

## Original articles

### Estimates of need

#### A document prepared for the South Manchester District Health Authority

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#### *Common mental disorders*

Most common mental disorders – becoming anxious, distressed or depressed – are dealt with by family doctors. In order to be able to understand the situation in South Manchester, we start by comparing figures for all mental disorders here with the situation in the country as a whole (Table I). The figures in the vertical columns are like Russian dolls: each figure below is contained within the figure above it!

It can be seen that episodes of distress are relatively common in the community: somewhere between one-quarter and one-third of the population will have such an episode (by definition, lasting at least two weeks) during the course of a year. However, only about 2% of the population will be seen by a mental health specialist during the course of a year.

Two other things are striking about these numbers. Only a minority of the people recognised as distressed are referred to the specialist mental health services; and many people who are distressed are not recognised as such by their family doctors.

The figures in the right-hand column of Table I are for South Manchester – they were obtained during 1989/90 on the Wythenshawe Estate. It can be seen that the family doctors recognise disorder more fre-

quently, but they refer only about the same numbers to the mental illness services as their colleagues elsewhere.

#### *Severe mental disorders*

In Table II, schizophrenia, bipolar illness and organic psychoses have been grouped together as 'severe disorders'. While these are much less common, almost all of them are treated by the specialist services. In the left hand column below we repeat the figures from Table I, but now show the figures for severe disorders for comparison.

It can be seen that severe disorders represent less than 4% (6.9 expressed as a percentage of 196) of mental disorders seen by family doctors; but they are about 40% of those seen by the specialist services, and about half of those admitted to hospital. The situation is very different from that for common disorders regarding referral onwards: the family doctors are asking the specialist services to see almost all of these patients during the course of a year, and the psychiatrists are admitting to hospital almost one-third of these patients at some point during each year.

TABLE I  
*Mental illness in hospital and community settings: Data for England during 1982–1983; and for South Manchester during 1989–1990 (from Goldberg & Huxley 1991; Goldberg & Gater, 1991)*

	Annual rates/1000	
	England	South Manchester
Mental disorders in the community	250–315	n/k
Mental disorders among GP attenders	230.0	257.0
Mental disorders recognised by GP	101.5	196.0
Mental disorders treated by MI services	20.8	16.3
Mental disorders admitted to hospital	3.3	4.1

TABLE II  
All mental disorders, and severe disorders in hospital and community settings: data for South Manchester DHA during 1989–1990

	Annual rates/1000	
	All disorders	Severe disorders
Mental disorders recognised by GP	196.0	6.9
Mental disorders treated by MI services	16.3	6.6
Mental disorders admitted to hospital	4.1	2.0

TABLE III  
Mental disorders seen during 1989–1990 for South Manchester residents only; estimates for a population of 184,700 inhabitants

Diagnosis	ALL patients treated including out-patients and day patients	Patients admitted to hospital
Schizophrenia and mania	803	291
Organic psychoses	424	79
Depression	715	124
Anxiety states	150	61
Alcohol and drugs	415	150
All other problems	503	88
TOTAL	3009	750

### The work of the mental illness services

Table III considers the work of the specialist services, and is obtained from our present case register for 20,934 people in Wythenshawe receiving our usual service. We estimate numbers for the whole district by assuming that the rest of our population uses the services in a similar way. In this way we avoid counting anyone twice, and ignore work done by our unit for people from outside the district. Just over 3000 local people receive treatment each year, of whom 750 are admitted to hospital. Most patients with depression can be expected to receive all their treatment without coming into hospital.

### Three groups with special needs

We next consider three special groups of person: those needing specialist nursing care because of disturbed or challenging behaviour associated with a mental disorder; those in need of joint care plans between health and social services because of a severe mental disorder; and those in need of counselling during an episode of severe distress.

Only a minority of the mentally ill have severely challenging behaviour, and these are well-known to the specialist services. Most are nursed in hospital or

in special settings such as the hostel ward or other staffed residential settings. A count of such patients during 1990 revealed only 77 such individuals among the 3,000 treated by the service.

Most of those with severe mental disorders who are discharged into the community should have joint care plans made for their discharge between health and social services; we therefore use our estimates already given for this important group. It is our view that it will only be possible to carry out such plans using existing human resources if both health and social services pool their resources, and we have therefore made plans to do this.

It is possible to estimate the needs for counselling acute episodes of distress from the experimental community service based upon primary care, which is described in the next section. No limitation was put upon the family doctors to refer patients to the service, although we did our best to dissuade them from referring people whose distress was likely to clear up without intervention from our staff. The figures are obtained by adding together the numbers seen with adjustment disorders, anxiety disorders and depressive disorders, and then estimating numbers that would be seen if the service were to be extended to the whole district. It can be seen that substantial numbers of such patients exist – indeed, it is *more than three times* the number seen by our existing staff. It would therefore only be possible to extend this service if extra resources were made available.

### Extending mental health services to primary care

We are at present engaged in a comprehensive assessment of the effects of introducing a multidisciplinary mental health service in primary care settings. A group of family doctors serving 19,358 people have had such a new service for the past two years, with another matched group of doctors serving 20,934 people continuing with the traditional services, and so serving as controls (Jackson *et al*, 1991).

Table V shows the numbers of people in each diagnostic group treated by the specialist mental illness

TABLE IV  
Estimates of the numbers of three special groups of patients during calendar year for South Manchester DHA

Group of special need	Estimated numbers in whole district	Rate per 1000 population at risk
Mental disorders with challenging behaviour	77	0.42
Severe disorders needing joint care plans	1226	6.64
Episodes of acute distress	3053	16.52

TABLE V  
Effects of a new community mental health service based upon primary care clinics on the annual period prevalence of mental disorders

Diagnostic group	Traditional hospital-based services n = 20,934	New community based services n = 19,358	Percentage increase in rates/1000 at risk
Severe mental disorders	139	152	+ 18%
Anxiety states	17	102	+ 549%
Depressive illness	81	166	+ 122%
Alcohol and drugs	47	58	+ 33%
Other problems	57	119	+ 126%
Total	341	597	+ 89%

service over the first full year of operation of the new service. The percentage increase in the numbers treated by the new service (after the figures have been converted to rates/1000 at risk) is shown in the right hand column.

It can be seen that there are very great increases in the treated rates for common disorders such as depressive illnesses and anxiety states, but also that there are substantial increases in treated rates for severe illnesses, and for those with alcohol and drug-related problems.

### Conclusions

- Filters to care:* The existing mental illness services are in contact with almost *all* those with severe disorders in the course of a year, but with only a minority of those with common disorders.
- There are substantial numbers of mentally ill people needing joint care plans – 1226 represents a substantial number of cases, bearing in mind that each case potentially needs on-going care – and this will necessitate the most efficient possible working practices between health and social services if the

recommendations of *Care in the Community* are to be carried out effectively.

- In order for community mental health teams to be available to assist those known to their family doctor to be experiencing acute episodes of distress – we estimate there would be over 3000 such episodes for our whole catchment area each year, of whom we at present see 980 (or eight additional episodes each working day!): we would need additional staff to meet such needs. Our staff are enthusiastic about such a service, but their enthusiasm would have to be shared by the Purchasing Board of the DHA for such plans to become a reality.

### References

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- JACKSON, G., GATER, R. A., GOLDBERG, D. P., TANTAM, D., TAYLOR, H. & LOFTUS, L. (1991) A new community mental health team based in primary care. *British Journal of Psychiatry* (submitted).