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One-off assessments within a community mental health team

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ABSTRACT

Aims and method We conducted a postal survey to describe the reactions of service users and their general practitioners (GPs) when service users were referred to a community mental health team (CMHT) but not taken on by the service. Routinely collected data were used to describe the diagnostic and demographic characteristics of this group.
Results During a 10-month period the team received 325 referrals, of which 80 (25%) were assessed but not taken on for further treatment. Those with psychotic illness were most likely to be taken on, and those with substance-related problems were least likely to be offered treatment by the CMHT. The majority of respondents, both GPs and service users, found the assessment to be beneficial and were not dissatisfied at not having been taken on for further treatment by the CMHT.
Clinical implications Our positive findings regarding the usefulness of one-off assessments suggest that despite the substantial amount of clinical time devoted to this, it may be time well spent. However, potential gaps at the interface between primary and secondary mental health care have also been highlighted.

Keywords: assessment, primary care, community mental health team

Introduction and aims

Recent years have seen a trend in government policy towards community mental health teams (CMHTs) concentrating on looking after service users with more severe mental illnesses.[1,2] One of the consequences of this is that those service users whose illness is perceived as being less severe, should have their mental health needs met in the primary care setting, with little or no input from CMHTs. A potential consequence of this is a conflict at the interface between general practitioners (GPs) and CMHTs, with increasing numbers of referrals leading to once-only assessments and not being offered further treatment by the CMHT after assessment.

Although assessing service users adds further variety to clinical work and helps to ensure that diagnostic and formulation skills are maintained, it is unclear whether this is an efficient use of limited clinical resources within the CMHT. This raises the question as to whether the assessment process itself is beneficial for GPs and service users, providing advice that they find useful and are able to follow. Potential advantages for GPs include assistance with diagnosis and further management, educational benefits and a medico-legal defence, while for service users, the assessment in itself may form part of a therapeutic intervention.

The aim of this study was to describe the views and reactions of service users and their GPs when service users were referred to a CMHT for assessment, but have not been taken on by the service, and to describe the socio-demographic and diagnostic characteristics of this service-user group.

Methods

The study was approved by the local research and ethics committee and took place over a 10-month period in 2003–2004.

The study setting is a CMHT serving a population of 31 000 adults of working age. The catchment area is urban, spans the social classes and has a higher than average number of university students and temporary residents. The population covered has been shown to have a high psychiatric morbidity rate, with mental Illness Needs Index (MINI) scores ranging from 107–118,[3] according to the different electoral rolls. The team receives approximately 330 new referrals per year, and has an active caseload of approximately 340.

The CMHT covers a total of 15 GP practices. These range from smaller single-handed practices, of which there are three, to larger practices of up to eight GPs. The catchment area also includes a student health centre. Approximately one-third of the referrals come from the largest practice of eight GPs, 16% from a five-handed practice and 14% from a six-handed practice. The single-handed practices, taken together, comprise 10% of new referrals.

Senior members of the multidisciplinary team, including medical, nursing and occupational therapy staff assess new referrals, which are then discussed in a multidisciplinary team meeting. Approximately one session of clinical time is spent per service user on this process. This represents a significant proportion of the resources available, and for one-off assessments amounts to the equivalent of 57 full working days per annum for the team.

The CMHT uses a database which contains referral, demographic and assessment details. Following assessment, information on broad diagnostic category is entered into the database. The categories closely follow those contained in the International Classification of Diseases (ICD).[4]

For each service user not taken on by the team, a questionnaire and an explanation letter was sent to the GP along with an assessment letter. In addition, each service user who was assessed but not taken on was sent a similar questionnaire and explanation letter. Questionnaires were sent to a total of 80 service users, with the same number being sent out to GPs.

There were nine questions on the GP and eight questions on the service-user questionnaire (see Appendices for full questionnaires).

Results

Thirty (38%) service-user questionnaires and 32 (40%) GP questionnaires were returned, out of 80 sent to each group.

Background referral data

During the 10-month period, the CMHT received a total of 325 referrals, of which 58 (18%) were urgent. Slightly more of the referrals were for females (56%) than males (44%). Eighty (25%) of these referrals were assessed but not taken on by the CMHT, compared with 136 (42%) who were assessed and taken on by the team for further treatment. A further 44 (14%) did not attend, 35 (11%) were unsuitable for assessment, and 10 (3%) cancelled. There are no outcome data for 30 (9%) of the referrals. Of those assessed but not taken on, the majority (47, 59%) were female.

Diagnostic information of all those assessed

All service-users with a primary diagnosis of schizophrenia or delusional disorder were offered treatment by the CMHT, as were 88% (7) of those with a primary diagnosis of bipolar affective disorder. Seventy-two per cent (62) of those with other mood disorders and 71% (10) of those with eating or sexual disorders were offered treatment by the CMHT. Of those with a primary diagnosis of personality disorder, 64% (9) were offered treatment by the CMHT, whilst just over half (52%) (34) of those with an anxiety-related disorder were offered treatment by the CMHT. Those with a primary diagnosis of substance-related problems were least likely to be offered treatment by the CMHT (18%) (2) (see Table 1).

Survey results

Reason for referral

Fourteen GPs (47%) gave advice on non-pharmacological treatment as the reason for referral. Ten

Table 1 Distribution of diagnostic categories of service-users assessed by the CMHT during the study period

Primary diagnosis	Accepted for treatment			Not accepted for treatment		
	Number	% of total accepted	% of total with this diagnosis	Number	% of total not accepted	% of total with this diagnosis
Schizo/delusional (F20–29)	8	6	100	0	0	0
Bipolar (F30–31)	7	5	88	1	1	12
Other mood (F32–39)	62	46	72	24	30	28
Eating/sexual (F50–59)	10	7	71	4	5	29
Personality (F60)	9	7	64	5	6	36
Anxiety (F40–48)	34	25	52	32	40	48
No diagnosis	4	3	36	7	9	64
Substance related (F10–19)	2	2	18	7	9	82

(33%) gave advice on medication and a further ten (33%) gave advice on risk management as the reason for referral. Advice on diagnosis was a reason for referral in nine (30%) of cases and the least-frequent reason for referral, given by three GPs (10%) was for long-term support.

The reasons for referral as understood by the service user were very similar. The most frequent reasons, each given by 12 service-users (41%), were advice on non-pharmacological treatment and advice on medication. Nine service users (31%) understood the reason for referral as being long-term support, which was a greater percentage than that of GPs.

Service-user request as reason for referral was given by 9 (30%) GPs and 7 (24%) service users.

Did the assessment help to clarify the diagnosis?

GPs were asked to indicate on a five-point scale whether the assessment had helped to clarify the diagnosis. (1 – not at all, 5 – extremely). The most frequent response (10, 33%) was 3, with a further 13 (43%) answering more positively. The mean score was 3.2.

Service-users had been asked to indicate on an identical scale whether the appointment had helped to clarify their problems. Again, the most frequent response (9, 31%) was 3, with a further 12 (41%) answering more positively. The mean score was 3.1 (see Figure 1).

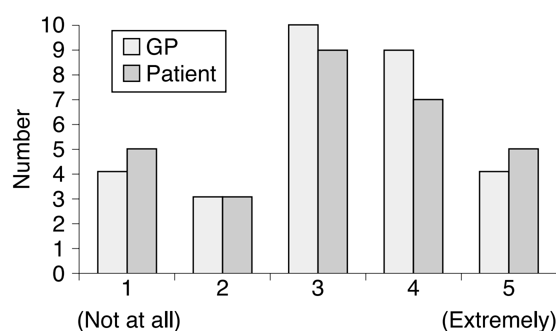

Figure 1 Did the assessment help to clarify the diagnosis?

Was the assessment helpful for the future?

GPs were asked whether the assessment was helpful in their future management of the service user. Again, the most frequent response (12, 40%) was 3, with a further 14 (47%) answering more positively. The mean score was 3.4. When asked whether their appointment was useful for the future, service users responded more positively, with the most frequent response (13, 45%) being 4, although the mean score was 3.3 (see Figure 2).

Level of dissatisfaction at not being taken on

Thirteen GPs (43%) were not at all dissatisfied that the service user had not been taken on by the team, with only one (3%) being extremely dissatisfied,

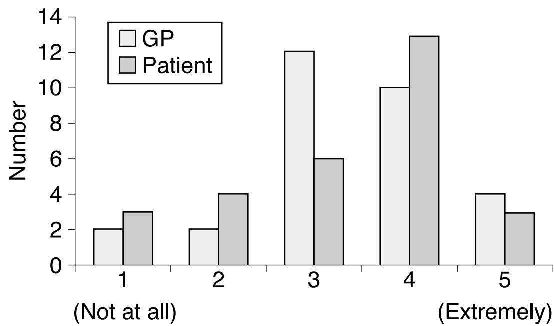

Figure 2 Was the assessment useful for the future?

which is also reflected in the mean score of 2.1 (1 – not at all dissatisfied, 5 – extremely dissatisfied). Service users responded slightly less favourably, with 9 (31%) being not at all dissatisfied and 2 (7%) being extremely dissatisfied about not being taken on. (mean score 2.3) (see Figure 3)

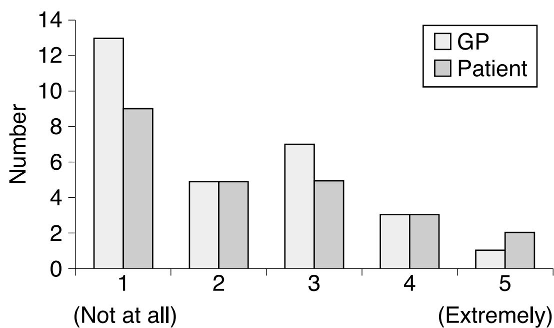

Figure 3 Level of dissatisfaction at not being taken on

Free-text comments

Comments received from 10 GPs (32%) revealed that while they felt the services for those with severe mental illness were good, there was a deficient service for those with moderate mental illness, who were nonetheless very disabled. Psychological therapies, particularly cognitive-behavioural therapy (CBT) were perceived as being lacking.

These sentiments were echoed in the seven service-user comments (23%).

Discussion

The conclusion of this study was that the majority of respondents (both GPs and service users) viewed the assessment process as being useful. The limited previous research is in line with this finding that GPs are satisfied when an outpatient was seen on only one occasion.[5]

We were able to make use of routinely collected data to look at the diagnostic characteristics of those more likely to be accepted by the CMHT for treatment. All of those with a schizophrenic or delusional disorder, and a majority of those with bipolar affective disorder were offered ongoing treatment. The CMHT was much less likely to offer treatment to anyone with a primary diagnosis of substance-related disorders or anxiety disorders. This is also in keeping with previous research showing that those with a psychotic diagnosis are normally prioritised for treatment.[6] However, evidence from the literature,[7–9] and from current practice, suggests that the CMHT may have accepted more of those with non-psychotic disorders than other similar services.

Our design allowed direct comparison of levels of satisfaction between GPs and patients when the service user is not taken on by the team; however the study is limited by its small size. Although the response rate is reasonable for a postal questionnaire, the possibility of response bias cannot be excluded. The data we collected were primarily quantitative; further qualitative methodology may help achieve a better understanding of the complexities of this area.

Our results suggest the assessment process in itself is perceived as a very useful function for both service users and GP. Its purpose appears multifunctional, acting either as a second opinion or a request for advice on treatment and diagnosis, or as a means of clarifying risk assessment. Comparatively more service users expected to be taken on by the CMHT than was expected by the GPs. It would be helpful if the purpose of assessment were made explicit to service users at the point of referral. Despite this expectation, the majority of service users were not disappointed when they were not taken on.

In cases of dissatisfaction the issues were lack of availability at psychological therapies (CBT) or lack of services being available for those with an illness of moderate severity, despite a degree of functional impairment or significant risk. The local service level agreement between the primary care trust and mental health service clarifies that only service users with severe and enduring mental illness are taken on by the CMHT. This can lead to disagreements as to when the severity threshold is reached. In respect of CBT, the National Institute for Clinical Excellence (NICE) guidelines (2004) add little clarity as to when this is appropriate.[10] They suggest CBT should be considered for depressed patients who express a preference for psychological interventions but also for patients with mild or moderate depression. This can significantly raise the expectations of

patients and GPs as to the availability of such interventions from secondary mental health services.

Variations at the interface between primary and secondary care add to the complexity. Brief CBT is suggested by the NICE guidelines as a treatment for mild depression.[11] In some areas this may be provided within primary care based services, and in other places by graduate mental health workers. This is in line with previous research which has suggested an urgent need to address the shortfall between the demand for psychological treatments for mental health problems and their current provision in general practice.[12]

The advent of practice-based commissioning might help resolve this and other potential service gaps in the interface between primary and secondary care.[13] The evolution of CMHTs into primary care liaison teams in line with the *National Service Framework for Mental Health*[2] may also help to clarify the exact roles of assessment and treatment by these teams. Currently, a significant amount of clinical time is spent by the CMHT in assessing service users who are then not offered any further treatment by the team. This detracts from clinical time available for ongoing interventions for those service users with severe and enduring mental illness. The positive findings from this study as to the value of one-off only assessments suggest that assessment remains an important role for secondary mental health services.

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CONFLICTS OF INTEREST

None.

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