

A Good Place to Talk: Mapping Mental Health Advocacy Services in London using a GIS.

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ABSTRACT

The NHS Executive for London carried out an investigation in 2002 as part of their wider mental health strategy to establish whether existing mental health advocacy provision in the city was meeting need. Advocacy in mental health is currently provided by a combination of health, statutory and voluntary agencies. Using updated data collected via the Greater London Mental Health Advocacy Network and additional geographical data from health and government sources, the location and provision of advocacy was mapped within a GIS. Additionally qualitative data was gathered via interviews and focus groups with key stake-holders about service delivery and satisfaction. The GIS enabled the identification of spatial gaps in existing services which was augmented by qualitative results on service provision and the need for more thinking about models of advocacy provision linked to more specialist need. Additionally, improved collection and access to spatial data linking community and acute mental health care was identified as a significant barrier to geographical work in this area.

Keywords and phrases: GIS, mental health, advocacy, service planning, needs assessment, service quality.

Introduction

The NHS Executive London Regional Office established the Advocacy Advisory Group in October 2000 with the aim of integrating advocacy within the scope and remit of the London Mental Health *Strategy for Action* (NHSE 2001). As a part of this process, a research project was commissioned to look at mapping Mental Health Advocacy Services in London (Johnson 1998, Fitzpatrick & Jacobson 2001). The particular focus of the exercise was to look at capacity, stability and funding and particularly to identify gaps in relation to service provision, unmet need and accessibility (Lewis 2001, Pyke et. al. 2001). Examples included provision to ethnic and other minority and disadvantaged groups (Silvera & Kapasi 2000, Sproston et. al. 2001). GIS was used as a key element of both the service mapping and gap identification parts of the project but was also integrated with qualitative research to provide a fuller picture of the current position (Gatrell & Senior 1999, Richards et. al. 1999, Stevenson 2001). GIS is also an underused resource in a developing geography of mental health with little or no application within the UK (Bhana & Pillay 1998).

Aims & Objectives

The initial aim of the project was to use the GIS to aid decision-making and policy development on a specific aspect of mental health service provision, advocacy. This was broken down into a number of objectives namely; 1) Identifying the capacity of Mental Health Advocacy services across London; 2) Establishing the financial stability of Mental Health Advocacy Services across London and 3) Identifying gaps in Mental Health Advocacy services across London in terms of service provision and unmet need. There are a variety of models of advocacy provision ranging from individual and group advocacy to non-instructed advocacy. It was hoped that the mapping of existing services would identify the extent to which different models of advocacy were used across the city and the extent to which each model of advocacy was available to meet potential need.

Methodology & Data Issues

The methodology for the project involved collecting detailed information on existing advocacy provision initially based on a 1998 database of agencies providing mental health advocacy as collated by the Greater London Mental Health Advocacy Network. The database was saved in electronic format and sent back to each of the 57 original agencies for updating with additional information on location, funding and specific types of advocacy provision. Additionally the agencies providing advocacy in 1998 were checked in consultation with nine additional bodies to check their current status as well as through direct phone calls. Around 51% responded directly and the data updating process also identified that around a quarter of groups providing advocacy four years previously were either no longer functioning or were operating in a different way. This highlighted the fact that one of the key factors in the original aim, the stability and capacity of service provision remained a problem due to on-going difficulties with short-term funding and fluidity in service provision.

From the point of view of modelling need, a large amount of data was collected at ward, district and health authority level on actual mental health acute admission rates as well as extensive data variables which related to 'at-risk' populations. These ranged from measures of deprivation to levels of homelessness, ethnicity, levels of alcohol consumption as well as key age and gender demographic data. Existing literature on advocacy and mental health identified a series of key groups included the elderly, the young, black and minority ethnic groups, Refugees and asylum seekers, lesbians and gay men, the homeless, carers and offenders (Thornicroft 1991, Harrison 1995, Harvey 1996).

The revised database of service information was then geo-referenced from an Access database and fed into the GIS and matched against background data maps on mental health risk factors and need mapped against a number of geographical levels from ward up to health authority level. Obvious geographical issues here include the difficulty of access and in some cases, the complete lack of any primary mental health data at a detailed geographical scale below district level. The issue of access to detailed data in a wider joint public health/social care context is an on-going issue for GIS work in this area (Dunn et. al. 2001, Foley 2002). Additional GIS based data was collected from the NHS, Office of National Statistics and the London Public Health Observatory. Advocacy workers, service users, user groups and commissioners were also consulted through direct communication and focus groups to identify gaps in services, funding arrangements and approaches to providing advocacy (GLMHAN 2001). This was particularly significant in terms of discussing existing provision in terms of different models of advocacy and how successful or otherwise these were perceived to be. Quality and appropriateness of service provision came up as a significant issue based on these focus groups and remains an issue, which has perhaps not always been grasped within mental health.

The key demographic data on mental health need were identified and entered into the GIS. The process of data identification, collation and management identified a number of key issues, which were particularly relevant to GIS use in mental health service mapping. These include data access, confidentiality and data protection, currency, comparability and gaps in linking up primary and acute mental health care data (O'Dwyer & Burton 1998). All of these need to be considered in any work on service delivery. A particularly important issues which arose related to data and information on community mental health data and the relationship between this data and acute data.

Analysis & Results

The mapping exercise and consultation showed that there is a reasonably broad provision of mental health advocacy across the capital with each borough being served by at least one local service as well as by London wide specialist schemes. However at local level, no borough has the full range of specialist provision, which

matches local demography. Furthermore, no one organisation has a full range of specialist provision or delivered their services in a full range of settings based within both acute and community care. There are gaps in provision for many groups who are minorities and/or have specialist needs (Buston 2002). Many of these groups benefit most from a style of advocacy, which incorporates both personal advocacy with support and working with communities. It is perhaps also the most likely approach to enable closer working with communities and in the community and the most likely method to increase capacity for user involvement and empowerment. GIS outcomes also included detailed mapping and overlay of service catchments as well as identification of levels of service, ward level mapping of mental health need and point mapping of costs associated with each service (Fig. 1 below).

Figure 1. Average Funding per Advocacy Case, London 2002



In terms of the original aims and objectives of the project that related to service capacity, stability and funding there were a number of key outcomes. There is a wide range in the level of funding which partly reflects provision of specialist services as well as models of advocacy provision. For those organisations who provided funding information, the average amount of funding for each new case was approximately £450 while the average number of new cases taken on by each advocate each year was 206. The average number of cases that each advocate currently worked with was 43. For the funding source it was identified that most mental health advocacy in the capital is funded by the statutory sector (76%) with a further 21% from charities and 3% from central government funding. More significantly the average amount of time for which such funding is secured is 2 and a quarter years, which has a significant impact on service delivery. A number of organisations additionally commented that a significant amount of staff time and resources, which should have been focused directly on service provision, was spent instead on trying to guarantee additional and on-going funding.

Conclusion

The mapping showed that where there is higher need in inner London this is matched by a clustering of mental health advocacy provision. However, some outer London boroughs with high needs have relatively less advocacy provision (this pattern is the same for specialist provision for minority-ethnic populations). This outcome linked to relative financing provoked considerable internal discussion among the steering group and

pointed to some interesting issues associated with presentation of findings from a GIS in a service delivery and planning framework, especially one where GIS has not been previously used.

Ultimately the report will assist the Advisory Group to provide Health and Social Care commissioning agencies with clear guidelines in relation to the development of local mental health advocacy services and on gaps in current advocacy provision and previously unconsidered geographical dimensions of that provision. Additional discussions with service users and providers identified a number of important issues relating to existing service provision that feeds into decision-making and mental health policy. Existing advocacy services were operating in a climate of instability and uncertainty, which seriously affected future service planning. The political nature of advocacy as a broad subject area also identified on-going tensions between need and provision.

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