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Editorial

Needs Assessment

Involvement of staff and users will help to meet needs

MIKE SLADE

The National Health Service and Community Care Act 1990 defines needs as "the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life" (Department of Health Social Services Inspectorate, 1991). Other definitions of need have also been used by researchers, based on different theoretical perspectives. Psychological theories have used the concept of need as a basis for understanding action. Psychiatry, by contrast, often employs the construct to inform service provision, and plan individual care. These issues are important because implementing the NHS and Community Care Act in a consistent manner will involve agreement on defining and prioritising need.

Here it is argued that there are no assessment instruments which fully meet the requirements of the NHS and Community Care Act 1990. Existing schedules have been categorised by Brewin (1992) into three types, measuring: lack of health; lack of access to services or institutions; and lack of action by lay or professional mental health workers. These schedules are reviewed, and recommendations are made for the development of more appropriate tools, which are both practical to use and meet statutory requirements.

Needs for improved health

The first category equates need with social disablement (i.e. a reduced level of psychological, social and physical functioning). In assessing social disablement, three categories of social functioning measures have been proposed: social attainment measures, social role performance measures, and instrumental behaviour measures (Wykes & Hurry, 1991).

Social attainments are achievements in the major life roles, such as marriage and employment. Jarman *et al* (1992) compared the incidence of mental health problems and social attainments, using population census data. However, it is difficult to establish whether the variables being measured are causally associated. Such coarse measures are inappropriate for assessing need at the individual level.

Social role performance measures assess performance in major roles such as work, relationships, home and self-care. They give a more detailed assessment of a person's performance than social attainment measures, and are more sensitive to minor disablement in social function. One difficulty with this approach is the necessity to consider performance in relation to the person's social and cultural background.

Instrumental measures record detailed descriptions of social behaviour. By focusing on observed behaviours, instrumental measures are sensitive to individual differences. However, they do not take account of the context in which behaviour takes place. Furthermore, many of these scales rely solely on staff reports. Finally, social behaviour measures can be based on a list of symptoms. For example, categories in the Social Behaviour Scale include "panic attacks and phobias", "overactivity and restlessness", "laughing and talking to self" and "suicidal and self-harming ideas and behaviour" (Wykes & Sturt, 1986). These items were selected on the basis of being frequently mentioned by care staff as problems contributing to the individual's dependence on psychiatric care. This can result in assessment of a client's psychiatric symptoms, rather than their needs.

Needs for services

The second category of needs assessment schedules includes those measuring access to psychiatric services. Underlying these measures is the assumption that some needs require services, and so an unmet need may indicate a lack of access to some form of psychiatric service. This category is used to inform the provision and development of mental health services.

Most of these scales, such as the Community Placement Questionnaire (Clifford *et al*, 1991), are designed for use with long-term patients, prior to resettlement. This limits their use for a broader population of people with mental health problems. They tend to rely on staff reports, and the data collected is typically not sensitive to change. Furthermore, scales tend to consider broad categories

of institutional services rather than individual needs. They therefore may not assess what would be the best response to an individual's needs.

Needs for action

The third group of needs assessment schedules measure the need for action by mental health workers, and are based on the assumption that needs are alleviated by interventions. The Medical Research Council's (MRC) Needs for Care Assessment defines need as present when the person's clinical or social functioning falls below a specified level *due to a potentially remediable cause* (Brewin *et al*, 1987). It may be difficult to assess when there is an available intervention which would be at least partly effective – for example, deciding when a medication regime has been shown to be ineffective is seldom easy. This use of the term 'need' can reduce the extent to which assessment is needs-led, since intervention effectiveness rather than need is being assessed.

There may also be a cultural bias in stating what constitutes a problematic level of functioning, and what are appropriate interventions. While acknowledging this, Bebbington (1992) notes, "the inevitable value judgements inherent in the procedure have the virtue of being public and consequently accessible to argument".

Perceived needs

Underlying the attempts to assess need formally is the assumption that needs can be objectively (i.e. reliably and validly) measured. This assumption is reflected in the design of most tools, which use the staff member's perceptions as the main basis for assessment. Indeed, the MRC Needs for Care Assessment schedule is premised on the assumption that need is "a normative concept which is to be defined by experts" (Bebbington, 1992). However, the difficulty in agreeing what constitutes a need is because of the socially negotiated nature of need. What is a need to one person in one particular context may not be to another. Indeed, over time one person's expectation and perception of their rights may change, leading to new beliefs about their needs. This suggests that assessment of need should take account of the views of both the staff member and the mental health service user. The user's view will be filtered through their particular sociocultural context, and will be tempered by their expectations and past experiences. The staff perspective will be informed by the values of British caring professions, and will be influenced by their professional training and personal agenda. By taking account of both

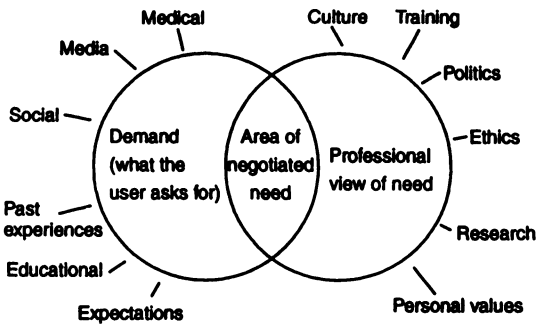

Fig. 1 Factors influencing perceptions of need.

viewpoints, neither of which is 'right' in itself, a more balanced consideration of the person's needs can be made, as illustrated in Fig. 1. Here it is assumed that a balanced view is a desirable goal of a needs assessment procedure.

In the learning disabilities field there is wide application of the principles of normalisation. The central tenet of this philosophy of care is that the needs of a person should be considered in relation to someone who comes from the same cultural background, but does not have the disability. Thus needs exist when culturally-valued goals are not being met by the user. Normalisation has applicability to psychiatry, by considering a user's circumstances in relation to a person from the same background who does not have a mental illness. The approach focuses attention on cultural factors, which may not otherwise be considered. This does not mean that needs can be objectively assessed, as the interpretation of cultural norms will vary. However, since needs are relative, their assessment should include cultural factors, rather than being defined by 'professionals'. Naturally, this process should also recognise the disabling nature of mental health problems, meaning that sometimes special community support needs to be available – normalisation is not an excuse for poor community care.

User involvement

The distinction between need and demand has been described by Stevens & Gabbay (1991). They define need as what people can benefit from, and contrast this with demand – what people ask for. Using this terminology, it is wrong to assume that need equates with a professional's assessment. It is unlikely that the staff member will have a complete view of a user's life. Furthermore, psychiatry is not yet able to state in advance the extent to which an individual will benefit from a particular intervention. Needs

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assessment should therefore entail considering demand as well as need. This is in accordance with Government guidance on assessing need, which states that

> "all users . . . should be encouraged to participate to the limit of their capacity . . . Where it is impossible to reconcile different perceptions, these differences should be acknowledged and recorded" (Department of Health Social Services Inspectorate, 1991).

Practical benefits arise from more active user involvement in assessing needs. An assessment which gives equal weight to the perceptions of user and staff member (ideally allowing direct comparison of views) provides an appropriate vehicle for discussion of differences. When sensitively employed, this can facilitate user participation in prioritisation of need, an area that has previously been the domain of professionals. A second benefit of user involvement is that the assessment process becomes a more exploratory and useful process yielding new insights and perspectives on the situation. This contrasts with the paper exercise which sometimes takes place at present, in which the professional records their preconceptions (which may or may not still be accurate) about the patient's deficits and capabilities. Accurate needs assessment requires maximal user involvement.

One concern about user involvement is that there will be a greater demand for limited resources. Some research has tangentially addressed this issue, but the results are inconclusive. Formal evaluative studies will be required to assess any impact on service use.

A second concern with the involvement of a psychotic user in needs assessment is that lack of insight may lead to distorted assessment. The assessment process can help to identify areas in which a user can make rational judgements. A person with no insight might not be able to evaluate the benefits of medication, but may have valid opinions about their need for alternative accommodation. A good assessment procedure will take account of user views in as many areas of life as possible.

Needs-based assessment

Ethical service delivery should entail assessments that are comprehensive, and focus on the individual's needs, rather than diagnostic category. MIND (the National Association for Mental Health) advocates a policy framework based on "the actual wishes and needs of people who use the service" (Sayce, 1990). Government guidance notes suggest the need for revised assessment proformas, which promote the needs-led approach (Department of Health Social Services Inspectorate, 1991). Social and policy pressures therefore require that assessment should be in terms of needs, and not of services. Service-based assessments can fail to take account of users' needs that do not mesh with available services.

If assessment is to be comprehensive and needs-based, then service users should be consulted about what are important areas of need to them. The results of this consultation should be incorporated into the assessment proforma. Furthermore, the assessment stage of care delivery should be kept separate from the planning stage, since planning will involve consideration of local resources. By this separation the needs-based assessment can inform the planning, and unmet need can be identified. In other words, there should be a clear differentiation between the stage of identifying need and the stage of supplying resources to meet these needs. When this distinction is not made, unmet need is often neither recognised nor addressed.

In a health and social care system with finite resources, the assessment document can be used to inform negotiation for services. A corollary of service-based assessment may be that negotiations focus on services and their associated costs, rather than their relative benefits to the users. By negotiating on the basis of a needs-based assessment, the negotiation process is more easily focused on practical benefits to the individual user.

Conclusion

Many needs assessment schedules are useful in informing service provision, but these schedules are inappropriate for assessing the needs of an individual. Existing tools also do not meet the requirements of the NHS and Community Care Act 1990 for needs-based assessment. The design of a schedule should recognise that need is a socially negotiated concept. The measurement of need cannot be objective, but rather should arise from negotiation between the user and staff members, and should take account of the user's cultural background. An assessment tool for everyday clinical use should therefore go beyond symptomatology and behaviour observed by professionals, and incorporate the user's perceptions. While demonstrating psychometric properties, it should be needs-led rather than service or intervention based. With needs assessment now an integral part of social and medical care, assessment techniques must take account of both user and staff views. Methods need to be developed for integrating these often differing perspectives.

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Mike Slade, RMN, PRiSM, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF

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