

'Health of the Nation': measuring mental health outcomes

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Two years ago, the government set out a strategy for improving health in ways that can be measured. *Health of the Nation* set down specific targets, including those for reductions in death rates from heart disease, cancer and accidents. For mental health, targets are more difficult to specify. The goal the government set is "to improve significantly the health and social functioning of mentally ill people".

Currently this cannot be measured since the necessary information is not collected nationally. It was therefore decided to commission the construction of a set of brief outcome scales for use in everyday clinical practice. These scales would be useful both to the clinicians (psychiatrists, psychologists, nurses, occupational therapists, social workers) who collect the data, and for the purposes of district and national monitoring. In addition to the primary purpose, this should enable clinicians and managers to talk in terms of outcomes as well as processes such as admissions, beds and face-to-face contacts.

The Research Unit of the Royal College of Psychiatrists has developed a set of scales for use in general adult mental health services; these are currently being evaluated in clinical field trials in a number of sites around the country. It is already clear that a set of 12 items covering behavioural, impairment, symptomatic and social problems is acceptable to health care workers and feasible in practice. The 12 items that comprise the scales are aggression; self-harm; alcohol/drugs; memory/orientation; physical problems; mood disturbance; hallucinations/delusions; other mental or behavioural problems; social relationships; housing and locality; employment, recreation, finance; and functional disability rating.

The present 12-item version of the scales has been developed from earlier drafts. Initially, a 20-item version was piloted. This was assessed for feasibility, acceptability and internal structure during a six-month study. In this pilot study large numbers of nurses and other health care practitioners completed a few charts each in routine clinical settings. More structured piloting was undertaken by four clinical teams. This

pilot work provided very valuable feedback; for example, that 20 items were too many; that a 0–4 rating would be preferable to the initial 0–3 rating; that brief 'definitions' should be included for each rating point and that a brief period of training, prior to using the scales, would be helpful. In general, the pilot version was found simple to use after the first few occasions and required only a few minutes to complete.

The internal structure was found to be reasonably economical, with low correlations between the four sections. However, several items did not contribute much to the total score or the Global scale. This provided the opportunity to shorten the scale to 12 items (listed above) although retaining the original four sections.

Field trials

The field trials involve 14 contrasting districts and focus on acceptability in routine use and sensitivity to change. Data on some 2000 cases will be analysed to examine change scores, profiles, variation among raters and socio-demographic characteristics. Smaller side-studies are being set up to examine reliability and 'validity' in more detail, and to make comparisons with some established rating scales. The value of the scales within clinical subspecialties (dementia, forensic, learning disabilities etc.) will also be studied, including comparison with rating scales used in these areas.

Local use of the scales

In addition to collecting data for the purpose of evaluating the scales, it is hoped that the data will be useful locally. At this stage in the development of these Health of the Nation Outcome Scales, (HoNOS), it is important that as wide a range of clinicians as possible should have access to the scales and the opportunity to try them out. As well as helping the development of the scales, the data collected could be useful in considering questions likely to be of local interest, since measures of outcomes can make a

valuable additional contribution to some audit projects and to reviewing care plans, care programmes, etc.

All members of mental health teams need to have a degree of ownership of the scales in order to feel free to adopt them as part of their clinical practice. This will be helped by widespread use and the opportunity to comment on and thus help refine the final version. During the rest of this year the test draft of HoNOS will be freely available to anyone who wishes to contribute in this way. A conference for clinicians and managers who have been involved in the evaluation of the scales will be held in March 1995.

In addition to the clinical uses of HoNOS data, it is expected that the widespread use of these scales will be of great value in public health, resource planning and the collation of accurate and meaningful central records. At the moment, mental health indicators are restricted by the limitations of Körner data, which measure activity volumes rather than data relevant to patients' problems and outcomes.

Separate scales for users and carers are being developed and will be tested during later stages of the project.

Anyone who wishes to use the scales in their routine clinical practice is welcome to do so. We can provide a standard pack, including rating charts that can be photocopied. We would very much like specific comments to be returned to the Research Unit (please use A4 paper, headed *HoNOS Comments*, and include information on the setting in which the HoNOS chart was completed).

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Consent to medical treatment and people with learning disability

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For those people who have the cognitive and social impairments described as a learning disability, personal choice is more often than not a limited experience, (Mencap, 1989). Simple choices may be usurped by the preferences of carers, and more serious decisions may be correctly or incorrectly deemed beyond their capacity. We will address two questions which repeatedly face clinicians working with adults with learning disabilities. First, how do we ascertain a person's level of competence to give consent in relation to medical treatment? Second, in the case where a person with learning disability is considered unable to give informed consent to treatment, how do we proceed to make a decision regarding treatment?

What is informed consent?

There is a wealth of research on informed consent in different situations (King, 1986) but in this article, the focus will be on clinical aspects. Informed consent can be broken down into three necessary elements: an understanding of the basic information which is relevant to the decision about the proposed medical treatment; the capacity to make the choice; and that consent must be voluntary and free of coercion.

The basic information that needs to be understood is stated in the Code of Practice of the Mental Health Act, 1983. The patient must be able to understand why the treatment is being proposed; the nature of the proposed treatment;