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Reviews

Coding and Mental Health Information Systems: A Review of Current Approaches. By Simon Shanks. Produced by the Research Unit of the Royal College of Psychiatrists. 1992. Pp 32.

This review of current approaches to coding and mental health information systems has been produced by the Research Unit of the Royal College of Psychiatrists and comes as a slim, glossy 32 page document. The review has been produced as part of a coding project funded by the Department of Health to evaluate and standardise approaches to coding in Mental Health Services. The contents are arranged in four chapters, and a final brief summary. The four main chapters are arranged as an Introduction and then an overview of the three main coding systems in use in the UK; ICD-10 and SCAN, the READ Codes and the FACE recording and measurement system.

Chapter 1 introduces the role of computers in the NHS and also considers the breadth of information that a coding system for mental health must cover. This ranges from clinical data such as diagnoses through to mobility, incontinence and employment status. The author reviews the way such data has to be constructed for a computerised system and briefly outlines the benefits of this.

Chapter 2 overviews ICD-10 and the Schedules for the Clinical Assessment in Neuropsychiatry (SCAN) system. Most psychiatrists in the UK will have some idea about the Present State Examination and its computerised scoring programme (CATEGO) so the text introducing the most recent version (now named SCAN) will be much more familiar.

Chapter 3 considers the READ codes. Although as the author states these have not been relevant in mental illness to date, many psychiatrists will have heard how the READ system relates to general practice. The codes act as a glossary of terms used by the medical profession and there are plans to extend the READ system to include terminology and classification from psychiatry in due course.

Lastly, Chapter 4 considers the functional analysis of care environment (FACE) recording and measurement system. This system seems much more ambitious than either the READ or SCAN systems and has been developed to "support the major intelligent functions required of Mental Health Services". These functions include realistic service specifications, measurement and management of resource use and outcome, the assessment of clinical needs, care planning and to enable medical and clinical audit to be carried out. The system allows two types of information to be collected; "presentations" namely clinical signs and symptoms etc and "activity" which records information regarding intervention.

This is an important and interesting review of the most important coding systems in the UK. While the author will lose a general audience in places due to an excessive use of technical language, in the main the document is a well written comprehensive yet reasonably easily digested review.

In the summary the author points out the different aims and objectives of the coding systems described and the further work that will be required before any system is fully operational. In addition each system requires the gathering and entering of considerable amounts of data and the motivation of mental health professionals in undertaking this process will be the main factor in utilising each system to its maximum potential.

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Measuring Outcomes in the Mental Health Services. By Susie Green. Discussion Paper No. 29 Health Services Management Centre, 40 Edgbaston Park Road, Birmingham B15 2RT. 1992. Pp 80.

St Mathew's Hospital is one of the many in the country that are experiencing the problems associated with running down to closure. This booklet describes the work of a team set up to try to maintain a high quality of care in two wards for elderly ladies, in spite of ward closures, the consequent relocations and staff changes, and the well-known difficulties of maintaining high morale as services begin to crumble. The staff members included a psychologist, physiotherapist, occupational therapist, three nurses, social worker and nurse manager. The absence of a medical contribution to the assessment is emphasised but not explained.

> "The approach used a model based on detailed analysis of each individual's situation, leading to the formulation of problems, priorities and goals. The extent to which these goals were achieved was measured against a baseline, yielding an indicator of progress. Further goals could then be established relating to changes in the patient's condition."

The booklet describes how the approach was put into practice and contains sections of comment and

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description by each team member as well as by the author, who was in charge of research and development. The headings under which the assessment procedure was carried out are listed in detail. Some problems could be quantified, as in the case of the lady who screamed a good deal (baseline: 102 screams in a 2-hour period); the lady who banged on the table; the lady whose knees were stiff; the lady who needed a hearing aid; the lady with untreated diabetes, and the lady with unrecognised parkinsonism associated with a recognised dementia. Examples are given to illustrate the success of care in such cases.

The principles involved in 'single case experiments' are well known. In general, it is difficult to standardise the procedures in order to make comparisons. The demonstrable results (as in the examples mentioned above) come from undoing past neglect. Maintaining improvement is just as important but less easy to measure.

The authors therefore had problems with quantifying their system and provide no scales or statistics. They do not provide references to quantitative research into similar projects from the 1950s to TAPS, nor mention clinical audit, perhaps because they do not seem to know the highly relevant psychiatric literature. They do, however, cite a few of the excellent social work studies (with which psychiatrists should be more familiar) and correctly point out that the creation of mental health information systems should make routine evaluation easier.

Apart from its heartening illustration of the resource and energy with which people can tackle difficult problems when starting, as they think, from scratch, the booklet illustrates two sadder facts. The real skills and real knowledge acquired during the early postwar reform period in the best mental hospitals has only rarely been handed on to the present generation of carers, whether in residential or in non-residential settings. And the ideological and administrative divide that opened between the health and social services after the Seebohm Report seems as difficult to bridge as ever, on the brink of transfer of responsibility for community care from one to the other.

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The Royal College of Physicians of Edinburgh: Continuing Medical Education for Trained Physicians. RCPE, 9 Queen Street, Edinburgh. 1992. Pp 14.

This is a very valuable succinct report on issues that will affect all practising doctors. Although directed at a non-psychiatric service, it is clearly of relevance to psychiatry and especially to those involved in the supervision of audit and postgraduate training.

The document neatly summarises the background and the reasons for continuing medical education (CME) becoming such a prominent issue. It is not surprising to find that this section overlaps considerably with the early sections of the report by the College working group on Continuing Medical Education (*Psychiatric Bulletin*, 1992, **15**, 711–715).

At first reading the document appears reassuring for current psychiatric practice. Many of the recommendations are already standard practice in psychiatric services, e.g. regular academic programmes including case conferences, journal clubs, audit meetings and regular College inspection visits. Repeat reading dissolves this cosy picture. It becomes increasingly clear that full implementation of the proposals could have profound effects on psychiatric practice.

The Physicians appear to be convinced of the need for mandatory rules on CME and propose tough penalties for failure to comply. These include loss of junior staff and imposing a temporary category of specialist accreditation until compliance was confirmed. Section 9 of their document cogently argues the case for this viewpoint and Section 13 acknowledges the resource implications. The College working group did not go so far in their recommendations but appear to have been thinking along similar lines. The systems proposed would require enormous additional manpower in order to free doctors to attend CME but also to run programmes, to conduct the individual assessments and to run the vetting and monitoring arrangements.

CME is clearly a good thing and will have an impact on all psychiatrists. It is now over a year since the report of the College working group was published and members of the College should make themselves aware of developments. The risk is clearly that mandatory rules will be introduced by default "within existing resources" and we all know what that means!

In summary, this report clearly demonstrates why CME is good for patients and doctors alike. Why then am I left with a clear picture of the big stick but without any sign of the carrot?

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Health Trends, Vol. 24, 2, 1992, Department of Health. HMSO. £2.80. (Annual subscription £10.80).

A review of health and social services for mentally disordered offenders and others requiring similar

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