Family casework with families referred to Child Guidance Clinics or Social Services Departments.

Behaviour modification or behaviour therapy with children where the parents or foster parents alone, or in conjunction with school staff or residential workers, are trained to use behavioural principles to deal with children's problems. A full spectrum of problems will be considered, including mental handicap, learning difficulties, developmental delays, conduct and emotional problems, psychoses, acute and chronic physical illnesses and the sequelae of child abuse.

Behaviour modification, behaviour therapy or cognitive therapy with adults who present with problems or illnesses such as depression, agoraphobia, obsessive compulsive disorder, addiction, chronic back pain or multiple sclerosis and where the patient's family play an important role in the treatment programme.

Family support or education groups where a number of families meet because they share a common problem such as having a chronically ill member or an addicted member.

Foster-parents support and training programmes for couples who foster problem children.

Family therapy and intervention studies which focus on the following issues will be reviewed:

Therapy outcome where some quantitative assessment of the impact of the intervention on one or more family members is made.

Therapy process where some aspect of therapist or family behaviour during the intervention is quantitatively assessed.

Consumer surveys of therapy where the satisfaction of families and referring agents with the family based intervention is assessed using survey research or other quantitative methods.

It is hoped that the review will be comprehensive, so please contact me if you have been connected with research projects that fall within the parameters outlined above.

I look forward to hearing from you.
Thank you for your help.

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The College

The Royal College of Psychiatrists: Preliminary report on medical audit

Remit of the Working Party from Council:

(1) To define and distinguish between clinical audit, peer review and performance indicators.
(2) To collect information within the general area of audit, appraise what is most useful for measuring performance in psychiatric practice and make proposals for audit that can be subsequently evaluated.
(3) To examine ways in which audits of service and individual units are carried out and what variations have been devised to meet local circumstances and requirements.
(4) To consider issues to do with management appraisal.

Definitions

(1) **Medical audit** can be defined as the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patients. (Working paper 6, paragraph 1.1. of the National Health Service Review).

Throughout its discussions, the Working Group has preferred to use the term 'clinical audit' which includes the work of all members of the multidisciplinary team, and which is therefore more appropriate to psychiatry. In addition to the one just given, the following definitions have been made.

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(2) **Clinical audit** is the generic term used to cover ways in which evaluation can be for:

(a) to determine the effectiveness of a specific treatment, a treatment regime, or a treatment setting

(b) a random evaluation of run-of-the-mill cases

(c) an examination of the occurrence of unusual but undesirable events such as maternal deaths in childbirth, acts of violence, absconding etc.

(d) to provide statistics for financial planning and accounting.

Clinical audit resembles clinical research in several ways, but is not research as no hypothesis is tested.

There are two aspects of clinical audit: quantitative and qualitative.

The managerial emphasis has been on measures of quantity (e.g. as in the Körner data) but the clinicians should give at least equal emphasis to measures of quality.

(3) **Peer review** is a method of clinical audit in which the quality of the performance of a particular practitioner is measured by and compared with that of his colleagues.

(4) **Performance indicators** are ratios of output to input. They measure quantity.

Input measures include: wtes (whole-time equivalents) of consultant time, members of paramedical staff such as psychologists, occupational therapists, etc.

Output measures include: bed occupancy, numbers of patients seen in a clinic session. Department of Health performance indicators have used Körner recommended minimum data which are found to be unsuitable for those specialities which have moved away from traditional hospital practice, especially child and adolescent psychiatry (Nicol, 1989), the psychiatry of old age (see report of working group) and the psychiatry of mental handicap.

(5) **Quality assurance** is another generic term meaning methods employed to maintain and improve standards. One example of this would be the College's educational approval visits.

(6) **Monitoring** is a technique of clinical audit whereby there is regular re-assessment of some aspect of the service, e.g. routine examination of untoward incidents such as suicide, aggression or wandering off under section (see 2(c)).

Levels of audit

(1) Within clinical teams, e.g. critical review, ward rounds, or discharge meetings. The contribution of individual members may be monitored.

(2) Between clinicians or clinical teams. This is peer review and there will be detailed review of randomly chosen cases.

(3) Within a hospital, e.g. prescribing practices; readmission of schizophrenic patients.

(4) Between units or hospitals, such as the comparison of process and outcome of similar cases in two different districts of which one might be a teaching hospital; the function of liaison psychiatry within different medical firms or in different hospitals.

(5) Regional – this might include the management of unusual or particularly difficult cases. The example in general psychiatry given was that of investigating the management of anorexia nervosa.

(6) National – would include Health Advisory Service, the National Development Team, Training Approval Visits and the College's ECT exercise. In Scotland, the Mental Welfare Commission has an important role in monitoring care of psychiatric patients.

Audit within the service cannot be seen in a vacuum. There are three main components.

(1) *Resources* include the input category of performance indicators but psychiatric resources provided within the hospital must be related to community services and specific features of the neighbourhood.

Resources in hospital include buildings, secretarial support, computers, access to laboratories and other investigations, etc. Resources in the community would also include staff and buildings, as well as those provided by social services, including social workers and various types of hostel accommodation, children's homes or respite provisions; those provided by education such as educational psychologists, and those in the voluntary sector such as the Richmond Fellowship and the Samaritans. Demographic data concerning social class, owner-occupancy, unemployment, etc., are all relevant (Hirsch, 1988).

(2) *Process*, the second major component, comprises what is done to the patient during diagnosis and treatment. One measure of quality is the satisfaction of the patient and/or the nearest relative, and another is the personal cost born by the patient or relative in terms of pain, inconvenience and indignity.

(3) *Outcome*, the third major component, presents major difficulties in psychiatry in terms of how and when it should be measured. Mortality is rarely applicable as death is an uncommon outcome except in psychiatry of old age and even there presents difficulties. Should death be rated as the worst possible outcome?

A simple rating scale of global improvement from 0 = no change to 4 = complete recovery was

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used in the study of in-patient treatment at the Cassel hospital (Denford *et al*, 1983; Rosser, 1988). However, since many patients have complex psychopathology, others have used multiple measures which can be conflicting where a patient is rated as improved in mood but having more problems of social impairment. As well as complex psychopathology, there is also often a problem of chronicity. A helpful idea is that of "met needs". Assessment of needs, as described by Wing and his colleagues, is based on the following:

(a) Need is present when (i) a patient's functioning falls below or threatens to fall below some minimum specific level, and (ii) this is due to some remedial, or potentially remediable, cause.
(b) A need (as defined above) is met when it has attracted some at least, partially effective intervention, and when no other interventions of greater effectiveness exist.
(c) A need (as defined above) is unmet when it has attracted only partially effective or no intervention and when other interventions of greater potential effectiveness exist.

Scales of disability and distress can be applied to psychiatry and to variety of medical and surgical specialities (Rosser, 1988).

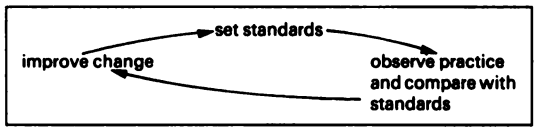
For the purposes of planning services, measures of quality of life are being developed from descriptions of states as judged by different groups. Such global indices combined with measures of prognosis form the basis of Quality Adjusted Life Years (QALY).

Implementation of audit

Clinicians will recognise from the account of clinical audit above many examples of good practice. Other methods of audit also being carried out may be improved upon such as making the review of case notes mandatory by all visiting approval teams.

Audit has an important educational function for senior doctors as well as for those more junior. It is most beneficial when all grades of medical practitioners work together.

However, unless the reviews of clinical practice as encompassed in audit lead to improvement in patient care, the collection of data is a waste of time. Mitchell & Fowkes (1985) suggest a "Cycle of Audit".



How to begin: It is a mistake to be over-ambitious. A simple project with minimum of cost in terms of both time and money expended is recommended as a start. Peer review meetings should be brief and initially no more than monthly until such time as all are able to make a regular, more substantial commitment. Other forms of audit should start by addressing only one question. A modest project successfully undertaken will generate ideas as well as increase enthusiasm.

Clinicians will find the booklet on *Medical Audit* by Charles Shaw, published by the King's Fund, very helpful.

The Southampton psychiatrists have published a paper in the *Bulletin* describing how audit was put into practice in general psychiatry (Guy Edwards *et al*, 1987).

Confidentiality: since review of cases, especially those chosen at random, can appear threatening to some, confidentiality of the doctors concerned as well as of patients should be preserved. Results of audit should be published and not suppressed or diluted for the purpose of obtaining contracts for medical services as suggested in the NHS Review White Paper.

Participation of all consultants should be encouraged and sufficient time allowed. The experience of those already involved in audit has shown that voluntary participation is effective and the benefits such that the majority of consultants are enthusiastic.

Management appraisal

It is recommended that all clinicians, including psychiatrists, should take the initiative for clinical audit. It should not be imposed or prescribed by management. Measures of quality must be given at least the same emphasis as in resources as well as for improving process and outcome.

The College recommends that every consultant should be allowed to devote one session a week to audit. The College has also stated its belief in a regular multidisciplinary forum for auditing management which should complement the auditing of medical and clinical procedures.

Future development of audit in psychiatric practice

The research currently under way on assessment of need and on global indices of health are highly relevant. The work in progress of monitoring the Daily Living Programmes by Professor Marks will also provide much to guide others in auditing new or existing services.

Particular problems exist in the psychiatric specialties. As pointed out by the Working Group from the Child and Adolescent Section, family work is hard to measure and to evaluate. Community based work as in the psychiatry of old age and the psychiatry of mental handicap requires appraisal over a period of a year in the community rather than as "consultant episodes", but no systematic method of auditing such care of chronic cases in the community exists. Pilot studies need to be established.

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Simple suggestions such as the improvement of discharge letters to general practitioners can be pursued by every consultant and offer an ideal of setting standards for junior doctors.

Computer systems to help medical audit

The two systems the Working Group are considering are (i) The CRISP system set up by Dr P. Rohde, and (ii) the system by Ed Sein set up in Newcastle and also in Leicester.

Recommended Reading

1. *Medical Audit* – Hospital Handbook, King's Fund, edited by Charles Shaw.
2. NICOL, A. R. (1989) Performance indicators in child and adolescent psychiatry. *Psychiatric Bulletin*, **13**, 94–97.
3. GUY EDWARDS, J., NUNN, C. M. H. & RICKETTS, B. S. (1987) Three years of medical audit in a psychiatric unit. *Bulletin of the Royal College of Psychiatrists*, **11**, 154–155.
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5. *Medical Audit*: – A report of the Royal College of Physicians published in March 1989.
6. Royal College of Psychiatrists Research Committee Report from Pilot Survey on the Use of Depot Neuroleptics (not yet for publication).
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8. COCHRANE, A. L. (1971) *Effectiveness and Efficiency: Random Reflection on Health Services*, Nuffield Provincial Trust.
9. Section for the Psychiatry of Old Age: report of Working Group on Performance Indicators.
10. Health Service Indicators Group: A Report on Körner Indicators, December 1988.
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13. HIRSCH, S. R. (1988) *Psychiatric Beds and Resources: Factors Influencing Bed Use and Service Planning*. London: Gaskell (Royal College of Psychiatrists).

Membership of the Working Party:

Dr Ann Gath – Registrar and Convenor
Dr Fiona Caldicott – Sub-Dean
Dr James Higgins – Sub-Dean
Dr Norman Kaye – representing the Public Policy Committee
Professor John Wing – Research Director (from September, 1989)
Professor Michael Gelder – Chairman, Research Committee.

Approved by Council
June 1989

Training in the psychiatry of old age

While the number of patients admitted to psychiatric hospitals aged 18–65 has fallen slightly, the number aged 65+ (and especially 75+) has risen considerably, so that they constitute a third of all psychiatric admissions.

Many general psychiatrists will be treating elderly patients and will need to acquire the skills and methods of the psychiatry of old age. This should be obtained, wherever possible, in a unit with a consultant specialising in the subject.

Experience in the psychiatry of old age will be recognised for Part I of the MRCPsych, provided that the following conditions are met:

(a) there is wide variety of types of patients and clinical conditions, including those with functional disorders, treated and assessed in a variety of settings

(b) teaching focuses on general principles and techniques of general psychiatry as well as on the particular aspects of psychiatry in old age.

The Court of Electors has made it clear that a candidate in the Part I of the Examination may be expected to examine a patient with an organic mental state. Training in old age psychiatry may be particularly useful for this.

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19 June 1989

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