Psychiatric Bulletin (1990), **14**, 626–630

Correspondence

Evaluating treatment outcomes

DEAR SIRS

There is evidence from both research and clinical studies which stresses the importance of evaluating treatment outcomes, possibly through the measurement of social role functioning. We report a proposal to apply these research findings in a brief instrument to measure role performance, requiring a minimum time to complete.

Social role performance as an outcome takes into account the major impact which psychiatric illness has on the sufferer as well as on those family and community members who have close or regular contact with the patient. It is meaningful when used in conjunction with other assessments of treatment outcome, e.g. the level of symptomatology, and should not be seen as an alternative single measure of outcome.

Attempts to measure social role performance extended back some 30 years; however, the usefulness of the measure has been limited by the problem that performance of social roles is governed to a large extent by social and cultural norms, which will vary over time and circumstances. These are identifiable in the form of expectations held by relatives or significant others as to which roles should be performed. The Social Behaviour Assessment Schedule (Platt *et al*, 1980) is a recent instrument for the assessment of role performance which specifically recognises these limitations by allowing non-completion of social role items that are inapplicable.

Extensive use of this schedule in two major studies (Creed *et al*, 1989, 1990) and subsequent statistical analyses using multivariate techniques (Anthony, 1989) have suggested that it is possible to develop a brief instrument, capable of measuring social role performance on a routine basis and concentrating on critical everyday role items. Some of the criteria for this brief instrument include that it should be limited to a maximum of 20 items, it should be available in two formats, a self report and an informant report version, and it should be simple and quick to complete. A third format for completion by the clinician would provide an additional source of information.

A brief instrument encompassing the above criteria has been written and we propose to conduct a validation study of this new instrument. We aim to identify whether the new questionnaire is sensitive to changes in a patient's role performance, and whether it elicits a similar response pattern to that seen in the parent instrument. The study will be multicentred, involving approximately ten consultant psychiatrists, interviewing patients and informants on admission and at follow-up, approximately three months later. A sample of informants will also be interviewed using the original SBAS. All adult psychiatric patients referred with a diagnosable illness will be interviewed, excluding alcohol and drug dependency categories, whether managed as in-, out- or day-patients. Evaluation of the results will be carried out and the results made available to the psychiatric community.

Comments or suggestions from anyone interested would be very gratefully received.

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What are the necessary qualities of a senior registrar in psychiatry?

DEAR SIRS

'If a man was called a Scientist during his lifetime and an Honoured one at that, it was the end of him as a doctor. The honour and glory of it would get in the way of his treatment of his patients, just as elaborate clothing hinders a man's movements.' Solzhenitsyn, A. (1971, *Cancer Ward*. London: The Bodley Head; Harmondsworth: Penguin.)

Recent correspondence in the *Bulletin* and *Journal* emphasises the career difficulties for those of us applying for SR posts and the need to "publish something – anything". The number of papers published is seen as proportional to the likelihood of selection of the candidate. In the world of psychotherapy SR training, colleagues have told me that selection committees look especially for candidates who have affiliations with particular psychoanalytic institutions or even personal analysis with a well known figure. These are criteria on which the quality of the potential candidate is judged.

Surely while these measures may have some relevance in selecting a potential consultant psychiatrist or psychotherapist they leave out a good deal of data of a more subjective yet arguably equally important nature. What do the candidate's peers think of his/her quality of clinical care on the wards? Does the individual turn up on time to ward rounds, meetings and clinics? Do patients have to wait for him/her? Does he/she write clear concise clinical notes and helpful punctual letters to GPs? How do the clerical and ancillary staff view the trainee? But perhaps most important of all, does he or she possess the qualities outlined by Persaud & Meux (*Psychiatric Bulletin*, February 1990, **14**, 65–72) as important to psychiatric patients: empathy, a caring attitude and the ability to listen. Although these qualities are difficult to measure, it is surely our responsibility to start taking these issues into account in line with the Audits Commission's goals of economy, efficiency and effectiveness in our services.

I recently worked for 15 months in an out-patient psychiatry clinic in the USA linked with a health maintenance organisation. The chief psychiatrist in the clinic kept very careful records of all the staff's clinical hours and activities and we had a weekly meeting in which the multidisciplinary team discussed ways of improving our service and making it more attractive to the public and "user friendly". Regular retreat meetings were held away from our work place where interpersonal issues could be discussed in an open and democratic fashion. These meetings included the clerical and reception staff. This seems to me to be a step toward the kind of peer review that will be required for us to audit the process of our work in addition to providing valuable data for appointment committees faced with making difficult decisions. Perhaps this would also help selection committees to break away from their rather stifling overdependence on easy to measure data of questionable value in the choosing of future consultant psychiatrists and help in selecting empathic human beings as a priority of as much value as "Honoured Scientists".

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Beyond 'community care'

DEAR SIRS

The Mental Deficiency Act of 1913 empowered town councils to provide residential services for people now called mentally handicapped or with severe learning difficulty. In the 1950s the NHS in the Leeds, later the Yorkshire, region – population 3,000,000 – had over 3,000 hospital beds for mental handicap. A peak of just over 4,000 beds was reached in 1966 on a basis of the then norm of 1.3 beds per 1,000 of population.

Since then, the numbers have fallen to 3,400 in 1980, 3,100 in 1983, 2,500 in 1986 with a rapid drop to around 1,700 in 1990 due to the care in the community initiatives. Had the run-down continued at the same rate as during the '70s, it would have been the year 2040 before the hospitals were empty. If the present closure policy continues there should be virtually none of the original hospital beds by the mid-nineties.

In lecturing on the evolution of services I am struck by the guarded response from many young students and trainees, as well as older professionals and parents and relatives of patients, who might be naturally reactionary, to the Gadarene swine-like rush to close down mental hospitals, even though the Department of Health repeatedly claims that closure is not a primary aim. Life never stands still and it prompts the question as to what will be the next step in the evolution of services when the present institutions have vanished without trace.

In a generation or two will a revolutionary idea emerge, i.e. to create a residential centre where people with severe learning difficulty would live in an environment adapted to meet their needs and abilities? Instead of their living isolated in scattered small residencies with costly time-consuming transport to day care they would have their own campus. The centre would have a resource, research, study and teaching function for therapists, teachers, carers and others involved. The centre would develop a collegiate style of life for mentally handicapped people which they would have the right to choose, no less than others who go to a residential college or university.

The above is what many parents and relatives and open-minded professionals suggest some of the hospitals for mental handicap could have become today.

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An experience with the implementation of psychotropic law in Kuwait

DEAR SIRS

Substance abuse has been a growing problem over the past few years in developed as well as developing