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Quality assessment and improvement in mental health services: A qualitative study

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Abstract

This paper reports a qualitative evaluation undertaken to investigate the perceived impact of the FACE quality assessment tool across a range of mental health settings and to identify factors critical to the successful implementation of quality assessment (QA) and quality improvement (QI) systems in mental health services. The 'FACE initiative' led to positive changes in service provision but there was some variation in its perceived effectiveness among settings. Support from management and senior medical staff, staff ownership of QA/QI initiatives and adequate resourcing were identified as key factors in ensuring the success of QA/QI in mental health. QA/QI techniques such as FACE can lead to improvements in the quality of care but further research is required to provide conclusive evidence about the effectiveness of these initiatives in improving patient outcomes.

Introduction

Assuring quality in mental health and other health and social services has gathered increasing momentum since the 1980s (e.g. Wells & Brook, 1988; Smith, 1992) and is now enshrined in current government policy (Department of Health, 1997). Methods and models derived primarily from trade and industry – and including programme evaluation, consumer feedback and clinical audit – have been employed to assess the quality of mental health services (Clifford *et al.*, 1989). Structured quality assessment (QA) and quality improvement (QI) systems have also been

used including, among others, the Model Standards Questionnaires (Lavender, 1985), QUARTZ (Clifford *et al.*, 1989), Psychiatric Monitor (Goldstone and Doggett, 1990) and the Nottingham Psychiatric Nursing Audit (Balogh, 1990). The first of these was developed to measure the quality of care in 12 psychiatric rehabilitation wards, but subsequent systems such as QUARTZ have been applied to a range of settings. While each of the above has, to a greater or lesser degree, been evaluated (e.g. Lavender, 1987; Leiper & Hill, 1993; Tomalin *et al.*, 1991; Balogh, 1991), there is still considerable uncertainty about the effectiveness of these kinds of

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systems and whether or not they lead to systematic improvements in mental health care.

This paper describes a qualitative evaluation of FACE (Functional Assessment of Care Environments) (Clifford & Wolfson, 1989) – a multi-axial coding, classification and measurement system for mental health services which has been implemented widely (Quinn *et al.*, 1992). It comprises 52 ‘care elements’ (e.g. the management and treatment of disturbed mental state and behaviour) subsumed within seven major areas of assessment including: mental health; compensatory care; rehabilitation; social circumstances; interpersonal relationships; physical environment; and individual care. A key feature of FACE is the multi-professional context within which mental health care provision is assessed and rated. Clifford states that FACE ‘is designed to support organisational change and may be construed as an approach to implementation of Total Quality Management in mental health services’.

The ‘FACE initiative’ was implemented in conjunction with Quality Improvement Teams (QITs) across six settings in the largest of the four integrated Health and Social Services Boards in Northern Ireland. These settings were considered representative of all types of mental health provision. In this study, focus group methods were used to: (1) evaluate professional attitudes to QA and QI programmes generally; (2) investigate the perceived impact of the FACE quality system; and (3) identify the factors critical to the successful implementation of QA and QI programmes and, in particular, the FACE system in mental health services.

Method

Participants and settings

Study participants were recruited from two in-patient units, two day-care centres and two

psychiatric day hospitals. In-patient Unit A is a 36-bed single-sex acute psychiatric ward with 39 staff members comprising five multi-disciplinary treatment teams. In-patient Unit B is a 24-bed acute mixed psychiatric in-patient ward located within a general hospital and staffed by 36 people. A total of 11 staff at day centre Unit C provide care for approximately 50 clients with mental health problems and physical disabilities. Day centre Unit D is a larger 24-staff unit providing a wide range of day-care services to a similar client group. Day hospital Unit E is a purpose-built day facility – located within a general hospital – with a mainly nursing staff complement of 36. The second community-based day hospital, Unit F, has a smaller staff complement of 25.

All staff at each unit were invited to take part. Each focus group was broadly representative of the professional disciplines at each unit and usually comprised at least four members. Group membership was decided on the basis of whether or not all participants felt sufficiently comfortable with each other to express their ideas and opinions openly. Staff in three units (in-patient Unit B, day care Unit C and day hospital Unit F) participated in one large focus group discussion only.

Nine focus groups – comprising 62 participants – were conducted over a 3-month period. Around three-quarters of the mainly female participants included: nursing staff members (18); occupational therapists (nine); day-care workers (eight); psychiatrists (five consultants) (eight); and social workers (four). Other participants included day care or clinical service managers (four, two); care assistants (two); clerical/catering personnel (three); and an audit co-ordinator. Three participants in the smallest focus group (Unit E) refused to specify their job position for reasons of

confidentiality. No information on age or sex was collected for the same reason.

Study design and analysis

The study was designed according to the guidelines stipulated by several authors including Morgan & Krueger (1993). The key issues and questions to be addressed in each focus group were included (as is the convention) in the Topic Guide. This covered 10 major topics beginning with QA/QI in general (e.g. understanding of, and training in, QA/QI) but focusing on questions about the FACE system (e.g. comparison with other initiatives), its impact on the quality of care (e.g. benefits for staff and clients) and the process of implementation (e.g. difficulties encountered). A 10-item questionnaire was also administered at the end of each focus group as a means of obtaining a brief easy-to-complete measure of each participant's views. Respondents were asked about: QA training; participation in FACE 'interviews'; the extent to which the quality of care in their respective units had changed during the previous year; and the contribution of FACE and/or other factors to this change.

Each focus group discussion – which was approximately 1 hour in duration – was recorded, transcribed in full and subjected to content analysis using the method described by Knodel (1993). This involved subdividing and classifying the text into relevant categories using the Topic Guide as the initial basis for classification, but including newly defined sub-categories for material which arose naturally during the discussions. Descriptive categories comprised a list of the key topics of interest while conceptual categories were used to locate any potentially interesting features of the discussion such as useful quotations (see Knodel, 1993). Every category was assigned a unique colour code and the 'coded' material was then examined in order to extract meaningful and informative themes.

Results

The questionnaire responses are shown in Table 1 (six people were unable to complete the questionnaire). In three of the six settings, everyone had participated in FACE interviews and the FACE evaluation reports were, in all but 16% (9/56) of cases, judged to reflect accurately the quality of care. Ninety-four per cent indicated that the quality of care had improved in their unit during the previous year. All participants in day hospital Unit F – in contrast to in-patient Unit A and day hospital Unit E – felt that FACE had accounted for at least 50–75% of the change in their units. However, half of all respondents felt that the FACE initiative had accounted for at least 50% of the improvement in care at their respective care units. The more extensive focus group findings from which several salient themes were identified are described below.

Theme 1: The role of management

The perceived lack of managerial commitment was identified as an important theme in three of the six settings (see Table 2). For example, staff in day hospital Unit E expressed concern at the absence of any recognition for their efforts from top and middle level management and this appeared to be the single largest factor influencing staff motivation, particularly among those who were not QIT members. Consequently, QA/QI initiatives (including FACE) tended to be viewed by staff as disguised economy drives involving little or no managerial commitment:

'...A number of projects have been undertaken here, some of which have been stymied by management's lack of commitment and involvement...I'm very cynical now.' (day hospital Unit E)

While the QA/QI process had been more successful at day centre Unit D, perceived

Table 1: Number of people responding ‘Yes’ to questionnaire items

Item	Unit ¹						Total (%)
	A	B	C	D	E	F	
Aware of FACE assessments	9	8	9	12	7	11	56 (100)
Participated in FACE interview	2	5	9	12	5	11	44 (79)
FACE reflects quality of care in unit	6	7	8	12	3	11	47 (84)
QIT member	7	8	5	9	4	10	43 (77)
Quality much improved	5	6	4	4	2	10	31 (55)
Quality slightly improved	3	2	5	7	4	1	22 (39)
No change in quality	–	–	–	–	–	–	–
% change due to FACE:							
0–25	6	–	1	2	4	–	13 (23)
25–50	–	2	3	3	1	–	9 (16)
50–75	2	5	4	5	–	3	19 (34)
75–100	–	1	–	–	–	8	9 (16)
Don’t know	1	–	1	2	2	–	6 (11)
Received training in QA	6	6	6	5	6	2	31 (55)
Length of training (days):							
0–1	2	2	3	1	1	–	9 (29)
1–2	–	2	–	3	1	–	6 (19)
2–3	1	1	–	–	1	–	3 (10)
>3	3	1	3	1	3	2	13 (42)
Total no. who completed questionnaires	[9]	[8]	[9]	[12]	[7]	[11]	56

Note: ¹. A & B = Acute in-patient units; C & D = day centres; E & F = psychiatric day hospitals.

managerial apathy had been unhelpful in alleviating fears that initiatives such as FACE were merely cost-driven or inspection/monitoring tools:

‘...it can be very disheartening and dispiriting for people when higher and middle management keep saying we need to keep on producing quality and you know you have...but it’s never been really recognised’.

Notably, Unit B was only one of two focus groups which included a middle-management representative. Here, active managerial support had been instrumental in successfully assuring quality in that, contrary to staff expectations, managers had been sympathetic in their views of QA/QI and sensitive to the need for greater resourcing. Staff had been

further encouraged by tangible changes in service provision.

Theme 2: Staff ownership of QA/QI initiatives

Staff ‘ownership’ of the FACE initiative – having developed as a slow and sometimes painstaking process – had helped to improve multi-disciplinary working and teamwork, particularly in in-patient Unit B and the two day care centres where all staff were involved in the QIT (Table 2). There also appeared to be additional spin-off benefits in terms of greater staff empowerment and accountability:

‘...suddenly it put a bit of onus on me... the responsibility that each member of staff bears

Table 2: Number of occurrences of each ‘theme’ across units

Theme	Unit					
	In-patient		Day centre		Day hospital	
	A	B	C	D	E	F
The role of management		x		x	x	
Staff ownership		x	x	x	x	x
Other secondary factors:						
context/setting	x				x	
consultant involvement	x				x	
practical difficulties		x		x		x
Perceived impact of FACE	x	x	x	x		x

in the whole context of quality assurance. That never really struck me before...everybody was held accountable...’ (day hospital Unit F)

In the four larger hospital settings, it was not feasible to involve everyone in the QIT and there was evidence to suggest that this might have had an alienating effect on some staff:

‘...most of the staff do care about the work they individually are doing...but I think there are some staff who think “Well, the QIT do all of that and we don’t need to be involved”’. (day hospital Unit E)

Theme 3: Other factors important in the successful implementation of FACE

Context/setting

A number of other factors appeared to be instrumental in the successful implementation of the FACE initiative, but were identified less often than the other themes described here (see Table 2). First, the context and/or the type of setting in which FACE is implemented may be important in the extent to which it gains acceptance among staff. For example, in in-patient Unit A (only one of two units which had quality programmes in place prior to FACE) there was evidence to

suggest that QA/QI initiatives had led to service improvements such as better multi-disciplinary working and more patient information. However, staff appeared less happy with FACE than other quality initiatives such as audit. This appeared to be due, in large part, to the perception that other tried-and-tested quality initiatives with which staff were familiar were more effective than the FACE system and were more likely to be favoured by consultants:

‘...we (the consultants) would see very much audit as being the cutting edge of the quality machine, if you like, and the measurement edge of the quality machine’.

In day hospital Unit E – where the lack of managerial support had led to disillusionment and cynicism – the major criticism concerned the FACE tool itself. For example, its underlying philosophy was considered too ‘psychological’ in its emphasis, but more importantly, the approach was judged to be unsuitable for day hospital settings. It is worth noting that day hospital Unit E was the second of only two units with a previous history of QA/QI initiatives.

Consultant involvement

The findings also raise questions about the role of consultant medical staff in imple-

menting the FACE (and other QA/QI) initiatives. There was tentative evidence to indicate that four of the five participating consultants at in-patient Unit A and day hospital Unit E, while not overtly critical *per se*, were not fully supportive of the FACE initiative:

‘I think that FACE is a good effort at scratching that surface, but I don’t think FACE is a sharp enough tool yet to distinguish a good thing.’ (in-patient Unit A)

‘There would be a number of things that FACE recommends which the consultants wouldn’t agree with or support.’ (day hospital Unit E)

Practical difficulties

Almost all staff experienced practical difficulties in implementing the FACE system particularly in finding time to: conduct and participate in the FACE interviews; write up and discuss the subsequent FACE evaluation reports; and then to initiate and sustain quality improvement programmes. For example, participants tended to view the FACE initiative as an ‘add-on’ to their daily workload:

‘FACE was, in a way, a very complicated tool. It took quite a lot of time...for the whole thing to go through...But whenever you complete the circle and you can look back and see that improvements have been made, then I think that’s the thing which stimulates you...’ (day hospital Unit F)

‘...we have had difficulty in finding spare time to move FACE on...it’s on top of everybody’s existing work load’. (day care Unit C)

There had also been some teething problems in implementing FACE in most settings due to concern about its exact purpose:

‘...There was a lot of mistrust at the beginning...But once we got over the first area of suspicion it was “all-go” then.’ (day care Unit C).

A number of staff felt that seconding someone to work specifically in ‘Quality Control’

would be helpful, particularly in hospital settings where QA tasks/activities tend not to be shared equally among all staff. This arrangement was implemented successfully in in-patient Unit B where management had dedicated a staff nurse to ‘quality’ on a full-time basis.

Theme 4: The perceived impact of the FACE initiative

The FACE initiative appeared to have led to improved care provision in all units but there was some variation in the types and degree of change. For example, the initiative was viewed most positively in in-patient Unit B and day hospital Unit F, both of which recorded the highest levels of QIT activity and improvements in care. The first changes implemented in most settings were to the physical surroundings, partly because these could be executed quickly and relatively easily. Other positive aspects of the FACE initiative – aside from the explicit implementation of Quality Enhancement Programmes (QEPs) – concerned changes in staff attitudes and the practical application of the technique:

‘...you always associate it (quality) with cutbacks...whereas I honestly do believe with FACE that we have seen a different perspective on it in that there have been changes made here which have cost very little money but have made a very big impact on the unit’. (day hospital Unit F)

‘...the genius of the FACE technique is that it is very simple. For example...Let’s measure what we have got first of all’. (in-patient Unit B)

However, comparatively few of the changes resulting from the FACE initiative appeared to impact directly on client outcome, although according to staff, clients had benefited from some of the changes to the physical environment. For example, there had been redecoration at day centre Unit C in

which the clients themselves had played a role. Most clients in the six settings also had more information available to them in the form of leaflets or booklets on, for example, ECT (in-patient Unit A) and medication (day hospital Unit F). In addition, a number of other more process-oriented changes had taken place in some of the units including the introduction of care plans in in-patient Unit B and patient timetables in day hospital Unit E.

Typically, participants indicated that they would like to think that the patients/clients had derived some benefit from the implementation of QA/QI but there was some uncertainty about the actual impact on clients. The sentiments of most staff in the six settings are summed up by the following:

‘But at the end of the day we don’t know if our individual patients have noticed the slightest improvement in the quality of the service that they receive....’ (in-patient Unit B).

Discussion

The results presented here are based on reported perceptions of staff rather than direct client outcomes and the study design did not include control or comparison groups of staff. However, the study represents one of the few attempts to evaluate the implementation of a structured quality improvement system in a wide range of mental health settings. The key themes identified from the data are discussed below.

The role of management

The findings suggest that, *ceteris paribus*, the involvement of management is critical to the QA process and, therefore, to the success of an initiative such as FACE. The precise nature of this involvement is not always clear, but it would seem that it need not, at least with respect to day care provision, extend beyond

providing support and recognition for staff. However, staff in both day hospitals highlighted a need for explicit managerial intervention in, for example, seconding staff to work in QA/QI. These findings are consistent with both theoretical and empirical work highlighting the importance of managerial commitment and subsequent reward in QA/QI programmes both in mental health and public services generally (e.g. Clifford *et al.*, 1989; Pollitt, 1990; Smith, 1992). However, some attitudinal change may be necessary before management is able to adopt ‘a stance of respect, helpfulness and an attentive understanding that one is moving into an area characterised by strong beliefs, understandable sensitivities and large uncertainties’ (Pollitt, 1990). This may be achieved, at least in part, through structured courses or ‘Quality Awareness Days’ to provide top and middle-level managers with an appreciation of their important ‘facilitating’ role in QA/QI. However, real commitment can only be shown through the release of appropriate resources and by implementing the recommendations identified from QA/QI initiatives.

Staff ownership

The findings suggest, in line with previous work (e.g. Berwick *et al.*, 1992; Lavender *et al.*, 1994; Chowanec, 1996), that an important additional requirement for the success of QA/QI initiatives is staff ownership of, and individual responsibility for, effecting change. This has clear benefits in terms of improving teamwork and staff morale and has important implications, therefore, in view of the renewed emphasis on multi-disciplinary team working in mental health care (Quinn *et al.*, 1992). It is possible that the more hierarchical staff structures in hospitals may hinder the involvement of staff in, or their motivation toward, a structured QA/QI process. Despite the comparatively wide availability

of QA/QI training for local staff, these findings suggest, as elsewhere (e.g. Chowanec, 1996) a need for widespread attitudinal change aimed at all staff and not only QIT members.

Consultant support

There appeared to be a general consultant-led perception that FACE was less relevant or effective than other more medically-orientated audit procedures. It is likely that the FACE initiative was perceived to threaten or rival these well-established practices. The largely negative response to FACE, albeit from a small group of consultants, may be due, in part, to the fact that traditionally, hospital consultants have enjoyed a considerable degree of independence and autonomy from quality assessment and improvement (Furnham, 1988). This may be a source of concern for the successful implementation of QA/QI initiatives in hospital settings as these are likely to flounder without an active and supportive medical 'structure'.

Practical difficulties

The most frequently reported practical difficulty in implementing the FACE initiative was the extra time required to plan and execute QEPs. This supports claims by Clifford *et al.* (1989) that significant change is unlikely to take place without the necessary time and sustained commitment of all staff particularly QIT members. Furthermore, it appeared critical that changes were seen by staff to have occurred and that staff were approached sensitively when the FACE system was first introduced in their units and given adequate reassurance, for example, that the tool was not designed for inspection or monitoring purposes. Berwick (1989) states that staff need to be treated with respect in order that quality improvement in health care can be achieved. Our findings suggest, similarly, that all staff should, at the very least, be

appropriately informed in advance and made aware of the reasons and philosophy underpinning a proposed QA/QI initiative.

Perceived impact of the FACE initiative

The findings reported here illustrate the difficulties involved in ascertaining whether or not a QA/QI programme improves patient outcome (as opposed to the inputs and processes of care). There was a perception among participants that clients had benefited from the implementation of FACE. However, beyond positive comments from clients on changes to the 'physical environment', the benefits in terms of individual client outcome were unclear. The most frequently cited benefits of the FACE initiative were staff-related involving, for example, improved multi-disciplinary working and better teamwork (e.g. through greater staff empowerment) which may also be indirectly beneficial to clients.

Some staff also felt that FACE provided an objective 'structure' within which to effect change. The approach appeared particularly well-suited to day-care settings (in which FACE has previously been untried) which cater for very different client groups, but more importantly, do not have the more formal, hierarchical and institutional features which tend to characterise hospital-based care. However, there was some variation in the extent to which the FACE initiative was perceived as having effected change. This may be due, in part, to the different number of QEPs implemented in each unit. It is also important to note that the FACE initiative provided staff in four of the settings with only their first contact with QA/QI. Therefore, it may be premature to expect marked improvements in client care before more challenging and specifically client-centred QEPs are undertaken. The introduction of a QA/QI system such as FACE may also necessitate ma-

major organisational change and difficulties should, therefore, be anticipated, at least in the crucial early stages of the process.

Conclusion

The findings reported here suggest that FACE can be successfully applied within a variety of mental health care settings provided the appropriate conditions already exist or can be developed. Its successful implementation relies, among other things, on co-operation between all professionals 'at the coalface' and sympathetic managerial intervention (ideally including the full integration of QA/QI within management structures), both of which have been highlighted elsewhere (e.g. Batolden & Stolz, 1993). Appropriate managerial and consultant support (where applicable) should, in turn, provide the necessary impetus for QITs to effectively implement quality initiatives alongside appropriate QA/QI training. This should be delivered sensitively and tailored to specific settings in order to overcome initial apprehension and to motivate staff to become and remain involved in the QA/QI process.

Finally, our results highlight the continuing need to evaluate QA/QI systems such as FACE in order to identify the range of complex factors most likely to impact on the QA/QI process in mental health services. Having completed a careful evaluation, the next challenge is to ensure that the momentum for change is sustained through a multi-disciplinary process of feedback and continuous improvement.

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