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978-1-904-67154-1 — CAN-M: Camberwell Assessment of Need for Mothers
Louise Howard , Katherine Hunt , Mike Slade , Veronica O'Keane , Trudi Seneviratne , Morven Leese , Graham Thornicroft , Malcolm Wiseman
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1 Needs assessment

Mike Slade

Introduction

There is growing international consensus that a needs-led approach should underpin care provided to people with SMI. For instance, the Swedish Psychiatric Care Reform, introduced in 1995, emphasises the patient's and carer's experiences of their needs (Arvidsson, 2001). In Australia, the importance of individual needs assessments for informing service development and evaluation is recognised (Mental Health Branch, 1997). In the UK, the National Service Framework for Mental Health sets standards for assessing mental health needs in primary care, and for the provision of specialist mental health services for people with multiple and complex needs (Department of Health, 1999*b*).

The term 'need' is used in two broad ways: individual and population (Slade & Glover, 2001). Individual level need refers to the problems and difficulties of an individual person. In a healthcare context, these people are actual or potential users of mental health services. Population level need refer to the needs of defined segments of the population, expressed either in terms of levels of morbidity or in terms of need for particular forms of healthcare provision. This book focuses on needs at the individual level.

Attempting to assess individual needs raises several important questions. What are needs? How are they assessed? How useful is needs assessment information, once collected? Why is a specific approach for assessing the needs of pregnant women and mothers necessary? The remainder of this chapter will address these questions.

What are needs?

At the individual level, the concept of need has been grounded in various theories. The American psychologist Maslow proposed a hierarchy of need when attempting to formulate a theory of human motivation (Maslow, 1954). His belief was that fundamental physiological needs, such as the need for food, underpin the higher needs of safety, love, self-esteem and self-actualisation. He proposed that people are motivated by the requirement to meet these needs, and that higher needs can only be met once the lower and more fundamental needs are met. This approach can be illustrated by the example of a pregnant woman who is mentally ill and homeless and who is not concerned about attending her antenatal appointments while she is cold and hungry. Maslow therefore highlights that not all needs are equal. However, not intervening to meet a need (e.g. because addressing other needs is prioritised) should be a conscious choice rather than based on ignorance. In this example it remains important to identify the need for friends, even if no help is to be provided initially. This indicates that assessment of need should be separate from decisions about interventions to provide, a fundamental principle of needs assessment which is enshrined in the National Health Service and Community Care Act (Department of Health, 1990).

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Different types of need have been identified by Bradshaw (1972): felt (experienced), expressed (experienced and communicated), normative (judgement of professionals) and comparative (based on comparison with the position of other individuals or reference groups). This taxonomy indicates that different perceptions of need can exist. Bradshaw's taxonomy provides an important set of distinctions in a mental healthcare context.

Individual patients may have impoverished expectations (e.g. due to institutionalisation), and may consequently not experience felt needs in situations where other members of the population would.

Patients may not choose to express a felt need to professionals. For example, risk to children may not be disclosed because of fears that this will lead to children being taken away. Ongoing psychotic symptoms may not be acknowledged for fear that reporting voices leads to compulsory hospitalisation.

The concept of normative needs prioritises clinical judgement over other perspectives, such as that of the patient or their informal carer. The Medical Research Council (MRC) Needs for Care Assessment (NCA) Schedule (Bebbington, 1992), for example, is based on the definition of need as 'a normative concept which is to be defined by experts' (p. 107). This approach is not consistent with the aim of the 'informed patient', and may not promote active partnership between the patient and staff.

Finally, comparative need highlights the involvement of a reference group in identifying a need. The choice of reference group is a value-based choice. For example, does a patient with SMI need a mobile phone, access to the internet, or enough money to go out for a meal? The expectations (and, therefore, the identified comparative needs) are driven by cultural, political and economic values.

Overall, the Bradshaw taxonomy highlights that need is a subjective concept, and that the judgement of whether a need is present or not will, in part, depend on whose viewpoint is being taken. There can be differences in perception between, for instance, the mental health patients and their involved professionals. If differences are identified, then it becomes possible for negotiation between staff and patient to take place so as to agree to a care plan.

Stevens & Gabbay (1991) have distinguished need (the ability to benefit in some way from healthcare), demand (wish expressed by the service user) and supply of services. These concepts can be illustrated by different components of mental health services. For instance, mental health services for people who are mentally ill and homeless are rarely demanded by people who are homeless, but most professionals would agree that a need exists. In contrast, the demand for counselling services frequently outstrips supply.

Approaches to needs assessment

There is no perfect individual needs assessment tool. The requirements of different contexts vary, and there is inevitable conflict between factors such as brevity and comprehensiveness. Numerous approaches to assessment of need have been developed by individual teams around the country to aid care planning and reviews. There is little consistency in the information that is collected, with a tendency to concentrate on qualitative, rather than quantitative, data. Psychometric properties are frequently ignored. Although the development of such instruments help to focus a team's approach, they do not provide valid or accurate information to service planners.

One well-established needs assessment approach is the Camberwell Assessment of Need (CAN) (Phelan *et al*, 1995), which is the focus of this book. Other carefully designed needs assessment instruments include:

1. MRC Needs for Care Assessment (NCA)

The NCA was designed to identify areas of remediable need (Brewin *et al*, 1987). Need is defined as being present when (a) a patient's functioning (social disablement) falls below or threatens to fall below

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some minimum specified level, and (b) this is due to a remediable, or potentially remediable, cause. A need is defined as being met when it has attracted an item of care that is at least partly effective, and when no other item of care of greater potential effectiveness exists. A need is said to be unmet when it has only attracted a partly effective or no item of care, and when other items of care of greater potential effectiveness exist. The NCA has proved itself to be a robust research instrument, and there is a substantial body of research describing its use (Brewin *et al*, 1988; Lesage *et al*, 1991; van Haaster *et al*, 1994; O'Leary & Webb, 1996). However, it is probably too complex and time consuming for routine clinical use, and difficulties have arisen when it has been used among long-term in-patients (Pryce & Griffiths, 1993) and those who are mentally ill and homeless (Hogg & Marshall, 1992).

2. Cardinal Needs Schedule (CNS)

The CNS is a modification of the NCA (Marshall *et al*, 1995). It identifies cardinal problems which satisfy three criteria:

(i) the 'cooperation criterion' (the patient is willing to accept help for the problem);
(ii) the 'co-stress criterion' (the problem causes considerable anxiety, frustration or inconvenience to people caring for the patient);
(iii) the 'severity criterion' (the problem endangers the health or safety of the patient, or the safety of other people).

A computerised version known as AUTONEED is also available. Its use has been evaluated in routine clinical settings (Lockwood & Marshall, 1999; Marshall *et al*, 2004).

3. Bangor Assessment of Need Profile (BAN–P)

The BAN–P comprises a self-report schedule designed to give a brief and simple indication of the expressed need of people with a long-term mental illness, and a schedule to assess need as perceived by a key informant (Carter et al, 1996). Need is present when an item falls below that which the respondent (user or key informant) perceives to be normal or ordinary functioning, and is absent when the respondent perceives normal and independent functioning. Reliability is explored, and the instrument is primarily intended for research use.

4. Avon mental health measure

The Avon measure is an approach to mental health needs assessment that has been developed by Mind, a national mental health charity (Markovitz, 1996). It assesses need in 25 domains identified by mental health service users as important, and is completed by the service user, possibly with help from an advocate or care worker as necessary (Lelliott, 2000). It appears to offer some advantages over staff-rated or unstandardised assessments (Hunter *et al*, 2004), but its psychometric properties have not yet been published.

Development of the adult Camberwell Assessment of Need (CAN)

The adult CAN was originally developed for use with adults of working age (16–65 years) with SMI. Four broad principles governed the development of the adult CAN. First, everyone has needs, and although people with SMI have some specific needs, the majority of their needs are similar to those of people who do not have a mental illness, such as having somewhere to live, something to do and enough

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money. Second, the majority of people with an SMI have multiple needs, and it is vital that all of them are identified by those caring for them. Therefore a priority in the adult CAN is to identify, rather than describe in detail, serious needs. Specialist assessments can be conducted in specific areas if required, once the need is identified. Third, needs assessment should be both an integral part of routine clinical practice and a component of service evaluation, so the adult CAN should be useable by a wide range of staff. Lastly, the adult CAN is based on the principle that need is a subjective concept, and that there will frequently be differing but equally valid perceptions about the presence or absence of a specific need. The adult CAN therefore records the views of staff, service users and carers separately.

The original criteria that were established for the adult CAN are that it:

(a) has adequate psychometric properties
(b) can be completed within 30 minutes
(c) can be used by a wide range of professionals
(d) is suitable for both routine clinical practice and research
(e) can be learnt and used, without formal training
(f) incorporates the views of both service users and staff about needs
(g) measures both met and unmet need
(h) measures the level of help received from friends or relatives as well as from statutory services.

The psychometric properties of the adult CAN were published in 1995 (Phelan *et al*, 1995), and have been further investigated and shown to be adequate in subsequent studies (e.g. Andresen *et al*, 2000; McCrone *et al*, 2000; Arvidsson, 2003).

Three versions of the adult CAN exist. The CAN – Research (CAN–R) is intended primarily for research use. The CAN – Clinical (CAN–C) is primarily for clinical use. The CAN Short Appraisal Schedule (CANSAS) is suitable for both research and routine clinical use. Each version of the adult CAN assesses 22 domains of health and social needs, shown in Box 1.

The adult CAN has been translated into 23 other languages, and is now the most widely reported approach to needs assessment internationally (Evans *et al*, 2000). It has been published as a book (similar in format to this volume), which contains all three versions in a form suitable photocopying, along with training and scoring materials (Slade *et al*, 1999*a*). Purchasing the adult CAN book allows unlimited use

Box 1 Domains assessed by the adult CAN

1. Accommodation
2. Food
3. Looking after the home
4. Self-care
5. Daytime activities
6. Physical health
7. Psychotic symptoms
8. Information on condition and treatment
9. Psychological distress
10. Safety to self
11. Safety to others
12. Alcohol
13. Drugs
14. Company
15. Intimate relationships
16. Sexual expression
17. Childcare
18. Basic education
19. Telephone
20. Transport
21. Money
22. Benefits

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for research, clinical or teaching purposes. Further information about the adult CAN is available from www.iop.kcl.ac.uk/prism/can.

Adult CAN research

What has research using the adult CAN shown? Some features of the adult CAN were driven by prescient policy. The emphasis on the patient perspective allows explicit comparison of the staff and patient perspective on the same scale, a feature not present in other assessments. Similarly, the emphasis on needs, rather than needs for care, broke free from the restricted approach of considering only those areas of life in which mental health services have expertise, such as symptomatology and social functioning. The adult CAN domain of sexual expression illustrates this point, since it is not always routinely assessed despite the evidence for higher rates of sexual dysfunction in schizophrenia (MacDonald *et al*, 2003). Overall, some consistent findings have emerged from CAN research (in decreasing order of certainty):

1. Patient and staff assessments of need differ (e.g. Wiersma *et al*, 1998; Lasalvia *et al*, 2000; Hansson *et al*, 2001), and patient assessments are more reliable than staff assessments (Slade *et al*, 1999*b*).
2. Level of need is cross-sectionally associated with quality of life (UK700 Group, 1999; Hansson *et al*, 2003).
3. The cross-sectional association with quality of life is stronger for patient-rated unmet need than staff-rated unmet need (Slade *et al*, 1999*b*; Hansson *et al*, 2003).
4. Changes in patient-rated unmet need temporally precede changes in quality of life (Slade *et al*, 2004, 2005), indicating that needs cause quality of life.
5. A similar causal relationship exists between patient-rated unmet need and therapeutic alliance (Junghan *et al*, 2007).

Specifically in relation to mothers, seminal work by our group has characterised the needs of mothers with psychotic disorders (Howard *et al*, 2001). For this client group, there was no significant difference in the total number of met needs rated by the patient and by staff, although patients rated higher levels of unmet need than staff. There was strong evidence that women with children were more likely than women without children to rate themselves as having a problem with intimate relationships. Patients with a history of having a looked-after child were more likely to have problems with childcare and basic education. However, this research also highlighted the need for a specific instrument to measure the needs of mothers with psychotic disorders as the available instruments did not measure some of their specific needs.

The adult CAN is used routinely in many services internationally (e.g. in Australia, England, Italy, Scotland, Spain, Sweden). Most routine uses of the adult CAN are driven by local requirements to introduce needs assessment, and are not formally evaluated. The impact is therefore difficult to judge. Formal evaluations of the impact of routine use of the CAN (Slade, 2002; Slade *et al*, 2006) and its variants (Ashaye *et al*, 2003; van Os *et al*, 2004) are only just becoming available, and research investigating the routine use of CAN in typical clinical services will be a high priority in the future.

The need for CAN variants

In addition to the different versions of the adult CAN (CAN–R, CAN–C, CANSAS), it has been necessary to develop variants for use with other client groups. Three variants have been published.

The CAN for Developmental and Intellectual Disabilities (CANDID) is intended for use with adults with learning disabilities and mental health problems (Xenitidis *et al*, 2000), and has been published

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in book form (Xenitidis *et al*, 2003). The CAN – Forensic (CANFOR) is for use with people with mental health problems who are in contact with the criminal justice system ('mentally disordered offenders') (Thomas *et al*, 2008), and is available in book form (Thomas *et al*, 2003). The CAN – Elderly (CANE) is for use with older adults with mental health problems (Reynolds *et al*, 2000), and has also been published in book form (Orrell & Hancock, 2004). Each variant has been developed to be consistent with the adult CAN, but with new or amended domains which are particularly relevant to the specific client group.

There is a need for a CAN variant that particularly assesses the needs of women who have mental health problems and are pregnant and/or mothers. To justify this assertion, some of the specific needs of this client group are outlined in the next three chapters. The development of the CAN variant for pregnant women and mothers with mental health problems is then described. The overall aim is to add to the existing family of CAN assessments, to ensure that the needs of mothers and pregnant women are not neglected.

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