Brief assessment of perceived need for mental health care - development of an instrument for primary care use

Project report submitted to beyondblue the National Depression Initiative

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EXECUTIVE SUMMARY

The Perceived Need for Care Questionnaire (PNCQ) is a fully structured questionnaire, addressing the construct of perceived need for mental health care.

We have condensed the essential requirements of data collection from the PNCQ as relevant to the GP waiting room context, as a readily understandable self report pencil and paper version within a design constraint of one A4 page at no less than 11pt typeface.

The development phase involved trialling of a substantial series of draft versions, and discussion of these in development with GPs, mental health care professionals, and consumers of primary mental health care.

The resulting instrument, the General-practice Users Perceived-need Inventory ('GUPI') was the outcome of this. The GUPI is a brief, stand-alone version of the PNCQ, tailored to be administered within the primary health context

The developed GUPI was delivered to beyondblue early in 2002, and has come into use in a number of beyondblue supported applications while further testing has been under way.

The approach taken to further development has addressed Evans et al's (2000) Mental Health Needs Assessment Critical Appraisal Checklist. This includes: conventional psychometric validation, but also stakeholder perspectives and user-centredness, feasibility, and utility.

For utility, reliabililty and validity studies, potential participants were approached in waiting rooms before their GP consultation. Those consenting were administered a range of clinical status questions and the GUPI. A feedback questionnaire explored

the acceptability and utility of the GUPI. A week later, participants were telephoned for administration of the GUPI a second time.

Participant feedback suggests that the GUPI has good 'consumer validity'; participants overwhelmingly found the questionnaire easy to understand and complete, and generally found it useful and potentially helpful in communicating concerns.

Higher scores on items associated with adverse mental health experience were associated with perceived need on the GUPI, suggesting that perceived need as measured with the GUPI is associated with poorer general health, and a greater level of disability due to both physical and emotional difficulties.

Reliability within this study was fond to be less well supported than validity. This however does not necessarily undermine the utility of the instrument. It may partly be a function of different administration techniques over time, and/or the possible role of the GUPI in reducing perceived need by allowing an opportunity for reassurance or the meeting of need within a GP consultation subsequent to its administration. It is suggested that a reliability study in a general population setting without the intervention of the GP consultation might be more appropriate for the true estimation of reliability.

The data suggests that reducing the GUPI to three 'psychological/psychiatric need' items (i.e., the first three items) would allow the retention of psychometric properties, while creating a measure that is even more brief and simple to administer and complete. In this form, the GUPI goes a substantial way towards meeting the stated evaluative criteria.

On the basis of these findings, we suggest that the continued use and further evaluation of the GUPI, generally, and with consideration of the use of the GUPI short form where extreme brevity is desirable, is appropriately supported.

INTRODUCTION

Assessing mental health care needs

There has been increasing recognition of the importance of assessing mental health needs, largely driven by legislative reform linking needs assessment to government policy on care of people with mental illness, both in Australia (Burgess et al., 2002) and overseas (e.g., (Secretary of State for Health, 1990). However, standardised mental health needs assessments vary widely. This is at least partly due to difficulties in defining the construct of 'need' itself. Health economists have focused on supply and demand as cornerstones of the 'need' construct (e.g., (Stevens & Gabbay, 1991). On the other hand, researchers in spheres of public health and epidemiology have turned to such ideas as 'need for care' or 'the ability to benefit from services', as well as simply 'requirements of achieving health and well-being', in operationalising 'need' (Evans, Greenhalgh, & Connelly, 2000; Ramsay, Welch, & Youard, 2001). Additionally, assessment of mental health need differs across instruments with reference to content, format, aims, and appropriate contexts for instrument use.

Mental health needs assessment has also differed across informants. Until the last decade, the assessment of need has largely utilised techniques of examining 'objective' markers of need, e.g., mental health service utilisation or informant (predominantly clinician) ratings of the degree to which consumers meet diagnostic criteria for a psychiatric disorder (e.g., (Brewin, Wing, Mangen, Brugha, & MacCarthy, 1987). However, while utilisation- and prevalence-based approached are in and of themselves useful, they fail to fully conceive of the range of forms of need that consumers may present with. Those with actual need may fail to perceive need, and as such, interventions targeted at this group may be greeted with bemusement or irritation. Additionally, individuals may fail to fulfil full criteria for psychiatric diagnosis, and yet may perceive need that, if addressed in a timely fashion, may allow preventive measures for the development of future psychopathology. The current study focuses on the consumer perspective of need, i.e., perceived need.

Existing needs assessment measures also appear to differ with respect to level of psychometric evaluation they have been subjected to. Those that have undergone psychometric examination include the Cardinal Needs Schedule ('CNS': Marshall, Hogg, Gath, & Lockwood, 1995), designed for use in a research setting, and the Camberwell Assessment of Need ('CAN': (Phelan et al., 1995), appropriate for both research and clinical use. Measures without available psychometric information include the Avon Mental Health Measure (Avon Measure Working Group, 1996), and single-item measures probing consumer

perception of need, such as that used in the National Comorbidity Survey (Kessler, 1994) and the Epidemiological Catchment Area study (Regier et al., 1993) ('was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your emotions or nerves or your use of alcohol or drugs?'). The former approach is clearly advantageous, as it allows adequate examination of the degree to which measures consistently examine what they are designed to measure. However, the CNS and the CAN take on average more than ten minutes to complete; this time commitment may be problematic in a number of contexts.

Assessing mental health care needs in primary care

A particularly relevant context for the assessment of mental health needs is that of primary care. Data suggests that at least a third of patients in general practice have common forms of depressive, anxiety or somatoform disorders, while 10% to 25% have depressive disorders severe enough to justify evidence-based treatment (Hickie, Davenport, Naismith, Scott, & Secretariat, 2001). However, treatment of depression accounts for less than 4% of consultation in Australian general practice (Bridges-Webb et al., 1992; Britt & Miller, 2000). Remuneration schedules in primary care that encourage procedure rather than time spent talking (Ellis, Smith, & Bushnell, 2001), combined with general time pressure (Higgins, 1994) and possible consumer reluctance to report mental health needs in a relatively hectic and 'medical' environment, render the development of appropriate tools assessing mental health need within this context of high priority. The assessment of need within this environment requires brief measures that are 'user-friendly', easily and quickly completed, possibly within a waiting room context, providing valid and reliable indicators of mental health needs. Given that it is envisaged that busy general practitioners would undertake scoring within this environment, ease of scoring procedure should also be a priority. Current tools are inappropriate for this purpose, either due to their length and scoring complexity, or lack of examination of psychometric properties.

Perceived need assessment – the PNCQ

The Perceived Need for Care Questionnaire ('PNCQ': Meadows, Fossey, Harvey, & Burgess, 2000) was developed as a measure of perceived need to be administered as part of the Australian National Survey of Mental Health and Wellbeing's household survey targeting high-prevalence disorders such as depression and anxiety ('NSMHWB': Australian Bureau of

Statistics, 1998; Henderson, Andrews, & Hall, 2000). The PNCQ is a fully structured questionnaire, addressing the construct of perceived need for mental health care. It does so by firstly an enquiry into services received for a mental health problem, if any, and where services have been received, asking about adequacy of these. It also collects information around perceived need for those with detected disorders who are not in contact with services. To do this the PNCQ has a branching structure. Firstly, other modules of the NSMHWB field questionnaire determine whether the PNCQ questions are administered; the PNCQ was administered when respondents reported either probable psychiatric morbidity in the last year, or mental health service use for a mental health problem in the same time period. Subsequently, in the branched structure, which involves presentation of between 10 and 20 questions, the PNCQ examines perceived need for drugs (medicine or tablets), information (information about mental illness, its treatments, and available services), psychotherapy (discussion about causes that stem from your past), cognitive behaviour therapy (learning how to change your thoughts, behaviours, and emotions), counselling (help to talk through your problems), social intervention (help to sort out housing or money problems), and help to improve ability to work, or to use time in other ways. Within this structure it also examines barriers to perceived need being met, including the specified barriers of: self-reliance ('I preferred to manage myself'), pessimism ('I didn't think anything could help'), ignorance ('I didn't know where to get help'), stigma ('I was afraid to ask for help or what others would think of me'), finance ('I couldn't afford the money'), non-response ('I asked but didn't get help'), and alternative provision ('I got help from another source'). The design group, which included mental health professionals and a consumer, created these categories and barriers, based on detailed review of content coverage of alternative measures of mental health needs. The PNCQ has demonstrated acceptable feasibility, reliability, and validity, with inter-rater reliabilities generally exceeding kappas of 0.6, and a multi-trait multi-method approach (using a semi-structured interview as an alternative method) lending support to the instrument's construct validity (Meadows, Harvey, Fossey, & Burgess, 2000).

The full version of the PNCQ, and associated service utilisation questions, is included as an appendix to this report. This version is in use in a number of current service evaluation studies. It represents a slightly extended version of the NSMHWB version, but has substantially similar structure. The service utilisation questions and other screens take up the early part of the questionnaire, with the PNCQ questions themselves commencing at item B5.

Adapting the PNCQ for primary care

While the PNCQ is a useful measure, it is a fully structured interview with complex administration, due to skip rules and training requirements as a paper instrument. Although the computerised format of the measure is considerably more straightforward to administer, this mode of delivery is not an acceptable option for all settings. Its length also mitigates against its use in general primary care. Prior to this presently reported project, the PNCQ did not exist in a self-report pencil-and-paper format. This project set out to develop a stand alone instrument addressing the central concepts sampled through the PNCQ, but for use in the GP waiting room.

The aims of this development phase were:

- To condense the essential requirements of data collection from the PNCQ as relevant to the GP waiting room context.
- To present this as a readily understandable self report pencil and paper version.
- To do this within a design constraint of one page at no less than 11pt typeface.

The development phase involved trialling of a substantial series of draft versions, and discussion of these in development with GPs, mental health care professionals, and consumers of primary mental health care. Specific focus groups were run to facilitate and support the development, (these were conducted by investigators GP and IB). The General-practice Users Perceived-need Inventory ('GUPI') was the outcome of this process. The GUPI is a brief, stand-alone version of the PNCQ, tailored to be administered within the primary health context. It is designed to be easier to complete and code than the PNCQ, with all participants completing the same items, regardless of responses to previous items. It is primarily intended as a tool for general practitioners, highlighting that a consumer perceives need and that therefore this might be a fruitful area to explore within a consultation.

Given the length of the original PNCQ, there was plainly a need for drastic pruning and adaptation of the questionnaire structure. Various decisions were made to facilitate condensation of the central constructs into this now very brief form, as presented on the following page. These included:

- A tight focus on the GP consultation as current context.
- The simplification of skip rule structures.

- Simplification of items tapping barriers to care by only request one general barriers response, rather than a response per perceived need item; multiple barriers could however be endorsed in this general barrier response.
- Concentration on discrimination between those with unmet need for this kind of help from the GP and other kinds of need. For instance, the GUPI is less well structured than the PNCQ for the making of the distinction between partially met need or fully met need for care from other providers than the GP.

This development phase led to the instrument that came to be termed the GUPI, and which is presented below. The central aim of developing an instrument within one page of A4 was achieved, with retention of the most important elements of the structure for data collection within the GUPI.

The General-practice Users Perceived-need Inventory (GUPI)

These questions ask whether you would like your General Practitioner to discuss with you any of the following kinds of help, for common emotional problems such as feeling depressed or anxious. Your GP might offer to help you in this way, or you might prefer your GP to suggest an alternative source of help.
Please first carefully read the list of three choices, one at the top of each of the columns, then fill in one circle like this ● in each row, for the option which best applies to you.

Type of help	I would like my GP to discuss this kind of help with me	I don't need to discuss this kind of help.	I am already getting this kind of help, (either from my GP or somewhere else).
1. Information about emotional problems or getting treatment for these problems	○	○	○
2. Medication or tablets to help you with emotional problems	○	○	○
3. Counselling; including any kind of help to talk through your problems	○	○	○
4. Help to sort out practical issues such as housing or money problems	○	○	○
5. Help to improve your ability to work, to care for yourself, to use your time or to meet people	○	○	○

Fill one circle in each row

Have any of the following reasons stopped you in the last few weeks, from getting any of these kinds of help, or from getting as much help as you may have needed. Fill in any circles that apply to you

Not Applicable, I haven't needed any of these kinds of help…..	○
I preferred to manage myself…….	○
I didn't think anything would help……...	○
I didn't know where to get help…….	○
I was afraid to ask of help or what others would think of me…	○
I couldn't afford the money……...	○
I asked but didn't get help…….	○

Fill in (like this ●) any of the circles that apply to you

Thankyou for your help

Preliminary reporting of this project.

The developed GUPI was delivered to beyondblue early in 2002, and has come into use in a number of beyondblue supported applications while the further work on formal reliability testing and validation has been under way. This later work will now be reported and forms the bulk of the empirical material within the present report.

Relevant Considerations for assessing the GUPI

A checklist for consideration

The approach taken was to evaluate whether the GUPI satisfies Evans et al's (2000) Mental Health Needs Assessment Critical Appraisal Checklist. This includes: conventional psychometric validation, but also stakeholder perspectives and user-centredness, feasibility, and utility.

AIMS OF THIS STUDY

The aims of the current study, following from consideration of the above checklist, were therefore:

- to examine the GUPI's properties with reference to consumer acceptability and utility
- to explore the psychometric properties of the GUPI, with specific reference to:
    - assessment of homo- and hetero-trait, homo-method validity, which would provide some support for construct validity
    - test-retest reliability
    - concurrent criterion validity

METHOD

Ethics clearance

The full design of the study to be described was approved through the University of Melbourne Human Research and Ethics Committee (HREC). All research conduct and data management has been within the framework provided by the approved University of Melbourne HREC application document, and guided by relevant University procedures.

Procedure and setting

Participating general practices were engaged through existing collaborative networks, and four group general practices in NW Melbourne took part in the study. Following agreement to participation at practice meetings within the participating clinics, reception staff and GPs were briefed on the project. Forms outlining the study and allowing for expression of patient interest in being approached by a researcher for participation were displayed at reception when a researcher was present.

Those who consented to this were approached in waiting rooms before their GP consultation, and were administered questionnaires in quiet rooms within the general practice, in the presence of the recruiter. In a small number of instances (largely due to vision difficulties), the questionnaire was read out to participants, and they indicated their response to the recruiter. An average of seven days later (s.d. = 0.74, range = 6-10), participants were telephoned for administration of the time 2 GUPI.

Measures

At time 1, participants were administered a battery of pencil-and-paper tests. These included:

- A general demographics questionnaire, tapping age, gender, marital status, and employment status;
- A feedback questionnaire which explored the acceptability and utility of the questionnaire from the point of view of participating GP patients;
- Validation measures chosen for brevity and practicality of administration in this primary care context. The instruments used were:
    - The Somatic and Psychological Health Report ('SPHERE': (Hickie, Davenport, Hadzi-Pavlovic et al., 2001),
    - Three items selected from the Short-Form Health Survey (eight item version: SF-8 (Ware, Kosinski, Dewey, & Gandek, 2001)) tapping general, physical, and emotional health

difficulties over the previous four weeks (on a seven-, five-, and five-point scale respectively);

- The GUPI.

At time 2, participants were administered the GUPI via telephone.

The GUPI already presented is a six-item questionnaire, tapping five different categories of perceived need, and barriers to care. The need categories include information ('Information about emotional problems or getting treatment for these problems'), medication ('Medication or tablets to help you with emotional problems'), counselling ('Counselling, including any kind of help to talk through your difficulties'), social intervention ('Help to sort out practical issues, such as housing or money problems'), and skills training ('Help to improve your ability to work, to care for yourself, to use your time, or to meet people'). The three-point response format allows for responses of 'I would like my GP to discuss this kind of help with me' (unmet need), 'I don't need to discuss this kind of help' (no need), or 'I am already getting this kind of help, so I don't need to discuss this with my GP (met need). Dichotomous distinctions were drawn from these responses, with unmet need and met need being combined into the category of 'perceived need' (given that the meeting of need intuitively requires that the need exist), with 'no need' being renamed 'no perceived need'.

An *a priori* assumption made was that that the occurrence of a consultation between time 1 and time 2 may interfere in the transition of a need from unmet to met, but that the consultation would be less potent in generating a transition between any type of need (met or unmet) and no need.

The GUPI also includes a subscale with dichotomous yes/no items tapping reasons for unmet need ('barriers'), including self-reliance ('I preferred to manage myself'), pessimism ('I didn't think anything could help'), ignorance ('I didn't know where to get help'), stigma ('I was afraid to ask for help or what others would think of me'), finance ('I couldn't afford the money'), and non-response ('I asked but didn't get help').

The SPHERE is a 12-item screening tool for common mental disorders in general practice. It shows acceptable validity and reliability, predicting disability ratings, rates of lifetime psychiatric diagnoses, patient and GP report of reasons for presentation, and doctors' rating of risk as a result of mental disorder. Administration of the SPHERE yields scores relevant to two different levels of mental disorder, or 'caseness' – report of both psychological and somatic symptoms beyond threshold (level 1), and report of either psychological or somatic symptoms beyond threshold (level 2) (Hickie, Davenport, Hadzi-Pavlovic et al., 2001). Some controversy exists as to the degree to which SPHERE caseness can serve as a proxy for general psychiatric caseness, with reports that level 2 caseness has

the highest level of overall efficiency (i.e., percentage of cases classified by the SPHERE as reaching 'caseness' that also fulfil diagnostic criteria for any disorder according to the Composite International Diagnostic Interview-Auto (CIDI: (World Health Organisation Collaborating Centre for Mental Health and Substance Abuse, 1997) among the different caseness levels, and the only SPHERE output variable with greater overall efficiency than the GHQ-30 (Clarke & McKenzie, 2003). For this reason, only SPHERE level 1 caseness is considered in this paper.

The SF-8 (Ware et al., 2001), is a brief modification of the SF-36 (Ware, Snow, Keller, Kosinski, & Gandek, 1993) with each item assessing one of eight aspects of quality of life: physical functioning, role limitations due to physical health problems, role limitations due to emotional health problems, pain, general health, vitality, social functioning, and mental health. The current study used three-items from the SF-8, canvassing general health (scored on a 6-point Likert scale), role limitations due to physical health problems (scored on a 5-point Likert scale), and role limitations due to emotional health problems (similarly scored on a 5-point Likert scale).

Concurrent criterion-related validity was examined using SPHERE 'caseness' and continuous scores on the three items taking from the SF Health Survey as criterion-related validity measures. Individuals achieving caseness on the SPHERE or reporting difficulties on the SF-Health may not perceive mental health need, and may therefore be more resistant to general practice attempts to intervene than if need were perceived. For this reason, the GUPI is proposed to be a more appropriate indicator of the appropriateness of intervention in general practice than is the SPHERE or the SF-Health. The GUPI attempts to tap perceived need for a range of mental health services, rather than objective need. Therefore, while not all those attaining caseness on the SPHERE or reporting difficulties on the SF-Health would be expected to report need on the GUPI, criterion-related validity would be demonstrated by at least some concordance of the reporting of need on the GUPI with also reaching caseness on the SPHERE or reporting difficulties on the SF-Health. For ecological validity purposes, when examining relationships between scores on the GUPI and criterion measures cross-sectionally, scores at time 1 have been utilised.

RESULTS

Participants

One hundred and twenty-two people attending general practices in north-western Melbourne were recruited to the study; 83 of these participants were available for re-test.

Characteristics of the sample

The mean age of participants was 45 years (sd = 16.12). Females made up 77% of the sample. The modal employment status was that of pensioner (33.6% of the sample), followed by working full-time (24.6%) and full-time home duties (14.8%). 61.5% of completers of the initial recruitment form agreed to be involved in the study; given the design of the study, it was not possible to determine whether refusers differed from participants with reference to clinical or demographic variables.

Utility of the GUPI; the results from the feedback questionnaire

The feedback questionnaire results follow:

Among those declaring opinions other than neutral ones on the provided Likert scales, the majority views were that the GUPI was:

- easy to understand (with 92.6% of responders suggesting that they agreed or strongly agreed with this statement),
- easy to complete (95.3% responding 'agree' or 'strongly agree'),
- relevant (45.5% responding 'agree' or 'strongly agree', 32.3% responding 'neither agree nor disagree'),
- helpful in clarifying needs (36.2% responding 'agree' or 'strongly agree', 27.9% responding 'neither agree nor disagree'),
- possibly helpful in communicating concerns to GPs (45.2% responding 'agree' or 'strongly agree', 27.9% responding 'neither agree nor disagree'),
- inoffensive (93.3% responding 'agree' or 'strongly agree'),
- not upsetting (88.5% responding 'agree' or 'strongly agree'),
- useful (62.1% responding 'agree' or 'strongly agree'),

A substantial proportion reported that they would be prepared to complete the GUPI every time they visit a GP (43.2% responding 'agree' or 'strongly agree', 26% reporting 'neither agree nor disagree').

General descriptive statistics for GUPI responses

59% of participants indicated some form of need on the GUPI at either time 1 or time 2. Chi-square analysis did not reveal any association between demographic variables and perceived need.

Of participants who reported need on the GUPI, the modal barrier reported to accessing means of meeting need was a preference to manage oneself (38.3%), followed by not being able to afford accessing help (11.3%) and being afraid to ask due to stigma (10.4%). Participants were generally more likely to report the absence than the presence of a barrier to meeting need, with the exception of the barrier of 'I preferred to manage myself', which participants were as likely to repond in the affirmative as the negative to (χ^2 (1) = .061, p = 0.81).

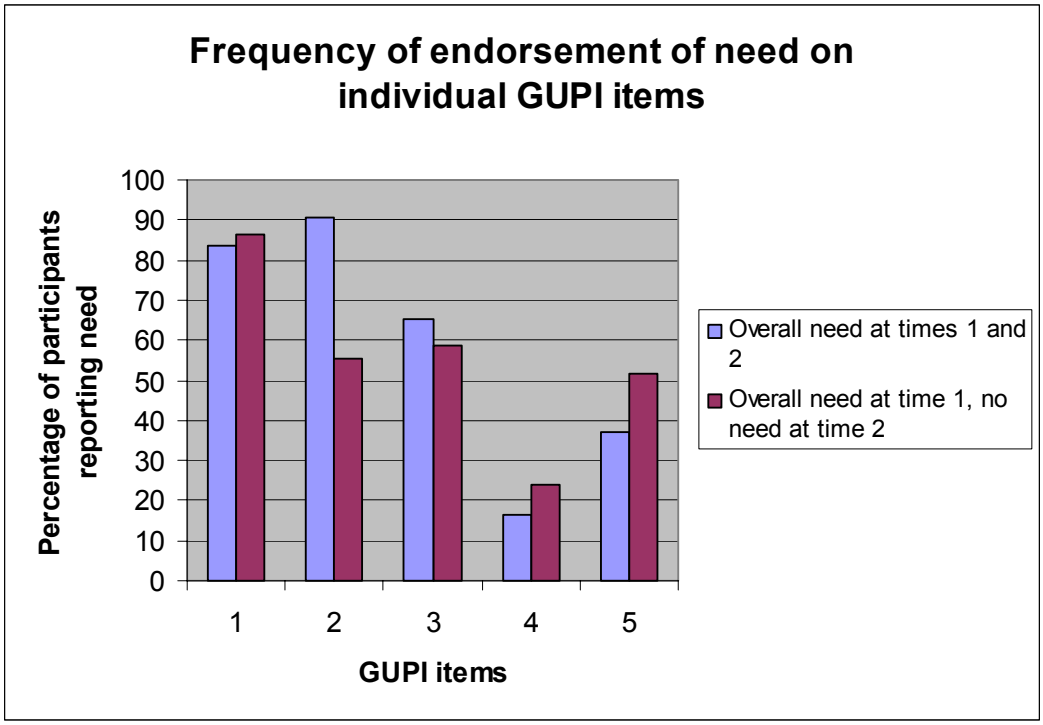
Reliability and validity of the GUPI

Overall stability of reporting of need

In examining the endorsement of any level of need across all GUPI items at time 1 and time 2, it emerged that there was a change in reporting of any need (n = 83, p < 0.01); 59% of the sample reported need at time 1, while 35.2% reported need at time 2. This change was statistically significant (n = 83, p < 0.01, McNemar test).

To explore this apparent drift in overall rate of perceived need, the frequency of need response for each item of the GUPI at time 1 was examined for those who reported overall need at time 1 and overall need at time 2, and those who reported overall need at time 1 and no overall need at time 2. Figure 1 presents these data; for clarity here, the five items on the GUPI are repeated:

1. information ('Information about emotional problems or getting treatment for these problems').
2. medication ('Medication or tablets to help you with emotional problems')
3. counselling ('Counselling, including any kind of help to talk through your difficulties')
4. social intervention ('Help to sort out practical issues, such as housing or money problems')
5. skills training ('Help to improve your ability to work, to care for yourself, to use your time, or to meet people')..



The notable difference between these two groups is that those who report need at time 1 and at time 2 appear more likely to report a need for medication at time 1 than those who report need at time 1 and not at time 2; this difference was however not significant (χ^2 (1) = 2.72, $p < .01$).

Construct validation and reliability testing; time 1 and time 2 data

The GUPI was utilised to examine homo- and hetero-trait, homo-method validity, using data of participants available for both test and re-test. For those unavailable for re-test, data still provided an opportunity to examine hetero-trait, homo-method validity. To frame this analysis reasonably simply: Construct validity would be lent support by higher levels of agreement for the same item over time than between different items over time (using time 1 and time 2 data), and by low levels of agreement generally between different items tapping different constructs within the same administration (using time 1 data only). Test-retest reliability is included for reporting within this framework, as being equivalent to homo-method homo-trait validation.

If items designed to examine different constructs within the GUPI were performing as distinct items, it would be expected that agreements between these items within over time would be low, and that levels of agreement over time between the same items would be high.

Table 1 is a general reporting of relationships between all items on the GUPI at time 1 and 2, utilising the McNemar statistic. This statistic examines test-retest reliability in dichotomous data (c.f., the Kappa statistic, which is more appropriate for assessing inter-rater reliability). A significant statistic ($p<0.05$) suggests significant differences in participants' responses between time 1 and time 2, and hence non-optimal test-retest reliability. The degree to which reports at time 1 differ from reports at time 2 on the same item (i.e., test-retest reliability) lies along the diagonal from top left to lower right.

Table 1: Homo-method homo/hetero-trait validity of the GUPI: McNemar probability statistic (n = 83).

Time 1	Time 2				
	Information	Medication	Counselling	Social interventions	Skills training
Information	0.55	0.02	0.04	0.00	0.00
Medication	0.50	0.00	0.06	0.00	0.00
Counselling	0.38	0.82	1.00	0.00	0.00
Social interventions	0.00	0.00	0.00	1.00	0.10
Skills training	0.00	0.04	0.15	0.02	0.73

These figures show that test-retest reliability for distinctions between 'perceived need' and 'no perceived need' indicated stability over time of all items of the GUPI apart from the medication item. In line with the preliminary descriptive analysis, there was considerable instability in rate of reporting of this item through time, with 45.1% of participants reporting need for medication at time 1 and 37.3% reporting such need at time 2.

As introduced above in the descriptive summary, in examining the endorsement of any level of need across all GUPI items at time 1 and time 2, it emerged that there was a significant change in reporting of any need (n = 83, $p < 0.01$); 59% of the sample reported need at time 1, while 35.2% reported need at time 2.

If the categories operationalised by the GUPI are qualitatively different, it would be expected that there would be significant differences (i.e., significant disagreement) between different categories over time. However, using the McNemar statistic, Table 1 indicates that these differences did not emerge in a number of instances, including time 1 medication and time 2 information needs, time 1 counselling and time 2 information needs and time 1 counselling and time 2 medication needs, as well as time 1 skills and time 2 counselling needs, and time 1 social interventions and time 2 skills needs. This suggests some overlap over time between the categories sampled in the GUPI, particularly those

of information, counselling, and medication on the one hand, and social interventions and skills training on the other.

In order to examine whether unreliability of the medication item was rendering the whole measure invalid, reliability of the measure was examined using only items 1, 3, 4 and 5; McNemar's test still indicated a significant difference over time ($n = 83$, $p < 0.001$).

Construct validation: internal agreements at time 1

If items designed to examine different constructs within the GUPI were performing as distinct items, it would be expected that agreements between these different items within time 1 would be low. Cramer's phi (Φ_c) is a measure of the degree of association between categorical variables, and was calculated to examine cross-sectional relationships between different items on the GUPI at time 1; results are demonstrated in Table 2. This data suggests that responses on different items are highly interrelated, with all revealing a significant association at $p < 0.001$. It therefore appears that no item can be regarded as fully specific and distinct from other items of the GUPI.

Table 2: Hetero-trait validity of the GUPI within time 1 (Φc).

	Information	Medication	Counselling	Social interventions	Skills training
Information					
Medication	0.77				
Counselling	0.66	0.61			
Social interventions	0.31	0.35	0.36		
Skills training	0.43	0.38	0.37	0.44	

A principal components extraction with promax rotation was performed on the GUPI data. Two components were extracted, due to the intuition that items tapping information about emotional problems, medication for emotional problems, or counselling all assume some level of 'psychological need', while items regarding practical issues or social skills appeared less related to 'psychological need' and more to a broader need for social assistance. The first three items of the GUPI loaded heavily on the first factor (all loadings > 0.8), with the fourth item loading on the second factor (loading = 0.65) and the fifth item on both the first (loading = 0.66) and second (loading = 0.50) factors. Communality values were also high, suggesting that variables were largely well defined by this solution.

The suggestion developed through these analyses would be that items 1, 2, and 3 can be seen as to some degree distinct from other items on the GUPI.

Criterion validation: Sensitivity and specificity

Table 3 demonstrates the sensitivity and specificity of each item, as well as GUPI as a whole. Results indicate that no items are high in sensitivity using SPHERE level 2 'somatic caseness' as the criterion variable; that items 1, 2, and 3 are consistently high in sensitivity and moderate in specificity; and that items 4 and 5 are low in sensitivity and high in specificity. Overall efficiency scores for the GUPI are 63.1% with reference to SPHERE level 1 caseness, 54.92% with reference to SPHERE level 2 psychological caseness, and 39.34% for SPHERE level 2 somatic caseness.

Table 3: Sensitivity and specificity of the GUPI, item-by-item, the long form and the short form.

	item 1	item 2	item 3	item 4	item 5	long form
Level 1 caseness						
sensitivity	0.76 (CIs: 0.62 – 0.86)	0.71 (CIs: 0.57 – 0.82)	0.6 (CIs: 0.46 – 0.73)	0.2 (CIs: 0.11 – 0.34)	0.40 (CIs: 0.27 – 0.55)	0.80 (CIs: 0.66 – 0.89)
specificity	0.65 (CIs: 0.54 – 0.75	0.70 (CIs: 0.59 – 0.79)	0.77 (CIs: 0.66 – 0.85)	0.94 (CIs: 0.86 – 0.97)	0.83 (CIs: 0.73 – 0.90)	0.53 (CIs: 0.42 – 0.64)
Level 2 caseness: psychological caseness						
sensitivity	0.78 (CIs: 0.45 – 0.94)	0.67 (CIs: 0.35 – 0.88)	0.56 (CIs: 0.56 – 0.81)	0.11 (CIs: 0.01 – 0.44)	0.22 (CIs: 0.06 – 0.55)	0.78 (CIs: 0.45 – 0.94)
specificity	0.52 (CIs: 0.43 – 0.61)	0.57 (CIs: 0.47 – 0.65)	0.65 (CIs: 0.55 – 0.73)	0.89 (CIs: 0.81 – 0.93)	0.74 (CIs: 0.66 – 0.82)	0.43 (CIs: 0.34 – 0.56)
Level 2 caseness: somatic caseness						
sensitivity	0.26 (CIs: 0.12 – 0.49)	0.22 (CIs: 0.09 – 0.45)	0.21 (CIs: 0.09 – 0.43)	0.05 (CIs: 0.00 – 0.25)	0.16 (CIs: 0.06 – 0.38)	0.37 (CIs: 0.19 – 0.59)
specificity	0.46 (CIs: 0.36 – 0.55)	0.46 (CIs: 0.36 – 0.55)	0.51 (CIs: 0.41 – 0.60)	0.87 (CIs: 0.80 – 0.93)	0.73 (CIs: 0.64 – 0.81)	0.37 (CIs: 0.28 – 0.47)

Multivariate analyses of variance revealed significant relationships between perceived need at time 1 and scores on the SF Health survey, with those reporting need scoring more highly on the 'general' (F (1, 116) = 13.09, $p < 0.001$), somatic (F (1, 116) = 6.03, $p < .05$), and 'psychological' (F (1, 116) = 34.75, $p < 0.001$) health items of the survey.

Table 4 demonstrates results examining concordance between reported need on the GUPI and SPHERE caseness, including level 1 caseness (reaching caseness threshold on both the somatic and psychological subscales), level 2 psychological caseness (reaching caseness threshold on the psychological subscale) and level 2 somatic caseness (reaching caseness threshold on the somatic subscale). All items of the GUPI at time 1 were significantly associated with 'level 1' caseness on the SPHERE. On no item was GUPI 'need perceived' associated with psychological caseness alone; items 1 and 2 were associated with somatic caseness alone item 1. However, only when comparing GUPI 'need perceived' on individual items and SPHERE overall caseness were lower bounds of odds ratio confidence intervals consistently greater than 1 (item 1: OR = 5.72, CI = 2.51-13.07; item 2: OR = 5.78, CI = 2.58 – 12.97); item 3: OR = 4.92, CI = 2.22-10.90; item 4: OR = 3.60, CI = 1.12-11.53; item 5: OR = 3.28, CI = 1.41-7.63). Overall need on the five-item GUPI was associated with SPHERE 'level 1' and 'level 2' somatic caseness, but not with 'level 2' psychological caseness. Again, however, only when comparing overall GUPI need perceived and SPHERE overall caseness were odds ratios greater than 1 (OR = 4.56, CI = 1.93-10.73).

Table 4: Concurrent criterion-related validity of the GUPI with the SPHERE.

	GUPI item 1	GUPI item 2	GUPI item 3	GUPI item 4	GUPI item 5	LF
SPHERE level 1 caseness	χ^2 (1) = 18.63 Fisher's $p < 0.001$	χ^2 (1) = 19.51, Fisher's $p < 0.001$	χ^2 (1) = 16.36, Fisher's $p < 0.001$	χ^2 (1) = 5.10, Fisher's $p < 0.05$	χ^2 (1) = 8.01, Fisher's $p < 0.01$	χ^2 (1) = 12.98, $p < 0.005$
SPHERE level 2 – caseness somatic	χ^2 (1) = 5.05, $p < 0.05$	χ^2 (1) = 5.25, $p < 0.05$	χ^2 (1) = 2.42, *ns*	χ^2 (1) = 0.86, *ns*	χ^2 (1) = 2.00, *ns*	χ^2 (1) = 4.58, $p < .05$
SPHERE level 2 - caseness psychological	χ^2 (1) = 3.00, *ns*	χ^2 (1) = 1.82, *ns*	χ^2 (1) = 1.46, *ns*	χ^2 (1) = .001, *ns*	χ^2 (1) = 0.05, *ns*	χ^2 (1) = 1.41, *ns*

Logistic regression was conducted to examine the degree to which GUPI items, singly and in combination, predicted 'level 1' SPHERE caseness. No single item significantly predicted SPHERE caseness. Results to this stage were suggestive of a qualitative difference between the first three items of the scale and the final two, given results of the principal components and of sensitivity and specificity analyses. Therefore, the first factor of the principal components analysis (i.e., items 1, 2, and 3) were entered in a sequential logistic regression, followed by a second block consisting of the final two items. The first block contributed significantly to the prediction of SPHERE caseness (χ^2 (3)

= 23.96, $p < 0.001$), but the second block did not contribute significantly over and above this (χ^2 (2) = 0.66, $p > 0.10$).

Using the short form of the GUPI, comparisons with criterion variables are largely unchanged. Scores on the SF-Health items are all associated with perceived need reported on the GUPI short form (item 1: F (1, 116) = 14.04, $p < 0.001$; item 2: F (1, 116) = 6.64, $p < 0.05$; item 3: F (1, 116) = 33.25, $p < 0.001$). Similarly, it is only 'level 1' SPHERE caseness that is related to perceived need on the GUPI short form, in terms of both traditional and odds ratio analysis (χ^2 (1) = 15.05, Fisher's $p < 0.001$, odds ratio = 4.92, CIs = 2.13-11.36). Likelihood ratio analyses suggested that participants who report perceived need on the GUPI short form were 1.87 (CI: 1.38 – 2.55) times more likely to report level 1 SPHERE caseness than those who did not. Comparison of table 6 with table 4 demonstrates minimal differences in sensitivity and specificity between the long and short versions of the GUPI. Overall efficiency scores were however marginally higher than those of the long form for SPHERE level 1 caseness and level 2 psychological caseness (65.57% and 59.02%, respectively), although marginally lower for somatic caseness (36.89%).

Table 5: Sensitivity and specificity of the GUPI Short Form.

	SPHERE level 1 caseness		SPHERE level 2 somatic caseness		SPHERE level 2 psychological caseness	
	sensitivity	specificity	sensitivity	specificity	sensitivity	specificity
GUPI short form	0.78 (CIs: 0.64-0.88)	0.58 (CIs: 0.47-0.69)	0.32 (0.15-0.54)	0.41 (0.32-0.50)	0.78 (0.45-0.94)	0.47 (0.38-0.56)

DISCUSSION

Utility of the GUPI

Participant feedback suggests that the GUPI has good 'consumer validity'; participants overwhelmingly found the questionnaire easy to understand and complete, and generally found it useful and potentially helpful in communicating concerns. Many participants did not report an objection to completing the GUPI every time they attended a general practice setting; that most general practice patients agreed to participate in the study is also consistent with a general preparedness to complete the GUPI. Encouragingly, participants who reported perceived need rarely reported barriers to filling this need; the only barrier endorsed more than would be expected was 'I preferred to manage myself'. This suggests that a preference for autonomy, alternatively framed as a stoical stance, may be what hinders individuals from seeking help, rather than stigma or lack of hope, knowledge, finances or appropriate response to requests for help; this may point to future directions of encouraging help-seeking while promoting such help-seeking as not inconsistent with a sense of personal autonomy.

Reliability of the GUPI

Despite participants responding fairly consistently on categories separately examined, apart from the medication category, the reliability of the GUPI as a whole was not optimal; people were less likely to report both a mental health need generally and a medication need specifically at time 2 than time 1. This result cannot be explained by the unreliability of the medication item alone. However, descriptive analysis of differences between participants who reported need at time 1 and time 2, and those who reported need at time 1 and not time 2, suggested that participants who reported need at both times showed a greater tendency to report need for medication at time 1 than those who reported need at time 1 and not time 2. Overall, among those with stability in perceived need overall status, medication is a very frequently endorsed item in the need profile.

A number of speculations can be made regarding explanations for the overall change in frequency of identification of need with time. We had expected that given that the GUPI was administered prior to participants seeing their general practitioner; it might be that completing the GUPI would prompt participants to raise perceived need with their GP in their subsequent appointment. Raising this need may in itself might operate to allow general practitioners to meet need, thereby rendering the need met. We had therefore grouped together those with unmet and met need.

On reflection guided by the study findings, perhaps in primary care it may be that the transition from a perceived unmet need to no perceived need is at least as frequent in practice as that from a perceived unmet need to a perceived met need. Here the activity in action may be reassurance. , The intervention of the GP consultation serves, through provision of information or a professional opinion, to promote a situation wherein the need is no longer perceived. The need is no longer perceived, not because it has been met, but because it has been extinguished by reassurance. The GUPI was developed primarily as a tool for general practitioners to enquire about mental health needs. This study did not seek to establish whether administration of the GUPI results in *consumers* raising issues with their general practitioner after completing it, and thereby receiving reassurance; this issue deserves further examination.

A further potential explanation of these findings might lie in some form of schism in the sample itself. If participants who are more likely to consistently report need report a need for medication to a greater extent than those who do not report need at follow-up, this suggests a number of possibilities. Those who consistently report need on the GUPI may be quite a different 'sub-sample' than those who do not in terms of severity of pathology and/or distress. Furthermore, linked to the previous comment, the inconsistent reporters may be more likely to be assuaged or reassured within the general practice consultation than those who perceive their difficulties to have a more 'biological' or 'severe' component; inconsistent responders' difficulties may also, in accordance with a lesser severity, be more likely to remit over the course of time. Given sample size constraints, it was not possible to examine the degree to which the sensitivity and specificity of the GUPI differs across consistent and inconsistent responders; it is possible, however, that the measure's sensitivity and specificity would be greater in a sample of consistent responders.

Another possible explanation for these results is a methodological one; the GUPI was administered at time 1 in a questionnaire format in the presence of a researcher, but at time 2 was administered verbally over the telephone. While this procedure ensured a greater sample size at follow-up, it may have had its disadvantages, in that clients may have been more reluctant to disclose perceived need verbally than in a less personal questionnaire format.

Validity of the GUPI

Criterion-related concurrent validity of the GUPI was generally supported. Higher scores on items drawn from the SF-Health were associated with perceived need on the GUPI, suggesting that perceived need is associated with poorer general health, and a greater level of disability due to both physical and emotional difficulties. Participants who reported need on the GUPI generally demonstrated level 1 caseness on the SPHERE (i.e., caseness based on reaching threshold on both

psychological and somatic items). The failure of the GUPI to be related to level 2 caseness (i.e., caseness based only on psychological or somatic threshold) may suggest a lack of sensitivity of the measure. On the other hand, however, it is also possible that it is only individuals experiencing a constellation of difficulties, both psychological and somatic, who perceive need; those without these significant levels of symptomatology may experience a degree of *objective* need, but no *perceived* need.

Examination of the validity of the GUPI suggests that there is a degree of overlap between most items designed to examine different categories of need. This is perhaps not surprising, given that each category is designed to tap a feature of the common construct of perceived need for mental health care. Agreement between different items over time was particularly high between the first three items of the GUPI, tapping information about emotional problems or getting treatment for them, medication for emotional problems, and counselling; and between the final two items, tapping practical issues and social skills. Intuitively, the first three items of the GUPI tap a more 'psychological' or 'psychiatric' component of mental health care (i.e., recognition of psychological difficulties and pursuit of different treatment options), as opposed to the final two items which appear to tap more socially-oriented features of perceived need; this higher level of agreement between the first three items is therefore perhaps not unexpected. Factor analysis also served as partial support for this 'two factor' structure of the GUPI, with the first three items clearly loading on one factor (which could be termed 'treatment for emotional problems'), the fourth item on a second factor (which could be termed 'practical assistance'), and the final item on both factors.

Logistic regression analyses were conducted, based on the position that items 1, 2 and 3 appeared to be tapping a common theme of 'recognition of emotional difficulties and need for intervention' that was not shared with items 4 and 5. Results of these analyses suggested that items 4 and 5 of the GUPI did not significantly contribute to the prediction of level 1 SPHERE caseness over and above items 1, 2, and 3. This suggests that the GUPI may perform adequately in a psychometric sense, even if items 4 and 5 are deleted. This suggestion has further support from the data.

Sensitivity and specificity analyses suggested that no item of the GUPI, or the GUPI as a whole, is particularly sensitive or specific, using somatic caseness on the SPHERE as the criterion. On the other hand, items 1, 2, and 3 demonstrate high sensitivity and lower but still moderate specificity using level 1 caseness and level 2 psychological caseness on the SPHERE as criteria; however, items 4 and 5 consistently suggest very low sensitivity and high specificity. The best overall efficiency scores were reported with reference to level 1 caseness, the form of caseness that has been best supported as an indicator of psychiatric caseness (Clarke & McKenzie, 2003). Given that the GUPI is a tool designed to detect need for mental health care which can be overlooked within the general

practice context, and the limited cost of type I error (i.e., probing for consumer need for mental health care when perceived need is absent), it is reasonable to suggest that sensitivity be prioritised above specificity. Thus, items 1, 2, and 3 appear more useful within this context than items 4 and 5. Furthermore, patterns of item overlap over time suggested by McNemar's statistic further suggest a distinction between items 1, 2, and 3, and items 4 and 5.

In examining psychometric qualities of the short form of the GUPI, patterns were generally unchanged; patterns of sensitivity and specificity, overall efficiency, multivariate analysis of variance linking items from the SF-Health survey and perceived need on the GUPI short form, and chi-square analysis of links between the GUPI short form and SPHERE caseness, were the same as those for the GUPI full version. It appears, therefore, that a reformulated GUPI, containing only the first three items, may have advantages of brevity of completion time and simplicity of administration, without sacrificing psychometric qualities.

CONCLUSIONS

The GUPI is a generally well-received measure. Concurrent criterion-related validity is strongly supported.

Within this study, reliability is fond to be somewhat equivocal. This may partly be a function of different administration techniques over time, and/or the possible role of the GUPI in reducing perceived need by allowing an opportunity for reassurance or the meeting of need within a GP consultation subsequent to its administration. With this consideration, and given the findings from this study, it is suggested that a reliability study in a general population setting without the intervention of the GP consultation might be more appropriate for the true estimation of reliability.

The data suggests overlap between categories tapping the same underlying construct of perceived need, notably between those items tapping 'psychological/psychiatric need', and between those tapping 'social need'. Analyses suggest that reducing the GUPI to these 'psychological/psychiatric need' items (i.e., the first three items) would allow the retention of psychometric properties, while creating a measure that is even more brief and simple to administer and complete. In this form, the GUPI goes a substantial way towards meeting evaluative criteria for Evans et al.S's (2000) Mental Health Needs Assessment Critical Appraisal Checklist:

- It has gained some support through psychometrically validation, particularly in respect of criterion validation;
- It has included stakeholder perspectives in its development;
- Feedback suggests that:
    - it is appropriately user-centred,
    - its use is feasible within a general practice setting
    - it is perceived as useful by a majority of participants.

Further research on the GUPI is advised, including reliability testing within a general population setting. Future exploration could usefully include assessment of the degree to which it prompts consultation; also exploration of the extent to which it prompts (a) consumers or (b) general practitioners to raise issues of mental health needs within other consultations, as well as the degree to which general practitioners find it a useful aid in clinical planning and decision making; in the meantime, on the basis of these findings, the continued use and further evaluation of the GUPI, generally, and with consideration of the use of the GUPI short form where extreme brevity is desirable, is warranted.

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APPENDIX: THE PERCEIVED NEED FOR CARE QUESTIONNAIRE:

Coverage: Mental health problems, Service use, Perceived need

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A. MENTAL HEALTH PROBLEMS

A1. IS SUBJECT A KNOWN CLIENT OR PATIENT OF MENTAL HEALTH SERVICES?

NO 1
YES 5 (SKIP TO A3)

A2 Please think back over the last year, and consider if you have had any difficulties with your mental health over that time.: Do you think that, in the last year, you have at any time had any problems with your mental health?

NO 1 (SKIP TO SECTION B)
YES 5

A3 (IF A1 CODED 5, PROMPT WITH 'I understand you have been receiving help for mental health problems during the last year '.)
What would you call the problem or problems that you have had with your mental health ?
(PROBE AS NECESSARY. INFORMATION MAY BE ADDED HERE FROM RESPONSES EARLIER IN THE INTERVIEW. CREATE AND RECORD A DESCRIPTION OF MENTAL HEALTH PROBLEMS EXPERIENCED WHICH WILL BE FAMILIAR TO THE SUBJECT)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

B. HEALTH CARE USE /PERCEIVED NEED

The next questions concern your own health care

B1	In the last 12 months have you been admitted for at least one night to any hospital ?	NO (SKIP TO B5) YES	1 5

B2	Have you been admitted overnight to a general hospital ?	NO (SKIP TO B3) YES	1 5
	a. Was that for a physical illness?	NO (SKIP TO b) YES	1 5
	a1. Over the last 12 months, how many times were you admitted for at least one night to a general hospital for a physical illness ?		_____/_____ # OF ADMISSIONS
	a2. (For that admission/over those (A1) admissions,) how many nights in total did you stay in a general hospital because of physical illness ?		_____/_____ TOTAL #OF NIGHTS
	b. Have you been admitted to a general hospital overnight for nerves or mental problems within the last 12 months ?	NO (SKIP TO B3) YES	1 5
	b1. Within the last 12 months, how many times were you admitted for at least one night to a general hospital for nerves or mental problems ?		 # OF ADMISSIONS
	b2. For that admission/over those (B1) admissions, how many nights in total did you stay in a general hospital because of nerves or mental problems ?		 TOTAL # OF NIGHTS
	b3. Was that in a private or a public bed ?	PRIVATE PUBLIC	1 5

B3	In the past 12 months have you (also) been admitted overnight to a psychiatric hospital ?	NO (SKIP TO B4) YES	1 5
	a1. Within the last 12 months, how many times were you admitted for at least one night to a psychiatric hospital?		 # OF ADMISSIONS
	a2. (For that admission/over those (A1) admissions) how many nights in total did you stay in a psychiatric hospital ?		_____/_____ TOTAL # OF NIGHTS
	a3. Was that in a private or public psychiatric hospital ?	PRIVATE PUBLIC	1 5

B4	In the past 12 months have you been admitted overnight to a drug and alcohol unit in a hospital ?	NO (SKIP TO B5) YES	1 5
	a1. Within the last 12 months, how many times were you admitted for at least one night to a drug and alcohol unit ?		_____/_____ # OF ADMISSIONS
	a2. (For that admission/Over those (A1) occasions,) how many nights in total did you stay in a drug and alcohol unit ?		_____/_____ TOTAL # OF NIGHTS
	a3. Was that in a private or public unit ?	PRIVATE PUBLIC	1 5

SHOW CARD B1 TO RESPONDENT

B5 In the past 12 months,(apart from time you were in hospital,) have you seen any of the doctors or health professionals listed on this card regarding your own health ? NO 1 YES 5

IF B1 AND B5 CODED 1, SKIP TO B15.
[IF NO HOSPITALISATIONS OR CONSULTATIONS, SKIP TO B18]
IF B2b, B3 OR B4 CODED 5 AND B5 CODED 1, SKIP TO B9,
[IF HOSPITALISED FOR A MENTAL HEALTH PROBLEM BUT NO CONSULTATIONS FOR MENTAL HEALTH /DRUG PROBLEMS, ASK B9]
IF B2b, B3 AND B4 NOT CODED 5 AND B5 CODED 1, SKIP TO B18
[IF HOSPITALISED IN A GENERAL HOSPITAL BUT NO MENTAL HEALTH SPECIFIC HOSPITALISATIONS OR CONSULTS, SKIP TO B18]

OTHERS **[MOST]** ASK:

a. Which of the listed health professionals did you see ?

IN THE TABLE BELOW, MARK BOXES CORRESPONDING TO CONSULTED PROFESSIONALS.

FOR EACH MARKED GROUP OF PROFESSIONALS,
ASK B6 THROUGH B8 AND CODE ANSWERS IN
APPROPRIATE COLUMN OF TABLE.

B6 How may times did you consult a (NAME OF HEALTH PROFESSIONAL) within the past 12 months ?

INT: TIMES EQUALS VISITS

B7 How many of these consultations were related to mental problems of any sort ?
[IF THIS >0, YOU WILL ASK B9 WHEN YOU REACH IT]

IF B7 IS NIL, THEN SKIP TO NEXT PROFESSIONAL OTHERWISE ASK:

B8 Where did those mental health consultations mainly take place ?

CODE RESPONDENTS ANSWER ACCORDING TO THE FOLLOWING LOCATION CODES -

1) In their rooms (surgery: clinic or shop)
2) In your home
3) At a community health clinic
4) At a drug or alcohol service
5) As a hospital outpatient (including accident or emergency)

B5	HEALTH PROFESSIONALS	R6: TOTAL # CONSULTATIONS	R7 MENTAL HEALTH CONSULTATIONS	R8 LOCATION CODE
1	General Practitioner			
2	Radiologist or have X-rays etc.			
3	Pathologist or have blood tests etc.			
4	Physician or other medical specialist			
5	Surgical specialist or gynaecologist			
6	Psychiatrist			
7	Psychologist			
8	Social worker or welfare officer			
9	Drug and alcohol counsellor			
10	Other counsellor			
11	Nurse			
12	Mental health team			
13	Chemist for professional advice			
14	Ambulance officer			
15	Other health professional specify:			

IF B7 ALL CODED 0, AND SKIP TO B18.
OTHERS ASK B9.

B9 SHOW CARD B2 TO RESPONDENT

[ASK IF A SERVICE USER FOR MENTAL HEALTH /DRUG PROBLEMS]
IF (ONE OR MORE B7 CODED >=1) AND (B2b, B3, OR B4 ARE CODED 5) THEN INSERT 'consultations and hospital admissions'
IF (ONE OR MORE B7 CODED >=1) AND (B2bB, B3, AND B4 CODED 1), INSERT 'consultations'
IF (ALL B7s UNCODED OR 0) AND (B2b, B3, OR B4 CODED 5), INSERT 'hospital admissions'.

Look at the items listed on this card. Which of these forms of help did you receive from those (consultations/ (and) hospital admissions), for any problems with your mental health ?

CIRCLE NUMBERS FOR ALL TREATMENTS MENTIONED

(1) Information about mental illness, its treatments, and available services ?	1
(2) Medicine or tablets?	2
(3) Psychotherapy - discussion about causes that stem from your past?	3
(4) Cognitive behaviour therapy - learning how to change your thoughts, behaviours and emotions ?	4
(5) Counselling - help to talk through your problems	5
(6) Help to sort out housing or money problems ?	6
(7) Help to improve your ability to work, or to use your time in other ways?	7
(8) Help to improve your ability to look after yourself or your home	8
(9) Help to meet people for support and company ?	9
(10)Other - example:_____	10

B10 IF B9 1 IS NOT CIRCLED, SKIP TO 2.

1. You mentioned that you received information about mental illness, its treatments and available services.

a. Do you think you got as much of this kind of help as you needed ?

NO 1
YES (SKIP TO B11) 5

b. Why didn't you get more help from health professionals ? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source _____

REASON
CODE (1-7)_____
SKIP TO B11

2. You mentioned that you did not receive information about mental illness, its treatment and available services.

a. Do you think you needed this type of help?

NO..(SKIP TO B11) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON
CODE (1-7)_____

B11 IF B9.2 IS NOT CIRCLED SKIP TO 2

1. You mentioned that you received medicine or tablets.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES, (SKIP TO B12) 5

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
SKIP TO B12

2. You mentioned that you did not receive medicine or tablets.

a. Do you think you needed this type of help ?

NO (SKIP TO B12) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B12 IF B9.3,9.4 AND 9.5 ARE ALL UNCIRCLED, SKIP TO 2.

1. You mentioned you received counselling or a talking therapy.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES (SKIP TO B13) 5

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
SKIP TO B13

2. You mentioned that you did not receive counselling or a talking therapy.

a. Do you think you needed this type of help ?

NO (SKIP TO B13) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B13 IF B9.6 IS NOT CIRCLED, SKIP TO 2.

1. You mentioned that you received help to sort out practical issues such as housing or money problems.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES (SKIP TO B14) 5

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
SKIP TO B14

2. You mentioned that you did not receive help to sort out practical issues such as housing or money problems.

a. Do you think you needed this type of help ?

NO (SKIP TO B14) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B14 IF B9.7 AND 9.8 ARE BOTH UNCIRCLED, SKIP TO 2.

1. You mentioned that you received help to improve your ability to work, to care for yourself or to use your time.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES (SKIP TOB15) 5

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
SKIP TO B15

2. You mentioned that you did not receive help to improve your ability to work, to care for yourself or to use your time.

a. Do you think you needed this type of help ?

NO (SKIP TO B15) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B15 IF B9(7) UNCIRCLED, SKIP TO 2

1. Specifically you mentioned that you received help to improve your ability to work, or to use your time in other ways.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES (SKIP TO B16) 5

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
SKIP TO B16

2. Specifically you mentioned that you did not receive help to improve your ability to work, or to use your time in other ways.

a. Do you think you needed this type of help ?

NO (SKIP TO B16) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B16 IF B9(8) UNCIRCLED SKIP TO 2

1. Specifically you mentioned that you received help to improve your ability to look after yourself or your home.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES (SKIP TO B17) 5

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
SKIP TO B17

2. Specifically you mentioned that you did not receive help to improve your ability to look after yourself or your home.

a. Do you think you needed this type of help ?

NO (SKIP TO B17) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B17 IF B9 (9) UNCIRCLED, SKIP TO 2

1. You mentioned you received help to meet people for support and company.

a. Do you think you got as much of this kind of help as you needed from health professionals ?

NO 1
YES 5 (**FINISH**)

b. Why didn't you get more help from health professionals? Please choose the main reason, or the single reason which most closely applies. INT: SHOW CARD B3 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything more could help
3. I didn't know how or where to get more help
4. I was afraid to ask for more help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
(FINISH)

2. You mentioned you did not receive help to meet people for support and company.

a. Do you think you needed this type of help ?

NO (**FINISH**) 1
YES 5

b. Why didn't you get this help? Please choose the main, or the single reason which most closely applies. INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____
FINISH

B18 IF A1AND A2 CODED 1, **FINISH,** OTHERWISE REFER TO PROBLEM LIST IN A3

I understand you have had a problem with your mental health, such as (INT: RELATE PROBLEMS FROM A3) but you haven't mentioned being in hospital or getting help from any health professional. Were there any types of help which you think you needed during the last twelve months but did not get ?

SHOW CARD B2 TO RESPONDENT

Do you think you needed information about mental illness, its treatment and available services ?

NO (SKIP TO B19) 1
YES 5

a. Why didn't you get this help? :INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES. Please choose the main reason, or the single reason which most closely applies.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B19 Do you think you needed medicine or tablets ?

NO (SKIP TO B20) 1
YES 5

a. Why didn't you get this help? :INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES. Please choose the main reason, or the single reason which most closely applies.

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B**20** **Do you think you needed counselling or talking therapy ?** NO (SKIP TO B21) 1
YES 5

A. Why didn't you get this help? Please choose the main reason, or the single reason which most closely applies.
INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON
CODE (1-7)_____

B21 **Do you think you needed help to sort out practical issues such as housing or money problems ?** NO (SKIP TO B22) 1
YES 5

A. Why didn't you get this help? Please choose the main reason, or the single reason which most closely applies.
INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON
CODE (1-7)_____

B22 **Do you think you needed help to improve your ability to work, to care for yourself or to use your time?** NO (SKIP TO B23) 1
YES 5

a. Why didn't you get this help? Please choose the main reason, or the single reason which most closely applies.
INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON
CODE (1-7)_____

B23

Specifically do you think that you needed help to improve your ability to work, or to use your time in other ways.

No (skip to B24)
Yes

a. Why didn't you get this help? Please choose the main reason, or the single reason which most closely applies.
INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B24:

Specifically do you think that you needed help to improve your ability to look after yourself or your home.

No (skip to B25)
Yes

A. Why didn't you get this help? Please choose the main reason, or the single reason which most closely applies.
INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

B25

Do you think that you needed help to meet people for support and company.

No (**FINISH**)
Yes

a. Why didn't you get this help? Please choose the main reason, or the single reason which most closely applies.
INT: SHOW CARD B4 AND PROMPT FOR ONE RESPONSE, OR RANK RESPONSES

1. I preferred to manage myself
2. I didn't think anything could help
3. I didn't know where to get help
4. I was afraid to ask for help, or of what others would think of me if I did
5. I couldn't afford the money
6. I asked but didn't get the help
7. I got help from another source: _____

REASON CODE (1-7)_____

FINISH