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Psychiatric Bulletin (2002), **26**, 208–209

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Commentary: audit of case-load and case mix of higher specialist trainees in child and adolescent psychiatry†

The Child and Adolescent Psychiatry Specialist Advisory Sub-Committee (CAPSAC) of the Royal College of Psychiatrists has produced a detailed set of advisory papers covering all aspects of training in child and adolescent psychiatry, the existence of which makes the audit of training a more straightforward task than in the past (Royal College of Psychiatrists Higher Specialist Training Committee, 1999). The paper by Sharp and Morris (see pp. 212–215, this issue) is part of a continuing tradition of audit and evaluation of higher training in child and adolescent psychiatry (Garralda *et al*, 1983; Bools & Cottrell, 1990; Smart & Cottrell, 2000). In the past, supervision (or lack of it) has been a preoccupation (see Kingsbury & Allsopp, 1994). However, the most recent national survey of higher trainees in child and adolescent psychiatry suggests that the number of trainees receiving inadequate supervision is continuing to fall (Smart & Cottrell, 2000). Sharp and Morris focus instead on case-load and case mix and are to be commended for persevering over three annual cycles with an audit that clearly demonstrates changes being made in the light of data collected, followed by re-audit and re-evaluation – audit projects rarely 'close the loop' so clearly.

The audit found substantial variations in case-load and goes on to explore why this might be, finding an association of high case-load with deliberate self-harm (DSH) assessments and with attention-deficit hyperactivity disorder (ADHD). The CAPSAC guidance on case-load states:

> 'Full time trainees would normally be expected to have a clinical caseload of between 20–30 cases at any one time and to have had some direct responsibility for the assessment/treatment of between 50–75 new cases each year. It is recognised that there may be good reasons for variations outside of these limits at some times and in some placements depending on the nature of the placement. However, significant variations over long periods would be a matter of some concern.' (p. 6)

The intention behind this guidance is to allow trainees time to think and read about their work in order to allow integration of theory and practice. Consistently high case-loads are therefore of concern and it is encouraging that over time the programme was able to reduce case-loads. However, CAPSAC does recognise that different case-loads are appropriate in different posts – good examples are cited within this paper for trainees in in-patient units and in research posts and those new to the programme.

Work with young people who self-harm typically involves brief interventions and drop-out rates are often high. If the trainees' role is medication review, ADHD follow-up is not necessarily time consuming and so more cases can be seen. It is not surprising that over a 1-year placement a trainee seeing significant numbers of DSH cases or ADHD follow-up cases might breach the suggested upper case-load limit. However, CAPSAC does not expect trainees who do relatively high proportions of short-term work to stop work after 8 months if annual case-load levels are reached! The key training issue here is not the case-load but whether the cases seen are providing the depth and breadth of clinical experience required. DSH can bring a trainee into contact with a wide variety of underlying problems and aetiologies and lead to a variety of therapeutic interventions involving other agencies. A relatively high case-load because of DSH work may, therefore, be appropriate, depending on specific training needs. Similarly, trainees need experience of medication use in ADHD, although if case-loads are high because trainees are being used just for medication monitoring then the training value must be questioned if this persists over time.

Well-maintained logbooks and regular reviews of training objectives are the best way of ensuring that the balance between case-load and case mix is maintained. Audits such as this provide an additional safeguard to ensure that all trainees are receiving adequate training.

A tension for trainers is the need to prepare specialist registrars for the 'real world' where consultant

†See pp. 212–215 this issue.

https://doi.org/10.1192/pb.26.6.208 Published online by Cambridge University Press

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case-loads are often significantly higher than CAPSAC guidelines, and as a result some programmes encourage trainees to increase case-loads in a planned way in the final year of training. Nobody monitors consultant case-loads, few guidelines exist and high consultant case-loads provide questionable role models to trainees, especially if clinical work is at the expense of keeping up to date and continuing professional development. High reported levels of early retirement and 'burn-out' suggest that such work patterns are not in the long-term interest of either the individual consultants or the NHS. Perhaps the next audit should be of the case-loads of consultant child and adolescent psychiatrists.

Declaration of interest

None.

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https://doi.org/10.1192/pb.26.6.208 Published online by Cambridge University Press