Development of the Waltham Forest Local Mental Health Case Register*

LEONARD FAGIN, '608' Community Mental Health Centre, Leytonstone, London and HARRY PURSER, Department of Clinical Psychology, Leicester General Hospital and Leicester Polytechnic

Background

608 is a Community Mental Health Centre (CMHC) in Waltham Forest Health District which came into service in February 1983. It serves a catchment area in North East London of approximately 95,000, and caters primarily for the 16 to 65 age group. It is linked with the services provided by a large psychiatric hospital—Claybury—which has been scheduled for closure by 1993. Planning is now under way to provide alternative services in each of the five districts covered by the hospital.

The Community Mental Health Centre movement is a relatively recent development in the UK. With only a handful of facilities established during the last five years there is a paucity of information about the operational policies of the Centres and their methods of working in community settings. In the USA, CMHCs have typically tried to provide comprehensive mental health services employing a multidisciplinary operational policy.

However, many CMHC have been criticised for operating dogmatic policies, focussing on the less disturbed and disabled populations and for their inability to provide the full range of services that each community required. Unfortunately, there are very few descriptions in the literature of well monitored and evaluated practices. Added to this, interdisciplinary conflict has led many psychiatrists in CMHC to defect back into traditional psychiatric settings, with the concomitant and fruitless fragmentation of services.

In the case of 608 the aim was to reproduce the interdisciplinary teamwork operating in the hospital setting, maintaining links with admission facilities and other services still provided by Claybury. Most of the staff work both at the hospital and at 608, allowing for the key worker concept to be implemented as patients use various services. The Centre would replace the hospital as the co-ordinating headquarters of mental health work outside the institution. It was felt that in such a setting mental health professionals would be in touch with the community they were serving and more able to suggest relevant practices to the particular needs of a particularly deprived London borough.

The Centre was also charged with delivering a local mental health service which would be responsive to primary care referrals, as well as providing a gateway to more specialised hospital and community services. By placing it within the area of its catchment we aimed at making it a more accessible and friendly a place than the traditional psychiatric setting.

The move to community practice in Waltham Forest preceded the announcement of Claybury's closure by a few years. A number of innovative services were initiated by different professional groups. Psychologists established a district psychology service with attachments to the majority of the local large GP surgeries. Psychiatrists developed an *ad hoc* crisis intervention service, with joint home assessments, as well as emergency out-patient clinics based within the social services departments. The community psychiatric nurses also began to take direct referrals from primary care settings. Whilst each discipline felt the need to establish its own identity by such moves, it was also felt that a Centre could provide a forum where cases could be discussed and shared, work could be rationalised and a better integrated service offered to consumers and referrers.

The CMHC is now a focus for new mental health service developments in the southern half of the borough. It has established close links with ethnic minority groupings and voluntary associations, and the staff at the Centre have got to know personally many of the referrers, both by working together and by visiting them at their places of work. The 'community' has become much less of a vague concept, in that it is associated with real people living in environments that the staff recognise and acknowledge in their work.

Most planners and clinicians would predict that the advent of more localised mental health services is likely to alter the existing patterns of demand. Indeed, by making mental health services more readily accessible the implicit assumption is that a wider range of referrals will be made. However, only a detailed analysis of referral patterns can reveal the effects of any new service provision.

The staff at the Centre therefore acknowledged the need for some means of monitoring the referrals it received from community agencies, whilst keeping track of the demand for the other community mental health services provided in the catchment area. The availability of powerful but relatively inexpensive microcomputers suggested operating a local mental health case register.

The local case register

Large psychiatric case registers have been established in different parts of the UK over the past 20 years. Their value lies in the opportunities they provide to observe the incidence and prevalence of psychiatric illnesses within well defined regions of the country. Because these registers log virtually all new and continuing mental health cases within

a region they inevitably have to be very selective about the quantity of data they include on each individual case. Local case registers, although lacking the geographical power of the large register, are capable of describing both the nature and progress of psychiatric disorder in much greater detail than would be feasible within a large register context.

Several criteria were adopted by the case register planners which guided the creation of the 608 case register format.

(1) It needed to be sufficiently detailed in its clinical contents to be meaningful and useful to Centre workers in their everyday work. At the same time, it needed to be based on a valid and reliable system of describing psychiatric problems.

(2) It had to conform precisely to the operational policy and practice of the Centre.

(3) It had to be capable of storing changes in an individual's problem formulation through time.

(4) It had to provide quick access to data, which could be used for routine administrative purposes, as well as *ad hoc* enquiries in the course of Centre workers setting up small-scale evaluation projects.

Regular team discussions over many months were necessary to determine the optimum data set and record format required to monitor and evaluate the work of the Centre. What emerged from this exercise, in addition to a workable case register system, was a number of valuable 'spin off' benefits in terms of staff training and interdisciplinary exchanges. The introduction of a case register project stimulated the team to think more carefully about the ways in which the new service was operating, and ways in which it might be improved. A number of issues arose which helped clarify our legal, professional and personal roles.

The assessment formulation was seen as the core of the case register system, and was the subject of much discussion. Although standard classifications of psychiatric illness can claim clinical validity within hospital settings, doubt is often expressed about their utility in community settings. Rather than dealing with cases of acute and florid psychiatric symptomatology it is more likely that community referrals will consist of either chronic long-standing difficulties, or incipient psychiatric disorder. In order to achieve an adequate assessment of these types of problems a detailed Assessment Formulation scheme was drawn up by the team which consists of noting the presence or absence of key psychiatric symptoms, together with a variety of related data. The case register format was therefore based on a multivariate description of psychological distress (see Fig. 1).

This solution can be quickly and objectively coded with adequate staff training. A handbook has been prepared which offers operational definitions of all key terminology within the case register system, together with examples of how these descriptors would be used in practice. The full assessment formulation includes detailed information about the individual's previous psychiatric history, current medication, duration of present problems, self reported problems, and an assessment formulation component which allows the description of specific key symptoms, as

well as more formal mental state classifications. This system has proved to be acceptable and helpful in categorising groups of clients with highly diffuse problem constellations.

Database structure and system design

Modern 16 bit microcomputers using the MS-DOS/PC-DOS disk operating system offer access to a growing

Code:	Not present	0
	Dubious/Minimal	1
	Definitely Present	2
	Not Known	3

Memory Problems	—
Confusional State	—
Psychotic State	—
Hallucinations	—
Delusions	—
Mild Depression	—
Moderate Depression	—
Severe Depression	—
Abnormal Mood Elevation	—
Disinhibition/Overactivity	—
Suicidal Ideation	—
Suicide Risk	—
Eating Disorder	—
Anxiety State	—
Phobic Problem	—
Obsessive/Compulsive Problems	—
Sexual Difficulties	—
Hypochondriasis	—
Social Difficulties	—
Relationship Difficulties	—
Irritability	—
Intellectual Impairment	—
Danger to Others	—
Aggressive/Hostile	—
Drug/Alcohol Dependency	—

Social and Precipitating Factors	
Situational Reaction	—
Specific Reaction to Life Event(s)	—
Mental Disturbance in Other Family Members	—
Discordant Intra-Family Relations	—
Discordant Inter-Family Relations	—
Inadequate Living Conditions	—
Stress at Work	—
Stress from Unemployment	—
Migration/Social Transplantation	—
Persecution/Discrimination	—
Bereavement	—
Inadequate Social Environment	—
Moderate/Severe Financial Pressures	—
Puerperium	—
Other	—

FIG. 1 Current Assessment Formulation

range of dedicated, medium-sized, database management applications. Developing a database software suite from scratch is a very expensive and time-consuming business. In response to this fact a number of software houses now offer packages which allow system developers to create customised information management systems in a fraction of the time it would normally take to set up a new computer application.

Further, with this generation of microcomputers the cost of hard disk storage (for the database files) has fallen dramatically. A typical configuration for a modern database system would include 256k RAM and 20 megabytes of hard disk storage, costing as little as £2,500. Database management software for these machines can hold up to 32,000 individual records on clients, with each record containing up to 255 individual data fields. Machines like the Apricot, IBM PC, Compaq, and Olivetti can be set up as dedicated case registers by people with little or no previous programming experience through the use of modern program generators like Compsoft's DELTA package. These menu-driven packages allow someone with minimal computing experience to set up a case register system within a few days.

The 608 case register is made up of two separate database systems created using DELTA. The first record (Card 1) contains personal details, referrer details, contacts, and the client's case register number. The second record is in two parts. Card 2 is the heart of the case register and contains demographic and clinical information about the referral, including the Centre assessment formulation. It is completed at the end of the initial assessment period by the client's keyworker. Card 3 is an update/closure statement which is completed for each case every six months, or at the point of closure. This card allows the assessment formulation originally specified in Card 2 to be updated, whilst preserving the initial data, as many times as necessary for an individual case. Cards 2 and 3 only have the client's case register number as an identifier. The system is outlined in Fig. 2.

Each individual record in the case register is made up of 120 data fields, with each field containing a unique item of information about the case. Forty-two of these fields (Assessment Formulation & Service Utilisation) can accept multi-values over time, and so allow the storage of longitudinal data. This record structure satisfied the needs of the Centre both in its ability to describe the basic clinical problems, and to outline the activities that resulted from direct involvement with the Centre. The system also meets the requirements of the current Data Protection Act in terms of security of access, as well as providing data subjects the opportunity of enquiring about the data stored in the register. There is, however, some deliberation within the team (as well as the health services in general) as to the extent of information that should be made accessible, especially if previous diagnoses made by other psychiatric agencies are to be disclosed.

The register does not replace the clinical records, which are used jointly by all the disciplines at the Centre. With the closure of Claybury Hospital firmly in mind, the Register

Card One
Name, Address
Referrer, Address
GP, Address
Urgency

Card Two
1. *Demographic*
Age
Sex
Borough Location
Ethnicity
Marital Status Information
Employment/Financial Status
Accommodation Details
Family Characteristics

2. *Service Utilisation*
Referrer Details
Previous Service Contact History
Current Service Contacts

3. *Clinical Presentation*
Client Reported Problems
Duration of Problems
Previous Psychiatric History
Medication Regime
Current Assessment Formulation

4. *Centre Actions*
Allocation Procedures
Type of 608 Help Offered
Additional Specialised Assessments
Referral to Further Specialised Services

Card Three
Update Current Assessment Formulation
Update Service Utilisation
Evaluate Problem Severity
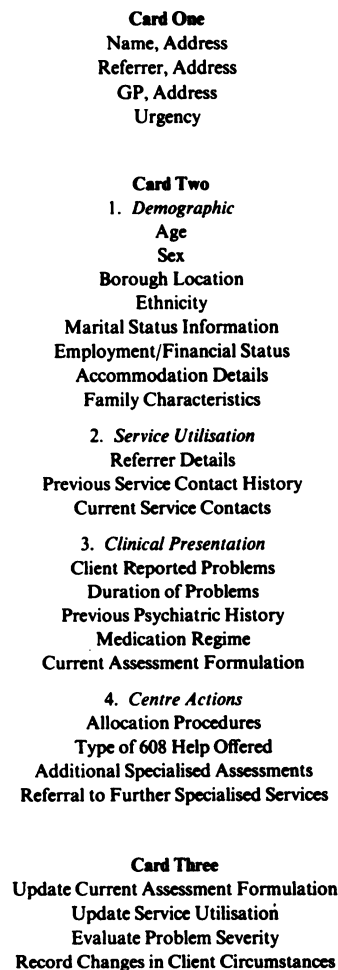Record Changes in Client Circumstances

FIG. 2   608 Community Mental Health Centre Case Register

will have an important role to play in keeping in touch with patients with long term disabilities who may be dispersed in a variety of settings within the District. The anxiety expressed by clinicians, that patients may be 'lost' in the community maze, may be partly forestalled by effective reminders of regular contacts of key workers which would appear on the screen at predetermined and agreed intervals.

Future directions

Apart from the obvious advantages of having the work of the Centre 'on-line', the microcomputer can also be used to establish a variety of other database applications. Maintaining a register of local facilities and expertise, which is readily accessible to staff formulating intervention options, is one potential application. Word processing usually is

incorporated in the software provided with the micro-computer, which can facilitate office work and repetitive administrative tasks, such as letters of appointment and addressing envelopes.

The beauty of local microcomputer based case registers is that they can all talk to a centralised database maintained on a more powerful computer. In this way a number of geographically disparate sites can run their own local systems, customised to their own operational needs and interests, whilst maintaining a common core of clinical information that can be pooled for a more comprehensive analysis. This kind of link-up can be achieved cheaply over the telephone line with the purchase of a modem.

In the fairly near future, with the growing availability of multi-user operating systems for microcomputers (e.g. Xenix, Unix) another generation of database management software will become available to local case register projects. Here it will be possible not only to operate highly sophisticated local case registers, with theoretically un-limited storage capacity and complex query options, but also to connect up a number of local sites 'on-line'. Each site could then share a common database where the records relating to each service user are readily available within seconds. We would hope that this type of development would generate the same kinds of 'spin-off' benefits we enjoyed at 608.

Ethnic Minorities and the Mental Health Act

Patterns of Explanation

ROLAND LITTLEWOOD, Senior Lecturer, University Department of Psychiatry, All Saints Hospital, Birmingham

Explanations of the over-representation of black psychi-atric patients under the Mental Health Act tend to empha-sise either the particular psychopathology of black patients or alternatively to locate it within the decisions of individual psychiatrists and police in a racist society. Both contain specific (conspiratorial) and general (cultural) variants. The two models are incomplete in themselves.

Investigations of British hospital records have demon-strated a disproportionate number of black patients, both born in Britain and in the Caribbean and West Africa, who are involuntary patients in psychiatric hospitals under the Mental Health Act. Some studies have found that Asian-born patients are also over-represented. The degree of over-representation varies but most studies suggest that it is between two and three times the white UK-born rate; whereas about 8% of white UK-born patients in psychiatric hospitals and units are involuntary, the figure for black patients is about 20 to 30%. As far as we know this pattern is similar in different areas of Britain. To an extent the figures may be explained by increased rates of schizophrenia in the black community relative to other diagnoses; this is likely to be associated with involuntary admission. There is evidence however that the increase is independent of diag-nosis, whilst the frequency of the diagnosis of schizophrenia in minorities has been called into question.

Research in this area tends to be orientated towards the simple collection of data in ignorance of the implicit models which govern its collection. In this paper I shall consider the two broad groups of explanations which have been offered: one implicates factors in the patients themselves and in black society, the other is concerned with the practice of psychiatry in the context of black/white relations.

Explanations orientated to the black patient

Not surprisingly these are the explanations offered by psychiatrists.

A. *The specific suggestion that psychiatric illness in black patients is different.* Among the terms which are commonly used are 'florid', 'acute' and so on; black patients are regarded as more antisocial and dangerous and thus legiti-mately more likely to be placed on sections of the Mental Health Act, whilst the police are more often involved in the admission of black patients in general. Although there are few studies on the numbers of black patients in locked wards, secure units and special hospitals (partly because of the reluctance of the Home Office and individual psy-chiatrists to be accused of racism), it appears that black patients are over-represented in these settings too. Why should the presentation of psychiatric illness in blacks be more anti-social than in whites? Amongst the arguments put forward (usually by analogy with suggestions made by colonial psychiatrists in Africa and elsewhere) are that:

(i) The illness is precipitated by organic factors such as anaemia and therefore the symptoms are more 'toxic' and delirious and there is less responsiveness to social context. There is no evidence that this is the case, although the nutri-tional status of minority psychiatric patients in Britain has not been investigated, perhaps surprisingly given the medical preoccupation with the diets of Rastafarians and Hindus.

(ii) Different cultures do have different patterns of mental illness and another explanation has been that the illness in the black British community (which is regarded as a separ-ate culture) represents a 'migration' of the illness itself. (The majority of patients in Caribbean psychiatric hospitals are involuntary). This offers a sort of acculturation model: black illnesses will come to resemble indigenous white ones; or an evolutionary one—with industrialisation, psychopathology becomes more 'psychologised', private and internalised. A variant of this thesis is that illnesses are somehow shaped by the ambient culture and, as the Caribbean is regarded in general as akin to West Kingston,