NEEDS AND SERVICES AT WARD ONE, VALKENBERG HOSPITAL

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ABSTRACT

The mental health needs of patients entering the program at ward one, Valkenberg Hospital, are not routinely measured. Their presenting problems are frequently complicated by basic and social needs, which impact on recovery and re-integration into the community. The Camberwell Assessment of Need is a valid and reliable instrument used to measure the mental health needs of psychiatric patients. In this study, this instrument was used with some modifications to assess the needs of patients on admission to ward one. At discharge, these needs were explored to measure the extent to which services and interventions were useful in meeting those needs. Where not, questions aimed at elucidating impediments to care were asked.

All 60 patients completing the program agreed to participate. The average number of total needs on admission was 9.2, which included an average of 6.7 unmet needs. Psychiatric needs were the most commonly reported, with a need in the area of "depression" being declared in 59 patients. Help received prior to admission was scant, and patients had high expectations of ward one.

Help received from ward one was highest in areas of psychiatric needs, with 89.8% of patients receiving moderate or high help in the area of depression. More than two-thirds of patients reported receiving low help in basic areas such as, accommodation, self care, and sexual expression. The services most often regarded as useful were organised group activities and therapies. Paired t-tests revealed that the patients without borderline personality had more unmet needs on admission. Regression analysis suggests that younger age and lower level of education confer a greater risk of unmet needs on admission and discharge.

The routine use of a needs assessment instrument is recommended as an aid to guide clinicians. Attention needs to be given to basic and social needs, such as accommodation, daily activities and company, prior to admission to hospital. Where these needs persist, the active involvement of a social worker and occupational therapist is suggested. The high numbers of unmet needs in domains other than psychiatric problems, requires the input of the multidisciplinary team.

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DECLARATION

I, John Anton Joska, hereby declare that the work comprising this dissertation is based on my original work (except where indicated otherwise) and that neither the whole work or any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Signed by candidate

J.A. Joska

12 March 2004

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1. INTRODUCTION

This chapter will serve three purposes: firstly, to outline the reasons for conducting this study; secondly, to introduce a number of important concepts and define key terminology; and thirdly, to describe three important needs assessment instruments.

1.1. Context

Ward one at Valkenberg Hospital, Observatory, is a short stay therapeutic unit. Patients admitted to the unit are usually referred from primary care services or from within the mental health care system itself. As such, the majority enter the system with diagnoses that are derived from semi-structured diagnostic interviews administered by mental health care practitioners.

The diagnostic system applied in this setting is based on the Diagnostic and Statistical Manual, fourth edition (DSM IV) of the American Psychiatric Association (A.P.A., 1994). Patients admitted to the unit suffer from a variety of conditions, the majority of which are depressive or anxiety disorders. Not uncommonly, patients also attract personality disorder diagnoses on axis II. Once on the unit, the individual is entered into a program aimed at symptom reduction and re-integration into the community. Discharge follows when case managers, together with the staff team, have decided that sufficient amelioration of symptoms has taken place for the person to be re-integrated into the community. In a few cases, discharge follows an inability to follow ward protocol, because of anti-social behaviour, disinhibited or disorganised behaviour. In these cases, management is more appropriate elsewhere in the admissions system.

In every case, the patient is allocated a case manager who attempts to tailor treatment according to the presenting symptomatology. The degree to which patient and therapist

concur on treatment needs may be highly variable, and is not always easily measured. For example, patients may require interventions aimed more at psycho-social issues, whilst therapists may target mood or anxiety symptoms directly, using medication or psychotherapy. Even when a patient's perceived needs and the therapist's opinion are in agreement, the paucity of resources may not allow for an adequate resolution of the presenting problem. In our community, issues such as housing shortages and depleted financial resources are prominent. Unemployment due to psychiatric disability and low literacy rates complicate many management scenarios. The issue of whether complex therapeutic interventions are appropriate and effective in this setting forms the subject of this study: are patient's perceptions of their needs on admission met by the services provided by the program?

1.2. Motivation for the study

As a trainee in psychiatry, I was allocated to the ward one program in my third year of training. During my five months on the unit, I noticed that patient's symptoms frequently resolved shortly after admission, only to return shortly after discharge. I assumed that their psycho-social context was responsible for this idiosyncratic display of symptoms. In addition, I observed that ward one was a complex environment. It offered multiple therapeutic opportunities, as well as a number of social encounters. The latter group included free leisure time, visiting hours under controlled conditions, and informal interactions with fellow patients. It then occurred to me that these were not insignificant experiences, and I resolved to measure their effects in some way. Rudimentary discharge questionnaires I found to be arbitrary and unhelpful. It became apparent that a careful study of the ward one program was required.

1.3. Broad outline of the study

Following on the above motivation, the aims and objectives of the study can be summarised as follows: An assessment of the needs of patients admitted to the ward one psychiatric service was be done. This took place within 2 days of admission, as far as possible. The results were kept until the patient was ready for discharge. At this time, in addition to basic information about length of stay and discharge diagnosis, patients were asked about each recorded need. If needs were sufficiently met, the usefulness of a set of ward interventions was be noted. If the need was not sufficiently met, patients were asked to record what barriers accounted for the need not being met.

1.4. Definitions

1.4.1. Need

The term "need" has created controversy through its inherent ambiguity (Slade, 1994). In general terms, needs may be defined as deficits in skills, accommodation, social function, and health (Stein and Test, 1980). While health deficits in the mental health setting emphasise psychiatric symptoms, physical symptoms may be just as disabling and produce need just as frequently (Hansson et al, 1995). These needs are frequently ignored or attributed to psychopathology.

The concept of lack of intervention for needs is also important in defining need. Shapiro et al proposed that the lack of access to care or appropriate level of care was also by definition a need (1985). In addition, need may be defined as the lack of specific interventions by health professionals (Brewin, 1993). The latter may reflect either a need for care (including specific interventions), or a need for services (services to provide these interventions).

In the first instance, needs in a population may be reported by clinicians: so-called "expert-based" needs assessments. An

underlying assumption is that that clients are less able to report their own needs, and particularly if they are mentally ill. Secondly, health care users (or "subjects") themselves, provide so-called "perceived" needs assessments (Slade and Thornicroft, 1994). Lasalvia et al (2000) refer to the expert-based approach as "objective" (or "normative") and the client-based approach as "subjective" (or "negotiated"). A negotiated approach requires a dynamic and flexible view, which is more client-centered. There is some debate as to the contribution of these views. Expert defined assessments are described as having the "considerable potential" for idiosyncrasy (Bebbington, 1997), chiefly through individual bias. Others have emphasised the importance of considering perceived needs as a means to understand health-seeking behaviour and service utilisation (Meadows et al, 2002; McCrone et al, 2000).

An obvious solution to these two approaches would be to combine information from the two sources. However, differences in expert and perceived needs assessments also require review, as the degree to which the two agree is highly variable. Where high rates of agreement prevail, either approach will suffice. Where there is poor agreement, both views must be considered (Lasalvia et al, 2000). There is considerable evidence that the rate of agreement between clinician and client is poor (Slade et al, 1996). The "consumer's" perspectives have only recently been regarded as important (Meadows et al, 2002).

Needs, then, may be defined as deficits in function, physical environment, or mental and physical health. These needs may be reported by consumers of services - so-called "perceived needs" - or by clinicians - so-called "normative needs". Certain researchers refine the above definition of need to include the concept that a need exists where there is a lack of access to care or services.

1.4.2. Met versus unmet need

Where a need is identified, it is essential to ascertain whether the need is met or unmet. If it is met, it is important to establish whether it is fully or partially met. In a model of perceived need assessment, Meadows et al (2000a) propose 4 levels of perceived need: 1. Met need - the individual receives as much help as they perceive they needed, 2. Partially met need - help received is not as much as they perceive is needed, 3. Unmet need - a need is perceived but no help is received and 4. Mental health problem but no perceived need- help not perceived to be needed. This latter category may describe patients with psychiatric diagnoses, who do not define themselves as having needs. These categories were derived from earlier work on needs assessments (Brewin et al, 1987).

The issue of met and unmet needs in non-clinical populations addresses issues of equity and distribution of resources, as well as deficiencies in community services (Bebbington et al, 1997). Epidemiological surveys reveal that mental illness is frequently undiagnosed and therefore remains untreated (Regier et al, 1993; Kessler et al 1994). The burden of mental illness on this untreated population suggests that efforts be made to increase service provision. This argument depends on 3 hypotheses: first, that a disorder equates to a need, second, that service utilisation equates to need, and third, that non-users with disorder stand to benefit from services (Lefebre et al, 2000). Patients who present to psychiatric hospitals have made use of services and have usually been diagnosed with mental illness. However, as it has been mentioned before, service utilisation does not correlate with the meeting of needs (Lefebre et al, 2000).

Furthermore, it appears that individuals with met needs differ from those with unmet needs. A higher risk of unmet needs is associated with the presence of lifetime DSM III R disorder, childhood abuse, difficulties in the primary social network,

no intimate relationships, and low employment (Lefebre et al, 2000). These findings raise the issue of whether needs exist at intrinsic or intra-personal levels, and whether they are chronic and enduring. Where these problems result in mental health needs, it is possible that these needs are difficult to meet or are un-meetable. To date, most studies address only on external needs. A category of "no meetable needs" has been described, which refers to a situation where disability exists, but no effective intervention can be offered (Bebbington, 1997).

1.4.3. Barriers to meeting of need

The importance of enquiring about barriers to the meeting of need has recently been highlighted in a large Australian survey: The Australian National Survey of Mental Health and Wellbeing (Whiteford, 1993). The instrument used in this survey, The Perceived Need for Care Questionnaire (see below), includes a section on barriers to meeting of need (Meadows et al, 2000a, 2000b, 2002). These barriers are defined by consumer's explanations for services not being sufficient to meet the need. These include:

a. "I prefer to manage myself" (self-reliance)
b. "I didn't think anything could help" (pessimism)
c. "I didn't know where to get help" (ignorance)
d. "I was afraid to ask for help" (stigma)
e. "I couldn't afford the money" (finance)
f. "I asked but didn't get the help" (non-response)
g. "I got help from another source" (alternative provision).

These barriers are the kinds of things that consumers commonly report that stop them from having needs met (Meadows et al, 2000c). The reporting of barriers is not widespread in the literature, but other authors have reviewed reasons for needs being unmet: Lefebre et al (2000) report on reasons for not using services in a Canadian study using the MRC Needs For Care Schedule. Barriers in this study included items such as,

"cost", "thought that the problem would go away", and "wanted to resolve the problem themselves". Information about barriers to the use of mental health services may be even more useful in psychiatric in-patients. In this group of consumers, psycho-social needs precipitating admission may well be those which should have been met at earlier levels of mental health care. Understanding barriers to these needs therefore becomes crucial to developing the primary care service. In addition, patients who declare needs that repeatedly remain unmet despite frequent admission, may have needs that are unmeetable, for a variety of reasons. In some cases, admission may be counter-productive and could be avoided. The value of recording barriers therefore becomes apparent.

1.4.4. Assessment of need

A rational mental health service would periodically review the needs of its users in order to plan appropriate and cost-effective interventions. Mentally ill patients have wide-ranging needs, exceeding the purely physical (Meadows et al, 2000c). Only 24% of homeless people who were assessed as having a need for services by interviewers, reported having such a need themselves (Herman et al, 1993).

The "ideal assessment tool" for use in a clinical setting would be brief, easily learned, easily administered by a range of staff, and is valid and reliable across a range of settings and cultures (Meadows et al, 2000c). In addition, needs assessments should form the basis of service development and monitoring, to ensure that services are needs -led (Hansson et al, 1995).

Population-based needs assessments use primarily epidemiological methodologies: service utilisation studies, social indicators and community surveys (Hansson et al, 1995). Social indicators approaches infer that social and demographic factors predict service use, while community surveys make use of prevalences of disorders. The criticism of prevalence

studies is that diagnosis does not correlate with need (Meadows et al., 2000a)

Service utilisation studies assume that mental health needs are expressed as demand for services, but the relationship between the two has been disputed (Falloon, 1984 ; Bachrach, 1982; and Slade, 1994). The trend is towards needs-based assessments and away from service-based assessments (Slade and Thornicroft, 1995; Slade 1994).

Many needs assessment instruments have been described. They differ in respect to the degree to which clinical ratings are included, symptom scales, social function, and material needs, as well as in the manner in which information is reported.

Many of the current needs assessments instruments are based on earlier designs. These included instruments such as the Goldberg-Hillier Questionnaire (GHQ-28), described by Goldberg and Hillier in 1979 and used by Bebbington (1997) as a screening tool in the Camberwell Needs for Care Survey. The Schedule for Clinical Assessment in Neuropsychiatry (SCAN) measures psychopathology, and includes the Present State Examination (version 10), Item Group Checklist (IGC), and the Clinical History Schedule (CHS) (Wing et al, 1990). A quantitative assessment of social performance is made by the MRC Social Role Performance Schedule (SRPS) (Hurry and Sturt, 1981). The Life Events and Difficulties Schedule (LEDS) is valuable where a survey intends to demonstrate that affective symptoms are the result of adjustment disorders (Brown and Harris, 1978).

Three current needs assessment instruments ought to be reviewed in more detail. A review of the current literature on the assessment of need reveals that these are the instruments in common use (see section 2). These include, (a) the Camberwell Assessment of Need, (b) the MRC Needs For Care Assessment Scale and (c) the Perceived Need for Care Questionnaire

1.4.5. Review of instruments

The attempt to match need with intervention in a non-clinical population was crystallised in The **MRC Needs For Care Assessment Scale** (NFCAS-C) (Brewin, 1993). This instrument set out very specific criteria for need: First, a decline in function, usually with symptoms and distress, and second, the need is potentially reversible. The need for care is met when an intervention that is at least partly effective is offered. The need is unmet when the intervention fails or a better intervention exists. The value of this instrument is its attempt to define a level of need and then an appropriate intervention or item of care. However, it is aimed at psychiatric population surveys and therefore remains a community-based screening tool (Brewin et al, 1987). It therefore does not measure whether needs are met in clinical or in-patient settings. Another disadvantage is its length, being time-consuming to administer.

The Cardinal Needs Schedule (CNS) was developed by Marshall (1995), and is represents a modification of the MRC NFCAS. Marshall defined needs as "cardinal problems" when they met 3 criteria: the patient is willing to accept help, the problem is stressful to care-givers, and the problem is severe enough to cause threat to the patient or the community. The CNS was developed as an instrument in order to shorten previous schedules, to systematically include patient's views, and to define needs in such a way that they are easy to interpret.

The Australian National Survey of Mental Health and Well-being (NSMHWB) was carried out in 1997, and was based in the ECA and NCS surveys done in the U.S.A. **The Perceived Need for Care Questionnaire** (PNCQ) described by Meadows et al (2000a and 2000b) and used a 4 stage approach. The instrument was drawn from previously described instruments, such as the NFCAS-C, the CAN and the Cardinal Needs Schedule. Stage one is a structured enquiry into services received in the last 12

months. If mental health problems are reported as having used services, then stage two enquires about what types of interventions were used. Subsequent to these responses, stage three explores whether interventions are perceived as being adequate or not. Inadequate interventions are reviewed in the fourth stage. Each stage of the PNCQ is tiered from the previous, so that only relevant portions of the instrument are followed in each case.

Categories of perceived need include: Drugs, information ("psycho-education"), psychotherapy, cognitive behaviour therapy, counselling, social interventions, work skills, and self-care\home-care skills. Where individuals report that the perceived need was not met, questions follow about "barriers" to the meeting of the need (see above). The PCNQ has the advantage of being brief, with an administration time of 2 minutes in the community (Meadows et al, 2000a). Data suggest that this instrument is valid, reliable and a useful asset in mental health services evaluation.

The PNCQ is available in a longer format intended to measure perceived need with differentiation within categories, allowing for comprehensive insight into needs being met by interventions. This format may be modified and developed into a valuable instrument in service evaluation. The disadvantage of the PNCQ is its brevity, and where a comprehensive coverage in clinical populations is sought, it does not appear to assess needs adequately.

The Camberwell Assessment of Need (CAN) attempted to introduce consumer perspective as complimentary to clinician-derived information, and so was an advance on the NFCAS-C in this respect. The CAN was developed at the Institute of Psychiatry in London and has demonstrated validity and reliability. It takes the form of a structured interview, which evaluates the clinical and social needs of patients suffering from serious mental illness (Phelan et al, 1995). The CAN seeks to identify

needs as opposed to describe them in detail. It assesses need in 22 domains. A version in use in South Africa today includes 24 domains of need. For each of these domains, need is rated on a three point scale: 0= "no problem (need), 1= no or moderate problem due to help given (met need), or 2= serious problem (unmet need).

For each declared need, information sought by the CAN includes the amount of help received from friends or relatives and local services, the amount of help needed from local services, the appropriateness of that help, and patient satisfaction. Its use extends to include information on both patient and clinician perceptions (Lasalvia et al, 2000; Slade and Thornicroft, 1995). The CAN also meets criteria for routine use in clinical practice, being brief, easy to administer, and valid and reliable with respect to gender, setting and culture (Hansson et al, 1995). It assesses need independently of intervention (Slade and Thornicroft, 1995). The CAN is an appropriate instrument in clinical populations, and can thus be used for reviewing in-patient groups (Hansson et al, 1995). However, where information about the effects of interventions is sought, the CAN does not elaborate, and modifications would be required.

1.5. Race and Culture

In a multi-cultural and multi-lingual society such as South Africa, the need to be sensitive to cultural and racial issues is readily apparent. Prior to democratic elections in 1994, services were divided primarily along racial lines, and whilst these lines have disappeared in law, the current access to and use of, psychiatric services bears further scrutiny. The effects of race on the pattern of psychiatric admission was reported by Strebel and Msomi (1999). In a one-year review of admissions to psychiatric hospitals in the Western Cape in South Africa, it was noted that blacks tended to be hospitalised more frequently but for shorter periods. In addition, the numbers of black patients being admitted to

neuro-clinics was very low. The majority of neuro-clinic patients were white. One of the reasons offered was the relative paucity of clinicians and staff who speak black African languages. Another possibility is that blacks are more likely to attract diagnoses of serious mental illness than those of neuroses (Strebel and Msomi, 1999).

Wells et al (2001) report a significantly greater unmet need in U.S. minority groups (African American and Hispanic) in over 9000 patients of the Healthcare for Communities sample. Alongside greater unmet needs, less access to care and poor quality of care were also found. The finding in this sample that minority groups were less likely to have private medical insurance suggests that race and socio-economic profile are not entirely unrelated. It is argued that race and socio-economic status "interact to increase psychiatric symptoms" in African-Americans (Strebel and Msomi, 1999, p54).

Hunter (2000) points out that in socially deprived communities, the issues of physical and mental health becomes blurred. More specifically, mental health promotion tends to ignore the basic needs of these communities in its expectation of response to these interventions. The population in question was indigenous to Australia. It therefore becomes all the more important to evaluate all types of need in these populations.

The lack of access to care in South Africa is highlighted by referral patterns. Blacks admitted to hospital were mostly self - or family -referred, as opposed to whites who were referred by private medical practitioners (Strebel and Msomi, 1999). This suggests that communities and families are required to take responsibility for their member's mental health. Another hypothesis is that blacks use non-Western models of healing. This may be driven as much by cultural beliefs as lack of health care services.

The use of instruments such as the CAN has been demonstrated to be valid in a wide range of cultural settings in Europe (McCrone et al, 2000). An earlier review by Hansson et al (1995) showed similar results but suggested that interviewers be clinically trained. The value of the CAN resides in its use of simple language and short words, which allows for translation.

1.6. Unmet needs in the community

Community based reviews of need have tended to detect either prevalence rates of disorder or service use figures (Bebbington et al, 2000). The point prevalence of neuro-psychiatric disorders in adults worldwide has reached 10% (W.H.O. 2001). According to the same report, 24% of patients attending primary health care settings have a mental disorder-most commonly depression, anxiety and substance abuse. The Epidemiological Catchment Area Study reported that between 50-75% of depressive and other significant mental illness remained undiagnosed and untreated (Regier et al, 1993).

Bebbington et al (1997) argued against the idea that these figures translated directly into unmet need in the community. He bases his argument on weak correlation between ICD diagnosis and actual need for treatment. In the Camberwell study described by Bebbington, several cases not meeting criteria for disorder were identified as those needing treatment. More specifically, a quarter of cases of anxiety were assessed as needing treatment but did not meet criteria for disorder. In Camberwell at that time, 7% of people assessed had unmet needs.

Lefebre et al (2000) supports the finding that cases do not equate to needs, and adds that use of services does not equate to needs being met. In this sample, 44% of respondents had needs unmet by services in the last year. The poor association between needs and services has led to services being more

needs driven as opposed to service based (Slade and Thornicroft, 1995).

The W.H.O. reports that mental disorders impose burdens not only on individuals, but also families and communities (2001). Family needs such as stigma, physical and emotional support are often overlooked. Community burden includes the costs of care and loss of productivity. The impact of disorders, apart from the assessment of need, has led to other measures of disease disability and chronicity being described. The Disease-Adjusted Life Year (DALY) reflects the years of life lost due to premature death in the population, as well as disability. The Global Burden of Disease 2000 report states that 30,8% of all years lived with disability are attributable to mental disorders (W.H.O. 2001).

1.7. Unmet needs in in-patient populations

A relative paucity of literature appears to exist on whether specific interventions in in-patient groups significantly met needs that were present on admission. Hansson et al (1995) reviewed inter-rater reliability in a cross-section of Swedish patients but did not distinguish between in-patient and out-patient groups in the needs assessment. The Epsilon study included very few schizophrenic in-patients, in most centres less than 7% (McCrone et al, 2001).

Unmet needs in in-patients persisting despite interventions may reflect a variety of issues. These may include a lack of staff perception of need and a discrepancy between staff and patient views of need (see above), an underreporting of needs, as may occur in substance abuse, or due to inability of the intervention to meet the need. In addition the concept of "unmeetable need" should be considered: a need is identified but the intervention is refused by the patient. An unmeetable need may include wilful refusal to use psychotropic medication, refusal to cooperate in psychotherapy or early

departure from treatment programs. The recording of barriers to the meeting of need will be reviewed in the next section.

1.8. Purpose of the study

Patients admitted to ward one have a wide range of needs, which include social issues, skills deficits and psychiatric disorders. Their entry into the psychotherapeutic program depends on the presence of a psychiatric disorder for which psychotherapy and\or medication is available. The case manager's knowledge of the patient's broader needs is limited to general information given at the intake interview, or to that provided by the referring agent. Also, the degree to which these needs have been addressed in the community remains unknown. Furthermore, it is possible that staff-assessed needs may differ from those of the client, and that the services provided may be inappropriate. The issue of whether the services provided by the program meet the expressed needs of patients forms the question of this study.

1.9. Aims

1. To establish the perceived needs of patients entering the ward one program
2. To establish whether services were able to meet or not meet these perceived needs

1.10. Objectives

1. To establish patient's perceptions of a range of needs in the last month on admission to ward one.
2. To establish the degree to which these perceived needs were met by the program.
3. To describe perceived barriers to meeting these needs.
4. To describe how patients felt needs were met by the ward program.
5. To compare socio-demographic and psychiatric variables with respect to unmet needs on admission and discharge.

6. To examine the relationship between these socio-demographic and psychiatric variables, and unmet needs on admission and discharge.

1.11. Implementation objectives

1. To establish where needs could have been met prior to admission.
2. To describe patient's satisfaction with the effectiveness and nature of services.
3. To determine where services could be improved or developed

1.12. Overview of dissertation

The following chapter will review the literature on the assessment of need for mental health services. Studies done on adult populations from 1995 were included. This review describes needs in these samples, as well as some of the known associations of unmet need.

The methodology of this study is described in chapter 3. The interview schedule, data management and ethical issues are outlined.

Chapter 4 presents the findings of this study. The socio-demographic characteristics are first described, followed by the findings of the intake interview. Thereafter, the services and barriers to care at ward one are presented. Finally, analysis of data to establish predictors of numbers of unmet needs was done.

The findings of the study are discussed in chapter 5. This follows the sequence presented in the results section

2. LITERATURE REVIEW

2.1. Introduction

This section reviews the literature relevant to the assessment of need in mental illness. In this review, the reader will be guided through this developing field, in order to understand the role of need in mental health services research. The purpose of this chapter is to provide a systematic review of literature pertinent to this field

A systematic review is necessary to develop a research question that is based on established practice, but which does not repeat it. Furthermore, the ensuing research must be relevant to the field of psychiatry in general. The review may guide the research inasmuch as it highlights areas where research is lacking. This will provide the impetus for the new study.

2.2. Scope and methodology of literature review

2.2.1. Search strategy

The review of this topic was conducted using four approaches:

1. Using a key word search of the *MEDLINE* and *PSYCHINFO* databases, searching for articles in English - the key words used were combinations of "mental health needs", "assessment of need" and "needs assessment".
2. Reviewing the reference sections of key articles found in this way and searching for relevant publications.
3. Using a hand search to review the tables of contents of key journals, searching for relevant publications. These key journals included: *Psychiatric Services*, *Social Psychiatry and Psychiatric Epidemiology*, *Psychological Medicine*, *The British Journal of Psychiatry*, and *Acta Psychiatrica Scandanavica*.
4. Personal communication with key researchers in the field: This included a discussion with Professor Graham Thornicroft, Head of the Department of Community

Psychiatry, at the Institute of Psychiatry, London, and correspondence with Dr Graham Meadows, Department of Psychiatry, University of Melbourne, Australia.

2.2.2. Inclusion criteria

1. Studies published from 1995 to present.
2. The source was a peer-reviewed journal.
3. An established needs assessment instrument was used during the study.
4. The study population described patients suffering from psychiatric disorders.
5. The assessment of need, not the relevant psychopathology, was the focus of the study.

2.2.3. Exclusion criteria

1. Studies in which outcome assessment was the focus were not included.
2. Studies based on samples with children, the elderly, and those with intellectual disability were not included.

2.3. Results of literature search

The results of the search are summarised in table 1.

2.3.1. Number of studies

A total of 21 publications was retrieved. In this review, publications will therefore be referred to using the Harvard Reference method, namely, author and date. Where the actual *number* of publications is referred to, the symbol "n=" precedes it.

2.3.2. Sites of studies

21 publications represents a relatively small number of studies published in this field, even taking into account the inclusion criteria. A large proportion of the articles were based on or included data from South London in the United Kingdom (n=10). Investigators from the section of Community Psychiatry at the Institute of Psychiatry, London, are active

Table 2.1. Needs of psychiatric patients

STUDY	SETTING	SAMPLE METHODOLOGY	N	INSTRUMENTS	METHOD OF ANALYSIS	KEY FINDINGS
Bebbington 1997	South London	Radomised from electoral role Then screened	408	GHQ-28, SCAN, SRPS, NFCAS-C, LEDS	Percentages and frequencies	1. 9,5% need for treatment in sample 2. 13-28% of meetable need in neuroses being met (high unmet need)
Bebbington 2000	U.K.	Stratified random sample using post codes and KISH grids	10108	CIS-R ADL	Frequencies, percentages, logistic regression analysis for severity and contacting behaviour	1. 2\3 of patients with neuroses did not contact their GP 2. Severity strongly predicts health care seeking 3. 1% had psychiatric admission in preceding year
Bengsston-Tops 1999	Malmo, Sweden	Stratified random sample from case register	120	CAN, LqoLP, BPRS, GAF	Frequencies and percentages; stepwise multiple regression analysis	1. Median number of expressed needs=7 2. Lower GAF and higher BPRS score produced higher total needs 3. Illness duration does not predict higher needs
Gallagher 2000	Sydney, Australia	Case manager case identification	283	CAN, HoNOS	Frequencies and percentages; comparisons using t-tests	1. Patient-staff ratings of need differ 2. CAN and HoNOS ratings correlate highly 3. Patients receiving assertive case management had higher needs and disability
Hansson 1995	Malmohus county, South Sweden	In- and out-patients using cross-sectional approach	119	CAN	Percentages: comparisons using kappa coefficient	1. Interrater reliability of CAN established 2. Mean number of needs= 5,29 3. Patients with personality disorder or neurosis showed more needs than affective psychosis
Henderson 1999	London, UK and Verona, Italy	Case identification, inclusion criteria, then random sample of UK group	130	VSSS	Frequencies and percentages; comparison using Mann-Whitney or Chi-square test	1. Patients never previously compulsorily detained have higher satisfaction on some domains VSSS 2. Patients prefer routine community services to hospital services
Issakidis 1999	South-East Sydney, Australia	Case register and inclusion criteria	123	CAN, HoNOS	Frequencies and percentages; kappa coefficient for agreement	1. Staff and client ratings of need differ significantly 2. Unmet needs on CAN correlates with disability on HoNOS
Lasalvia 2000	South Verona Community Service	Case register clinic attenders	365	CAN BPRS GAF, DAS	Frequencies, percentages, comparisons using t-tests\ANOVA	1. Mean total needs 3,34 2. Significant discrepancies between staff and patients in aggregated needs domains 3. Higher needs in diagnosis of personality disorder\psychosis 4. Patient needs predicted by disability

STUDY	SETTING	SAMPLE METHODOLOGY	N	INSTRUMENTS	METHOD OF ANALYSIS	KEY FINDINGS
Leese 1998	South London	Case identification then random sample	302	CAN, VSSS, BPRS	Frequencies and percentages; analysis of co-variance	1. Satisfaction correlates negatively with unmet need 2. Greater satisfaction correlated with longer duration of service contact
Lefebre 2000	Montreal, Canada.	Random sample of 2 groups of DISSA identified disorder and community	82	NFCAS-C DISSA SCL-90 SAS-SR	Frequnecies and percentages Comparisons using Chi-square, tau-b, ANOVA	1. Higher needs where primary social network difficulties 2. >2\3 of patients with unmet needs felt they needed more\different services 3. Unmet\met need records scored worse on social distress\social function scales
McRone 2001	Residential middle class in 5 European cities	Research criteria for schiziphrenia in clinics using case identification	404	CAN-EU GAF BPRS ESMS	Frequencies, comparison using regression and chi-square\fisher's	1. Highest needs in London and Amsterdam 2. Lower GAF correlates highly with unmet needs
Meadows 2000 (a)	4 catchment areas in Australia	Clustered probability sampling	10641	PNCQ, CIDI	Frequencies and percentages	1. 13,8% of Australians have a perceived need for care 2. Diagnosis, perceived need and service use not closely correlated 3. 11% of Australians are "untreated prevalence"
Meadows 2000 (b)	NSW, Australia	1.Clinic sample 2.Advertisement at clinic	145+ 51= 196	PNCQ	Frequencies and percentages; logistic regression	1. The PNCQ (including barriers to care) has validity and reliability- in the setting of a specialist anxiety disorders clinic
Meadows 2002	4 catchment areas Australia	Clustered probability sample	10641	PNCQ, CIDI	Frequencies and percentages; logistic regression	1. Highest perceived needs in patients with anxiety and affective disorder 2. Perceived need increased by female gender, middle age and mental health-induced disability
Parkman 1997	South London	Case identification then random sample	202	VSSS	Frequencies and percentages; comparisons using t-test, chi-square, ANOVA; stepwise multiple regression	1. Blacks more likely to have been detained, admitted and used servies 2. Blacks less satisfied with services- more marked if UK-born

STUDY	SETTING	SAMPLE METHODOLOGY	N	INSTRUMENTS	METHOD OF ANALYSIS	KEY FINDINGS
Phelan 1995	London	Parallel case\staff selection	109	CAN	Frequencies and percentages; degree of agreement between discrete variables	1. CAN has adequate validity and reliability 2. Mean number of needs= 7,55 by staff and 8,64 by patients- needs do not always match
Simons 2002	Scotland, post discharge patients	Inclusion criteria, with invitation to participate	173	CAN	Comparison using Mann-whitney\ Chi-square	1. Mean total needs 6 weeks post discharge 5,8 2. Non-psychotic group reported higher needs than psychotic group 3. Health needs more easily met than functioning or social needs
Slade *1998*	South London, UK	Case identification, then random selection with over-sampling	320	CAN, GAF	Frequencies and percentatges; kappa coefficient for agreement	1. Staff-client ratings of unmet need fair (kappa=0,28) 2. Agreement on met need moderate (kappa= 0,43) *1= total agreement
Slade 1999 (a)	South London Hospital and community	Case identification and randomisation	320	GAF CAN LQoLP	Multiple regression, using hierarchical block structure; Co-variate analysis	1. Incr unmet need related to QOL 2. Patients rated more needs than staff 3. Patient ratings of unmet need more reliable than others
Slade 1999 (b)	1.Mental health register, UK 2.Croydon, UK	1.Random sample 2.Point prevalence sample	259+ 123	CANSAS, HoNOS	Frequencies and percentages	1. HoNOS score strongly correlates with unmet need on CANSAS 2. HoNOS and CANSAS measured different constructs 3. Staff rated 7.5 total needs per patient on average
Wells 2001	Community sample, USA	Stratified Random sample	9585	CIDI 12-SFHS	Comparison using logistic and linear regression, and percentages	1. Clear differences in ethnic groups for demographics and access to care 2. Hispanics less satisfied with services

KEY TO ABBREVIATIONS

AUDI: Alcohol use disorders identification test

BPRS: Brief psychiatric rating scale

CAN: Camberwell Assessment of Need

CANSAS: Camberwell Assessment of Need, Short Assessment Scale

CIDI: Composite international diagnostic interview

CIS-R: Clinical interview schedule

DAS: Disability assessment schedule

DISSA: Diagnostic interview schedule, self-administered

ESMS: European service mapping schedule

GHQ: General health questionnaire

HoNOS: Health of the nation outcome scale

LEDS: Life events and difficulties schedule

LqoLP: Lancashire quality of life profile

NFCAS-C: Needs for care assessment- community version

SAS-SR: Social assessment schedule, self-report

SCAN: Composite instrument using Present State Examination, IGC, CHS

SCL-90: Symptom checklist 90

SRPS: Social role performance schedule

VSSS: Verona service satisfaction scale

12-SFHS: 12-iten short form health survey

in this field. A wider collaboration included some wider European samples, such as from the EPSILON study (A comparison of needs of patients with schizophrenia in five European countries)- other sites included Amsterdam, Copenhagen, Santander and Verona. Other research in this field includes a number of Australian studies (Gallagher and Teeson, 2000; Issakidis and Teeson 1999; Meadows et al 2000a), and some from community services in Italy (Henderson et al, 1999; Lasalvia et al, 2000). The other articles included are single publications out of Scotland (Simons and Petch, 2002) and North America (Wells et al, 2001).

2.3.3. Nature of studies

The assessment of need was examined in the general population (n=4), including one study which reported on whether services can meet identified needs at that level (Bebbington et al, 1997; Bebbington et al 2000; Meadows et al 2000a; Meadows et al 2002). The remaining 17 studies all reported on needs in psychiatric patients. Psychotic disorders and schizophrenia were the disorders most commonly referred to in six studies (Bengsston-Tops and Hansson, 1999; Leese et al 1998; McRone et al, 2001; Parkman et al, 1997; Slade et al, 1998; Slade et al, 1999a). Other psychiatric disorders were specified in two studies (Bebbington et al, 2000; Wells et al 2001), while the remainder did not specify. These articles either defined "severe mental illness" (n=2) (Phelan et al, 1995; Slade et al 1999b) or simply reported on broad diagnostic groups (n=8). For example only schizophrenia was mentioned as a stand-alone diagnosis, while "groups" were: affective disorders and personality disorders.

The assessment of need was reported on in the context of ethnic differences (n=2)(Parkman et al 1997; Wells et al 2001), the association between needs and quality of life (n=2) (Bengsston-Tops and Hansson, 1999; Slade et al, 1999a), patient satisfaction (n=3) (Henderson et al, 1999; Leese et

al, 1998; Parkman et al, 1997), and outcome scales (n=3) (Gallagher and Teeson, 2000; Issakidis and Teeson, 2000; Slade et al, 1999a). Seven studies included differences in ratings of need between staff and patients or clients (Gallagher and Teeson, 2000; Lasalvia et al, 2000; Phelan et al, 1995; Simons and Petch, 2002; Slade et al, 1998; Slade et al 1999a; Slade et al, 1999b).

Of all the studies, only four included data on psychiatric in-patients. Two included in-patients as part of the sample in cross-sectional analysis and simply reported this aspect under sample characteristics. Another study compared in- and out-patients with respect to satisfaction, while the fourth study looked at patients' needs six weeks after discharge. No study examined needs of patients at admission and the effect of admission on those needs.

The approach taken by the majority of studies is the "patient-centered" or "subjective" needs assessment. As mentioned above, seven studies commented on differences in staff-patient perceptions of need, while only two studies used this difference as a point of departure. All articles used a needs or satisfaction assessment in order to evaluate services or outcomes. The value of using such instruments in planning services thus becomes apparent.

2.4. Methodological issues

2.4.1. Characteristics of study samples

As mentioned above, the majority of studies were conducted in the United Kingdom (n=10) in urban settings, with a minority in other European countries (n=4), North America (n=2) and Australia (n=5). As such, it can be seen that studies of this nature have until now largely been conducted in cities in a handful of developed countries.

Three of the populations reported in four publications involved large community based samples of around 10 000 people. The remainder were smaller samples of between 100 and 400 patients. These latter studies obtained their samples using a variety of strategies, including case identification with randomisation (n=8), case identification without randomisation (n=7), random community sampling (n=2), and clustered probability sampling (n=2).

Smaller sample sizes of 100 to 120 were used in studies involving instrument reliability, specifically the Camberwell Assessment of Need (CAN) (Phelan et al, 1995; Hansson et al, 1995) and the Perceived Need for Care Questionnaire (PNCQ) (Meadows et al, 2000a). Adequate test-retest and inter-rater reliability were obtained with these sample sizes.

Some studies obtained smaller samples because of strict inclusion criteria, or applicability of the relevant instrument. For example Henderson et al (1999) report on 59 patients from South Verona and 70 from Nunhead on this basis. Prior to this sample being selected, 50 patients refused to participate. Of the 230 cases considered in Issakidis' study, only 123 were selected, either because they were too ill, or because case managers "were too busy or on extended leave" (1999). In the view of the latter author, the study was "naturalistic" for the clinical setting, in that it was conducted under usual clinical conditions, where resources are limited. The study by Leese et al (1998) further illustrated the practical limitations of obtaining a sample. In this case, 302 patients were selected, but only 131 and 125 patients were able to complete the Verona Service Satisfaction Scale (VSSS) and CAN at times 1 and 2 respectively. Likewise, Slade et al (1998; 1999a) faced a similar attrition rate from a sample of 320 to 137 who completed the study. It would therefore appear that studies of clinical samples frequently involve samples of between 100 and 200 subjects.

2.4.2. Study instruments

Instruments used in these analyses fall into 4 broad groups: (i) Diagnostic instruments, such as the SCAN, CIS, BPRS and CIDI, (ii) Needs assessment instruments, such as the CAN and PNCQ, (iii) Satisfaction instruments, such as the VSSS, and (iv) Quality of life measures, such as the HONOS, LQOLP and GAF.

As a needs assessment instrument, the Camberwell Assessment of Need (CAN) appears to dominate the literature at present, with 12 of 21 (57.1%) studies included in this review making use of it. Only two relied on the Needs For Care Assessment Schedule (NFCAS) developed by the British Medical Research Council (Bebbington et al 1997; Lefebre et al 2000), while Meadows et al (2000a; 2000b; 2002) developed their own instrument, the Perceived Need for Care Questionnaire (PNCQ) for their series, which resulted in 3 included studies. The remaining studies used the Verona Service Satisfaction Scale (VSSS) (Henderson et al, 1999; Parkman et al, 1997), Clinical Interview Schedule (CIS) (Bebbington et al, 2000) and the Composite International Diagnostic Interview (CIDI) (Wells et al, 2001) as the basis for reviewing needs. A number of studies included other well established instruments in order to compare patient's needs with quality of life. These latter scales included the Lancashire Quality of Life Profile (LqoLP) (n=2), the Global Assessment of Function (GAF)(n=5), and the Health of the Nation Outcome Scale (HoNOS)(n=3).

The trend in the use of these instruments appears to be that the CAN and the VSSS were used in smaller series based on clinical populations (n=14), while the CIS, CIDI and PNCQ were used to screen larger community based samples. In addition, needs assessment instruments, for example, the CAN, was most commonly used to extract basic information upon which comparisons to other measures could be made. Examples include measuring needs versus global functioning (Bengsston-Tops et

al, 1999; Lasalvia et al, 2000) and needs versus disability (Gallagher et al, 2000; Issakidis et al 1997).

2.4.3. Methods of analysis

3 studies examined population data in order to establish needs in the general population (Bebbington et al, 2000; Meadows et al 2000a; Meadows et al 2002). In all three studies the data were weighted. The remainder of the studies - focussing on clinical samples - did not weight the data. In every case, frequencies and percentages (weighted or unweighted) were used to express need or satisfaction data. A number of statistical methodologies were then employed, depending on the variables under study.

Cohen's Kappa coefficient was used in 6 studies to establish the level of agreement between raters. Where categorical data were compared, the chi-square test was most commonly used (n=6). These analyses included comparing domains of need between sites, or comparing the status of psychiatric disorder to need. The Mann-Whitney test was used in 3 cases to compare needs between subgroups, such as men vs. women, or high vs. low BPRS scores. Similar analyses using the ANOVA were done in 4 studies. In these cases, ANOVA was used either to compare satisfaction or needs scores at two points in time, or to test for differences in satisfaction between two demographic groups. Other methodologies included: Fisher's exact test- used to test for site differences, Spearman's Rank Coefficient (n=3)- for testing correlation between help needed and help received, and independent t-tests- used to compare concurrent validity of two measures, the HONOS and the CAN.

Regression models were fitted in 8 studies (38.1%), with 4 of these using multiple regression models. Logistic regression was used to model a number of dependent variables, ranging from severity of illness on contacting behaviour (Bebbington et al, 2000), severity of needs and quality of life (Bengsston-Tops et al, 1999), total needs and staff-patient

differences (Lasalvia et al, 2000), global satisfaction (Parkman et al, 1997), and ethnicity (Wells et al, 2001). These dependent variables were regressed on a range of demographic, clinical and service use variables.

2.5. Substantive findings

2.5.1. Socio-demographic data

The socio-demographic characteristics of samples varied. Most reported similar gender distribution with men and women represented in ranges from 45%-55% of the sample. Departures from this range were seen in five studies. There was no consistent bias, with both men and women respectively being more represented in various studies. It was not possible to discern a trend or reason for the few studies that reported these differences. The vast majority of the studies that reported mean or median ages, gave a range of 41-48 years. Almost half of the studies (n=9) commented on marital status, and in most cases, more than 70% of the sample was single. Where it was reported on, the rates of people living alone varied between 15-45%.

Information on employment status was variably reported. Figures for unemployment ranged from 14% (Lasalvia et al, 2000) to 87% (Bengsston-Tops et al, 1999). Samples of patients with schizophrenia tended to report higher rates of unemployment, whilst community based samples registered lower ones. In addition, figures were reported differently: Lasalvia's sample (above) included 121 (49.0%) individuals who were either "housewife, student or retired". In local settings, many of these would be recorded as "unemployed".

Similarly, diagnostic categories varied according to the sample methodology. Many of these selected papers were based on psychotic, or specifically schizophrenic populations (n=7). In the other series, there was again a wide range of prevalences amongst diagnostic categories: for example,

schizophrenia ranged from 19% (Simons et al, 2002) to 67,5% (Henderson et al 1999). Affective disorders, neuroses and personality disorders were generally less frequent but similar wide ranges were seen.

In all the studies where service contact was recorded, this was reflected as time since first contact with services, and frequently as time since first admission. Where schizophrenia was the commonest diagnosis, duration of contact usually averaged 15-20 years (Bengsston-Tops et al 1999; Leese et al, 1998; Parkman et al 1997). A few studies report shorter contact periods: 6,03 years (Lasalvia et al, 2000) and 40% less than 4 years, in Hansson et al's study (1995). The latter reported on general psychiatric populations.

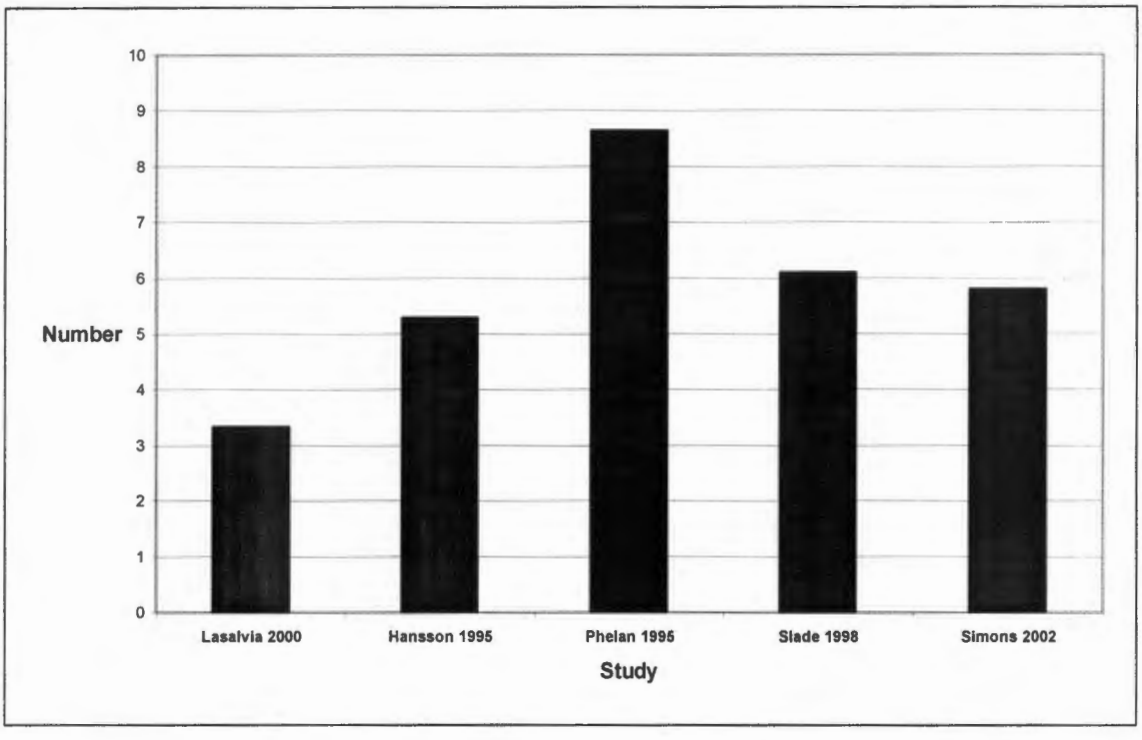
2.5.2. Needs in the general population

Two studies examined needs in large community samples in excess of 10 000 (Bebbingotn et al, 1997; Meadows et al, 2000a). In the first study, the one month weighted prevalence of needs for care was 9,5%. This reflected a rate of 5,9% unmet need and 3,6 met need. In the same population, 9,8% were rated on the SCAN as having psychiatric disorders. The authors contend that case identification and need do not necessarily correlate: 13% of those needing treatment for depression and 25% of those with needs for treatment for anxiety, did not meet criteria for ICD 10 diagnosis. In the Australian sample, 13,8% of Australians were rated as having a perceived need for care. 4,4% of the sample expressed perceived need, but did not meet criteria for disorder, using the CIDI. However, 7,4% of the sample met criteria for disorder but did not express perceived need. These last 2 figures again emphasise the point that case identification and perceived need do not necessarily correlate. In terms of service use, 94,5% of Australians with psychiatric disorder and who are in contact with services, expressed perceived need. Of those who have disorder and are not in contact with services, only 32,5% expressed perceived need.

2.5.3. Needs in psychiatric samples

The numbers of needs in subjects with psychiatric disorders ranged from 3,34 to 8,64 - see figure 2.1. The lowest figure was obtained in a community sample in South Verona (Lasalvia et al, 2000). In Sweden, a range of needs of 4,4-6,4 was obtained (Hansson et al 1995). This sample included both in- and out-patients. The range of needs also varied according to psychiatric diagnosis. Needs of severely mentally ill patients in London ranged from 7,55-8,64. Patients rated more needs than staff (Phelan et al, 1995). In patients with psychosis, the range of patient and staff needs was 6,1-6,7 (Slade et al, 1998). In a sample of patients at 6 weeks after discharge, the number of needs was 5,8 (Simons and Petch, 2002).

Figure 2.1. Needs of psychiatric patients



Studies have consistently shown that staff and patients rate needs differently (Gallagher et al, 2000; Lasalvia et al, 2000; Phelan et al, 1995; Slade et al, 1998). There were no

consistent patterns in terms of whether the highest number of needs was reported by patients or staff.

2.5.4.Correlates of unmet need

A number of correlates of unmet need have been found. Studies report differently on these, depending on which instruments were used, the manner in which psychiatric diagnoses were recorded, and the reporting of socio-demographic variables.

A number of socio-demographic variables have been reported to correlate with higher rates of unmet need. Female gender was found to be correlated to higher total needs in one study (Meadows et al, 2002). Hansson et al reported that women rated different CAN needs more highly - for example, psychological distress and physical health (1995). Meadows et al (2002) also found that middle age was a variable that contributed to higher total needs. Lefebre et al (2000)described several other demographic correlates of unmet need on the NFCAS-C instrument: being unmarried, being unemployed, and childhood sexual abuse. This study also reports that "difficulties in the primary social network" are more often associated with unmet need. In a review of ethnic disparities, Wells et al (2001) reported that Blacks and Hispanics were more likely to rate higher unmet need for alcoholism and drug abuse. In addition, these groups were also less likely to be covered by medical aid schemes, have high education, or high incomes.

Bebbington et al (2000) reported on service contacting behaviour of a sample of British households. In this study, subjects were more likely to have contacted services if they were female, were older, not currently in a relationship, unemployed, and suffered from physical illness. Whilst contacting behaviour does not equate to need, other studies have reported on degree of contact with service and need. Gallagher et al (2000)found higher needs in cases who were in receipt of "assertive case management" vs those receiving

"standard case management". Lasalvia et al (2000)also reported higher total needs in subjects with more service contacts.

Several studies have examined the effects of quality of life and disability measures on need. Slade et al found that low social functioning, as measured by the HONOS, correlated highly with unmet need on the CAN (1999b). Low quality of life and high disability scores are highly correlated with unmet need (Slade et al, 1999a; Meadows et al, 2002; McRone et al, 2001; Bengsston-Tops 1999).

Another important correlate of unmet need is psychiatric diagnosis. However, some disagreement exists as to which diagnoses are most significant. At the very least, the presence of a psychiatric diagnosis confers a higher rate of unmet need (Lefebre et al, 2000). In community samples, anxiety and depression\affective disorders were most commonly associated with higher levels of need (Meadows et al, 2002; Bebbington et al, 1997). In Phelan et al's sample of severely mentally ill patients, those with neurosis or personality disorder reported more total needs (1995). The higher reporting of needs in non-psychotic vs psychotic illnesses was borne out by Simons et al's series (2002). Slade et al, however, found the opposite, but specified that unmet need was associated with psychotic disorders other than schizophrenia (1999a).

The differences in ratings of unmet need between in-patients and out-patients has not been well documented. Hansson et al commented that in-patients were more likely to rate higher CAN needs for accommodation, self care and alcohol. More specifically, in-patients were most likely to rate daily activities as an unmet need (1995). Conversely, Parkman et al (1997) found that Black UK-born subjects were more likely to be dissatisfied with services with an increasing number of previous admissions. No study has specifically examined needs in a group of in-patients at admission, and reviewed whether

the admission improved these needs. CAN ratings of need were done 6 weeks after discharge in a Scottish study. In this group, needs were more likely to be met in health domains, as opposed to functioning domains. Help received from relatives and friends was also more likely where resources were available (Simons and Petch, 2002). By inference, needs are more likely to be unmet in functional domains, such as daily activities, relationships, and sexual expression.

2.5.5. Meeting of need and service satisfaction

Leese et al (1998) examined CAN needs and service satisfaction in a British sample of 302 subjects. A moderate effect size was seen when an intensive service was introduced and met needs were measured at time 2. In addition, higher met needs were associated with longer duration of service contact. (0,6 met needs for each 10 years of contact). Greater service satisfaction was also associated with longer duration of contact. Only the latter finding was partially confounded by age. Henderson et al reviewed 130 cases in London and Verona, but only satisfaction was recorded (1999). Subjects who had never been detained were more likely to rate satisfaction on the domain of "professional skills and behaviour". They also preferred routine community services to hospital services.

2.6.Conclusions

A number of important general conclusions may be drawn from the preceding literature review:

The assessment of need is a valuable tool to guide clinician and client assessment and planning. Where service planning requires specific information to assist with cost evaluation, this approach may be essential. While the presence of psychiatric disorder clearly is associated with needs, it does not necessarily equate to unmet need. Many needs are the result of psycho-social stressors which may be met outside of the field of psychiatry.

A number of variables have been found to be associated with unmet need. A number of these are unmodifiable, such as age and gender. Others are less easy to modify, such as housing and unemployment, but may be improved where resources allow. Still others are more amenable to interventions: treatable psychiatric conditions such as neuroses or mood disorders. The understanding of needs in these terms, may assist the clinician in allocating time and resources more effectively. Clinicians may be tempted to address psychiatric needs above psycho-social, or basic needs, but the latter may be as important in the treatment.

One important aim of needs assessment may be to increase the number of met needs. Where a more intensive service intervention has been shown to be effective, it may be possible to allocate resources accordingly. Conversely, where it has been shown to be ineffective, then the intervention is best reserved for other clients. This approach may be especially relevant in resource scarce settings. Similarly, the mobilisation of an individual's primary social network may turn out to be a crucial intervention in some instances. This intervention may be used independently of admission status.

In resource scarce settings such as South Africa, it is encumbent on health care managers to allocate resources appropriately. Furthermore, it is desirable that most needs are met at primary care level. Where these needs cannot be met, a secondary level of care is indicated. Lastly, tertiary level of care should be available to the fewest number of cases, where previous care levels have failed to provide for the need. In this way, a pyramid of care, or tiered structure can be applied. This ensures access to care in the community, the widest coverage of needs and the appropriate allocation of resources. This approach, however, is not always possible in practice. It is not uncommon for patients with several "primary level" needs, to filter directly to tertiary care,

when admission to hospital is required, for example. It is not possible to say that this could have been prevented, but it is highly desirable. Perhaps the value of a needs assessment instrument and a service assessment tool, then, is that an attempt can be made to meet needs when they arise. If a need is met at its source, it may be possible to do so in a cost effective manner, and with involvement of the primary social network. This would prevent the need outgrowing its potential solution, and the demand for tertiary services. A systemic understanding of how needs arise and how they are best met would seem to be an informed manner in which to tackle the immense mental health needs of the South African population.

This review has highlighted the need for a study which examines the effect of admission to a psychiatric hospital on the meeting of needs.

3. METHODS

3.1. Methods

3.1.1. Study design

A prospective descriptive and analytic study.

3.1.2. Study population and sampling

Valkenberg Hospital is one of three major psychiatric hospitals draining patients from greater Cape Town and the Western and Southern Cape. Patients admitted to Valkenberg Hospital represent a cross-section of cultures, races and languages, but generally excludes those who can afford private psychiatric care. A wide range of socio-economic groups are represented in this community, with unemployment, homelessness and social deprivation being common. Referrals to the ward are made by both community services and from within the secondary and tertiary psychiatric services.

Patients range between 18 and 60 years, and are of both genders. The range of psychiatric problems includes depressive and anxiety disorders, substance use problems, and personality disorders. In general, the presence of active psychosis and suicidal ideation excludes patients from the program.

All patients admitted to ward one from 01-01-2003 to 19-09-2003, and who completed the program, were included. A patient was deemed to have completed the program, if they had spent a minimum period of 2 weeks in the ward, and if the clinical team agreed that the patient was ready for discharge. Program "drop-outs" were those patients who did not comply with program requirements: they did not return from weekend leave, broke ward rules, or were considered unsuitable for the program. The number of patients admitted to the program varies from 2-4 per

week. Data was gathered from 60 consecutive patients on admission and discharge during this time period.

3.1.3. Procedure

A pilot study of 2 patients was run prior to initiating the study. This was in order to establish logistics such as the time taken to administer the instrument, and to develop liaison with ward staff. In addition, the instrument itself was tested in terms of the administration of new portions applicable to this study.

Following this, the ward secretary or sister in charge notified the investigator of impending admissions to the ward. During the first 3 days of admission, the investigator or research assistant interviewed patients privately in an office in the ward. They were given a patient information sheet and the broad aims and objectives of the study described. Confidentiality issues were discussed and patients asked to sign informed consent forms if they agreed to take part in the study. The interviewer then proceeded with the demographic details and C.A.N. admission questionnaire. The average interview took approximately 20-30 minutes. Ward staff were not made aware of patients who did not agree to participate in the study. At study completion, no patient declined to participate. Also, ward staff were not involved in administering the instrument, in order to reduce the impact that the study had on ward procedures.

On discharge, the ward secretary or sister in charge notified the investigator or research assistant who then administered the exit interview using the discharge component of the questionnaire. This was done either on the day of discharge itself or the day before. Each need identified on admission was recorded onto separate discharge sheets and information relevant to that need gathered.

A number of patients were lost to the exit interview for the following reasons: Did not return from weekend leave, were considered not suitable for the program at some point after admission, or were referred to other services. These were regarded as program "drop-outs" and were not included in the study.

3.1.4. Measurements

Of the current needs assessment instruments available, the CAN was deemed most suitable for its coverage, brevity and well-established reliability and validity. For the purpose of this study, 4 extra domains were included: Anxiety symptoms, post-traumatic stress symptoms, depressive symptoms, and cigarette smoking. The domain "psychological distress" was dis-aggregated into "depression" and "anxiety" domains, and the domain of "post-traumatic stress" was added. This was necessary in order to adequately capture the nature of problems that are encountered in this setting. The majority of patients admitted to this unit have a DSM IV axis 1 diagnosis of one or more of these conditions. An additional section to each domain was added, which made enquiry about the patient's expectation of the need being met by the ward one program. The resulting instrument represents the "CAN-admission questionnaire".

In order to review whether needs were met by the admission, it was necessary to derive a suitable discharge questionnaire. This component extracts simple clinical information about duration of admission and diagnosis, and then proceeds to enquire about needs that the patient described at the admission interview. If a need was identified, then information is sought about the degree to which the need was met, and reasons for unmet need (so-called "barrier" questions). Patients reporting "none" or "low" to the degree of help received, were

regarded as having an unmet need for that problem. The interviewer then proceeded to ask a series of barrier questions about why that need was unmet. These barrier questions were described in the PNCQ instrument (Meadows et al, 2000). Where patients described met needs (answers of "moderate" or "high" on help received), a range of interventions that are deemed to be part of the ward program were offered. The person was then asked to indicate which intervention was helpful for that particular need. This list was derived from the investigator's own experience in the unit, and from a discussion with current ward staff. Following this section, a satisfaction question was included, as in the admission questionnaire.

The instrument was administered in English, as this was the language used in the ward program, and all patients are required to speak English before entering the program. The interviewers were fluent in both English and Afrikaans. Therefore any difficulties in first language Afrikaans speakers were dealt with. Where first language Xhosa speakers were encountered, a interpreter was made available in order to clarify any problems.

Questionnaires were kept in a locked cabinet and information contained in them was not conveyed to ward staff.

3.2. Data management and analysis

A database was developed using the "Microsoft Access" program. This system is ideally suited to capture of information that depends on certain answers for routing. Data analysis was performed using the "query" function of the Access program, and statistical functions of "Microsoft Excel".

Data was analysed according to numbers, percentages and 95% confidence intervals for percentages. Paired t-tests were used for comparison when the variable had two levels, such as gender, presence of borderline traits and presence axis 1 diagnosis of affective disorder. Analysis of variance (ANOVA) was used for comparison where variables had three ot more levels, such as age groups, and educational level. Two multiple regression models were developed using numbers of unmet needs at admission and discharge as dependent variables. Independent variables entered into the models included age, gender, marital status, number of admissions, and duration of contact with services.

3.3. Ethical and legal considerations

3.3.1. Potential benefits and harms of the study

(beneficence and non-maleficence) - Benefits included the potential to review the admission together with trained personnel and revisit areas not properly explored. Areas that required further attention could then have been brought to the attention of staff. Harm may have befallen patients who became distressed about re-discussing issues or who felt these were inadequately dealt with. The investigator referred these back to the consultant in charge, Dr R. Bothwell, for further investigation.

3.3.2. Equity and justice

Related to the above issue, was the problem of unmeetable needs, particularly where resources are unable to provide services. Again, the investigator undertook to refer all such problems to the appropriate agency. Where resources were unable to meet need, this constituted a higher ethical debate which may have demanded feedback to higher authorities, such as regional psychiatric administrators. If services are

clearly deficient in an area, then this study aims to provoke a corrective response.

3.3.3. Informed consent

All patients were provided with a patient information sheet, which described the scope and aims of this study. The investigator and research assistant explained any other issues as they arose. Patients who decided not to partake in this study were reassured that their decision would not bias them or be held against them at any future junction. This information was not fed back to the treating team so as to avoid such bias.

3.3.4. Confidentiality

Patients names were required in order to obtain diagnostic and demographic information. These remained within the confines of the questionnaire and were not reported in any way which could have revealed their identity. Completed forms were stored in a locked drawer in an office. Where disclosure was deemed to be desirable, such as where further interventions were needed, the patient's informed consent was sought. Any written or verbal reports or presentations of this information will retain the patient's anonymity. Third party information will also be held confidentially.

The study protocol was approved by the Faculty of Health Sciences Research Ethics Committee (University of Cape Town).

4.RESULTS

4.1. Characteristics of sample

4.1.1. Introduction

From 01 January 2003 to 19 September 2003, a total of 92 patients were admitted to ward one. A total of 60 patients entered the ward one program and successfully completed the treatment. All 60 agreed to be interviewed at the beginning and end of the program. A total of 32 completed initial interviews but were prematurely discharged. Therefore no data is available for the exit interview, and these patients were not included in this analysis. Data are presented here on the 60 patients completing the program for whom there is both admission and discharge data.

4.1.2. Socio-demographic characteristics

The mean age of patients was 37.1 (SD 11.8) years, with a range of 21-66 years (Table 4.1.).

Two thirds (66.7%) of patients were women, and only 5 out of 60(8,3%) were married. There were 31 (51.7%) divorced or separated patients and 21 were single (35.0%). The majority of patients had at least a standard 8 (grade 10) education (46 or 76.7%)- of these 12 (20.0%) had a tertiary education. Unemployment affected 37 (61.7%) at the time of admission, with the remainder being distributed between the professional (5 or 8,3%), technical (6 or 10.0%) and artisan (12 or 20.0%) occupational groups.

A number of patients spoke more than one home language: 43 of the 60 (71.7%) were English first language speakers and 34 (56.7%) were Afrikaans first language speakers. 19 of these spoke both languages fluently. There were 2 Xhosa speakers, and 1 foreign language speaker. 20 (33%) lived in their own house, and a further 32 (53%) lived in a family house. Of

Table 4.1. Socio-demographic characteristics (N=60)

		n	%
Age (years)	Mean	37.12	
	18-25	8	13.3
	26-35	25	41.7
	35-45	16	26.7
	45+	11	18.3
Gender	Male	20	33.3
	Female	40	66.7
Marital status	Single	21	35.0
	Married	5	8.3
	Divorced or separated	31	51.7
	Widow(er)	3	5.0
Education	Std 6	4	6.7
	Std 6-8	10	16.7
	Std8-10	34	56.7
	Tertiary education	12	20.0
Occupation	Professional	5	8.3
	Technical	6	10.0
	Artisan	12	20.0
	Unemployed	37	61.7
Home language	English	43	71.7
	Afrikaans	34	56.7
	Xhosa	2	3.3
	English and Afrikaans	19	31.7
	Other	1	1.7
Home environment	Own house	20	33.3
	Family house, lives inside	29	48.3
	Others house, lives inside	5	8.3
	Family house, lives outside	3	5.0
	Others house, lives outside	0	-
	No fixed abode	3	5.0

these, 3 lived "outside"- usually in a semi-permanent wooden structure or "wendy house". 3 patients had no fixed abode.

4.1.3. Service utilisation characteristics

Data regarding service utilisation characteristics are presented in table 4.2. Patients present to ward one from a number of referral sources. The majority (45 or 75.0%) were referred by local psychiatric services: 16 or 26.7% were referred both from the psychiatric emergency unit ("C23") at Groote Schuur Hospital and community psychiatric clinics, while a further 13 (21.6%) were referred from other wards at Valkenberg Hospital. A few were referred from private psychiatrists (2 or 3.3%), local secondary hospitals (4 or 6.7%), or other locations (7 or 11.7%). These included non-governmental organisations and non-psychiatric medical practitioners.

Almost all patients referred to ward one all had easy access to psychiatric services (53 or 88.3%). With regard to previous psychiatric admissions, 16 (26.7%) had never been admitted before. Almost half (26 or 43.3%) had been admitted on 1 or 2 prior occasions, while 14 (23.3%) had been admitted 3-5 times before. A few patients (4 or 6.7%)had been admitted more than 5 times. Most patients declared that their problem had begun some 1-6 months previously. Of these, 27 (45.0%) began 1-3 months before admission, and 21 (35.0%) 4-6 months before. Only 3 (5.0%) had experienced brief symptoms of less than one month's duration, and 1 (1.7%) had chronic symptoms exceeding 12 months. Time since first contact followed a similar pattern: 13 (21.7%) had less than 1 month's contact, while 36 (60.0%) had made contact from 1-6 months prior to being admitted.

Table 4.2. Service utilisation characteristics (N=60)

		n	%
Referral source			
	C23	16	26.7
	Valkenberg ward	13	21.7
	Community clinic	16	26.7
	Private psychiatrist	2	3.3
	Secondary hospital	4	6.7
	Other	7	11.7
	Unknown	2	3.3
Accessibility of services			
	Near enough to walk	53	88.3
	Needs taxi\public transport	6	10.0
	relies on others for lift	1	1.7
	Not easily accessible	0	0.0
Number of psychiatric admissions			
	None	16	26.7
	1 to 2	26	43.3
	3 to 5	14	23.3
	5 to 10	4	6.7
	more than 10	1	1.7
Duration of problem			
	Less than 1 month	3	5.0
	1 to 3 months	27	45.0
	4 to 6 months	21	35.0
	7 to 12 months	8	13.3
	More than 12 months	1	1.7
Time since first contact			
	Less than 1 month	13	21.7
	1 to 3 months	26	43.3
	4 to 6 months	10	16.7
	7 to 12 months	5	8.3
	More than 12 months	6	10.0

4.1.4. Discharge diagnosis

Discharge diagnoses based on intake interviews and continuous assessment by the ward team were recorded. Criteria according to Diagnostic and Statistical Manual Version IV (DSM IV) were used. Data for axes I, II, and III are reported on in this study. Discharge diagnoses as recorded by clinicians are presented in table 4.3. A clear preponderance of depressive disorders is seen, with a total number of diagnoses of DSM IV major depression made in 41 (68.3%) patients. A total of 25 (41.7%) diagnoses of anxiety disorders was made, including those which were co-morbid with depressive and other disorders.

With regard to axis II, a total of 39 (65.0%) diagnoses of "cluster B" personality traits was made; this broke down into 7 diagnoses of borderline personality traits, 7 borderline personality disorders, and 6 "cluster B" personality traits. A further 14 (23.3%) patients were diagnosed with histrionic, anti-social or narcissistic personality traits or disorder.

The commonest physical problem occurred in 5 (8.3%) patients who were discharged with axis III diagnoses of "seizure disorders", including non-epileptiform seizures (so-called "pseudo-seizures"). A further 2 had other nervous system abnormalities. A number of other physical problems were noted only in individual patients, but are not shown in table 4.3.

Table 4.3. Discharge diagnosis including co-morbidity (N=60)

			n	%
Axis I	**Depressive disorders**	Major depressive episode\disorder	41	68.3
		Dysthymic disorder	14	23.3
		Adjustment disorder	5	8.3
		Bipolar disorder- depressive episode	2	3.3
	Other mood disorders	Bipolar disorder- manic or other	4	6.7
		Other mood disorder	6	10.0
	Psychotic disorders	Psychotic disorder	1	1.7
	Anxiety disorders	Panic attacks\disorder	5	8.3
		PTSD	11	18.3
		Obssesive-compulsive disorder	2	3.3
		Social phobia	3	5.0
		Other anxiety disorder	4	6.7
	Other disorders	Conversion disorder- incl pseudoseizures	2	3.3
		Alcohol abuse\dependence	8	13.3
		Other substance abuse\dependence	9	15.0
		Eating disorders	2	3.3
		V-codes	0	-
		Bereavement	2	3.3
Axis II		Cluster A personality traits\disorder	1	1.7
		Borderline traits	7	11.7
		Borderline personality disorder	7	11.7
		Cluster B personality traits	6	10.0
		Anti-social personality traits\disorder	6	10.0
		Narcisstic personality traits\disorder	3	5.0
		Histrionic personality traits\disorder	5	8.3
		Dependent personality traits\disorder	13	21.7
		Avoidant personality traits\disorder	2	3.3
		Other personality traits\disorder	1	1.7
Axis III		Seizure disorder	5	8.3
		Other CNS problem- neuropathy	2	3.3
		Tuberculosis- current or recent	4	6.7
		Hypertension	4	6.7
		HIV\AIDS	2	3.3
		Peptic ulcer disease	3	5.0
		Gynaecological problem	4	6.7

4.2. C.A.N.-assessed needs on admission

The mean total numbers of needs of the 60 patients completing the ward one program was 9.2 (SD 3.4, range 2-21). This reflects a mean met needs of 2.5 (SD 1.6, range 0-7) and a mean unmet needs of 6.7 (SD 2.8, range 2-14). Needs are defined as deficits in function, physical environment, mental or physical health. Unmet need occurs where these deficits are perceived to be fully or partially provided for be available services.

The numbers of patients recording met needs and unmet needs on the 26 domains of the modified C.A.N. are presented in table 4.4. Almost every patient declared a need in the area of "depression" (59, 98.3%). Only "self-harm" and "anxiety" were comparable, with 48 (80.0%) and 46 (76.7%) total needs respectively. For these high scoring domains, "depression" and "self-harm", included only 1 met need, while for "anxiety", 20 of the 46 (43.5%) declared that the need was met on admission.

Other need domains where more than half of the patients recorded a need: "money" (38, 63.3%), "daily activities" (35, 58.3%), "company" (35, 58.3%), and "information" (33, 55.0%). No patient declared a met need for "daily activities" and only 1 for "company". However, 26/38 (68.4%) and 19/33 (57.6%) declared met needs for "money" and "information" respectively.

Other than those domains mentioned above, relatively high proportions of unmet need were reported for the following domains: "psychotic symptoms" (15/21, 71.4%), "post-traumatic stress" (24/28, 85.7%), "safety to others" (24/25, 96.0%), "physical and sexual abuse" (4/6, 66.7%), "alcohol" (7/8, 87.5%), "childcare" (11/13, 84.6%), "transport" (5/5, 100.0%), "cigarette smoking" (14/14. 100.0%), "intimate relationships" (29/29, 100.0%), and "sexual expression" (24/25, 96.0%).

Table 4.4.C.A.N.-assessed needs on admission (N=60)

Need (numbers of needs)	Unmet need	Met need	Total needs	%
Accommodation (13)	2	11	13	21.7
Food (12)	1	11	12	20.0
Looking after the home (14)	3	10	14	23.3
Self care (3)	0	3	3	5.0
Daily activities (35)	35	0	35	58.3
Physical health (22)	4	18	22	36.7
Psychotic symptoms (21)	15	6	21	35.0
Information (33)	14	19	33	55.0
Depression (59)	58	1	59	98.3
Self harm (48)	47	1	48	80.0
Anxiety (46)	26	20	46	76.7
Post-traumatic stress (28)	24	4	28	46.7
Safety to others (25)	24	1	25	41.7
Physical and sexual abuse (6)	4	2	6	10.0
Alchohol (8)	7	1	8	13.3
Drugs (1)	0	1	1	1.7
Childcare (13)	11	2	13	21.7
Basic education (0)	0	0	0	-
Telephone (0)	0	0	0	-
Transport (5)	5	0	5	8.3
Money (38)	12	26	38	63.3
DG (8)	2	6	8	13.3
Cigarette smoking (14)	14	0	14	23.3
Intimate relationships (29)	29	0	29	48.3
Sexual expression 25)	24	1	25	41.7
Company (35)	34	1	35	58.3

A low number of needs in the domains of "physical and sexual abuse" (6 total needs, 10.0%), "alcohol" (8 total needs, 13.3%) and "drugs" (1 total need, 1.7%) was reported.

The dis-aggregated domains of "depression", "anxiety" and "post-traumatic stress" yielded 133 total needs. The added domains of "physical and sexual abuse" and "cigarette smoking" added a total of 20 needs.

4.2.1. Informal help received

The C.A.N.-assessed informal help received from friends and relatives is shown in table 4.5. For each form of help, the patient reports either "none", "low", "moderate", or "high" help having been received. More than 50% of the patients reported "no help" received from informal sources for these specific needs: "daily activities", "physical health", "information", "anxiety", "post-traumatic stress", "safety to others", "physical and sexual abuse", "drugs", "disability grant", "intimate relationships", "sexual expression", and "company". A "high" amount of informal help was received by more than 50% of patients who declared needs for "food" and "childcare".

4.2.2. Formal help received

The level of formal help received is reflected in table 4.6. In this respect, it can be seen that fairly high percentages of "no help" are seen in a number of need domains. More than 70% of respondents said that they received "no help" from formal services in "accommodation", "food", "looking after the home", self-care", "daily activities", "post-traumatic stress", "safety to others", "transport", "money", intimate relationships", sexual expression", and "company". Low levels of formal help were seen, as evidenced by smaller percentages in the "moderate" and "high" help columns. The only exception to this was for "drugs" where 100% of "high" help was seen, but then there was only 1 patient who declared a need in this area.

Table 4.5. Informal help received (N=60)

Need (number of needs)	None		Low		Moderate		High		Unknown	
	n	%	n	%	n	%	n	%	n	%
Accommodation (13)	5	39	0	0	2	15	4	31	1	15
Food (12)	1	8	1	8	3	25	7	58	0	0
Looking after the home (14)	3	21	3	21	5	36	2	14	0	0
Self care (3)	0	0	0	0	2	67	1	33	0	0
Daily activities (35)	22	63	8	23	2	6	2	6	0	0
Physical health (22)	13	59	0	0	4	18	2	9	1	5
Psychotic symptoms (21)	10	48	7	33	1	5	2	10	0	0
Information (33)	26	79	4	12	3	9	0	0	0	0
Depression (59)	18	31	17	29	7	12	17	29	0	0
Self harm (48)	22	46	6	13	5	10	15	31	0	0
Anxiety (46)	26	56	7	15	5	11	7	15	1	2
Post-traumatic stress (28)	20	71	6	21	0	0	1	4	0	0
Safety to others (25)	21	84	2	8	0	0	3	12	0	0
Physical and sexual abuse (6)	5	83	1	17	0	0	0	0	0	0
Alchohol (8)	3	38	2	25	2	25	0	0	0	10
Drugs (1)	1	100	0	0	0	0	0	0	0	0
Childcare (13)	1	8	3	23	2	15	7	54	0	0
Basic education (0)	0	0	0	0	0	0	0	0	0	0
Telephone (0)	0	0	0	0	0	0	0	0	0	0
Transport (5)	0	0	0	0	3	60	2	40	0	0
Money (38)	11	29	9	24	7	18	11	29	0	0
DG (8)	5	63	1	13	0	0	0	0	2	25
Cigarette smoking (14)	6	43	6	43	2	14	0	0	0	0
Intimate relationships (29)	24	83	2	7	2	7	1	3	0	0
Sexual expression (25)	25	100	0	0	0	0	0	0	0	0
Company (35)	22	63	6	17	4	11	3	9	0	0

Table 4.6. Formal help received (N=60)

Need (number of needs)	None		Low		Moderate		High		Unknown	
	n	%	n	%	n	%	n	%	n	%
Accommodation (13)	11	85	1	8	0	0	0	0	0	8
Food (12)	11	92	0	0	0	0	1	8	0	0
Looking after the home (14)	13	93	0	0	0	0	0	0	0	7
Self care (3)	3	100	0	0	0	0	0	0	0	0
Daily activities (35)	33	94	1	6	0	0	0	0	0	0
Physical health (22)	5	23	0	0	10	45	4	18	1	5
Psychotic symptoms (21)	8	38	4	19	8	38	0	0	0	0
Information (33)	18	55	12	36	2	6	1	3	0	0
Depression (59)	15	25	13	22	21	36	10	17	0	0
Self harm (48)	21	44	12	25	7	15	7	15	1	2
Anxiety (46)	28	61	14	30	3	6	1	2	0	0
Post-traumatic stress (28)	20	71	2	7	3	11	2	7	0	0
Safety to others (25)	22	88	3	12	1	4	0	0	0	0
Physical and sexual abuse (6)	4	50	1	17	0	0	3	33	0	0
Alchohol (8)	4	50	2	25	0	0	1	13	0	13
Drugs (1)	0	0	0	0	0	0	1	100	0	0
Childcare (13)	8	62	0	0	3	23	2	15	0	0
Basic education (0)	0	0	0	0	0	0	0	0	0	0
Telephone (0)	0	0	0	0	0	0	0	0	0	0
Transport (5)	5	100	0	0	0	0	0	0	0	0
Money (38)	30	79	2	5	6	16	0	0	0	0
DG (8)	4	50	1	13	2	25	0	0	1	13
Cigarette smoking (14)	9	64	5	36	0	0	0	0	0	0
Intimate relationships (29)	22	76	7	24	0	0	0	0	0	0
Sexual expression (25)	23	92	1	4	1	4	0	0	0	0
Company (35)	34	97	1	3	0	0	0	0	0	0

4.2.3. Help required from formal services

The C.A.N.-assessed help required from formal services is reported in 4.7. These percentages reflect a wide range of help required, with a relative polarisation between "none" required and "high" help required. High numbers of patients did not require help for "food"(83.3%), "looking after the home"(85.7%), and "self care"(100.0%). "High" help was required for "information"(75.8%), "self harm"(62.5%), "drugs"(100.0%), and "sexual expression"(76.0%).

4.2.4. Right type of help received

Figures describing reflecting the appropriateness of help are reported table 4.8. "yes\no\unknown" answers are given to the question of whether help is of the right type. Approximately equal percentages of "yes" and "no" were recorded for "accommodation" (54\38), "psychotic symptoms" (48\48), "information" (61\39), "depression" (41\56), "self harm" (50\48), "anxiety" (59\39), "alcohol" (50\38), "childcare" (54\46), "transport" (60\40), "disability grant" (38\38), and "cigarette smoking" (50\36). More than 70% of patients reported "no" to "right type" of help for "daily activities", "safety to others", "sexual expression", and "company". "Yes" answers in more than 70% of patients who reported that need, were seen in "food", "self care", "drugs", and "money".

4.2.5. Satisfaction with help received

Patient satisfaction with services, both formal and informal, is reflected in table 4.9. Need domains where satisfaction exceeded 70% of patients recording that need, were seen for "food", self care", and "drugs". There were many more need domains in which more than 70% of patients said "no" to the question of satisfaction: "daily activities", "information", "anxiety", "post-traumatic stress", "safety to others", "disability grant", "cigarette smoking", "intimate relationships", "sexual expression", and "company". For the remainder of the domains of need, patients were more divided on the issue of satisfaction.

4.2.6. Patient expectations of ward one

The majority of patients reported a moderate or high expectation of help needed from ward one for the particular need. These results are presented in table 4.10. 20% or more patients who reported a need in the domains of "accommodation" (23.1%), "food" (33.3%), "transport" (20.0%), "money" (21.1%), and "disability grant" (25.0%), reported "none" for help required from ward one. "Moderate" help was required fairly commonly when the need was "physical and sexual abuse" (50.0%), "drugs" (100.0%), "childcare" (92.3%), "intimate relationships" (82.8%), "sexual expression" (84.0%), and "company" (91.4%).

Domains where low percentages of "high" help expected from ward one were evident, included those mentioned above under "moderate" help expected. This clustering of "moderate" and "high" help required, was less prominent in those needs mentioned first in this section. A relative polarisation of "none" versus "high\moderate" help required was seen, but with a preponderance of "high" help required.

Table 4.7. Formal help required (N=60)

	None		Low		Moderate		High		Unknown	
Need (number of needs)	n	%	n	%	n	%	n	%	n	%
Accommodation (13)	7	54	0	0	2	15	3	23	1	8
Food (12)	10	83	1	8	0	0	1	8	0	0
Looking after the home (14)	12	86	0	0	1	7	0	0	1	7
Self care (3)	3	100	0	0	0	0	0	0	0	0
Daily activities (35)	14	40	5	14	3	9	10	29	2	6
Physical health (22)	3	14	0	0	10	45	6	27	1	5
Psychotic symptoms (21)	1	5	4	19	10	48	5	24	0	0
Information (33)	4	12	3	9	1	3	25	76	0	0
Depression (59)	3	5	5	8	23	39	28	47	0	0
Self harm (48)	4	8	3	6	11	23	30	63	0	0
Anxiety (46)	6	13	9	20	12	26	18	39	1	2
Post-traumatic stress (28)	5	18	5	18	7	25	10	36	0	0
Safety to others (25)	3	12	3	12	3	12	17	68	0	0
Physical and sexual abuse (6)	2	33	1	17	0	0	3	50	0	0
Alchohol (8)	3	38	0	0	0	0	4	50	1	13
Drugs (1)	0	0	0	0	0	0	1	100	0	0
Childcare (13)	5	38	0	0	5	38	3	23	0	0
Basic education (0)	0	0	0	0	0	0	0	0	0	0
Telephone (0)	0	0	0	0	0	0	0	0	0	0
Transport (5)	2	40	0	0	0	0	2	40	1	20
Money (38)	39	15	8	3	24	9	29	11	0	0
DG (8)	1	13	1	13	4	50	1	13	1	13
Cigarette smoking (14)	7	50	2	14	0	0	5	36	0	0
Intimate relationships (29)	8	28	4	14	3	10	14	48	0	0
Sexual expression (25)	5	20	1	4	0	0	19	74	0	0
Company (35)	17	49	4	11	3	9	9	26	2	6

Table 4.8. Right type of help received (N=60)

	No		Yes		Unknown	
Needs (numbers of needs)	%	n	%	n	%	n
Accommodation (13)	54	7	38	5	8	1
Food (12)	8	1	92	11	0	0
Looking after the home (14)	29	4	50	7	21	2
Self care (3)	0	0	100	3	0	0
Daily activities (35)	77	27	14	5	6	2
Physical health (22)	29	6	61	13	7	1
Psychotic symptoms (21)	48	10	48	10	5	1
Information (33)	61	20	39	13	0	0
Depression (59)	41	24	56	33	3	2
Self harm (48)	50	24	48	23	2	1
Anxiety (46)	59	27	39	18	2	1
Post-traumatic stress (28)	57	16	29	8	11	3
Safety to others (25)	84	21	16	4	4	1
Physical and sexual abuse (6)	67	4	17	1	17	1
Alchohol (8)	50	4	38	3	13	0
Drugs (1)	0	0	100	1	0	0
Childcare (13)	54	7	46	6	0	0
Basic education (0)	0	-	0	-	0	-
Telephone (0)	0	-	0	-	0	-
Transport (5)	60	3	40	2	0	0
Money (38)	24	9	76	29	0	0
DG (8)	38	3	38	3	25	2
Cigarette smoking (14)	50	7	36	5	14	2
Intimate relationships (29)	69	20	28	8	3	20
Sexual expression (25)	96	24	4	1	0	0
Company (35)	77	27	20	7	3	1

Table 4.9. Satisfaction with help received (N=60)

	Satisfied			
	No		Yes	
Needs (numbers of needs)	n	%	n	%
Accommodation (13)	7	62	5	38
Food (12)	0	0	12	100
Looking after the home (14)	9	64	4	29
Self care (3)	0	0	3	100
Daily activities (35)	31	89	3	9
Physical health (22)	8	41	12	59
Psychotic symptoms (21)	11	57	9	43
Information (33)	31	94	2	6
Depression (59)	34	58	25	42
Self harm (48)	27	56	21	44
Anxiety (46)	33	72	13	28
Post-traumatic stress (28)	22	79	5	18
Safety to others (25)	22	88	4	16
Physical and sexual abuse (6)	4	67	2	33
Alchohol (8)	5	63	2	38
Drugs (1)	0	0	1	100
Childcare (13)	8	62	5	38
Basic education (0)	0	-	0	-
Telephone (0)	0	-	0	-
Transport (5)	3	60	2	40
Money (38)	21	55	17	45
DG (8)	6	75	2	25
Cigarette smoking (14)	11	79	3	21
Intimate relationships (29)	25	86	4	14
Sexual expression (25)	25	100	0	0
Company (35)	31	89	4	11

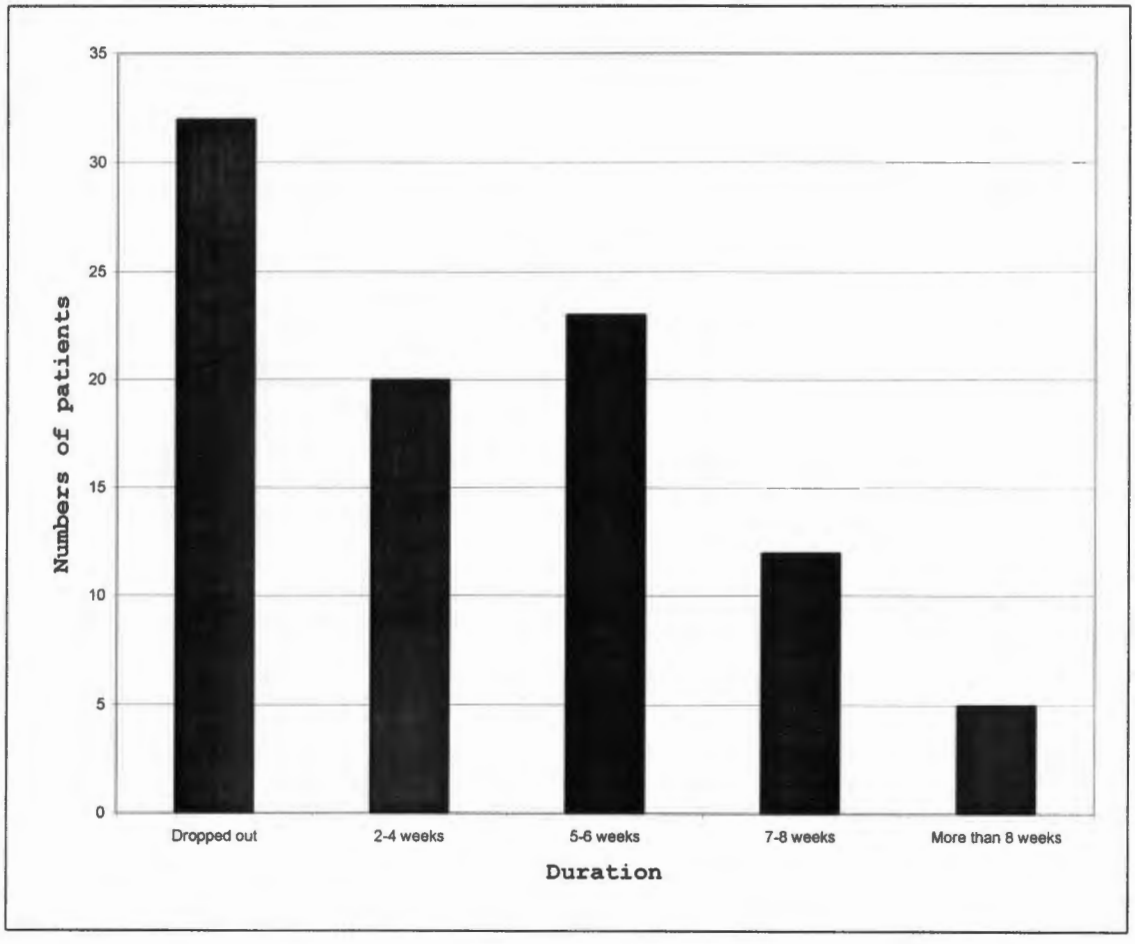
Table 4.10. Patient expectations of ward one (N=60)

	None		Low		Moderate		High		Unknown	
Needs (numbers of needs)	n	%	n	%	n	%	n	%	n	%
Accommodation (13)	3	23	0	0	3	23	6	46	1	7
Food (12)	4	33	0	0	0	0	7	58	1	8
Looking after the home (14)	1	7	0	0	2	14	10	71	0	0
Self care (3)	0	0	0	0	1	33	2	66	0	0
Daily activities (35)	0	0	0	0	1	3	32	91	1	0
Physical health (22)	1	5	0	0	2	9	16	73	1	3
Psychotic symptoms (21)	2	10	1	5	1	5	16	76	1	5
Information (33)	0	0	0	0	0	0	32	97	1	5
Depression (59)	0	0	0	0	3	5	56	95	0	3
Self harm (48)	2	4	0	0	0	0	45	94	1	0
Anxiety (46)	0	0	1	2	1	2	43	93	1	2
Post-traumatic stress (28)	3	11	1	4	0	0	22	79	1	2
Safety to others (25)	0	0	1	4	2	8	23	92	0	4
Physical and sexual abuse (6)	1	17	0	0	3	50	2	33	0	0
Alchohol (8)	0	0	1	13	0	0	6	75	0	0
Drugs (1)	0	0	0	0	1	100	0	0	0	0
Childcare (13)	0	0	0	0	12	92	1	8	0	0
Basic education (0)	0	0	0	0	0	0	0	0	0	0
Telephone (0)	0	0	0	0	0	0	0	0	0	0
Transport (5)	1	20	0	0	0	0	4	80	0	0
Money (38)	8	21	1	3	3	8	23	61	3	0
DG (8)	2	25	0	0	0	0	4	50	2	8
Cigarette smoking (14)	1	7	0	0	1	7	8	57	4	25
Intimate relationships (29)	1	3	0	0	24	83	2	7	2	6.9
Sexual expression (25)	2	8	0	0	21	84	2	8	0	7
Company (35)	1	3	2	5	32	91	0	0	1	0

4.3. Duration of admission

Figures reflecting the duration of the admission of ward one patients is seen in graph 4.6. As previously mentioned, 32 patients "dropped out" of the program, and were prematurely discharged. 20 of the 60 spent 2-4 weeks in the ward, and a further 23, spent 5-6 weeks. The mean duration of admission was 5.7 weeks (range 2-12, SD 2,1).

Figure 4.1. Duration of admission (N=92)



4.4. Help received from ward one at discharge

The degree of help received from ward one is presented in table 4.12. Patients rated the degree of help from "none", "low", "moderate", "high", or "unknown". For the purposes of recording barriers to help received, patients who rated "none" or "low" help, were asked to define a barrier to that need being met. If they rated "moderate" or "high" help received, they were not asked to answer a barrier question, but to proceed onto rating services at ward one.

According to the clusters as above, a greater degree of unmet need ("none" + "low") was seen for needs "accommodation" (10 vs. 2), "looking after the home" (7 vs. 6), "post-traumatic stress" (16 vs 11), "child care" (7 vs. 6), "transport" (3 vs. 2), "money" (22 vs. 16), "cigarette smoking" (13 vs. 1), and "sexual expression" (21 vs. 3). All other needs were at least equally met or more frequently reported as being met.

More than 50% of patients reported a "moderate" or "high" degree of help with regard to "daily activities" (24 vs. 10), "physical health" (16 vs. 4), "information" (23 vs. 10), "depression" (53 vs. 5), "self harm" (34 vs. 14), "anxiety" (38 vs. 8), "physical and sexual abuse" (5 vs. 1), and "alcohol" (5 vs. 2).

4.5. Barriers to receiving help from ward one

When patient reported receiving a degree of help as "none" or "low", they were presented with possible reasons for this. The numbers of "barrier" questions with respect to individual needs are presented in table 4.9. If a patient indicated that they had received "moderate" or "high" help, then the barrier was regarded as "not applicable"- these are recorded in column 1 of table 4.9.

The first barrier- "I prefer to manage myself"- was fairly commonly reported. For "accommodation", 6/11 barriers were attributed to this. Other needs not met due to this barrier

included "looking after the home" (2 out of 8 barriers, 25%), "daily activities" (2 out of 11, 18.2%), "information" (3 out of 10, 30.0%), "self harm" (5 out of 14, 35.7%), "safety to others" (3 out of 12, 25.0%), "childcare" (4 out of 7, 57.1%), "money" (7 out of 22, 31.8%), "cigarette smoking" (7 out of 13, 53.8%), and "company" (7 out of 16, 43.8%).

The barrier- "nothing more could help"- was infrequently reported as the cause for needs being unmet in the ward. It was encountered in "looking after the home" (3 out of 8, 37.5%), and "company" (3 out of 16, 18.8%) most commonly.

Similarly, "I didn't know where or how to get more help", was an uncommon barrier, only in "self care" (2), "daily activities" (4), "safety to others" (2), and "company" (2), was it more evident. Patient's reported a fear of asking for help ("I was afraid to ask for help") for a few specific needs: 4 out of 9 (44.4%) in "psychotic symptoms", 2 out of 10 (20.0%) in "information", 3 out of 14 (21.4%) in "self harm", 3 out of 17 (17.6%) in "post-traumatic stress", and 8 out of 22 (36.4%) in "sexual expression".

"I asked for help but it wasn't given" was encountered in many need areas, but to a limited degree. It did appear to be particularly problematic for "depression" (3 out of 5 barriers), "self harm" (3 out of 14, 21.4%), "anxiety" (2 out of 8, 25.0%), and "money" (4 out of 22, 18.2%).

The wrong type of help ("I asked but got the wrong type of help" was most commonly reported in 3 need areas: "post-traumatic stress" (3 out of 17, 17.6%), "safety to others" (5 out of 12,41.7%), and "money" (5 out of 22.7%).

Table 4.11.Help received from ward one (N=60)

Needs (numbers of needs)	Low\no help		moderate\high help		unknown	
	n	%	n	%	n	%
Accommodation (13)	10	76.9	2	15.4	1	7.7
Food (12)	5	41.7	5	41.7	2	16.7
Looking after the home (14)	7	50.0	6	42.9	1	7.1
Self care (3)	3	100.0	0	0.0	0	0.0
Daily activities (35)	10	28.6	24	68.6	1	2.9
Physical health (22)	4	18.1	16	72.7	2	9.0
Psychotic symptoms (21)	8	38.1	12	57.1	1	4.8
Information (33)	10	30.3	23	69.7	0	0.0
Depression (59)	5	8.5	53	89.8	1	1.7
Self harm (48)	14	29.2	34	70.8	0	0.0
Anxiety (46)	8	17.4	38	82.6	0	0.0
Post-traumatic stress (28)	16	57.1	11	39.3	1	3.4
Safety to others (25)	12	48.0	13	52.0	0	0.0
Physical and sexual abuse(6)	1	16.7	5	83.3	0	0.0
Alchohol (8)	2	25.0	5	62.5	1	12.5
Drugs (1)	0	0.0	1	100.0	0	0.0
Childcare (13)	7	53.8	6	46.1	0	0.0
Basic education (0)	0	0.0	0	0.0	0	0.0
Telephone (0)	0	0.0	0	0.0	0	0.0
Transport (5)	3	60.0	2	40.0	0	0.0
Money (38)	22	57.9	16	42.1	0	0.0
DG (8)	3	37.5	5	62.5	0	0.0
Cigarette smoking (14)	13	92.9	1	7.1	0	0.0
Intimate relationships (29)	14	48.3	14	48.3	1	3.4
Sexual expression (25)	21	84.0	3	12.0	1	4.0
Company (35)	16	45.7	19	54.3	0	0.0

Table 4.12. Barriers to receiving help from ward one

Need (numbers of needs)	Not applicable		"I prefer to manage myself"		"Nothing more could help"		"I didn't know where or how to get help"	
	n	%	n	%	n	%	n	%
Accommodation (13)	2	15.4	6	46.2	1	7.7	0	0.0
Food (12)	7	58.3	1	8.3	1	8.3	1	8.3
Looking after the home (14)	6	42.9	2	14.3	3	21.4	0	0.0
Self care (3)	0	0.0	1	33.3	0	0.0	2	66.7
Daily activities (35)	24	68.6	2	5.7	0	0.0	4	11.4
Physical health (22)	17	77.3	0	0.0	0	0.0	0	0.0
Psychotic symptoms (21)	12	57.1	0	0.0	0	0.0	0	0.0
Information (33)	23	69.7	3	9.1	0	0.0	0	0.0
Depression (59)	54	91.5	0	0.0	0	0.0	0	0.0
Self harm (48)	34	70.1	5	10.4	0	0.0	1	2.1
Anxiety (46)	38	82.6	1	2.1	1	2.1	0	0.0
Post-traumatic stress (28)	11	39.3	3	10.7	1	3.6	1	3.6
Safety to others (25)	13	52.0	3	12.0	1	12.0	2	24.0
Physical and sexual abuse (6)	5	83.3	0	0.0	0	0.0	0	0.0
Alcohol (8)	5	62.5	1	25.0	0	0.0	0	0.0
Drugs (1)	1	100.0	0	0.0	0	0.0	0	0.0
Childcare (13)	6	46.1	4	30.8	0	0.0	1	7.7
Basic education (0)	0	0.0	0	0.0	0	0.0	0	0.0
Telephone (0)	0	0.0	0	0.0	0	0.0	0	0.0
Transport (5)	2	40.0	1	20.0	0	0.0	1	20.0
Money (38)	16	42.1	7	18.4	2	5.3	0	0.0
DG (8)	6	75.0	0	0.0	0	0.0	0	0.0
Cigarette smoking (14)	1	7.1	7	50.0	0	0.0	0	0.0
Intimate relationships (29)	13	44.8	4	13.8	1	3.4	1	3.4
Sexual expression (25)	3	12.0	4	20.0	2	20.0	2	20.0
Company 35)	19	54.3	7	20.0	3	8.6	2	5.7

Table 4.12 continued. Barriers to receiving help from ward one

Need (number of needs)	"I was afraid to ask for help"		"I asked for help but it wasn't given"		"I asked for help but got the wrong type of help"		Other	
	n	%	n	%	n	%	n	%
Accommodation (13)	0	0.0	1	7.7	1	7.7	1	7.7
Food (12)	0	0.0	1	8.3	0	0.0	1	8.3
Looking after the home (14)	0	0.0	0	0.0	0	0.0	2	14.3
Self care (3)	0	0.0	0	0.0	0	0.0	0	0.0
Daily activities (35)	0	0.0	2	5.7	0	0.0	2	5.7
Physical health (22)	0	0.0	2	9.1	0	0.0	1	4.5
Psychotic symptoms (21)	4	19.0	1	4.8	1	4.8	2	9.5
Information (33)	2	6.1	2	6.1	2	6.1	1	3.0
Depression (59)	0	0.0	3	5.1	2	3.4	0	0.0
Self harm (48)	3	6.3	3	6.3	1	2.1	1	2.1
Anxiety (46)	2	4.2	2	4.2	1	2.2	1	2.2
Post-traumatic stress (28)	3	10.7	3	10.7	3	10.7	2	7.1
Safety to others (25)	0	0.0	0	0.0	5	20.0	2	8.0
Physical and sexual abuse (6)	0	0.0	0	0.0	1	16.7	0	0.0
Alchohol (8)	0	0.0	1	12.5	0	0.0	0	0.0
Drugs (1)	0	0.0	0	0.0	0	0.0	0	0.0
Childcare (13)	0	0.0	1	0.0	0	0.0	0	0.0
Basic education (0)	0	0.0	0	0.0	0	0.0	0	0.0
Telephone (0)	0	0.0	0	0.0	0	0.0	0	0.0
Transport (5)	0	0.0	1	20.0	0	0.0	0	0.0
Money (38)	0	0.0	4	10.5	5	13.2	4	10.5
DG (8)	0	0.0	0	0.0	0	0.0	2	25.0
Cigarette smoking (14)	0	0.0	1	7.7	1	7.7	3	23.1
Intimate relationships (29)	2	6.9	2	6.9	1	3.4	4	13.8
Sexual expression (25)	8	32.0	4	11.4	0	0.0	1	2.9
Company (35)	1	2.9	1	2.9	1	2.9	1	2.9

4.6. Services at ward one

A description of all services and interventions at ward one was presented to patients on discharge. For each need, they were asked to report whether the intervention was useful, not useful or not applicable. Interventions which patients found useful are presented in table 4.14. These figures therefore represent the proportion of patients who had the recorded need, who found the particular intervention useful.

The highlighted figures represent usefulness figures of more than 50%. In other words, where an intervention was rated as useful by more than 50% of the patients who had that need. As can be seen in the table, there is a clustering of higher usefulness around the psychiatric needs domain: "information", "depression", "self harm", and "anxiety". Other needs areas with high usefulness figures include "daily activities", "physical and sexual abuse", and "alcohol". For these needs, most interventions were useful, apart from "family\couple therapy", "employment assistance", "other organisations", "telephone", "visits (by family or friends), and "social work".

Certain interventions or services appear to have higher usefulness. Interventions that helped more than 50% of patients in 5 or more need areas included "group therapy", "life skills", "group education", "individual therapy", "informal patient interactions", and the "ward environment".

It must be pointed out that many interventions are rendered "not applicable" to particular needs. For example: the need of "food" would appear to be little helped by therapies or relaxation. Likewise, the need for a "disability grant" is only met by the intervention of "social work"- but for this service, there was high (more than 50%) usefulness.

Table 4.13. Numbers of patients finding Services useful[1]

Need (numbers of needs)	Group	Art	Life skills	Grouped	Leisure	Relax-ation	Ind therapy	Inf patient	Family\couple	Employ assist	Other org	Intake	Ward env	Tele-phone	Inf staff	Ward routine	Visit	Social work
Accommodation (13)	1	1	1	1	1	0	2	1	1	1	1	2	2	0	1	0	1	1
Food (12)	3	2	4	2	1	3	3	2	1	0	0	5	3	0	2	5	0	1
Looking after the home (14)	5	5	4	4	3	4	5	4	1	0	0	5	6	1	3	6	0	3
Self care (3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Daily activities (35)	15	**19**	**20**	14	9	13	**20**	**19**	7	4	2	17	**18**	7	13	**20**	7	8
Physical health (22)	2	2	2	2	1	3	6	2	3	0	0	4	3	2	3	2	2	0
Psychotic symptoms (21)	7	5	7	5	6	6	**12**	5	7	0	0	7	6	0	4	3	2	3
Information (33)	**17**	14	**19**	**20**	6	7	**19**	**17**	9	0	1	13	9	3	12	15	6	6
Depression (59)	**50**	**46**	**46**	**42**	**29**	**38**	**49**	**40**	17	2	2	**33**	**44**	19	**39**	**42**	23	10
Self harm (48)	**29**	**25**	**30**	**24**	14	22	**29**	**27**	9	0	0	**27**	30	16	23	21	15	6
Anxiety (46)	**25**	**24**	**30**	**25**	16	**27**	**32**	**24**	9	0	0	22	**25**	10	27	24	11	4
Post-traumatic stress (28)	10	9	8	7	4	5	11	10	1	0	0	4	6	2	4	3	3	2
Safety to others (25)	11	9	12	8	5	9	12	11	2	0	0	10	11	4	7	10	3	2
Physical and sexual abuse (6)	**4**	2	2	2	0	1	**5**	**4**	0	0	0	**3**	2	1	**4**	2	0	0
Alcohol (8)	**4**	2	**4**	**4**	2	3	3	**4**	2	0	3	2	3	2	2	3	2	0
Drugs (1)	0	0	0	0	0	0	**1**	0	0	0	**1**	**1**	**1**	0	**1**	0	0	0
Childcare (13)	6	4	4	4	3	4	6	5	3	0	0	5	4	2	4	3	1	2
Basic education (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Telephone (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transport (5)	2	2	1	2	1	1	2	2	1	0	0	2	1	0	1	1	0	1
Money (38)	2	3	3	2	1	2	13	6	2	0	1	6	3	0	4	3	0	8
DG (8)	0	0	0	0	0	1	3	0	0	0	0	1	0	0	1	0	0	**4**
Cigarette smoking (14)	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Intimate relationships (29)	11	9	10	8	3	3	12	11	2	0	1	6	**16**	3	4	5	3	1
Sexual expression (25)	1	1	1	2	0	1	3	2	2	0	0	3	2	1	1	2	1	0
Company (35)	16	13	14	15	13	7	16	14	3	0	2	13	14	7	11	14	6	3

[1] Bold type used where at least 50% of service declared useful

Table 4.13 continued. Percentages of patients finding services useful[2]

Need (numbers of needs)	Group	Art	Life skills	Group ed	Leisure	Relax-ation	Ind therapy	Inf patient	Family\couple	Employ assist	Other org	Intake	Ward env	Tele-phone	Inf staff	Ward routine	Visit	Social work
Accommodation (13)	7.7	7.7	7.7	7.7	7.7	0	15.4	7.7	7.7	7.7	7.7	15.4	15.4	0	7.7	0	7.7	7.7
Food (12)	25	16.7	33.3	16.7	8.3	25	25	16.7	8.3	0	0	41.7	25	0	16.7	41.7	0	8.3
Looking after the home (14)	35.7	35.7	28.6	28.6	21.4	28.6	35.7	28.6	7.1	0	0	35.7	42.9	7.1	21.4	42.9	0	21.4
Self care (3)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Daily activities (35)	42.9	**54.3**	**57.1**	40	25.7	37.1	**57.1**	**54.3**	20	11.4	5.7	48.6	**51.4**	11.4	37.1	**57.1**	20	22.9
Physical health (22)	9.1	9.1	9.1	9.1	4.5	13.6	27.3	9.1	13.6	0	0	18.1	13.6	9.1	13.6	9.1	9.1	0
Psychotic symptoms (21)	30.0	23.8	30.0	23.8	28.6	28.6	**57.1**	23.8	30.0	0	0	30.0	28.6	0	19.0	14.3	9.5	14.3
Information (33)	**51.5**	42.4	**57.6**	**60.6**	18.1	21.2	**57.6**	**51.5**	27.3	0	3.0	39.4	27.3	9.1	36.4	45.5	18.2	18.1
Depression (59)	**84.7**	**78.0**	**78.0**	**71.2**	49.2	**64.4**	**83.0**	**67.8**	28.8	3.4	3.4	**56.0**	**74.6**	32.2	**66.1**	**71.2**	39.0	16.9
Self harm (48)	**60.4**	**52.1**	**62.5**	**50.0**	29.2	45.8	**60.4**	**56.3**	18.8	0	0	**56.3**	62.5	33.3	47.9	43.8	31.3	12.5
Anxiety (46)	**25**	**24**	**30**	**25**	16	**27**	**32**	**24**	9	0	0	22	**25**	10	27	24	11	4
Post-traumatic stress (28)	35.7	32.1	28.6	25.0	14.3	17.9	39.3	35.7	3.6	0	0	14.3	21.4	7.1	14.3	10.7	10.7	7.1
Safety to others (25)	44.0	36.0	48.0	32.0	20.0	36.0	48.0	44.0	8.0	0	0	40.0	44.0	16.0	28.0	40.0	12.0	8.0
Physical and sexual abuse (6)	**66.7**	33.3	33.3	33.3	0	16.7	**83.3**	**66.7**	16.7	0	0	**50.0**	33.3	16.7	**66.7**	33.3	0	0
Alcohol (8)	**50.0**	25.5	**50.0**	**50.0**	25.0	37.5	37.5	**50.0**	25.0	0	37.5	25.0	37.5	25.0	25.0	37.5	25.0	0
Drugs (1)	0	0	0	0	0	0	**100.0**	0	0	0	**100.0**	**100.0**	**100.0**	0	**100.0**	0	0	0
Childcare (13)	46.2	30.8	30.8	30.8	23.1	30.8	46.1	38.5	23.1	0	0	38.5	30.8	15.4	30.8	23.1	7.7	15.4
Basic education (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Telephone (0)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Transport (5)	40.0	40.0	20.0	40.0	20.0	20.0	40.0	40.0	20.0	0	0	40.0	20.0	0	20.0	20.0	0	20.0
Money (38)	5.3	7.9	7.9	5.3	2.6	5.3	34.2	15.8	5.3	0	2.6	15.8	7.9	0	10.5	7.9	0	21.0
DG (8)	0	0	0	0	0	12.5	37.5	0	0	0	0	12.5	0	0	12.5	0	0	**50.0**
Cigarette smoking (14)	0	0	0	7.1	0	0	0	0	0	0	0	0	0	0	7.1	0	0	0
Intimate relationships (29)	37.9	31.0	34.5	27.6	10.3	10.3	41.4	37.9	6.9	0	6.9	20.7	**55.2**	10.3	13.8	17.2	10.3	3.4
Sexual expression (25)	4.0	4.0	4.0	8.0	0	4.0	12.0	8.0	8.0	0	0	12.0	8.0	8.0	8.0	8.0	4.0	0
Company (35)	45.7	37.1	40.0	42.9	37.1	20.0	45.7	40.0	8.6	0	5.7	37.1	40.0	20.0	31.4	40.0	17.1	8.6

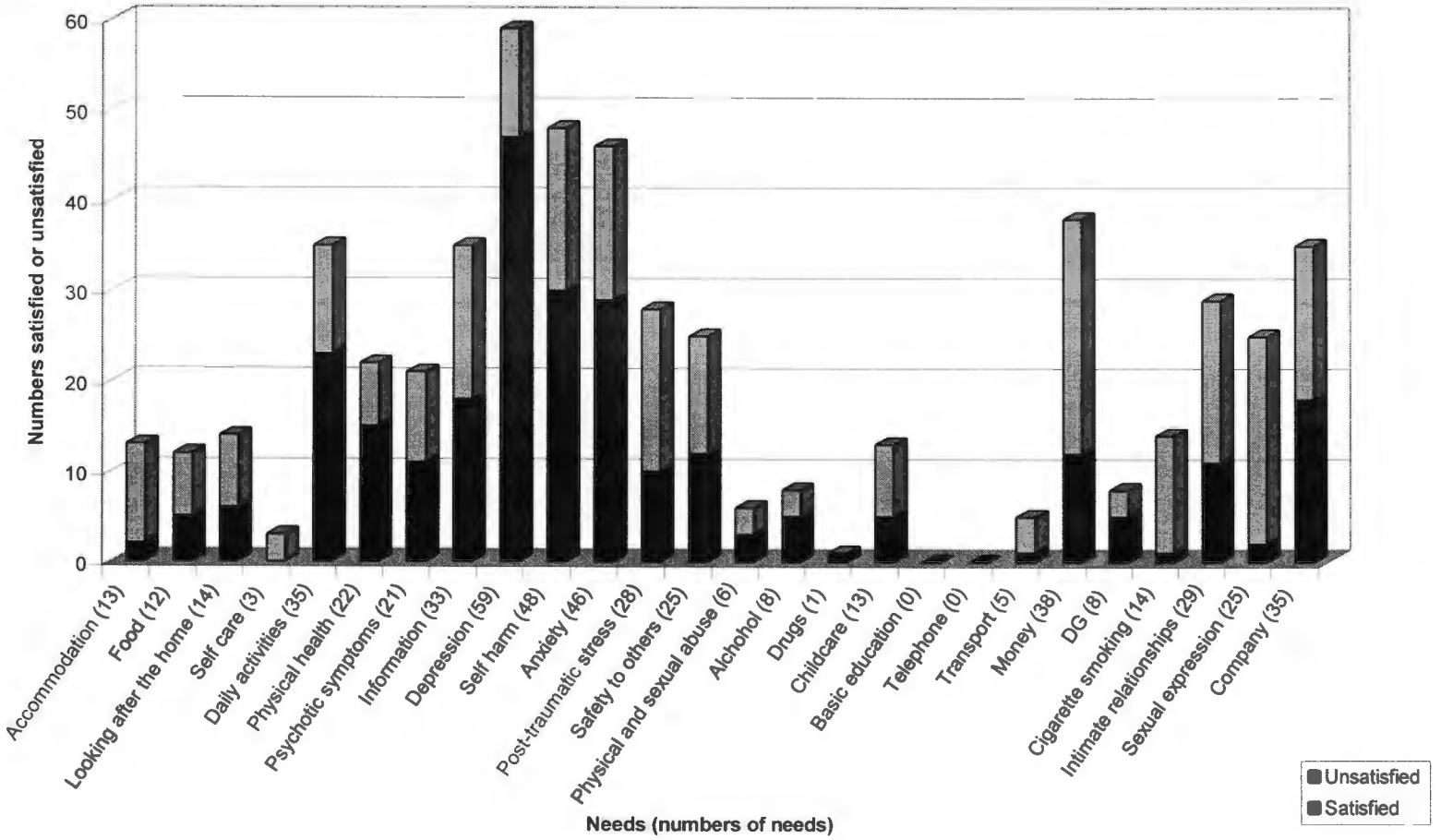
[2] Bold used where services at least 50% useful

4.7. Patient overall satisfaction with ward one

Patient responses to overall satisfaction for needs are presented in graph 4.15. The numbers of satisfied patients (blue) can be seen against the numbers of needs (purple).

The graph demonstrates that satisfaction is greatest for psychiatric needs- 47 out 59 patients were satisfied with help received for "depression". Similarly 30 out 48 were satisfied for "self harm", and 29 out 46 for "anxiety". "Daily activities" (23 out of 35), "physical health" (15 out of 22), "psychotic symptoms" (11 out of 21), "information" (18 out of 33), and "company" (18 out of 35), achieved similar numbers of satisfied patients. Other needs achieved high satisfaction, but had low total needs scores: "alcohol" (5 out of 8) and "disability grant" to name 2.

Figure 4.2. Patient satisfaction with services by need



4.8. Comparison of unmet needs on admission

A number of comparisons of patient characteristics were compared with respect to unmet needs on admission. These are shown in table 4.14. and 4.15. Where comparisons were between 2 groups or categories of patients (such as men and women), then a paired t-test was used to test for significance. Where 3 or more groups or categories were compared, then an ANOVA was used to test for variance between groups. Significance at the $p<0.05$ level was only obtained for patients who had axis II borderline traits or personality disorder: patients without borderline features were more likely to have more unmet needs on admission than those with. Regression analysis of unmet need on admission was performed, using a range of socio-demographic and clinical characteristics as dependent variables. Using this model, an R-value of 0.33 was obtained. Furthermore, age was found to account for a significant amount of the variance. The coefficient of -0.47 suggests that younger age accounts for a greater number of unmet needs on admission.

4.9. Comparison of unmet needs on discharge

A similar comparison to the above was performed, with respect to unmet needs on discharge (see table 4.12). In this analysis, there were no significant differences between groups at the $p<0.05$ level. There was a trend to significance in level of education, with a p-value of 0.08. A regression model similar to the above was also used to explain variance. In this instance, 23% of the variance was explained using this model, and age was similarly found to contribute significantly to the variance ($p=0.02$, coefficient= -0.46)).

Table 4.14. Comparison of patient characteristics for number unmet needs on admission (t-test or ANOVA)

Variable	Category	n	mean	SD	t\F	df	P
Age							
	18-24	7	7.29	3.3			
	26-34	25	6.64	2.66			
	35-44	15	7.07	3.2			
	45+	13	5.92	2.21	**0.52**	**3**	**0.67**
Gender							
	male	20	6.65	2.83			
	female	40	6.7	2.68	**1.67**	**58**	**0.47**
Marital status							
	Single	21	7.29	3.02			
	Married	5	6.45	2.67			
	Divorced or separated	31	6.4	2.7			
	Widow(er)	3	5	1.73	**0.79**	**3**	**0.51**
Education							
	Std 6	4	9.5	1.91			
	Std 7-8	10	6.8	3.22			
	Std 9-10	34	6.53	2.74			
	Tertiary education	12	6	2.3	**1.74**	**3**	**0.17**
Referral method							
	C23	16	7.13	2.66			
	Valkenberg ward	13	7.85	2.64			
	Community clinic	16	6.81	3.1			
	Private psychiatrist	2	5	1.41			
	Secondary hospital	4	6	1.63			
	Other	9	4.56	2.13	**1.97**	**5**	**0.10**
Number of psychiatric admissions							
	None	16	7.63	2.53			
	1 to 2	26	6.27	3.28			
	3 to 5	14	6	1.8			
	6 or more	4	7.75	2.06	**1.32**	**3**	**0.28**
Duration of current admission							
	2-4 weeks	19	6.84	2.19			
	5-6 weeks	24	6.83	2.71			
	7-8 weeks	11	6.91	3.56			
	9 or more weeks	6	5	3.1	**0.80**	**3**	**0.50**
Axis I affective disorder only							
	Yes	38	6.87	2.86			
	No	22	6.32	2.92	**1.67**	**58**	**0.23**
Axis II borderline traits or PD							
	Yes	38	6.16	2.57			
	No	22	7.55	2.91	**1.67**	**58**	**0.03***

*** P< 0.05**

Table 4.15. Comparison of patient characteristics for number of unmet needs on discharge (t-test or ANOVA)

Variable	Category	n	mean	SD	t\F	df	P
Age							
	18-24	7	4	4.83			
	26-34	25	3.68	2.23			
	35-44	15	4	2.11			
	45+	13	2.69	1.55	**0.77**	**3**	**0.52**
Gender							
	male	20	3.55	2.59			
	female	40	3.65	2.32	**1.67**	**58**	**0.44**
Marital status							
	Single	21	4.19	3.22			
	Married	5	3.58	2			
	Divorced or separated	31	2.2	1.3			
	Widow(er)	3	1.67	1.15	**1.57**	**3**	**0.21**
Education							
	Std 6	4	6.25	5.5			
	Std 7-8	10	3.8	2.61			
	Std 9-10	34	3.56	2.09			
	Tertiary education	12	2.58	1.57	**2.36**	**3**	**0.08**
Referral method							
	C23	16	4.06	1.88			
	Valkenberg ward	13	4.77	3.35			
	Community clinic	16	3.1875	2.14			
	Private psychiatrist	2	3.5	3.54			
	Secondary hospital	4	3.25	1.26			
	Other	9	1.89	2.26	**1.75**	**5**	**0.14**
Number of psychiatric admissions							
	None	16	4.31	2.302			
	1 to 2	26	3.31	2.936			
	3 to 5	14	3.43	1.828			
	6 or more	4	3	2.161	**0.65**	**3**	**0.59**
Duration of current admission							
	2-4 weeks	19	6.84	2.19			
	5-6 weeks	24	6.86	2.95			
	7-8 weeks	11	6.91	3.56			
	9 or more weeks	6	5	3.1	**0.76**	**3**	**0.52**
Axis I affective disorder only							
	Yes	38	3.89	2.9			
	No	22	3.05	1.43	**1.67**	**58**	**0.10**
Axis II borderline traits or PD							
	Yes	38	3.47	2.29			
	No	22	3.77	2.84	**1.67**	**58**	**0.33**

Table 4.13. Regression models for unmet need on admission and discharge

	Unmet need on admission			Unmet need on discharge		
Independent variable	Coefficient	SE	P	Coefficient	SE	P
Gender	-0.05	0.74	0.1	0.24	0.71	0.74
Age	-0.47	0.2	0.02*	-0.46	0.19	0.02*
Referral source	-0.01	0.04	0.78	-0.01	0.03	0.75
Marital status	-0.19	0.48	0.7	0.03	0.46	0.95
Education level	-0.99	0.42	0.02	-0.9	0.4	0.04
Number of admissions	0.25	0.14	0.09	-0.06	0.14	0.69
Current admission duration	0.19	0.16	0.26	-0.28	0.16	0.08
Affective disorder only	-0.22	0.71	0.76	-0.67	0.68	0.33
Borderline personality	1.08	0.72	0.14	0.49	0.69	0.49
R- squared	0.33			0.23		
Adjusted R-squared	0.21			0.09		

P< 0.05

5.DISCUSSION

5.1. Summary of findings

Of the 60 patients completing the ward one program from 01 January 2003 to 19 September 2003, 66.7% were women. Only 16 (26.7%) had never been admitted to a psychiatric hospital before. The discharge diagnoses of 41 (68.3%) of the patients was major depressive disorder. Similarly, the presence of "cluster B personality traits" or "personality disorder" was made in 39 (65.0%) patients.

The mean number of unmet needs assessed by the C.A.N. on admission was 6.7. The domains that were most frequently included were "depression" (58, 96.7%), "self-harm" (47, 78.3%), and "daily activities" (35, 58.3%). For most C.A.N. domains, levels of informal and formal help received were low. Patient expectations of the ward one program were generally high: most reported moderate or high expectations of their need being met (see table 4.10).

The mean duration of admission to ward one was 5.7 weeks. Unmet need at discharge was more commonly reported for basic and skills domains, for example "accommodation", "looking after the home ", and "transport". Patients declaring unmet need on discharge were asked to report on barriers to receiving help. The commonest barriers were "I prefer to manage myself", "I was afraid to ask for help", and "I asked for help but it wasn't given".

Services at ward one appeared to be more useful for the domains of "daily activities", "information", "depression", "self-harm", and "anxiety". Services that were consistently rated as not useful were "family or couple therapy", "employment assistance", "other organisation", "visits", and "social work". Overall satisfaction with services at ward one appears to be highest for psychiatric needs, as opposed to social, skills or functional deficits needs domains.

Patient characteristics for the numbers of unmet needs on admission and discharge were compared. Patients without borderline personality were significantly more likely to have a greater number of unmet needs on admission. Logistic regression analyses for unmet need on admission and discharge yielded R-squared values of 0.33 and 0.23 respectively.

5.2. Contributions of study

This study has contributed to the field of mental health research in the following ways:

5.2.1. Setting

It was not possible to unearth any studies in which an assessment of mental health needs has utilised a sample of South African subjects. The value of an assessment of need may be enhanced in resource scarce settings, where service planning is dependent on information about consumer requirements.

5.2.2. Effect of services on need

To date, a study reviewing clinical services' impact on unmet needs has not been conducted. Previous studies have examined service satisfaction (see Henderson et al, 1999; Leese et al, 1998), but never impact on specific service items. This study has extracted the individual service items and explored their usefulness in meeting unmet need.

5.2.3. Use of barrier questions

In addition, this study has included barrier questions to explore reasons for persistence of unmet need. This approach has been used before (See Meadows et al 2002), but only in a community sample. The use of barrier questions in an in-patient population is novel. Closer scrutiny of barriers to the meeting of need may yield important information for service providers.

5.2.4. Correlates of unmet need

A number of previous studies have attempted to describe correlates of unmet need (Bebbington et al, 2000; McRone et al, 2001; Meadows et al, 2002; Parkman et al, 1997; Slade et al, 1999a). The value of the current study with regard to correlates is in the setting as described above. Most studies to date have examined either out-patient or mixed out-patient and in-patient samples. The impact of the admission to hospital *per se* appears to be unstudied. This study reports on differences between patient characteristics with respect to unmet needs, both on admission and discharge. Logistic regression models were also applied using numbers of unmet need on admission and discharge as dependent variables.

5.3. Systematic discussion of results

5.3.1. Characteristics of study sample

The sample size used in this study was 60. This number reflects all the ward one program completers. Studies previously mentioned in section 2 ("Literature Review") use varying numbers of subjects. The smallest sample studied was 120 (Bengsston-Tops et al., 1999) to 82 (Lefebre et al., 2000). However it must be re-iterated that none of the studies described samples who had entered an in-patient clinical program.

With regard to the socio-demographic characteristics of this sample, a number of differences were seen, compared to previously described samples. The mean age of patients in this sample was 37.1, which is slightly younger than many of the other series, where the mean age was from 41 to 48 years. It is possible that patients in our setting present to mental health services at a younger age. This may be the result of socio-economic differences, such as age of school-leaving being younger. Only 20% of this sample had a tertiary education. Few other studies mentioned this parameter. Lefebre et al. (1999) quote an average of at least 12 years of

schooling in their sample. Women were clearly over-represented in this sample (66.7%). An unpublished study of patients discharged from Valkenberg Hospital acute wards revealed that men represent 62% of discharges (Milligan, unpublished data). The preponderance of women at ward one is probably due to a combination of health-seeking behaviour in women, together with the nature of the program offered at ward one. As previously mentioned, ward one deals mainly with anxiety and depressive disorders, most of which are more common in women. Men are also more likely to be employed and therefore unable to enter into an in-patient program.

It is frequently reported in the reviewed literature that patients with mental illness are single more often than not. The vast majority of samples in the literature reviewed report rates of single status of over 60% (Phelan et al, 1995; Meadows et al, 2000; McRone et al, 2001). This is in keeping with the 8.3% of this sample who were married at the time of interview. Published studies do not report single status as a correlate of unmet need. Slade et al (1999a) included marital status in a regression model, but could not demonstrate significant effect of this variable on unmet need. It can only be speculated that single status is a consequence of psychiatric illness and not a predictor of unmet need.

The number of unemployed patients was 61.7%, again being consistent with other studies: McRone et al report on 5 European countries where unemployment ranged from 57.9%-91.7%(2001). Similarly, Bengsston-Tops et al (1999) report unemployment rates of 87%. A number of factors probably contribute to this, such as functional impairment, lack of employment opportunity, and loss of work through illness. Lasalvia et al (2000) reported that a higher number of staff rated needs was predicted by patient disability and unemployment. Similarly, Slade et al (1999b) showed that higher scores on the HoNOS (Health of the Nation Outcome Scale) were associated with unmet needs, than with met needs.

The vast majority of ward one patients speak either English or Afrikaans, with most speaking English. The absence of first language Xhosa speakers must be a cause for concern. It follows that a number of Xhosa speakers with anxiety and depressive disorders are not áccessing a tertiary level neuro-clinic program. Whilst primary psychiatric services are widely distributed within these communities, it is possible that the geographic situation of Valkenberg Hospital makes access more difficult. In addition, the majority of clinicians within the service are not Xhosa - speaking, which may signal difficulties in interpreting the way that these conditions present, or the way in which they are managed. Simple barriers to including Xhosa speaking patients at ward one, may include the paucity of staff who speak Xhosa. Drennan (1996) reported that 20-30% of admissions to Valkenberg and Groote Schuur Hospitals psychiatric departments required interpretation. The absence of interpreters (usually nursing staff), contributes to delays in diagnosis, management and discharge. This problems divide must be urgently addressed.

Only 3 patients reported "no fixed abode". A further 3 lived in semi-permanent wooden structures ("wendy houses"). While this number does not directly correlate with the 2 patients reporting an unmet for "accommodation", a further 11 did report a met need, implying that a need was present but was being addressed to some degree.

5.3.2. Service utilisation characteristics

The referral sources of patients admitted to ward one reflect the patterns of psychiatric service delivery within the service. Nearly 75% (n=45) are referred by a psychiatric service. Of this number, 26.7% (16) were referred by community psychiatric clinics. As a primary level service, it could be argued that more needs could have been met at this level. However, resources such as social workers, home visit teams and counselling services are lacking in these settings. The

numbers of patients referred from clinics may be reduced by addressing these deficiencies; a decreased load on ward one would be one way to measure outcome.

Most patients were able to walk to clinics (88.3%), which suggests either that clinics are sufficiently spread out in communities, or that people are prepared to walk substantial distances without reporting a need. Another more sinister possibility exists: that patients unable to access care at all are not represented in this study. It would take a community epidemiological survey to resolve this issue.

Only 16 (26.7%)of the patients had never been admitted before, suggesting the chronicity of problems dealt with at ward one. More worrying are the numbers of patients who are admitted 3 or more times: 18 (30.0%). The reason for this was not explored. Also, this parameter is not reported on in the studies reviewed. The numbers of patients who report a duration of current problem of less than 6 months (49 or 81.7%) suggests that even for those above with recurrent problems, that some amelioration was obtained. In other words, the re-admission was a recurrence of a problem or development of a new problem, rather than an untreated old one.

The reviewed studies most commonly reported long durations of time since first contact: 15-20 years (Bengsston-Tops and Hannsson, 1999; Leese et al., 1998), but the samples were of patients with schizophrenia. Shorter durations reported by some (Hansson et al, 1995) of less than 4 years are more in keeping with this study. Most patients had only made contact within 1 year of admission. This may reflect lengthy periods of untreated disorder or lack of access to care, but is in keeping with the reported duration of problem, as commented on above.

5.3.3. Discharge diagnosis

A clear preponderance of anxiety and depressive disorders was seen in the discharge diagnosis data - in keeping with the nature of service provided at ward one. More than two thirds (68.3%) presented with DSM IV major depression. Only 5 patients attracted a diagnosis of adjustment disorder. This figure was expected to be somewhat higher, given the stressor-related problems seen at ward one. If one examines the discharge data, then of the 59 patients reporting a need in the area of depression, 53 (89.8%) reported being helped by the admission. This is a heartening statistic, and suggests that ward one is effective in meeting this need.

Similarly, a preponderance of axis II borderline personality traits or disorder was seen: 39 (65.0%) patients attracted this diagnosis. It is possible that borderline personality was being over-reported. The presence of axis I disorder may account for some of the disruptive behaviours and distress attributed to borderline personality style. The net result of a diagnosis of this personality may engender counter-transference in the clinical staff. It is possible that these and other clinicians may then regard these patients as "untreatable".

Axis III diagnoses were also reported. One remarkable figure was the low prevalence of HIV positive patients in the ward. It is assumed that HIV positive rates in this service would exceed the 3.3% seen. This may reflect a conservative testing policy currently in place. The absence of freely available anti-retrovirals may evoke a less enquiring clinical stance, due to the unavailability of treatments. The expected advent of these therapies has required that clinicians raise their levels of suspicion and enquiry to as to include as many infected patients as possible. Two other socio-demographic factors contributing to low rates of HIV positive patients are age and decreased social contact. In the first instance, the highest rates of HIV in South Africa are seen in a younger

population of patients than is reported on in this study. In the second instance, people with depressive and anxiety disorders are also less likely to engage in social interactions, let alone sexual behaviours, as a result of their psycho-pathology.

5.3.4. C.A.N.-assessed needs on admission

The finding of a mean total needs of 9.2 in the ward one population is high when compared to previous samples: Hansson et al (1995) found 4.4-6.4 in a Swedish population and Phelan et al (1995) found a mean number of needs of 7.6-8.6 in a severely ill British population. However, none of the reviewed studies exclusively examined an in-patient psychiatric population. One explanation is that fewer community services are available in this setting. This may result in fewer basic and social needs being met at this level. In additions, the local population may actually have more psycho-social needs than British or Swedish populations, due to a lack of resources. Large numbers of the population are physically without water, electricity or housing. In part, this is consequent to the political history of the country. Another possible phenomenon is that of factitious or embellished symptoms. Patients with depressive disorders may find gain in their symptomatology. They may be truly indigent or unable to find work, and receipt of a disability grant may prove essential to survival.

The needs domains reported by ward one patients are in keeping with the nature of service offered there: needs for "depression", "self-harm", and "anxiety" for example, were among most commonly rated domains. Of the psychiatric domains, a high number of needs for "safety to others" was reported. This represents a rate of 46.7% of patients who had experienced a problem with homicidal ideation or intent to harm others. This may be the result of severe and enduring *inter*personal conflict, or poor *intra*personal coping skills. If the first explanation is accepted, then the area of

interpersonal relationships should be a priority of treatment. It is surprising that only four total needs in the area of "physical and sexual abuse" were reported. As mentioned above, the majority of ward one patients are women, and almost half of the patients report needs in "safety to others". It therefore is s a strong possibility that physical and sexual abuse are being under-reported. Reasons or this are unclear. A threat to the patient may remain, preventing declaring the need. Also, memory of the event(s) may be too traumatic to re-open. Lastly, it is possible that patients are unwilling to declare a need in perhaps the most sensitive domain, to a recently met interviewer, who will not contribute to treatment.

The social and functioning clusters also revealed high levels of need, particularly in the areas of "daytime activities", "intimate relationships", "sexual expression", and "company". The high levels of unmet need for "daily activities" (35 patients) begs comment. One may postulate that patients have a limited access to social resources such as social clubs, occupational therapy or vocational training. This appears to be a glaring deficit in the mental health system. Patient's sense of self-efficacy, relationships and general functioning may all develop is this need area were addressed. Furthermore, it is possible that psychiatric needs may be met if this area was improved. The only way to resolve this would be a study comparing populations with differing levels of needs in the area of "daily activities".

5.3.5. Help received

The amount of informal help received from friends or relatives was generally in the low range. With the exceptions of "food" and "childcare", less than 50% of patients reported a highdegree of help. The trend towards "none" or "low" help received may signify a problem of "unmeetable need". Similarly, the levels of formal help received, were in the

"none" or "low" ranges. Simons and Petch (2002) comment on the finding that needs were more likely to be met in the "health" domains rather than the "functional" ones. The implication being that practical and measurable forms of help are easier to provide than are those required for "functional" problems. In addition, "functional" problems may be intrinsically more difficult to improve.

In this study, however, levels of help received were uniformly low. A number of reasons for this are possible. Firstly, low levels of help may be offered. This may hold true for resource-poor settings, where money spent on mental health is low, and numbers of patients requiring services are high.

Secondly, factors which correlate with unmet need in the literature are relevant to this study, namely: Middle age (Meadows et al, 2002), single status, unemployment (Lefebre et al, 2000), low social functioning (Slade et al, 1999b), and presence of psychiatric diagnosis (Lefebre et al, 2000). Meadows et al define middle age from 25-44 years (2002). This is in keeping with the average age of 37.1 in participants in this study. It is not clear why younger adult report less needs, but older adults may feel more self reliant or be unwilling to seek help. The presence of single status, unemployment and low social functioning are related to an inability to create and maintain interpersonal relationships (Lefebre et al, 2000). These are thought to interfere with help-seeking behaviours, which are so dependent on social interactions. Whether or not these deficits are primary or secondary is unclear, but require considerable effort to overcome.

Thirdly, the presence of help, does not equate to help received. Patients may not be able to make use of or accept help. This may result from extrinsic factors, such as lack of access to services, difficulties within the primary social network, or poor living conditions. Other factors, regarded as

intrinsic, such as persistence of psychiatric disorders, or personality disorder, may be contributory.

5.3.6. Help required

In theory, patients reporting an unmet need, ought also to report a requirement for help. The C.A.N. only enquires about formal help required, so that may explain why a wide variation in levels of help required was seen. The trend was for patients to need help in "health" and "interpersonal" domains. It is possible that it is only in these domains that patients feel help can be offered from formal services. One possible role of the C.A.N. could be to identify these perceptions and then try to offer alternatives, or to coordinate informal types of help.

5.3.7. Right type of help received

No clear trend is visible from this set of data. The distribution of yes and no answers appears to be varied, with few domains demonstrating a clear preponderance. As this question is general in its nature, it is possible that the information gained is too non-specific and therefore unclear. Alternatively, there truly is a large amount of variability in the type of help received, and that this depends on the patient, the family environment, and the availability of resources.

5.3.8. Satisfaction with help received

The trend in answers to whether patients were satisfied with help received prior to admission was towards "no" answers. This seems to be especially true for health and interpersonal domains. This is understandable in the light of patients presenting for admission to ward one. Their attempts to get help from both formal and informal services, has seemingly been insufficient, and the admission was then required.

5.3.9. Patient expectations of ward one

Patients' expectations of ward one are generally high. This is altogether in keeping with the admission procedure, whereby patients are screened and then offered admission. Similarly, the few domains where expectations are lower ("food", "accommodation", "transport", "money", "disability grant"), are those for which social resources are required, as opposed to health or psychiatric ones. A number of patients expressed "uncertain" expectations of ward one in the area of "cigarette smoking" (4 or 25%). Most patients probably see smoking as a way of life and not as a need *per se*.

5.4.Duration of admission

Of the 92 patients interviewed, 32 dropped out and 60 completed the program. This represents a significant attrition rate. Data for the drop out patients are not presented here, but a brief comment is warranted. It is possible that this figure is in keeping with drop out rates at neuro-clinics elsewhere, but this issue was not explored. In addition, this figure need not imply a failure of the service to meet these patients' needs. The value of an assessment period is not to be underestimated, even if it simply concludes that this individual is unsuitable for this intervention at this time. An comparison between program completers and non-completers is envisaged.

The mean duration of admission was 5.7 weeks. Under current service constraints, it is possible to argue that this is too long, while others may argue that it is too short to acquire a therapeutic advantage. It may be useful in the future to compare the needs of patients admitted for different periods of time. It is conceivable that there are a number of patients for whom longer admissions are unhelpful or are not useful.

5.5. Help received from ward one

A need was regarded as unmet in ward one, when patients reported "none" or "low" help received during admission. There

was a trend for higher numbers of patients to report unmet need in non-psychiatric domains. These included "accommodation", "self-care", "transport", "cigarette smoking", and "sexual expression". An exception was "post-traumatic stress" where 57.1% of patients reported unmet need. Other domains that were equally spread included interpersonal needs, such as "intimate relationships" and "company".

The high degree of unmet need for these basic and social needs domains is understandable if it is assumed that patients are admitted primarily for psychiatric reasons. While it may be convenient for in-patient services to hand over responsibility for these needs to social services or primary care clinics, a fully integrated approach ought to be available. In many cases, the presence of psycho-social needs underlies the precipitation or perpetuation of psychiatric disorder. However, it is acknowledged, that in some cases, these needs are unmeetable due a lack of resources. A desperate lack of housing, vocational assistance and psychological support persists. The meeting of need in ward one for each need is discussed below:

Accommodation - Of the 13 patients reporting this need, 76.9% (10) reported that it was unmet at discharge. At face value, the explanation offered above may be satisfactory i.e. that this issue falls into the domain of social services, but this may not be sufficient. If the necessity of accommodation is accepted as a basic need, then its lack may impact on every other need. Patients who present to ward one with this need are relatively few (13 of 60 patients). In itself, this implies that this area is being addressed. The persistence of unmet need, though, in the remaining 10 of 13 patients, suggests a more enduring problem. These individuals may be those who reject assistance, or who are disordered enough so as to disrupt attempts at finding accommodation. This is a reality in this patient population. Lastly, services at ward one that address this need may not be sufficient: only 1

patient reported that social work was a useful service in the ward (see table 4.14).

Food - Equal numbers of the 12 patients who had this need reported met or unmet need. As mentioned above, this is a basic need, which needs to be addressed. There are few formal resources in this setting that provide food, and this need is most commonly met either directly by informal services (friends or family) or indirectly by the provision of disability grants. Although this need was identified by the C.A.N., it is possible that many patients do not directly declare this need.

Looking after the home - As with "food", similar numbers of patients reported this need being met or unmet. The kind of help required to look after the home, is not readily available in ward one, where the program is aimed at psychiatric needs, distress and social functioning. In addition, patients may vary in their expectation of how this need could be met: some may expect practical help with their home, i.e. someone to come to their home, or they may expect ward one to demonstrate how the home could be looked after, i.e. a life-skills approach.

Self care - Very few patients reported this need (3, 5%), and all said that the need was unmet. This need may be understood as an intrinsic deficit in motivation and self care routine, as a result of poor self-esteem or learnt behaviour. Alternatively, previously motivated patients may be impaired by mental illness, lack of facility for self care, or financial constraints. The high degree of unmet need in ward one may be either due to a lack of service for this need, or due to unmeetable need intrinsic to the patient. The presence of this area of need on admission ought to provoke a response from relevant services, such as occupational therapy and nursing staff. Such a response might involve education, life-skills training, routine, and encouragement.

Daily activities - This was a highly reported need, implying the central role of patients' ability to busy themselves during the day. More than two thirds (68.6%) reported that the need had been met by the program. This appears to be a satisfactory result, especially in light of the frequency of reporting of this need. Improvement in the numbers of met need for this problem may follow similar lines to the previous need. Occupational therapy staff may need to be particularly aware of the numbers of patients reporting this need, and endeavour to not only provide activity in the ward, but means of sustaining it after discharge. Welcome clubs, church groups and industrial therapies are a few avenues currently available locally.

Physical health - Similarly, 72.7% of patients who had a problem with physical health, were helped by ward one. This is an expected finding in the context of a tertiary level psychiatric facility, with access to all levels of medical care. It may be argued that the remaining 18.1% ought also to have been met. In some cases, these needs were unmeetable- a diagnosis of chronic disease, such as HIV, renal disease or epilepsy. In this regard, 2 diagnoses of HIV were made at discharge- at time of writing, anti-retrovirals are not freely available, and therefore this need is unmeetable. Similarly, 5 diagnoses of seizure disorders were made, and 4 of gynaecological problems. While these are treatable conditions, many are chronic and incurable, and may represent unmeetable need to patients having them.

Psychotic symptoms - It may be surprising that 38.1 of patients reporting this need found it to be unmet at discharge. In patients presenting with predominantly anxiety and depression, it is possible that psychosis was not detected by clinical staff. In some cases, symptoms may have been resistant to treatment, or would take longer than the admission period (on average 5.7 weeks) to resolve. One

explanation for symptom persistence is the presence of pseudo-hallucinations. As mentioned previously, factitious symptomatology may benefit the patient both in terms of sick role, as well as receipt of a disability grant. The presence of active psychosis is an exclusion criteria from the ward one program. Therefore patients who are paranoid, responding to voices, or are behaviourally disturbed are not admitted. Those who suffer mild or transient symptoms may be entered into the program, but in almost all cases, the presence of depression or anxiety following social stressors is the presenting problem.

Information - Just more than half of the program completers (33, 55%) patients needed information about their mental health problems. Of these, 69.7% (23) had their need met. This appears to be an adequate number, but it may be important to see why the remaining 30.3% did not. This may be seen as an especially large number of unmet needs if "information" is seen as an easier need to address. Attention may need to be paid to the amount of information given, the complexity of information, and the frequency with which it is given. Non-English first language speakers may not benefit to the same degree as first language speakers. Also, information may be given in a group or individual context. Meadows et al reported that 5.2% of the Australian population had a perceived need for information (2000b). Of these, almost half (2.4% of Australians) had an unmet need for information.

Depression - As 59 patients reported a need for this problem, depression may be regarded as a key area of measuring the value of services at ward one. 89.8% of patients said that their need had been met. This represents a high proportion of met need and affirms that this aspect of consumer need is being well met. It then becomes important to explore which aspects of the program were useful and which were not.

issue, 83.3% felt that they had been helped by the admission to ward one.

Alcohol - A drinking problem was declared by only 8 patients (13.3%). Of these 62.5% reported that this need had been met at discharge. It was ward one policy that patients with primary substance abuse enter rehabilitation programs before attempting the ward one program. As a result, services were not geared towards dealing with alcohol problems. If identified, these patients were usually directed to outside organisations (such as A.A. groups) for assistance.

Drugs - This was a need in only 1 patient, and was apparently met by the admission.

Childcare - This basic need was reported by 13 patients (21.7%). In 53.8% of cases, patients felt that the issue had not been dealt with at discharge. Similar results were obtained in other basic and social needs domains, and this maybe an area that requires attention. Childcare problems may be unmeetable, as they frequently follow failure of the primary social network. Chidcare facilities in poorer communities may not be easily identified by social workers. They also require money, which indigent patients do not have.

Basic education - not applicable

Telephone - not applicable

Transport - Few patients had difficulty with transport. Of the five who did, 60.0% said that their need was unmet. Public transport in greater Cape Town depends greatly on the informal taxi industry. Patients who do not have access to these routes, or who cannot afford fares, may well have an unmeetable need in this area.

Money - While money was frequently reported as a need, it was not the most common. More than half of the respondents (22 out of 38) declared this need as unmet at discharge. Reasons for this may follow the other basic and social domains outlined above. In addition, this need is most commonly met by a disability grant, which in this setting, is usually dealt with at community level, and takes some time to resolve.

Disability grant - Fewer patients (8, 13.3%) reported a problem with a disability grant than with money. This may be because only unemployed patients, who are impaired by their mental illness, qualify for a grant. By the time of discharge, 62.5% had had the matter resolved. This is a satisfactory figure, given the constraints mentioned above.

Cigarette smoking - Most of the 13 patients (21.7%) who reported this as a need, felt that it was unmet at the time of discharge (92.9%). As mentioned in the other substance misuse domains, ward one does not offer a focussed substance program. In addition, large numbers of patients do smoke, but do not report this as a need. There may be a perception among clinicians that smoking is an acceptable pastime for distressed patients. Experienced with more seriously ill patients may re-inforce that patients are more sedate when they smoke. The chronic diseases and mortality produced by smoking should require that doctors review this stance. At the very least, brief interventions should be given to all smokers who enter the program, who do not report this need. Those who do have a need, should be acknowledged as having a contemplative position on their substance misuse, and be supported more actively in its cessation (Prochaska and Di Clemente, 1983).

Intimate relationships - This need was declared by almost half of ward one program completers (29, 48.3%). Equal numbers of patients reported this need met or unmet (48.3%). Possible reasons for unmet need in this area include personality

difficulties, enduring psychiatric illness, and social stressors. As mentioned above, the presence of high numbers of patients with borderline personality traits may explain ongoing problems in this domain. As previously mentioned, problems in the area of interpersonal relationships tends to affect health seeking behaviours, and may account for higher numbers of unmet needs (Lefebre et al, 1999). The presence of a relatively large number of patients reporting this need should alert staff to address this area, or even to recommend an interpersonal therapy.

Sexual expression - A surprisingly large number of patients declared a need in this area (25, 41.7%). The majority, however, (84.0%) were not helped to a significant degree at discharge. This may be the result of many patients feeling this to be a personal and embarrassing area to discuss openly. However, if the need is indeed as common as reported, then the clinical team will need to be aware of its ramifications and be able to deal with it sensitively. An open approach by staff may go some way to reduce embarrassment. Furthermore, if as many patients as 41.7% report this need, then group education programs must include this as a priority. With the AIDS epidemic reaching its peak, every effort must be made to empower patients to communicate more effectively in the area of sexual needs. An important cause of sexual problems in psychiatric samples is the use of psychotropic medication. This may be both under-reported and under-explored.

Company - This commonly reported need was met by just over half of patients who declared it (54.3%). Difficulties in meeting this need may arise from similar reasons as mentioned under "intimate relationships" and "safety to others". The regulated social environment at ward one may contribute to some patients feeling helped, but the duration of admission may not be sufficient for others.

5.6. Barriers to receiving help from ward one

Patients recording "none" or "low" levels from ward one were asked why their need was unmet. This was done by asking which of a series of 6 barriers to help was most applicable.

The barrier "I prefer to manage myself" (self-reliance) was commonly reported. In some cases, this would be appropriate, if basic or social needs were being addressed outside of the ward one program. Other possible reasons for this barrier being used include needs which involve sensitive or embarrassing information, such as "sexual expression" (20.0% of barriers) or "self care" (33.3% of barriers). Patients wanting to manage their own accommodation needs may have wanted to do so as a result of awkward social problems or interpersonal relationships (46.2% of barriers). Cigarette smokers who had unmet need in this area offered this barrier in 50% of cases. One may speculate that their levels of motivation were low to begin with.

Patients who felt that "nothing more could help" (pessimism) were generally few. This barrier was noted in about 20% of cases for unmet need in the areas of "looking after the home" and "sexual expression". The use of this barrier implies a certain degree of hopelessness, as if the patient has given up being helped in this area. Furthermore, there is the suggestion that various kinds of help have been offered and have been unsuccessful. It would be useful to explore the reasons for citing this barrier, in order to understand whether this is indeed the case (that concerted efforts at help have failed), or if the barrier represents an intrinsically hopeless attitude to being helped.

A lack of access to help for whatever reason is implied in the barrier "I didn't where or how to get help" (ignorance). This was the commonest reason for unmet need in "self care" (66.7%). This may imply a certain degree of apathy or lack of motivation in a psychiatrically ill individual. Patients

reporting unmet need for "safety to others" may have felt overwhelmed by feelings of guilt or anger at their experience (24.0% of barriers). As a result, they may have felt that help for this very awkward and evocative issue was not readily accessible. Similar reasons may exist for "sexual expression" (20.0% of barriers). If clinicians become aware of unmet need for these problems, perhaps a greater awareness of their ability to deal with these problems should be created.

In some instances, patients reported "I was afraid to ask for help" (stigma). This is to be expected in areas such as "psychotic symptoms" (19.0% of barriers), where paranoid thinking may predominate, and "sexual expression" (32.0% of barriers), where fear or embarrassment might prevail. In other needs areas, few or no patients cited this barrier to help.

Small numbers of patients reported not being helped despite asking: "I asked for help but it wasn't given" (non-response). The highest incidence among the barriers was found in "safety to others" (20.0%). At face value, clinicians may feel overwhelmed by aggressive feelings and thoughts, preferring to work with depressive and anxiety symptoms. Case workers may be threatened by patients, and therefore prefer to not evoke tense and hostile thoughts. Conversely, it is difficult to envisage what type of help patients wanted in this area. At the very least, a therapist's empathy with these ideas may be difficult to achieve.

The last named barrier was "I asked for help but got the wrong type of help" (wrong response). This was reported by only a few patients with unmet need. The highest percentage (20.0%) was noted by patients who were not helped in the area of "safety to others". Reasons for this probably follow those given above. This need is a particularly difficult one to articulate and confront.

An open category of "other" was also offered to patients who felt that none of the above barriers were applicable. The only domains above 20% were "disability grant" and "cigarette smoking". In many cases of disability grant difficulties, problems lie in slow administrative processing or abuse of the funds by others. These problems are often difficult to identify and resolve. "Cigarette smoking" in psychiatric patients is a complex problem. As previously mentioned, it is unclear whether patients mentioning this as a need are truly motivated to stop. In addition, ward one does not offer substance abuse counselling.

5.7. Services at ward one

The usefulness of services at ward one was measured by asking patients whether their needs were met by that service (see table 4.10). Overall, more patients reported services being useful in health domains- "information", "self harm", "depression", and "anxiety".

Services that were less commonly reported as useful in these needs areas were: family or couple therapy, employment assistance, other organisations, telephone, visits and social work. In most of the above examples, these services are infrequently or sporadically offered at ward one. The 2 areas that require exploration are family\couple therapy and social work. These services ought to be regarded as essential to the ward one program and should play a more prominent role. It may also prove invaluable if ward one were to improve the vocational and occupational services, along with making use of other organisations. The latter group includes trauma centres and drug counselling services, both of whom may prove invaluable support resources. It has been suggested in the literature that it is important to enquire about specific aspects of care, if deficiencies are to be uncovered (Bruster et al, 1994). A qualitative approach may tease out how services mentioned above may be improved, or better address needs.

Valuable interventions where patients more commonly reported usefulness appear to be those that are integral to the current ward one program and that apply to the abovementioned health domains. These include group therapy, art, life skills, group education, and individual therapy. Other informal activities also rate highly in patients' minds: informal patient interactions and the ward environment. The value of these "services" would appear to suggest ward one patients' difficulties in interpersonal relationships. As previously mentioned, many patients are discharged with a diagnosis of at least borderline traits. Many present with relationship difficulties. The experience of living with people in similar life situations must bring a great sense of relief. As a result it is not uncommon to find patients who find it difficult to leave, or who frequently are re-admitted.

5.8. Patient satisfaction with services by need

In general, the levels of service satisfaction by need reflects the persistence of unmet need at discharge. To this end, satisfaction rates for needs rarely exceed 50%. The highest satisfaction rates are seen in the psychiatric domains. These domains are those for which interventions at ward one are specifically aimed. Similarly, satisfaction levels are lower for basic domains, such as "accommodation", "money" and "transport". It would be anticipated that interventions aimed at these needs, such as social work, would go some way to improve satisfaction rates. Leese et al report on user satisfaction using the Verona Service Satisfaction Scale (VSSS) (1998). Patients receiving an intensive intervention (defined as shifting the centre of care into the community) were more likely to report satisfaction with services. In this study, the intensive intervention specifically addressed patient's concerns and priorities. The value of the routine use of a needs assessment instrument, is that it would allow for a user-defined approach to treatment.

At the time of this study, information gained from the C.A.N. was not shared openly with ward staff.

5.9. Unmet needs on admission

A number of comparative analyses using demographic and service utility data yielded only one significant difference: patients without borderline traits had more unmet needs on admission. Two other studies appear to contradict this finding, although the compared sub-groups were different. Hansson et al (1995) found that patients with neurosis or personality disorder displayed a higher number of total C.A.N. needs. Lasalvia et al (2000) comment that personality disorder or psychosis confers a risk of a higher number of unmet needs. In both cases, however, no distinction between the personality disorders was made. Furthermore, comparison did not involve patients with and without a specific personality trait or disorder. No other study has attempted to define the needs of patients with borderline personality.

This is an unexpected finding which may describe some aspects of the borderline personality. One possible explanation is that patients with borderline personality traits may offer similar numbers of needs as non-borderline patients, but may report met need more frequently in order not to alienate clinical staff. This aspect is commented on by Linehan (1993), who describes the emotional dysregulation of the borderline personality, who also "may engage in intense and frantic attempts to keep significant individuals from leaving them". This may be a strategy used to remain in contact with services, or to manipulate services into addressing needs that may not actually exist. The impression created by patients with borderline personality traits in our service is one of frequent admissions, poor adherence to treatment, yet persistent engagement with services. In addition, it is not uncommon to find these patients reporting frequent changes in need status: the so-called "borderline crisis". For example, an unmet need today of "self harm", becomes tomorrow's met

need as the crisis passes. Bank and Silk (2001) support this argument by reporting on a study comparing suicidal behaviour in borderline personality, major depression, and those with co-morbidity. Patients with co-morbidity had the greatest number of, and most serious suicide attempts.

A few notable non-significant findings were seen: There were no significant differences in unmet needs between patients of single status, or of low education status. Similarly, significant differences were not found between patients with different numbers of previous psychiatric admissions- a longer psychiatric history does not appear to confer risk in this setting. As previously mentioned, Lasalvia et al (2000) report that a higher number of staff rated needs was predicted by the number of service contacts. Parkman et al (1997) comment that user satisfaction diminishes with each admission for Black Caribbean patients.

A multiple regression analysis was performed to explore the effects of various socio-demographic and clinical variables on unmet needs on admission: 33% of the variance is explained by this model. In this analysis, age and education level reached significance, but were negatively correlated: younger age and lower level of education appeared to predict higher levels of unmet need. The former finding is supported by Parkman et al (1997), who report that higher service satisfaction is seen in increasing age. In another study, middle-age contributed to higher numbers of unmet needs (Meadows et al, 2002). The tendency for older people to report lower unmet need may reflect either a tendency in the natural history of psychiatric illness to improve, or a greater resignation that services do not help. Another explanation is the manner in which needs are met: older patients may have broader expectations and be more patient. Younger patients may be more adolescent in their thinking that services need to provide unilaterally for their needs.

The contribution of lower levels of education to unmet needs has not been examined elsewhere. Patients with a lower level of education may report higher levels of unmet need due to poorer coping skills. They may have less opportunity to obtain work and the rewards that employment brings. In addition, the lower education status may be the result of intrinsically lower personal efficacy and the inability to deal with problems - which in the first instance have led to poor ability to deal with schooling

5.10. Unmet needs on discharge

There were no significant differences between patient characteristics when comparing for unmet need on discharge. The p-value of 0.08 for education status suggests a trend towards significance for this variable. This suggests that education status confers a degree of risk for unmet need at discharge. In this regard, patients with a standard 6 (grade 8) education had more unmet needs than other educational groups (6.3). This may reflect a reduced capacity of this sub-group of patients to solve problems, or utilise resources.

The presence of borderline traits did not confer a significantly greater number of unmet needs at discharge. Again, this is an unexpected finding, but one which may be explained similarly as before. Patients with borderline personality may be loathe to alienate themselves from services by reporting needs as unmet. Their desire to remain in contact with clinicians may be too great for this. In addition, as previously mentioned, their needs may be more crisis-related than patients with enduring depressive symptoms.

When the regression model was applied to unmet need on discharge, only 23% of the variance was explained by the model. In similar fashion to the admission model, only age and education level was predictive of unmet need. Another variable approached significance: duration of current admission. The p-value of 0.08 suggests a trend towards statistical significance. It is possible that a larger sample may have

yielded significance: the sample\variable ratio may have been too small. Nonetheless, the data suggest that a shorter duration of admission predicts higher number of unmet needs on discharge. This may be explained by the simple absence of sufficient time to allow services to meet needs. If this trend were to be replicated in other studies, then the clinical team should take measures to correct this problem. One possible strategy would be to administer a needs assessment instrument near to, but not at discharge. This would allow the team to address the unmet needs in a focused way.

5.11. Implications for clinical practice

A number of important implications for clinical practice can be described as a result of this study:

5.11.1. Addressing unmet needs

The purpose of this study was to examine how the needs of patients presenting to ward one are currently being met. The problem of unmet need can be addressed in two ways. Firstly, where significant numbers of patients report unmet needs in previously unidentified (or under-identified) domains, then the clinical team should develop new ways of meeting those needs. For example, high numbers of unmet needs in the area of "daily activities" should draw the team's attention to the need for more focussed occupational therapies. It be may be desirable to explore the individual's qualitative problems in this area in the initial interview. These may then be targeted more comprehensively. The need for help with "self care" could also be addressed in this way. Of the 25 patients reporting a need in the area of "sexual expression", 21 (84.0%) reported that it was unmet at discharge. Sensitive exploration of this need area should be done. Simple measures such as education, family planning, and communication techniques may increase the numbers of met needs in this area. More than half (57.1%) of patients reported an unmet need for "post-traumatic stress". Clinicians may require training in techniques that address this problem, such as exposure therapy, relaxation methods or

stress inoculation. The involvement of outside organisations that specialise in treatment of trauma could be increased.

Secondly, services at ward one that are not rated as useful by patients should be explored. Services most commonly reported as less useful include family and couple therapy, employment assistance, use of other organisations, visiting hours and social work. These may be interventions that have changed or disappeared when clinicians leave, or simply be the result of inadequate resources. If they are identified as important aspects of the treatment program, and figures from patient needs assessments prove that they are essential services, then authorities can be lobbied.

5.11.2. Routine use of the C.A.N.

The C.A.N. has been widely used in a number of settings. These include general psychiatric populations, as well as mainly schizophrenic populations. The value of using an instrument such as the C.A.N. or its short form, the C.A.N.S.A.S. (Camberwell Assessment of Need, Abridged Scale), lies in its delineating clinical as well as psycho-social needs. One of the motivations for initiating this study, was the perceived lack of clarity of the clinical team when addressing complex psychiatric problems. Many of these problems are precipitated and maintained by enduring psycho-social needs. The routine use of the C.A.N. would enhance the assessment of these complex problems. C.A.N. findings need not dictate clinical practice, rather it should inform it.

5.11.3. Resource allocation

In this study population, a number of services could be addressed. The paucity of social work services requires attention, as well as measures to address unmet needs in the areas of relationships and intimacy. Some research may be required in this regard- the role of occupational and group therapists may need to be reviewed. Patients may need to be consulted as to means in which these unmet needs could be met.

It is more difficult for a study of this scope to comment on the allocation of resources to community clinics. At face value, needs areas of accommodation, self- care or money ought not to be addressed in an admission unit. The reality is that many complex factors contribute to this apparent deficiency: overwhelming numbers of patients in these clinics, absence of cial workers, enduring social deprivation, and poor patient motivation to name a few. A study of this sort may need to be extended into the community to highlight these kinds of deficiencies.

5.11.4. Patient selection and prediction of need

The finding that younger, less educated patients continue to report unmet needs does not preclude them from an intervention. Rather, it should allow clinicians to seek new ways to meet those needs. It may also free the clinical team to understand mechanisms of unmet need, and not feel frustrated at apparent lack of clinical progress. Some units may choose to adopt a policy that other services (primary care clinics) address basic and psycho-social needs prior to entry into a clinical program. This will naturally follow a needs assessment performed by the clinical team. In reality, the demands of the service in this setting are such that if this policy were followed, no patients would be admitted.

5.12. Limitations of study

A number of limitations of this study arise from the nature of the sample. The sample size is small. Other similar studies in the literature make use of samples of at least 100 patients (n=119: Hansson et al, 1995; n=130: Henderson et al, 1999). As a result, some needs areas may be too small to comment on- for example, only 3 out 60 patients reported a need in the area of self care. While this is an important finding in itself, it becomes difficult to extrapolate from it, in terms of service usage and satisfaction data.

Furthermore, this sample comes from one clinical setting within one psychiatric hospital. Patients with psychosis are largely excluded. Similar units at other psychiatric hospitals may attract a different socio-demographic profile, for example, patients may speak other languages and represent other cultural groupings. Other problems of this clinical sample are the result of idiosyncratic aberrations in patient selection at ward one, namely an under-representation of ethnic groups in Cape Town. All patients admitted to ward one who completed the program were included.

A number of modifications of the C.A.N. were introduced in this study, the main one being the dis-aggregation of the domain "psychological distress" into " depression", "anxiety", and "post-traumatic stress". These domains were considered essential for the setting in which this study was performed, Nevertheless, this version of the C.A.N. has not been evaluated for interrater and test-retest reliability. In addition, the discharge component of this questionnaire was developed by the author and therefore has little empirical basis, other than the "barrier" component (see Meadows et al, 2000). Therefore the results should be seen in this light.

The information rendered by this version of the C.A.N. is quantitative in nature but frequently begs questions that only qualitative data can supply. In this setting, particularly where the development of the instrument for local purposes is relevant, qualitative data would be invaluable. This is advisable for future research in this area.

An artificial contraction of the study population was obtained by the exclusion of program drop-outs. Although this study was intended to evaluate the impact of services of declared needs, a useful analysis may have been conducted using this group. In practice, for every 2 patients completing the program, 1 drops out. A comparison between these groups may yield useful and informative data about why patients leave the program, and yet

use resources. In many cases, these patients are a drain on the services through their need of services, and their simultaneous lack of collaboration.

A frequently noted problem in the literature was not addressed in this study, namely differences in patient-staff ratings of need (Slade et al, 1998). The use of patient ratings was intended to describe perceived need and patient perceptions of services. The inclusion of staff ratings of need may have provided clues as to unmet need, particularly where discrepancies occurred.

5.13. Recommendations for future research

Future research in the area of needs assessment and service utilisation will greatly enhance clinical practice in South Africa. Ongoing needs assessments within this service will add to this study by replicating and expanding on these findings. Routine use of the C.A.N. in other settings and units would allow for comparisons of needs among different patients populations. This may inform service provision and resource allocation. The inclusion of community samples would provide information on whether basic and social needs differ between hospital and community samples.

The development of this type of approach, using the C.A.N., would be greatly enhanced by a qualitative study. This would serve to define and delineate services at ward one, and hopefully render them more robust in analysis. In addition, it may be possible to modify the C.A.N. appropriately to the setting in which it is used: in this case, extra domains were added to increase its sensitivity for the types of problems frequently seen at ward one.

A study examining the cost-effectiveness of services may be useful. It may be possible to create a hierarchy whereby basic and social needs are costed according to where they are met. A basic need addressed in the community would incur less cost

than a similar intervention in hospital. Similarly, hospital-based interventions could be examined according to personnel required to provide these services. An appropriate model for this evaluation would have to be sought.

The effect of duration of psychiatric contact could be explored by means of repeated C.A.N. assessments over a prolonged period of time. This may give information about whether unmet needs change over time, and possibly explain why, independent of service use. The associations between unmet needs could also be explored in this way. If new unmet needs arise, are they contingent on new problems, or on previously unmet needs?

Finally, a local version of the C.A.N. could be developed and its psychometric properties established. Elements of culture, language and spirituality may be considered for inclusion. An instrument for routine use that incorporates an aspect of service evaluation would be invaluable.

5.14.Conclusions

This study has attempted to demonstrate that the use of a needs assessment instrument may be useful adjunct to clinical assessment. The C.A.N. is currently a widely used instrument that can be adapted to a number of settings. The routine use of a shortened version, along with a review of unmet need at the end of an admission, may allow services to review their effectiveness and allocate resources accordingly.

The findings of higher numbers of psychiatric needs in this study population is not surprising. Relatively high rates of unmet need in other domains should prompt action on the part of service authorities: at the very least an attempt to duplicate these findings.

Patients presented with an instrument that enquires about needs from all areas of their lives may feel that services are

more holistic in their approach. This may stimulate a greater sense of collaboration and hopefully reduce the burden of unmet need in the population.

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APPENDIX 1: PATIENT CONSENT AND INFORMATION

University of Cape Town

Consent to participate in a medical research study

Formal title: Needs and services at ward one, Valkenberg Hospital

Study Purpose
You are being invited to participate in a medical research study being conducted by researchers from the University of Cape Town. The purpose of this study is to evaluate needs of patients admitted to ward one and the way in which those needs were addressed in the ward. We hope that the results of this study will lead to improvement in the quality of care for patients at clinics and hospitals, in addition to improving our overall understanding of these important health problems.

Study Procedures
If you decide to participate in this study, an interviewer will fill in a brief questionnaire with you on admission and on discharge. Each questionnaire will take you approximately 20-30 minutes to complete. All information obtained from you will be kept strictly confidential and will be known only to the researchers.

Possible risks
Filling out the questionnaire may bring on ideas or feelings you usually avoid or were not aware of in the past. Some people may experience some initial embarrassment when asked about certain topics included in the questionnaire.

Possible benefits
You personally may benefit by identifying problems or needs for yourself which can be addressed in the ward or in the community. The ward team may benefit by understanding how patients are helped in the ward and how to improve the program.

Alternatives
You may choose not to participate in this study, and this decision will not affect your medical care or your relationship with the clinic or hospital in any way. The ward team will not be made aware of your decision.

Voluntary participation
Participation in this study is completely voluntary. You are free to refuse to answer any question. Your decision regarding participation in this study will not affect your medical care. If you decide to participate, you are free to change your mind and discontinue participation at any time without any effect on your medical care or future care.

Confidentiality

Information about you obtained for this study will be kept confidential. Your name and other identifying information, will be included on the questionnaire. It and this consent form will be kept in separate, locked file cabinets, and there will be no link between the consent form and the questionnaire. Neither the information obtained from the questionnaire or the interview will become a part of your medical record in any way, nor will it be made available to anyone else. Any reports or publications about the study will not identify you or any other study participant.

Questions

Any study-related questions, problems or emergencies should be directed to the following researchers:

Dr John Joska 021-440 3198

Professor Alan Flisher 021-404 2164

Questions about your rights as a study participant, comments or complaints about the study also may be presented to the Ethics Review Committee, Faculty of Health Sciences, University of Cape Town, Rondebosch, 7700, telephone 021-406-6492.

*****

I have read the above and am satisfied with my understanding of the study, its possible benefits, risks and alternatives. My questions about the study have been answered. I hereby voluntarily consent to participation in the medical research study as described. I have been offered copies of this three-page consent form and of the Information Sheet.

_____ _____

Signature of participant Date

_____ _____

Name of participant (printed) Witness

University of Cape Town

Information Sheet

Needs and services at Ward One, Valkenberg Hospital

When you filled in the questionnaire, you may have worried about some of your answers. After discharge from ward one, you will be referred to a clinic, either at Valkenberg Hospital or at your local community c ntre. Any problems or needs that you feel you need help with could be mentioned here. Before you leave the ward, you should have date and place to attend this appointment.

For information about community clinics or contact numbers:
Valkenberg Hospital (Out-patients department) 021-440 3157
Community health services organisation 021-460 9100

For substance abuse (drug or alcohol problems):
SANCA 021-9454080
Cape Town Drug Counselling Centre 021-4478026

For trauma exposure (if you have experienced violent situations that still bother you):
The Trauma Centre for Survivors of Violence and Torture 021-465-7373
Rape Crisis (Cape Town) 021-447 1467

For sexual health (including HIV-relate issues) problems:
LoveLife Thetha Junction 0800-12-1900
Planned Parenthood 021-448-7312
ATTIC (AIDS Training and Treatment Information Centres) 021-797-3327

For family or marriage counselling:
FAMSA (Family and marriage organisation South Africa) 021-461 7360

For information about social pensions and grants:
Department of social services 021-4834322\
080 0220250

For general mental health information:
Mental health information centre (Tygerberg Hospital) 021-938 9229

APPENDIX 2: C.A.N. QUESTIONNAIRE

Department of Psychiatry and
Mental Health
University of Cape Town

NEEDS AND SERVICES AT WARD ONE, VALKENBERG HOSPITAL

CAMBERWELL ASSESSMENT OF NEED-ADMISSION QUESTIONNAIRE

IDENTIFYING DATA

1. Interviewer: _____

2. Date: _____

3. Name: _____

   Address:

   _____

   _____

   Folder number _____

4. Gender: 1 = female; 2 = male ☐

5. Age: _____ ☐

6. Marital status:
   1 = single, never married
   2 = married, divorced or separated
   3 = married
   4 = spouse died ☐

7. Highest educational level
   1= less than std 6
   2= std 6-8
   3= std 8-10
   4= tertiary education ☐

8. Home language(s):
1 = Afrikaans
2 = English
3 = Xhosa
4= English AND Afrikaans
5 = other (or other combination) ☐

9. Occupation
1= professional (i.e. has registered qualification and employed)
2= technical\artisan (i.e. practices a trade or learnt skill)
3= non-professional (i.e. uses basic skills not requiring training)
4= unemployed (may be trained) ☐

10. Home environment
1 = own house
2 = family house, lives inside
3 = others house, lives inside
4 = family house, lives outside
5 = others house, lives outside
6 = no fixed abode ☐

11. Accessibility of services (select MOST accessible)
1= near enough to walk
2= needs taxi\public transport
3= relies on friends\family for lift
4= not easily accessible ☐

12. Total number of admissions to a psychiatric hospital ☐

13. Duration of the current problem\disorder (refers to the current episode, if chronic condition)
years ☐
months ☐

14. Length of time since first contact with health services for current psychiatric problem (refers to the current episode, if chronic condition)
Years ☐
Months ☐

1. ACCOMODATION

DOES THE PERSON HAVE A PROBLEM WITH ACCOMODATION?
Do you have a place in which to live?

0 = NO PROBLEM	e.g.	Person does have an adequate home
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Person is living with relatives, other people or in a boarding house because of a SPC
2 = SERIOUS PROBLEM	e.g.	Person is homeless
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH ACCOMODATION?

0 = NONE		
1 = LOW HELP	e.g.	Occasionally supplies a few pieces of furniture
2 = MODERATE HELP	e.g.	Substantial help with improving accommodation, such as redecoration of dwelling or maintenance
3 = HIGH HELP	e.g.	Living with relative because own accommodation is unsatisfactory or because the person is unable to provide own accommodation or because of mental disorder
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH THEIR ACCOMODATION?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH THEIR ACCOMODATION?

0 = NONE		
1 = LOW HELP	e.g.	Address of housing agency
2 = MODERATE HELP	e.g.	Referral to housing agency
3 = HIGH HELP	e.g.	Living in group home or hostel (e.g. Abri House, Rose parents, community care)
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH THEIR ACCOMODATION?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH THEIR ACCOMODATION?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH ACCOMMODATION?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

2. FOOD

DOES THE PERSON HAVE DIFFICULTY IN GETTING ENOUGH FOOD TO EAT?
What kind of food do you eat?
Are you able to prepare your own meals and do your own shopping?

0 = NO PROBLEM	e.g.	Eating adequately and is able to buy and prepare food if necessary
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has meals provided and is unable to prepare food (if that would have been expected)
2 = SERIOUS PROBLEM	e.g.	Very restricted diet, culturally inappropriate food
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH GETTING ENOUGH TO EAT?

0 = NONE		
1 = LOW HELP	e.g.	Meals provided weekly or less
2 = MODERATE HELP	e.g.	Weekly help with shopping or meals provided more than weekly but not daily
3 = HIGH HELP	e.g.	Meal provided daily
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH GETTING ENOUGH TO EAT?

HOW MUCH HELP HAS THE PERSON *NEEDED* 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 per day
2 = MODERATE HELP	e.g.	More than 4 meals a week provided, or assisted for all meals
3 = HIGH HELP	e.g.	All meals provided
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH GETTING ENOUGH FOOD TO EAT?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH GETTING ENOUGH FOOD TO EAT?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH FOOD?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

3. LOOKING AFTER THE HOME

DOES THE PERSON HAVE DIFFICULTY 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 the person (or somebody else)(**) keeps it basically clean
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Unable to look after home and has regular domestic help
2 = SERIOUS PROBLEM	e.g.	Home is dirt and a potential health hazard
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH LOOKING AFTER THE HOME?

0 = NONE		
1 = LOW HELP	e.g.	Prompts or helps tidy or clean occasionally
2 = MODERATE HELP	e.g.	Prompts or helps tidy or clean at least once a week
3 = HIGH HELP	e.g.	Supervises the person more than once per week, washes all the clothes and cleans the home
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH LOOKING AFTER THE HOME?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH LOOKING AFTER THE HOME?

0 = NONE		
1 = LOW HELP	e.g.	Prompting 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		

HAS THE PERSON RECEIVED 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 HAVE RECEIVED WITH LOOKING AFTER THE HOME?

(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH LOOKING AFTER THE HOME ?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

4. SELF CARE

DOES THE PERSON HAVE DIFFICULTY WITH SELF CARE?
Do you have problems keeping clean and tidy? Do you ever need reminding?

0 = NO PROBLEM	e.g.	Appearance may be eccentric or untidy, but basically clean
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, smells
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH THEIR SELF CARE?

0 = NONE		
1 = LOW HELP	e.g.	Occasionally prompt the person to change their clothes
2 = MODERATE HELP	e.g.	Run the bath/shower and insist on its use, daily prompting
3 = HIGH HELP	e.g.	Provide daily assistance with several aspects of care
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH THEIR SELF CARE?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH THEIR SELF CARE?

0 = NONE		
1 = LOW HELP	e.g.	Occasional prompting
2 = MODERATE HELP	e.g.	Supervise weekly washing
3 = HIGH HELP	e.g.	Provide daily assistance with several aspects of care
9 = NOT KNOWN		

HAS THE PERSON RECEIVED 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 HAVE RECEIVED WITH SELF CARE?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED WITH SELF CARE FROM WARD ONE?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

5. DAILY ACTIVITIES

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

0 = NO PROBLEM	e.g.	In full-time employment, or adequately occupied with household/social activities
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Unable to occupy self, so attending protected or sheltered workshop
2 = SERIOUS PROBLEM	e.g.	No employment of any kind and not adequately occupied with household/social activities
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES IN FINDING OR KEEPING REGULAR AND APPROPRIATE DAILY ACTIVITIES? ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional advice about daytime activities
2 = MODERATE HELP	e.g.	Has arranged daytime activities such as adult education or protected or sheltered workshop attendance
3 = HIGH HELP	e.g.	Daily help with arranging daytime activities
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES IN FINDING OR KEEPING REGULAR AND APPROPRIATE DAILY ACTIVITIES? ☐

HOW MUCH HELPHAS THE PERSON *NEED*ED FROM LOCAL SERVICES IN FINDING OR KEEPING REGULAR AND APPROPRIATE DAILY ACTIVITIES? ☐

0 = NONE		
1 = LOW HELP	e.g.	Employment training/adult education
2 = MODERATE HELP	e.g.	Sheltered employment. Day centre 2 – 4 days per week.
3 = HIGH HELP	e.g.	Protected or sheltered workshops
9 = NOT KNOWN		

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

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH DAILY ACTIVITIES? ☐
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH DAILY ACTIVITIES? ☐

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

6. PHYSICAL HEALTH

DOES THE PERSON HAVE ANY PHYSICAL DISABILITY OR ANY PHYSICAL ILLNESS?
How do you feel physically?
Are you getting any treatment for physical problems from your doctor?

0 = NO PROBLEM	e.g.	Physically well
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Physical ailment, such as hypertension, receiving appropriate treatment
2 = SERIOUS PROBLEM	e.g.	Untreated physical ailment, including side effects
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR PHYSICAL HEALTH PROBLEMS?

0 = NONE		
1 = LOW HELP	e.g.	Prompting to go to doctor or clinic
2 = MODERATE HELP	e.g.	Accompanied to doctor or clinic
3 = HIGH HELP	e.g.	Daily help with going to the toilet, eating or mobility
9 = NOT KNOWN		

HOW MUCH HELPHAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR PHYSICAL HEALTH PROBLEMS?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR PHYSICAL HEALTH PROBLEMS?

0 = NONE		
1 = LOW HELP	e.g.	Given dietary or family planning advice
2 = MODERATE HELP	e.g.	Prescribed medication. Regularly seen by doctor, nurse or clinic
3 = HIGH HELP	e.g.	Frequent hospital appointments. Alterations to home
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR PHYSICAL PROBLEMS?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR PHYSICAL PROBLEMS?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH PHYSICAL PROBLEMS?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

7. PSYCHOTIC SYMPTOMS

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

Do you ever hear voices? Do you ever feel that people are against you or have plotted to hurt you? Are you on any medication or injections? What is it for?

0 = NO PROBLEM	e.g.	No positive symptoms, not at risk from symptoms and not on medication
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 at risk
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR THESE PSYCHOTIC SYMPTOMS? ☐

0 = NONE		
1 = LOW HELP	e.g.	Some sympathy and 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 HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR THESE PSYCHOTIC SYMPTOMS? ☐

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR THESE PSYCHOTIC SYMPTOMS? ☐

0 = NONE		
1 = LOW HELP	e.g.	Medication reviewed three monthly or less, support group
2 = MODERATE HELP	e.g.	Medication reviewed more than three-monthly, structured psychological therapy
3 = HIGH HELP	e.g.	Medication and 24 hour hospital care or crisis care at home
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR PSYCHOTIC SYMPTOMS? ☐
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR PSYCHOTIC SYMPTOMS? ☐
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR PSYCHOTIC SYMPTOMS? ☐

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

8. INFORMATION (ON CONDITION AND TREATMENT)

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

Have you been given clear information about your medication or other treatment? How helpful has the information been?

0 = NO PROBLEM	e.g.	Has received and understood adequate information
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has received information, but it has not been sufficient or it has not all been understood
2 = SERIOUS PROBLEM	e.g.	Has received no information
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES IN OBTAINING SUCH INFORMATION?

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

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?

HOW MUCH HELP HAS THE PERSON *NEEDED* 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 on drugs and alternative treatments.
3 = HIGH HELP	e.g.	Has been given detailed written information or has had specific personal education
9 = NOT KNOWN		

HAS THE PERSON RECEIVED 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 HAVE RECEIVED IN OBTAINING INFORMATION?

(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE IN OBTAINING INFORMATION?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

9. DEPRESSION

DOES THE PERSON SUFFER FROM CURRENT DEPRESSIVE SYMPTOMS?
Have you recently felt very sad or low?
Have you recently had little energy, poor appetite or feelings of worthlessness?

0 = NO PROBLEM	e.g.	Occasional or mild depression
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Needs and gets ongoing support
2 = SERIOUS PROBLEM	e.g.	Depression affects severely, such as preventing person going out
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR DEPRESSION?

0 = NONE		
1 = LOW HELP	e.g.	Some sympathy or support
2 = MODERATE HELP	e.g.	Has opportunity at least weekly to talk about depression to friend or relative
3 = HIGH HELP	e.g.	Constant support and supervision
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR THIS DEPRESSION?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR THIS DEPRESSION?

0 = NONE		
1 = LOW HELP	e.g.	Assessment of mental state or occasional support
2 = MODERATE HELP	e.g.	Specific psychological or social treatment for depression. Counselled by staff at least once per week.
3 = HIGH HELP	e.g.	24-hour hospital care or crisis care
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR THIS DEPRESSION?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR THIS DEPRESSION?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THIS PERSON NEED FROM WARD ONE WITH THIS DEPRESSION?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

10. SELF HARM

IS THE PERSON A DANGER TO THEMSELF?
Do you ever have thoughts of harming yourself, or actually harm yourself? Do you intentionally put yourself in danger in other ways?

0 = NO PROBLEM	e.g.	No suicidal thoughts
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Suicide risk monitored by staff or others, receiving counselling
2 = SERIOUS PROBLEM	e.g.	Has expressed suicidal ideas during the last month or has exposed themselves to serious danger
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES TO REDUCE THE RISK THAT THEY MIGHT HARM THEMSELF?

0 = NONE		
1 = LOW HELP	e.g.	Able to contact friends or relatives if feeling unsafe
2 = MODERATE HELP	e.g.	Friends or relatives in regular 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 HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES TO REDUCE THE RISK THAT THEY MIGHT HARM THEMSELF?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES TO REDUCE THE RISK THAT THEY MIGHT HARM THEMSELF?

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

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP TO REDUCE THE RISK THAT THEY MIGHT HARM THEMSELF?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP TO REDUCE THE RISK THAT THEY MIGHT HARM THEMSELF?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE TO REDUCE THE RISK THAT THEY MIGHT HARM THEMSELVES?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

11. ANXIETY

DOES THE PERSON CURRENTLY EXPERIENCE SYMPTOMS OF ANXIETY?
Do you ever have panic attacks? Do you worry excessively and find it difficult to control your worry? Do you feel tense and irritable most of the time?

0 = NO PROBLEM	e.g.	No anxiety
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some anxiety, monitored by staff, is able to function
2 = SERIOUS PROBLEM	e.g.	Is tense and anxious all the time, needs constant reassurance, does not go out
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR ANXIETY?

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

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR ANXIETY?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR ANXIETY?

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

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR ANXIETY?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR THIS ANXIETY?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR THIS ANXIETY?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

12. POST-TRAUMATIC STRESS

IS THE PERSON CURRENTLY SUFFERING FROM SYMPTOMS OF POST-TRAUMATIC STRESS?
Have you ever been exposed to a life-threatening and traumatic event? Do you ever have flashbacks or nightmares of this event? Are you tense and anxious as a result of this? Do you try to avoid thinking about it?

0 = NO PROBLEM	e.g.	No traumatic event
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has had trauma, but does not bother much or has overcome most symptoms
2 = SERIOUS PROBLEM	e.g.	Has recurrent intrusions or nightmares, constantly anxious and seldom goes out.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR POST-TRAUMATIC STRESS?

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

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR POST-TRAUMATIC STRESS?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR POST-TRAUMATIC STRESS?

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

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR POST-TRAUMATIC STRESS?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR POST-TRAUMATIC STRESS?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR POST-TRAUMATIC STRESS?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

13. SAFETY TO OTHERS

IS THE PERSON A CURRENT OR POTENTIAL RISK TO OTHER PEOPLE'S SAFETY?

Do you ever lose your temper and hit somebody?
Do you think you could be a danger to other people's safety?

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

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES TO REDUCE THE RISK THAT THEY MIGHT HARM SOMEONE ELSE?

0 = NONE		
1 = LOW HELP	e.g.	Help with threatening behaviour weekly or less
2 = MODERATE HELP	e.g.	Help with threatening behaviour more than weekly
3 = HIGH HELP	e.g.	Almost constant help with persistently threatening behaviour
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES TO REDUCE THE RISK THAT THEY MIGHT HARM SOMEONE ELSE?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES TO REDUCE THE RISK THAT THEY MIGHT HARM SOMEONE ELSE?

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. Anger management programme.
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP TO REDUCE THE RISK THAT THEY MIGHT HARM SOMEONE ELSE?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED TO REDUCE THE RISK THAT THEY MIGHT HARM SOMEONE ELSE?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE TO REDUCE THE RISK THAT THEY MIGHT HARM SOMEONE ELSE?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

14. PHYSICAL AND SEXUAL ABUSE

IS THE PERSON CURRENTLY BEING ABUSED OR AT RISK FOR ABUSE?

Does anything another person does make you feel pain, discomfit or shame?

0 = NO PROBLEM	e.g.	Not being abused
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	At risk for abuse but has been told how to access the appropriate help if abuse appears imminent
2 = SERIOUS PROBLEM	e.g.	Currently being abused
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES?

0 = NONE		
1 = LOW HELP	e.g.	Availability of a trusted person who can be consulted about abuse
2 = MODERATE HELP	e.g.	Steps taken to avoid abuse, such as ensuring company or confronting perpetrator
3 = HIGH HELP	e.g.	Constant protection, intervention from agency, reporting to SAPS, arranging an interdict, moving to a safe place
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES?

0 = NONE		
1 = LOW HELP	e.g.	Raising awareness of the issue in general
2 = MODERATE HELP	e.g.	Individual discussions about what strategies to avoid abuse
3 = HIGH HELP	e.g.	Arranging police protection or an interdict, admission
9 = NOT KNOWN		

HAS THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR PHYSICAL OR SEXUAL ABUSE?

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

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR PHYSICAL OR SEXUAL ABUSE?

(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR PHYSICAL OR SEXUAL ABUSE?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

15. ALCOHOL

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

Does drinking cause you any problems?
Do you wish you could cut down your drinking?
How much do you drink? How often do you drink?

0 = NO PROBLEM	e.g.	No problem with controlled drinking
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	At risk from alcohol and receiving help
2 = SERIOUS PROBLEM	e.g.	Current drinking harmful or uncontrollable
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR THEIR DRINKING?

0 = NONE		
1 = LOW HELP	e.g.	Told to cut down
2 = MODERATE HELP	e.g.	Advised about AA or other sources of help
3 = HIGH HELP	e.g.	Daily monitoring of alcohol
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR THEIR DRINKING?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR THEIR DRINKING?

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

HAS THE PERSON RECEIVED 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 HAVE RECEIVED FOR THEIR DRINKING?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR THEIR DRINKING?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

16. DRUGS

DOES THE PERSON HAVE PROBLEMS WITH DRUG ABUSE?
Do you take any drugs that aren't prescribed?
Are there any drugs you would find hard to stop taking?

0 = NO PROBLEM	e.g.	No dependency or abuse of drugs
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Receiving help for dependency or abuse
2 = SERIOUS PROBLEM	e.g.	Dependency or abuse of prescribed, non-prescribed or illegal drugs
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES FOR THEIR DRUG ABUSE?

0 = NONE		
1 = LOW HELP	e.g.	Occasional advice or support
2 = MODERATE HELP	e.g.	Regular advice, put in touch with helping agencies
3 = HIGH HELP	e.g.	Supervision, liaison with other agencies
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED FROM* LOCAL SERVICES FOR THEIR DRUG ABUSE?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR THEIR DRUG ABUSE?

0 = NONE		
1 = LOW HELP	e.g.	Advice from GP or clinic
2 = MODERATE HELP	e.g.	Drug dependency clinic
3 = HIGH HELP	e.g.	Supervised withdrawal programme, inpatient care
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR THEIR DRUG ABUSE? (0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR THEIR DRUG ABUSE?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR THEIR DRUG ABUSE?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

17. CHILDCARE

DOES THE PERSON HAVE DIFFICULTY LOOKING AFTER THEIR CHILDREN?

Do you have any children?
Do you have any difficulty looking after them?

0 = NO PROBLEM	e.g.	No problem or no problem with looking after them
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Difficulties with parenting and receiving help
2 = SERIOUS PROBLEM	e.g.	Serious difficulty looking after children
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH LOOKING AFTER THEIR CHILDREN?

0 = NONE		
1 = LOW HELP	e.g.	Occasional babysitting less than once per week
2 = MODERATE HELP	e.g.	Help most days
3 = HIGH HELP	e.g.	Children living with friends or relatives
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH LOOKING AFTER THEIR CHILDREN?

HOW MUCH HELP HAS THE PERSON NEEDED FROM LOCAL SERVICES WITH LOOKING AFTER THEIR CHILDREN?

0 = NONE		
1 = LOW HELP	e.g.	Attending day nursery
2 = MODERATE HELP	e.g.	Help with parenting skills
3 = HIGH HELP	e.g.	Children in foster home, or in care
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH LOOKING AFTER THEIR CHILDREN?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH LOOKING AFTER THEIR CHILDREN?
(0 = NOT SATISFIED; 1 = SATISFIED;9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH LOOKING AFTER THEIR CHILDREN?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

18. BASIC EDUCATION

DOES THE PERSON LACK BASIC SKILLS IN NUMERACY AND LITERACY (IN ANY LANGUAGE)? ☐
Are you able to read, write and understand any language?
Can you count your change in a shop?

0 = NO PROBLEM	e.g.	Able to read, write and understand forms in any language
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Difficulties in reading and has help from a relative
2 = SERIOUS PROBLEM	e.g.	Difficulty with basic skills, lack of fluency in any language
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH NUMERACY AND LITERACY? ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional help to read or write forms
2 = MODERATE HELP	e.g.	Has been put in touch with literary classes
3 = HIGH HELP	e.g.	Teaches the person to read
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH NUMERACY AND LITERACY? ☐

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH NUMERACY AND LITERACY? ☐

0 = NONE		
1 = LOW HELP	e.g.	Help filling in forms
2 = MODERATE HELP	e.g.	Given advice about classes
3 = HIGH HELP	e.g.	Attending adult education
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH NUMERACY AND LITERACY? ☐
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECIEVED WITH NUMERACY AND LITERACY? ☐
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH NUMERACY AND LITERACY? ☐

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

19. TELEPHONE

DOES THE PERSON HAVE ANY DIFFICULTY IN GETTING ACCESS TO OR USING A TELEPHONE?
Do you know how to use a telephone?
Is it easy for you to find one you can use?

0 = NO PROBLEM	e.g.	Has working telephone in house or easy access to payphone
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has to request use of telephone
2 = SERIOUS PROBLEM	e.g.	No access to telephone or unable to use telephone
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELPHAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES TO MAKE TELEPHONE CALLS?

0 = NONE		
1 = LOW HELP	e.g.	Help to make telephone calls but less than monthly or only for emergencies
2 = MODERATE HELP	e.g.	Between monthly and daily
3 = HIGH HELP	e.g.	Help whenever wanted
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES TO MAKE TELEPHONE CALLS?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES TO MAKE TELEPHONE CALLS?

0 = NONE		
1 = LOW HELP	e.g.	Access to a telephone available in the community at large
2 = MODERATE HELP	e.g.	Access to a telephone for that individual specifically, or on request
3 = HIGH HELP	e.g.	Arranges to have telephone fitted in home
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP TO MAKE TELEPHONE CALLS?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED TO MAKE TELEPHONE CALLS?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH MAKING TELEPHONE CALLS?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

20. TRANSPORT

DOES THE PERSON HAVE ANY PROBLEMS USING PUBLIC TRANSPORT?
How do you find using the bus, train or taxi?

0 = NO PROBLEM	e.g.	Able to use public transport, or has access to car
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Bus tickets, clipcards or other help provided with transport
2 = SERIOUS PROBLEM	e.g.	Unable to use public transport
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH TRAVELLLING?

0 = NONE		
1 = LOW HELP	e.g.	Encouragement to travel
2 = MODERATE HELP	e.g.	Often accompanies on public transport
3 = HIGH HELP	e.g.	Provides transport to all appointments
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH TRAVELLING?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH TRAVELLING?

0 = NONE		
1 = LOW HELP	e.g.	Given information about time tables
2 = MODERATE HELP	e.g.	Given discount cards for public transport
3 = HIGH HELP	e.g.	Provided with transport
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH TRAVELLING?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH TRAVELLING?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH TRAVELLING?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

Self harm - This need was also frequently reported (48, 80%) and more than two thirds were helped by ward one (70.8%). As satisfactory as this number seems, 29.2% have an unmet need in this area? Do they attempt suicide, or do they live with intermittent thoughts of suicide and self harm? This may be the subject of further study, but is not reported on in this discussion.

Anxiety - The results for this need were similar to the 2 domains above. High levels of anxiety are seen in ward one patients (48, 80%). In the main, this need was met (82.6%).

Post-traumatic stress - The lower proportion of met need for this problem area is cause for concern (57.1% unmet need). Almost half of the patients reported this need (28, 46.7%), and it frequently precipitates admission to the unit. A possible explanation is that patients may be the victims of ongoing abuse or witness in court cases. As a result, the issues of post-traumatic stress remain unresolved. It may be necessary for clinical staff to identify barriers to this need being met.

Safety to others - In a similar fashion to "self harm", this need was met in only half of patients who reported it (52.0%). While the idea of safety to others does not necessarily imply homicidal intent, it is of concern that almost half of patients deem it unmet at discharge. The large numbers of patients with borderline personality styles, many of whom present with relationship problems, may partly explain these figures. Many patients may retain anger towards others, particularly if relationship problems persist. The presence of this degree of unmet need may require ward one to re-examine the role of relational therapies, such as interpersonal therapy.

Physical and sexual abuse - As previously mentioned, this need was rarely reported (6, 10%). Of those who mentioned this

21. MONEY

DOES THE PERSON HAVE SUFFICIENT MONEY?
Do you have enough money for your needs?

0 = NO PROBLEM	e.g.	Has enough money for food clothing, accommodation etc.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Receives money or in kind help
2 = SERIOUS PROBLEM	e.g.	Hungry at times because of lack of money, in serious debt
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH MONEY OR IN KIND HELP?

0 = NONE		
1 = LOW HELP	e.g.	Occasional contributions or loans for small amounts, or occasional assistance with food etc.
2 = MODERATE HELP	e.g.	Regular contributions or loans, or occasionally with large amounts, or regular assistance with food etc., or partially dependent
3 = HIGH HELP	e.g.	Completely dependent on family or friends for money or basic needs
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH MONEY OR IN KIND HELP?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH MONEY OR IN KIND HELP?

0 = NONE		
1 = LOW HELP	e.g.	Occasional help, e.g. food parcels
2 = MODERATE HELP	e.g.	Regular help, or DG or other subsidisation such as a child care grant, or accommodation
3 = HIGH HELP	e.g.	DG plus needs accommodation
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH MONEY OR IN KIND HELP?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH MONEY OR IN KIND HELP?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH MONEY?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

22 DISABILITY GRANT (DG)

DOES THE PERSON RECEIVE A DG?

Do you currently receive a disability grant? Do you get it every month? Do you get the money yourself?

0 = NO PROBLEM	e.g.	Receiving DG regularly or not eligible for one
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Receiving DG intermittently, or an application has been submitted
2 = SERIOUS PROBLEM	e.g.	Not receiving DG and is eligible to receive one, or it is not used for the patient,
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH THEIR DG?

0 = NONE		
1 = LOW HELP	e.g.	Reminds the person to fetch the grant or assists with the process of applying for or receiving grant
2 = MODERATE HELP	e.g.	Helps with the application or obtaining the grant
3 = HIGH HELP	e.g.	Fetches the money or takes the main responsibility in getting the grant
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH THEIR DG?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH THEIR DG?

0 = NONE		
1 = LOW HELP	e.g.	Advising to set in motion or giving forms
2 = MODERATE HELP	e.g.	Help with following the application through
3 = HIGH HELP	e.g.	Monitoring that the DG is appropriately used or administering it
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH THEIR DG?

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

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH THEIR DG?

(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH RECEIVING THEIR DG?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

23. CIGARETTE SMOKING

DOES THE PERSON SMOKE?
Do you smoke? If so, how many per day?

0 = NO PROBLEM	e.g.	Person does not smoke
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Person has recently stopped smoking or smokes less than once daily following advice or encouragement
2 = SERIOUS PROBLEM	e.g.	Currently smoking on a daily basis
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH SMOKING?

0 = NONE		
1 = LOW HELP	e.g.	Told about dangers, encouraged to stop smoking
2 = MODERATE HELP	e.g.	Not allowed to smoke at home, advised about nicotine patches or tablets
3 = HIGH HELP	e.g.	Daily monitoring, cigarettes removed
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES?

0 = NONE		
1 = LOW HELP	e.g.	General anti-smoking messages, e.g. posters
2 = MODERATE HELP	e.g.	Actively speaking to the person individually about the dangers of smoking
3 = HIGH HELP	e.g.	Prevention programme, provision of medication or nicotine patches or tablets
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH SMOKING?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR THEIR SMOKING?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH SMOKING?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

24. INTIMATE RELATIONSHIPS

DOES THE PERSON HAVE ANY DIFFICULTY IN FINDING A PARTNER OR IN MAINTAINING A CLOSE RELATIONSHIP?
Do you have a partner?
Do you have problems in your partnership/marriage?

0 = NO PROBLEM	e.g.	Satisfactory relationship or happy not having a partner.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Receiving couple therapy which is helpful, wants a partner and is helped to meet people
2 = SERIOUS PROBLEM	e.g.	Domestic violence, wants a partner but is unable to establish a relationship
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH FORMING AND MAINTAINING RELATIONSHIPS?

0 = NONE		
1 = LOW HELP	e.g.	Some emotional support
2 = MODERATE HELP	e.g.	Several talks
3 = HIGH HELP	e.g.	Intensive talks and support in coping with feelings
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES WITH FORMING AND MAINTAINING RELATIONSHIPS?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES WITH FORMING AND MAINTAINING RELATIONSHIPS?

0 = NONE		
1 = LOW HELP	e.g.	A few talks/discussions
2 = MODERATE HELP	e.g.	Several talks, regular support
3 = HIGH HELP	e.g.	Couple therapy, social skills training
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP WITH FORMING AND MAINTAINING RELATIONSHIPS?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED WITH FORMING AND MAINTAINING RELATIONSHIPS?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE WITH FORMING AND MAINTAINING RELATIONSHIPS?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

25. SEXUAL EXPRESSION

DOES THE PERSON HAVE PROBLEMS WITH THEIR SEX LIFE?
How is your sex life?

0 = NO PROBLEM	e.g.	Happy with current sex life, or lack thereof, and not practising unsafe sex
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Benefiting from sexual therapy or has sufficient information
2 = SERIOUS PROBLEM	e.g.	Serious sexual difficulty such as erectile dysfunction
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH PROBLEMS IN THEIR SEX LIFE?

0 = NONE		
1 = LOW HELP	e.g.	Some advice
2 = MODERATE HELP	e.g.	Several talks, information material, providing contraception (including condoms)
3 = HIGH HELP	e.g.	Establish contact with counselling centres and possibly accompanying the person in going there. Consistent accessibility to talk about the problem
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES FOR PROBLEMS IN THEIR SEX LIFE?

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES FOR PROBLEMS IN THEIR SEX LIFE?

0 = NONE		
1 = LOW HELP	e.g.	Given information about contraception, safe sex, drug-induced erectile dysfunction
2 = MODERATE HELP	e.g.	Regular talks about sex
3 = HIGH HELP	e.g.	Sexual therapy
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP FOR PROBLEMS IN THEIR SEX LIFE?
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED FOR PROBLEMS IN THEIR SEX LIFE?
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE FOR THEIR SEX LIFE?

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)

26. COMPANY

DOES THE PERSON NEED HELP WITH SOCIAL CONTACT WITH PEERS OUTSIDE THE FAMILY/HOME? ☐

Are you happy with your social life?
Do you wish you had more contact with others outside the family/home?

0 = NO PROBLEM	e.g.	Able to organise enough social contact, has enough friends
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Friends go to the person to keep company, help given through sheltered workshops or psychosocial clubs
2 = SERIOUS PROBLEM	e.g.	Frequently feels lonely and isolated
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO THE NEXT QUESTION

HOW MUCH HELP HAS THE PERSON RECEIVED FROM FRIENDS OR RELATIVES WITH SOCIAL CONTACT? ☐

0 = NONE		
1 = LOW HELP	e.g.	Help with seeing peers outside the family/home less than weekly
2 = MODERATE HELP	e.g.	Help with seeing peers outside the family/home weekly or more often
3 = HIGH HELP	e.g.	Help with seeing peers outside the family/home at least four times a week
9 = NOT KNOWN		

HOW MUCH HELP HAS THE PERSON *RECEIVED* FROM LOCAL SERVICES IN ORGANISING SOCIAL CONTACT? ☐

HOW MUCH HELP HAS THE PERSON *NEEDED* FROM LOCAL SERVICES IN ORGANISING SOCIAL CONTACT? ☐

0 = NONE		
1 = LOW HELP	e.g.	Given advice, e.g. about sheltered workshops, psychosocial clubs
2 = MODERATE HELP	e.g.	Attends sheltered workshops or psychosocial clubs up to 3 times per week
3 = HIGH HELP	e.g.	Attends sheltered workshops or psychosocial clubs 4 or more times per week
9 = NOT KNOWN		

HAS THE PERSON RECEIVED THE RIGHT TYPE OF HELP IN ORGANISING SOCIAL CONTACT? ☐
(0 = NO; 1 = YES; 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY HAVE RECEIVED IN ORGANISING SOCIAL CONTACT? ☐
(0 = NOT SATISFIED; 1 = SATISFIED; 9 = NOT KNOWN)

HOW MUCH HELP DOES THE PERSON NEED FROM WARD ONE IN ORGANISING SOCIAL CONTACT? ☐

(0 = NONE; 1= LOW HELP; 2= MODERATE HELP; 3= HIGH HELP; 9= NOT KNOWN)