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LETTERS TO THE EDITOR

Standard assessment scales for elderly people. Recommendations of the Royal College of Physicians of London and the British Geriatrics Society

Sir,—In 1989 the Research Unit of the Royal College of Physicians initiated a workshop to consider scales that could be recommended for the assessment of elderly people in geriatric medicine services. At the outset, the main motive behind this initiative was to provide the tools for part of a minimum dataset in geriatric medicine. The workshop was convened in association with the British Geriatrics Society and included participants drawn from associated professions.

At the workshops, precirculated expert papers were presented briefly and discussed in detail. Topics included the individual assessment domains, the science of assessment, the interface with primary care, and the ethics of assessment. The assessment domains that were considered comprised activities of daily living, communication, mood, cognitive function, social status, and quality of life. Between the workshops, each domain was the subject of consideration in much greater detail by smaller working groups drawn from among workshop participants. The background papers, minutes of workshop discussions, results of the deliberations of the small working groups, and other miscellaneous comments were incorporated into a report which was published this year.[1]

The report includes background comments on standard assessments and provides the rationale for assessment in each domain. A standard scale is recommended for each domain (table) and potential areas for future research are highlighted.

The report reproduces the individual scales along with any instructions for the ones that are available. In general, the scales recommended are simple and well established. For activities of daily living, the Barthel ADL Index probably reflects existing informal assessments and formalises existing activities, while the scale for cognitive impairment—the Abbreviated Mental Test—is probably in widespread use already. The mood and morale scales are probably less familiar although recognising depression is clearly good practice. Particular difficulty was encountered in recommending a scale for measuring social status, partly because social status has so many different aspects. Instead, a simple social checklist has been proposed.

Recommended assessments scales for elderly people.

Primary ADL	Barthel ADL Index (Mahoney and Barthel, 1965;[2] Collin *et al*, 1988[3])
Memory	Abbreviated Mental Test (Hodkinson, 1972[4])
Communication	Lambeth questionnaire screening questions (Peach *et al*, 1980[5])
Mood	Geriatric Depression Scale (Yesavage *et al*, 1983[6])
Morale	Philadelphia Geriatric Center Morale Scale (Davies and Challis, 1986[7])
Social status	Social status checklist (Royal College of Physicians, 1992[1])

The workshops and report have been accompanied by a parallel research project—the SAFE (standard assessment for the elderly) study. This consisted of a multicentre evaluation of the use of the recommended scales in the real world. Data are currently being analysed and reports should be available later this year. Participants in this study, which was cofunded by seed money from the Research Unit of the Royal College of Physicians and locally raised audit and development monies, also carried out associated studies as part of the overall project. These included use in community settings and development of information systems.

Efforts have been made to try and maximise the potential of the recommended scales. There has been close liaison with The Royal College of General Practitioners to ensure congruence between this report and their forthcoming recommendations as to the "over 75s checks". There have been links with the National Centre for Classification and Coding/NHS Management Executive "clinical terms projects" and the recommended scales will appear as Read codes.

During the production of the report it has become clear that there may be many other potential benefits from the use of the standard scales than their use in clinical audit; they may have a role in describing outcome since they are pitched at the appropriate level of disease impact, namely disability; their use may allow credible casemix assessment; their adoption may improve the activities of care, by ensuring assessment takes place, both in geriatric medicine and in other hospital settings providing health care for elderly people; there are major opportunities for basing a common language of assessment on the recommended scales. This would assist the development of community care, record linkage, common software, and community based needs assessments. There may be gains in interprofessional health services research. Finally, health status according to assessments using the recommended scales could be defined in order to devise measures of the health of populations, such as "active life expectancy".[8]

Future developments are on the way. At a simple level the Research Unit of The Royal

College of Physicians is developing a common format for the everyday use of the recommended scales. A scientific network has been formed in Europe that may have a future opportunity to develop an EC-wide consensus on standard assessment scales (further details from the author).

E J DICKINSON
Royal College of Physicians Research Group
London Hospital Medical College
London E1

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Predicting mortality from cervical cancer

Sir,—A few months ago 1990 mortality data for England and Wales were interpreted as providing some reassurance that the cervical cancer screening programme was working, though given the dearth of information about sexual behaviour, "safer sex" might also be playing a part in the reversal of trends under age 50 years.[1 2]

A preliminary assessment of 1991 mortality data is encouraging. Population estimates revised in the light of the 1991 census are not yet available, only projections and estimates based on the 1981 census, so we have concentrated our attention on the number of deaths observed.

We recently predicted deaths over the decade 1991–2001, by modelling the death rates from 1959–88. The lowest estimate for deaths expected in 1991 was 674 for women aged 20–49 and 1329 for those aged 20–69 years.[3] In fact, 461 and 1030 deaths at these ages respectively were observed (compared to 488 and 1119 in 1990), considerably lower than predicted. Although we acknowledged that our predictions might be too high (as other forecasts have been) we are gratified they have turned out to be so much greater than the observed numbers.

It seems likely that the screening programme is finally having really noticeable effects, though without monitoring trends in sexual behaviour, we are still guessing.

M MURPHY
J CHARLTON
Unit of Health Care Epidemiology
Department of Public Health and Primary Care,
University of Oxford

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