



original papers

of the need to proceed to gender reassignment that they place significant pressure on inexperienced clinicians to prescribe hormone therapy before full multi-disciplinary assessment. Clearly there are dangers of clinicians working in isolation in this complex area. The Royal College of Psychiatrists has recently recognised the need in adolescent transsexualism for a standardised multi-disciplinary approach based on agreed criteria and has supported the development of a national consensus (Royal College of Psychiatrists, 1998). Currently, only six adult transsexual clinics appear to be established along such lines and therefore it is unlikely that treatment is delivered in a standardised manner across Great Britain. Despite this, there are a number of very good existing local initiatives that aim to provide more comprehensive and standardised services.

There is evidence of confusion among those responsible for commissioning in some health authorities/boards as to what services were available to them. Inevitably, this must translate into confusion for the service users and their doctors at the first point of contact. It may serve to alienate them further and reinforce the perception that their needs are being denied or ignored. Commissioners of health services have responsibility for ensuring that the contracted service delivers a reasonable standard of care and it is clear that this vital function is not being addressed by some health authorities.

Many health authorities/boards have different commissioning priorities that result in substantially different rates of referral from the populations served.

In the case of some health authorities, treatment of gender dysphoria was considered to be of a 'low priority' and they do not normally fund NHS surgery. Given the 1998 High Court ruling against Lancashire Health Authority's refusal to fund treatment, they may be considered to be in breach of the Human Rights Act. The cost of legal action is high and paradoxically might exceed the cost of providing the clinical service in the first place.

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\***Sarah Murjan** Specialist Registrar in General Adult Psychiatry, Nottinghamshire Healthcare NHS Trust, Stonebridge Centre, Cardiff Street, Carlton Road, Nottingham NG3 2FH, **Michelle Shepherd** Consultant in General Adult Psychiatry, Derby City General Hospital, **Brian G. Ferguson** Consultant Psychiatrist, Nottinghamshire Healthcare NHS Trust

Psychiatric Bulletin (2002), **26**, 212–215

NICOLA SHARP AND TIM MORRIS

# Audit of case-load and case mix of higher specialist trainees in child and adolescent psychiatry<sup>†</sup>

## AIMS AND METHOD

The aim of the audit was to ensure that the case-load and case mix for trainees in child and adolescent psychiatry met Child and Adolescent Psychiatry Specialist Advisory Committee guidelines and that trainees were seeing cases with an appropriate mix of age, gender and diagnoses. Data on case-load and case mix were analysed annually and problem areas were identified and reviewed when the audit cycle was

repeated. The audit cycle has been repeated three times.

## RESULTS

Specific findings from the audit included: female trainees were seeing a high percentage of girls; male trainees were seeing a high percentage of boys; some trainees were seeing a high proportion of cases of deliberate self-harm; and there was a recent increase in the number of cases of attention-deficit

hyperactivity disorder. The first two issues were rectified as a result of the audit process; the last is being monitored.

## CLINICAL IMPLICATIONS

Training needs should come before service needs. Auditing trainees' case-loads and case mixes helped best to utilise the time available for clinical work during training.

One of the consequences of the Calman reforms of postgraduate training for child and adolescent psychiatrists is shorter training (Department of Health, 1993). Of central importance to effective training is the range of clinical experience. The specific training requirements are

set out in the Child and Adolescent Psychiatry Specialist Advisory Sub-Committee (CAPSAC) advisory papers, which specify the number of cases open at one time to a trainee and the total number of cases seen in a year. The CAPSAC also expects trainees to have 'experience in

<sup>†</sup>See pp. 208–209 this issue.



developing skills in the assessment, formulation and treatment of all the main psychiatric disorders encountered in children and adolescents' (Royal College of Psychiatrists' Higher Specialist Training Committee, 1999: p. 6). To ensure that training needs are met requires careful planning and ongoing monitoring.

An audit of specialist registrars' case-load and case mix has been undertaken since 1996 in the Mersey deanery. The training scheme in child and adolescent psychiatry includes placements in community out-patient settings, an adolescent in-patient unit and an in-patient unit for the under 14-year-olds. There is also a day patient unit and specialised placements in learning disability and clinical research. The scheme as a whole therefore offers a wide range of training opportunities. Although case-loads are monitored individually in placements, the case-load and case mix can vary widely with the different experiences available in the various training posts, especially in the more specialised placements. The trainee group therefore felt that it was important to monitor the scheme as a whole.

The findings from this audit have been presented annually to trainers and trainees in various forums. These include the annual Mersey Regional Group of Child and Adolescent Psychiatrists' research and audit meeting, the trainer/trainee meetings and the specialist registrar teaching programme.

## The study

Each trainee kept an agreed minimum set of data on his or her own cases. At the end of each placement, data were collected and analysed using a computerised spreadsheet. The results of the audit were presented to trainers and trainees. Problem areas were identified and possible solutions discussed. A handout was prepared for each audit and distributed to trainers and trainees. Individual trainees and trainers could then use the information to help plan the trainee's case-load for the next year. Case-load and case mix were re-audited annually and problem areas reviewed.

Data collected included:

- (a) Numbers of cases open on 31 January each year.
- (b) Total number of cases seen in a year's placement (from beginning of April to end of March).
- (c) Gender of cases.
- (d) Age of cases. This was divided into four age groups: 0–5 years, 6–11 years, 12–16 years and 17 years and over.
- (e) Primary diagnosis: ICD–10 (World Health Organization, 1992) diagnoses were used and then grouped using a list of diagnoses derived from a variety of logbooks used by other training schemes.

## Findings

Three trainees took part in the audit in the year ending 31 March 1997, four the next year, eight the following year and seven in the year ending 31 March 2000. Overall 42% of trainees were male, 58% female, 33% were flexible

trainees and one trainee was completing a dual training in child psychiatry and learning disability. For the purpose of the audit, figures for flexible trainees were adjusted to the full-time equivalent. A total of 60% of trainees on the scheme took part in the audit in the first year, 67% the next year, 89% the following year and 100% in the year ending 31 March 2000. Of the trainees who did not take part in the audit, one was a flexible trainee on maternity leave, one was a trainee who had gained his Certificate of Completion of Specialist Training (CCST) and was applying for consultant posts and the other two were flexible trainees.

## Annual case-load

Annual case-loads were highest in the first year of the audit, with two of the three trainees having annual case-loads above the CAPSAC guidelines of 50–75 (highest=109) (Royal College of Psychiatrists Higher Specialist Training Committee, 1999). On reviewing the case mix, the reason for this was the assessment of large numbers of cases of deliberate self-harm (DSH). Since then, trainees have not been expected to assess all cases of DSH and most trainees have achieved annual case-loads that fall within the CAPSAC guidelines. Recently, high annual case-loads have been associated with seeing a high percentage of cases of attention-deficit hyperactivity disorder (ADHD). The only trainee with a low annual case-load was doing a specialised learning disability placement, where much of the work was done by consultation.

## Point case-load

Point case-loads varied widely, with a range of 9–52. (The CAPSAC guidelines advise a point case-load of 20–30 cases.) Certain jobs were always associated with low point case-loads: the two in-patient posts and the research post. Trainees who had recently started on the scheme had low case-loads. High case-loads were associated with particular posts and appeared to be related to the types of cases seen, especially where a high percentage of cases of ADHD was seen (see case mix by diagnosis, below).

## Case mix by diagnosis

In the first 2 years of the audit, trainees saw large numbers of cases of DSH. Following the initial audit cycle, changes were made to the scheme and there has been a trend away from trainees seeing an excess number of DSH cases (Fig. 1). Some trainees now lack experience of DSH assessments. Other diagnostic groups are becoming more prominent, in particular ADHD (Fig. 1).

## Case mix by age

As expected, most cases seen fell into the 5–11-year and 12–16-year age groups. Most trainees had seen some children under the age of 5 years but few had seen cases in the 17 years and over group.

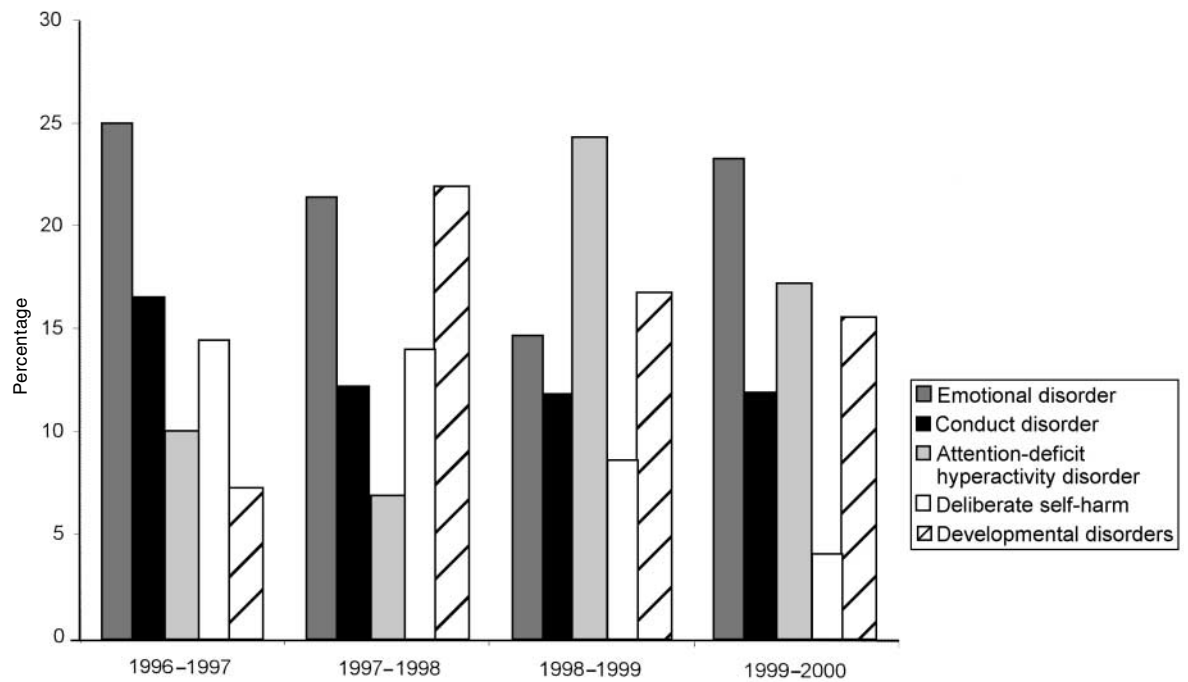
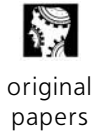


Fig. 1. Percentage of cases seen by trainees: the main diagnostic groups.

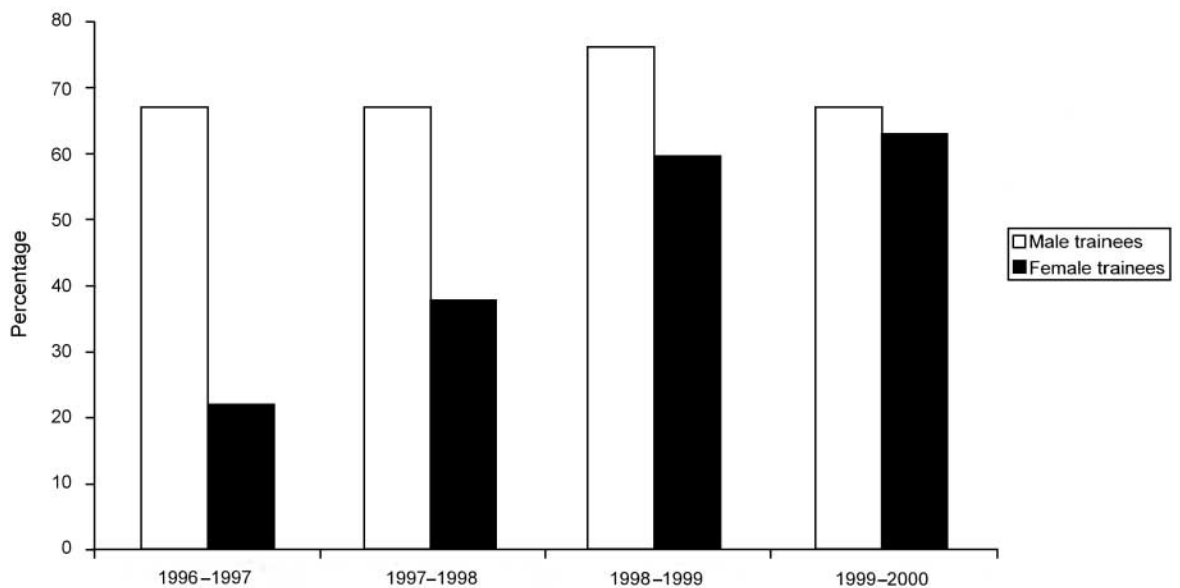


Fig. 2. Boys as a percentage of case-load.

### Case mix by gender

In the first 2 years of the audit, female trainees were mainly seeing girls and male trainees were mainly seeing boys (Fig. 2). It was felt that the trainees' case-loads should reflect that of the consultants, who were seeing more boys. The issue was tackled following the audit, and in the subsequent 2 years nearly every trainee was seeing more boys. (The only trainee who was seeing more girls was working on the eating disorders unit.)

### Discussion

The audit has allowed the scheme to modify the overall training on offer. For example, DSH assessments were seen previously as being the trainees' responsibility. Changes in working patterns in placements mean that this is no longer the case.

Trainees used audit findings and their own personal data to help plan their clinical training. A selection of clinical cases helps to ensure that clinical and non-clinical



training needs are met in the reduced time available for specialist registrar training. It can be difficult to balance training needs with the clinical demands in placements. The information from the audit helped trainees to set boundaries and say 'no' to certain types of cases that were meeting clinical, rather than training, needs.

Some trainees had high point and annual case-loads. This was discussed at length at the audit presentations. It was felt that high case-loads were acceptable if the trainee concerned felt this to be a useful training experience and if it did not prevent the trainee from meeting other essential training requirements. Numbers of cases seen does not accurately reflect the workload involved. Some cases, for example routine ADHD reviews or one-off assessments, will take up relatively little clinical time. Smart and Cottrell surveyed training experiences in child and adolescent psychiatry and found a wide variation in point case-loads (Smart & Cottrell, 2000).

Some trainees expressed concerns about revealing details regarding their personal workload because it was difficult to completely anonymise the data. However, the percentage of trainees taking part in the audit increased each year, suggesting that trainees found the audit useful. Trainees not taking part in the audit included flexible trainees and one trainee who had gained his CCST. There should be caution in interpreting the results as being representative of all the trainees on the Mersey scheme or trainees elsewhere in the country.

As the role and working practices of child psychiatrists continue to change and develop, it is likely that the training scheme and training opportunities will change too. We therefore think that it is important to continue to monitor and audit training. The case-load/case mix audit is an important part of this process.

## Declaration of interest

None.

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\***Nicola Sharp** Specialist Registrar in Child and Adolescent Psychiatry, Adcote House, Columbia Road, Oxton, Birkenhead L43 6TU, **Tim Morris** Consultant Child and Adolescent Psychiatrist, Burnley General Hospital, Lancashire

*Psychiatric Bulletin* (2002), **26**, 215–218

PAUL EGLESTON AND MICHAEL D. HUNTER

# Improving the quality of medical reports to mental health review tribunals

## AIMS AND METHOD

We aimed to determine, using clinical audit, the effect of implementing national guidelines on the quality of responsible medical officers' (RMOs') reports to the mental health review tribunal (MHRT). We blindly assessed the quality of 50 consecutive reports concerning patients detained under Sections 3 and 37. Twenty-five reports were written before

guidelines were circulated; a further 25 were written following the distribution of guidelines and a checklist with every request for a report.

## RESULTS

The quality of reports, as measured by our checklist, significantly improved following the circulation of guidelines.

## CLINICAL IMPLICATIONS

Increasing the awareness of guidelines by widespread circulation and the audit process is an effective way of improving the quality of RMOs' reports to the MHRT.

Since the inception of the Mental Health Act (MHA) 1983, the number of applications to the mental health review tribunal (MHRT) by detained patients has risen (Blumenthal & Wessely, 1994). Because tribunals require the responsible medical officer (RMO) to submit a detailed clinical report for each application, report writing has become an increasingly important (and time-consuming) part of everyday psychiatric practice.

Previous literature regarding the quality of reports has, for the most part, offered expert opinion as to which points should specifically be included by RMO authors (Woolf, 1991; Langley, 1993). Audit has demonstrated that the majority of reports do not address the basic criteria for detention required by the MHA (Ismail *et al*, 1998) but that improvement might follow the formulation of local guidelines (Davison & Perez de