trainee and supervisor. It is not sufficient just to have lunch or play golf with one's colleagues!

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Returning home

DEAR SIRS

Dr Araya's sad article (*Psychiatric Bulletin*, February 1993, **17**, 109–110) is a reminder of the obstacles faced by overseas doctors attempting to return home (Patel & Araya, 1992). I have resisted the desire to return to India, since the regulations imposed by the Medical Council of India virtually ensure that I could never work in an academic setting. For example, a research proposal I had submitted to the Indian Council of Medical Research to study traditional healing and mental illness in primary care in India was rejected on the technical ground that my postgraduate qualifications were not recognised by them. Ironically, I received a three year grant from the Beit Trust to conduct a similar study in Zimbabwe.

Many institutions in the UK which "assist" doctors from the developing world by bringing them to the UK for "training" entertain a naive view that, regardless of exposure to material wealth and political stability in the UK, these doctors would voluntarily return to their homes. Many have no means to re-establish a career, lack of financial support and failure of academic bodies in their home countries to recognise the value of their experience in the UK being the main problems.

However the Royal Colleges and the WHO could establish a direct communication with policy making bodies in developing countries to discuss cross-recognition of postgraduate qualifications to facilitate transfer of health care personnel around the world. An international "doctors job bureau" to match individual doctors' needs with those of different clinical settings is long overdue, as is the establishment of research or resettlement funds for doctors returning to the developing world.

I disagree with Dr Araya on one point; I do not believe that legislative controls are useful. Doctors are individuals who have the right to search for and establish a lifestyle of their own. Many doctors from the Indian subcontinent would return home if the right opportunity arose. In place of coercion we need recognition of our difficulties and help to establish means to return home. The only other recourse would be to stay in the West, or return home to full-time private medical practice.

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Reference

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Audit in the psychiatry of learning disabilities

DEAR SIRS

We were interested in Carpenter & Kanagaratnam's account of group audit in the South Western Region (*Psychiatric Bulletin*, February 1993, **17**, 91–92). Given the complex needs of adults with learning disabilities (LD), regional audit with specialist peers is complementary to local audit activities with multidisciplinary teams and general psychiatry colleagues. Since 1990, our four-monthly Psychiatry of LD Sub-speciality Committee meetings have included a two hour audit session attended by all consultants and senior registrars in the South East Thames region.

Initially, case-notes were peer-reviewed using a specially designed audit questionnaire to compare the quality of note-keeping, clinical assessment and management practices. We record essential socio-demographic, historical, functioning and management data but have difficulties applying the ICD-9/10 and DSM-III-R diagnostic classification to clients' diverse mental health needs (MHN). Peer-review of previously audited case-notes assesses the implementation of clinical management plans and evidence for client and carer satisfaction.

Specific audit projects completed include a regional survey of depot neuroleptic usage, pilot survey of services for adults with LD and MHN, and a district survey of GP satisfaction. Current projects include a regional survey on use of the Mental Health Act and district audit on the appropriateness of referrals. Our pilot survey revealed a lack of specific data on service-users and we are currently undertaking a regional survey of health and social care services for adults with LD and MHN.

We agree that establishing regional audit requires a well-attended and supportive peer-review group with individuals willing to coordinate audit projects. Our current audit cycle difficulties also concern agreeing and revising process standards for the assessment and care of specific client groups. Future hospital and community audit projects could include less well-defined client groups such as those with depression, schizophrenia, dementia or challenging behaviours. Audit should also demonstrate that our interventions maintain or improve the functioning and quality of life for clients with various MHN (Gravestock *et al*, 1991). Given that many clients have multiple chronic health and social care needs,

developing standardised multi-dimensional outcome measures remains a long-term goal.

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Reference

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NHS reforms

DEAR SIRS

I enjoyed the article by Harrison (*Psychiatric Bulletin*, January 1993, **17**, 29–31) and share some of her concerns. To determine whether the new reforms are leading to improvements over the 'old NHS', it is necessary to specify their objectives of improving efficiency and equity, and more scope for consumer choice (Culyer *et al*, 1990). The consumer-patient plays a slight role in the reformed NHS and it is the purchaser guardians of the patients' interest (GPs and DGMs) and providers who shall be held accountable.

One principle of the reforms is to create a situation in which need is better assessed at the community level with the delivery of care responding to this expressed need more efficiently. The author failed to underscore the problems with needs assessment. Was she refering to the total needs of psychiatric patients when discussing the issue of significant unmet need? I hope not! Resources are scarce and I expect public health departments to use their influence with purchasers to concentrate on the costs and benefits of marginal changes in what we are already doing. It is important that the morality of recognising that need is not absolute and cannot be met in full is accepted (Mooney, 1986). By highlighting the choices to be made, and the opportunity costs involved, Goldberg & Gater (1991) are at the cutting edge of this form of decision making.

I agree that psychiatric services face many challenges but I would caution against alarmist overreaction. It may be appropriate that our profession concentrate on the more severely ill! Audit of the effectiveness of our inputs and linking these to output and costs can be enlightening. In the short-term competition between provider units may introduce discrepancies in negotiating terms and conditions of service. However, because the NHS is highly labour intensive it is particularly sensitive to wage cost inflation (Culyer *et al*, 1990). Any sensible manager will recognise the need to manage capital resources effectively with the appropriate skilled labour.

Once contracting as a process is fully understood, it is probable that contracts will become longterm relationships permitting the purchaser to acquire economies of scale and influence service quality (Culyer *et al*, 1990). Self interest may lose out and be replaced by mutual inter-dependence and a sense of duty. My fear is the use to which data on costs will be used. Decisions based on quantifiable financial criteria may lead to neglect of quality of care which is much more difficult to measure.

Any good options appraisal will consider the 'what if we do nothing' scenario and must remind the author that standing on the sidelines will remain an option for some. However I intend to comply with her prescription and wonder if she had any depot preparations due out before April for my more recalcitrant colleagues!

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Reply

DEAR SIRS

Since I wrote this article with the hope of stimulating debate about the impact of the NHS reforms on psychiatry, I welcome the opportunity to respond to Dr Travers' comments.

I agree that mental health needs are complex and diverse, and that, as yet, the methodology required to assess such needs is not sufficiently developed. However, having recently worked in a purchasing department for 18 months, I am very aware that purchasers are pressing ahead with such assessments, whether or not local service providers are working with them. This has two unfortunate consequences. The first is a very real danger of re-inventing the wheel, as researchers with little experience in mental health expend significant time and money on methodologically flawed prevalence studies, only to find that much of the work has been done before. The second, and perhaps more serious difficulty, is that where such assessments have not been undertaken collaboratively, neither side will be able to agree on the service implications arising from the results. Such conflicts are unlikely to be productive, but district service providers ignore, at their peril, the reality that purchasers can and will take their money elsewhere. But