Eur Psychiatry 1999 ; 14 : 186-8

EDITORIAL

Who needs needs?

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(Received 8 February 1999; accepted 3 May 1999)

Summary – The idea of assessing needs both in individuals and in populations is popular in health and social care, but has serious conceptual shortcomings. The concept of needs does not distinguish between the identification of a problem and its solution. It inhibits a consideration of the probabilities as to how effective various interventions may be in any given case – nor does it reflect the iterative process that is the reality of most health and social care. It does not specify goals and oversimplifies evaluation of outcome because it does not take into account different degrees of change. In assessing population needs, there is the special risk of equating service use with service need, thereby entrenching the status quo. Instead of assessing needs, it is proposed that we identify problems, specify goals and choose interventions on the basis of probabilities of effectiveness. The outcome of any given intervention can be repeatedly reviewed with respect to its goals, and priorities may be reset accordingly. © 1999 Elsevier, Paris

assessment / evaluation / mental health planning / needs

The term 'needs' has become very popular in mental health planning and research in the UK [18]. Health and social services are expected to meet the needs of people with mental illness, and to conduct needs assessment of both the individual and the population. The term 'need' implies a feature in individuals or populations which can be objectively assessed, and it predicts specific treatments or interventions needed for re-establishing or maintaining health. If a need is met by the indicated treatment, it disappears or remains as a 'met need'. Such a close fitting relationship is very attractive. Its existence would simplify and rationalize clinical decision making and mental health care planning. According to this concept of needs 'met needs' may be regarded as ubiquitous. All of us have needs for social contacts, intimate relationships, food, etc., that are met by someone, though in most cases not by the health and social services. Thus, it is the specific need for professional health and social care that is of interest.

Several standardized instruments have been developed for assessing mental health needs in individuals [3, 10-13]. If patients, their key-workers, and others involved in their care are independently interviewed, the congruence of answers (even for very basic questions) has mostly been found to be low to moderate [7, 9, 16]. Different persons' views on an individual's needs seem to have little correlation. Cohen and Eastman [5] suggested substituting the term 'perspectives on need' for the term 'needs assessment' acknowledging that any needs assessment is value-laden and that no single truth about need exists.

There is exhaustive research in psychology, sociology, and philosophy dealing with the meaning of desires, wants, demands and wishes, all of which are closely related to self-expressed individual needs. This research has illustrated that the concept is intuitively appealing but actually complex, and that it is tempting but very difficult to use the concept in a simplified and straight-

forward manner [2, 8]. Freud [6] described a patient who created and kept a desire (in more modern terms a 'self-rated need') that she consistently avoided fulfilling. Rescher [15] concluded that while individuals are always the best judges of their own happiness, they are not always the best judges of what is in their own interest. Furthermore, self-rated needs seem to overlap with other constructs such as subjective quality of life and self-rated symptoms [14]. Neither extensive theoretical literature nor empirical research have yielded a consistent concept of individual mental health needs, and there is only limited evidence for the validity of any of the proposed concepts.

Regardless of theory and research, the term 'needs' is in routine use. To identify a mental health need – and not just a problem – implies that there is an existing treatment to meet that need, i.e., that is 'needed'. Is a patient with hallucinations and delusions in need of antipsychotic medication? If that patient receives antipsychotics, but does not improve, does this mean that there had never been a need for that particular treatment – a 'false need'? What this example might illustrate is that the concept of needs inappropriately simplifies the actual complex process of clinical decision making. There is hardly any treatment in psychiatry that is guaranteed always to be effective.

Clinicians have to consider probabilities of effects and side-effects in each individual case. Based on empirical evidence, personal experience and available resources they will then reach a decision about which intervention to apply, and they will constantly revise their decision depending on the treatment outcome. The concept of needs does not provide a framework for considering probabilities or to reflect this iterative process. It dichotomises any decision-making, and enforces one of only two possible conclusions: a need for a defined treatment does or does not exist. It also simplifies the assessment of outcome because a need is either met or not met. In patients with severe mental illness, symptoms and problems are likely to persist, although not to a consistent and invariable degree. Substantial improvement and clinically relevant goals may be achieved without making a 'need' disappear.

When assessment of population needs is based on individual need assessments in representative samples [1], it is associated with the same conceptual shortcomings. When it has been attempted as a more general evaluation, it has proved a very difficult exercise. This is of particular importance in the current context of 'contract setting' (when providers and purchasers of health care must agree the nature and volume of local care provision). Stevens and Gabbay [17] provided a detailed review of the development of the concept of needs and its borders with supply and demand.

What is the need for mental health services in a society, and what are the indicators of under-supply and of over-supply? Two examples from opposite ends of the spectrum may illustrate this. Developing countries with hardly any professional psychiatric services demonstrate that while a complete lack of mental health care services certainly poses various problems, it hardly leads to social or political collapse. At the other end of the spectrum, health authorities and insurance companies in Germany argue that there is an overprovision of psychiatric hospital beds and of psychiatrists in office practice in some regions. The debate about how many of those services are really needed has led to the conclusion that any position will be politically motivated, and that real need is impossible to establish by objective methods. There is no agreement on what the services are intended to achieve or on what the outcome criteria should be. In short, the assessment of a population need makes little sense without a clear specification of what exactly the service that is alleged 'to be needed' is needed for.

As in the assessment of individual need, the assessment of population needs produces very different answers depending on the methodology used. A judgement based on deprivation indices shows greater need in urban areas, but a judgement based on scarcity of provision may demonstrate greater need in rural areas. There is a high risk of circularity in analyzing population-based needs. For example, the use of hospital beds might be proposed as establishing the need for them. Similarly if some groups with specific sociodemographic characteristics have higher bed use than others, it might be concluded that they have a higher need for beds. According to such logic, patients living closer to a psychiatric hospital would have a greater need for hospital treatment because they are more likely to get admitted than people living further away, for whom it would take longer to get to the hospital.

To use a historical analogy, the frequent use of bloodletting over several centuries implies a need for it, a need that has decreased within the last 200 years. In the 17th and 18th century, bloodletting was more frequently used in higher social classes. Were social characteristics, therefore, indicators for the need for bloodletting? Two hundred years ago, the answer would have been yes

because it would have been based on the current assumptions and ideas that determined clinical practice. Needs assessment may run the risk of being led by current practice and of merely confirming current hypotheses and convictions.

The term needs does not imply a definition of the goal that is to be achieved by the 'needed' treatment or service. Without setting goals, however, effectiveness cannot be judged [4]. More importantly, the concept confuses the identification of a problem with its potential solution and is therefore logically flawed. The current usage of 'need' does not acknowledge that there might be various solutions for the same problem and that various problems might require the same solution.

What could replace the current concept of needs? Depending on which subject, one might usefully retain a variety of concepts such as problems, illnesses, symptoms, deficiencies, impairments, handicaps, or disabilities. If a problem is identified and a goal for intervention is specified, e.g., a defined reduction of psychopathology in an individual or of suicide rate in a population, one may consider which interventions are more or less likely to achieve those goals best, and set priorities accordingly. Depending on the outcome of the interventions or on changes occurring independently of the interventions, priorities may be re-set and interventions adjusted or changed. That, however, does not imply that a need for any of the interventions had been identified at the beginning. Using a concept of problems would still leave the possible disagreement of different perspectives and the necessity for defining a level of health that the interventions aim at achieving. Yet, the concept of a problem – no matter whether this or other terms are used – would not imply the nature of the remedy.

Both the terms 'need' and 'problem' carry a sort of internal imperative that something should be done about it. 'Goal' carries the same, but is not as negative and stigmatizing. 'Goal identification' and 'goal achievement' both have positive connotations. Considering the views of different people involved in treatment, the question of whether there are shared goals arises more naturally than whether there is a joint perspective on needs. If different staff members are required to collaborate towards the same goal with a patient, 'goal' allows for different tasks to be identified simultaneously or successively by different staff working towards a common goal.

Clinical decision making and mental health service planning are complex. They are based on a negotiation between individuals and populations with health problems and professionals with knowledge and experience. The term 'needs' oversimplifies this process, and we suggest that 'goals' may help to clarify it.

REFERENCES

1 Bebbington PE, Marsden L, Brewin CR. The need for psychiatric treatment in the general population: the Camberwell needs for care survey. Psychol Med 1997 ; 27 : 821-34.
2 Bradshaw J. A taxonomy of social need. In: Mclachlan G, ed. Problems and progress in medical care. Oxford: Oxford University Press; 1972. p. 7182.
3 Brewin CR, Wing JK, Mangen SP, Brugha TS, Maccarthy B, Lesage A. Principles and practice of measuring needs in the long-term mentally ill. The MRC needs for care assessment. Psychol Med 1987 ; 17 : 971-81.
4 Burns T, Priebe S. English mental health care failure: myth and reality. Br J Psychiatry 1999 ; 174 : 191-2.
5 Cohen A, Eastman N. Needs assessment for mentally disordered offenders and others requiring similar services. Br J Psychiatry 1997 ; 171 : 412-6.
6 Freud S. Gesammelte Werke. London: Imago; 1940. p. 1952.
7 Hansson L, Björkman T, Svensson B. The assessment of needs in psychiatric patients – Inter-rater reliability of the Swedish version of the Camberwell assessment of needs instrument and results from a cross-sectional study. Acta Psychiatr Scand 1995 ; 92 : 285-93.
8 Heinze M, Priebe S. On the term needs in psychiatric research (in German). Fundamenta Psychiatrica 1995 ; 9 : 52-60.
9 Hoffmann K, Priebe S. Needs for help and support in the view of schizophrenic long-term patients and of their therapists (in German). Fortschritte der Neurologie Psychiatrie 1996 ; 64 : 473-81.
10 Hoffmann K, Priebe S, Isermann M, Kaiser W. Quality of life, needs, and assessment of treatment in long-term hospitalized patients. Part II of the Berlin deinstitutionalisation study (in German). Psychiatrische Praxis 1997 ; 24 : 221-6.
11 Marshall M. The cardinal needs schedule – A modified version of the MRC needs for care assessment schedule. Psychol Med 1995 ; 25 : 605-17.
12 Phelan M, Slade G, Thornicroft G, Dunn G, Holloway F, Wykes T, et al. The Camberwell assessment of need (CAN): the validity and reliability of an instrument to assess the needs of the seriously mentally ill. Br J Psychiatry 1995 ; 167 : 589-95.
13 Priebe S, Gruyters T, Heinze M, Hoffmann C, Jäkel A. Subjective criteria for evaluation of psychiatric care – Methods for assessment in research and routine care (in German) Psychiatrische Praxis 1995 ; 22 : 140-4.
14 Priebe S, Kaiser W, Huxley P, Röder-Wanner UU, Rudolf H. Do different subjective evaluation criteria reflect distinct constructs. J Nerv Ment Dis 1998 ; 186 : 385-92.
15 Rescher R. Welfare: the social issues in philosophical perspective. Pittsburgh: University of Pittsburgh Press; 1972.
16 Slade M, Phelan M, Thornicroft G, Parkman S. The Camberwell assessment of need (CAN): comparison of assessment by staff and patients of the needs of the severely mentally ill. Soc Psychiatry Psychiatr Epidemiol 1995 ; 31 : 109-13.
17 Stevens A, Gabbey J. Needs assessment needs assessment. Health Trends 1991 ; 23 : 20-3.
18 Wright J, Williams R, Wilkinson JR. Development and importance of health needs assessment. Br Med J 1998 ; 316 : 1310-2.