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EDITORIAL

Assessment of need

Hospital doctors will be familiar with the situation in which the general practitioner's referral letter mentions one problem, the patient complains of another and their carer describes a third. In the busy clinic, having to untangle three sets of problems may be frustrating—it prolongs the consultation and necessitates more complex explanations than might otherwise be the case. However, we all realise that professional, patient and carer perspectives are central to a full assessment of an older person. In both inpatient and outpatient geriatric practice, this is usually achieved by comprehensive multidisciplinary assessment. This includes team discussion, which enables individual perspectives to be synthesized into a common goal-orientated treatment plan.

In general practice, where staffing levels are often more limited, a different approach is required. In the United Kingdom, the over-75 check typically involves an uni-professional assessment. It can be undertaken in a wide variety of ways, covering the required areas of physical health, medication, mobility, special senses, cognition and social support. A recent review has highlighted the diversity of practice in where the assessment is done, the approaches used (opportunistic *versus* mailing), the discipline of the person doing the assessment and the use of standardized assessment tools [1]. This variation is even more interesting in that the practices involved had all identified themselves as being exemplars of good practice.

Tools for the assessment of need

The undoubted benefits of accurate assessment of need and on-going treatment [2] have fostered the development of easy-to-use screening tools, such as the Epic Assessment System (EASY) [3]. An investigation using a new instrument, the Camberwell Assessment of Need for the Elderly (CANE), in this issue of *Age and Ageing* gives further insights into the complexity of evaluating need [4]. The unusual features of this instrument are that both met and unmet need are identified and that information is sought from the patient, carer (if they have one) and the patient's 'lead health professional' (which in this case was most frequently the general practitioner). The questionnaire derives from an instrument intended for the assessment of mental health problems in people at home, the Camberwell Assessment of Need [5].

The CANE was developed following a modified Delphi process. It has undergone validation, with good correlation between its relevant parts and other tools widely used for assessing disability, carer stress, health status and dependence [6]. CANE examines 24 physical, psychological and social patient domains, including often-neglected areas such as alcohol, caring for someone else, company, benefits and two carer domains—need for information and psychological distress. Once a problem is identified, further information is obtained about its severity and whether help for this problem is appropriate and satisfactory.

The sample studied was relatively small (84 subjects drawn randomly from four London general practices) and therefore the results should be treated cautiously—particularly as CANE has not been validated outside the mental health setting. However, two sets of interesting findings emerge. Although not entirely surprising, they lend credibility to the approach that has been developed. The first is that, despite the existence of over-75 checks in the general practices studied, many unmet needs were identified. The patients reported eyesight, hearing problems and psychological distress most frequently, whilst lead health professionals identified needs in the domains of daytime activity and accommodation. The second interesting observation was the general lack of agreement between patients and health professionals about their needs. This level was judged to be poor or fair in 18 of the 24 patient domains, moderate in three and good in three. However, none met the criteria for very good agreement. The reasons for these differences of view need to be explored further.

Implications

This study raises several questions: can there ever be a standard method of assessing need across the wide range of domains covered by CANE? Do people tell the truth about their needs, or is there a tendency to tell interviewers what they think interviewers might want to hear? Do some of the differences detected in met and unmet need by the different groups reflect different meanings of the word 'need'?

The observation that no cases of unmet need were found in certain areas indicates that CANE might be too complex for routine use in primary care. Indeed, Walters *et al.* are developing a simplified version for routine use. Modifications might also be needed for assessing need in residential homes and other social-care settings. Minority ethnic elders may have different health perceptions and beliefs [7, 8], and tools such as CANE will need to be evaluated in each such group individually. This would then lead on to a more detailed assessment when needs are identified.

At the moment (in the UK at least) there appears to be a general reluctance to use a common standard instrument to assess need and it is unlikely that this attitude will change in the foreseeable future. The Government seems committed to developing a health service workforce trained to assess and improve the health and welfare of older people [9]. Integrating instruments such as CANE will be part of that process and may be of value in developing a consensus on needs assessment. The question, then, is how best to meet needs, thus realising for all the benefits that have been demonstrated in clinical trials.

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