WORKSHOPS

NEED ASSESSMENT
(oral presentations)

A MULTI-METHOD APPROACH TO PROGRAM DESIGN AND EVALUATION.

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Contrary to current evaluation strategies, the approach presented here is anchored in the clarification of illness processes as a basic component in planning services. This gives new meaning to the demand vs. need controversy and help us to re-allocate funds to existing care products and use our new insights to design relevant new activities. New methods will be discussed that bridge the gap between need and demand because epidemiolic defined prevalence has not proven to be an accurate predictor for demand for services. The gap, however, between theoretical need based on prevalence and the use of health services has remained largely unsolved due the lack of multi-staged research techniques which are capable of focussing on relevant target populations or activities.

Impact studies have been able to partially determine whether programs or interventions have brought about significant change from the baseline situation in those populations which have been identified and reached. That something has changed can be determined, the what and why are less apparant. None of these approaches has proven to be able to provide a working model for the prediction of occurance of illness and recovery in relationship to the necessary programs or interventions to deal with it. They have, however, showed a number of weaknesses in their assuming either the use of baseline measurement for assessing the effects of intervention programs on certain subject characteristics or the use of reference groups to determine change. This approach to evaluation is more than likely to have been based on assumptions of population profile using classical epidemiologic methods of measurement such as prevelance and incidence and in the second place, the retrospective questionnaire studies which are often the basis of evaluation studies often appear to be totally non-representative.
The crux of the issue and the focus of this paper is to link these new data gathered by means of multi-method and multi-stage sampling techniques about illness processes with existing and required services and to adequately evaluate them. Although we are just at the beginning of this specific line of research, we feel it to be important to clearly demonstrate the essential alliance between health care planners and multi-method researchers.
The way we design programs will ultimately determine the outcome of effect and impact studies. When services and interventions are designed according to the above mentioned multi-method approach, using a cascade design and incorporating methods such as 'snow-ball sampling' and 'experience sampling', the evaluation procedure can logically follow in a pre- / post-treatment design using valid concepts of behavior/illness within a real-life context and in this way answer the questions of why and how the changes took place (process evaluation) in a focal setting/population. A valid interpretation of the impact on the environment of the patient can also be made in this fashion. We aim, therefore, to provide simple tools for effectively measuring and evaluating the quality of services for specific groups.

The use of this approach in design and evaluation of health care services will be discussed and illustrated.

Developing Reliability in Client-centred Needs Assessment

Recent statutory legislation has given rise to increasing attention being given to the process of determining the nature of an individual's mental health needs and responses to those needs by mental health services in the UK. The Bangor Needs Assessment Profile (B - NAP) is a new research instrument designed to assess the needs of the long-term mentally ill. The model used attempts to distinguish both at conceptual and operational level the measurement of need in terms of lowered physical, psychological and social functioning compared with what would ordinarily be expected in society. To date 57 people with a long term mental illness and 57 formal carers have been assessed. The justification for researching needs assessment in this way is that it provides a means of exploring and advancing the development of a standardised approach to needs assessment both at the level of individually expressed need and at the level of perceived need from someone who knows the person with a mental illness well. The B - NAP includes 32 specific items which rate both quantitatively and qualitatively the absence or presence of need, the importance of need, whether or not the need is met and who is or should be meeting the need.

Early results indicate a) reliability of agreement ratings between patients and staff: mean Kappa of .25, mean percentage agreement of 60%, suggesting poor agreement beyond chance; b) Test-retest reliability for i) staff (N = 20) mean Kappa of .6, mean percentage agreement of 80%; ii) patients (N = 19) mean Kappa of = .4, mean percentage agreement 75% suggesting "fair to good agreement beyond chance".

Justification for content, structure and reliability of the B- NAP will be presented. It is hoped that issues for discussion will include the perspective of different values in needs assessment and how satisfactory are e.g., the methods of agreement for what is essentially a judgmental task? How straight forward is the interpretation of reliability data in needs assessment? What if the theoretical concept has changed? What if staff and patients simply disagree? What if test-retest agreement underestimates need by interpreting true change as measurement error? Suggestions for further exploration is the issue of measuring and interpreting staff perceptions of client need and client expressed need and their relation to the use of summary indices of agreement and disagreements on the presence and absence of need.

THE VALIDITY AND RELIABILITY OF THE CAMBERWELL ASSESSMENT OF NEED (CAN)

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The Camberwell Assessment of Need (CAN) is a new needs assessment instrument, which has been designed to measure the multiple clinical and social needs of people with serious mental illness. The CAN incorporates both staff and patient perceptions of the level of need in 22 areas, and records the level of help being received from staff and informal carers. Validity and reliability (n=60) studies have been conducted, and the results demonstrate that the CAN is both valid and reliable. Research and clinical versions of the instrument are available. Results can be analysed item by item for clinical purposes. Collaborators in seven other European countries are currently working on translations of the instruments, and a computerised version of the instrument is under development.

THE "PATTERN OF CARE" OF PSYCHOTIC PATIENTS IN DIFFERENT SETTINGS IN SWEDEN. Monica E Holm and Bengt André, Psychiatric Clinic, University Hospital, Box 638, S-22009, Lund, Sweden.

Starting in Lund 1986, a case-register for psychiatric care has developed, located in different parts of Sweden. The register covers in- and out-patient care for about 1,5 million people. The catchement area represents a variety of communities in different parts of Sweden, both rural, urban and suburban, some of them close to the three biggest cities.

One of the most constant findings in case-registers is different rates of psychosis in urban compared to suburban or rural communities. In our material the most "heavy" sectors have rates of psychosis 3-4 times as high as others. We suggest the migration of young people to central city areas as one of factors contributing to the higher prevalence in these areas.

This study is focused on the "pattern of care" found in high and low psyhosis areas in 1993. There are differences in utilization of psychiatric services, and some possible explanations are shown.

There are also practical aspects of the findings. In financing the psychiatric care, authorities in Sweden very seldom consider epidemiological differences. "Health indexes" developed for somatic care are sometimes used, which means that a population higher in age utilizes more care. In the study is shown that the financial demands in psychiatry are quite the reverse, as a young population utilizes more expensive care.

From the Psychiatric Clinic of Varberg, head: B Spångberg, and the University Clinic of Lund, head: Prof Rolf Öhman

NEED FOR CARE IN SCHIZOPHRENIA: A FOLLOW-UP STUDY OF DISCHARGED SCHIZOPHRENIA PATIENTS. Teija Honkonen * and Raimo K R Salokangas**, *Department of Public Health, University of Tampere, Lääkärinkatu 3, 33101 Tampere, Finland; ** Department of Psychiatry, University of Turku, 20520 Turku, Finland.

The purpose of the present study was to assess needs for care among schizophrenia patients in community. The study sample consisted of 123 schizophrenia patients who had been discharged from mental hospital in 1986 and investigated three years later. The MRC Needs for Care Assessment was applied for assessment of needs in clinical and social functioning. Further information was obtained by using the Present State Examination and by interviewing relatives and staff.

At follow-up nearly 15 percent of the patients were out of contact with psychiatric services. 29 percent of the sample were having unmet needs in neurotic symptoms, 24 percent in positive psychotic symptoms and 15 percent in physical disorders. About one fifth were having unmet needs in basic self care skills. In general unmet needs were greatest among patients out of psychiatric care. However, in some important clinical areas - namely, in neurotic symptoms and physical disorders - unmet needs appeared to be as common among patients using psychiatric services, aswell.

The results suggest need for more active actions in order to offer treatment for patients who have dropped out of contact with psychiatric services. In addition, there seems to be need for further development of prevailing care system, to be able to meet needs for care among long-term mentally ill in community.

NEEDS FOR CARE IN SCHIZOPHRENIA AFTER 15 YEARS SINCE ONSET OF PSYCHSOSIS. D. Wiersma, R. Giel, A. de Jong, F.J. Nienhuis & C.J. Slooff. Department of Social Psychiatry, P.O.Box 30.001, 9700 RB Groningen, the Netherlands.

Patients suffering from a first life time psychosis of non-affective type and coming from a circumscribed area in the north of the Netherlands were in 1978 included in the study after a contact with a mental health service. They were investigated in the context of the WHO Collaborative Study on the Assessment and Reduction of Psychiatric Disability (de Jong et al 1985, Wiersma et al 1983) and followed up over a period of three years with the help of standardized instruments as the PSE and the DAS. WHO is currently co-ordinating a multi-center study on the course and outcome of schizophrenia in 26 centers and 17 countries. The Dutch study included the MRC Needs for Care Assessment, as developed by Brewin and Wing (version 2 sept. 1989; see also Brewin et al. 1987 & 1989).
The Dutch study completed the 15 years follow up in 1993 and found out that 19 patients (23.2%) of the total cohort of 82 patients could not be contacted anymore, due to suicide (11.0%), migration abroad and privacy regulations (6.1%) and refusal (6.2%). The remaining 63 (76.8%) patients could more or less be fully interviewed. Half of them were still or again psychotic but one third received no current axis-I diagnosis over the last month anymore. 22% were admitted to a hospital or sheltered accomodation, 25% were in outpatient mental health care, and 17% were treated by their general practitioner. Of all clinical problems encountered 14% received no or inadequate care which led to the assessment of an unmet need; this percentage is for the problems in social functioning 7%. About one out of every four patients had one or more unmet needs, but an additional 19% had at least one no meetable need indicating in several cases a neglect of psychotic illness by mental health care. Methodology of needs assessment, and the relationship of needs status with sociodemographic and other variables like diagnosis and setting of care will be discussed.

NEED ASSESSMENT - THERAPISTS AND PATIENTS POINT OF VIEW.

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170 long term psychiatric patients, mostly schizophrenics, were interviewed with a structured questionnaire. All were cared for within the specialized psychiatric service in Oslo. They lived in different residential situations, but most of them in the community. Patients rated themselves on fixed scales measuring different dimensions of subjective well being, social support and need for housing, activity, support and treatment. At the same time a professional knowing the patient fairly well made ratings on parallel scales. The relation between the patients own evaluation and the professionals view are illustrated and explained. Conceptual and value issues in need assessment research are discussed.

NEED FOR PSYCHIATRIC TREATMENT IN MEDICAL, SURGICAL, AND GYNECOLOGICAL WARDS

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Research psychiatrists estimated in 728 patients of medical, gynecological and surgical departments the actual need for referral to consultation psychiatrists or to psychiatric departments. This estimation was based on the information obtained from a standardized interview as well as on the judgement whether the patient needed further diagnostic assessment (e.g. course of psychopathology) and/or specialized therapy (e.g. high dosage of psychotropics, occupational therapy) by a consultation psychiatrist or in a psychiatric ward. The ratings were made on a simple scale developed for the purposes of our survey (Interrater reliability: r = 0.88 – 0.96). The prevalence according to case criteria of the Clinical Interview Schedule was highest in the medical departments (38.2%), followed by surgical departments (32.5%). In gynecological departments the rate was lowest (20.7%). In medical and surgical patients dementia and addiction were the most frequent psychiatric disorders, while in gynecological departments neurotic disorders showed the highest frequency. The need for psychiatric consultation was highest in the medical departments (17.8%), followed by the surgical (13.4%) and the gynecological departments (7.9%). Futhermore 5.8%, 2.4%, and 0.8% were judged as needing referral to a psychiatric inpatient unit. The rate of actual consultations and admissions to psychiatric hospital departments was markedly lower than the estimated need.

NEED ASSESSMENT
(poster presentations)

MONITORING TREATMENT PROGRAMS BY THE USE OF ROUTINE DATA: POSSIBILITIES AND LIMITATIONS.

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Objective: To demonstrate how routinely collected data can be used to monitor health care delivery systems.

Material and methods: From 1981 all psychiatric wards i Oslo, Norway have registered on a routine basis data concerning every admission. This paper will present results from the period 1981-1991 for three acute wards which together covered a catchment area of 300 000 people. I will limit the presentation to the annual numbers for each ward for the following variables: 1. The number of admissions. 2.The percentage of admittances that were: a.emergencies, b.committed, c.due to psychosis. 3. The average length of stay.

Results: The number of admissions was basically unchanged during the period. In contrast there was a marked increase in the percentage of emergencies (from 60 to 90), admittances due to psychosis (from 50 to 70) and committed admissions (from 45 to 85). Two of the wards had a fairly short length of stay throughout the period (about 18 days). The third ward had a length of stay of 40 days at the start of the period, but was forced to reduce the length to the same level as the two other wards.

Conclusion: The above mentioned routine data were clearly sufficient to demonstrate a dramatic change in the acute wards in Oslo during the 80's. However, additional data will be required to document possible changes in patient improvement during the period.

MONITORING NEED CONCEPTS IN OPTIMAL TREATMENT FOR SCHIZOPHRENIA. Bo A.R. Ivarsson, Lennart Lundin and Ulf Malm. Dept of Clinical Neuroscience, Section of Psychiatry CBP, S-413 45 Göteborg, Sweden.

In connection with an international, multi-centre, long-term, controlled outcome research study in schizophrenia (SVEGOT), additional studies will be conducted in a rural area(Sveniunga) and a large city (Gothenburg) on the feasibility of a service co-operation model in contrast to a formally coordinated care and service organization. An array of methods will be used for the outcome evaluation and resource utilization. The need and satisfaction assessment should cover quality of life goals, medical, psychological, social and vocational areas. One determinant of successful actions to meet needs will depend on the patient-professional therapist alliance and trust. This relational dyad is part of the network of important structures to the patient and the treatment conducting team (co-workers, authorities etc). We hypothesize that common understanding of concepts to express needs is necessary to fulfil need-related goals. The methods used are reviewed and their possibilities and short-comings to monitor the conceptual views on different need areas within the patient-treatment network system will be discussed. A model to facilitate communication within the network to reach concensus and common understanding will be presented.

ASSESSING NEEDS IN SMI PATIENTS SUBJECT TO INTENSIVE CASE MANAGEMENT.

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The Department of Health in the UK has funded a multicentre trial of intensive case management for severely ill patients in the community. The trial is based at Manchester and at two sites in London. Each site aims to recruit 100 patients each to either the intensive case management or control service. St George's has established a parallel and very similar study of 200 patients and will collect the same core data set with a view to possible meta-analysis.

At present we are exploring the choice of a suitable measure of needs. We are particularly concerned to identify and measure needs which may remain unmet by standard community care. We will present the scale which we have chosen and discuss its merits and drawbacks, using our initial experiences to illustrate our findings.

ONE RESPONSIBLE AGENCY FOR SCHIZOPHRENIA. Ulf Malm, Lennart Lundin and Bo A.R. Ivarsson. Dept of Clinical Neuroscience, Section of Psychiatry, Sahlgren Hospital CBP, S-413 45 Göteborg, Sweden.

A science and consumer driven consortium (CoS-West) for schizophrenia will provide comprehensive and continuous care and services according to a shared risk model. One hypothesis that is to be field tested in a naturalistic comparative outcome assessment of delivery of health care is that a better long term prognosis is related to a higher level of coordination and integration of services.

The strategy of integrated clinical care will be carried out in a professional setting of case management. A comprehensive battery of measurement methods to evaluate the achievement of goals of the patients and the community will provide the empirical data on structure, process, outcome, quality and costing, that decision makers need for the planning of effective future mental health care services to people suffering from any severe and persistent mental illness - and their families.

The organizational structure of CoS-West, the shared risk model for health care delivery, the measures and the procedure to obtain reliable empirical data will be outlined.

MEASURING NEEDS AND ASSESSING PROGRESS IN A SCOTTISH COMMUNITY OF CARE OF THE ELDERLY.

Dr A A McKechnie Rosslynlee Hospital Midlothian UK

Amanda Levine.

Richard McGill.

East and Midlothian NHS Trust provides most components of a comprehensive Health Service including Community based care and continuing care for the elderly with (total population of 170,000). This population lives in small towns and villages, Midlothian was formerly an area associated with coal mining.

Care of the Elderly services have developed in Midlothian making extensive use of Community Psychiatric Nurses. There remains a core of approximately one hundred long stay patients receiving continuing hospital care. The revised elderly persons' disability scale (REPDS) (Fleming 1990) has been designed "so that direct carers can collect and present first hand information in a clear objective fashion making use of their detailed knowledge of the patient (resident)." This covers seven areas, physical problems, self help skills, confusion, behaviour, sociability, psychiatric observations, nursing dependency. It's use in Scotland has been promoted by the Dementia Development Centre, University of Stirling, in consultation with Dr Fleming. It also has advantages in that it measures change.

It has been used within the hospital long-stay population to identify those suitable for alternative residential care. A particular feature of the assessment was that it identifies social isolation in a substantial proportion. It has proved reliable and valid.

FUTURE PLANS

To utilise this scale to look at levels of dependence, impairment of sociability in institutional population in all types of residential care, to measure change in quality of care provided.

THE NEEDS OF THE FAMILIES AND OF THE PATIENTS ADMITTED IN A SHORT-TERM CHILDREN PSYCHIATRIC DEPARTMENT

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The needs of the neuropsychiatric patients admitted for short period of time were dominantly medical, very similar with those of the non-psy chiatric,physically ill. The analysis of group of 97parents and 93 children and adolescents admitted in a clinical university department, for different neuropsychiatric disorders, ensued that the families were concentrated in the search for a better and "more reliable diagnosis" 27% of them coming spontaneous without any referral. They needed a comprehensive explanation for the illness, its causes, course and an improved treatment. For the profound insecurity related to the psychiatric hospital mithology, or other real dangers, they expected an substantial support and intensive contacts especially with their physicians. The therapeutic expectations were dominated by the hope of getting a "better" drug. Only 4% were interested in psychotherapy and 3% in rehabilitation, in clear contradictionwith the real needs for treatment of their offsprings.The patients more adolescents wished a caring attitude from the staff, richer daily activities and the maintainance of the contacts with their families during the admission. Also, there were recorded significant difference between the needs of the users and those expressed by their parents.

The concept of the need would be completed in the light of other items as the: the diagnosis, the typology of the psychiatric units and the local cultural patterns, including those related to the treatments. A classification of the needs eg in medical and social, more fit for pacients with chronical course, could allow a differentiated approach, related to the economical resources of the country, the profile of the unit and other demands.The short term admission units could also benefit from the concept of need in planning in a more specific way their improvment.

WHO AND WHY NEEDS THE PSYCHIATRIC CARE IN RUSSIA?

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As it is known the system of obligatory record-keeping of all mentally ill persons addressed for aid existed in the USSR for many years. Therefore they believed, that psychiatrists obtained an information about all persons with mental disorders, presented in population. However already in 70's it was found out that at least three quarters of mentally ill were not registrated. Since that time some attempts were made to determine an actual number of mentally ill, a number of persons that needed psychiatric aid and what organizational forms of psychiatric facilities were satisfactory for them. These approachs are especially actual in now days when the system of psychiatric care is being reformed.

The analysis of official statistic data, a series of epidemiological researches and of our own work permits to assume, that the general number of the inhabitants of Russia which have this or that psychical disorder can reach about 54 million, i.e. approximately 36.5% of population. The following groups can be distinguished among all the mentally ill:

— the most severe patients requiring mainly the hospital treatment or the caring: 385 thousand. These patients are provided with necessary aid in general;

— the patients suffering from schizophrenia, affective psychoses or other severe mental disorders, which, however, don't require the stationary help during the greater part of their life: approximately 8.7 million. Only 2.5% of these ill are provided with the aid;

— the persons, suffering from the relatively slight, but longitudinal mental disorders (neuroses, somatoforming states and etc.) — approximately 27 million. These people practically do not receive any aid. We have some establishments where these persons are treated in terms of scientific programs only;

— the persons with incidental mental frustration — approximately 7.5 million. The quantitive evaluation of this group is the most difficult, therefore given data can be strongly underestimated. As a rule these people also practically do not receive help;

— the persons suffering from posttraumatic stress disorder (PTSD). Their number can reach 10 million, and they also don't receive any help.

Thus given data determine a number of problems that Russian psychiatrists and organizers of psychiatric care have to deal with.

NEED FOR CARE AND TREATMENT SITUATION AMONG SCHIZOPHRENIC PATIENTS DISCHARGED FROM HOSPITAL.

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During the past decade, the number of beds in mental hospitals in Finland have decreased quickly and an increasing number of long-stay patients have been discharged to the community. This change has raised a question concerning the needs for care among patients in the community and how these needs are met by community psychiatric services. This question was studied in a national sample of Discharged Schizophrenic Patients in Finland (DSP study).
The DSP sample consisted of 1097 15-64 year-old schizophrenic patients who in 1986 were discharged from mental hospitals in Finland and then investigated three years thereafter.
At the follow-up, 20 % of the patients were in mental hospital, 7 % in other residential care, 7 % in day care, 45 % visited in the Community Mental Health Centres (CMHC), and 21 % were out of psychiatric care. According to the assessment of psychiatric teams, about 7 % of patients were lacking of therapeutic contacts they needed, in rehabilitation the corresponding figure was as 20 %. There were practically no unmet needs in drug treatment. The rate of unmet needs was greatest among hospitalized patients, but rather high also among patients who were out of psychiatric care or who only visited the CMHC. Compared with the assessments of an independent researcher, the teams saw more unmet needs among hospitalized patients and less among patients out of care. Reasons for these differences are discussed. In any case, findings emphasize the need for developing psychiatric care system.

ASSESSMENT OF THE PSYCHIATRIC SERVICES IN TURKEY.Armagan Y.Samancı,Anxiety Disorders Department,Bakirkoy Psychiatric Hospital Bakirkoy,Istanbul,Turkey

Bakirkoy psychiatric hospital is the biggest psychiatric institution in Turkey.Therefore,its services reflects Turkish psychiatric services and its inadequacies.This study assess The Turkish psychiatric services by taking the hospital as an example.Additionally,,the study proposes changes in the existing hospital based mental health care services.The rehabilitation and community psychiatry services are proposed alternatives to the present services.
The study sees underlying trend towards community care, which occured naturally over the years,and takes this trend to propagate further changes needed.
Our study also looks into previous attempts to reform the existing services and reasons of failure to achieve that.
The assessment of the hospital covers the changes in line with the trust status if the hospital undertakes.
This includes checking of hospitals' financial structure and its feasibility for such status.It outlines steps to be taken for a succesfull restructuring.
The study includes medical staff's view on the trust status and the changes which would be brought about by it.

ASSESSMENT OF NEED BY STAFF AND USERS - DOES IT DIFFER?

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In many European countries mental health services are becoming more consumer-centred. The implications of this shift have not been fully explored. One issue is the effect that greater user involvement will have on needs assessment. We addressed this question using a new comprehensive needs assessment schedule, the Camberwell Assessment of Need (CAN). The CAN is divided into 22 topics, assessing social, physical and psychological needs. The level of need and current help received from either friends and relatives or formal sources is assessed by both the user and the member of staff. We interviewed 49 mental health service users, and their keyworkers In this paper we report on the areas in which staff and user perceptions of need match, and those in where there is a wide disparity. This leads to a discussion of the implications for mental health services of more consumer-centred needs assessment.

NEED IN PSYCHIATRIC CARE AND ITS ORGANIZATIONAL FORMS.

V. Yastrebow. Dept. of organization of psychiatric services, National Research Center for Mental Health, Moscow, Kashirskoe shosse, 34, Russia.

During the last seventy years there were the state psychiatric institutions in Russia: psychiatric hospitals, out-patient clinics, day-hospitals and remedial labour workshops. The change of socio-political and ecnomic situation in Russia led to the change of the forms and methods of psychiatric care. As a result of the new psychiatric law defending human rights, was a decrease of number of the voluntary visits to the psychiatrists (about 24%). Inspite of this fact a level of necesity in psychiatric care became high. Social and psychological tension in our country led to the increase of number of those suffering from PTSD. The list of the traditional and new psychiatric, psycho-social, psychological forms of care can include now:

1. For the patient with the principal forms of mental illness, which are charactrized, by the acute, chronic or mild forms it is necessary function of traditional psychiatric institutions: psychiatric hospitals, out-patient clinics and remedial labour workshop.
2. For the patients of different age-groups must be organized the special psychiatric services (for children and adolescents, geronto-psychiatric, psychosomatic Dept.)
3. High level of borderline states prevalence in population requires the development of psychiatric and psycho-therapeutic services at the general profile policlinics.
4. Obvious increase of number of cases with PTSD calls for the necessity of organization of services with the psychiatrists, psychologists, sociologists and other specialists.
5. For many patients, who need in social and professional adaptation it is necessary to develop defferent forms of psycho-social rehabilitation. In these processes the organisations, associations of parents and relatives, which accomplish social, psychological and moral support of the mentally ill are of great importance.
6. In modern Russia private psychiatric services are in the process of development.

In functioning of mentioned above services the qualifications of the psychiatrists, nurses, financial support and patients' satisfaction with psychiatric care play a significant part. On elaborating of criterious of Quality of psychiatric care is also very important. These and a number of other problems are being investigated in our research department.