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A pilot study of needs assessment in acute psychiatric inpatients

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Abstract The needs of acute psychiatric patients have been less studied than those of long-term patients. A pilot study of needs assessment using the MRC Needs for Care Assessment Schedule is reported in 35 consecutive acute inpatients who had been in hospital for 1 month or more. Unmet clinical needs included treatment of drug side effects and dangerous and socially embarrassing behaviour. Unmet social needs were widespread and included household shopping, cooking meals, occupation and money management. Although the MRC Needs for Care Assessment was found unsuitable for assessing needs in very acutely ill patients whose mental status was rapidly changing, we did find it a useful instrument in more stable acute patients, both on an individual basis and for identifying service underprovision.

Introduction

Measuring patient need is important because it offers a rational way of allocating resources. In the last decade standardised methods for measuring met and unmet needs in the long-term mentally ill have been developed (Brewin et al. 1987). However, the needs of acute inpatients have received less attention, even though they are no less important. Without careful planning to meet needs, and follow-up, there is a risk of care being frag-

mented and of persons with severe mental illness dropping out of service contact and potentially deteriorating.

Standardised assessment of need in the long-term mentally ill was first developed by defining an operational concept of need and using information from patients, relatives and staff to assess overprovision as well as underprovision (Wykes et al. 1982; 1985). This led to the development of the MRC Needs for Care Assessment, designed to measure both health and social needs of psychiatric patients (Brewin et al. 1987). This was devised with the needs of patients in the community with long-term mental illness in mind, but has not been tested in acute psychiatric inpatients. Additional issues involved in researching the needs of acute psychiatric patients include choosing which needs should be addressed first, which is not such a concern in the longer time scale of continuing care patients, and a consensus on suitable acute care (Brewin 1992). This paper reports the needs for care of a consecutive series of adult psychiatric patients admitted for 1 month or more to an acute psychiatric unit, with the aim of describing the profile of typical needs and assessing the usefulness of the MRC schedule in their assessment.

Method

Sample

Our initial strategy was to examine needs in all psychiatric admissions over a limited time period. This proved impractical because of the rapidity of patient turnover and the difficulties of assessing needs in a situation of rapidly changing mental state. Thus, we decided to look at only those patients who had been admitted for 1 month or more. This method tended to emphasise those with more serious mental illness who had more stable needs and in whom the acute psychosis (if any) had settled. We examined needs in a consecutive series of 35 patients admitted over a 10-week period.

Procedure

All new admissions, aged between 16 and 65 years, to two adult admission wards and two rehabilitation wards at Princess Alex-

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andra Hospital, Harlow, serving the Harlow/Dunmow and East Herts catchment areas, were considered eligible for this study. Patients with primary drug/alcohol problems or dementia were excluded. Needs were assessed in all those who had spent 1 month or more in the acute wards during a 10-week period. Needs were agreed at fortnightly research team meetings by a research psychologist (R.M.) and three psychiatrists (M.O., D.N., S.S.). All raters attended the MRC Social Psychiatry Unit training course on needs assessment prior to the study.

Instruments

Patients' needs were evaluated using the MRC Needs for Care Assessment Schedule (Brewin et al. 1987), based on the views of ward staff, including nurses, social workers, psychologists and occupational therapists. This schedule assesses need in 9 types of 'symptoms and behaviour problems' and 11 types of 'personal and social skills' (Brewin and Wing 1989). In each area of social disablement, between one and eight items of care are specified. Social needs were assessed taking into account both performance in the hospital setting and performance anticipated after discharge from hospital. Need is categorised as 'no need', 'met need' and 'unmet need' (where there is a significant problem which has 'attracted only partially effective or no intervention and when other interventions of greater potential effectiveness exist' (Brewin et al. 1987). 'Met need' includes those problems that require intervention and for which there are effective interventions being tried. 'No meetable need' is defined as when there is a significant problem but no suitable, even partially effective, or feasible, intervention. The Social Behaviour Schedule (SBS; Wykes and Sturt 1986) was also administered by R.M. to assess behaviour problems in 17 areas. Current mental state of patients was assessed by a psychiatrist (D.N.) with the aid of the Brief Psychiatric Rating Scale (BPRS; Overall and Gorham 1962), a standardised rating scale suitable for use in clinical practice.

The Needs for Care Assessment took about 90 min of data collection per subject, including the BPRS and the SBS. Rating the needs took on average 40 min per patient.

Results

Details of patients

Needs for care were assessed in 35 patients (20 men and 15 women) over a 10-week period. The mean age of patients was 37 years (SD 1.9 range 19–63 years). The casenote diagnosis, based on ICD 9 criteria, was schizophrenia (12.34%), manic-depressive psychosis, circular type (12.34%), manic-depressive psychosis, depressed type (7.20%) and obsessive-compulsive disorder

(2.6%), anxiety state (1.3%) and simple paranoid state (1.3%). The mean SBS score for patients was 10.2 (SE 0.9). The mean BPRS score for patients was 18.3 (SE 1.7). The median value for lifetime psychiatric inpatient care was 9 months (range 1–135 months) and for day-hospital attendance was 13 months (range 1–109 months).

Clinical needs of inpatients

Clinical primary needs status is reported in Table 1. Needs for treatment of psychiatric and physical symptoms were largely met and there were fairly few unmet needs. There were unmet needs, however, for treatment of side effects of neuroleptic drugs, for instance tardive dyskinesia. The highest numbers of unmet needs were found in the treatment of socially embarrassing and dangerous behaviour. For instance, a 35-year-old single man with a manic depressive illness, who brought a large number of 'friends' to the ward, brought illicit drugs to the ward and continually kissed the nurses on the hand, was rated as having unmet needs for management of socially embarrassing behaviour.

There were also cases of 'no meetable need', particularly for dangerous and socially embarrassing behaviour and treatment of drug side effects. One such case was a middle-aged man with a known history of recent violence against the police, associated with heavy alcohol use, with an acute paranoid state who was admitted under Section 2 of the Mental Health Act and refused further supervision or monitoring after discharge despite continuing problems.

Social needs of inpatients

There were many more unmet social needs than unmet clinical needs (Table 2). This may relate to the relative urgency of attending to clinical rather than social needs. Nevertheless, at the time of assessment most patients were not too ill for social treatments to be tried. The assessment of social needs took into account what patients might be expected to achieve after discharge as

Table 1 Clinical needs of acute psychiatric inpatients (percentages)

	No need	No meetable need	Met need	Unmet need	% Of total needs unmet
Positive psychotic symptoms	6 (17.1)	0	29 (82.9)		
Slowness	28 (80.0)	2 (5.7)	5 (14.3)		
Side effects ^a	15 (42.9)	4 (11.8)	14 (41.2)	1 (2.9)	6%
Neurotic symptoms	15 (42.9)	1 (2.9)	19 (54.3)		
Physical symptoms	28 (80.0)	2 (5.7)	5 (14.3)		
Dangerous behaviour	14 (40.0)	7 (20.0)	12 (34.3)	2 (5.7)	14%
Socially embarrassing behaviour	21 (60.0)	5 (14.3)	6 (17.1)	3 (8.6)	33%
Distress	15 (42.9)	5 (14.3)	15 (42.9)		

^a For one case needs for treatment of side effects was judged 'not applicable'

Table 2 Social needs of acute psychiatric inpatients (percentages)

	No need	No meetable need	Met need	Unmet need	% Of total needs unmet
Hygiene	23 (65.7)	5 (17.1)	7 (17.1)		
Household shopping	25 (71.4)	2 (5.7)	2 (5.7)	4 (11.4)	66%
Cooking meals	22 (62.9)	1 (2.9)	5 (14.3)	2 (5.7)	29%
Household chores	26 (74.3)	6 (17.1)	2 (5.7)	1 (2.9)	33%
Use of public transport	26 (74.3)	5 (17.1)		1 (2.9)	
Use of amenities	27 (77.1)	5 (14.3)	1 (2.9)	1 (2.9)	50%
Education	34 (97.1)	1 (2.9)			
Occupation	7 (20.0)	13 (37.1)	5 (14.3)	2 (5.7)	29%
Communication	32 (91.4)		2 (5.7)	1 (2.9)	33%
Money management	25 (71.4)	1 (2.9)	7 (20.0)	2 (5.7)	22%
Managing affairs	17 (48.6)	7 (20.0)	7 (20.0)	1 (2.9)	13%
Additional needs	1 (2.4)		0	3 (7.3)	

Missing values indicate needs assessment judged 'not applicable'

well as during admission in the light of their pre-admission levels of performance. Every category of social needs, except hygiene and education, had some unmet needs. The unmet needs were greatest for household shopping, occupation, cooking meals and money management. There were also high levels of 'no meetable need', particularly for occupation, managing affairs, hygiene, use of public transport and household chores. Many of these were unmeetable at the time because patients were still too ill to carry out these functions. For instance, a 28-year-old woman with a persistent manic depressive illness, currently depressed, who lived alone, was unable to manage household chores, use public transport or public amenities, manage her own affairs or undertake an occupation and was rated as 'no meetable need' on all these items.

Future needs, possible needs and depression

As might be expected in these acute patients whose functioning was likely to improve, there were many ratings of future need. Eighteen patients had 41 future needs; 9 were clinical needs but most were social needs of which the most common, found in 15 patients, was 'occupation'. There were also nine possible needs and four ratings of overprovision, largely for antipsychotic drugs in the treatment of positive psychotic symptoms.

Discussion

In this study of patients admitted to a district psychiatric service, there were clinical unmet needs for treatment of socially embarrassing and dangerous behaviour, and social unmet needs for a range of domestic, occupational and leisure skills. These results are only preliminary because of the small number of patients involved, but may indicate directions for further research.

Initially, it became clear that in the acute stages of severe psychiatric illness, the rapid changes in mental state and, accompanying this, the changes in the patients' social relations, made any longer term assessment

of either clinical or social needs impractical, because needs were also rapidly changing. The only needs that could be measured were appropriate to that acute stage (e.g. medication, information, containment, support from relatives). Any item of care that is implemented will be 'potentially effective' according to the Needs for Care Assessment Schedule, because of the rule that no item of care can be judged ineffective until there has been a 3-month trial. However, after 1 month's admission assessment of needs was feasible.

The MRC schedule has been criticised as taking too long to complete. This is undoubtedly a problem in a busy acute psychiatric setting. The length of time could be reduced by streamlining the assessment to include a core group of needs, and would become even faster to complete with greater familiarity. The absence of carers' views is likely to give an inadequate picture of unmet needs if many of the need assessments in acute patients are carried out largely in hospital. The ratings of need are also technically complex and not easily comprehensible to those unfamiliar with the instrument. This is particularly the case in determining 'no meetable need'. However, by assessing those patients who had been in for 1 month or more, the MRC Needs For Care Assessment did prove a useful instrument, which gave both information on the needs of individuals and an overall view of areas of underprovision of services. In the future it would be informative to test its utility against other recent briefer measures of need such as the Camberwell Assessment of Need (Phelan et al. 1995).

In general, as might be expected among hospital inpatients, clinical needs were better fulfilled than social needs. Among the clinical needs there was unmet need for dangerous and socially embarrassing behaviour, often difficult to manage in open wards, where there may be less than adequate staffing. Unmet needs for dangerous behaviour may also imply a need for review of medication. There may be a need for behaviour programmes or a review of nursing procedures and staff training to cope with difficult behaviour and staffing levels. Many of these problems subside with treatment of the underlying psychotic illness and needs may thus be transient and coped with adequately by containment in

the most acute phase. There were high rates of 'no meetable need' for treatment of side effects, dangerous behaviour and socially embarrassing behaviour. This points to areas in which there may be scope for new initiatives in tackling these very difficult problems. These are also behaviours that carers, and the community in general, find difficult to tolerate.

The high rates of social unmet need might be expected in a population who are still at an early stage of re-integration back into the community. Nevertheless, the high rates of 'no meetable need', particularly for occupation, suggests areas where creative thinking might develop interventions in the future or emphasises the high level of handicap in the patients seen. Because much of the assessment of need was based on performance and behaviour in hospital, it may be that we missed unmet needs would have become apparent if more of the assessments had been carried out at home. Thus needs will have to be assessed again after discharge, at home.

This research needs to be replicated on a larger scale and potential modifications to the Needs for Care Assessment schedule could make it more suitable for acute patients. Standardised objective assessments of need are essential for guiding rational clinical management and the development of a suitably modified instrument to measure needs in acute inpatients may be the most effective next step.

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