



1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, **11**, 261–278.

KOSTEN, T. R., ROUNSAVILLE, B. J. & KLEBER, H. D. (1987) A 2.5-year follow-up of cocaine use among treated opioid addicts: have our treatments helped? *Archives of General Psychiatry*, **44**, 281–284.

MARZUK, P. M., TARDIFF, K., LEON, A. C., et al (1982) Prevalence of cocaine use among residents of New York City who committed suicide during a one-year period. *American Journal of Psychiatry*, **149**, 371–375.

NATIONAL ADVISORY COMMITTEE ON DRUGS (2007) *An Overview of Cocaine Use in Ireland II*. The Stationery Office Dublin.

NATIONAL ADVISORY COMMITTEE ON DRUGS & THE DRUG AND ALCOHOL INFORMATION AND RESEARCH UNIT (2008) *Drug Use in Ireland and Northern Ireland: First Results from the 2006/2007 Drug Prevalence Survey*. NACD.

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RAWSON, R. A., HUBER, A., McCANN, M. J., et al (2002) A comparison of contingency management and cognitive-behavioral approaches during methadone maintenance treatment for cocaine dependence. *Archives of General Psychiatry*, **59**, 817–824.

Psychiatric Bulletin (2009), **33**, 91–95. doi: 10.1192/pb.bp.107.017392

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Older people with enduring mental illness: a needs assessment tool

AIMS AND METHOD

There is a lack of tools to assess the needs of older people with enduring mental illness who have 'graduated' from adult mental health services and little is known about this population. The Elderly Psychiatric Needs Schedule (EPNS) was developed and applied to older people with enduring mental illness in

contact with the old age and general adult components of an inner-city mental health service.

RESULTS

The EPNS proved reliable (mean agreement 96%, mean Kappa $\kappa=0.90$). The mean number of needs identified was 7.6, of which 4.3 were unmet and 3.3 were met.

CLINICAL IMPLICATIONS

The EPNS provided a reliable method of needs assessment in this population. The authors offer the EPNS as a tool to assess service needs of older adults with functional psychiatric disorders having 'graduated' from adult mental health services.

In common with mental healthcare in general the provision of services for elderly people is shifting from in-patient treatment to the community (Gatz & Smyer, 1992; Campbell, 1994). There is evidence that functionally mentally ill, former long-stay elderly patients who are resettled into community provision do well (Holloway et al, 1994; Anderson & Treiman, 1995). However, less is known about the fate of those becoming 'older people with enduring mental illness' in contemporary community-oriented services (Abdul-Hamid et al, 1998). 'Graduate' is a term that describes people with severe psychiatric disorders who have graduated into old age (Arie & Jolly, 1982).

The pragmatic approach to needs for care assessment has informed the development of a series of needs assessment tools (Wykes et al, 1982; 1985, Brewin et al, 1987; 1988; Brugha et al, 1988; Abdul-Hamid, 1991; Marshall et al, 1995). The Camberwell Assessment of Need (CAN) was developed by Phelan et al (1995). It provides comprehensive needs assessment for adults and has been shown to be easy to use, valid and reliable. McWalter et al (1998) described the development and reliability and validity of the Care Needs Assessment Pack for Dementia (CARENAPD). There is, however, a lack of simple and effective tools to assess the needs of elderly people with a functional mental illness (older people with enduring mental illness). In the current study we report the development and application of such an assessment

tool to a population of older people with enduring mental illness.

Method

The aims of this study were to: determine the reliability and validity of a novel needs assessment method, the Elderly Psychiatric Needs Schedule (EPNS); to undertake a point prevalence survey of older people with enduring mental illness in contact with specialist mental health services (both generic and elderly); and to undertake a needs assessment of this population.

The study was carried out in Norwood, which had a total population of 41 740 and is an ethnically diverse and socially deprived part of inner London, of whom 5472 were over 65 years (1991 census). The study population included all people at or over the age of 60 with a functional mental illness who were in contact with the catchment area psychiatric services (both old age and general adult services) and who had an onset of illness before the age of 60.

Along with people who were over 65 years of age, a pre-elderly group of people who were 60–65 years of age were included since these 'pre-elderly group' people are likely to become older people with enduring mental illness within 5 years. Hospital medical notes of more than 300 Norwood patients who were at or over the age of 60 were reviewed and 77 older people with enduring



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mental illness were identified. The definition of older people with enduring mental illness used was that of Arie & Jolley (1982): those who have functional psychiatric disorder before the age of 60 and continue to be in contact with psychiatric services. To make the survey more representative, this included both those under the community team and those seen at the out-patient department only. A recent study showed that these two groups of patients could need different levels of intervention provided between 'complex' and 'routine' patients (Mehta et al, 2007). Of the 77 people identified, 75 were interviewed (2 were untraceable) and their psychiatric keyworker was also interviewed separately.

Development of the EPNS

The EPNS is a needs assessment procedure that was developed to assess the mental health services needs of elderly people. The old age psychiatry community team serving the East Lambeth catchment area was surveyed in a non-structured way using qualitative methods to identify the needs the team was currently meeting. Items generated by this exercise were fed back to the team in a structured questionnaire in order to assess the relevance of each item of need identified in the first stage. The items that were scored by the team as relevant or very relevant were chosen and were used to construct the EPNS (see online supplement to this paper). This scale uses a scoring system similar to that of the CAN (Phelan et al, 1995) and the Needs Schedule (Abdul-Hamid, 1991), but it differs in the fact that the needs assessment procedure has followed Stewart's (1979) assessment scheme with the judgement on the presence of need flowing from the presence of a 'problem' to the 'desires' of the patients and their carers and finally to the intervention ('solution') applied to meet the need if any. It also differs in the inclusion of the carers' perception of the presence or absence of need in addition to that of staff and patients. The scoring is in two stages. First, to assess whether there is a problem that causes the need on each item. A second rating is then made as to whether the patient and their carer desire the need to be met and then what has been done to meet the need. The EPNS provides ratings on individual need domains and can additionally provide an overall score of total need, met need (fully and partially met) and unmet need (owing to lack of service or assessment and patient refusal). Two independent raters rated the needs of a subsample of the participants using the EPNS to assess the inter-observer reliability.

Statistical analysis

The statistical analysis included the following statistical methods: producing simple frequencies of study variables in the sample, and bivariate analysis to establish reliability (using Kappa test and weighted Kappa tests) and the internal consistency (using Cronbach's alpha reliability test).

Results

Table 1 presents basic demographic features of the sample. The ethnic origin reflected the demographic structure of the elderly population of Norwood. In contrast with samples of younger people with severe mental illness, only a minority (34%) were single and 35% were married or cohabiting. The majority of participants had a case-note diagnosis of a psychotic illness (schizophrenia 41%, schizoaffective psychosis 5% and bipolar affective disorder 7%). Forty-one per cent of the sample had a diagnosis of depression without psychotic features.

The EPNS was used to assess the needs of Norwood's older people with enduring mental illness. This schedule covers 20 items that constitute the different needs of elderly people with psychiatric illness. The global scoring of each item identifies the need as either non-existent (no need), unmet because of lack of provision of service, unmet because of a patient's refusal to utilise services, partially met need when the service used was not effective in meeting the need, or need met when an effective intervention was used to alleviate the need (Table 2).

Table 1. Demographic and clinical characteristics of Norwood's older people with enduring mental illness

Characteristic	Participants (n=77)
Age group: years, n (%)	
60–65	20 (26)
65+	57 (74)
Gender, n (%)	
Male	30 (39)
Female	47 (61)
Marital status, n (%)	
Single	26 (34)
Married	23 (30)
Divorced/separated	15 (19)
Widowed	9 (12)
Cohabiting	4 (5)
Ethnic origin, n (%)	
White	69 (89)
Caribbean	4 (5)
African	1 (1)
Asian	3 (4)
Diagnosis, n (%)	
Schizophrenia	32 (41)
Bipolar disorder	5 (7)
Schizoaffective disorder	4 (5)
Depression	32 (41)
Psychopathology scores, mean (s.d.)	
Brief Psychiatric Rating Scale score	35.5 (10.7)
Clifton Assessment Procedures for the Elderly score	6.5 (6.5)
Mini-Mental State Examination score	26.5 (4.4)
Geriatric Depression Scale score ^a	5.1 (4.0)

a. Yesavage et al, 1983.

**Table 2. The psychiatric needs of Norwood's older people with enduring mental illness**

Item	No need, n (%)	Unmet need, n (%)	Patient refused, n (%)	Partially met need, n (%)	Met need, n (%)
1. Psychiatric assessment and treatment needs	0	0	7 (10.6)	16 (24.2)	43 (65.2)
2. Dementia assessment and management needs	60 (90.9)	2 (3)	1 (1.5)	2 (3)	1 (1.5)
3. Management of medication	42 (63.6)	0	6 (9.1)	2 (3)	16 (24.2)
4. Substance misuse services needs	60 (90.9)	1 (1.5)	4 (6.1)	0	1 (1.5)
5. Physical health needs	36 (54.5)	1 (1.5)	1 (1.5)	13 (19.7)	15 (22.7)
6. Communication needs	63 (95.5)	1 (1.5)	0	2 (3)	0
7. Mobility needs	42 (63.6)	3 (4.5)	2 (3)	11 (16.7)	8 (12.1)
8. Incontinence service needs	55 (83.3)	3 (4.5)	2 (3)	0	6 (9.1)
9. Self-care needs	40 (60.6)	1 (1.5)	2 (3)	8 (12.1)	15 (22.7)
10. Domestic management needs	37 (56.1)	3 (4.5)	2 (3)	5 (7.6)	19 (28.8)
11. Food and eating needs	39 (59.1)	0	1 (1.5)	3 (4.5)	23 (34.8)
12. Safety and protection needs	50 (75.8)	3 (4.5)	1 (1.5)	5 (7.6)	7 (10.6)
13. Social activity needs	33 (50)	5 (7.6)	18 (27.3)	4 (6.1)	6 (9.1)
14. Day-care needs	32 (48.5)	5 (7.6)	18 (27.3)	5 (7.6)	9 (13.6)
15. Money and benefits needs	47 (71.2)	0	1 (1.5)	2 (3)	16 (24.2)
16. Transport needs	44 (66.7)	6 (9.1)	1 (1.5)	3 (4.5)	12 (18.2)
17. Housing needs	48 (72.7)	3 (4.5)	4 (6.1)	3 (4.5)	8 (12.1)
18. Ethnic and cultural needs	62 (93.9)	1 (1.5)	0	0	3 (4.5)
19. Management of patient's affairs	54 (81.8)	0	1 (1.5)	0	11 (16.7)
20. Other needs	61 (90.9)	1 (1.5)	2 (3)	1 (1.5)	1 (1.5)

Table 3. Reliability of the Elderly Psychiatric Needs Schedule

Item	Agreement, %	κ
1. Psychiatric assessment and treatment needs	99	0.95
2. Dementia assessment and management needs	100	1.00
3. Management of medication	100	1.00
4. Substance misuse services needs	99	0.78
5. Physical health needs	100	1.00
6. Communication needs	100	1.00
7. Mobility needs	96	0.89
8. Incontinence service needs	100	1.00
9. Self-care needs	98	0.94
10. Domestic management needs.	97	0.94
11. Food and eating needs.	73	0.41
12. Safety and protection needs	100	1.00
13. Social activity needs	100	1.00
14. Day-care needs	99	0.97
15. Money and benefits needs	85	0.65
16. Transport needs	100	1.00
17. Housing needs	98	0.95
18. Ethnic and cultural needs	100	1.00
19. Management of patient's affairs	88	0.56
20. Other needs	100	1.00

The reliability the EPNS

Two interviewers assessed 20 of the study participants independently using the EPNS. The percentage agreement and Kappa (κ) scores were calculated for each item (Table 3). The percentage agreement varied between 73% in the food and eating needs to 100% on ten of the items. The mean percentage agreement was 96%. Kappa varied from $\kappa=0.41$ in food and eating needs to $\kappa=1$ on ten of the items; mean $\kappa=0.90$. The internal consistency of the items of the scale using Cronbach's alpha reliability test has revealed a value of 0.84, which indicates that the scale has a good internal consistency and justifies the summing across items.

The prevalence of need

The mean number of total needs (met, unmet, partially met and not met because of refusal) was 7.4 (s.d.=5.5). The needs could be classified into unmet needs and met needs.

Unmet needs

This includes unmet needs due to lack of provision or because of a patient's refusal. The mean number of unmet needs of the sample was 4.3 (s.d.=5.4). The breakdown of the overall score of the EPNS is shown in Table 2. The unmet needs due to lack of service was highest for transport needs (9.1% of the sample) then social activity

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(7.6%) and day care (7.6%). Mobility needs, incontinence service needs, self-care needs and housing needs were each identified in 4.5% of the sample. The unmet needs because of patient refusal was highest for social activity needs (27.3%), day-care needs (27.2%), management of medication (9.1%), substance misuse service needs (6.1%) and housing needs (6.1%).

Met needs

These needs could be classified into partially met needs and met needs. The partially met needs were highest in psychiatric assessment and treatment needs (24.2%), physical health needs (19.7%), mobility needs (16.7%), self-care needs (12.1%), safety and protection needs (7.6%), day-care needs (7.6%) and social activity needs (6.1%). The met needs were highest in psychiatric assessment and treatment needs (65.2%), food and eating needs (34.8%), domestic management needs (28.8%), management of medication (24.2%), physical health needs (22.7%) and self-care needs (22.7%).

Discussion

The literature on older people with enduring mental illness raises more questions than it answers (Abdul-Hamid & Silverman, 1998). In this era of community care there is still very little information on the numbers of these people in the community, their problems, needs or the service provision already in place to satisfy their needs.

It is known that a significant number of older people with enduring mental illness who were placed in the community are living in nursing homes. There are conflicting reports about the suitability of these homes as places to meet the needs of these people (Dencker & Gottfries, 1991; Holloway *et al*, 1994). We do not know how much psychiatric input there is into these homes and how far the services are involved in the assessment, monitoring, rehabilitation, treatment and follow-up of these individuals.

There is clearly a need for studies to locate and quantify the elderly graduate population. This study has aimed to assess the psychiatric and medical needs of older people with enduring mental illness using a needs schedule derived from previous needs tools but specifically developed for this purpose. The first aim of this study was to assess the reliability and validity of this scale. The interrater reliability was generally very good and on 10 out of the 20 items the agreement was complete. The two raters (W.A-H. and K.L-C.) undertook training on the assessment and a manual was developed (the EPNS and manual are available from the first author). Construct validity of the EPNS was assessed by comparing it with a variety of well-known assessment tools used in the elderly population. The total needs score of the EPNS correlated highly with the Clifton Assessment Procedures for the Elderly (CAPE; Pattie & Gilleard, 1979) total score, which is a measure of overall disability. It correlated less well with the Brief Psychiatric Rating Scale (BPRS; Ventura *et al*, 1993), which is a measure of psychiatric symptoms, and the Mini-Mental State

Examination (MMSE; Folstein *et al*, 1975), which is a measure of cognitive state. The total score of unmet needs showed a similar pattern. The unmet needs scores showed the highest correlation with the BPRS, which suggests that people who are not receiving the full range of services are exhibiting more symptoms.

It is important to note that one of the study limitations is the lack of control for different diagnoses. As recent work has shown that the level of intervention provided could differ between 'complex' and 'routine' patients (Mehta *et al*, 2007), a larger study might be needed to control for diagnosis. The findings on the prevalence of need identifies the range of problems that older people with enduring mental illness present to community mental health services, which differs significantly from their younger counterparts. Unsurprisingly, all participants had needs for psychiatric treatment and care. Although the mean MMSE score for the sample was 26.5, clinically significant dementia was rated as being uncommon in the sample that had an EPNS rating (9%). However, overall, more than 40% of the sample had needs in the domains of day care (54%), social activity (50%), physical health (46%), domestic management (44%) and food (41%). A small but significant proportion had a need for incontinence services (17%).

Encouragingly, none of the psychiatric and treatment needs of the older people with enduring mental illness were unmet due to lack of service provision. One may say that this is expected in a sample that is chosen from people in contact with the service. However, 11% had unmet needs due to refusal and 24% had only partly met psychiatric and assessment needs. The service should develop ways of reaching and meeting the needs of these individuals.

The main unmet needs due to lack of service provision were in the domains of transport, social activities and day care, mobility needs, incontinence service needs, self-care needs, housing needs and dementia assessment needs. That the unmet needs for dementia assessment were higher than the met needs (though small in numbers) highlights the problem of underestimation of dementia in the elderly graduate population (Harvey *et al*, 1992; Anderson & Trieman, 1995).

Refusal was, in general, more common than unmet need because of a lack of service or failure to carry out an assessment. The main unmet needs identified in the study that resulted from a patient's refusal were social activity needs, day-care needs, management of medication, substance misuse service needs and housing needs. Clearly these are important aspects of the care of older people with enduring mental illness and the services should address the reasons for refusal and seek ways of making services more acceptable.

Declaration of interest

None. Funding detailed in Acknowledgements.



Acknowledgements

This study was funded by the Maudsley Hospital Health Research Grant which funded the salary of K.L.-C. for 6 months.

References

- ABDUL-HAMID, W. (1991) *Homeless People and Community Care: An Assessment of the Needs of Homeless People for Mental Health Services*. University of London, PhD thesis.
- ABDUL-HAMID, W. & SILVERMAN, M. (1998) Needs assessment in old age psychiatry. *International Journal of Geriatric Psychiatry*, **10**, 533–540.
- ANDERSON, J. & TRIEMAN, N. (1995) The TAPS Project. 21: functional and organic comorbidity and the effect of cognitive and behavioural disability on the placement of elderly psychiatric inpatients – a whole hospital survey. *International Journal of Geriatric Psychiatry*, **10**, 959–966.
- ARIE, T. & JOLLEY, D. J. (1982) Making services work: organization and style of psychogeriatric services. In *The Psychiatry of Late Life* (eds R. Levy & F. Post), pp. 222–251. Blackwell.
- BREWIN, C. R., WING, J. K., MANGEN, S. P., et al (1987) Principle and practice of measuring need in the long-term mentally ill: the MRC Needs for Care Assessment. *Psychological Medicine*, **17**, 971–981.
- BREWIN, C. R., WING, J. K., MANGEN, S. P., et al (1988) Needs for care among the long-term mentally ill: a report from Camberwell high contact survey. *Psychological Medicine*, **18**, 457–468.
- BRUGHA, T. S., WING, J. K., BREWIN, C. R., et al (1988) The problems of people in long-term psychiatric care. An introduction to the Camberwell High Contact Survey. *Psychological Medicine*, **18**, 443–456.
- CAMPBELL, P. G. (1994) Graduates. In *Psychiatry in the Elderly* (eds R. Jacoby & C. Oppenheimer). Oxford University Press.
- DENCKER, K., GOTTFRIES, C. (1991) The closure of a major psychiatric hospital: can psychiatric patients in long-term care be integrated into existing nursing homes? *Journal of Geriatric Psychiatry and Neurology*, **4**, 149–156.
- FOLSTEIN, M., FOLSTEIN, S. & MCHUGH, P. (1975) 'Mini-Mental State' a practical method of grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 189–198.
- GATZ, M. & SMYER, M. A. (1992) The mental health system and older adults in the 1990s. *American Psychologist*, **47**, 741–751.
- HARVEY, P. D., DAVIDSON, M., POWCHIK, P., et al (1992) Assessment of dementia in elderly schizophrenics with structured rating scales. *Schizophrenia Research*, **7**, 85–90.
- HOLLOWAY, F., RUTHERFORD, J., CARSON, J., et al (1994) 'Graduates' and a hospital closure programme. *Psychiatric Bulletin*, **18**, 534–537.
- MARSHALL, M., HOGG, L., LOCKWOOD, A., et al (1995) The Cardinal Needs Schedule. A modified version of the MRC Needs for Care Schedule. *Psychological Medicine*, **25**, 605–617.
- McWALTER, G., TONER, H., McWALTER, A., et al (1998) A community needs assessment: the care needs assessment pack for dementia (CARENAPD) – its development, reliability and validity. *International Journal of Geriatric Psychiatry*, **13**, 16–22.
- MEHTA, S., SALVAJI, A., ABED, R. (2007) Roles of general adult psychiatrists in follow-up clinics. *Psychiatric Bulletin*, **31**, 381–384.
- PATTIE, A. H. & GILLEARD, C. J. (1979) *Clifton Assessment Procedures for the Elderly*. Stoughton Educational.
- PHELAN, M., SLADE, M., THORNICROFT, G., et al (1995) The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry*, **167**, 589–595.
- STEWART, R. (1979) The nature of needs assessment in community mental health. *Community Mental Health Journal*, **15**, 287–295.
- VENTURA, J., GREEN, M. F., SHANTER, A., et al (1993) Training and quality assurance with the Brief Psychiatric Rating Scale: 'the drift buster'. *International Journal of Methods in Psychiatric Research*, **3**, 221–244.
- WYKES, T., CREER, C. & STURT, W. (1982) Needs and the deployment of services. In *Psychological Medicine Monograph Supplement No. 2* (ed. J. K. Wing), pp. 41–55. Cambridge University Press.
- WYKES, T., STURT, E. & CREER, C. (1985) The assessment of patients' needs for community care. *Social Psychiatry*, **20**, 76–85.
- YESAVAGE, J. A., BRINK, T. L., ROSE, T. L., et al (1983) Development and validation of a geriatric depression screening scale: a preliminary report. *Journal of Psychiatric Research*, **17**, 37–49.

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Psychiatric Bulletin (2009), **33**, 95–98. doi: 10.1192/pb.bp.107.018853

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Unilateral and bilateral electroconvulsive therapy: what informs Scottish psychiatrists' choices?

AIMS AND METHOD

A postal questionnaire was sent to Scottish consultant psychiatrists asking about their attitudes towards unilateral and bilateral electroconvulsive therapy (ECT), and the difference in effectiveness between the two ECT types that they considered clinically significant.

RESULTS

The response rate was 61%. Of those that responded, 62% were prescribers of ECT and most (79%) favoured bilateral ECT over unilateral ECT. The outcome that they were most concerned with was remission rate: 97% believe that an absolute difference of more than 5% in

remission rate would make the difference in effectiveness between the two types of ECT clinically important.

CLINICAL IMPLICATIONS

Future investigators should focus on comparative remission rates of bilateral and unilateral ECT.

In 2003, the UK ECT Review Group published a systematic review and meta-analysis reviewing the evidence on a number of variables relating to electroconvulsive therapy (ECT). In this review, bilateral ECT was found to be moderately more effective than unilateral ECT, and the

latter produced fewer adverse cognitive effects. However, all stimulus intensities were combined when comparing bilateral with unilateral ECT including sub-optimal dosages of unilateral ECT, which makes the evidence for advantage of bilateral over unilateral ECT