

**The effectiveness of the Camberwell  
Assessment of Need for the Elderly (CANE)  
as a needs assessment tool in the psychiatric  
day hospital care of older people**

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## **Abstract**

The current practice of multidisciplinary team assessments that take place in day hospitals for older persons is compared in this study with the use of a structured needs assessment tool, the Camberwell Assessment of Need for the Elderly (CANE).

New admissions attending two different day hospitals, were assessed and then randomly allocated to two groups. The assessments involved the routine day hospital assessments at admission, along with using the CANE, Health of the Nation Outcome Scales (HoNOS) and the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales (CAPE-BRS). In the experimental group, key workers received the results of the CANE assessment with suggested interventions to meet needs and in the control group, no feedback was given. Three months later, all the patients were reassessed using the same instruments,

At first assessment, there was a significantly greater number of needs identified by CANE than through the routine day hospital practice. After three months in the day hospitals, patients in both groups had a substantial decrease in number of unmet needs and lower mean total HoNOS scores, indicating that day hospitals are effective at identifying and meeting needs. There was no significant difference between the experimental and control groups, in terms of the total

number of unmet needs, total HoNOS scores and total CAPE-BRS scores on follow-up. However, there were differences at follow-up on two individual CANE needs, accommodation and company.

This study has shown that day hospitals are effective at identifying and meeting the needs of older people with mental health problems and that the use of a standardised needs assessment measure may have some advantages over regular clinical practice. More research into how improved needs assessment may be translated into better outcome in day hospital care is required. This should include longer study periods using a structured needs assessment tool in different psychiatric settings for older people and means to enable professionals to utilise better needs assessment to improve outcome.

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## **Statement of Originality**

This thesis represents original work that I carried out at the Haymeads Day Hospital, Essex & Herts Community NHS Trust, Bishop Stortford and the Camden Mews Day Hospital, Camden and Islington Community Health Services NHS Trust.

## **Ethical Considerations**

Ethical approval was obtained from the ethics committees of the Essex & Herts Community NHS Trust, and the Camden & Islington Community Health Services NHS Trust.

The consent of all patients who were involved in this study was obtained, as well as the approval of all consultant psychiatrists responsible for their care in both day hospitals. Patients were given verbal explanations about what the study involved and how, if any way, it would affect their care and that at any time they could withdraw from the study.



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# 1. Introduction

## 1.1. The importance of measuring outcome in psychiatry

Psychiatry has evolved from mere documentation of observations to the use of widely used classification systems like the International Classification of Diseases (World Health Organisation, 1992) developed by using standardised and structured instruments to give rise to uniform diagnoses.

The development of rating scales or other instruments in psychiatry have been of value not just in making individual diagnoses, but also in monitoring change and outcome, including response to treatment in various clinical trials, without which it would be impossible to assess benefits of new treatments over old ones. The value of using standard scales to measure outcome in service development is underlined by the fact that wide use in clinical practice means services can be compared, monitored, evaluated and improved.

In addition, rating scales and outcome measures can be used at population level. The world population of people aged over 65 years is expected to continue to increase (United Nations, 1979). There will therefore be an increase in needs for healthcare in this group. To address this increasing demand on health services, advances in health care of older people both in actual treatment of diseases and

service delivery is required. One of the central purposes to health and social care intervention is to identify and meet needs. It is essential that the needs of the population at large and of individual patients presenting to services are identified and addressed. It can be argued that assessment of met and unmet needs is the best available index of outcome. One way to address the issue of needs, is by using standardised, structured needs assessment tools which can then be used to provide information on local population needs, individual needs of patients or the service needs of a group, for example, older people with mental health problems.

## 1.2. Introduction to the present study

In this study, a needs assessment instrument is evaluated, to see what if any are the benefits to the mental health care of older people. Orrell (1998) notes that the systematic assessment of needs allow unmet needs to be prioritised so that the most important needs can be provided for, rather than just those identified by ad hoc methods. The identification of needs, followed by interventions to meet those needs are essential to improve outcome. Recording of met and unmet needs by services can be used as indicators of the benefits of care and services provided for the individual patient and services as a whole. Other benefits include identifying gaps in provision and thus enabling an improvement

in the efficiency and effectiveness of mental health services. One of the ways forward for psychiatry in general is likely to be a wider use of standardised needs assessment instruments in everyday clinical practice, ensuring more objective means of monitoring.

Monitoring and evaluating the local population and patients' needs may enable improved delivery of care, in that areas of need are identified and suitable interventions can be introduced. Patients' needs can be assessed, recorded and monitored in a structured and standardised manner, so that individual requirements and a general picture of service needs can be obtained. Monitoring of needs, interventions and outcome can form part of the evaluation of services.

### 1.3. Quality of healthcare and evaluation of services

The quality of health care and the evaluation of services is a growing concern throughout the world, as there is an explicit requirement for value for money in health care (Higginson, 1994). Evaluation involves structure and inputs, process (how resources are used), output (productivity or throughput) and outcome. In evaluating services, there is a need to keep the individual in perspective, as the users or patients of the health service have varying needs with each individual coming with their own unique requirements. Outcome should hence include the

meeting of patients' expressed needs as well as those identified by service providers.

Quality of health care can be described in terms of effectiveness (achieving the intended benefits in the population, under usual conditions of care); acceptability to the consumer and provider; equity and accessibility (the provision and availability of services to everyone likely to benefit); and efficiency (greatest benefit for the least cost) (Shaw, 1989; Black 1990). It is essential that means to identify, monitor and meet the needs of service users are adequate in order to improve quality of care. Awareness of which services meet needs and which do not will allow resources to be allocated effectively.

Evaluation of health services is the use of the scientific, rigorous and systematic collection of research data to assess the effectiveness of organisations, services and programmes in achieving predefined objectives (Shaw 1980). It is central to health services research and audit, aiming to record what changes occurred and what led to those changes (Bowling, 1997). As in other mental health services, it has been recommended that evaluation processes be initiated in old age psychiatry services and that collection of data be developed in a manner that allows for service comparability, the assessment of ongoing community needs and the determining of effectiveness (Harris et al, 1990). The result will be a

more comprehensive assessment of services required and how well community needs are met.

Orrell (1998) notes that outcome measures in older people which might be most useful are not always the most obvious. For example, 49 older patients attending a geriatric day hospital gave their priorities as reduced disability, improving quality of life and reduction in carer burden rather than reduced mortality rates (Roberts et al, 1994). This emphasises the importance of the use of outcome measures and needs assessment tools which record the patients' expressed desires, needs and outcomes as well as the observations of the health professionals.

#### 1.4. Concepts of need

In the current medical literature, need has various definitions or interpretations which include:

- i) Subjective expressions of want or desire (Tracy, 1986).
- ii) Objective requirement to avoid a state of illness (Mallman & Marcus, 1980).
- iii) A shortfall compared with a state of being which is generally acceptable (Davies & Challis, 1986).

- iv) An inadequate level of service for the severity of the problem (Lehtinen et al, 1990).
- v) The combination of definite morbidity and lack of utilisation of mental health services (Shapiro et al, 1985).
- vi) The MRC Social and Community Psychiatry Unit definition: Requirements for specific activities or interventions that have the potential to ameliorate disabling symptoms or reactions (Brewin, 1992).
- vii) An official statement on needs, from 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).

This latter definition is adopted for the purpose of this study as it centres on the needs of individuals and as well as encompassing those identified by carers and health professionals.

In a recent editorial, Slade (1994) argued that there were no assessment instruments which fully met the requirements of the National Health Service and Community Care Act. He quoted Brewin (1992) in categorising available instruments into three types. These were those instruments measuring, lack of health, lack of access to services or institutions and lack of action by lay or



professional mental health workers. He described them in terms of need for improved health, need for services and need for action. They failed to address the individuals' expressed needs. Slade (1994) noted that this is important, as what is a need to one person in one context, may not be to another, and over time a person's expectations and perceptions of their rights change. This leads to new beliefs about their needs. Factors he described as contributing to what the user asked for, included information obtained from medical sources, media, past experiences, education, expectations and social situations. In the case of the professionals' views of need, these were influenced by culture, training, politics, ethics, research and personal values. The desired goal could be achieved as the area of negotiated need, where both the individual and professional views on needs are taken into consideration. The benefits of giving weight to the perceptions of users and health professionals are that it will provide a vehicle for discussion of differences and the assessment process becomes more exploratory yielding new insight and perspectives.

A review of the literature suggest that there are only two needs assessment tools designed to meet the NHS and Community Care Act (1990) requirements of needs assessment in which views of both users and carers are recorded. These are the Camberwell Assessment of Need (Phelan et al, 1995) designed to provide a comprehensive assessment of need for people with severe mental illnesses and the Bangor Assessment of Need Profile (Carter et al, 1996) which

aimed to embrace items of need from the individual client and mental health care perspective.

### 1.5. Needs and needs assessment

Epidemiological research indicating the prevalence of particular disorders or levels of morbidity has been shown to be a poor indicator of service requirements (Bebbington, 1992). For example, one can not assume that subjects in the community need psychiatric treatment simply because they meet symptomatic case criteria. This is not necessarily true, as need for treatment is related to persistence of disorder, level of persistence and social performance. It is for these reasons that recent developments in service evaluation have begun to focus on need assessment (Middleton et al, 1996). Actual population needs can only be assessed by surveying the local population. Due to lack of adequate resources, many services who are unable to carry out such surveys, rely on extrapolation of results of surveys done on similar populations. The adoption of the widespread use of standardised needs assessment tools will make such information more readily available.

Recent national and local mental health policy reforms in the United Kingdom emphasis that needs assessment should include both the normative assessment

of need by health professionals and the individual's expressed need (The National Health Service and Community Care Act, 1990; Welsh Health Planning Forum, 1989; Managing Care: Guidance on Assessment and the Provision of Social and Community Care, Welsh Office, 1991). Such reforms are likely to make services more user friendly in that they address express needs of individual patients.

There are continuing debates over the differing approaches to needs assessment (Holloway, 1994). Bradshaw (1972) classifies need into normative need (what the experts define), felt need (what clients would like), expressed need (what clients demand) or comparative need (differences in service provision between one area and another). In another approach, Brewin (1992) refers to need, as lack of health, lack of access to services or lack of action by lay or professional health workers. All these varying approaches could give rise to services providing different information after needs assessment. Standardised needs assessments, where the requirements are consideration of both users' and providers' views on needs will ensure some uniformity on how needs are assessed and recorded in different services.

The ability to identify and meet the needs of psychiatric patients and their carers should help to ensure adequate treatment and rehabilitation. Needs have been defined either in terms of impairment or other factors causing social

disablement, or as a model of treatment or other interventions required to meet it (Wing, Brewin & Thornicroft, 1992). The fact that needs are defined in this way however, does not mean they will be met. Various reasons may account for this, such as other problems needing to be solved first, lack of effective methods locally, availability of the necessary resources limited by rationing or even patients being unwilling to accept suggested interventions.

The National Health Service and Community Care Act (1990) requires Local Authority Social Services and District Health Authorities agreeing, co-ordinating, publishing and implementing Joint Care Plans and making individual assessments of need for community care services. However, across England and Wales, there is considerable variation in the way in which needs are assessed by social services (Martin et al., 1999). 'Assessment of need' in the Act, is intended to constitute a process through which refinements of service provision and user uptake can be made accessible, appropriate, efficient and effective. User uptake is likely to be greater where they are involved in their needs assessment with provisions made for their views.

Carter et al (1995) wrote about the need for a client centred need assessment. In a review of the literature, they noted that the assessment of need from the expressed view of a person who needs mental health services was one of the most neglected areas of research in the United Kingdom. They also highlighted

the possible opportunities offered by needs-assessment, especially client-centred needs-assessment, in relation to better care, support, and treatment of the long-term mentally ill. In conclusion, they suggest what is important is the participation of individuals in their needs assessment to redress the balance between need which is defined normatively and that expressed by the person with a mental illness. A clearer understanding of what the mental health service user has to say concerning their own needs is required in relation to individual client mental state and quality of life outcome measures (Carter et al, 1996).

Awareness of the needs of the population can play an important role in service provision and planning. Kamis-Gould & Minsky (1995) discussed multiple approaches to mental health needs and the utilisation of results in service planning and systems management. Generation of information on needs from the local population or patient group is likely to enable better planning of the kind of services required.

The lack of suitable needs assessment instruments suggest that there is an opportunity for the development of a needs assessment method that is standardized for older people with mental health problems and measures need for the range of interventions offered by old age psychiatry services (Hamid et al, 1995). Later on in this study, the development of such an instrument, the

Camberwell Assessment of Need, modified for use in older people as the CANE is described.

Structured needs assessment like the MRC Needs for Care Assessment have been observed to be useful in acute mentally ill patients (Stansfeld et al, 1998). It identified both clinical and social unmet needs like drug side effects, embarrassing social behaviour, shopping, cooking meals and managing finances. In psychiatric rehabilitation, it is believed that patient participation is essential, though reliable response to needs assessment may be affected in the cognitively impaired (Corrigan et al, 1996). This means that instruments for assessing needs must take this into account by being sufficiently structured or by enabling the information to be obtained from carers and keyworkers. Using the Camberwell Assessment of Need in people with severe mental illness, it was observed that patients and staff rated a similar number of needs, though mix of identified needs differed (Slade et al, 1996). The mean number of needs identified by patients was 7.9 compared to 7.5 by staff. Better agreement was observed between staff and patients in the areas of accommodation, alcohol and daytime activities where kappa scores were above 0.7. Food, transport, drugs and money were also among the areas of greater correlation between staff and patients assessment of needs. These findings suggest that in the areas of need for service provision, staff are able to identify quite well the needs of patients. This could have implications amongst patients who are mute or cognitively impaired

leading to communication difficulties and inability to express their needs. In such cases, reliance will be on staff or carer assessments of needs. There was no staff-patient agreement in two areas, need for information on treatment and diagnosis, and risk to others. Concerns about the former in patients with dementia would suggest if it is poorly carried out, there may be need for written and regular verbal information on management. Especially as cognitively impaired persons aside from difficulties in expressing or correctly identifying their needs and have memory problems. Furthermore in this group of people, information from carers and relatives may be all that can be relied upon to identify needs. Hence, it is important that a needs assessment tool for older people with mental health problems amongst whom a significant proportion may be cognitively impaired, allows the source of information from carers to be recorded.

Formal needs assessment has successfully been used in persons with enduring mental illnesses to assess quality of care by Middleton et al (1996). Using a derivative of the MRC Needs for Psychiatric Care Assessment Schedule, they were able to adopt its use for ordinary clinical practice and assess needs for care amongst a population of patients with enduring mental illnesses. Comparing their sample population with other studies, they indicated that their more rural population had less problems than more urban populations. This highlights the value of systematic needs assessment in being able to inform and

compare needs in different populations, giving the benefit of adapting services as required to varying needs.

Carter et al. (1995) noted that formal assessment of need has the potential to influence individual psychiatric practices with respect to users, providers, planners and purchasers of mental health services. In their view at the time, there was little evidence of a standardised needs assessment methodology in relation to the expressed need of a mental health service user in the United Kingdom. They went on to develop the Bangor Assessment of Need Profile, a needs assessment tool which included the expressed needs of users.

Mental disorders are characteristic of conditions that require common information systems to meet needs, as they are widely distributed, have a broad spectrum of severity and type and affect social functioning (Wing et al, 1992). The use of standardized needs assessment tools will enable development of such systems and also ensure the incorporation of the various concepts of need. As a result, needs assessment could become more useful in policy-setting if there were a greater use of such instruments (Royse & Drude, 1982). Policies and decisions made in developing services are likely to become more relevant to users with the availability of information on user needs.



## 1.6. Developing structured needs assessment instruments

The only two assessment tools which aim to identify needs as defined in the National Health Service and Community Care Act (1990) and provide a comprehensive need assessment of persons with mental health problems are:

- 1) The Camberwell Assessment of Need (Phelan et al, 1995).
- 2) The Bangor Assessment of Need Profile (Carter et al, 1996).

The development of both instruments is now described. In developing new instruments, validity and reliability need to be assessed to ensure they actually measure what they claim to measure and assessments using the instruments are similar between different raters or over a period of time when no change is expected in the same group of patients.

The Camberwell Assessment of Need was developed along the lines of the following four principles (Phelan et al, 1995):

1. Everyone has needs and that although people with mental illnesses have specific needs, most of their needs are similar to those of people not suffering from mental illness.
2. People with mental illness may have multiple needs which are not recognised by mental health services.

3. Needs assessment should be an integral part of routine clinical practice and a component of service evaluation.
4. Needs should not be defined by staff alone.

Content validity was ensured by a panel of experts and users. The items included 22 items, to ensure the instrument covered the appropriate areas. The Camberwell Assessment of Need follows an identical structure for all areas of need, with each area consisting of four sections. The first section establishes whether there is a need, rating 0 - no need or no serious problem; 1 - no serious problem or moderate problem because of continuing intervention (met need); 2 = current serious problem (unmet need). Section 2 asks about help received from friends, relatives and other informal carers, while section 3 asks about help or need of help from local statutory services. Section 4 differs between two versions, a clinical one in which views of users about help received is asked and in a research version, where specific questions are asked about whether the person is getting the right help and is satisfied.

In the study on the Camberwell Assessment of Need by Phelan et al.(1995), 59 people with severe mental illness rated accommodation the most important need and help with drugs the least important. Timing during assessments indicated patient and staff interviews lasted 16.2 and 9.4 minutes respectively (mean total minutes of 25.6 minutes).

Correlations of the inter rater and test re-test reliability of total number of needs identified by staff were 0.99 and 0.78 respectively. Mean number of needs identified in severe mental illness ranged from 7.55 to 8.64. These findings suggested that the Camberwell Assessment of Need appeared to be a reliable and valid instrument. On average less than half an hour was needed to undertake a comprehensive formal needs assessment.

The intentions in developing the Bangor Assessment of Need Profile was to embrace items of need considered important from the mental health users' and providers' perspective (Carter et al, 1996). The Bangor Assessment of Need Profile consists of the Client Profile, a self report schedule designed to give a brief and simple indication of the expressed need of people with a long term mental illness and the Staff Profile intended to assess the perceived need by key informants of those clients who have responded to the self report assessments. There are 32 items of need, scored as present when an item falls below what the client or key informant perceives to be normal or ordinary functioning, and scored as absent when normal and independent functioning is perceived. Reliability studies for client and key informant agreement indicated a mean kappa of 0.25 and test-retest reliability of 0.42 with mean percentage agreement 75%. This indicated that with this instrument there was unsatisfactory client and

key worker reliability. It is less reliable than the Camberwell Assessment of Need with substantially lower kappa values for test-retest reliability.

The two instruments were both designed for mentally ill patients and obtain patients and carers' views on need. They differ in terms of the number of items of need identified with the Bangor Assessment of Need Profile identifying a total of 32 needs compared to 22 needs in the Camberwell Assessment of Need. The authors of the Bangor Assessment of Need Profile suggest its use as a research instrument, whereas the Camberwell Assessment of Need, while having fewer items of need has both research and clinical versions. The latter is designed with the intent of using in everyday clinical practice. One other difference is the classifying of each item of need into present or absent in the Bangor Assessment of Need Profile compared to unmet, met and no need in the Camberwell Assessment of Need.

Of the two instruments the Camberwell Assessment of Need had been modified for use in older people and along with the above findings, these were the reasons for the use of the Camberwell Assessment of Need for the Elderly in this study.

### 1.7. The development of psychiatric day hospitals

The first psychiatric day hospitals were opened in the Soviet Union in the 1930s, probably as a result of inpatient bed shortages and by the early 1950s had been opened worldwide in developed psychiatric services (Almaz-Serrano et al, 1997). In the United Kingdom, the first psychiatric day hospital was the Marlborough Day Hospital in London, opened in 1946 (Farndale, 1961). Other psychiatric day care services for older people followed, with dramatic increases in the 1960s and 1970s (Fasey, 1994).

The main factor in the growth of day hospitals was attributed to the development of new psychiatric treatments such as neuroleptics. They enabled the mentally ill to be treated in day hospitals, providing a high level of care during the day, but returning to their homes each evening.

### 1.8. The role of day hospitals in psychiatry

The development of effective community support systems are essential for the successful shift from inpatient to community care for mental health services. The identified needs of severely mentally ill individuals in the community include medication monitoring and therapy; psychosocial treatment, day and vocational

activities; supported and supervised residential services (Ford et al, 1992). Day hospitals with their various functions are ideally placed to play a significant role in assessment and community care.

The psychiatric day hospital provides short and medium term care to the mentally ill, with the option of receiving at times intensive psychiatric care without hospitalisation. In the 1970s, a fully integrated psychiatric service for older people was described by Donovan et al (1971) to include a day hospital serving four functions. These functions were:

- (a) The outpatient investigation and treatment of older patients with physical and psychiatric disorders.
- (b) The continued observation of patients discharged from hospital.
- (c) To prevent deterioration from self neglect, loneliness or apathy.
- (d) To offer respite to carers, hence delaying or preventing inpatient admission.

Like Donovan et al. (1971), Holloway (1988) described four main functions of day hospitals for mentally ill persons. They are similar to those above and include:

1. An alternative to admission for people who are acutely ill and cannot be maintained as outpatients.

2. A service for support and monitoring in the often difficult transition between a stay in an inpatient ward and life at home.
3. A source of long-term structure and support for those with chronic handicaps, preferably in a friendly, low pressure environment.
4. A site for relatively, brief, intensive therapy for people with personality difficulties, severe neurotic illnesses or in need of short-term focused rehabilitation.

As a result of the identified contributions to the care of older people, guidelines for current service provision for older people with mental health problems have included the provision of day hospital places (Royal College of Physicians and Royal College of Psychiatrists, 1989; Department of Health, 1997).

For older people, Corcoran et al (1994) described two objectives of the day hospitals established in Ireland as being:

1. To provide acute psychiatric treatment, thereby functioning as an alternative to admission for patients with functional psychiatric illness over 65 years.
2. To treat patients with behavioural disturbances associated with dementia.

These objectives are similar to those described earlier for generic psychiatric day hospitals by Donovan et al. (1971) and Holloway (1988), though the distribution of diagnoses differ. This is especially in the case of persons with

dementia who are more likely to be found in a day hospital for older people than in a generic psychiatric day hospital.

With such varied clientele, outcome and needs in various day hospitals will depend a lot on the type of patients being served and available resources.

One benefit of the above listed functions taking place in day hospitals is that attenders are not taken away from home into hospital, but return home each day. This ensures that routines which may be difficult to re-establish after a long stay in hospital are less disrupted other than due to illness, and so probably reduces the risk of institutionalisation. Furthermore, reports obtained from home, by relatives and carers give day hospital staff an extra tool in monitoring progress of attenders. For patients with cognitive impairment, maintaining them at home while attending the day hospital is likely to reduce problems of disorientation, resulting from movement into new environments like inpatient wards, as day hospital patients return to the familiar surroundings of their homes each day.

Shah & Ames (1994) described potential functions of an old age psychiatry day hospital as including: assessment, treatment, rehabilitation, longterm support, development of social networks and support of carers. These are also similar to functions listed above by Donovan et al. (1971) and Holloway (1988).



Rosenvinge (1994) described the characteristics of older patients' needs most likely to be met in a psychiatric day hospital in functional and organic illnesses.

They included:

- i). Assessment and management of acute functional illness.
- ii) Maintenance treatment of high risk or vulnerable patients.
- iii) Continuation of treatment of discharged inpatients.
- iv) Assessment and management of patients suffering from dementia.
- v) Provision of longterm support for those with severe dementia.
- vi) Treatment possibilities in dementia, such as advances in drug treatments requiring close supervision.

Rosenvinge (1994) concluded that day hospitals should be flexible and needs led in approach, acting as a centre for training and good liaison with other professionals and carers. He also suggested that the process and outcome of day hospital care be subject to regular audit and review. The latter will ensure day hospitals will be sensitive to the needs of the local population, and ensure resources are best used to meet those needs.

Woods & Phanjoo (1991) in a retrospective study of day hospital patients with dementia observed the outcome of care after three years. Circumstances of discharges were classified into planned and unplanned. 65 (45%) of the 145

discharges were unplanned with reasons ranging from emergency hospital admission in 14 (9%), death or physical illness in 40 (28%) and refusal to attend among 11 (8%) patients. Of the planned discharges from the day hospital, only 11 (8%) were discharges to the community with the remaining 69 (48%) transferred to long term care in hospital or nursing\residential homes. Though not a randomised controlled study, the authors suggested that outside factors, such as the presence or absence of spouses or others who have taken on the role of carers affected outcome among day hospital attenders. Day hospital patients with spouses were observed to less likely be admitted to residential or nursing homes than those without spouses. Reasons that they proposed to account for the differences were that the patients with dementia remained longer with their spouses, and that when care was required, the severity of problems presented with at the time would require longterm hospital care rather than placement in residential or nursing homes. The findings of their study would suggest that it is essential that day hospital studies take into consideration such external factors as living spouses, carers and social support networks of patients.

## 1.9. Evaluation of day hospital services

As discussed earlier, evaluation of services can be categorised into four main areas of structures, process, output and outcome (Higginson, 1994). Examples of measures for each area in day hospitals would include:-

1. Structure: staffing mix, financial resources and equipment available.
2. Process: number of attendances, documentation and number of multidisciplinary clinical reviews.
3. Output: rate of discharge, completed patient management plans and early arrival of discharge slips to general practitioners.
4. Outcome: improved mental health, patient satisfaction, reduced carer strain and needs met.

Rating scales are frequently used in psychiatry with the aim of achieving objective measures of outcome. They range from global assessment scales to more specific scales rating an individual symptom or diagnosis like depression. In this study, a needs assessment scale and two other scales are used to measure outcome and described in greater detail later on.

In a study, reviewing the impact of closure of a geriatric day hospital, following closure due to staff industrial action, Bhattacharyya et al. (1980) found little ill-effects on patients over a six week period. Ratings of mobility, self care,

continence, mental state and need for services such as general practitioner, meals on wheels, day care or home help revealed minimal differences before and during the day hospital closure. Of the 55 patients in the study, most had cerebrovascular disorders, arthropathy and/or cardiovascular disorders. Nine patients had problems with dementia or depression.

In a similar study in older patients with mental health problems, Rolleston & Ball (1994) observed the impact of two weeks closure of a psychiatric day hospital. Data on well-being of patients and their carers were collected over eight weeks, to include three weeks prior to closure, two weeks of day hospital closure and three weeks following reopening of the day hospital. They used two brief questionnaires designed for patients and their main caregivers respectively, asking whether they felt the same, better or worse than usual, during the preceding week. Values to responses were rated, - 2: feeling much worse; - 1: feeling a bit worse ; 0: feeling the same; + 1: feeling a bit better and + 2: feeling much better. They found a trend towards decline in well-being during the day hospital closure which returned to preclosure levels for both carers and patients on reopening the day hospital. These findings would suggest that the day hospital was of benefit to both carers and patients. However, this study suffers from the arguments against many day hospital studies, in that they are not randomised controlled studies, hence no consideration is taken for confounding variables, such as the festive season during which closure took place,

compliance with medication and/or social network available to replace the day hospital over the same period.

Corcoran et al (1994) noted that day hospital treatment enabled the older people with functional illnesses to be treated in the community with low usage of beds and provided short/medium term care for patients with dementia who had little support from statutory services. They reviewed all regular attenders of two day hospitals over a three year period, in which 139 (59%) patients had an organic disorder, mainly dementia and 98 (41%) patients had a functional disorder, with the most common diagnosis being depression. There was a low uptake of community services at the time of day hospital admission, despite the relatively high level of dependency especially amongst patients with dementia. During the course of the study, the uptake in community services such as meals on wheels, home help and day care doubled. The average length of admission was five months for those with functional disorders and eight months for those with dementia. Seventy-one per cent of those patients with functional disorders were managed effectively through the day hospital and community psychiatric nursing visits, while twenty-five per cent of them required inpatient care, of whom two-thirds were for deterioration in physical health. In the case of those patients with organic disorders, 88 (63%) of them entered into residential care, on average about eight months after initial referral to the day hospitals. In twenty per cent of patients with dementia, the day hospitals served as a

longterm supportive facility, with average attendance of eighteen months amongst this group of patients with severe dementia. This study highlights the benefits of day hospital care in older persons with both functional and organic disorders, though it can be argued that the lack of a control group or comparison with any alternative form of care weaken its findings. The authors, themselves acknowledge the importance of increased range of support services in the community, for day hospital attenders.

Johansson and Gustafson (1996) observed that the old age psychiatry day hospitals offered flexible and effective care, especially in supporting the demented persons at home. The most frequent psychiatric symptoms that they observed amongst the day hospital attenders included delirium, anxiety, sleep disturbances and depressed mood.

The mix of social, medical and psychiatric problems, these studies have reported in older day hospital attenders with mental health problems, highlight the value for a multidisciplinary team approach and a comprehensive needs assessment tool, for accessing, targeting and evaluating services.

The Audit Commission's report on Mental Health Service published in 2000 indicated that day care can be provided through day hospitals and day centres. The report suggested that day hospitals are better used for time limited

assessment and treatment, with day centres used to cater for people's longer term needs. In some day hospitals, the average length of stay was over eight years indicating that they were not being used effectively. To overcome this problem, health and social services need to plan provision of day care together, so as to prevent overlap of services provided and better use of resources.

In its review on day care, the Audit Commission Report failed to comment or review studies on the effectiveness of day care for older people with mental health problems, possibly because of the paucity of research in this area.

#### 1.10. Day hospital versus community mental health teams: the debate

The lack of adequate scientific data concerning the effectiveness of day hospitals has led to both an enthusiasm for newer service models and contrastingly the more conservative approach of leaving the day hospitals as they are. According to Howard (1995), in favour of day hospitals for older people is the fact that carer support by day hospitals has been endorsed by the National Institute of Social Work. Most psychiatrists with access to day hospitals find that it can be used to prevent inpatient admission and facilitates

early discharge from wards. Howard mentions that day hospitals may increase carer strain caused by preparing patients to attend day hospitals and disruption of normal routines. Other arguments include that there is no evidence that day hospital attendance delays or prevents admission of patients with dementia to acute or continuing care placements.

Ball (1993) reviewed the future of day care in old age psychiatry, in which day hospitals undertook a wide range of activities, ranging from acute management of functionally ill to longterm management of patients with dementia. He noted that high levels of distress and depression were found among carers of patients with dementia and this could be relieved by attendance at a day hospital. Though claiming that models exist to examine the effectiveness and efficiency in day hospitals, he failed to give any examples, except to propose that their days may be limited with the coming of community teams working with small local units. To the present date, no randomised control trial of the two services in older people with mental health problems has been undertaken.

Day hospitals and day centres provide not only social contact for the elderly mentally ill and support over crisis periods, but the former also provides treatment in the community. It is argued however, that these are roles that community mental health teams could also be able to undertake. The community teams working with small local units would be able to target specialist care at



groups of patients in need of support, and guidance to those carers providing for their ordinary needs (Murphy 1991).

The day hospital is no longer uniformly or unreservedly accepted as an essential service component in old age psychiatry (Howard, 1995). Despite the wide use of day hospitals in old age psychiatry, debates still continue over the effectiveness of day hospital care, as it has not been well researched (Fasey, 1994; Howard, 1994). In a debate on day hospitals in Old Age Psychiatry, Fasey (1994) in arguing against day hospitals, highlighted the expenses which included transport, capital investments and highly trained staff. He questioned whether there could be a better and more cost effective way of delivering the same service. An example he gave, was the use of day centres with professional staff providing support and training to less skilled day centre staff. In reviewing the literature, he also noted that stated aims of day care, such as delaying or preventing admission of persons with dementia and decreasing carer burden with day time respite were not achieved (Woods and Phanjoo, 1991; Diesfeldt, 1992; Berry et al, 1991). However, ten of the 155 day hospital patients with dementia followed up by Woods & Phanjoo (1991) were still attending after three years, indicating that day hospitals can serve long term needs of patients and their carers. The study is discussed in detail earlier on in this chapter. Diesfeldt (1992) undertook a retrospective, longitudinal study of older people with dementia, involving a day care centre rather than a day hospital. Over the

five year period of the study, 150 (67%) of the 224 patients admitted to day care died. At time of admission, 148 lived in the community, but by the 5th year, only 9 (4%) patients still lived in the community and 65 were in long term care residential/nursing homes. This study highlighted the well-known fact that dementia is associated with increasing dependency and mortality. However, the outcome of day care is difficult to identify, in light of the fact that it was a retrospective, longitudinal, descriptive study rather than a randomised controlled one.

Hassall et al. (1972) and Arie (1978) have highlighted problems with day hospitals to include the fact that a high proportion of day hospital attenders had been inpatients. This implies that the day hospital failed to serve as an alternative to inpatient care and is further supported by Greene & Timbury's findings (1979) that significant number of day hospital attenders were admitted to longstay care six months later. In this latter study, most of these patients who went onto longterm care in a residential\nursing home or hospital had dementia and had been admitted on account of their families' inability to cope. Their admission to the day hospital was on average six months.

Despite doubts about the usefulness of day hospitals, in a study discussed in greater detail earlier on in this chapter, Corcoran et al (1994) indicated that 71% of patients with functional disorders were managed effectively in the

community with a combination of day hospital care and visits by nurses. They also observed that day hospital attendance enabled thorough assessment, and treatment ensuring that only those with illnesses who could not manage in the community with maximum support were transferred into residential care.

The focus of shifting psychiatric care to the community coupled with poor scientific evidence of day hospital care effectiveness has resulted in support for community mental health teams in place of day hospitals (Howard, 1995). In evaluating the multidisciplinary approach of community mental health teams to psychiatric diagnoses in the elderly, Collighan et al (1993) noted a high degree of accuracy when compared to independent formal assessments and consensus diagnoses by research psychiatrists. 378 new referrals to a community mental health team for older people were assessed independently by the team and a research psychiatrists. The research assessment consisted of a structured psychiatric interview, full medical and psychiatric history, physical examination and routine blood investigations. Level of agreement between team and research diagnoses was between 90% and 99%. This finding suggests that community multidisciplinary team assessments are at least no worse than those done by psychiatrists and possibly more likely to flag up problems in non-clinical areas like housing and social support.

Community mental health teams like day hospitals are staffed by nurses, occupational therapist, psychologists, psychiatrists and social workers (Tyrer et al, 1998). The teams are said to provide care that is less focused on hospital or institution setting (Merson et al, 1992). However, it is uncertain whether they lead to benefit for seriously mentally ill people, their carers and society with respect to how they function or behave (Dowell & Ciarlo, 1993). Lives of carers, especially relatives of persons with severe mental health problems may be disrupted by the high degree of dependency and uncertainty care involves. The profile of mental health is frequently heightened in the media when there is an untoward event involving persons with mental health problems heightening the negative attitude and fear of the public at large. Some of the problems of community mental health teams and possibly day hospitals too, emanate from this, in that people frequently do not want mental health resources near their homes or make relocation and employment of persons with mental health problems more difficult.

A review of the sparse literature on the use of community mental health teams in the care of older people does not indicate a marked difference in outcome from day hospital care. In a follow-up study of older people with mental health problems, referred to four community mental health teams, Bedford et al. (1996) reviewed outcome after six months of referral to the teams. They noted a poor outcome in patients with dementia, in that over the six month period, 22

of the 63 patients with dementia moved from living at home into institutional care settings and 11 (17%) had died. Unmet needs amongst the patients with dementia after six months included residential care in 10 (16%), carer respite in 6 (10%), extra supervision in 5 (8%) and patient stimulation and loneliness in 5 (8%). Amongst the 68 patients who had a functional disorder, most common diagnosis being depression, the unmet needs after six months included, stimulation and loneliness in 7 (10%) and residential care in 3 (4%). As observed in some of the day hospital studies discussed earlier in this chapter, a significant number of older people with dementia became institutionalised, despite referral to community mental health teams. Melzer et al. (1996) reviewed the perspective of carers of people with dementia referred to community mental health teams. Using the General Health Questionnaire (Goldberg, 1972; Goldberg, 1978) to rate carer stress after six months, 15 out of the 26 carers had scores suggesting some degree of psychological distress. 10 carers identified unmet needs in the areas of patient stimulation or carer respite. The former and possibly the latter, may be addressed through day hospital care which offers group and individual activities, as well as day time respite for carers.

It would appear that in day hospitals and community mental health teams for older people with mental health problems, there have been no randomised, controlled studies which compare outcome between these forms of care.

Without such objective studies, no conclusions can be reached about which form of care may better serve older people with mental health problems. The most probable conclusion from current evidence available is that neither service can function well in isolation and some patients will benefit from one or the other. A comprehensive and flexible mental health service is likely to best serve older people with mental health problems allowing the availability of both forms of care.

### 1.11. Measuring effectiveness of services

To measure effectiveness of services, the use of appropriate targets or outcomes and assessment tools are necessary. The desired outcome of an episode of psychiatric care is an improvement in the clinical health status which would not otherwise have occurred (Russell & Buckwalter, 1991) or the amelioration of deterioration which otherwise would have occurred (Moak, 1990). Others include carer respite, needs met, changes in social function and quality of life. Suitable standardised instruments of outcome should measure such change, and with cost data, produce cost effectiveness measures (Harrison & Sheldon, 1994). There are several instruments in use for these purposes, ranging from those for specific disorders to more global scales which measure clinical and social problems.

In a literature review on the effectiveness of day hospital treatment outcomes for adult patients with psychiatric disorders, aged between 18 and 65 years, Almaraz-Serrano et al,1997 were grouped into four. They included:

- (a) Number of patients maintaining contact with the service.
- (b) Extent of hospital care received.
- (c) Clinical and social outcome.
- (d) Costs of care.

These groupings can also be applied to day hospital care for older people with mental health problems.

### 1.12. Needs led healthcare

Needs assessment is an important component in planning, developing and evaluating psychiatric services (Hansson et al, 1995). Data on the needs of users, potential users and their carers at population, collective and individual levels, should be used in developing services for the elderly mentally ill (Furnish, 1994). As an expanding community-based speciality, it is important for services in old age psychiatry to be need-led to ensure better targeting of limited resources (Hamid et al, 1995).

Needs are likely to vary between services and catchment populations. As a result, needs led healthcare help to ensure that local health services meet the identified needs of the population they serve. Holloway (1991) noted that seven units providing day care to an inner city had different proportion of clinical and social problems rated as unmet needs. The day care services, compared included two day hospitals, three day centres, work centre and a sheltered employment centre. The differences in client groups and staff at the various services could explain the differences observed, as more impaired or ill patients are likely to attend a day hospital rather than a day centre or sheltered employment. This study gives an example of the ability to compare services following needs assessment. Furthermore, use of structured needs assessment provide useful information on the needs of day care clients, enabling planning and evaluation of the services rather than extrapolating from assessments done elsewhere which may not accurately reflect local needs.

Current psychiatric practice in many units in England, involve multidisciplinary teams, with various professionals in the teams offering their expertise. This is relevant to the day hospital where the interaction between social and health problems may be less apparent, as patients remain within the community while receiving treatment. Multidisciplinary teams need to be able to address the varied nature of needs identified in older people with mental health problems,



who as a group are likely to have associated or unrelated physical health and social needs.

### 1.13. Needs of older people - how do they vary?

The general needs of older people with mental health problems are similar to other people, for example in terms of need for shelter, food, money and companionship (Department of Health, 1997). However, in addition they are more susceptible to physical disorders like heart disease, stroke, cancer, osteoporosis and arthritis. These associated problems lead to difficulty with mobility and activities of daily living such as eating, washing and dressing. As a group, older people become more dependent on others and services to meet their needs, although many individuals remain independent. The mental health problems of ageing are similar to the younger population but in addition age related disorders like dementia are much more common, which results in increased dependency from worsening cognitive impairment. When mental health and physical problems coexist as frequently is the case in the elderly, they may become more difficult to diagnose and manage.

The results of ageing mean the needs and problems of older people require the use of assessment instruments which have been adapted or designed for use in

older people. There were no needs assessment tools specific for older people covering all mental health problems available until recently. The Camberwell Assessment of Need for the Elderly (see Appendix) has been developed for that purpose (Reynolds et al, 2000). It is a modification of the Camberwell Assessment of Need and has been discussed in greater detail earlier on in this chapter.

A needs assessment tool specific for persons with dementia has been described by McWalter et al (1998), called the Care Needs Assessment Pack for Dementia. It was designed to assess the needs of people with dementia and their carers in the community. It consists of four sections, basic and referral information, two sections on persons with dementia and their carers respectively, and personal history. No part of the Care Needs Assessment Pack for Dementia was intended as an interview schedule, hence information is gathered from various sources, such as direct knowledge of and discussion with individual patients and their carers. As Care Needs Assessment Pack for Dementia was designed for older persons with dementia, suggestions were made by its authors to extend development to other client groups.

#### 1.14. Care planning for older people

Structured needs assessment are able to identify required interventions. For example, specific needs could include collaboration between different professionals, problem solving for carers, emotional support, respite care and need for continued care. The current practice of Care Programme Approach meetings in which multidisciplinary team members, clients and their families meet may provide a suitable forum for needs to be discussed and interventions planned and implemented. These needs can be identified through a comprehensive standardised tool, such as the Camberwell Assessment of Need for the Elderly.

With training, staff have been reported to make reasonable and reliable brief assessment about needs for different kinds of day and residential placement (Clifford et al, 1991). The Community Placement Questionnaire was designed to assess the needs of patients in hospital for more than a year who did not have a primary diagnosis of dementia. Inter rater and test retest reliability gave varying kappa scores for the various items rated. Social functioning and hard to place had reliability kappa scores of over 0.6. According to Clifford et al (1991), the staff found the questionnaire easy to use and relevant. To support their claim, they reported that several hospitals adopted the Community Placement Questionnaire as the routine method of assessing longstay patients

for placements in the community. This supports the belief that a comprehensive needs assessment tool could be used routinely in psychiatric day hospital services, where staff see the benefits, in terms of improved assessments and patient care, planning and service evaluation.

Comparing methods to improve service delivery by staff, Smith (1995) observed that feedback on performance to staff was better than training or provision of a checklist. This indicates the value of discussions with keyworkers on the care of their individual clients and patients. The methods available include individual or group feedback involving discussions with key workers and can be enhanced by also providing documentation of feedback for key workers to refer to later on. Multidisciplinary team meetings may provide the forum for group feedback to take place, as well as developing care plans following comprehensive needs assessments.

### 1.15. Summary

The current level of scientific evidence on day hospital care still leaves the question on its effectiveness unanswered. This is likely to remain the case until more randomised controlled studies on day hospital care, using standardised instruments to measure outcome become available. These studies need to be

extended to include comparison with alternative forms of care, such as community mental health teams.

The use of needs assessment to provide comprehensive assessment of older day hospital patients has been discussed. A structured needs assessment will provide detailed assessment of individual patient needs and can form the basis for planning and evaluating health care services in meeting the needs of its catchment population. The ideal instruments should be valid and reliable. To ensure easy, everyday use by day hospital staff, they should be brief, comprehensive and easy to use by all health care professionals working within the service. The lack of suitable instruments to assess needs of older people with mental health problems has only recently begun to be addressed with the development of the Camberwell Assessment of Need for the Elderly and the Care Needs Assessment Pack for Dementia.

Wide use of structured needs assessment would provide the comprehensive information required in day hospital care to improve, monitor, compare and evaluate services.

## **2. Aims of study**

1. To compare the routine assessments carried out in psychiatric day hospitals for older people using the care programme approach, with a standardised needs assessment instrument, to measure needs.
2. To determine whether systematic needs assessment and identification of interventions, followed by feedback of needs and interventions to the day hospital staff is more effective in ensuring that needs are met, than the standard day hospital practice.
3. To consider the above two aims, 1 and 2, in the two commonest diagnostic groups, dementia and depression, amongst older day hospitals patients.
4. To consider the impact of routine day hospital care and systematic needs assessment on outcome according to the Health of the Nation Outcomes Scales and dependency according to the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales.
5. To identify interventions for meeting unmet needs.

## **3. Method**

### **3.1. Development**

An initial literature review revealed a lack of scientific evidence for the effectiveness of day hospitals and needs assessments in older people with mental health problems, as discussed in the introduction. On account of the literature search findings and the recent introduction of the Camberwell Assessment of Need for the Elderly, it was decided to develop a study on the use of a standardised needs assessment tool in day hospital practice.

Before commencing the study, successful application to the local ethics committees for the Haymeads and Camden Mews day hospitals was made through their respective hospital trusts. Visits were made to both day hospitals to familiarise staff with the study and to develop a strategy on the best times to see new day hospital referrals. All the responsible consultants of both day hospitals were contacted, given information on the study and their permission obtained to carry out the study on the patients under their care.

An information sheet was designed for patients, relatives and carers (see Appendix). This ensured that patients were fully aware of what the study

entailed. They were assured that they could choose to participate or not without any consequences to their treatment.

Statistical advice was sought on developing a protocol, to identify sample size and suitable statistical analysis, from Dr. Jenny Head of the Department of Epidemiology and Public Health, University College London.

### 3.2. Design

All new day hospital patients over a period of one year were assessed using the Camberwell Assessment of Need for the Elderly, the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scale (Pattie & Gilleard, 1979) and the Health of the Nation Outcome Scales (Royal College of Psychiatrists Research Unit, 1995 a & b). These instruments are described in greater detail in the next section. The assessments were done twice by the primary investigator (O.A.), firstly at the time of admission and then after three months in the day hospital or at the time of discharge. Three months was taken as the time for reassessment, since it allows sufficient time for assessment and treatment in many cases and gives enough time for the day hospitals' multidisciplinary reassessment meetings following admission.



In both day hospitals, formal cognitive assessments included the use of the Mini Mental State Examination (Folstein et al, 1975), designed to assess cognitive impairment. The total scores of the Mini Mental State Examination were used in this study to aid ratings of cognitive impairment on the three instruments used.

**Randomisation:** All patients were randomly placed into two groups, the experimental and control groups respectively. Randomisation was done by placing numbers 1 to 120 in separate envelopes and after completing each assessment and identifying the required interventions, an envelope was picked blindly. Those patients with odd numbers were placed in the experimental group and those with even numbers were placed in the control group.

**Experimental group:** Key workers of patients in this group received the results of the Camberwell Assessment of Need for the Elderly assessment defining areas of unmet needs. The primary investigator identified interventions for each of the unmet needs and discussed this information with the key workers who were asked to make this information available to the rest of the multidisciplinary team members. A list of unmet needs and suitable interventions were also placed in patients' case notes for team members to have direct access to.

**Control group:** In this group of patients, a summary of the Camberwell Assessment of Need for the Elderly results and requirements for interventions was

prepared but not fed back to the staff. They relied on the current day hospital practices of assessment to identify needs. This included the usual treatment and the Care Programme Approach (CPA), in which multidisciplinary meetings were held to design and review care plans. During the meetings, a Care Programme Approach form was filled by the key worker highlighting each professional's role, along with met and unmet needs. A list of needs identified by the staff was obtained from the hospital records of the different professionals involved in patient care and Care Programme Approach forms. The format of the list was the same as the 26 items listed in the Camberwell Assessment of Need for the Elderly.

**Follow-up:** Three months after the initial assessments or at discharge if it occurred earlier, assessments using the Camberwell Assessment of Need for the Elderly, the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales and the Health of the Nation Outcome Scales were repeated. After the follow-up needs assessment, discussions were held with respect to met and unmet needs with key workers of patients in both the experimental and control groups.

### 3.3. Instruments

**1. Camberwell Assessment of Need for the Elderly:** The Camberwell Assessment of Need was designed for use with patients aged under 65 years of age. It was modified for use in older people (aged over 65 years). The Camberwell Assessment of Need (CAN) is a brief, valid and reliable scale which has been designed to provide a comprehensive assessment of the clinical and social needs of the severely mentally ill (Phelan et al, 1995). The specific criteria set in designing the Camberwell Assessment of Need by its authors were that it should:

1. Have adequate psychometric properties.
2. Be completed within 30 minutes
3. Be usable by a wide range of professionals.
4. Be suitable for both routine clinical practice and research.
5. Be easily learned and used without formal training.
6. Incorporate both patients' and staff views of needs
7. Measure both met and unmet need.
8. Measure the level of help received from friends and relatives, as well as from statutory services.

The Camberwell Assessment of Need has been successfully used in countries other than England where it was developed and observed to have high inter-rater

reliability (Hansson et al, 1995). Development of the Camberwell Assessment of Need for the Elderly involved the research and clinical versions of the Camberwell Assessment of Need which were amalgamated to produce 24 items with recording of responses from patients, staff or main carer.

The 24 items on the Camberwell Assessment of Need for the Elderly plus two carer's need are listed (see appendix for full instrument):

Accommodation.	Looking after the home.
Food.	Self-care
Caring for someone else.	Daytime activities.
Memory.	Eysight\hearing.
Mobility.	Continence.
Physical health.	Drugs.
Psychotic symptoms.	Psychological distress.
Information on management.	Deliberate self-harm.
Inadvertent self-harm.	Abuse or neglect.
Behaviour.	Alcohol.
Company.	Intimate relationships.
Money.	Benefits.
Carers need for information.	Carers' psychological distress.

An identical structure for all areas of need is followed with each consisting of four sections (see Appendix). The first section establishes whether there is a need. Responses are rated on a three point scale: 0 = no serious problem; 1 = no serious problem or moderate problem because of continuing intervention (met need); 2 = current serious problem (unmet need). Section 2 asks about help received from friends, relatives and other informal carers. Section 3 asks about how much help is received from local statutory services and also how much help is needed. For both sections 2 and 3, a four point scale is used with ratings: 0 = none; 1 = low; 2 = moderate and 3 = high. Section 4 consisted of two specific questions, asking whether individuals are getting the right help and whether they are satisfied with the amount of help given.

The development, validity and reliability of the Camberwell Assessment of Need for the Elderly was described by Reynolds et al. (in press). Its development from the Camberwell Assessment of Need followed an extensive process which included focus groups, a modified Delphi process and a consensus conference. Carers and staff were observed to identify the approximately the same number of total needs (9), while patients rated about 30% less. The most frequent unmet needs amongst the 102 patients in their study were memory in about 25%, and in about 20% unmet needs included household skills, food, daytime activities and psychological distress. Content and face validity were observed to be good following rigorous scrutiny by a large number of experts, clinicians,

carers and service users. It correlated well with the Clifton Assessment Procedure for the Elderly-Behaviour Rating Scales, with correlation coefficient of 0.66 observed between the total number of needs and scores respectively. The Camberwell Assessment of Need for the Elderly had good inter rater reliability with 90% of the items having kappa values higher than 0.8. These findings suggested that the Camberwell Assessment of Need for the Elderly was systematic and comprehensive method of assessing needs in older people.

**2. The Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales (CAPE - BRS):** These are scales for rating the level of dependency and behavioural function of older patients across a variety of problems, behaviour and activities of daily living using information from an informant. They consist of 18 items, rated 0 - 2, with 0 indicating no problems, 1- mild to moderate problems and 2 - severe problems (see Appendix for full scale).

The Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales have been observed to be a useful tool in assessing appropriate placement and to monitor ongoing need in severely mentally ill in all age groups in the community (Robson, 1995). In several studies, the scales have been used to monitor and compare behaviour and cognition in older psychiatric patients in different settings (Clarke et al, 1996; Martin et al, 1994; Sabin & Morrison, 1996; Ward et al, 1992). The scales have shown some usefulness as a predictor

of survival in older psychiatric patients (Gamsu et al, 1990; McLaren et al, 1986; Moran et al, 1990). These findings and studies support the use of the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales as a monitoring and assessment tool in older people. With 18 items and ratings for each item between 0 and 2, it is brief, easy to use and is used in routine clinical assessments of older persons with mental health problems.

The Audit Commission (2000) report on Mental Health Services used the scales to measure dependency amongst attenders of day centres and day hospitals in several centres. They observed a greater dependency amongst those persons attending day centres, explained by the fact that day hospitals are used for time limited assessments and treatment with day centres meeting longer term needs. In the report, the scales were described as being widely used in services for older people. The decision to use the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales in this study over similar scales measuring non- cognitive symptoms, dependency, and activities of daily living, were further supported by previous experience (Ashaye et al., 1999) and the findings of Reynolds et al (2000) that the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales' total scores had a correlation coefficient of 0.66 with the total number of needs identified by the Camberwell Assessment of Need for the Elderly. Shergill et al (1999) also noted that the total scores of the Health of the Nation Outcome Scales had a correlation coefficient of 0.78 with

the Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales' total scores.

**3. The Health of the Nation Outcome Scales(HoNOS):** These were designed as a concise and simple instrument to help monitor outcomes of mental health care (Wing et al, 1994; Wing et al, 1998). The scales have shown good reliability in independent trials and compared favourably with equivalent items like the Brief Psychiatric Rating Scales and Role Functioning Scales (Wing et al, 1998). It consists of 12 scales covering the four areas of behavioural, impairment, symptomatic and social problems. Each scale is rated between 0 and 4. The ratings represent: 0 - no problems, 1 - subclinical problems, 2 - mild clinical problems, 3 - moderate problems and 4 - severe problems.

Shergill et al (1999) looked into the reliability and validity of the Health of the Nation Outcome Scales in older people using the adult version. They assessed 100 patients over the age of 65 years who were in contact with various mental health services such as inpatients wards, day hospitals, outpatient clinics and liaison services. Interater and test retest reliability for the various items on the scales were from above 0.56 and they had a Cronbach's alpha value of 0.61. The correlation coefficients between the total scores on the Health of the Nation Outcome Scales and other instruments used were:



- a) The Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales (Pattie & Gilleard, 1979) - 0.78.
- b) The Global Assessment Scale (Endicott et al., 1976) - 0.74.
- c) The Brief Psychiatric Rating Scale (Overall & Gorham, 1962) - 0.64.
- d) The Quality of life Assessment (Blau, 1977) - 0.51.
- e) The Medical Outcomes Study 36-item short form (Ware & Sherbourne, 1990) - 0.6.

Shergill et al. (1999) found that the Health of the Nation Outcome Scales had good validity and reliability amongst older people with mental health problems. They suggested the need for minor modifications to make it better suited for older people. These have been addressed with the development of HoNOS 65 + (see Appendix) and is the version used in this study.

Since its introduction, the Health of the Nation Outcome Scales have been used in an audit on cost and outcome in a mental health service (Brooker et al, 1997); to monitor disability and outcome in acute psychiatric inpatients (Boot et al, 1997); compared with general practitioners' opinion in monitoring psychiatric outpatients (Taylor and Wilkinson, 1997); and used as an instrument to compare elderly psychiatric and learning disabled patients (Ashaye et al, 1997). The Health of the Nation Outcome Scales have been used to monitor a cohort of resettled elderly psychiatric patients reflecting expected changes some

scale scores and some worsening of scores in a similar group of longstay patients left in hospital over an 18 month period (Ashaye et al, 1998). As a predictor of outcome, the Health of the Nation Outcome Scales have been used in a follow-up study of elderly psychiatric patients. Higher total scores were associated with worse outcomes on one year follow-up (Ashaye et al, 1999).

These studies highlight the ability of the scales to monitor change and predict outcome in varying circumstances in older persons with mental health problems. Aside from monitoring change, the Health of the Nation Outcome Scales are also observed to be sensitive to lack of change when this is to be expected like in stable, longstay patients with mental health problems and or learning disabilities (Wing et al, 1998; Ashaye et al, 1998).

Despite its successful use as a simple and concise monitor of mental healthcare and outcome, the Health of the Nation Outcome Scales, some researchers have observed it to be less able to discriminate between varying levels of disability in longstay psychiatric patients (Allan and McGonagle, 1997). Others have found that though the Health of the Nation Outcome Scales monitor change in psychiatric inpatients, it is not useful in predicting length of admission or in offering information on allocation of resources for individual patients (Goldney et al, 1998).

Though one of the aims of developing the Health of the Nation Outcome Scales were for routine clinical use, Stein (1999) believes this is unlikely to happen. Reasons for this include, the motive of assisting purchasers and gathering national statistics which may take away from the emphasis on trying to help individual patients, which is the main aim of time spent between clinician and patient.

The Health of the Nation Outcome Scales are far from the ideal in monitoring mental health care. However, most instruments available are either for specific disorders, long and do not rate globally such items as social, behavioural, clinical and physical health problems. Until better instruments are available, it can only be a good thing to have an instrument which is widely used and can give some indication individually and collectively of the impact of mental health care. Especially if it is concise and easy to use like the Health of the Nation Outcome Scales, making little change to the clinicians workload or distracting from normal patient care.

### 3.4. Subjects

New admissions to two day hospitals for older psychiatric patients over a period of one year (November 1997 to October 1998) were assessed. The subjects

were older (aged 65 years and over) psychiatric patients admitted for assessment and/or treatment. Patients to the day hospitals were usually admitted as transfers from inpatient care or as referrals from the community by general practitioners and other mental health workers or services, like community psychiatric nurses and outpatients clinics.

### 3.5. Day Hospitals

**Haymeads Day Hospital:** It has a catchment area covering the rural and urban populations of West Essex and East Hertfordshire. Haymeads Day Hospital is situated in a community hospital, the Herts & Essex Hospital in Bishop Stortford. Its projected catchment population from the 1991 census of people over 65 years of age was 36,000, with 21,000 from West Essex and 15,000 from East Hertfordshire.

Staffing levels included three consultant psychiatrists, four junior medical staff, four nurses, three qualified occupational therapists, one occupational therapy assistant and one nursing assistant. There was also input from the clinical psychology and pharmacy departments. Some of the day hospital activities included group activities, occupational therapy, liaising with other services,

running community support groups, individual key worker-patient sessions and regular reviews of management.

The day hospital had been adapted for use with older people, being on ground floor level with wheel chair access to all areas. It consisted of a large room for group activities which could also be partitioned off into two smaller group rooms, two therapy rooms for small group sessions, review meetings or individual sessions, library, activities of daily living kitchen and bedroom, domestic kitchen, bathroom and toilets.

The day hospital was open five days a week, Mondays to Fridays, providing 25 daily places. The total number of places available were between 65 and 70. Separate days were offered for patients who were cognitively impaired and for those with functional disorders respectively. According to its operational policy, the day hospital aimed to have no more than a third of the day hospital population consisting of patients who had progressive organic brain dysfunction, which in most cases would be those with a diagnosis of dementia.

**Camden Mews Day Hospital:** This is an inner London psychiatric day hospital for older people, with a catchment area covering Camden and parts of Islington. Its projected catchment population of people from the 1991 census of people over 65 years, was 29,738.

Staffing levels consisted of three consultant psychiatrists, three junior doctors, three registered mental health nurses, three support workers and one occupational therapist. The clinical psychology department offered some input to the day hospital. Day hospital activities included group sessions, occupational therapy, physiotherapy, individual patient-keyworker sessions, regular review of management and liaising with other agencies such as social services, housing department and voluntary agencies.

The day hospital had a daily capacity of 20 patients and on average had a total of 86 patients on admission. It was open five days a week, Mondays to Fridays. The day hospital building was purpose built for older people, ensuring easy and wheel chair access. It consisted of one large group room, an art therapy room, a quiet area room, a clinic room, three interview rooms, a communal office, staff room, a domestic kitchen and an activities of daily living kitchen.

### 3.6. Pilot Study

As part of a pilot study, 10 elderly psychiatric patients attending the Haymeads Day Hospital were assessed using the instruments in the study which included the Camberwell Assessment of Need for the Elderly, the Clifton Assessment

Procedures for the Elderly - Behaviour Rating Scales and the Health of the Nation Outcome Scales. The aim of the pilot study was to assess feasibility of using the three instruments, time required to see each patients and identify any possible difficulties in carrying out study. Assessments for each patient lasted between 60 and 90 minutes, and included information gathering from case notes, keyworker, patients and relatives. Using the Camberwell Assessment of Needs for the Elderly, the mean total needs were 6.47 (standard deviation = 3.81), with mean met needs 5.19 (standard deviation = 3.18) and mean unmet needs 1.28 (standard deviation were 1.74).

The information gathered from the pilot study indicated no difficulty in using the Camberwell Assessment of Need for the Elderly, Health of the Nation Outcome Scales and Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales in older day hospital attenders. As a result, no changes were made to the methodology.

The author was also involved in an earlier study using the Camberwell Assessment of Need for the Elderly by Reynolds et al. (2000) discussed earlier, on older patients in various psychiatric settings such as inpatients, day hospitals and outpatients clinics. This gave first hand experience on its use in a clinical setting.

### 3.7. Logistics

The study was self-funded. Visits to both day hospitals were made on several days a week to interview patients, carers and staff throughout the study period. These visits were undertaken during my allocated special interest and research sessions as a specialist registrar, which varied according to admission and follow-up assessment days.

### 3.8. Statistics

Statistical advice was obtained from the outset and at various stages of this study from Professor Stephen Senn and Dr. Jenny Head of the Department of Epidemiology & Public Health, University College London. They advised on power calculations, sample size and appropriate statistical analysis of results obtained from this study. An example of such advice received occurred during the analysis of results. It was observed that there was a significant difference in total unmet needs at initial assessment between the experimental and control groups. Professor Senn suggested the use of covariate analysis to account for differences observed in initial unmet needs between experimental and control groups in comparing outcome in terms of unmet needs at follow-up.



The sample size was estimated using graphs produced by Aleong and Bartlett (1979) for comparing two independent binomial distributions. Our estimated increase in met needs over three months of day hospital admission was 25%. This value was taken as the expected and acceptable improvement in met needs for new day hospital attenders after three months, as there were no previous studies using needs assessments as an outcome measure in older people with mental health problems to compare with. With 80 % (power) chance of finding a significant difference at the 5% level, the estimated sample size was 35 per group.

Descriptive and analytical statistics were used with the significance level set at 5%, to compare assessments at admission and at follow-up. Paired t-tests were used when comparing the same patients at onset and follow-up. Independent t-test were used to compare results between patients in each day hospital. Logistic regression analyses were undertaken as it allowed a comparison of the effects of both qualitative and quantitative data of independent variables on outcome in terms of presence of unmet needs at follow-up. The SPSS for Windows version 7.5 was used for analysis.

## 4. RESULTS

### 4.1. The characteristics of new referrals attending the day hospitals

There were 112 new admissions to both day hospitals over a one year period (1st November 1997 to 31st October 1998) who were assessed and agreed to take part in the study. They consisted of 54 patients from Camden Mews Day Hospital and 58 patients from Haymeads Day Hospital. Two patients died before their follow-up assessments were due to take place. All patients approached agreed to take part in the study.

The number of new referrals who did not attend or only attended once was difficult to ascertain in both day hospitals, as records of such patients and reasons for non-attendance were not always available. These patients were not included in the study.

54 (48.2%) patients were randomly allocated to the experimental group and 58 (51.8%) to the control group. Breaking down into the different day hospitals, the number of patients in the experimental group from Haymeads Day Hospital were 28 (48.3%) and from Camden Mews Day Hospital, 26 (48.1%).

There were 72 (64.3%) females and 40 (35.7%) males with a mean age of 76.4 years. 108 (96.4%) patients were living at home at the time of admission to the day hospital and the remaining four were either in residential care or hospital.

98 (87.5%) patients had good vision either with wearing glasses or without. The remaining 14 patients had mild (9) or moderate (5) visual impairment. 99 (88.4%) patients had normal hearing, eight patients had some degree of hearing impairment corrected by using a hearing aid and five patients had mild impairment despite using hearing aid.

In terms of mobility, 74 (66%) were fully ambulant and 16 (14.3%) were usually independent. The rest had varying levels of mobility difficulties, which included 19 (17%) patients with mild restriction, two patients with moderate restriction and one patient who was chair fast.

In terms of ethnic origin, 107 (95.5%) patients were of white British or European descent. The rest were of either Asian (1), black African (1) or Caribbean (3) descent.

52 (46.4%) patients were widowed, 39 (34.8%) were married, 13 (11.6%) were either divorced or separated and eight (7.1%) were single. In terms of their living situations at the time of admission, 55 (49.1%) patients lived alone, 41

(36.6%) lived with a spouse or partner, 10 (8.9%) lived with other relatives and six with others (four in long term care and two with friends).

58 (49.1%) patients had never been admitted to a psychiatric inpatient unit at the time of the day hospital assessment. 23 (20.9%) had been admitted once, while 5 (4.5%) had been admitted 10 or more times, with the latter group of patients mostly losing count of the actual number of previous admissions. The rest were evenly distributed between two and five previous admissions with only one patient being admitted six times.

#### 4.2. Comparing the new referrals to each day hospital

Table 1 shows details of comparison between the new referrals to each day hospital. The mean ages of patients in the study from Haymeads and Camden Mews Day Hospitals were 77.1 and 75.6 years respectively. 27 (46.6%) and 25 (46.3%) patients from Haymeads and Camden Mews Day Hospitals respectively were widowed. 22 (37.9%) patients from Haymeads Day Hospital compared to 17 (31.5 %) from Camden Mews Day Hospital were married. All 58 patients studied from Haymeads Day Hospital were white, compared to Camden Mews Day Hospital, of whom five patients were of Asian, Black African or

Afro-Caribbean descent. At the time of admission, 31 (53.4%) patients of the Haymeads Day Hospital and 24 (44.4%) of the Camden Mews Day Hospital patients were living alone.

**Table 1: The characteristics of Haymeads and Camden Mews Day Hospitals' patients**

	<b>Haymeads</b>	<b>Camden Mews</b>	<b>All</b>
<b>Mean age (S.d) years.</b>	77.1 (7.1)	75.6 (6.7)	76.4
<b>Gender (%):</b>			
- female	40 (69)	32 (59.3)	72 (64.3)
<b>Marital status (%):</b>			
- single	2 (3.4)	6 (11.1)	8 (7.1)
- married	22 (37.9)	17 (31.5)	39 (34.8)
- divorced	7 (12.1)	6 (11.1)	13 (11.6)
- widowed	27 (46.6)	25 (46.3)	52 (46.4)
<b>Usual residence (%):</b>			
- Own home	57 (98.3)	51 (94.5)	108 (96.4)
- Long-term care	1	3	4 (3.6)

Depression was the diagnosis made in 32 (55.2%) and 33 (61.1%) Haymeads and Camden Mews Day Hospital patients respectively (Table 2). Those patients with a diagnosis of dementia consisted of 24 (41.4%) and 11 (20.4%) from Haymeads and Camden Mews Day Hospitals respectively.

**Table 2: Distribution of diagnoses amongst the patients of Haymeads and Camden Mews**

**Day hospitals**

<b>Diagnosis</b>	<b>Haymeads (%)</b>	<b>Camden Mews (%)</b>
Depression	32 (55.2)	33 (61.1)
Dementia	24 (41.4)	11 (20.4)
Schizophrenia	2 (3.4)	6 (11.1)
Anxiety	-	1 (1.9)
Alcohol/drug misuse	-	3 (5.6)

**4.3. Initial assessments of each day hospital's new referrals**

There were no significant differences between the two day hospitals in terms of the mean total needs identified by either the day hospitals' multidisciplinary teams or the Camberwell Assessment of Need for the Elderly (Table 3). Comparing the total scores for the initial ratings of the Health of the Nation Outcome Scales and Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales there were also no significant differences observed.

**Table 3: Comparing the initial assessments of Haymeads and Camden Mews Day**

**Hospitals' patients**

	<b>Haymeads Day Hospital's patients</b>	<b>Camden Mews Day hospital's patients</b>	<b>p</b>
<b>MDT needs:</b>			
- total	5.8 (2.8)	5.4 (2.9)	0.56
- unmet	3.1 (1.7)	2.7 (1.7)	0.32
- met	2.7 (2.8)	2.8 (2.4)	0.8
<b>CANE needs:</b>			
- total	9.5 (3.1)	8.3 (3.3)	0.54
- unmet	3.5 (1.9)	3.4 (2.0)	0.77
- met	5.9 (2.9)	4.8 (3.2)	0.06
<b>HoNOS</b>	9.1 (4.2)	8.2 (3.6)	0.21
<b>CAPE-BRS</b>	6.9 (5.4)	5.7 (4.3)	0.2

**Key:** p - independent t test. ( ) - standard deviation.

The most frequent unmet needs identified at initial assessment amongst the 58 Haymeads Day Hospital patients using the Camberwell Assessment of Need for the Elderly were daytime activities, company, psychological distress, memory and information for patients on diagnosis and treatment (Table 4). Amongst the 54 Camden Mews Day Hospital patients, the most frequent unmet needs identified using the Camberwell Assessment of Need for the Elderly were psychological distress, daytime activities, company, memory and information for patients on diagnosis and treatment. The Camden Mews Day Hospital patients had about twice the number of Haymeads Day Hospital patients with unmet needs, in the areas of accommodation and looking after their homes. In the areas of behaviour, company, intimate relationships and carer distress, a greater

proportion of patients had unmet needs amongst Haymeads than Camden Mews Day Hospital patients.

**Table 4: Comparing the unmet needs identified by CANE in the two day hospitals**

Unmet Needs	Haymeads Day Hospital	Camden Mews Day Hospital
1. Accommodation	5 (8.6%)	10 (18.5%)
2. Looking after the home	3 (5.2%)	6 (11.1%)
3. Food	2 (3.4%)	1 (1.9%)
4. Self-care	2 (3.4%)	3 (5.6%)
5. Caring for someone else	0	0
6. Daytime activities	34 (58.6%)	31 (57.4%)
7. Memory	21 (36.2%)	19 (35.2%)
8. Eyesight/hearing	1 (1.7%)	3 (5.6%)
9. Mobility	2 (3.4%)	1 (1.9%)
10. Continence	3 (5.2%)	2 (3.7%)
11. Physical health	3 (5.2%)	1 (1.9%)
12. Medication	3 (5.2%)	4 (7.4%)
13. Psychotic symptoms	6 (10.3%)	6 (11.1%)
14. Psychological distress	32 (55.2%)	32 (59.3%)
15. Information for patient	14 (24.1%)	16 (29.6%)
16. Deliberate self-harm	3 (5.2%)	0
17. Inadvertent self-harm	2 (3.4%)	2 (3.7%)
18. Abuse/neglect	0	0
19. Behaviour	13 (22.4%)	6 (11.1%)
20. Alcohol	2 (3.4%)	7 (12.1%)
21. Company	34 (58.6%)	24 (44.4%)
22. Intimate relationship	11 (19%)	5 (9.3%)
23. Money	0	1 (1.9%)
24. Benefits	0	0
25. Information for carer	5 (8.6%)	4 (6.9%)
26. Carer's distress	5 (8.6%)	1 (1.9%)

The five most common unmet needs in the Haymeads Day Hospital patients identified by staff were psychological distress, memory, daytime activities, company and behaviour (Table 5). The Camden Mews Day Hospital staff identified psychological distress, company, memory, daytime activities, accommodation and psychotic symptoms, as the most frequent unmet needs at



initial assessment. According to the multidisciplinary teams of each day hospital, unmet needs in the areas of looking after the home, food, daytime activities, memory, behaviour and intimate relationships were identified in a greater proportion of Haymeads than Camden Mews Day Hospital patients. The latter day hospital had a greater proportion of patients with unmet needs than the Haymeads Day Hospital in the areas of accommodation, information for patients, and alcohol.

**Table 5: Frequency of unmet needs identified by the two day hospitals' multidisciplinary teams**

<b>Unmet needs</b>	<b>Haymeads Day Hospital</b>	<b>Camden Mews Day Hospital</b>
<b>Accommodation</b>	2 (3.4%)	10 (18.5%)
<b>Looking after the home</b>	6 (10.3%)	0
<b>Food</b>	3 (5.2%)	0
<b>Self-care</b>	3 (5.2%)	2 (3.4%)
<b>Caring for someone else</b>	2 (3.4%)	1 (1.9%)
<b>Daytime activities</b>	23 (39.7%)	15 (27.8%)
<b>Memory</b>	28 (48.3%)	19 (35.2%)
<b>Eyesight/hearing</b>	2 (3.4%)	2 (3.7%)
<b>Mobility</b>	2 (3.4%)	0
<b>Continence</b>	4 (6.9%)	2 (3.7%)
<b>Physical health</b>	5 (8.6%)	2 (3.7%)
<b>Medication</b>	2 (3.4%)	1 (1.9%)
<b>Psychotic symptoms</b>	7 (12.1%)	10 (18.5%)
<b>Psychological distress</b>	36 (62.1%)	36 (66.7%)
<b>Information for patient</b>	0	4 (7.4%)
<b>Deliberate self-harm</b>	3 (5.2%)	2 (3.7%)
<b>Inadvertent self-harm</b>	5 (8.6%)	1 (1.9%)
<b>Abuse/neglect</b>	0	0
<b>Behaviour</b>	14 (24.1%)	6 (11.1%)
<b>Alcohol</b>	3 (5.2%)	6 (11.1%)
<b>Company</b>	22 (37.9%)	21 (38.9%)
<b>Intimate relationship</b>	6 (10.3%)	1 (1.9%)
<b>Money</b>	0	1 (1.9%)
<b>Benefits</b>	0	1 (1.9%)
<b>Information for carer</b>	0	0
<b>Carer's distress</b>	2 (3.4%)	1 (1.9%)

#### 4.4. Initial assessments of all patients

The Camberwell Assessment of Need for the Elderly, at initial assessment, identified day time activities as the most frequent unmet need in 65 (58%) patients, followed by psychological distress in 64 (57.1%), company in 58 (51.8%), memory in 40 (35.7%) and information to patients on diagnosis and treatment in 30 (26.8%) patients (Table 6).

Provision for feeding was the most frequent met need found in 77 (68.8%) patients, followed by looking after the home in 71 (63.4%), self care in 65 (58%), physical health in 58 (51.8%) and dealing with money in 57 (50.9%) patients.

**Table 6: Frequency of unmet and met needs identified on admission using the CANE**

<b>CANE</b>	<b>Met Need</b>		<b>Unmet Need</b>	
<b>Accommodation</b>	2	1.8%	15	13.4%
<b>Looking after the home</b>	71	63.4%	9	8.0%
<b>Food</b>	77	68.8%	3	2.7%
<b>Self-care</b>	65	58.0%	5	4.5%
<b>Caring for someone else</b>	5	4.5%	0	
<b>Daytime activities</b>	14	12.5%	65	58.0%
<b>Memory</b>	20	17.9%	40	35.7%
<b>Eyesight/hearing</b>	20	17.9%	4	3.6%
<b>Mobility</b>	34	30.4%	3	2.7%
<b>Contenance</b>	21	18.8%	5	4.5%
<b>Physical health</b>	58	51.8%	4	3.6%
<b>Drugs</b>	34	30.4%	7	6.3%
<b>Psychotic symptoms</b>	14	12.5%	12	10.7%
<b>Psychological distress</b>	26	23.2%	64	57.1%
<b>Information for patient</b>	3	2.7%	30	26.8%
<b>Deliberate self-harm</b>	20	17.9%	3	2.7%
<b>Inadvertent self-harm</b>	17	15.2%	4	3.6%
<b>Abuse/neglect</b>	5	4.5%	0	
<b>Behaviour</b>	8	7.1%	19	17.0%
<b>Alcohol</b>	2	1.8%	9	8.0%
<b>Company</b>	6	5.4%	58	51.8%
<b>Intimate relationship</b>	1	.9%	16	14.3%
<b>Money</b>	57	50.9%	1	.9%
<b>Benefits</b>	19	17.0%	0	
<b>Information for carer</b>	0		9	8.0%
<b>Carer's distress</b>	8	7.1%	6	5.4%

The two day hospitals' multidisciplinary teams identified the most frequent unmet needs as psychological distress in 72 (64.3%) patients followed by memory in 47 (42%), company in 43 (38.4%), daytime activities in 38 (33.9%) and behavioural problems in 20 (17.9%) patients (Table 7). The most frequent met needs identified by both day hospitals' staff were provision of food in 46

(41.1%), looking after the home in 41 (36.6%), self-care in 35 (31.3%), physical health in 34 (30.4%) and dealing with finances in 26 (23.2%) patients.

**Table 7: Frequency of met and unmet needs identified on admission by the multidisciplinary teams (MDT)**

<b>MDT needs</b>	<b>Met need</b>		<b>Unmet need</b>	
<b>Accommodation</b>	3	2.7%	12	10.7%
<b>Looking after the home</b>	41	36.6%	6	5.4%
<b>Food</b>	46	41.1%	3	2.7%
<b>Self-care</b>	35	31.3%	5	4.5%
<b>Caring for someone else</b>	1	0.9%	3	2.7%
<b>Daytime activities</b>	9	8.0%	38	33.9%
<b>Memory</b>	12	10.7%	47	42.0%
<b>Eyesight/hearing</b>	11	9.8%	4	3.6%
<b>Mobility</b>	18	16.1%	2	1.8%
<b>Continence</b>	7	6.3%	6	5.4%
<b>Physical health</b>	34	30.4%	7	6.3%
<b>Drugs</b>	10	8.9%	3	2.7%
<b>Psychotic symptoms</b>	11	9.8%	17	15.2%
<b>Psychological distress</b>	9	8.0%	72	64.3%
<b>Information for patient</b>	1	0.9%	4	3.6%
<b>Deliberate self-harm</b>	9	8.0%	5	4.5%
<b>Inadvertent self-harm</b>	1	0.9%	6	5.4%
<b>Abuse/neglect</b>	3	2.7%	0	0%
<b>Behaviour</b>	1	0.9%	20	17.9%
<b>Alcohol</b>	0	0%	9	8.0%
<b>Company</b>	2	1.8%	43	38.4%
<b>Intimate relationship</b>	0	0%	7	6.3%
<b>Money</b>	26	23.2%	1	0.9%
<b>Benefits</b>	16	14.3%	1	0.9%
<b>Information for carer</b>	2	1.8%	0	0%
<b>Carer's distress</b>	6	5.4%	3	2.7%

The Camberwell Assessment of Need for the Elderly identified more unmet and met needs, than the multidisciplinary team assessments (Table 8). The differences were highly significant.

**Table 8: Comparing the CANE versus the multidisciplinary teams (MDT) needs assessments on admission of the 112 day hospital patients**

	<b>CANE</b>	<b>MDT</b>	<b>P</b>
<b>Total needs</b>	8.9 S.D.= 3.3	5.6 S.D.= 2.8	< 0.0001
<b>Unmet needs</b>	3.5 S.D.= 2.0	2.9 S.D.= 1.7	< 0.0001
<b>Met needs</b>	5.4 S.D.= 3.1	2.8 S.D.= 2.6	< 0.0001

**Key:** p - Level of significance in paired t test.  
S.D. - Standard deviation.

The most frequent problems rated using the Health of the Nation Outcome Scales in the 112 patients of both day hospitals were activities with daily living and depressive symptoms (Table 9). Nine patients had problems which were rated severe (score of 4), and these were five with problems in cognition, three patients with problems of activities of daily living and one patient with problems in relating with others.

The Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales on initial assessment identified problems in patients in 17 of its 18 items rated (Table 10). The only exception was in hoarding in which no patient was identified in either day hospital exhibiting this problem. The most frequent problems amongst the 112 patients assessed were problems with ability to go

out unsupervised, constructive activities, helping out at home, bathing or dressing, confusion and walking.

**Table 9: Frequency of HoNOS ratings in each of the 12 scales at initial assessment**

<b>HoNOS items</b>	<b>Mild - 2</b>	<b>Moderate - 3</b>	<b>Severe - 4</b>
1. Behaviour	18 (16.1%)	7 (6.3%)	0 (0%)
2. Self-harm	11 (9.8%)	1 (0.9%)	0 (0%)
3. Alcohol/drug misuse	7 (6.3%)	1 (0.9%)	0 (0%)
4. Cognition	24 (21.4%)	19 (17.0%)	5 (4.5%)
5. Physical illness	42 (37.5%)	16 (14.3%)	0 (0%)
6. Hallucinations & delusions	3 (2.7%)	6 (5.4%)	0 (0%)
7. Depressive symptoms	40 (35.7%)	33 (29.5%)	0 (0%)
8. Other problems	17 (15.2%)	3 (2.7%)	0 (0%)
9. Problems with relationships	11 (9.8%)	2 (1.8%)	1 (0.9%)
10. Activities of daily living	44 (39.3%)	30 (26.8%)	3 (2.7%)
11. Living conditions	8 (7.1%)	0 (0%)	0 (0%)
12. Problems with activities	38 (33.9%)	1 (0.9%)	0 (0%)

**Table 10: Frequency of scores for each item in the CAPE-BRS at initial assessment**

<b>CAPE-BRS items</b>	<b>Mild/ moderate</b>	<b>Severe</b>
1. Bathing or dressing	30 (26.8%)	25 (22.3%)
2. Walking	48 (42.9%)	1 (0.9%)
3. Incontinence	21 (18.8%)	8 (7.1%)
4. In bed during the day	19 (17.0%)	1 (0.9%)
5. Confusion	43 (38.4%)	7 (6.3%)
6. Orderliness	33 (29.5%)	6 (5.4%)
7. Supervision outside	33 (29.5%)	45 (40.2%)
8. Helping out at home	54 (48.2%)	15 (13.4%)
9. Activities	58 (51.8%)	12 (10.7%)
10. Socialisation	31 (27.7%)	4 (3.6%)
11. Compliance	12 (10.7%)	2 (1.8%)
12. Communicating to others	8 (7.1%)	1 (0.9%)
13. Communicating with others	7 (6.3%)	1 (0.9%)
14. Daytime disturbed behaviour	2 (1.8%)	2 (1.8%)
15. Night-time disturbed behaviour	2 (1.8%)	0 (0%)
16. Paranoid ideas	4 (3.6%)	4 (3.6%)
17. Hoarding	0 (0%)	0 (0%)
18. Sleeping pattern	25 (22.3%)	6 (5.4%)
Vision	14 (12.5%)	0 (0%)
Hearing	11 (9.8%)	2 (1.8%)

#### 4.5. Changes on follow-up: Needs, HoNOS and CAPE-BRS scores

There were no significant differences between the initial and follow-up mean total number of needs identified by either the Camberwell Assessment of Need for the Elderly or the day hospitals' multidisciplinary teams (Table 11). The

mean total unmet needs identified by both the Camberwell Assessment of Need for the Elderly and the day hospitals' multidisciplinary teams were significantly different at admission and on follow-up respectively. The mean total unmet needs were lower on follow-up. The mean total scores of the Health of the Nation Outcome Scales were 8.7 on admission and 7.5 on follow-up, while the mean total scores of the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales at admission and on follow-up 6.2 and 7, respectively (Table 11).

**Table 11: Initial and follow-up mean ratings of CANE, MDT, HoNOS and CAPE-BRS for all patients in both day hospitals**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>CANE - total needs</b>	8.8 (3.2)	8.8 (3.3)	0.52
<b>CANE - total unmet needs</b>	3.5 (2.0)	1.2 (1.6)	< 0.001
<b>CANE - total met needs</b>	5.3 (3.0)	7.6 (3.2)	< 0.001
<b>MDT - total needs</b>	5.6 (2.8)	5.6 (2.9)	0.61
<b>MDT - total unmet needs</b>	2.9 (1.8)	0.9 (1.3)	< 0.001
<b>MDT - total met needs</b>	2.8 (2.6)	4.6 (2.8)	< 0.001
<b>Total HoNOS</b>	8.7 (3.9)	7.5 (4.0)	< 0.001
<b>Total CAPE-BRS</b>	6.2 (4.9)	7.0 (5.3)	< 0.01

**Key:** p - paired t-test.

( ) - Standard deviation.



#### 4.6. Changes on follow-up in patients with depression or dementia

In patients with dementia or depression, there were significant differences between mean total number of unmet needs identified at admission and on follow-up by both the Camberwell Assessment of Need for the Elderly and the day hospitals' multidisciplinary teams (Tables 12 & 13).

There was no significant difference in mean total scores in the Health of the Nation Outcome Scales at admission and on follow-up for patients with dementia. The mean total scores of the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales were significantly higher on follow-up.

**Table 12: Initial and follow-up mean ratings of CANE, MDT, HoNOS and CAPE-BRS for the patients with dementia in both day hospitals**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>Total CANE:</b>			
- unmet needs	3.3 (1.9)	0.8 (1.1)	< 0.001
- met needs	6.3 (3.2)	8.9 (3.3)	< 0.001
<b>Total MDT:</b>			
- unmet needs	3.3 (2.1)	0.8 (1.1)	< 0.001
- met needs	3.5 (2.7)	5.9 (2.7)	< 0.001
<b>Total HoNOS</b>	10.3 (4.1)	9.6 (3.7)	0.12
<b>Total CAPE-BRS</b>	9.5 (6.0)	11.1 (5.7)	<0.01

Key: p - paired t test. ( ) - Standard deviation.

Significantly lower mean total scores of the Health of the Nation Outcome Scales in patients with depression were observed on follow-up compared to on admission (Table 13). There was no significant difference between mean total scores of the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales at admission and on follow-up in patients with depression.

**Table 13: Initial and follow-up mean ratings of CANE, MDT, HoNOS and CAPE-BRS for the patients with depression in both day hospitals**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>Total CANE:</b>			
- unmet needs	3.4 (2.0)	1.3 (1.5)	< 0.001
- met needs	4.9 (2.9)	7.1 (3.0)	< 0.001
<b>Total MDT:</b>			
- unmet needs	2.7 (1.5)	0.8 (1.2)	< 0.001
- met needs	2.4 (2.5)	4.0 (2.5)	< 0.001
<b>Total HoNOS</b>	8.0 (3.7)	6.7 (3.9)	< 0.001
<b>Total CAPE-BRS</b>	4.7 (3.6)	4.9 (4.1)	0.39

**Key:** p - paired t test.  
 ( ) - Standard deviation.

#### 4.7. Initial and follow-up ratings in each day hospital

In both day hospitals, there were significant differences in the initial and follow-up mean total Health of the Nation Outcome Scales scores and total number of unmet needs assessed by each day hospitals' multidisciplinary team and the Camberwell Assessment of Need for the Elderly (Tables 14 & 15).

The mean total scores of the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales showed a significant increase at follow-up compared with at admission in the Haymeads Day Hospital patients and no significant difference in the Camden Mews Day Hospital patients.

**Table 14: Initial and follow-up mean total number of needs identified by MDT and CANE, and total HoNOS and CAPE-BRS scores for the Haymeads Day Hospital patients**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>CANE needs:</b>			
- total	9.3 (3.1)	9.5 (3.3)	0.14
- unmet	3.5 (1.9)	1.3 (1.6)	< 0.001
- met	5.8 (2.8)	8.2 (3.2)	< 0.001
<b>MDT needs :</b>			
- total	5.8 (2.7)	5.7 (2.9)	0.82
- unmet	3.1 (1.7)	1.0 (1.2)	< 0.001
- met	2.7 (2.8)	4.7 (2.8)	< 0.001
<b>HoNOS</b>	9.1 (4.2)	8.1 (4.1)	< 0.01
<b>CAPE-BRS</b>	6.8 (5.4)	7.9 (5.9)	< 0.01

**Key:** p - paired t test. ( ) - Standard deviation.

**Table 15: Initial and follow-up mean total number of needs identified by MDT and CANE, and total HoNOS and CAPE-BRS scores for the Camden Day Hospital patients**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>MDT needs :</b>			
- total	5.5 (2.8)	5.4 (2.8)	0.5
- unmet	2.7 (1.7)	0.9 (1.4)	< 0.001
- met	2.8 (2.4)	4.6 (2.8)	< 0.001
<b>CANE needs:</b>			
- total	8.3 (3.3)	8.2 (3.2)	0.4
- unmet	3.4 (2.0)	1.2 (1.7)	< 0.001
- met	4.8 (3.2)	7.0 (3.2)	< 0.001
<b>HoNOS</b>	8.2 (3.6)	7.0 (3.9)	< 0.001
<b>CAPE-BRS</b>	5.7 (4.3)	6.0 (4.5)	0.4

**Key:** p - paired t test.

( ) - Standard deviation.

Comparing the differences between initial and follow-up ratings of both day hospitals for number of unmet needs, Health of the Nation Outcomes Scales and Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales, there were no significant differences noted between day hospitals.

When patients were grouped into those with depression and dementia, no significant differences were observed between the two day hospitals' differences in ratings at admission and on follow-up in number of unmet needs, Health of the Nation Outcome Scales and Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales for either of the two patient groups.

**4.8. Initial and follow-up Health of the Nation Outcome Scales subsection scores**

Table 16 shows the Health of the Nation Outcome Scales subsections scores of behaviour, impairment, symptoms and social problems. Significant improvement on follow-up was observed in behaviour, symptoms and social problems for the 110 patients assessed. In impairment, which consists of cognitive and physical health problems, there was no significant difference on follow-up compared to at admission.

**Table 16: Initial and follow-up HoNOS subsection scores of all patients**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>Behavioural (HoNOS 1 - 3)</b>	0.9 (1.2)	0.7 (1.1)	< 0.01
<b>Impairment (HoNOS 4 - 5)</b>	2.5 (1.6)	2.6 (1.7)	0.18
<b>Symptoms (HoNOS 6 - 8)</b>	2.2 (1.7)	1.6 (1.5)	< 0.01
<b>Social Problems (HoNOS 9 - 12)</b>	3.0 (2.1)	2.6 (1.9)	< 0.01

**Key:** p - paired t test.  
 ( ) - Standard deviation.

Patients with depression had significant improvement in Health of the Nation Outcome Scales subsection scores for symptoms and social problems (Table 17).

Those patents with dementia only had significant improved scores for behavioural problems, with no significant differences observed between initial and follow-up assessments for symptoms, impairment and social problems (Table 18).

**Table 17: Initial and follow-up HoNOS subsection scores of all patients with depression**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>Behavioural (HoNOS 1 - 3)</b>	0.6 (1)	0.5 (1)	0.24
<b>Impairment (HoNOS 4 - 5)</b>	2.1 (1.4)	2.1 (1.6)	0.38
<b>Symptoms (HoNOS 6 - 8)</b>	2.7 (1.6)	1.9 (1.6)	< 0.001
<b>Social Problems (HoNOS 9 - 12)</b>	2.6 (2)	2.1 (1.8)	< 0.001

**Key:** p - paired t test.  
 ( ) - Standard deviation.

**Table 18: Initial and follow-up HoNOS subsection scores of all patients with dementia**

	<b>Initial</b>	<b>Follow-up</b>	<b>p</b>
<b>Behavioural (HoNOS 1 - 3)</b>	1.5 (1.4)	1.1 (1.3)	0.03
<b>Impairment (HoNOS 4 - 5)</b>	3.6 (1.4)	3.8 (1.5)	0.22
<b>Symptoms (HoNOS 6 - 8)</b>	1.4 (1.7)	1.1 (1.3)	0.19
<b>Social Problems (HoNOS 9 - 12)</b>	3.8 (2.2)	3.6 (1.8)	0.35

**Key:** p - paired t test.  
 ( ) - Standard deviation.

**4.9. Effects on presence of unmet needs at follow-up, of day hospitals, interventions, age, gender, diagnosis and initial number of unmet needs**

Looking at independent variables which were likely to have an effect on outcome in terms of number of unmet needs identified by CANE at follow-up, six were selected and incorporated into a backward logistic regression analysis (Table 19). The independent variables were day hospitals, interventions, age, gender, diagnosis and initial CANE unmet needs. Of the six variables, only the number of initial unmet needs identified by CANE had a significant effect.

**Table 19: Logistic Regression analysis looking at independent variables likely to influence outcome in terms of presence of unmet needs identified by CANE on follow-up**

-----Variables in the Equation-----

<b>Variable</b>	<b>B</b>	<b>S.E.</b>	<b>Wald</b>	<b>df</b>	<b>Sig.</b>	<b>R</b>
<b>Day hospitals</b>	0.0815	0.452	0.033	1	0.859	0.00
<b>Interventions</b>	0.093	0.446	0.043	1	0.835	0.00
<b>Age</b>	0.0272	0.35	0.593	1	0.441	0.00
<b>Gender</b>	0.766	0.464	2.726	1	0.099	0.07
<b>Diagnoses</b>	1.022	0.526	3.772	1	0.052	0.11
<b>Initial unmet needs</b>	0.4742	0.131	13.166	1	0.0003	0.27
<b>Constant</b>	-5.409	3.133	2.98	1	0.084	

<b>Variable</b>	<b>Exp (B)</b>	<b>95% Confidence intervals</b>	
<b>Day hospitals</b>	1.085	0.447	2.63
<b>Interventions</b>	1.097	0.457	2.632
<b>Age</b>	1.028	0.959	1.101
<b>Gender</b>	2.152	0.866	5.347
<b>Diagnoses</b>	2.78	0.991	7.799
<b>Initial unmet needs</b>	1.607	1.244	2.076

**Key:** B - regression coefficient; S.E - standard error of B; df - degrees of freedom; sig.- level of significance; exp(B) - estimated odds ratio.



The backward stepwise logistic regression procedure was then used to select out all variables without significant contributions to the goodness of fit of the model. The final results are shown on Table 20. As a result of the backward stepwise procedure, all variables were removed except gender, diagnoses and initial number of CANE unmet needs.

**Table 20: Logistic Regression (LR) analysis likelihood ratios after backward stepwise selection procedure for variables associated with presence of unmet CANE unmet needs on follow-up**

<b>Term removed</b>	<b>Log Likelihood</b>	<b>-2 Log LR</b>	<b>df</b>	<b>Sig. of Log LR</b>
<b>Gender</b>	-65.149	2.824	1	0.0929
<b>Diagnoses</b>	-65.611	3.748	1	0.0529
<b>Initial unmet needs</b>	-72.787	18.1	1	< 0.001

**4.10. The randomised, controlled trial of feedback: experimental and control groups**

Significant differences were observed at initial assessment, between the experimental and control groups, in the total number of needs and unmet needs identified by the Camberwell Assessment of Need for the Elderly (Table 21). On

follow-up assessments, only the total number of needs identified by the Camberwell Assessment of Need for the Elderly remained significantly different (Table 22). There were no significant differences between the experimental and control groups at the time of admission or on follow-up, in terms of the number of needs identified by the day hospitals' multidisciplinary teams, Health of the Nation Outcomes Scales and Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales scores.

**Table 21: Comparing initial assessments of patients in the experimental and control groups**

	<b>Experimental group</b>	<b>Control</b>	<b>p</b>
<b>CANE:</b>			
- total needs	9.9 (3.0)	7.9 (3.2)	< 0.01
-unmet needs	4.0 (2.0)	3.0 (1.8)	< 0.01
-met needs	5.9 (2.7)	4.9 (3.3)	0.09
<b>MDT:</b>			
- total needs	5.8 (3.0)	5.5 (2.7)	0.5
- unmet needs	3.0 (1.7)	2.8 (1.8)	0.52
- met needs	2.9 (2.8)	2.7 (2.5)	0.76
<b>Total HoNOS</b>	8.9 (4.2)	8.4 (3.7)	0.53
<b>Total CAPE-BRS</b>	6.9 (5.1)	5.7 (4.7)	0.2

**Key:** p - independent t test.  
 ( ) - standard deviation.  
 MDT - multidisciplinary team.

**Table 22: Comparing follow-up assessments of patients in the experimental and control groups**

	<b>Experimental group</b>	<b>Control</b>	<b>p</b>
<b>CANE:</b>			
- total needs	9.7 (3.0)	8.0 (3.4)	< 0.01
-unmet needs	1.5 (1.9)	1.0 (1.4)	0.19
-met needs	8.3 (3.0)	6.9 (3.3)	0.03
<b>MDT:</b>			
- total needs	5.8 (3.0)	5.4 (3.0)	0.4
- unmet needs	1.1 (1.5)	0.8 (1.1)	0.3
- met needs	4.8 (3.0)	4.5 (2.6)	0.6
<b>Total HoNOS</b>	7.6 (4.3)	7.5 (3.7)	0.92
<b>Total CAPE-BRS</b>	7.5 (5.9)	6.5 (4.7)	0.37

**Key:** p - independent t test.  
 ( ) - Standard deviation.

Of six independent variables (day hospitals, age, gender, interventions, diagnoses and initial CANE unmet needs), only initial number of unmet needs had a significant effect on presence of unmet needs at follow-up (Table 19). As a result of significant differences in number of unmet needs at onset in experimental and control groups, analysis of covariance was used to allow for the effect to be taken into consideration in comparing outcome. Using this analysis, no significant difference was observed between the groups with respect of number of total CANE unmet needs on follow-up (Table 23). The trend was towards more unmet needs in the control than in the experimental group at follow-up assessment, but this was not a significance difference.

**Table 23: Analysis of covariance, comparing the number of CANE unmet needs on follow-up in experimental & control groups, with number of unmet needs at initial assessment as covariate**

<b>Source</b>	<b>Sum of squares</b>	<b>df</b>	<b>Mean square</b>	<b>F</b>	<b>p</b>
Corrected model	43.949	2	21.974	12.865	<0.001
Intercept	0.724	1	0.724	0.424	0.517
Initial unmet needs	42.109	1	42.109	24.654	< 0.001
<b>Experimental &amp; control groups</b>	<b>1.46</b>	<b>1</b>	<b>1.46</b>	<b>0.855</b>	<b>0.359</b>

**Estimated marginal means of number of CANE unmet needs on follow-up using analysis of covariance:**

Experimental group = 1.14

Control = 1.46

In patients with dementia, the analysis of covariance was used to compare the number of CANE unmet needs on follow-up between the experimental and control groups, initial number of CANE unmet needs as covariate (Table 24). This indicated no significant difference between the groups with respect of number of unmet needs on follow-up.

**Table 24: Using the analysis of covariance in patients with dementia, to compare the number of CANE unmet needs on follow-up in the experimental & control groups, with number of unmet needs at initial assessment as covariate**

Source	Sum of squares	df	Mean square	F	p
Corrected model	6.835	2	3.417	3.387	0.047
Intercept	7.609E-03	1	7.609E-03	0.008	0.931
Initial unmet needs	6.828	1	6.828	6.767	0.014
<b>Experimental &amp; Control groups</b>	<b>1.200E-02</b>	<b>1</b>	<b>1.200E-02</b>	<b>0.012</b>	<b>0.914</b>

**Estimated marginal means of number of CANE unmet needs on follow-up using the analysis of covariance:**

Experimental group = 0.74.

Control = 0.78

In patients with depression, the number of CANE unmet needs on follow-up in the experimental and control groups were not significantly different, with initial number of CANE unmet needs as covariate (Table 25 ).

**Table 25: Using the analysis of covariance in patients with depression, to compare the number of CANE unmet needs on follow-up in experimental & control groups, with number of unmet needs at initial assessment as covariate**

Source	Sum of squares	df	Mean square	F	p
Initial unmet needs	77.053	1	77.053	38.708	< 0.001
Experimental & Control groups	3.391E-02	1	3.391E-02	0.017	0.896

**Estimated marginal means of number of CANE unmet needs on follow-up:**

Experimental group = 1.23.      Control = 1.27

**Patterns of change in specific needs**

Table 26 shows the pattern of change in individual unmet needs for the experimental and control groups. The general trend in both groups was a reduction in the number of unmet needs at follow-up. Using chi-squared test, there was a significant difference between experimental and control groups for accommodation ( $\chi^2 = 6.85$ ,  $df = 2$ ,  $p < 0.05$ ), indicating a greater proportion of unmet needs in the experimental group. There was also a significant difference for company ( $\chi^2 = 10.07$ ,  $df = 2$ ,  $p < 0.01$ ) indicating a greater proportion of unmet needs amongst the control group. For all the other CANE needs, there were no significant differences between the experimental and control groups at follow-up.

**Table 26: Individual unmet needs using the CANE at onset and follow-up in the experimental and control groups**

CANE	Experimental Group		Control	
	Initial	Follow-up	Initial	Follow-up
Accommodation*	12 (21.8)	6 (11.3)	3 (5.3)	1 (1.8)
Looking after the home	4 (7.3)	5 (9.4)	5 (8.8)	4 (7.0)
Food	2 (3.6)	0	1 (1.8)	0
Self-care	2 (3.6)	1 (1.9)	3 (5.3)	1 (1.8)
Caring for someone else	0	0	0	0
Daytime activities	34 (61.8)	9 (17)	31 (54.4)	7 (12.3)
Memory	20 (36.4)	1 (1.9)	20 (35.1)	2 (3.5)
Eyesight/hearing	3 (5.5)	3 (5.7)	1 (1.8)	1 (1.8)
Mobility	2 (3.6)	2 (3.8)	1 (1.8)	1 (1.8)
Continence	3 (5.5)	2 (3.8)	2 (3.5)	1 (1.8)
Physical health	1 (1.8)	1 (1.9)	3 (5.3)	2 (3.5)
Drugs	6 (10.9)	3 (5.7)	1 (1.8)	1 (1.8)
Psychotic symptoms	8 (14.5)	5 (9.4)	4 (7.0)	1 (1.8)
Psychological distress	33 (60.0)	11 (20.8)	31 (54.4)	9 (15.8)
Information for patient	18 (32.7)	5 (9.4)	12 (21.1)	5 (8.8)
Deliberate self-harm	2 (3.6)	1 (1.9)	1 (1.8)	1 (1.8)
Inadvertent self-harm	2 (3.6)	1 (1.9)	2 (3.5)	1 (1.8)
Abuse/neglect	0	0	0	0
Behaviour	9 (16.4)	0	10 (17.5)	4 (7.0)
Alcohol	4 (7.3)	2 (3.8)	5 (8.8)	2 (3.5)
Company*	36 (65.5)	9 (17)	22 (38.6)	11 (19.3)
Intimate relationship	9 (16.4)	9 (17)	7 (12.3)	5 (8.8)
Money	1 (1.8)	0	0	0
Benefits	0	0	0	0
Information for carer	6 (10.9)	1 (1.9)	3 (5.3)	0
Carer's distress	3 (5.5)	1 (1.9)	3 (5.3)	1 (1.8)

Key : ( ) - %.

\* - significant difference in relative change in number of patients with unmet needs at onset and follow-up between the two groups with  $p < 0.05$  using chi-square tests.

## 4.11. Interventions generated using the Camberwell Assessment of Need for the Elderly

### **Specific interventions**

The most frequent suggested interventions following the use of the Camberwell Assessment of Need for the Elderly were day centre referral, review of medication, introduction to suitable social groups, multidisciplinary team assessment, supportive psychotherapy and information for patients on diagnosis and treatment. Medication review, multidisciplinary team assessment, day centre referral, supportive psychotherapy, introduction to suitable social groups and information for carers and patients on diagnosis and treatment were the most frequent interventions completed (Table 27). Chi square tests were used to compare the experimental and control groups in individual suggested interventions. The suggested intervention of housing support showed a significant difference in the proportion of suggested interventions completed ( $\chi^2 = 7.15$ ,  $df = 2$ ,  $p < 0.05$ ), indicating a greater proportion of completed interventions in the experimental group. In the introduction to social groups, there was also a significant difference ( $\chi^2 = 12.89$ ,  $df = 2$ ,  $p < 0.01$ ), indicating a greater proportion of suggested intervention were completed in the experimental group. For the other suggested interventions, there were no significant differences between the experimental and control groups, in terms of proportion of suggested interventions completed.



**Table 27: Frequency distribution of suggested interventions completed in experimental and control groups**

<b>Number of suggested interventions completed (%)</b>						
<b>Interventions</b>	<b>Experimental Group (53)</b>			<b>Control (57)</b>		
	<b>S</b>	<b>C</b>	<b>%</b>	<b>S</b>	<b>C</b>	<b>%</b>
<b>Day centre referral</b>	31	21	<b>67.7</b>	32	15	<b>46.9</b>
<b>Review of medication</b>	29	24	<b>82.7</b>	27	27	<b>100</b>
<b>Introduction to suitable social groups *</b>	34	17	<b>50</b>	18	6	<b>33.3</b>
<b>MDT assessment.</b>	20	18	<b>90</b>	22	22	<b>100</b>
<b>Supportive psychotherapy</b>	18	17	<b>94.4</b>	18	18	<b>100</b>
<b>Information on management.</b>	16	9	<b>56.2</b>	10	3	<b>30</b>
<b>Referral to clinical psychologist</b>	9	5	<b>55.5</b>	6	3	<b>50</b>
<b>Provision of information for carer.</b>	8	7	<b>87.5</b>	8	8	<b>100</b>
<b>Housing support.*</b>	9	9	<b>100</b>	4	2	<b>50</b>
<b>Provision of home care.</b>	4	3	<b>75</b>	6	3	<b>50</b>
<b>Address alcohol related problems.</b>	3	2	<b>66.7</b>	5	1	<b>20</b>
<b>Liaise with G.P/A district nurse over physical health.</b>	5	3	<b>60</b>	3	2	<b>66.7</b>
<b>Referral to other specialities and departments.</b>	4	1	<b>25</b>	2	1	<b>50</b>
<b>Anger management.</b>	2	1	<b>50</b>	4	2	<b>50</b>
<b>Marital counselling.</b>	2	2	<b>100</b>	3	3	<b>100</b>
<b>Anxiety management.</b>	0	0		3	1	<b>33.3</b>
<b>Bereavement counselling.</b>	0	0		2	1	<b>50</b>
<b>Meals on wheels.</b>	2	1	<b>50</b>	1	0	
<b>Community psychiatric nursing visit.</b>	0	0		1	1	<b>100</b>
<b>Respite care.</b>	2	2	<b>100</b>	1	1	<b>100</b>
<b>Power of attorney or receivership</b>	1	1	<b>100</b>	0	0	

**Key:** \* -  $p < 0.05$  using chi-square test to compare experimental & control groups..

S - Number of patients each intervention was suggested for.

C - Number of patients who completed each suggested intervention.

% - % of patients who completed each suggested intervention.

### **Number of interventions**

In both the experimental and control groups, the proportion of suggested interventions that were completed were about two-thirds respectively (Table 28). There were significant differences between the actual total number of interventions between the two groups.

**Table 28: Comparing the mean total number of interventions in the experimental and control groups**

	<b>Experimental group</b>	<b>Control</b>	<b>p</b>
<b>Number of suggested interventions</b>	3.5 (1.7)	2.8 (1.5)	0.02
<b>Number of completed interventions</b>	2.3 (1.3)	1.9 (1.1)	0.07

**Key:**

p - independent t.test.

( ) - Standard deviation.

Using the analysis of covariance to correct for differences in suggested number of interventions, there was no significant difference in number of completed interventions between the experimental and control groups (Table 29).

**Table 29: Analysis of covariance comparing the proportion of all suggested interventions completed between experimental and control groups, with number of suggested interventions as covariate**

Source	Sum of squares	df	Mean square	F	p
Suggested interventions	76.148	1	76.148	105.77	< 0.001
Experimental & Control groups	2.034E-02	1	2.034E-02	0.028	0.86

**Estimated means of number of interventions completed:**

Experimental group = 2.07.

Control = 2.04

In comparing differences for gender and between patients with a diagnosis of dementia and depression, there were no significant differences in the number of suggested or completed interventions between male and female patients or between those patients with a diagnosis of depression and dementia (Table 30).

**Table 30: Comparing the gender differences in the mean total number of interventions and between dementia & depression**

	<b>Males</b>	<b>Females</b>	<b>p</b>
<b>Suggested interventions</b>	3.0 (1.5)	3.2 (1.7)	0.66
<b>Completed interventions</b>	1.9 (1.0)	2.1 (1.3)	0.47
	<b>Dementia</b>	<b>Depression</b>	
<b>Suggested interventions</b>	2.8 (1.5)	3.2 (1.7)	0.19
<b>Completed interventions</b>	2.0 (1.3)	2.1 (1.2)	0.76

p - independent t test.

( ) - Standard deviation.

Day centre referral, introduction to suitable social groups and information for patients on diagnosis and treatment were the three most frequent interventions yet to be carried out at the time of follow-up assessment

In 26 instances, reasons were given for suggested interventions not having been implemented. The most frequent reasons for failure to carry out suggested interventions were admission to hospital and refusal of patients to accept interventions with a similar distribution between the experimental and control groups (Table 31). In 47 interventions, there were no recorded reasons for not being completed. Discussions with staff revealed that in cases where reasons were not recorded, the main reasons were patients not ready or lack of suitable resource.

**Table 31: Reasons for inability to complete suggested interventions amongst the 112 patients**

<b>Reasons</b>	<b>Frequency of recorded reasons for non-completion of interventions</b>	
	<b>Experimental Group</b>	<b>Control</b>
Admitted to hospital	3	6
Patient refusal	4	4
Self discharge	4	3
Died	1	1

## **5. Discussion**

### **5.1. Overview**

This study gave the opportunity to assess day hospital care as well as the impact of formal needs assessment. On literature review, it would suggest that there are few studies which look into day hospital care and needs assessment in older people and what difference they make.

As the study population included rural/urban and inner city dwellers it gave a picture of varying groups of patients attending day hospitals. It also gave an opportunity to compare outcome between two day hospitals covering different catchment populations.

While there was no comparison with an alternative form of care in this study, the observed trend of outcome using the study's instruments gives a pointer to the influence of day hospital care in older people. Especially, in two of the commoner mental health problems in older people, depression and dementia.

Needs assessment and the difference it can make to the care of older people was evaluated by comparing an intervention group with a control group. In the

former, information of formal needs assessment with interventions generated from the assessment were fed back to key workers.

## 5.2. Critique of study

As a randomised controlled study, this study eliminates the possibility of selection bias which could influence outcome. All new patients in both day hospitals during the study period who were approached agreed to take part in it. However, there were some patients who made just one visit to the day hospitals which was their admission day during which either staff or patients deemed it unsuitable. Reasons varied from patients not wanting to attend, to staff feeling that patients were inappropriately referred. This group of patients would have provided useful information in terms of what characteristics in patients or referrals make them unsuitable for day hospital care. However, they did not undergo a full day hospital assessment which made it impossible to include them in the study.

Limitation on resources and practical issues meant it was not possible to make this study double blind. For this to have been done a different person would need to administer the initial rating of patients from the person who gave feedback to staff on randomisation of patients into the two groups. It would

also be impossible for key workers and staff to be blind, as they were expected to carry out the suggested interventions and were made aware of unmet needs. However, the subjects were unaware of whose key worker had received feedback in terms of unmet needs identified and suggested interventions. Therefore, subjects were unlikely to influence the outcome of the study as they would not be aware of which group they belonged to.

The study period of three months from initial to follow-up assessment was agreed by both day hospitals to be sufficient time to start to implement initial assessment findings. It was also the minimum expected stay in the day hospitals for most attenders. After, three months, the expectation was that feedback would be given for all patients in the control (non-intervention) group, as ethically, it would be wrong to keep useful information on individual care from key workers indefinitely.

The instruments chosen for this study included two relatively new ones, the Camberwell Assessment of Need for the Elderly and the Health of the Nation Outcome Scales. The choice of the Camberwell Assessment of Need for the Elderly was considered appropriate, as from the literature at the time, it was the only one of its kind designed specifically for assessing the needs of older people and includes ratings, appropriate for use by both patients and carers. Reliability and validity studies have been carried out on both the Camberwell Assessment



of Need and Camberwell Assessment of Need for the Elderly to suggest that the latter provides a valid measure of need and is a reliable instrument (Phelan et al, 1995; Reynolds et al, 2000). These studies have been described in more details earlier on, in the method section.

The Health of the Nation Outcome Scales was designed as a concise simple measure of mental health care. The need for an outcome measure which was concise and simple to use was the reason for its choice. As the Health of the Nation Outcome Scales (and the modified version for use in older people, HoNOS 65+) have undergone validity and reliability studies in older people (Shergill et al, 1999), it was judged to be a suitable option. This was coupled with the first hand experience of the author in its use in several other studies (Ashaye et al. 1997; 1998; 1999). In those studies, the Health of the Nation Outcome Scales proved to be a brief, useful tool in monitoring and comparing outcome in older people with mental health problems.

In the study by Shergill et al (1999), the Health of the Nation Outcome Scales was compared with several other instruments including the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales. Their findings are described in greater detail in the method section. The Cronbach's alpha values for the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales and Health of the Nation Outcome Scales were 0.90 and 0.61 respectively. They

also had a highly significant concurrent validity of 0.78. In a follow-up to their study, Ashaye et al. (1999) found that the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales and Health of the Nation Outcome Scales changes correlated positively, 0.54 and 0.39, with clinically observed changes in mental health.

The findings in these studies provided the evidence for reliability and validity of the three instruments used in this study to measure needs and monitor outcome in older people with mental health problems. Their simple, concise nature make them suitable not just for research purposes but for everyday clinical use.

### 5.3. Characteristics of subjects compared to attenders of other elderly services and day hospitals

Greene and Timbury (1979) carried out a five year review of a day hospital for older people with mental health problems covering the residents in the Western District of Greater Glasgow Health Board and the Dumbarton District of the Argyll and Clyde Health Board. The aims of their study were identifying what sort of patients came to the day hospital and the outcome of care. The yearly mean ages of new admissions for the five year period ranged between 72.8 and 77.7 years. They grouped patients into organic and functional disorders. The

former referred to patients with organic brain disease such as the various forms of dementia, while functional disorders referred to those patients with no evident organic brain disease. Over the five year period, 210 patients were admitted with organic disorders compared to 80 with functional disorders. At the time of admission, amongst the patients with organic disorders, 83% were living at home, 13% were in hospital and 4% in residential care compared to 62% at home, 36% in hospital and 2% in residential care in the case of those patients with functional disorders. In terms of their domestic situation, 40% of dementia patients lived alone compared to 61% of those with functional disorders.

Rockwood et al (1991) reviewed the outcome of admission to an inpatient psychogeriatric service in Canada over a one year period. There were 128 patients admitted with 58 (45%) of them aged between 75 and 84 and 57 (44%) were less than 74 years of age. They consisted of 69 (53.9%) males and 59 (46.1%) females, of whom 49 (39%) were married, 48 (38%) were widowed, 17 (14%) single and 11 (9%) were divorced.

Both the above studies, involved new admissions of older people with mental health problems. Greene and Timbury (1979) noted that day hospitals for older people were increasingly caring for patients with dementia in the over 75 years group. This differs from the findings in either day hospital in this study where

depression rather than dementia was the most frequent diagnosis. In a review of the literature, Katona et al (1983) noted that amongst persons over the age of 65 years, functional disorders were more common than organic ones. As a result, mental health services would expect to have a greater proportion of patients with functional disorders, unless admission or referral criteria excluded or actively encouraged specific groups of patients.

There was a preponderance of male patients in the study by Rockwood et al (1991), which contrast with the finding amongst new admissions to both Haymeads and Camden Mews Day Hospitals where there were more female than male patients. Amongst the new admissions to another inpatient service for older people with mental health problems over a one year period, in Cambridge, England, there were 144 (68%) females compared to 68 (32%) male patients. This highlights the need for monitoring of gender distribution amongst patients attending mental health services for older people and local population surveys. The latter is further supported by the findings of Melzer et al. (1997), that local demographic differences in needs of older people with cognitive impairment are large and have substantial effects on overall prevalence and proportion of who would require care. This is important in terms of the service provision to meet patient needs which may differ due to gender differences or other local variations. An example of gender differences in ageing are the observations of Jagger et al. (1989) in a five year follow-up of a community survey of over 75

year olds, where increased cognitive impairment, physical disability and incontinence were seen, with women in the older age group having a significantly greater increase in physical disability than men. This would result in a greater dependency among women compared to men, the longer they lived in that community.

In the review by Greene and Timbury (1979), at the time of admission, 77% of patients were living at home compared to 96.4% among the Haymeads and Camden Mews Day Hospitals' patients. This may be explained by the much lower proportion of patients having a diagnosis of dementia in this study. Dementia may have increased the chances of hospitalisation and residential care amongst the day hospital patients reviewed by Greene and Timbury (1979).

55% of the day hospital patients reviewed by Greene and Timbury (1979) and 49% of patients in this study lived alone. Day hospitals serve a population of patients of whom many, may be widowed, divorced, single or an only living family member and are likely benefit from both treatment and social contact available through day hospitals.

Comparing between homeless men aged below and above 65 years, Abdul-Hamid (1997) noted that the older men had more physical health problems. Increased physical problems amongst older people need to be taken

into consideration when providing services for those with mental health problems. Amongst the new admissions of the Camden Mews and Haymeads Day hospital patients during the period of this study, physical health problems included visual impairment in 12.5% and hearing impairment in 11.6%. There were also varying degrees of mobility difficulties in nearly 20% of patients ranging from mild to chair bound. The consequences of these problems may include greater need for assistance with self care and support even while attending the day hospital.

In this study, only four patients were non white, with all four being resident in inner city London and none in the rural/urban populations of East Hertfordshire or West Essex. In an article titled, "Psychiatric services for ethnic elders", Hoxey et al (1999) noted that the number of older people from ethnic minority groups is rising in Britain and suggested that their uptake of health and social services was poor. Possible reasons they highlighted, were under-referral by general practitioners, reluctance of patients and relatives to be referred, communication difficulties and lack of awareness of where to go to seek help. They also suggested means to improve mental health services for ethnic elders. These included integration of services for older people from ethnic minorities with existing services, employing bilingual health workers and utilising trained professional interpreters to improve communication and the increased utilisation of day services as they are more likely to be willing to attend day services nearer

to their homes and rather remain in the community than be admitted. Another important role mentioned was the training of staff in cross-cultural issues, so that staff could be sensitive to the beliefs and practices of older people from ethnic minority backgrounds. Though the patients in this study from ethnic minority backgrounds are few, it is important that day hospital staff are educated and aware of issues important to them. As attendance of even the few who do attend may be jeopardised

#### 5.4. Comparing characteristics of subjects from each day hospital

The use of two different day hospitals gave us the opportunity to compare the patients attending an inner city day hospital with those attending a day hospital serving rural and urban populations. The mean ages of subjects from Haymeads and Camden Mews Day Hospitals were not significantly different (77.1 and 75.6 years respectively). In terms of sex distribution, both day hospitals had a preponderance of female patients with Haymeads Day Hospital having the greater proportion of females than Camden Mews Day Hospital.

A similar proportion of patients from each of the day hospitals were widowed representing about 46% of patients, with 22% of the Haymeads Day Hospital patients being married compared to 17% of the Camden Mews Day Hospital

patients. More Haymead Day Hospital patients lived on their own compared to the Camden Mews Day Hospital patients, and those living on their own were the largest category in both day hospitals. These differences may reflect the increased chance of living near relatives or significant others in the more densely populated inner cities. The rural-urban areas are less densely populated with fewer job opportunities taking many family members away to big cities or industrial areas for work.

In both day hospitals, most patients lived at home with thrice the number of Haymeads compared to the Camden Mews Day Hospital patients lived in sheltered accommodation. The high proportion of attenders in both day hospitals capable of some degree of independent living, was to be expected as the day hospitals offer services to individuals who can remain in the community while receiving treatment.

### 5.5. Distribution of diagnoses in both day hospitals

Depression was the most frequent diagnosis made among the patients of both day hospitals, being found in 61.1% of new attenders to Camden Mews Day Hospital and 55.2% of the Haymeads Day Hospital admissions during the study period. In comparison, the five year review of new admissions to a day hospital



for older people by Greene and Timbury (1979), the majority had organic disorders with affective disorders as the most frequent functional disorder identified. The difference in this study may reflect the current emphasis of day hospitals being for treatment, and the growth in number of community mental health teams, day centres and memory clinics serving dementia patients.

In a study of factors associated with outcome in older people, Katona et al, (1983) observed that outcome was uniformly poor for patients with a diagnosis of dementia. They also observed that aside from patients with functional disorders like depression having a better outcome than dementia, social variables such as younger age, female sex, previous admission and independent living prior to admission were associated with favourable outcome but not in patients with dementia. These findings indicate the importance of diagnoses in outcome. With Haymeads Day Hospital having twice the number of patients with dementia than Camden Mews Day Hospital, the expectation would be that in the longterm, the outcome would be worse for the Haymeads Day Hospital patients, though this did not reflect in this study probably due to the shorter period of follow-up.

## 5.6. Needs assessments of older patients with mental health problems admitted to the day hospitals

Older patients have special needs relating to cognitive decline, psychiatric problems coloured by social adversities and life events, proneness to physical problems and lower utilisation and accessibility of services (Hamid et al, 1995).

As a result, it is important to have a systematic and reliable documentation of needs for older people with mental health problems. In this study, this was achieved by using the Camberwell Assessment of Need for the Elderly. The ten most frequent needs identified using the Camberwell Assessment of Need for the Elderly were looking after the home, food, daytime activities, psychological distress, self care, company, physical health, memory, money and medication. Of these, the five predominant unmet needs were daytime activities in 65 (58%), psychological distress in 64 (57.1%), company in 58 (51.8%), memory loss in 40 (35.7%) and information on diagnosis & treatment in 30 (26.8%). These are similar to the needs in older people identified in other studies. Abdul-Hamid (1997) in assessing needs of older homeless men living in hostels identified the most frequent needs to include, medication and assessment, staff support, social assessment, day care and residential care. In a survey of the care needs of a population with dementia, Gordon et al. (1997), identified the most common needs were assistance with mobility in 48%, personal care in 70%, domestic tasks in 75% and behaviour in 57%. All these were identified among the 10

most frequent needs using the Camberwell Assessment of Need for the Elderly in this study. Amongst carers, Gordon et al. (1997) also noted that 23% felt they were not coping, 47% felt they had practical problems caring and 51% found care upsetting. The results in this study involving new day hospital attenders revealed much lower carer distress (12%), possibly because the greater proportion of patients had depression. However, carers still played a major role in meeting needs in this study especially in the areas of food, self-care, looking after the home, finances, mobility and sensory impairment.

Kay (1989) in a review of the literature identified musculoskeletal disease as the most common physical cause of dependency in older people. Dependency which is the inability to perform self-care activity of daily living without regular help of another person could be a consequence of both physical and psychological disorders. In this study, the Camberwell Assessment of Need for the Elderly identified needs due to physical health problems, cognitive impairment and psychological distress among the most frequent needs in new day hospital patients.

In terms of unmet needs, the day hospital multidisciplinary teams identified psychological distress, memory impairment, company, day activities and behaviour, as the most prevalent unmet needs. The Camberwell Assessment of Need for the Elderly identified more unmet needs in patients than the day

hospitals' multidisciplinary teams. As a tool, for assessing needs in individual patients it proved better than the current practice of assessment in both day hospitals. Furthermore, the ability to utilise the pooled results of individual needs assessments provides valuable information to both day hospitals on service needs for patients attending the day hospitals. This would be more difficult to obtain from the current practice of day hospital assessments where patient needs can only be obtained through reading the generally unstructured assessments done by staff.

There were no gender differences observed in terms of total number of needs identified by the Camberwell Assessment of Need for the Elderly or the day hospitals' multidisciplinary teams. These findings suggest that amongst older day hospital attenders in this study, there were no differences in the needs of males and females.

### 5.7. The Health of the Nation Outcome Scales and Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales in initial assessments

There are few studies available using the Health of the Nation Outcome Scales in older people. Using the adult version of the scales to compare older longstay

patients with mental health problems and learning disabilities, Ashaye et al. (1997) noted that older patients with mental health problems had significantly more problems with depressed mood, relationships and occupation or activities than those with learning disabilities. The scales identified cognition, physical health, relationships, activities of daily living, living conditions and activities, as the main problem areas. In another study, using the Health of the Nation Outcome Scales to compare outcome in resettled and longstay older patients with mental health problems, similar problems areas were identified (Ashaye et al, 1998). Comparing the findings in the two studies, to the initial assessments using the Health of the Nation Outcome Scales in the day hospital patients in this study, the five most prevalent problems were activities of daily living, depressive symptoms, physical illness, cognitive problems and problems with daytime activities. All these problems identified can be related to the most frequent unmet needs identified by the Camberwell Assessment of Need for the Elderly, which were daytime activities, psychological distress, company and memory.

With the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales, the five predominant problems identified at initial assessment in descending order were need for supervision in going out, constructive activities, self care, helping out at home and confusion. As with the Health of the Nation Outcome Scales, these problems relate to the most frequent unmet needs

identified by the Camberwell Assessment of Need for the Elderly. Other problems highlighted included incontinence in about 1 in 4 patients and difficulties socialising in a third of the subjects. The latter two may prove to quite distressing to carers and relatives, highlighting the need for support and provision of aids through the incontinence and district nurses, along with respite and management of difficult behaviour offered through day hospitals

The total scores of the Health of the Nation Outcome Scales and Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales were not significantly different between males and females in this study. These findings suggest that amongst older day hospital attenders in this study, there were no gender differences with respect of disabilities, needs and dependency. This differs from a community survey by Jagger et al (1994) which suggested that women became more physically disabled than men in older age. The fact that patients are admitted based on their suitability to utilise the day hospital services may mean that the more disabled people are not referred or admitted. Possibly, only those patients with a certain range of disabilities that can be managed in a day hospital setting are selected.

## 5.8. Comparing unmet needs between older day hospital attenders in inner city and rural-urban settings

The study gives the opportunity to compare the needs of patients in two different settings using a standardised needs assessment instrument, the Camberwell Assessment of Need for the Elderly. Amongst patients from inner city London attending the Camden Mews Day Hospital, psychological distress was the most frequent unmet need found in 32 (59.3%) which was a similar proportion to those from Haymeads Day Hospital. The most frequent unmet need identified amongst the Haymeads Day Hospital patients was daytime activities in 34 (58.6%) which was similar to the number amongst the Camden Mews Day Hospital subjects of 31 (57.4%).

Unmet needs occurred at different frequencies amongst the new attenders in both day hospitals, but the five most common unmet needs identified by the Camberwell Assessment of Need for the Elderly were the same. They included daytime activities, company, psychological distress, memory and information on diagnosis & treatment for patients.

## 5.9. Outcome of day hospital care

Various measures have been used to assess outcome of mental health care in older people. In monitoring outcome of referrals to community mental health teams for older people, Bedford et al. (1996) used such measures as survival, institutionalisation, key worker assessments, unmet needs, carer stress and global outcome for carers and patients. On follow-up, six months after initial assessments, 11 (17%) of dementia patients had died compared to 11 (15%) of patients with functional disorders. Though they did not use a standardised needs assessment instrument, on follow-up, 48% of patients with dementia were identified to have unmet needs (e.g. extra supervision, residential care and stimulation) compared to 27% of patients with functional disorders. There is however a likelihood that fewer needs would be identified by staff not using a formal needs assessment instrument, as the findings in this study have indicated.

Using outcomes of deceased, hospitalised, residential or nursing home care and living in the community, Woods and Phanjoo (1991) carried out a follow-up study of day hospital patients with dementia. Three years after admission, outcomes were that, 59% were deceased, 19% in hospital, 13% in longterm care and 9% at home. The follow-up period of three years rather than three months partially explain the differences in mortality rate seen with this study which also involves day hospital patients. Two out of the 112 patients initially



assessed in the two day hospitals in this study were deceased by the time of follow-up, three months after initial assessment. Furthermore, the patient group in this study had patients with depression and or dementia rather than only dementia.

Unlike the above two studies, Wattis et al. (1994) used several standardised instruments in assessing outcome in the admission of older patients to an acute inpatient psychiatric facility, though they did not assess their needs. The instruments used by Wattis et al. (1994) included the Montgomery Asberg Depression Rating Scale (Montgomery and Asberg, 1979) and the Hospital Anxiety Depression Scale (Zigmod and Snaith, 1983; Kenn et al., 1987). For dementia, the instruments used include the Abbreviated Mental Test Score (Hodkinson, 1972) measuring cognitive function, and an abbreviated form of the Crichton Royal Behavioural Rating Scale (Robinson, 1961) for measuring disability. There were improvements observed in the Montgomery Asberg Depression Rating and Hospital Anxiety Depression Scales for those patients who were depressed. In those patients with dementia, no such changes were seen in the scores of the Abbreviated Mental Test and the Crichton Royal Behavioural Rating Scale. Due to differences in outcome measures used, it is difficult to compare outcomes in the above studies.

On follow-up of the 112 new day hospital attenders, there was a reduction in total number of unmet needs identified by both the Camberwell Assessment of Need for the Elderly and the day hospitals' multidisciplinary teams. This was the same when patients were grouped into either dementia or depression. The mean number of unmet needs that were met during the study period were about two per patient, irrespective of whether patients had a diagnosis of dementia or depression and which of the two day hospitals they attended. This finding indicates that day hospitals identify and meet the needs of older people with mental health problems.

The Health of the Nation Outcome Scales also indicated an improvement on follow-up for all patients in both day hospitals, irrespective of whether they had a diagnosis of dementia or depression. This differs from the findings of Wattis et al. (1994) where no changes were seen on follow-up amongst patients with dementia in the instruments they used. The explanation for this is in the fact that the Health of the Nation Outcome Scales appears to perform fairly well as a global outcome measure and not just as a measure of disability. These results are supported by an earlier study involving a one year follow-up of 100 older psychiatric patients (Ashaye et al., 1999). In this study, higher Health of the Nation Outcome Scales total scores on initial assessment predicted poorer prognosis a year later, in terms of increased mortality or placement in longterm care.

The Health of the Nation Outcome Scales scores can be categorised into problems with behaviour, impairment, symptoms and social activities. Improvement was seen on follow-up in all categories except impairment, which remained unchanged for all subjects when grouped together and for those patients with depression. For patients with dementia, improvement was only seen in problems with behaviour. Impairment, symptoms and social activities were unchanged on follow-up in patients with dementia. These findings highlight one of the benefits in using the Health of the Nation Outcome Scales, which include aside from giving a global picture, the scales can be categorised into four. These are behaviour, impairment, symptoms and social functioning, which can be assessed separately, to identify more specific areas of change, as can also the 12 individual items of the Health of the Nation Outcome Scales. In terms of outcome, the above findings with using the Health of the Nation Outcome Scales in this study, supports the view that depressed patients have a better outcome than those with dementia. There is also some benefit for patients with dementia attending day hospitals, as an observed reduction in problems with behaviour was also identified by the Health of the Nation Outcome Scales.

The total scores of the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales were unchanged for patients with depression and worse for those with dementia. This supports the view that outcome for

depression is better than for dementia amongst day hospital patients. However, it would also suggest that the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales may not be sensitive enough for patients with depression. Its use is probably more appropriate for patients with dementia, as it is a measure of dependency and behavioural problems. Nevertheless, a one year follow-up study of older people with mental health problems indicated that it performs well as an outcome measure in both groups (Ashaye et al., 1999).

A review of the interventions not carried out on follow-up in this study indicate that the most common ones were day centre referral and introduction to suitable social groups. These two interventions are also among the most frequent suggested interventions, generated by using the Camberwell Assessment of Need for the Elderly. These findings indicate how factors beyond the control of the day hospital, like day centre places and community social groups or activities usually run by voluntary agencies or social services can affect outcome of day hospital care. In addition, many patients may not have been ready to be referred at the time of reassessment in this study, which was three months after admission in most cases.

Melzer et al. (1996) found that with the community mental health teams, carers considered lack of stimulation and respite among the most frequent unmet needs of older people with mental health problems. Hence the social network and

resources of the local community can play an important role in the outcome of care for older people. The follow-up assessment period in this study was only three months. Over a longer period of time, there is the chance that more needs will be met as more interventions, such as day centre referral and introduction to social groups, are carried out, and this would further improve outcome.

#### 5.10. Outcome of care comparing the use of the Camberwell Assessment of Need for the Elderly and current day hospital practice of assessments

The literature review indicated that there were no studies comparing the use of a formal needs assessment with routine practice in meeting needs of people with mental health problems. As a result, this study is unique in that it compares outcome amongst older patients grouped into those assessed using a formal needs assessment instrument, the Camberwell Assessment of Need for the Elderly and current assessment practices in two day hospitals.

The Camberwell Assessment of Need for the Elderly with provision of feedback to keyworkers led to a reduction in total number of unmet needs on follow-up. However, this reduction was similar to that which occurred amongst patients in the control group, even when the influence of initial number of needs were

taken into consideration using analysis of covariance. When patients were grouped by diagnoses into depression and dementia, a similar result was observed with no significant difference in number of unmet needs between patients in the experimental and control groups at follow-up.

One of the most emphatic findings of the study was the very high proportion of initial unmet needs which had become met needs at follow-up in the control group. This dramatic fall in unmet needs meant that the chance of finding a difference between the experimental and control groups was very much reduced. The finding also provides valuable support to the effectiveness of day hospital care.

The use of the initial number of CANE unmet needs as covariate in comparing unmet needs at follow-up was justified, as of six independent variables (day hospitals, age, gender, interventions, diagnosis and initial CANE unmet needs), it was only the initial number of CANE unmet needs, that had a significant effect on outcome in terms of presence of unmet needs.

Individual needs identified by CANE revealed no significant difference in the proportion of patients with unmet needs between the groups except in accommodation and company. In the case of company, the proportion of patients with unmet needs were less on follow-up in the experimental group.

This is explained by a greater proportion of these patients having the suggested intervention of introduction to suitable social groups completed. There was also a greater proportion of patients with accommodation as an unmet need on follow-up in the experimental group. This was despite housing support as an intervention being greater in the experimental group. Lack of suitable alternative accommodation or the housing department being slow to respond to requests appeared to be responsible for the differences observed between the groups, with the experimental group also having many more patients with accommodation as an unmet need at the onset.

There were no significant differences in mean scores between the groups of the Health of the Nation Outcome Scales and Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales at follow-up. These findings were replicated for both day hospitals, when results were analysed for each day hospital. Hence, the feedback from the Camberwell Assessment of Need for the Elderly made no difference in terms of outcome as rated by the Health of the Nation Outcome Scales and the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales. Possible reasons could be that the instruments were not sensitive enough to recognise such differences or a type 2 statistical error. The latter is unlikely in that the power analysis undertaken before this study was commenced, ensured the use of an adequate sample size, thus reducing the chance of such an error.

### 5.11. Interventions generated by needs assessment using the Camberwell Assessment of Need for the Elderly

Presence of psychological problems in older people at home have been associated with dissatisfaction with social network, but not with living alone or the size of the network (Furnish, 1994). A third of all admissions of older people have been estimated to be caused by breakdown in the care at home (Isaacs 1971). The unmet needs in this study hence reflect the importance of social issues in the care of the patients in this study. As a result, some of the most frequent interventions suggested, included day centre referral, introduction to suitable social groups, supportive psychotherapy and psychology referral. The prevalence of depression is estimated to be between 10 and 13% in the over 65s (Copeland et al., 1987; Gurland et al., 1983; Morgan et al., 1987) and that of generalised emotional distress and unhappiness about 10-25% in older people in the United States of America (Blazer et al., 1988). As depression is one of the more common mental health disorders in older people, it is important services are geared towards meeting those needs. Day hospital activities such as supportive, individual and group work can play a significant role, in meeting the needs of those with depression.

Other interventions suggested included medication review and multidisciplinary team assessments, which were also core needs observed by Abdul-Hamid



(1997) in homeless, older men living in hostels. Multidisciplinary day hospitals with regular review meetings are well equipped to carry out these functions. A review of the interventions generated in this study, using the Camberwell Assessment of Need for the Elderly indicated that they address social, psychological, physical and medication needs of the day hospital patients

In this study, there was no difference in the total number of interventions completed when the differences in the number of total suggested interventions between the experimental and control groups were taken into consideration. However in two of the interventions, housing support and introduction to suitable social groups the proportion of suggested interventions completed were greater for the experimental group. This appears to have made a difference in the outcome of the need for company, with a lower proportion of people with an unmet need at follow-up in the experimental group compared to control.

Looking at the list of interventions, many patients required agencies or services outside the influence or control of the day hospitals. Inability to meet all needs could be due to the lack of resources in the community to carry out some of the suggested interventions and the assessment period being too short for all interventions to be carried out. These were the two main opinions of staff when asked for reasons of non-completion of suggested interventions.

## 5.12. Limitations of study

Limitations which could have compounded outcome were the fact that though key workers were given feedback in the control group, its actual use could not be verified other than by verbal assurances of staff involved. Some members of the multidisciplinary team have claimed they were unaware of the feedback though they were placed in patients' case notes by their keyworkers. If all staff had been made aware of the feedback given using the Camberwell Assessment of Need for the Elderly, there is possibility that this may have influenced outcome.

In addition, the fact that staff were exposed to the systematic approach to needs evaluation and interventions during the study may have resulted in contamination between experimental and control groups due to the staff indirectly being trained to have a more comprehensive approach to needs assessment and case planning.

Random allocation of patients to either group were done by the rater which could be a source of bias. Attempts at reducing bias was done by allocating patients only after they have been assessed, so rater had no foreknowledge of which group they would go to. The ideal solution would have been a double

blind study, in which the rater was different from the person who allocated patients to each group.

### 5.13. Possibilities for future research

This study was carried out with three months follow-up, placing patients from two different day hospitals into experimental and control groups. Possibilities for further research could include a longer period of follow-up to observe the long term impact on outcome of day hospitals and benefits of using structured needs assessment.

To reduce the risk of contamination of staff exposed to the use of structured needs assessment highlighted amongst the limitations in this study, a multicentre study should be undertaken, involving several day hospitals which are randomly allocated to the experimental and control groups rather than randomising individual patients from the same day hospital into the two groups. In this type of study, it is essential to match day hospitals with similar catchment populations and services.

A double blind study will remove the possibility of bias noted in this study, in that the rater and patients will be unaware of which group the patients belong

to, by randomisation of the day hospitals being done by someone other than the rater and also feedback being given in the experimental group done by that person rather than the rater.

This study suggests that day hospitals are effective in meeting most unmet needs of patients. However, there was no control group to compare outcome with, and it can be argued that the trend was a naturalistic one. This point can be addressed by designing a similar study, but randomly allocating patients on a day hospital waiting list, to a day hospital for three to six months and a control group remaining on the waiting list or allocated to a different form of intervention such as community mental health teams or community psychiatric nurse follow-up.

The benefits of structured needs assessment in day hospital care were addressed in this study. As older people with mental health problems may present in other settings, a similar study involving patients presenting in inpatients wards, residential or nursing homes, outpatients clinics and day centres should also be carried out, enabling the effects of structured needs assessment in older people in other settings to be assessed.

In general, this study did not show a difference in outcome between the experimental and control groups, despite more effective needs assessments in

the experimental group. Future studies ought to involve research on why and how improved needs assessments can be translated into better outcome in the care of older people with mental health problems.

## 6. CONCLUSIONS

1. Structured needs assessment using the Camberwell Assessment of Need for the Elderly, identified more needs than the current day hospital practice of assessments in older people with mental health problems.
2. There was no improvement in outcome and number of unmet needs on follow-up from using structured needs assessment and intervention plan, when compared with the current practice of assessments in the two day hospitals studied.
3. More needs were identified amongst either patients with dementia or depression by structured needs assessment than the current practice of assessments in both day hospitals. However, this made no difference in outcome in terms of the total number of unmet needs on follow-up.
4. Patients who attended the day hospitals had most unmet needs met at follow-up, whichever group they were in. An improved outcome as rated using the Health of the Nation Outcome Scales was observed for most patients whether they had depression or dementia. Day hospital patients with dementia had most unmet needs met despite worsening in terms of dependency, as rated by using the Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales.
5. The Camberwell Assessment of Need for the Elderly proved a useful tool in identifying interventions to meet unmet needs.

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## **8. APPENDIX**

List of abbreviations.

Information sheet.

Examples of needs and interventions.

Clifton Assessment Procedures for the Elderly-

Behaviour Rating Scales.

HoNOS 65+ and Glossary.

Camberwell Assessment of Need for the Elderly.

Is CANE able?



## **List of abbreviations**

- CANE** - Camberwell Assessment of Need for the Elderly.
- CAPE-BRS** - Clifton Assessment Procedures for the Elderly - Behaviour Rating Scales.
- HoNOS** - Health of the Nation Outcome Scales.
- MDT** - Multidisciplinary team.
- NHS** - National Health Service.
- SPSS** - Statistical Package for the Social Sciences.

## **INFORMATION SHEET**

**A study on day hospitals for older people meeting the needs of their patients**

**Investigator:** Kunle Ashaye - Senior Registrar, St. Pancras Hospital, 4 St. Pancras Way, London NW1 0PE.

**Supervisors:** Dr. Gill Livingston and Dr. Martin Orrell, Senior Lecturer and Reader, respectively, Department of Psychiatry and Behavioural Sciences, University College London.

We have a duty to check the performance of the service which we provide so as to be sure that we are offering our patients what they need. When patients first attend to see us, we usually conduct a careful assessment of their problems and thereby work out a method for correcting those difficulties which we are able to help with. There are several different ways of conducting these assessments and we are interested in discovering which method is best.

We would like you to help us with a small study which compares a new method of doing assessments with what we now do routinely. If you agree to participate you would be assessed in our normal way, but in addition, you will also be

assessed using a special questionnaire. The staff working in the Day Hospital may not be given the information which is obtained by using the special questionnaire, but they will be given the information obtained from the normal assessment. The decision over whether to give the staff the additional information obtained from the new questionnaire will be decided by random code (like tossing a coin). The new questionnaire takes about thirty minutes to complete. After three or four months we will assess you again using the same methods which were used on the first occasion.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at anytime without having to give a reason. Your decision whether to take part or not will not affect the basic standard of care and management offered by the day hospital in any way.

All information gathered will remain confidential.

## **Examples of needs and interventions**

Feedback given on two patients with depression after using the Camberwell

Assessment of Need for the Elderly:

### **Patient A.**

#### **Identified needs and problems**

1. Psychological distress.
2. Social contact.

#### **Suggested Interventions**

1. Offer support and counselling through difficult family times.
2. Involvement in group activities in day hospital.
3. Introduction to social activities like luncheon clubs and excursion trips.
4. Review antidepressant therapy as and when necessary.

### **Patient B.**

#### **Identified needs and problems**

1. Blurred vision secondary to medication.
2. Psychological distress - depression.
3. Information: unclear about reasons for attending day hospital.
4. Company.

#### **Suggested Interventions**

1. Review of medication with response and side effects profile.
2. In need of explanation on diagnoses and management plans.
3. Social contacts other than immediate family, initially through day hospital group activities and later introduction to social clubs of possible interest to him in the community.

Feedback given on two patients with dementia after using the Camberwell

Assessment of Need for the Elderly:

**Patient C.**

**Identified problems and needs**

1. Day time activities.
2. Memory.
3. Behaviour.
4. Company.

**Suggested interventions**

1. Medical, nursing and occupational therapy assessments of memory and behavioural difficulties.
2. Provision of day care through referral to a day centre

**Patient D.**

**Identified needs and problems**

1. Day time activities
2. Memory
3. Company

**Suggested interventions**

1. Medical, nursing and occupational therapy assessments of memory and behavioural difficulties.
2. Provision of day care through referral to a day centre.

## Clifton Assessment Procedures for the Elderly-Behaviour Rating Scales:

1. When bathing or dressing, he/she requires:
  - no assistance. 0
  - some assistance. 1
  - maximum assistance. 2
2. With regard to walking, he/she:
  - shows no sign of weakness. 0
  - walks slowly without aid, or uses a stick. 1
  - is unable to walk, or if able to walk, needs frame, crutches or someone by his/her side. 2
3. He/she is incontinent of urine and/or faeces (day or night):
  - never. 0
  - sometimes (once or twice a week). 1
  - frequently (three times per week or more). 2
4. He/she is in bed during the day (bed does not include couch or settee):
  - never. 0
  - sometimes. 1
  - almost always. 2
5. He/she is confused (unable to find way around, loses possessions, etc.):
  - almost never confused. 0
  - sometimes confused. 1
  - almost always confused. 2
6. When left to his/her own devices, his/her appearance (clothes and/or hair) is:
  - almost never disorderly. 0
  - sometimes disorderly. 1
  - almost always disorderly. 2
7. If allowed outside, he/she would:
  - never need supervision. 0
  - sometimes need supervision. 1
  - always need supervision. 2
8. He/she helps out in the home/ward:
  - often helps out. 0
  - sometimes help out. 1
  - never helps out. 2
9. He/she keeps him/herself occupied in a constructive or useful activity (works, reads, plays games, has hobbies, etc.):
  - almost always occupied. 0
  - sometimes occupied. 1
  - almost never occupied. 2
10. He/she socialises with others:
  - does establish a good relationship with others. 0
  - has some difficulty establishing a good relationship. 1
  - has a great deal of difficulty establishing a good relationship. 2
11. He/she is willing to do things suggested or asked of him/her:
  - often goes along. 0
  - sometimes goes along. 1
  - almost never goes along. 2

12. He/she understands what you communicate to him/her (you may use speaking, writing or gesturing):
- understands almost everything you communicate. 0
  - understands some of what you communicate. 1
  - understands almost nothing of what you communicate. 2
13. He/she communicates in any manner (by speaking, writing or gesturing):
- well enough to make him/herself easily understood. 0
  - can be understood sometimes or with some difficulty. 1
  - understood for whatever reason. 2
14. He/she is objectionable to others during the day (loud or constant talking, soiling furniture, interfering in affairs of others):
- rarely or never 0
  - sometimes 1
  - frequently. 2
15. He/she is objectionable to others during the night (loud or constant talking, soiling furniture, interfering in affairs of others):
- rarely or never 0
  - sometimes 1
  - frequently. 2
16. He/she accuses others of doing him/her bodily harm or stealing his/her personal possessions:
- never. 0
  - sometimes. 1
  - frequently. 2
17. He/she hoards apparently meaningless items (wads of paper, string, scraps of food, etc.):
- never. 0
  - sometimes. 1
  - frequently. 2
18. His/her sleeping pattern at night is:
- almost never awake. 0
  - sometimes awake. 1
  - often awake. 2
- Eyesight:  
(tick as appropriate)
- can see (or can see with glasses)
  - partially blind.
  - totally blind.
- Hearing:  
(tick as appropriate)
- no hearing difficulties, without hearing aid.
  - no hearing aid, though requires hearing aid.
  - has hearing difficulties which interfere with communication.
  - is very deaf.

**Total Score =**

## HoNOS 65+ and Glossary

### Health of the Nation Outcome Scales 65+ Score Sheet

Each item is rated 0 - 4, with 0 = no problem, 1 = subclinical problem, 2 = mild problem, 3 = moderate problem and 4 = severe problem.

#### **SCORE**

- 1:** Behavioural disturbance.
- 2:** Non-accidental self-injury.
- 3:** Problem drinking or drug use.
- 4:** Cognitive problems.
- 5:** Physical illness or disability problems.
- 6:** Problems associated with hallucinations or delusions.
- 7:** Problems with depressive symptoms.
- 8:** Other mental & behavioural problems.
- 9:** Problems with relationships.
- 10:** Problems with activities of daily living.
- 11:** Problems with living conditions.
- 12:** Problems with activities.



# **HONOS 65+**



## **GLOSSARY**

**1. Behavioural disturbance e.g. overactive, aggressive, disruptive or agitated behaviour, uncooperative or resistive behaviour.**

*-include such behaviour due to any cause, e.g. dementia, drugs, alcohol, psychosis, depression, etc. Do not include bizarre behaviour, rated at Scale 6.*

0 - No problems of this kind during the period rated.

1 - Occasional irritability, quarrels, restlessness etc., but generally calm and co-operative and not requiring any specific action.

2 - Includes aggressive gestures, e.g. pushing or pestering others and/or verbal threats or aggression; lesser damage to objects/property (e.g. broken cup, window); significant overactivity or agitation; intermittent restlessness and/or wandering (day or night); uncooperative at times, requiring encouragement and persuasion.

3 - Physically aggressive to others (short of rating 4); more serious damage to, or destruction of, property; frequently threatening manner; more serious and/or persistent overactivity or agitation; frequent restlessness and/or wandering (e.g. day and night); significant problems with co-operation, largely resistant to help/assistance.

4 - At least one serious physical attack on others (over and above rating on 3); major and/or persistent destructive activity (e.g. fire-setting); persistent and serious threatening behaviour; severe overactivity or agitation; sexually disinhibited or other inappropriate behaviour (e.g. deliberate inappropriate urination and/or defecation); virtually constant restlessness and/or wandering, severe problems related to non-compliant/resistive behaviour.

**2. Non-accidental self-injury.**

*- do not include accidental self-injury (e.g. due to dementia or severe learning disability); any cognitive problem is rated at Scale 4 and the injury at Scale 5. Do not include illness or injury as a direct consequence of drug/alcohol use rated at Scale 3 (e.g. cirrhosis of the liver, or injury resulting from drunk driving are rated at Scale 5).*

0 - No problem of this kind during the period rated.

1 - Fleeting thoughts of self-harm or suicide but little or no risk during the period.

2 - Mild risk during period; includes more frequent thoughts or talking about self-harm or suicide (including 'passive' ideas of self-harm such as not taking avoiding action in a potentially life threatening situation e.g. whilst crossing a road).

3 - Moderate to serious risk of deliberate self-harm; includes frequent/persistent thoughts or talking about self-harm; includes preparatory behaviours e.g. collecting tablets.

4 - Suicide attempt and/or deliberate self-injury during the period rated.

### **3. Problem-drinking or drug-use.**

*- do not include aggressive/destructive behaviour due to alcohol or drug use, rated at Scale 1. Do not include physical illness or disability due to alcohol or drug use, rated at Scale 5. Do not include accidental misuse of alcohol or drugs (prescribed or otherwise) e.g. in the context of dementia where the cognitive problem is rated at Scale 4 and any resulting illness or disability at Scale 5.*

0 - No problem of this kind during the period rated.

1 - Some over-indulgence but within social norm.

2 - Occasional loss of control of drinking or drug use, but not a serious problem.

3 - Marked craving or dependence on alcohol or drug use with frequent loss of control, drunkenness, etc.

4 - Major adverse consequences/incapacitated from alcohol/drug problems.

### **4. Cognitive problems.**

*- include problems of orientation, memory and language associated with any disorder: dementia, learning disability, schizophrenia, etc. Do not include temporary problems (e.g. hangovers) which are clearly associated with alcohol or other drug/medication use, rated at Scale 3.*

- sub-type according to course and duration of cognitive difficulties:

a: acute

b: chronic

0 - No problem of this kind during the period rated.

1 - Minor problems with orientation (e.g. some difficulty with orientation to time) and/or memory (e.g. a degree of forgetfulness but still able to actively learn new information), no apparent difficulties with the use of language.

2 - Mild problems with orientation (e.g. frequently disorientated to time) and/or memory (e.g. definite problems learning new information such as names, recollection or recent events; deficit interferes with everyday activities); difficulty finding way in new or unfamiliar surroundings, able to deal with simple verbal information but some difficulties with understanding and/or expression of more complex language

3 - Moderate problems with orientation (e.g. usually disorientated to time, often to place) and/or memory (e.g. new material rapidly lost, only highly learned material retained, occasional failure to recognise familiar individuals); has lost the way in a familiar place, major difficulties with language (expressive and/or receptive).

4 - Severe disorientation (e.g. consistently disorientated to time and place, and sometimes to person) and/or memory impairment (e.g. only fragments remain, loss of distant as well as recent information, unable to effectively learn any new information, consistently unable to recognise or to name close friends/relatives); no effective communication possible through language/inaccessible to speech.

### **5. Problems related to physical illness or disability.**

*- include illness or disability from any cause that limits mobility, impairs sight or hearing or otherwise interferes with personal functioning (e.g. pain). Also include side-effects from medication; effects of drug or alcohol use; physical disabilities resulting from accidents or self-harm associated with cognitive problems, etc. Do not include mental or behavioural problems rated at Scale 4.*

**0** - No significant physical health, disability or mobility problems during the period rated.

**1** - Minor health problem during the period rated (e.g. cold); some impairment of sight and/or hearing (but still able to function effectively with the use of glasses and/or hearing aid).

**2** - Physical health problem associated with mild restriction of activities and/or mobility (e.g. restricted walking distance, some degree of loss of independence) moderate impairment of sight and/or hearing (with functional impairment despite the appropriate use of glasses and/or hearing aid), some degree of risk of falling, but low and no episodes to date, problems associated with mild degree of pain.

**3** - Physical health problem associated with moderate restriction of activities and/or mobility (e.g. mobile only with an aid - stick or zimmer frame -or with help); more severe impairment of sight and/or hearing (short of Rating 4); significant risk of falling  $\pm$  one or more falls; problems associated with a moderate degree of pain.

**4** - Major physical health problems associated with severe restriction of activities and/or mobility (e.g. chair or bed bound); severe impairment of sight and/or hearing (e.g. registered blind or deaf); high risk of falling  $\pm$  one or (usually) more falls because of physical illness or disability; problems associated with severe pain; presence of impaired level of consciousness.

### **6. Problems associated with hallucinations and/or delusions (or false beliefs).**

*- include hallucinations and delusions (or false beliefs) irrespective of diagnosis. Include odd or bizarre behaviour associated with hallucinations and delusions (or false beliefs). Do not include aggressive, destructive or overactive behaviours attributed to hallucinations and delusions (or false beliefs) which are rated at Scale 1.*

**0** - No evidence of delusions or hallucinations during the period rated.

**1** - Somewhat odd or eccentric beliefs not in keeping with cultural norms.

**2** - Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. present but mild clinical problem.

**3** - Marked preoccupation with delusions or hallucinations, causing significant distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.

**4** - Mental state and behaviour is seriously and adversely affected by delusions and/or hallucinations, with a major impact on the patient and/or others, i.e. severe clinical problem.

*- do not include overactivity or agitation, rated at Scale 1. Do not include suicidal ideation or attempts, rated at Scale 2. Do not include delusions or hallucinations, rated at Scale 6. Rate associated problems (e.g. changes in sleep, appetite or weight; anxiety symptoms) at Scale 8.*

- 0 - No problems associated with depression during the period rated.
- 1 - Gloomy: or minor changes in mood only.
- 2 - Mild but definite depression on subjective and/or objective measures (e.g. loss of interest and/or pleasure, lack of energy, loss of self-esteem, feelings of guilt).
- 3 - Moderate depression on subjective and/or objective measures (depressive symptoms more marked).
- 4 - Severe depression on subjective and/or objective grounds (e.g. profound loss of interest and/or pleasure, preoccupation with ideas of guilt or worthlessness).

## **8. Other mental and behavioural problems.**

*- rate only the single most severe clinical problem not considered in Scales 6 and 7. Specify the type of problem by entering the appropriate letter; A phobic; B anxiety; C obsessive-compulsive; D stress; E dissociative; F somatoform; G eating; H sleep; I sexual; J other (specify).*

- 0 - No evidence of any of these problems during period rated.
- 1 - Minor non-clinical problems.
- 2 - A problem is clinically present, but at a mild level e.g. the problem is intermittent, the patient maintains a degree of control and/or is not unduly distressed.
- 3 - Moderately severe clinical problem e.g. more frequent, more distressing or more marked symptoms.
- 4 - Severe persistent problem which dominates or seriously affects most activities.

## **9. Problems with relationships.**

*- problems associated with social relationships, identified by the patient and/or apparent to others/carers. Rate the patients most severe problem associated with active or passive withdrawal from, or tendency to dominate, social relationships, and/or non-supportive, destructive or self-damaging relationships.*

- 0 - No significant problems during the period.
- 1 - Minor non-clinical problem.
- 2 - Definite problems in making, sustaining or adapting to supportive relationships (e.g. because of controlling manner, or arising out of difficult, exploitative or abusive relationships with carers), definite difficulties reported by patient and/or evident to others/carers but mild.
- 3 - Persisting significant problems with relationships; moderately severe conflict or problems identified within the relationship by the patient and/or apparent to others/carers.
- 4 - Severe difficulties associated with social relationships (e.g. isolation, withdrawal, conflict, abuse); major tensions and stresses (e.g. threatening breakdown of relationship).

## **10. Problems with activities of daily living.**

*- rate the overall level of functioning in activities of daily living (ADL): e.g. problems with basic activities of self care such as eating, washing, dressing, toilet; also complex skills such as budgeting, recreation, use of transport, etc. Include any lack of motivation for using self-help opportunities, since this contributes to a lower overall level of functioning. Do not include lack of opportunity for exercising intact abilities and skills, rated at Scales 11 and 12.*

**0 - No problems during the period rated; good ability to function effectively in all basic activities (e.g. continent - or able to manage incontinence appropriately, able to feed self and dress) and complex skills (e.g. driving or able to make use of transport facilities, able to handle financial affairs appropriately).**

**1 - Minor problems only without significantly adverse consequences; e.g. untidy, mildly disorganised, some evidence to suggest a decline from previous functional level (especially with regard to complex skills) but still able to cope effectively.**

**2 - Self care and basic activities adequate (though some prompting may be required), but difficulty with more complex skills (e.g. problems organising and making a drink/meal, deterioration in personal interests especially outside the home situation, problems with driving, transport or financial judgements).**

**3 - Problems evident in one or more areas of basic self-care activities (e.g. needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted), inability to perform several complex skills in addition.**

**4 - Severe disability or incapacity in all or nearly all areas of basic and complex skills (e.g. full supervision required with dressing and eating, frequent urinary ± faecal incontinence)**

## **11. Problems with living conditions.**

*- Rate overall severity of problems with the quality of living conditions/accommodation and daily domestic routine taking into account the patients preferences and degree of satisfaction with their circumstances. Are the basic necessities met (heat, light, hygiene)? If so, does the physical environment contribute to maximising independence and minimising risk, and provide a choice of opportunities to facilitate the use of existing skills and the development of new ones? Do not rate the level of functional disability itself which is rated at Scale 10.*

*Rate the patients usual accommodation.*

0 - Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and minimising any risk, and supportive of self-help, the patient is satisfied with their accommodation.

1 - Accommodation is reasonably acceptable with only minor or transient problems related primarily to the patients preferences rather than any significant problems or risks associated with their environment (e.g. not ideal location, not preferred option, doesn't like food).

2 - Basics are met but significant problems with one or more aspects of the accommodation and/or regime (e.g. lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems or access); may be associated with risk to patient (e.g. of injury) which would be otherwise reduced.

3 - Distressing/multiple problems with accommodation; e.g. some basic necessities absent (e.g. unsatisfactory and/or unreliable heating, lack of proper cooking facilities, inadequate sanitation), clear elements of risk to the patient resulting from aspects of physical environment.

4 - Accommodation is unacceptable; e.g. lack of basic necessities, insecure, or living conditions otherwise intolerable, contributing adversely to the patients condition and/or placing them at high risk of injury or other adverse consequences.

## **12. Problems with activities.**

*- rate the overall level of problems with the quality of the day-time environment. Is there help to cope with disabilities, and opportunities for maintaining or improving occupational and recreational skills and activities? Consider factors such as stigma, lack of qualified staff, lack of access to supportive facilities e.g. staffing and equipment of day centres, social clubs etc. Do not rate the level of functional disability itself, rated at Scale 10. Rate the patients usual situation.*

0 - Patients day-time environment is acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and maximising autonomy.

1 - Minor or temporary problems e.g. good facilities available but not always at appropriate times for the patient.

2 - Limited choice of activities; e.g. insufficient carer or professional support; useful day setting available but for very limited hours.

3 - Marked deficiency in skilled services and support available to help optimise activity level and autonomy, little opportunity to use skills or to develop new ones; unskilled care difficult to access.

4 - Lack of any effective opportunity for day-time activities makes the patients problems worse or patient refuses services offered which might improve their situation

# CAMBERWELL ASSESSMENT OF NEED FOR THE ELDERLY

## (CANE)

Revised Version (II)

CODE	
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INTERVIEWEE	DATE	interview time
USER		
STAFF		
CARER		



# 1 ACCOMMODATION

DOES THE PERSON HAVE AN APPROPRIATE PLACE TO LIVE?

  

What kind of home do you live in? Do you have any problems with accommodation?

0 = NO PROBLEM	e.g.	Has an adequate and appropriate home (even if currently in hospital).
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Home undergoing adaptation/redecoration
2 = SERIOUS PROBLEM	e.g.	Homeless, inappropriately housed or home lacks basic facilities such as water, electricity, heating or essential alterations.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 2

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH THEIR ACCOMMODATION?

  

0 = NONE		
1 = LOW HELP	e.g.	Occasionally does odd jobs or minor redecorations.
2 = MODERATE HELP	e.g.	Substantial help with improving accommodation such as organising redecoration or specific adaptations.
3 = HIGH HELP	e.g.	Living with relative because own accommodation is unsatisfactory.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH THEIR ACCOMMODATION?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH THEIR ACCOMMODATION?

  

0 = NONE		
1 = LOW HELP	e.g.	Minor redecoration; referral to housing agency/assisted housing.
2 = MODERATE HELP	e.g.	Major improvements; actively pursuing change in accommodation.
3 = HIGH HELP	e.g.	Being rehoused; living in supported accommodation, residential care, nursing home or continuing care hospital ward.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH THEIR ACCOMMODATION?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH ACCOMMODATION?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

DOES THE PERSON HAVE DIFFICULTY IN LOOKING AFTER THEIR HOME?

Are you able to look after your home?  
Does anyone help you?

0 = NO PROBLEM	e.g.	Home may be untidy but kept basically clean.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Limited in looking after home and has regular domestic help.
2 = SERIOUS PROBLEM	e.g.	Unable to do any housework. Home is a potential health/fire/escape hazard.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 3

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH LOOKING AFTER THE HOME?

0 = NONE		
1 = LOW HELP	e.g.	Prompts or helps tidy up or clean occasionally.
2 = MODERATE HELP	e.g.	Prompts or helps clean at least once a week.
3 = HIGH HELP	e.g.	Does most or all of the household tasks.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH LOOKING AFTER THE HOME?

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH LOOKING AFTER THE HOME?

0 = NONE		
1 = LOW HELP	e.g.	Prompting/supervision by staff.
2 = MODERATE HELP	e.g.	Some assistance with household tasks.
3 = HIGH HELP	e.g.	Majority of household tasks done by staff.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH LOOKING AFTER THE HOME?

(0 = NO      1 = YES      9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH LOOKING AFTER THE HOME?

(0 = NOT SATISFIED      1 = SATISFIED)

COMMENTS

**DOES THE PERSON HAVE DIFFICULTY IN GETTING ENOUGH TO EAT?**

*Are you able to prepare your own meals and do your own shopping?  
 Are you getting the right sort of food?*

0 = NO PROBLEM	e.g.	Able to buy and prepare adequate meals.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Unable to prepare food and has some meals provided
2 = SERIOUS PROBLEM	e.g.	Very restricted diet; culturally inappropriate food; unable to do shopping or prepare any food.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 4

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH GETTING ENOUGH TO EAT?**

0 = NONE		
1 = LOW HELP	e.g.	Occasional meal provided and/or occasional help with shopping.
2 = MODERATE HELP	e.g.	Help with weekly shopping and/or meals provided more than weekly but not daily.
3 = HIGH HELP	e.g.	Meal provided daily
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH GETTING ENOUGH TO EAT?**

**HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH GETTING ENOUGH TO EAT?**

0 = NONE		
1 = LOW HELP	e.g.	1-4 meals a week provided or assisted for one meal a day.
2 = MODERATE HELP	e.g.	More than 4 meals a week provided or assisted for all meals. Weekly shopping.
3 = HIGH HELP	e.g.	All meals provided.
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH GETTING ENOUGH TO EAT?**

(0 = NO            1 = YES            9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH GETTING ENOUGH TO EAT?**

(0 = NOT SATISFIED            1 = SATISFIED)

**COMMENTS**

DOES THE PERSON HAVE DIFFICULTY WITH SELF CARE?

  

*Do you have any difficulty with personal care like washing, cutting your nails or dressing?  
Do you ever need help?*

0 = NO PROBLEM	e.g.	Appropriately dressed and groomed.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Needs and gets help with self care.
2 = SERIOUS PROBLEM	e.g.	Poor personal hygiene, unable to dress or wash.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 5

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS  
OR RELATIVES WITH SELF CARE?

  

0 = NONE		
1 = LOW HELP	e.g.	Prompts (e.g. to change clothes) or helps occasionally.
2 = MODERATE HELP	e.g.	Regular assistance e.g. weekly or more often.
3 = HIGH HELP	e.g.	Daily assistance with care e.g. dressing, bathing: Weekly laundry.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL  
SERVICES WITH SELF CARE?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL  
SERVICES WITH SELF CARE?

  

0 = NONE		
1 = LOW HELP	e.g.	Occasional prompting by staff.
2 = MODERATE HELP	e.g.	Supervise weekly washing and some other aspects of self-care.
3 = HIGH HELP	e.g.	Supervise most aspects of self care; assist most days.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP  
WITH SELF CARE?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT  
OF HELP THEY ARE RECEIVING WITH SELF CARE?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

# 5 CARING FOR SOMEONE ELSE

ASSESSMENTS  
USER STAFF CARER

DOES THE PERSON HAVE DIFFICULTY CARING FOR ANOTHER PERSON?

  

*Is there anyone that you are caring for?  
Do you have any difficulty in looking after them?*

- |   |      |   |
|---|------|---|
| 0 = NO PROBLEM                            | e.g. | No-one to care for or no problem in caring.                   |
| 1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN | e.g. | Difficulties with caring and receiving help.                  |
| 2 = SERIOUS PROBLEM                       | e.g. | Serious difficulty in looking after or caring for the person. |
| 9 = NOT KNOWN                             |      |   |

IF RATED 0 OR 9 GO TO QUESTION 6

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH LOOKING AFTER SOMEONE ELSE?

  

- |                   |      |  |
|-------------------|------|--|
| 0 = NONE          |      |  |
| 1 = LOW HELP      | e.g. | Occasional help less than once a week.                   |
| 2 = MODERATE HELP | e.g. | Help most days.  |
| 3 = HIGH HELP     | e.g. | Cared-for person goes to stay with friends or relatives. |
| 9 = NOT KNOWN     |      |  |

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH CARING?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH CARING?

  

- |                   |      |   |
|-------------------|------|---|
| 0 = NONE          |      |   |
| 1 = LOW HELP      | e.g. | Day care; weekly assistance at home.  |
| 2 = MODERATE HELP | e.g. | Nearly daily assistance at home; on-going carer support/training programme. |
| 3 = HIGH HELP     | e.g. | Respite care, 24-hour care package or plans for residential care.           |
| 9 = NOT KNOWN     |      |   |

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH CARING?

  

(0 = NO      1 = YES      9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR CARING FOR SOMEONE ELSE?

(0 = NOT SATISFIED      1 = SATISFIED)

COMMENTS

**DOES THE PERSON HAVE DIFFICULTY WITH REGULAR, APPROPRIATE DAYTIME ACTIVITIES?**  *How do you spend your day? Do you have enough to do?*

0 = NO PROBLEM	e.g.	Adequate social, work or leisure activities.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some limitation in occupying self, attending organised activities e.g. day centre.
2 = SERIOUS PROBLEM	e.g.	No adequate social, work or leisure activities.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 7

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN FINDING OR KEEPING REGULAR AND APPROPRIATE DAYTIME ACTIVITIES?**  

0 = NONE		
1 = LOW HELP	e.g.	Occasional help in arranging activities.
2 = MODERATE HELP	e.g.	Help at least weekly.
3 = HIGH HELP	e.g.	Daily help with arranging activities.
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES IN FINDING OR KEEPING REGULAR AND APPROPRIATE ACTIVITIES?**  **HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES IN FINDING OR KEEPING REGULAR AND APPROPRIATE ACTIVITIES?**  

0 = NONE		
1 = LOW HELP	e.g.	Adult education. Weekly day activity.
2 = MODERATE HELP	e.g.	Day centre 2-4 days a week. Day Hospital attendance.
3 = HIGH HELP	e.g.	Attends day hospital or day centre 5 or more days a week.
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH ACTIVITIES?**  

(0 = NO      1 = YES      9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH ACTIVITIES?**

(0 = NOT SATISFIED      1 = SATISFIED)

**COMMENTS**

DOES THE PERSON HAVE A PROBLEM WITH MEMORY?

  

*Do you often have a problem remembering things that happened recently?  
Do you often forget where you've put things?*

0 = NO PROBLEM	e.g.	Occasionally forgets but remembers later.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some problems but having investigations/assistance.
2 = SERIOUS PROBLEM	e.g.	Clear deficit in recalling new information; loses things; becomes disorientated in time and/or place.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 8

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR MEMORY LOSS?

  

0 = NONE		
1 = LOW HELP	e.g.	Prompting, occasional notes, reminders. Weekly visit.
2 = MODERATE HELP	e.g.	Assistance/supervision most days.
3 = HIGH HELP	e.g.	Living with relative. Constant supervision.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES FOR MEMORY LOSS?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES FOR MEMORY LOSS?

  

0 = NONE		
1 = LOW HELP	e.g.	Some advice.
2 = MODERATE HELP	e.g.	Undergoing investigations. Regularly sees health care professional, e.g. Memory Clinic, Day Hospital. Specialist day facility.
3 = HIGH HELP	e.g.	Residential/inpatient care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR MEMORY LOSS?

  

(0 = NO      1 = YES      9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR MEMORY LOSS?

(0 = NOT SATISFIED      1 = SATISFIED)

COMMENTS

**DOES THE PERSON HAVE ANY PROBLEM WITH SIGHT OR HEARING?**

*Do you have any difficulty hearing what someone says to you in a quiet room?  
Do you have difficulty in seeing newsprint or watching television?*

0 = NO PROBLEM	e.g.	No difficulties (may wear corrective lenses or hearing aid).
1 = NOMODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some difficulty but aids help to some extent.
2 = SERIOUS PROBLEM	e.g.	A lot of difficulty seeing or hearing.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 9

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH EYESIGHT/HEARING?**

0 = NONE		
1 = LOW HELP	e.g.	Help making appointments for sight/hearing problems.
2 = MODERATE HELP	e.g.	Regular help with difficult tasks e.g. reading correspondence.
3 = HIGH HELP	e.g.	Help with most tasks that are difficult because of hearing/vision problem.
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH EYESIGHT/HEARING?**

**HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH EYESIGHT/HEARING?**

0 = NONE		
1 = LOW HELP	e.g.	Advice.
2 = MODERATE HELP	e.g.	Investigations/treatment. Aids provided. Regular assistance with tasks.
3 = HIGH HELP	e.g.	Assistance several days a week. Hospital appointments/specialist services or specialist day facilities.
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH EYESIGHT/HEARING?**

(0 = NO      1 = YES      9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH EYESIGHT/HEARING?**

(0 = NOT SATISFIED      1 = SATISFIED)

**COMMENTS**



DOES THE PERSON HAVE RESTRICTED MOBILITY,  
FALLS OR ANY PROBLEMS USING PUBLIC TRANSPORT?

  

*Do you have any difficulty getting about outside or inside your home? Do you have falls?  
Can you use the bus or train?*

0 = NO PROBLEM	e.g.	Physically able and mobile.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some difficulty walking , climbing steps or using public transport but able with assistance (e.g. walking aids). Occasional fall.
2 = SERIOUS PROBLEM	e.g.	Very restricted mobility even with walking aid. Several falls in a month.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 10

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS  
OR RELATIVES FOR MOBILITY PROBLEMS?

  

0 = NONE		
1 = LOW HELP	e.g.	Occasional help e.g. with transport.
2 = MODERATE HELP	e.g.	Regular help with mobility/public transport. Help organising home alterations.
3 = HIGH HELP	e.g.	Daily help and supervision with mobility/transport.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL  
SERVICES FOR MOBILITY PROBLEMS?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL  
SERVICES FOR MOBILITY PROBLEMS?

  

0 = NONE		
1 = LOW HELP	e.g.	Advice; one or more aids.
2 = MODERATE HELP	e.g.	Currently undergoing investigations and/or O.T./Physiotherapy assessments. Regular transport, e.g. to day centre.
3 = HIGH HELP	e.g.	Fully appropriate home alterations and aids. Assistance most days.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP  
FOR MOBILITY PROBLEMS?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF  
HELP THEY ARE RECEIVING FOR MOBILITY PROBLEMS?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

**DOES THE PERSON HAVE INCONTINENCE?**

*Do you ever have accidents/find yourself wet if you can't get to the toilet quickly?  
(How much of a problem? Ever any soiling? Are you getting any help?)*

0 = NO PROBLEM	e.g.	No incontinence.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some incontinence. Receiving appropriate help/investigations.
2 = SERIOUS PROBLEM	e.g.	Regularly wet or soiled.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 11

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS  
OR RELATIVES FOR INCONTINENCE?**

0 = NONE		
1 = LOW HELP	e.g.	Prompts to maintain continence.
2 = MODERATE HELP	e.g.	Regularly assists with laundry, hygiene and use of aids.
3 = HIGH HELP	e.g.	Full assistance with continence (laundry, hygiene, aids).
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL  
SERVICES FOR INCONTINENCE?**

**HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL  
SERVICES FOR INCONTINENCE?**

0 = NONE		
1 = LOW HELP	e.g.	Prompts to maintain continence and provision of aids.
2 = MODERATE HELP	e.g.	Investigations/treatment. Regular help with laundry, hygiene and aids.
3 = HIGH HELP	e.g.	Planned medical intervention (e.g. surgery). Constant care and assistance (eg. in residential care or nursing home).
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP  
FOR INCONTINENCE?**

(0 = NO            1 = YES            9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF  
HELP THEY ARE RECEIVING FOR INCONTINENCE?**

(0 = NOT SATISFIED            1 = SATISFIED)

**COMMENTS**

DOES THE PERSON HAVE ANY PHYSICAL ILLNESS?

  

*How well do you feel physically?*

*Are you getting any treatment from your doctor for physical problems?*

0 = NO PROBLEM

e.g. Physically well.

1 = NO/MODERATE PROBLEM  
DUE TO HELP GIVEN

e.g. Physical ailment such as high blood pressure under control, receiving appropriate treatment.

2 = SERIOUS PROBLEM

e.g. Untreated serious physical ailment. Terminal illness. Awaiting major surgery.

9 = NOT KNOWN

IF RATED 0 OR 9 GO TO QUESTION 12

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS  
OR RELATIVES FOR PHYSICAL HEALTH PROBLEMS?

  

0 = NONE

1 = LOW HELP

e.g. Arranging appointments to see doctor.

2 = MODERATE HELP

e.g. Accompanied regularly to doctor/clinics.

3 = HIGH HELP

e.g. Daily help with condition arising out of physical health problems. e.g. Living with relative while convalescing or ill.

9 = NOT KNOWN

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL  
SERVICES FOR PHYSICAL HEALTH PROBLEMS?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL  
SERVICES FOR PHYSICAL HEALTH PROBLEMS?

  

0 = NONE

1 = LOW HELP

e.g. Given dietary or health advice. Occasional visit to GP.

2 = MODERATE HELP

e.g. Prescribed medication. Regularly seen by health care professional (GP, nurse, day hospital staff, out-patient clinic).

3 = HIGH HELP

e.g. Inpatient admissions. 24-hour nursing care.

9 = NOT KNOWN

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP  
FOR PHYSICAL HEALTH PROBLEMS?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF  
HELP THEY ARE RECEIVING FOR PHYSICAL HEALTH PROBLEMS?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

DOES THE PERSON HAVE PROBLEMS WITH MEDICATION OR DRUGS?

*Do you have any problems (eg. side effects) with medication? How many different tablets are you on?  
Has your medication been recently reviewed by your doctor? Do you take any drugs that are not prescribed?*

0 = NO PROBLEM	e.g.	No problems with compliance, side effects, drug-abuse or dependency.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Regular reviews, advice. District Nurse/CPN administers medication. Dosette boxes/aids.
2 = SERIOUS PROBLEM	e.g.	Poor compliance, takes too much or too little. Dependency or abuse of prescribed or non-prescribed drugs.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 13

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH THEIR MEDICATION?

0 = NONE		
1 = LOW HELP	e.g.	Occasional prompt. Advice about drug misuse.
2 = MODERATE HELP	e.g.	Collection, regular reminding and checking of medication. Advice about helping agencies.
3 = HIGH HELP	e.g.	Administers and holds medication. Support during drug withdrawal programme.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH THEIR MEDICATION?

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH THEIR MEDICATION?

0 = NONE		
1 = LOW HELP	e.g.	Advice from G.P. Prompts to take medication.
2 = MODERATE HELP	e.g.	Supervision by District Nurse/CPN/Day Hospital.
3 = HIGH HELP	e.g.	Daily administration of medication. Supervised withdrawal programme for drug dependency.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH MEDICATION?     
(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH THEIR MEDICATION?   
(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

# 13 PSYCHOTIC SYMPTOMS

ASSESSMENTS  
USER STAFF CARER

DOES THE PERSON HAVE SYMPTOMS SUCH AS DELUSIONAL BELIEFS, HALLUCINATIONS, FORMAL THOUGHT DISORDER OR PASSIVITY?

  

*Do you ever hear voices, see strange things or have problems with your thoughts?  
Are you on any medication for this?*

0 = NO PROBLEM

e.g. No definite symptoms. Not at risk or in distress from symptoms and not on medication for psychotic symptoms.

1 = NO/MODERATE PROBLEM  
DUE TO HELP GIVEN

e.g. Symptoms helped by medication or other help.

2 = SERIOUS PROBLEM

e.g. Currently has symptoms or is at risk.

9 = NOT KNOWN

IF RATED 0 OR 9 GO TO QUESTION 14

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR THESE PSYCHOTIC SYMPTOMS?

  

0 = NONE

1 = LOW HELP

e.g. Some support.

2 = MODERATE HELP

e.g. Carers involved in helping with coping strategies or medication compliance.

3 = HIGH HELP

e.g. Constant supervision of medication and help with coping strategies.

9 = NOT KNOWN

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES FOR THESE PSYCHOTIC SYMPTOMS?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES FOR THESE PSYCHOTIC SYMPTOMS?

  

0 = NONE

1 = LOW HELP

e.g. Mental state and medication reviewed three monthly or less often. Support group.

2 = MODERATE HELP

e.g. Mental state and medication reviewed more frequently than three monthly. Frequent specific therapy e.g. day hospital, high CPN input.

3 = HIGH HELP

e.g. Active treatment/ 24 hour hospital care, daily day care or crisis care at home.

9 = NOT KNOWN

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR THESE SYMPTOMS?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THESE SYMPTOMS?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

DOES THE PERSON SUFFER FROM CURRENT PSYCHOLOGICAL DISTRESS?

  

*Have you recently felt very sad or fed up? Have you felt very anxious, frightened or worried?*

0 = NO PROBLEM	e.g.	Occasional or mild distress.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Needs and gets ongoing support.
2 = SERIOUS PROBLEM	e.g.	Distress affects life significantly, e.g. prevents person going out.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 15

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR THIS DISTRESS?

  

0 = NONE		
1 = LOW HELP	e.g.	Some sympathy and support.
2 = MODERATE HELP	e.g.	Has opportunity at least weekly to talk about distress and get help with coping strategies.
3 = HIGH HELP	e.g.	Constant support and supervision.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES FOR THIS DISTRESS?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES FOR THIS DISTRESS?

  

0 = NONE		
1 = LOW HELP	e.g.	Assessment of mental state or occasional support.
2 = MODERATE HELP	e.g.	Specific psychological or social intervention for anxiety. Counselling by staff at least once a week e.g. at Day Hospital.
3 = HIGH HELP	e.g.	24 hour hospital care, or crisis care at home.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR THIS DISTRESS?

  

(0 = NO      1 = YES      9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THIS DISTRESS?

(0 = NOT SATISFIED      1 = SATISFIED)

COMMENTS

**HAS THE PERSON HAD CLEAR VERBAL OR WRITTEN INFORMATION ABOUT THEIR CONDITION AND TREATMENT?**

*Have you been given clear information about your condition, medication or other treatment?  
 Do you want such information? How helpful has the information been?*

0 = NO PROBLEM	e.g.	Has received and understood adequate information. Has not received but does not want information. Advanced stage of demenda precludes need.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has not received or understood all information.
2 = SERIOUS PROBLEM	e.g.	Has received inadequate or no information.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 16

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN OBTAINING SUCH INFORMATION?**

0 = NONE		
1 = LOW HELP	e.g.	Some advice.
2 = MODERATE HELP	e.g.	Given leaflets/fact-sheets or put in touch with self-help groups.
3 = HIGH HELP	e.g.	Regular liaison with mental health staff or voluntary groups (e.g. Alzheimer's Disease Society) by friends or relatives.
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?**

**HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?**

0 = NONE		
1 = LOW HELP	e.g.	Brief verbal or written information on illness/problem/treatment.
2 = MODERATE HELP	e.g.	Given details of self-help groups. Long verbal information sessions e.g. during Day Hospital attendance.
3 = HIGH HELP	e.g.	Has been given specific personal education with or without detailed written information.
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP IN OBTAINING INFORMATION?**

(0 = NO      1 = YES      9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN OBTAINING INFORMATION?**

(0 = NOT SATISFIED      1 = SATISFIED)

**COMMENTS**

IS THE PERSON A DANGER TO THEMSELVES?

*Do you ever think of harming yourself or actually harm yourself?*

0 = NO PROBLEM	e.g.	No thoughts of self-harm or suicide
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Suicide risk monitored by staff; receiving counselling.
2 = SERIOUS PROBLEM	e.g.	Has expressed suicidal intent, deliberately neglected self or exposed self to serious danger in the last month.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 17

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE RISK OF DELIBERATE SELF-HARM?

0 = NONE		
1 = LOW HELP	e.g.	Able to contact friends or relatives if feeling unsafe.
2 = MODERATE HELP	e.g.	Friends or relatives are usually in contact and are likely to know if feeling unsafe.
3 = HIGH HELP	e.g.	Friends or relatives in regular contact and are very likely to know and provide help if feeling unsafe.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES TO REDUCE THE RISK OF DELIBERATE SELF-HARM?

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES TO REDUCE THE RISK OF DELIBERATE SELF-HARM?

0 = NONE		
1 = LOW HELP	e.g.	Someone to contact when feeling unsafe.
2 = MODERATE HELP	e.g.	Staff check at least once a week; regular supportive counselling.
3 = HIGH HELP	e.g.	Daily supervision; inpatient care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE RISK OF DELIBERATE SELF-HARM?

(0 = NO      1 = YES      9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE RISK OF DELIBERATE SELF-HARM?

(0 = NOT SATISFIED      1 = SATISFIED)

COMMENTS



**IS THE PERSON AT INADVERTENT RISK TO THEMSELVES?**

      

*Do you ever do anything that accidentally puts yourself in danger (e.g. leaving gas taps on, leaving fire unattended or getting lost)?*

0 = NO PROBLEM	e.g.	No accidental self-harm..
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Specific supervision or help; e.g. memory notes or prompts.
2 = SERIOUS PROBLEM	e.g.	Frequent dangerous behaviour; e.g. getting lost, gas/fire hazard.
9 = NOT KNOWN		

**IF RATED 0 OR 9 GO TO QUESTION 18**

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE THE RISK OF INADVERTENT SELF-HARM?**

      

0 = NONE		
1 = LOW HELP	e.g.	Periodic supervision; weekly or less.
2 = MODERATE HELP	e.g.	Supervision on 3-5 days a week.
3 = HIGH HELP	e.g.	Almost constant supervision/24-hour care.
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES TO REDUCE THE RISK OF INADVERTENT SELF-HARM?**

      

**HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES TO REDUCE THE RISK OF INADVERTENT SELF-HARM?**

      

0 = NONE		
1 = LOW HELP	e.g.	Check on behaviour weekly or less.
2 = MODERATE HELP	e.g.	Daily supervision.
3 = HIGH HELP	e.g.	Constant supervision e.g. residential care.
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE RISK OF INADVERTENT SELF-HARM?**

      

(0 = NO            1 = YES            9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE RISK OF INADVERTENT SELF-HARM?**

(0 = NOT SATISFIED            1 = SATISFIED)

**COMMENTS**

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IS THE PERSON AT RISK FROM OTHERS?

Has anyone done anything to frighten or harm you, or taken advantage of you?

- 0 = NO PROBLEM e.g. No abuse/neglect.
- 1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN e.g. Needs and gets ongoing support or protection.
- 2 = SERIOUS PROBLEM e.g. Regular shouting, pushing or neglect. Financial misappropriation. Physical assault.
- 9 = NOT KNOWN

IF RATED 0 OR 9 GO TO QUESTION 19

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE RISK OF ABUSE?

- 0 = NONE
- 1 = LOW HELP e.g. Occasional advice.
- 2 = MODERATE HELP e.g. Regular support and protection.
- 3 = HIGH HELP e.g. Constant support; very regular protection; negotiation.
- 9 = NOT KNOWN

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES TO REDUCE THE RISK OF ABUSE?

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES TO REDUCE THE RISK OF ABUSE?

- 0 = NONE
- 1 = LOW HELP e.g. Someone to contact when feeling threatened or unsafe.
- 2 = MODERATE HELP e.g. Regular support; occasional respite.
- 3 = HIGH HELP e.g. Constant supervision; legal involvement via services; separation from abuser.
- 9 = NOT KNOWN

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE RISK OF ABUSE?

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE RISK OF ABUSE?

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

[Empty box for comments]

IS THE PERSON'S BEHAVIOUR DANGEROUS, THREATENING, INTERFERING OR ANNOYING TO OTHERS?

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*Do you come into conflict with others e.g. by interfering with their affairs, frequently annoying, threatening or disturbing them? What happens?*

0 = NO PROBLEM	e.g.	No history of disturbance to others.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Under supervision because of potential risk.
2 = SERIOUS PROBLEM	e.g.	Recent violence, threats or seriously interfering behaviour.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 20

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

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0 = NONE		
1 = LOW HELP	e.g.	Help/supervision weekly or less.
2 = MODERATE HELP	e.g.	Help/supervision more often than weekly.
3 = HIGH HELP	e.g.	Almost constant help/supervision due to persistently disturbing behaviour.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?


HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

0 = NONE		
1 = LOW HELP	e.g.	Check on behaviour weekly or less.
2 = MODERATE HELP	e.g.	Daily supervision or night-sitting service.
3 = HIGH HELP	e.g.	Constant supervision; behaviour management programme.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

(0 = NO            1 = YES            9 = NOT KNOWN)

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OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

(0 = NOT SATISFIED                            1 = SATISFIED)

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**COMMENTS**

DOES THE PERSON DRINK EXCESSIVELY OR HAVE A PROBLEM CONTROLLING THEIR DRINKING?

  

*Do you drink alcohol? How much? Does drinking cause you any problems?  
Do you ever feel guilty about it? Do you ever wish you could cut down your drinking?*

0 = NO PROBLEM	e.g.	Doesn't drink or drinks sensibly.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	At risk from alcohol abuse and receiving help.
2 = SERIOUS PROBLEM	e.g.	Current drinking harmful or uncontrollable.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 21

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR THEIR DRINKING?

  

0 = NONE		
1 = LOW HELP	e.g.	Advised to cut down.
2 = MODERATE HELP	e.g.	Advised about helping agencies, e.g. Alcoholics Anonymous.
3 = HIGH HELP	e.g.	Constant support and/or monitoring of alcohol intake.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES FOR THEIR DRINKING?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES FOR THEIR DRINKING?

  

0 = NONE		
1 = LOW HELP	e.g.	Given information and told about risks.
2 = MODERATE HELP	e.g.	Given support and details of helping agencies.
3 = HIGH HELP	e.g.	Attends alcohol clinic, supervised withdrawal programme.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR THEIR DRINKING?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THEIR DRINKING?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

DOES THE PERSON NEED HELP WITH SOCIAL CONTACT?

*Are you happy with your social life?*

*Do you wish you had more social contact with others?*

0 = NO PROBLEM	e.g.	Able to organise enough social contact, has enough contact with friends.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	May be lonely at night but attends appropriate drop-in or day centre or other eg. Lunch Club.
2 = SERIOUS PROBLEM	e.g.	Frequently feels lonely and isolated. Very few social contacts.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 22

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH SOCIAL CONTACT?

0 = NONE		
1 = LOW HELP	e.g.	Social contact/visit less than weekly.
2 = MODERATE HELP	e.g.	Social contact weekly or more often.
3 = HIGH HELP	e.g.	Social contact at least four times a week.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES IN ORGANISING SOCIAL CONTACT?

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES IN ORGANISING SOCIAL CONTACT?

0 = NONE		
1 = LOW HELP	e.g.	Occasional visits from befriender or voluntary worker. Referral to day centre.
2 = MODERATE HELP	e.g.	Regular attendance at day centre; regular luncheon club, organised social activity.
3 = HIGH HELP	e.g.	Day centre attendance or social home visits 3 or more times a week.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH SOCIAL CONTACT?

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH THEIR SOCIAL CONTACT?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

DOES THE PERSON HAVE A PARTNER, RELATIVE OR FRIEND WITH WHOM THEY HAVE A CLOSE EMOTIONAL/PHYSICAL RELATIONSHIP?

  

*Do you have a partner, relative or friend you feel close to? Do you get on well?  
Can you talk about your worries or problems? Do you lack physical contact/intimacy?*

0 = NO PROBLEM	e.g.	Happy with current relationships or does not want any intimate relationship.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Counselling/advice which is helpful.
2 = SERIOUS PROBLEM	e.g.	Desperately lonely. Lack of confidant.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 23

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH INTIMATE RELATIONSHIPS OR LONELINESS?

  

0 = NONE		
1 = LOW HELP	e.g.	Occasional emotional support.
2 = MODERATE HELP	e.g.	Regular support.
3 = HIGH HELP	e.g.	Help contacting counselling services (e.g. bereavement/marriage counselling) and possibly accompanying the person there.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES WITH INTIMATE RELATIONSHIPS OR LONELINESS?

  

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES WITH INTIMATE RELATIONSHIPS OR LONELINESS?

  

0 = NONE		
1 = LOW HELP	e.g.	Some support/advice.
2 = MODERATE HELP	e.g.	Regular support/advice.
3 = HIGH HELP	e.g.	Intensive support. Specific therapy, e.g. marital or bereavement counselling.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH RELATIONSHIPS?

  

(0 = NO                      1 = YES                      9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH RELATIONSHIPS?

(0 = NOT SATISFIED                      1 = SATISFIED)

COMMENTS

**DOES THE PERSON HAVE PROBLEMS MANAGING OR BUDGETING THEIR MONEY?**

        

*Do you have any difficulty managing your money?  
Are you able to pay your bills?*

0 = NO PROBLEM	e.g.	Able to buy essential items and pay bills.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Benefits from help with managing affairs or budgeting.
2 = SERIOUS PROBLEM	e.g.	Often has no money for essential items or bills. Unable to manage finances.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 24

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN MANAGING THEIR MONEY?**

        

0 = NONE		
1 = LOW HELP	e.g.	Occasional help sorting out household bills.
2 = MODERATE HELP	e.g.	Calculating weekly budget. Collecting pension.
3 = HIGH HELP	e.g.	Complete management of finances. Power of Attorney.
9 = NOT KNOWN		

**HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES IN MANAGING THEIR MONEY?**

        

**HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES IN MANAGING THEIR MONEY?**

        

0 = NONE		
1 = LOW HELP	e.g.	Occasional help with budgeting.
2 = MODERATE HELP	e.g.	Supervised in paying rent; given weekly spending money.
3 = HIGH HELP	e.g.	Virtual or complete management of finances; Court of protection; Enduring Power of Attorney.
9 = NOT KNOWN		

**DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP IN MANAGING THEIR MONEY?**

        

(0 = NO            1 = YES            9 = NOT KNOWN)

**OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN MANAGING THEIR MONEY?**

(0 = NOT SATISFIED            1 = SATISFIED)

**COMMENTS**

IS THE PERSON DEFINITELY RECEIVING ALL THE BENEFITS THAT THEY ARE ENTITLED TO?

Are you sure that you are getting all the money that you are entitled to?

- 0 = NO PROBLEM e.g. Has no need of benefits or receiving full entitlement of benefits.
- 1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN e.g. Receives appropriate help in claiming benefits.
- 2 = SERIOUS PROBLEM e.g. Not sure/not receiving full entitlement of benefits.
- 9 = NOT KNOWN

IF RATED 0 OR 9 FINISH OR GO TO CARER'S SECTION OVERLEAF

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT?

- 0 = NONE
- 1 = LOW HELP e.g. Occasionally asks whether person is getting any money.
- 2 = MODERATE HELP e.g. Make enquiries about entitlements and help fill in forms.
- 3 = HIGH HELP e.g. Has ensured full benefits are being received..
- 9 = NOT KNOWN

HOW MUCH HELP DOES THE PERSON RECEIVE FROM LOCAL SERVICES IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT?

HOW MUCH HELP DOES THE PERSON NEED FROM LOCAL SERVICES IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT?

- 0 = NONE
- 1 = LOW HELP e.g. Occasional advice about entitlements.
- 2 = MODERATE HELP e.g. Help with applying for extra entitlements.
- 3 = HIGH HELP e.g. Comprehensive evaluation of current entitlement.
- 9 = NOT KNOWN

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT?

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT?

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

[Empty box for comments]



# A. CARER'S NEED FOR INFORMATION

ASSESSMENTS  
USER STAFF CARER

HAS THE CARER BEEN GIVEN CLEAR INFORMATION ABOUT THE PERSON'S CONDITION AND ALL THE TREATMENT AVAILABLE?

  

*Have you been given clear information about X's condition and all the treatment and services available? How helpful has this information been?*

0 = NO PROBLEM	e.g.	Received and understood.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has not received or understood all information.
2 = SERIOUS PROBLEM	e.g.	Has received little or no information.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION B

HOW MUCH HELP DOES THE CARER RECEIVE FROM FRIENDS OR RELATIVES IN OBTAINING SUCH INFORMATION?

  

0 = NONE		
1 = LOW HELP	e.g.	Has had some advice.
2 = MODERATE HELP	e.g.	Given leaflets/fact-sheets or put in touch with self-help groups.
3 = HIGH HELP	e.g.	Regular liaison with doctors, other professionals, self-help or support groups by friends or relatives.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE CARER RECEIVE FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?

  

HOW MUCH HELP DOES THE CARER NEED FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?

  

0 = NONE		
1 = LOW HELP	e.g.	Brief verbal or written information on condition/problem/treatment.
2 = MODERATE HELP	e.g.	Given details of self-help groups. Personal explanations of drugs, alternative treatments/services and likely course of the condition.
3 = HIGH HELP	e.g.	Has been given detailed written information or has had specific personal education; e.g. from key worker.
9 = NOT KNOWN		

DOES THE CARER RECEIVE THE RIGHT TYPE OF HELP IN OBTAINING SUCH INFORMATION?

  

(0 = NO            1 = YES            9 = NOT KNOWN)

OVERALL, IS THE CARER SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN OBTAINING SUCH INFORMATION?

(0 = NOT SATISFIED            1 = SATISFIED)

COMMENTS

IS THE CARER CURRENTLY PSYCHOLOGICALLY DISTRESSED?

*Do you find it difficult or stressful caring for X? Do you feel you need a break or much more support for yourself?*

0 = NO PROBLEM	e.g.	Coping well.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some stress; receiving help.
2 = SERIOUS PROBLEM	e.g.	Consider themselves seriously stressed or depressed. Wants relief from caring.
9 = NOT KNOWN		

IF RATED 0 OR 9 FINISH

HOW MUCH HELP DOES THE CARER RECEIVE FROM FRIENDS OR RELATIVES FOR THIS DISTRESS?

0 = NONE		
1 = LOW HELP	e.g.	Occasional advice/support.
2 = MODERATE HELP	e.g.	Weekly practical and/or emotional support and/or relief from caring.
3 = HIGH HELP	e.g.	Regular respite and assistance with tasks (e.g. 3-4 times per week).
9 = NOT KNOWN		

HOW MUCH HELP DOES THE CARER RECEIVE FROM LOCAL SERVICES FOR THIS DISTRESS?

HOW MUCH HELP DOES THE CARER NEED FROM LOCAL SERVICES FOR THIS DISTRESS?

0 = NONE		
1 = LOW HELP	e.g.	Advice e.g. about other options such as residential care.
2 = MODERATE HELP	e.g.	Weekly day care; occasional respite; CPN visits; carers' support groups.
3 = HIGH HELP	e.g.	Regular respite admissions. Treatment and/or counselling for stress/depression.
9 = NOT KNOWN		

DOES THE CARER RECEIVE THE RIGHT TYPE OF HELP FOR THIS DISTRESS?

(0 = NO      1 = YES      9 = NOT KNOWN)

OVERALL, IS THE CARER SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THIS DISTRESS?

(0 = NOT SATISFIED      1 = SATISFIED)

COMMENTS

[Empty box for comments]

## Is CANE able?

**Dr Kunle Ashaye** of St Margaret's Hospital in Essex reminded delegates that the Community Care Act and other initiatives call for an assessment of patient needs, both those that are being met and those that are not being met. The Camberwell Assessment of Need is an instrument designed (among other things) to assess such needs in patients with severe mental illness. A version of this instrument has now been produced for older patients – the Camberwell Assessment of Need for the Elderly (CANE).

### *Day hospital test*

The CANE contains 24 items. It records the views of patients, staff and carers, and has both good construct validity and inter-rater reliability. The important questions are: does its use improve outcomes, compared with the multidisciplinary team assessment currently practised in day hospitals? and does feedback from CANE enable staff to improve the degree to which patients' needs can be met?

In an attempt to answer these questions, 112 patients at two day hospitals (one urban, one rural) were randomised into two groups. Patients had an average age of 76.4 and the ratio of women to men was 2:1. More than half were living alone, and 75% were widowed or single. Sixty-one percent had a diagnosis of depression.

All patients were assessed with the CANE on admission, and again three months later. They were also assessed using the Health of the Nation Outcome Scales (HoNOS) and with the Clifton Assessment Procedure for the Elderly – Behaviour Rating Scales (CAPE-BRS).

### *No difference in outcome*

In one group, information from the CANE with suggested interventions was fed back to the staff. In the other, it was withheld. Results showed that the number of needs identified by the CANE (nine) was greater than that for other routine day hospital assessments (six). Suggested interventions from the CANE included supportive psychotherapy, medical review, day centre referral and introduction to social groups.

However, there were no outcome differences at the three-month reassessment in the intervention group compared with the non-intervention group, in terms of proportion of needs met or HoNOS or CAPE-BRS scores.

So, despite that fact that the CANE was superior to team assessment for the measure-



**Dr Kunle Ashaye**

*St Margaret's Hospital, Essex*

ment of needs, outcome was not significantly affected. The day hospital procedures were found to be fairly adequate themselves in assessing the needs of older psychiatric patients, with no difference between urban and rural areas. However, Dr Ashaye concluded that: 'There is a need for more research into how improved needs assessment can be translated into better implementation of interventions and hence improved outcome.' ■



*An attentive audience*