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A survey of social services needs assessments for elderly mentally ill people in England and Wales

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Abstract

Objective: to examine variations in the needs assessment policies and practices of social services departments in England and Wales in dealing with elderly people who have mental illness.
Design: postal questionnaire survey.
Subjects: a random sample of 61 of 119 social services departments in England and Wales.
Main outcome measure: 99-item questionnaire.
Results: 40 responses were received (66%). There were substantial differences in the way referrals were screened before needs assessment and in the design of needs assessment procedures. Disagreements between health and social services were common and, although mechanisms existed to respond to urgent needs, almost one-third found such responses difficult to make.
Conclusions: there are national variations in the way needs assessments are performed by social services, which may lead to inequalities in provision of care to individuals. The lack of a standardized approach impedes comparisons of need between areas which might aid in the distribution of resources at a national level.

Keywords: *aged, health care reform, health services needs and demand*

Introduction

The National Health Service and Community Care Act 1990 implemented the government policy of targeting home-based social services towards those most in need. This required social service departments to develop eligibility criteria for defining which needs should be met [1] before assessing the needs of individuals for care.

There is no consensus on the definition of 'need'. The Community Care Act provides none and the Social Services Inspectorate defines it as "the requirement of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life" [2]. Alternatively, need has been defined as a deficit which can, at least in part, be alleviated by some intervention. Scales such as the Camberwell Assessment of Need for the Elderly [3] and the Medical Research Council Needs for Care Schedule [4] have been designed from this point of view. The Camberwell Assessment of Need for the Elderly is based on the consensus of many professionals and has good validity and reliability [3].

We have investigated national variations in the way needs are assessed and the way the public may gain access to needs assessment. We address the difficulties in determining the cost implications of needs assessments and the liaison between health and social services.

Methods

We developed a postal questionnaire from an in-depth analysis of the way two local authorities (Essex and Hertfordshire) approached needs assessment of elderly people with mental illness. We constructed a questionnaire from a shortlist of potential questions. The final version incorporated comments from experienced researchers in the field.

A random sample of half the social services

departments in England and Wales was constructed from the *Social Services Year Book 1996*. Where possible, the questionnaire was sent to a team leader for elderly mental health. If no name was recorded, the questionnaire was sent to "The Senior Social Worker (elderly team)". Non-responders were sent a second questionnaire, followed by telephone contact where necessary. The final sample of 61 included 59 randomly selected and the two local social services departments.

Results

We received responses to 40 (66%) of the 61 questionnaires. Comments indicated that the main reason for failure to respond was disruption caused by reorganization within local departments.

In screening referrals to social services departments, 24 (60%) required the initial referral to be made on a standard form and 27 (67.5%) rejected requests under some circumstances without seeking further information. Once the decision was made not to proceed with an assessment of need, 36 (90%) 'always or usually' informed the referrer and 20 (50%) 'always or usually' informed the subject of the referral. Where failure to provide urgent help would lead to a clear risk of harm or hardship, all but two (5%) said that resources could be released immediately, although 12 (30%) found this difficult in practice.

Sources of information used in the design of needs assessment schedules were: government publications (37, 97.5%), in-house research (27, 67.5%), consultation with other social services departments (22, 55%), specialists in needs assessment (16, 40%) and published scales (13, 31.5%). Those that used published scales were also more likely to have consulted specialists ($\chi^2 = 10.94$, $P = 0.001$) and those that consulted other social services departments were more likely to have used in-house research ($\chi^2 = 4.6$, $P = 0.033$).

A checklist assisted the identification of needs in 32 (80%) of the departments. In six the list aimed to cover 'all conceivable needs' and two of these had predetermined interventions to match each need. Fourteen of the checklists aimed to cover 'nearly all needs' and 12 aimed to cover 'most needs'. The areas of need that were routinely enquired about are listed in Table 1. Overall, there was little agreement as to which needs should be included, although a 'core' of 14 needs were selected by 29 (72.5%) of the departments.

The identification of multiple or expensive needs led to a review by senior staff (24, 60%) and a limit to the amount spent (25, 62.5%). Comments indicated that the cash limits equated to the cost of residential care.

Disagreements between health and social services were common, with only eight (20%) of the departments saying that they rarely or never occurred. Twenty-four (60%) adopted a procedural approach to resolving differences and 20 (50%) relied on the professionals involved coming to an agreement.

Table 1. Needs from the Camberwell Assessment of Need for the Elderly that departments of social services inquire about as a matter of routine

Need	No. (and %) inquiring
Ability to communicate[a]	
Benefits[a]	
Carer stress[a]	
Continence[a]	
Memory[a]	37 (92.5)
Physical health[a]	
Safety accidental self-harm[a]	
Self care[a]	
Physical disability/immobility[a]	
Safety abuse by others[a]	36 (90.0)
Money[a]	
Vision and hearing[a]	35 (87.5)
Care at home[a]	
Information for carers[a]	34 (85.0)
Daytime activity	
Safety: deliberate self-harm	33 (82.5)
Nutrition	32 (80.0)
Caring for others	
Company	30 (75.0)
Psychological distress	
Psychotic symptoms	29 (72.5)
Integrity of others	27 (67.5)
Information	
Transport	26 (65.0)
Drugs	24 (60.0)
Alcohol	20 (50.0)
Intimate relationships	18 (45.0)
Dental care	13 (32.5)
Sexual expression	8 (20.0)

[a]Core needs.

Discussion

The response rate was acceptable, but the effect of departmental reorganization suggests that the non-responders may represent more disrupted and pressurized departments.

Our results confirm repeated reports from the Social Services Inspectorate [5] that there is variation between areas. We found differences in the practice of screening referrals, sources of information used in designing needs assessment procedures and the needs routinely examined.

The variation in the use of standard referral forms and the degree to which further information is required before referrals are rejected suggests variation in the way referrals are screened for eligibility before needs assessment. While it is clear that mechanisms exist to process urgent requests for assistance, the finding that this is difficult in some areas gives cause for concern.

The use of predetermined interventions when certain criteria are fulfilled provides an explicit model of 'ideal' practice. Consequently, inherently subjective judgements about the presence of need become open to scrutiny [6], in contrast to the more inventive, tailored solutions advocated by the Social Services Inspectorate [2]. Variations in the use of checklists for needs and the identification in advance of interventions suitable for each need thus reflect fundamental differences in the process of needs assessment.

The fact that many departments routinely check a wide range of needs clearly assists the provision of effective packages of care. It also prevents the assessment of need merely becoming a response to the most salient problems [4].

It is of concern that one-fifth of departments do not enquire about needs for help with nutrition, psychological distress, deliberate self-harm or daytime activities. Psychological distress and deliberate self-harm are particularly important, as depression in elderly people is often overlooked [7] and increases the risk of suicide. In addition, lack of daytime activities may lead to boredom and low morale impairing quality of life.

Conclusions

There are marked inequalities in the access to and provision of social services needs assessments in England and Wales. In consequence, the services available to individuals with particular needs will vary. Furthermore, the lack of standardization in assessment makes it impossible to compare the needs of different local authority populations. This misses an opportunity to target resources at areas most in need.

A national review of needs assessment procedures, perhaps co-ordinated by the Social Services Inspectorate, could lead to better national guidelines for social services departments.

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Key points

- The policy of leaving individual local authorities to establish their own needs assessment protocols has resulted in a lack of standardization which may cause regional inequalities in social care provision.
- There are widespread difficulties in the release of resources to meet urgent needs.
- There is frequent disagreement between health and social services over proposed care packages.

References

1. Challis L, Henwood M. Equity in community care. Br Med J 1994; 308: 1496–9.

2. Social Services Inspectorate. Care Management and Assessment: practitioners' guide. London: HMSO, 1991.

3. Reynolds T, Orrell M. Preliminary results on the validity and reliability of the Camberwell Assessment of Need Elderly Scale. Presented at the Royal College of Psychiatrists Winter Meeting, London, 1998.

4. Brewin CR, Wing JK, Mangen SP *et al.* Needs for care among the long-term mentally ill: a report from the Camberwell High Contact Survey. Psychol Med 1988; 18: 457–68.

5. Social Services Inspectorate. The Cornerstone of Care: Report of an inspection of care planning for older people. London: HMSO, 1997.

6. Bebbington P. Assessing the need for psychiatric treatment at the district level: the role of surveys. In Thornicroft G, Brewin C, Wing J eds. Measuring Mental Health Needs. London: Royal College of Psychiatrists, 1992.

7. Bannerjee S, Shamash K, Macdonald AJ *et al.* Randomised trial of the effect of intervention by psychogeriatric team on depression in frail elderly people at home. Br Med J 1996; 313: 1058–61.

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