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Audit in practice

Providing a community mental handicap service

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It is acknowledged that assessing 'consumer satisfaction' is an important part of medical audit (The Royal College of Psychiatrists, 1991). For the mentally handicapped, it can be argued that 'carer satisfaction' is particularly relevant. This is particularly so at a time when the 'community' is being advocated as the preferred setting for the long-term care of the mentally handicapped, the families and neighbours of the handicapped being the main providers of this 'community care' (Griffiths, 1988).

In addition to assessing carers' satisfaction with services provided, the degree of emotional distress they exhibit may be an important indicator of the effectiveness of services provided.

Previous studies have suggested that carers of the mentally handicapped do show increased levels of emotional distress (Bradshaw & Lawten, 1978), and are often dissatisfied with services provided (Glendinning, 1983). How effective any particular aspect of services provided, such as respite care, day care, or more visits, is in relieving distress or increasing carer satisfaction remains unclear however (Whittick, 1988).

It has been suggested (Royal College of Psychiatrists, 1991) that audit can take place between geographical areas with different levels of resources. As community based services for the mentally handicapped in Dumfries and Galloway region of South West Scotland have developed over the last ten years, it has become clear that there are areas which have been relatively starved of resources, rural 'Upper Nithsdale' being one such area, while Dumfries, the main town of the region, has remained the centre for much of the region's resources. Hence there was an opportunity to perform an exercise in audit to clarify which parts of the service being developed are effective.

The study

The aims of the study were:

(1) to identify the use of available resources for the mentally handicapped in two contrasting areas – Upper Nithsdale, a largely rural area at a distance from any respite care, with no specialist housing and only a small Activity Resource Centre providing day care; and the town of Dumfries with specialist housing, including respite care facilities, a large and modern Activity Resource Centre, and a base for the regions's Community Mental Handicap Team (CMHT)

(2) to identify, for each mentally handicapped person living in a non-institutional setting in the two areas, that individual primarily responsible for their care – their 'primary carer'

(3) to assess the 'primary carers' satisfaction with the resources available to them by brief questionnaire

(4) to assess the degree of psychological morbidity in the two groups of carers using the General Health Questionnaire (GHQ), (Goldberg, 1972)

(5) to examine any relationship between these variables, with the aim of clarifying which aspects of service provision seemed important in satisfying the consumers and relieving stress (assuming any impact on this).

Findings

Information from the CHMT computerised register showed that the 42 mentally handicapped individuals in the Dumfries group and the 30 in the Upper Nithsdale group did not differ when compared in terms of age, sex, severity of mental handicap, and presence of associated physical handicap or epilepsy.

Fifty-six primary carers in Dumfries and 36 in Upper Nithsdale were identified, and interviewed in their own homes. When the two groups were compared in terms of age, sex, marital status, employment status, and in their own use of GP and psychiatric services, there were no significant differences. In both groups they were predominantly female and in 70% of cases were the mothers of the mentally handicapped person.

The two groups did not differ significantly in their use of the available resources. Despite their relative isolation, the rural group made as much use of their

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local ARC, and of respite care provided in Dumfries, as did the Dumfries group. However, in the rural group there were a small number of households (5) who had never been visited at home by a member of the CMHT, whereas all households in Dumfries had at some point been visited. In their opinion of available resources, however, the two groups of carers differed markedly. In Upper Nithsdale, 56% described the available services as poor compared to 16% in Dumfries (χ square test, $P<0.001$).

The two groups of carers also differed in terms of their psychological morbidity as assessed by the GHQ, although this did not reach statistical significance. In Dumfries, 19% of carers had scores corresponding to 'case' status, whereas in Upper Nithsdale the figure was 32%. There were no statistically significant differences between 'cases' and 'non-cases' in either area in any of the variables studied, including their opinion of services, their use of these services, and the characteristics of the mentally handicapped individuals they were caring for.

Comment

In this study the two groups of carers did not differ significantly in their use of services, despite the greater distances, and presumably greater effort, involved in the case of the rural group. The rural group did, however, have a poorer opinion of these services, possibly reflecting the greater effort they had to make to use them. There was also a trend towards increased levels of psychological morbidity among the rural group, perhaps reflecting this dissatisfaction. The carers in Dumfries showed a level of psychological morbidity similar to that found in the general population and lower than found in another study of the carers of the mentally handicapped (Whittick, 1988). This may mean that the provision of services as close as possible to the carers and their charges is effective in lowering the levels of psychological morbidity among these carers. Alternatively, there may be a protective effect of living in a reasonably well provisioned county town as opposed to a more isolated rural area or speculatively a deprived inner-city area.

In assessing which particular aspects of the services provided are important in alleviating a carer's stress, this study, like others before it (Whittick, 1988), is inconclusive. Some of the rural group had had no home visits although generally the frequency of such visits was similar to that in the town group. It may be that for those living in an isolated setting home visits are particularly important, and conversely are greatly missed by the carers if they do not take place.

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