to feel well informed of the context of evidence and opinion within which current mental health policy has been established. With this in mind, in late 2001 the National Institute for Mental Health in England (NIMHE) commissioned a review of recent literature on adult mental health services with a view to producing an accessible summary of the emerging cases for change.

Cases for Change comprises ten booklets.

- **Introduction:** describes the background and methodology of the review and also summarises the findings and suggests areas for future research/policy development.
- **Policy Context:** describes the context of the review with an overview of recent mental health policy.

The following seven booklets each consider a different aspect of mental health service provision:

- **Primary Care**
- **Community Services**
- **Hospital Services**
- **Forensic Mental Health Services**
- **Partnership Working Across Health & Social Care**
- **User Involvement**
- **Anti-discriminatory Practice**
- **Emerging Areas of Service Provision:** reviews the literature that does not fit neatly into any of the previous topics.

The review collates evidence from over 650 documents published between January 1997 and February 2002 concerning adult mental health service delivery and/or policy in England. With the information collected synthesised into a number of key themes or issues, the review aims to describe how we got to where we are today and sets out the cases for change from the evidence base.

The articles highlighted at the beginning of each booklet as The Nature of the Evidence are those that are particularly relevant to the cases for change cited in the booklet concerned. Each document within the review has been classified using the "hierarchy of evidence" adopted in the *National Service Framework for Mental Health (NSF)* (Department of Health, 1999a):

- Type 1 evidence represents at least one good systematic review, including at least one randomised controlled trial.
- Type 2 evidence represents at least one good randomised controlled trial.
- Type 3 evidence represents at least one well-designed intervention study without randomisation.
- Type 4 evidence represents at least one well-designed observational study.
- Type 5 evidence represents expert opinion, including the opinion of services users and carers.

At the end of each of the main booklets, there are critical commentaries by service users and practitioners/managers/policy analysts from across England. These commentaries are intended to emphasise that different groups of people have different priorities and identify different cases for change. All contributors have been encouraged to be as challenging as possible and, where they disagree with interpretations, to say so.

Each booklet can be read independently or alongside one another to bring together a full picture of the development of mental health services. We hope this will be helpful in enhancing our understanding of the history as well as emphasising the need to develop future individual services within the context of an integrated system of care and support.

Cases for Change should be seen as a starting point and as a means to an end rather than an end in itself. By summarising the key issues that have emerged from the literature and by emphasising the diversity of opinion that exists within mental health services, Cases for Change may help to encourage debate about the best way forward and the way in which different view points can be balanced to achieve mutually beneficial outcomes.

Cases for Change has been written by a multi-disciplinary research team based at

the University of Birmingham with the active support and encouragement of Susannah Rix at NIMHE Eastern, the guidance of the Expert Panel, and service users and practitioners who have provided written commentaries for the main sections of the review. Our thanks also to colleagues in the mental health group at the Department of Health for their editorial input to help finalise the publication.

The research team comprised:

- Jon Glasby, a qualified social worker and a lecturer at the Health Services Management Centre.
- Helen Lester, a GP, national primary care career scientist and Co-Director of the University of Birmingham's Interdisciplinary Centre for Mental Health.
- James Briscoe, a consultant psychiatrist and senior lecturer in the University of Birmingham's Department of Primary Care.
- Marion Clark, a former teacher who worked on this study as a user consultant.
- Steve Rose, Library and Information Services Manager at the Health Services Management Centre at the time of this review and now Health Care Libraries Manager, University of Oxford.
- Liz England, a clinical research fellow in the University of Birmingham's Department of Primary Care.

Four Seasons

These original artworks were designed and painted by a team at The Hollies in Ipswich, Suffolk. Working together the group generates ideas, energy and input. The community spirit engendered provides a platform that allows creativity to shine through. The group experience builds confidence and develops a sense of esteem. *"This kind of work may not cure our problems, but this is the first year I have not been admitted to hospital"*.

The Hollies is a Social Enterprise developing meaningful work opportunities for people who have used mental health services. Social Enterprise can and does create real jobs. The pictures illustrate a theme of constant change and renewal in nature. They reflect the changes that can evolve through Social Enterprise and working together.

For more information, contact Jeremy Beckett, Local Health Partnerships NHS Trust on 01473 329093 or email jeremy.beckett@lhp.nhs.uk

Emerging Areas of Service Provision

In addition to more traditional forms of services provision such as hospital services or primary care, this review concludes with a consideration of four emerging areas of policy and practice:

- Support services for carers.
- Direct payments.
- Responses to deliberate self-harm.
- The role of new technology.

These “miscellaneous” issues were recurring and important themes but did not fit neatly into any of the previous topics.

Support Services for Carers

The Nature of the Evidence

	Number of Articles
Type I	0
Type II	0
Type III	0
Type IV	3
Type V	8

Background

In 2001, the Department of Health and the National Schizophrenia Fellowship launched their Commitment to Carers campaign to coincide with National Carers Week (Department of Health/National Schizophrenia Fellowship, 2001). Figures published by the National Schizophrenia Fellowship (n.d.) suggest that almost one in four of Britain's 5.7 million carers (22% or 1.26 million people) are caring for someone with a mental health problem, often with limited support from statutory services.

In recent years, the needs of carers have been increasingly recognised by health and social service providers following a series of influential research studies and a range of government initiatives. In 1990, the *NHS and Community Care Act* provided the first official acknowledgement of the substantial role played by informal carers, and made support for carers a key priority (Department of Health, 1989). This was followed in 1995 by the *Carers (Services and Recognition) Act*, which gave people

Figure 1 The Impact of Caring

Hill et al's (1998) survey of 1113 carers of people with manic depression found that many participants saw caring as having a negative effect on their friends and social life, with some also reporting a negative impact on their own self-esteem, their family relationships and their work/work prospects.

Huang and Slevin's (1999) review of the literature on carers who live with someone who has schizophrenia suggests that many carers may experience:

- Physical problems (such as sleeping problems, headaches and chest tightness).
- Social difficulties (such as economic problems, stigma, social alienation and loss of leisure time/employment).
- Relationship difficulties (such as the disruption of family life, marriage problems or loss of friends).
- Psychological or emotional difficulties (such as anxiety about the future, grief reactions, mental health problems such as depression, loneliness and loss of motivation).

Leavey et al's (1998) study of 50 carers in north London found that 56 per cent saw caring as moderately stressful and 36 per cent considered it very stressful. Fifty-six per cent sometimes felt unable to cope with the person being cared for and 20 per cent often felt unable to cope.

In one evaluation of voluntary family support workers, interviews with 62 carers revealed the stressful nature of caring (Weinberg and Huxley, 2000, pp.500-501). Of the 62 people, 21 had consulted their GP for help with an emotional problem in recent months and a further 20 had received treatment for a potentially stress-related illness (such as high blood pressure, chest pains and palpitations). Carers also reported significant restrictions on their social and leisure activities, hidden expenses, a lack of understanding from family or friends and difficulties engaging in paid employment.

'Black' carers may have particular unmet needs as a result of culturally insensitive services and the difficulty of obtaining information in languages other than English (Arshad and Johal, 1999).

providing care on a regular basis to someone eligible for community care services the right to an assessment of their own needs as a carer (Department of Health, 1996). More recently, the first ever national strategy for carers has underlined the government's commitment to improving information, support and care for carers (Department of Health, 2000e), while the *Carers and Disabled Children's Act 2000* has enabled local authorities to provide a greater range of support services for carers (Department of Health, 2001k, l). Supporting carers is also a key feature of the National Service Frameworks for Mental Health and for Older People (Department of Health, 1999a, 2001m). Despite this emphasis on the needs of carers, there is evidence from the wider literature to suggest that such policy measures have not always been translated fully into practice:

1. A large body of research demonstrates

that carers may be unaware of their rights to an assessment of their needs, that they may feel unsupported in their role as carers and that health and social care agencies may not always perceive support for carers as a high priority compared to support for service users (see, for example, Henwood, 1998; Holzhausen, 1997).

2. Particular groups may not necessarily view themselves as 'carers' and may therefore not access available services. This is especially the case for young carers, older people, people from ethnic minorities and the carers of people with mental health problems (Department of Health/Social Services Inspectorate 1997, 1998a, 1998b; Heron, 1998; Rogers, 2000).
3. With regard to the carers of people with mental health problems, services tend to focus on the service user, rather than on their carer(s). Where carers are considered, this is often from the

Emerging Areas of Service Provision

perspective of trying to improve the mental health of the service user rather than an attempt to view the carer as a distinct and separate person with their own needs (Atkin, 1992; Heron, 1998; Perring et al., 1990). A number of studies have explored the pressures and problems that carers can face as a result of factors such as (Heron, 1998; MacInnes, 2000; Wright et al., 2000):

- Challenging and/or violent behaviour.
- Possible substance misuse.
- Suspicion and paranoia.
- The fluctuating needs of the person being cared for.

Cases for Change

Against this background, only 11 of the articles included in this review refer specifically to the support needs of the carers of people with mental health problems. Around half of people with severe mental illness live with family or friends, some of whom may experience demanding behaviours, extra financial burdens, restrictions upon their social or family life and, sometimes, a risk to their own safety. Despite this Wright et al's (2000) thematic review of NHS-funded research suggests that there are significant variations in terms of the amount of support available to carers, with many not receiving the services they need to continue in a caring role or to maintain their own health. This is echoed by a number of other commentators, who suggest that the contribution of carers is often undervalued and their needs unrecognised (see, for example, Allen, 1997a, p.34):

"Carers are the invisible corner-stone of community care. For the relatives and friends of someone with a severe and enduring mental health problem, community care represents a 24-hour burden with serious, often unacknowledged consequences."

It is clear that caring for someone with a mental health problem can have significant implications for almost every aspect of daily life, such as increasing self-confidence and putting other issues into perspective, as well as the potential impact on the carer's family and social life, work and health (see figure 1).

In response to these issues, carers have expressed a desire for a range of support services to enable them to carry on in their

caring role (see figure 2). In Leeds, a carers' support service has identified the importance of emotional support, respite, advocacy, 24-hour crisis support and good quality information (Allen, 1997a). Also in the north of England, an evaluation of voluntary sector family support workers found that carers valued the workers as a counselling, information, listening and advocacy resource, providing both emotional and practical support (Weinberg and Huxley, 2000). Similar findings have also emerged from Hill et al's (1998) study of the carers of people with manic depression. When asked to rate the importance of 17 areas of need and whether they had experienced any difficulties in accessing services in these areas, the carers concerned gave a very clear indication not only of the support they wanted, but also of the significant unmet need which continues to exist.

Crucially, many of the priorities expressed by carers are also highly valued by service users – information, being involved by professionals (see the User Involvement booklet) – and it may well be that a good quality service for users is also a good quality service for carers.

Similar issues have also been raised by Huang and Slevin (1999, pp.91-92) in their review of the literature on the carers of people with schizophrenia. According to this review, carers particularly value:

- Advice and guidance on the use of medication.
- Education in the use of cognitive and behavioural strategies.
- Education of total family regarding the need for family support.
- Contact information on external support groups.
- Family and individual counselling if required.
- Education about schizophrenia to improve family knowledge.

- Practical advice and guidance, including financial advice.
- Education on the use of stress-management techniques.
- Access to adequate respite services.
- 24-hour access to professionals in emergencies.
- Carer and client involvement in care planning.
- Access to multi-disciplinary services via a keyworker.
- Access to specialist mental health services when required.

As with user involvement, ensuring that services are responsive to the needs of carers is likely to require an explicit commitment to carer involvement, both in designing individual care packages and in shaping services more generally. As an example of the importance of carer involvement, Allen (1997a) describes the development of a carers' service in south Leeds, emphasising the following guiding principles:

- The participation of carers in service provision, service development and service evaluation.
- Involvement that gives carers the power to influence policy and practice.
- Carer-led rather than service-led provision.
- Commitment to a continuing process rather than a one-off activity.
- Flexibility in the face of diverse and potentially conflicting needs of users and carers.
- The strategic development of carer involvement in all aspects of the agency's work.

Further Information

In response to the relative lack of evidence regarding the carers of people with mental health problems, the NHS Service Delivery and Organisation Programme has commissioned a series of research studies

Figure 2 Carers' Priorities

Top Five Services Desired by Carers	% rating as a high priority	% reporting difficulty accessing service
24-hour professional support 7 days/week	67	67
Information about illness	61	55
Opportunity to learn personal coping strategies	41	70
Regular updates from professionals	35	60
More education about manic depression	31	53

to examine the needs of carers of people with mental health problems (for further information see www.sdo.lshtm.ac.uk).

Other useful resources include:

- The Department of Health carers website (www.doh.gov.uk/carers).
- Material for carers published by key voluntary agencies such as the National Schizophrenia Fellowship (1998, 2000).
- Carers UK (2002a, 2002b) has produced a number of studies on the needs of carers. This includes the recent study reported in the critical commentary below, Adding Value. For further information, contact Carers UK via 020 7566 7626 or access a free summary of the report via www.carersonline.org.uk

Critical Commentary: Carers

Three in five of us will become carers at some point in our lives and new figures from the ONS reveal that one in six adults, 6.8 million people in Britain and more than 7 million in the UK, are a carer (Carers UK, 2002a; Maher and Green, 2002). Approximately 1.5 million adults care for someone with a mental health problem. It is staggering to think that carers across the UK save the state £57.4 billion pounds a year – equal to a second NHS (Carers UK, 2002a).

The importance of taking a break from caring cannot be over-stated. That caring takes its toll on carers' own health is clear. More than two thirds of carers providing full time care say they have experienced ill-health as a result of caring. Over half of carers responding to one Carers UK study had sustained a physical injury and 52% had been treated for a stress-related illness since becoming a carer (Henwood, 1998).

Carers who are not able to take a break are twice as likely as other carers to suffer from mental health problems themselves (Singleton et al., 2002). And yet appropriate, accessible, affordable and flexible respite services for people who have a mental health problem are difficult to find, particularly given the often unpredictable and episodic nature of mental health problems.

The experience of the carers' service in Leeds, in involving carers in setting up appropriate services, has been reflected in recent research from Carers UK (2002b). The study, Adding Value, found that carers' frustration at the lack of services, and the difficulty in accessing information about them, drives carers to become involved in every aspect of service planning, delivery and evaluation in both statutory and voluntary organisations at a local level.

Too often carers feel that their contribution goes unrecognised and unsupported. It is vital that we recognise the value of the contribution that carers make, not only to the care of the person they care for, but also to the health and well-being of other carers in their communities and to society as a whole.

Vicky Pearlman, Carers UK

References

- Allen, C. (1997a) Somebody cares, *Health Service Journal*, 107(5558), 34-35
- Arshad, J. and Johal, B. (1999) Culture club, *Nursing Times*, 95(9), 66-67
- Atkin, K. (1992) Similarities and differences between informal carers, in J. Twigg (ed.) *Carers: research and practice*. London, HMSO
- Carers UK (2002a) *Without Us...? Calculating the value of carers' support*. London, Carers UK
- Carers UK (2002b) *Adding value: carers as drivers of social change*. London, Carers UK
- Department of Health (1989) *Caring for people: community care in the next decade and beyond*. London, HMSO
- Department of Health (1996) *Carers (Recognition and Services) Act 1995: policy guidance and practice guidance*. Wetherby, Department of Health
- Department of Health (1999a) *National service framework for mental health: modern standards and service models*. London, Department of Health
- Department of Health (2000e) *Caring about carers: a national strategy for carers (2nd ed.)*. London, Department of Health
- Department of Health (2001k) *Carers and Disabled Children's Act 2000: carers and people with parental responsibility for disabled children - policy guidance*. London, Department of Health
- Department of Health (2001l) *Carers and Disabled Children's Act 2000: carers and people with parental responsibility for disabled children - practice guidance*. London, Department of Health
- Department of Health (2001m) *A national service framework for older people*. London, Department of Health
- Department of Health/National Schizophrenia Fellowship (2001) *A commitment to carers*. London, National Schizophrenia Fellowship
- Department of Health/Social Services Inspectorate (1997) *Young carers: something to think about*. London, Department of Health
- Department of Health/Social Services Inspectorate (1998a) *Young carers: making a start*. London, Department of Health
- Department of Health/Social Services Inspectorate (1998b) *A matter of chance for carers? Inspection of local authority support for carers*. London, Department of Health
- Henwood, M. (1998) *Ignored and invisible? Carers' experience of the NHS*. London, Carers National Association
- Heron, C. (1998) *Working with carers*. London, Jessica Kingsley
- Hill, R.G., Shepherd, G. and Hardy, P. (1998) In sickness and in health: the experiences of friends and relatives caring for people with manic depression,

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Journal of Mental Health, 7(6), 611-620

Holzhausen, E. (1997) *Still battling: the Carers Act one year on*. London, Carers National Association

Huang, M.C. and Slevin, E. (1999) The experiences of carers who live with someone who has schizophrenia: a review of the literature, *Mental Health and Learning Disabilities Care*, 3(3), 89-93

Leavey, G., Healy, H. and Brennan, G. (1998) Providing information to carers of people admitted to psychiatric hospital, *Mental Health Care*, 1(86), 260-262

MacInnes, D. (2000) Interventions in forensic psychiatry: the caregiver's perspective, *British Journal of Nursing*, 9(15), 992-997

Maher, J. and Green, H. (2002) *Carers 2000*. London, TSO

National Schizophrenia Fellowship (1998) *Caring and coping: a resource pack for new carers*. London, National Schizophrenia Fellowship

National Schizophrenia Fellowship (2000) *Carers' assessment pack*. London, National Schizophrenia Fellowship

National Schizophrenia Fellowship (n.d) *Carers facts and figures*. Available online at www.nsf.org.uk (accessed 26/06/01)

Perring, C., Twigg, J. and Atkin, K. (1990) *Families caring for people diagnosed as mentally ill: the literature re-examined*. London, HMSO

Rogers, H. (2000) Breaking the ice: developing strategies for collaborative working with carers of older people with mental health problems, in H. Kemshall and R. Littlechild (eds) *User involvement and participation in social care: research informing practice*. London, Jessica Kingsley

Singleton, N., Maung, N.A., Cowie, A., Sparks, J., Bumpstead, R. and Meltzer, H. (2002) *Mental health of carers*. London, TSO

Weinberg, A. and Huxley, P. (2000) An evaluation of the impact of voluntary sector family support workers on the quality of life of carers of schizophrenia sufferers, *Journal of Mental Health*, 9(5), 495-503

Wright, S., Bindman, J., Thornicroft, G. and Butcher, M. (2000) *Thematic review of NHS R&D funded mental health research in relation to the National Service Framework for Mental Health*. London, Institute of Psychiatry

Direct Payments

The Nature of the Evidence

	Number of Articles
Type I	0
Type II	0
Type III	0
Type IV	0
Type V	2

Background

In 1996, the *Community Care (Direct Payments) Act* gave SSDs the power to make cash payments to disabled service users between the ages of 18 and 65 in place of directly provided services. In many ways, the Act was an important victory for the disability movement, which had been campaigning for direct payments for many years (see Glasby and Littlechild, 2002 for an overview). In particular, direct payments have been found to lead to:

- More responsive services and increased choice and control for service users.
- Improved morale and mental/psychological wellbeing.
- A more creative use of resources which may sometimes reduce costs, but which certainly ensures better value for money.

Cases for Change

Direct payments have yet to make a significant impact on mental health services. Only two of the documents included in this review refer to this relatively new way of meeting the needs of service users (see Brandon et al., 2000; Revans, 2000). According to some commentators, there may be as few as ten people with mental health problems receiving direct payments in the whole of the UK (quoted in Revans, 2000, p.12), and even this low estimate has

risen substantially from the four direct payment recipients described in an earlier study by Brandon et al. (2000). Although research into this topic is urgently required, anecdotal evidence suggests that key barriers to receiving direct payments may include:

- The emphasis of the 1996 Act on the needs of people with a physical impairment.
- A lack of information for users, carers and staff.
- A lack of knowledge about direct payments among service users, staff and carers.
- Low expectations of social services due to previous poor experiences.
- A tendency for people with mental health problems to have contact with the NHS (where direct payments are not available) rather than with social services.
- High eligibility criteria for access to social services, with some service users feeling that they have to be almost 'sectionable' before they receive any support.
- Difficulties which people with mental health problems may have managing money when ill and an awareness of being perceived as people not trusted to take care of themselves.
- The lack of other mental health service users using direct payments elsewhere.

Although based solely on the experience of a single person and therefore not included as an article in the main body of this review, a particularly powerful example of the benefits of direct payments for people with mental health problems comes from the testimony of a payment recipient living in a small village in Essex (Irish, 1998). After negative experiences with health and social care workers and adverse drug reactions, Hazel Irish (not her real name) describes how she was "virtually a zombie", unable to get out of bed, wash or dress by herself (Irish, 1998, p.28). After beginning to receive direct payments, she began to get help with cleaning her home and getting out of

the house. Hazel feels that direct payments are a major step forward (see figure 3).

Further Information

For agencies and service users seeking to find out more about direct payments and mental health, there are a number of key developments:

- The National Centre for Independent Living (NCIL) has produced a guide to direct payments for people with mental health problems (NCIL, n.d.), which is available via the NCIL website (www.ncil.org.uk).
- The Institute for Applied Health and Social Policy at Kings College is in the process of developing a three-year pilot scheme to promote direct payments for people with mental health problems in five pilot sites in England.
- The Scottish Executive's Central Research Unit has commissioned research into the barriers to direct payments for people with mental health problems (Ridley and Jones, 2002).

Figure 3 Direct Payments and Mental Health

"I benefit a lot from Direct Payments. The idea of getting cash you can control is brilliant... Instead of a social worker or nurse dictating what I can and cannot do, it gives me real control. If I'm going to get back to being me again, I can't achieve that with someone bossing me about... I'll fight to get more control over my life. Now that I have more energy and can think more clearly I want to direct what happens to me more and more."

(Irish, 1998, p.32)

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Critical Commentary: Direct Payments

Where I live – in Hampshire – Direct Payments has a long and successful history. People with physical disabilities campaigned vigorously to be let out of residential homes to live independent qualitative lives aspiring to what others take for granted. I take heart from this, which always lifts my depression.

But I plummet again when being told by so-called 'care' professionals why mental health users can't have a direct payment. Two reasons for non-compliance of mental health workers with direct payments legislation I've experienced are:

- That risk is always a negative concept and direct payments is viewed in these negative terms instead of facilitating a positive risk for positive change.
- That user's employing Personal Assistants or agency workers will create a new kind of dependence. I would feel so much better with help getting things done, alleviating the worry, stress and guilt of being unable to manage. Why can't I 'manage' this in my own home/life – others do at home and at work!

What I would like to see is mental health workers realising that they have institutionalised beliefs. That having direct payments in their toolbox can help promote independence, allow creative use of resources and aid recovery. I know which group of people I choose to be with to aid my own mental health!

Tina Coldham
Mental Health Service User Consultant

References

- Brandon, D., Maglajlic, R. and Given, D. (2000) The information deficit hinders progress, *Care Plan*, 6(4), 17-20
- Glasby, J. and Littlechild, R. (2002) *Social work and direct payments*. Bristol, Policy Press
- Irish, H. (1998) Direct payments, *Breakthrough*, 2(3), 27-32
- NCIL (n.d.) *Direct payments for mental health users/survivors*. www.ncil.org.uk/dpays_mh_users.asp (accessed 18.10.01)
- Revans, L. (2000) Payments reform stalls, *Community Care*, 1341, 12
- Ridley, J. and Jones, L. (2002) *"Direct what" – a study of direct payments to mental health service users*. Edinburgh, Scottish Executive Central Research Unit

Responses to Deliberate Self-Harm

The Nature of the Evidence

	Number of Articles
Type I	2
Type II	4
Type III	0
Type IV	7
Type V	0

Background

Deliberate self-harm (DSH) is a growing phenomenon and is thought to be the main reason for hospital admission in women and the second main reason for men, costing the NHS around £45-50 million each year (see Hawton et al., 1998; NHS Centre for Reviews and Dissemination, 1998 for all statistics quoted in this paragraph). Since the 1960s, the incidence of DSH has increased significantly, reaching an estimated rate of around 400 per 100,000 population - a figure which is higher than most other countries in Europe. Of those who present to general hospitals in the UK after DSH, at least 1 per cent kill themselves within a year and 3 to 5 per cent do so within five to ten years. Despite this, DSH remains under-researched and services have tended to be poorly organised.

In response to the increasing rate of DSH, a series of guidelines have been published by the Department of Health and Social

Security (1984), the Royal College of Psychiatrists (1994) and the Health Advisory Service (Williams and Gethin Morgan, 1994). These are not evidence-based, but do at least provide some professional consensus about best practice.

Cases for Change

Unfortunately, research to date suggests that these guidelines have not been implemented (see, for example, Butterworth and O'Grady, 1989; NHS Centre for Reviews and Dissemination, 1998; Slinn et al., 2001; see also figure 4).

Building on a previous systematic review by Hawton et al (1998), a review conducted by the NHS Centre for Reviews and Dissemination (1998) highlights the following limitations in existing literature:

- Most literature on DSH is based on studies of hospital attenders, yet many episodes of DSH may not lead to medical contact at all.
- Most research has focused on deliberate self-poisoning and data may not necessarily be generalisable.
- The methodological quality of some studies has been poor and there is insufficient evidence to recommend a specific clinical intervention.

Few of the studies contained in the Cases for Change review explored the experiences of individual service users who have harmed themselves or explored what patients would like from services. While we are aware that a range of user groups and voluntary organisations have produced material which focuses to a much greater extent on the needs and wishes of service users, these documents do not seem to have been cited in the studies contained within this review.

A further limitation is not considering the motivation of the individuals concerned. At the moment, the literature in this review fails to distinguish between those people who attempt to commit suicide and those who harm themselves for a different reason (such as feeling that the sense of release offered by self-harm is the only way they can cope with a particular situation). These two phenomena are qualitatively very different and the failure to distinguish between attempted suicide and self-harm is a major shortcoming in the existing literature. While further research is required, three approaches are described by the NHS Centre for Reviews and Dissemination (1998, pp.5-7) as "promising":

- Providing patients with a crisis card which gives advice about seeking help in the future when experiencing suicidal feelings (see also, Evans et al., 1999, 2000).
- Problem-solving therapy to enable patients to acquire basic problem-solving skills.
- Dialectic behaviour therapy (an intensive form of individual therapy for people who engage in chronic repetitive self-harm).

In addition, Hawton et al's (1998) systematic review suggests that depot neuroleptic medication (flupenthixol) may have a positive impact on DSH repetition rates, but that further research is required to explore this option in more detail.

Following the publication of Hawton et al's (1998) review, more recent documents included in the Cases for Change review have highlighted a number of additional issues. For example:

- A nurse-led DSH assessment service may be able to enhance relationships with the local poisons unit and reduce the workload of junior doctors without comprising training needs (Griffin and Bisson, 2001).
- Many patients presenting to medical services following DSH may not receive a follow-up via an outpatients' appointment, but do have high levels of contact with their GP. This suggests that primary care may be an important environment for targeting DSH (Crawford and Wessley, 2000).
- A randomised controlled trial of brief psychological interventions after deliberate self-poisoning concludes that this may be a valuable treatment (Guthrie et al., 2001). In the trial, those patients who received the intervention

Figure 4 National Survey of Hospital Services for the Management of DSH

Slinn et al's (2001, p.53) national survey of 129 mental health-providing NHS Trusts suggests that "standards for deliberate self-harm services fall substantially below existing national guidelines, particularly in the areas of planning and training." Contrary to the guidelines, the survey found that:

- Only 70% of cases of DSH are assessed by psychiatric services.
- Only 69% of participants have a designated ward for admitting most DSH cases.
- Only 60% have a DSH policy document.
- Only 59% of psychiatric nurses and 26% of social workers are trained to carry out DSH assessments.
- Only 52% have dedicated DSH liaison staff.
- Only 42% have a DSH planning group.

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were more satisfied with their treatment than those in the control group, were less likely to report repeat attempts to harm themselves and had a significantly greater reduction in suicidal ideation.

- Setting up a specialist DSH team – a requirement of the 1984 and 1994 guidance cited above – may improve the quality of assessment (Whyte and Blewett, 2001).

Finally, an exploratory study by Gournay and Bowers (2000) provides an extremely powerful illustration of the importance of improving services for people who harm themselves. Drawing on 31 cases of suicide/DSH where legal action was being taken against NHS Trusts and where the first author was asked to provide expert legal opinion, the study provides a 'snapshot' of the cases in question. Of the 31 case studies, 12 people committed suicide and 19 carried out serious acts of self-harm. Of the former, methods of suicide included jumping through ward windows, hanging, jumping under a car/train, drowning and jumping from a roof. In a significant number of cases there were contributing factors that could, arguably, have been addressed before the incident took place. For example:

- Environmental factors contributed to a number of cases. While seven of the 31 cases involved patients jumping through ward windows (six of which were not reinforced), the number of people who hanged themselves, drowned themselves or jumped from roofs raises issues about access to various areas of hospital wards.

- Seventeen cases involved nurses being instructed to be within sight of the patient at all times but not adhering to these instructions.
- Staff shortages were a contributing factor in at least six cases, although this may be an underestimate.

Overall, the researchers conclude with a poignant reminder of the human costs of a failure to respond appropriately to the needs of people who harm themselves:

"Each case in our series has resulted in enormous distress for all concerned. In many cases, the devastating consequences of the events will continue indefinitely. Although the financial cost of this case series alone may run into, literally, millions of pounds, this monetary outcome pales into insignificance when set against the effect on patients, their carers and families." (Gournay and Bowers, 2000, p.131)

Further Information

- For further information on DSH, the systematic review carried out by the NHS Centre for Reviews and Dissemination (1998) provides a concise and accessible introduction to the policy context, existing services and the effectiveness of different types of intervention, as well as highlighting a series of implications for practice and research.
- Additional material is available from the Bristol Crisis Service for Women, who produce a series of information leaflets, workbooks, training resources and other publications. The Service's website also

provides links to a number of other resources across the UK and beyond (www.users.zetnet.co.uk/BCSW/index).

- The government launched the *National Suicide Prevention Strategy for England* in September 2002. Over 300 million will be invested over the next three years in community mental health services as part of this strategy, which will be implemented by the National Institute for Mental Health (Department of Health, 2002d).

Critical Commentary: Self Harm

There is a significant difference between self-injury, self-harm and suicide. Self-injury is the deliberate damaging of body tissue without the conscious intent to kill oneself. Self-harm is a wider concept which includes harmful behaviours that are repetitive and occur over time, but again is without suicidal intent. Attempts to classify self-harm are based on the severity of three concepts (lethality, frequency and time). Suicide is deliberate intent to end life. Most people who self-harm are still treated as a suicide risk. This can be obstructive, is defensive and is not necessarily appropriate. Unfortunately, much of the research cited above tends to lump self harm and suicide together.

What works? Well, the jury is out on dialectic behaviour therapy despite the claims that are made for it and despite some studies. Attempts not to limit self-harm, but to keep people safe appear to be as effective and more popular with users. People who self-harm are more likely than the general population to kill themselves, but feelings are different (i.e. they self-harm to feel better or to stay alive, they become suicidal because they lose hope and see no future). Often, it seems that a general human response by people who care and are interested to help in the long term (i.e. the specialist teams referred to in prior Department of Health guidance) can be useful. We also need a variety of approaches, not just medication. Indeed, there is very little evidence that medication does anything except offer some symptomatic relief. It does not deal with the underlying problems and issues.

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References

- Butterworth, E. and O'Grady, T. (1989) Trends in the assessment of cases of deliberate self-harm, *Health Trends*, 21(2), 61
- Crawford, M. J. and Wessely, S. (2000) The management of patients following deliberate self harm: what happens to those discharged from hospital to GP care?, *Primary Care Psychiatry*, 6(2), 61-65
- Department of Health (2002d) *National suicide prevention strategy for England*. London, Department of Health
- Department of Health and Social Security (1984) *The management of deliberate self harm*. HN(84)25; LASSL(84)5
- Evans, M.O., Morgan, H.G., Hayward, A. and Gunnell, D.J. (1999) Crisis telephone consultation for deliberate self-harm patients, *British Journal of Psychiatry*, 175, 23-27
- Evans, M.O., Morgan, G. and Hayward, A. (2000) Crisis telephone consultation for deliberate self-harm patients: how the study groups used the telephone and usual health-care services, *Journal of Mental Health*, 9(2), 155-164
- Gournay, K. and Bowers, L. (2000) Suicide and self-harm in in-patient psychiatry units: a study of nursing issues in 31 cases, *Journal of Advanced Nursing*, 32(1), 124-131
- Griffin, G. and Bisson, J.I. (2001) Introducing a nurse-led deliberate self-harm assessment service, *Psychiatric Bulletin*, 25(6), 212-214
- Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., Marino-Francis, F., Sanderson, S., Turpin, C., Boddy, G. and Tomenson, B. (2001) Randomised controlled trial of brief psychological intervention after deliberate self-poisoning, *British Medical Journal*, 323(7305), 1-5
- Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., van Heeringen, K., House, A., Owens, D., Sakinofsky, I. and Traskman-Bendz, L. (1998) Deliberate self-harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition, *British Medical Journal*, 317, 441-447
- NHS Centre for Reviews and Dissemination (1998) *Deliberate self-harm (Effective Health Care, volume 4, number 6)*. York, NHS Centre for Reviews and Dissemination
- Royal College of Psychiatrists (1994) *The general hospital management of adult deliberate self-harm: a consensus statement on standards for service provision (Council Report CR32)*. London, Royal College of Psychiatrists
- Slinn, R., King, A. and Evans, J. (2001) A national survey of the hospital services for the management of adult deliberate self harm, *Psychiatric Bulletin*, 25(2), 53-55
- Whyte, S. and Blewett, A. (2001) Deliberate self-harm: the impact of a specialist DSH team on assessment quality, *Psychiatric Bulletin*, 25(3), 98-101
- Williams, R. and Gethin Morgan, H. (eds) (1994) *Suicide prevention: the challenge confronted*. London, HMSO

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The Role of New Technology

The Nature of the Evidence

	Number of Articles
Type I	0
Type II	3
Type III	0
Type IV	2
Type V	8

Background

Throughout the twentieth century, technological changes have been crucial in shaping the provision of health and social care. In services for older people, for example, a range of advances have contributed to increased life expectancy, shorter hospital stays and a greater understanding of conditions such as dementia.

Cases for Change

More recently, technological developments have begun to raise new possibilities for the way in which mental health services are delivered. Examples include:

- Computer modelling.
- Telephone helplines.
- Computer-based self-help packages.
- Videoconferencing.

While few of these areas have been fully researched, there are a number of key documents exploring the implications of technological developments for mental health services. At the same time, the pace of technological change in wider society more generally makes this an issue that providers and policy makers should acknowledge and address.

Computer modelling:

From outside England, Kettles and Bryan-Jones (1998) describe how an acute psychiatric ward at Grampian Healthcare NHS Trust piloted a computer simulation programme to explore different ways of carrying out nursing observations of suicidal patients. In particular, the aim was to use new technology in order to free staff from

administration tasks and enable them to spend more time with patients. Overall, the authors conclude that the project was a success and report that the pilot has been extended to other adult acute mental health wards.

Telephone helplines:

These are able to provide accessible 24-hour support to mental health service users. In Rochdale, for example, a helpline for people with serious mental health problems was highly commended in the Nursing Times/3M National Nursing Awards (Taylor and Birtles, 1998). Another example is provided by NHS Direct (Steele, 2001), a generic telephone advice and information service which, from April 2000, established

Figure 5 Telephone Helplines

From December 1996, Rochdale Healthcare NHS Trust piloted a 24-hour telephone helpline for people with serious mental health problems receiving the Trust's complex aftercare services. During a three month evaluation, 47 calls were received - 41 of them out of normal office hours. Benefits of the support line were found to include a potential reduction of inappropriate admissions and of admissions under the Mental Health Act 1983, more responsive services (especially at times of crisis) and reduced anxiety for patients (Taylor and Birtles, 1998).

Although NHS Direct offers generic health advice and information, mental health issues account for between 2 and 7 per cent of all calls, with nurses suggesting that many more calls may have a mental health component. Despite this, mental health calls cause considerable anxiety for nurse advisers and raise a range of issues about training and education. In April 2000, a mental health project was set up to map and establish links with local mental health services, identify the competencies required by nurse advisers to deal more appropriately with mental health calls, develop training materials and review current decision support systems. Progress against the various aims of the pilot is described in an article by the project co-ordinator (Steele, 2001).

Figure 6 Beating the Blues

"Beating the Blues is an eight-session programme (each lasting about one hour), with 'homework' assignments between sessions. A key feature of the programme is its use of highly realistic, filmed material depicting fictional patients who undergo [cognitive behavioural therapy] for anxiety and depression and so serve as models for the real patient. In this way, we find, strong patient engagement and commitment is obtained... The programme has been designed to be user-friendly... and is readily usable by patients with no previous computer experience."

(Gray, 2000, pp.17-18)

a specific mental health project (see figure 5). Telephone helplines may also be particularly effective as a response to deliberate self-harm (see previous section on Responses to Deliberate Self-Harm).

Computer-based self-help packages:

These are felt by many to be a useful addition to the range of existing responses to mental health problems. In contrast to more traditional face-to-face contact between professional and service user, computer programmes enable the individual to gather information or receive therapy in private and at their own pace (Laurent, 2001). Examples of relevant packages include:

- Beating the Blues: developed by Dr Julie Proudfoot at the Institute of Psychiatry with two private sector companies, Ultrasis PLC and Psychology at Work Ltd, to deliver cognitive-behavioural therapy (see Gray, 2000 and figure 6).
- Restoring the Balance: developed by the Mental Health Foundation to be used in a primary care setting by the less sophisticated computer user (Laurent, 2001).
- COPE is a 12-week self-help system for depression with an introductory videotape and 9 booklets accompanied by 11 telephone calls to a telephone-operated computer system (Osgood-Hynes et al., 1998).

Despite this, there are a range of unresolved issues that will need to be addressed such as which package is most effective, cost-efficiency and whether this way of working will be acceptable to and accessible for all service users. In particular, there is a danger that technology-based

services will favour those who already possess computer skills, disadvantaging people from certain educational backgrounds or who do not have access to a computer.

In addition, the National Institute for Clinical Excellence has recently concluded that there is insufficient evidence at present to recommend the general introduction of computerised cognitive behavioural therapy for anxiety and depression into the NHS and that further work is needed before widespread usage can be condoned (for further information, visit www.nice.org.uk). However, NICE did agree at an appeal in July 2002 that the reappraisal of computerised cognitive behavioural therapy will be brought forward from the original agreed date of 2005.

Videoconferencing:

Sometimes referred to as telepsychiatry or telemedicine, this has been proposed as a means of improving communication and speeding up the assessment/referral process. This may be particularly relevant to geographically remote areas where access to specialist mental health services can be extremely limited (see figure 7). In North-

Figure 7 Telepsychiatry in Remote Areas

Although deriving from a non-UK source and excluded from the Cases for Change review, Mannion et al (1998) describe the use of a telepsychiatry project in the Aran Islands (located off the west coast of Ireland). Traditionally, the 53 psychiatric patients resident permanently on the islands have had very little access to mental health services, which could only be accessed by travelling to the mainland or by mental health professionals travelling to the islands. As a result, an audiovisual link was established between one of the islands and a hospital on the mainland to facilitate emergency consultations with a duty psychiatrist. Overall, Mannion et al (1998, p.49) conclude that "though the number of patients involved has been small, the link has worked well and proved both acceptable and accessible to the patients concerned." As a result, the authors discuss the possibility of extending the use of the audiolink to other specialisms such as plastic surgery or dermatology.

Figure 8 Advantages and Disadvantages of Telemedicine

One evaluation of a telemedicine service found that possible advantages included increased efficiency and convenience, reduced stigma and easy access to expert support for service users. However, possible disadvantages included:

- Professional concerns about the possible distortion of the doctor-patient relationship.
- The importance of face-to-face contact, body language and touch in encounters between service users and professionals.
- Improved access may mean that service users may be in a much more volatile emotional state when they are using the videophone than if they had waited to access psychiatric services face-to-face.
- Technical restrictions such as the need to stay within view of the other person and delays in the signal.
- A sense of the encounter being artificial and impersonal.
- How to respond if the service user at the other end of the videophone has a panic attack or threatens to harm themselves.

(May et al., 2000, 2001)

West England, for example, an evaluation of a telepsychiatry service for people with anxiety and depression found a range of benefits and limitations (May et al., 2000, 2001; see figure 8). In London, a more descriptive article explores the way in which videoconferencing was used to improve communication between an off-site acute psychiatric ward and a specialist psychiatric intensive care unit (Haslam and McLaren, 2000). Key tasks included:

- Referring patients to a specialist mental health service.
- Carrying out assessments.
- Monitoring patient progress.
- Providing continued care advice for patients discharged from the specialist unit.
- Carrying out case conferences.
- Providing educational support for the adult acute ward in managing disturbed patients.

- Ethical issues such as confidentiality.
- The potential for computer dependence/addiction.
- The tendency for people to behave differently online than they would face-to-face (e.g. people disclosing large amounts of information at an early stage due to the relative anonymity offered by a computer or people sending highly emotionally charged messages in the heat of the moment).

Further Information

For a further discussion of the potential contribution of new technology, Oravec (2000) explores the advantages and disadvantages of different types of online mental health care from an American standpoint, including e-mail counselling, online family therapy, Internet support groups and the Internet as a mental health information resource. Despite many advantages, key limitations may include:

- The scope for misinterpretation in online interaction as opposed to face-to-face contact.
- The need for service users to develop computer and typing skills.

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Critical Commentary: New Technology

New technologies are exciting. They are also seen to be "modern" so people want to be associated with them. In the last few years money has been available to experiment with new technologies in the NHS. What is not yet clear is how useful these new methods will be in actually changing and improving the process and outcome of patient care. It is essential to tease apart the development of the technology, which often interests those people in the health service who like playing with computers and videos, and the complex process by which the technology will actually be employed by coal-face health-service workers who may have no interest in the software and hardware. How will it change their working day? Will it actually make their job easier or apparently more difficult or complex?

What we have so far are interesting developments but not a great deal of research to demonstrate their utility and potential for implementation in the NHS. Our research team has discussed the importance of context in evaluating the effectiveness of new technologies (May et al., 2000). Research carried out by means of a randomised controlled trial is exceptionally difficult to carry out when the technology is constantly changing and being updated, but more and better research utilising mixed methods is required before most technologies can be recommended.

On the other hand, one could also argue that much research isn't actually needed. Clinicians and patients will always embrace new technology if they actually find it sufficiently useful!

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References

- Gray, J. (2000) Beating the blues: computerised cognitive behaviour therapy, *Journal of Primary Care Mental Health*, 4(1), 17-18
- Haslam, R. and McLaren, P. (2000) Interactive television for an urban adult mental health service: the Guy's psychiatric intensive care unit telepsychiatry project, *Journal of Telemedicine and Telecare*, 6(S1), 50-52
- Kettles, A. and Bryan-Jones, J. (1998) Computer modelling for patient observation, *Nursing Standard*, 12(19), 43-46
- Laurent, C. (2001) I can see you now, *Health Service Journal*, 111(5736), 8-9
- Mannion, L., Fahy, T.J. and Duffy, C., Broderick, M. and Gethins, E. (1998) 'Telepsychiatry': keeping a link with an island, *Psychiatric Bulletin*, 22(1), 47-49
- May, C., Gask, L., Atkinson, T., Ellis, N., Mair, F. and Esmail, A. (2001) Resisting and promoting new technologies in clinical practice: the case of telepsychiatry, *Social Science and Medicine*, 52(12), 1889-1901
- May, C., Gask, L., Ellis, N., Atkinson, T., Mair, F., Smith, C., Pidd, S. and Esmail, A. (2000) Telepsychiatry evaluation in the north-west of England: preliminary results of a qualitative study, *Journal of Telemedicine and Telecare*, 6(s1), 20-22
- Oravec, J.A. (2000) Online counselling and the Internet: perspectives for mental health care and supervision and education, *Journal of Mental Health*, 9(2), 121-135
- Osgood-Hynes, D.J., Greist, J.H., Marks, I.M., Baer, L., Heneman, S.W., Wenzel, K.W., Manzo, P.A., Parkin, J.R., Spierings, C.J., Dottl, S.L. and Vitse, H.M. (1998) Self-administered psychotherapy for depression using a telephone-accessed computer system plus booklets: an open U.S.-U.K. study, *Journal of Clinical Psychiatry*, 59(7), 358-365
- Steele, C. (2001) NHS Direct: a new gateway to healthcare, *Mental Health Review*, 6(1), 14-17
- Taylor, S. and Birtles, C. (1998) New line on mental health care, *Nursing Times*, 94(4), 38-39

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