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The first nine months of a community mental health team: a study of communication and attitudes

A. G. CARDNO, Senior House Officer in Psychiatry; and C. J. SIMPSON, Consultant Psychiatrist, Friarage Hospital, Northallerton, North Yorkshire DL6 1JG

Community orientated mental health services are rapidly developing in Britain today, and as part of this development many community mental health teams (CMHTs) are being established. This study looks at some of the relationships between members of one CMHT and local primary health care team members and social workers, with particular emphasis on communication between these various professionals.

Background

The Southern Sector of Northallerton Health Authority consists of Wensleydale and some of the Vale of York; it is a rural area some 50 miles long and 20 miles wide with a population of approximately 32,000, and includes the market towns of Thirsk, Bedale, Masham, Leyburn and Hawes (Simpson, 1989).

In the context of local mental health service development a community mental health team (CMHT) was established, consisting of a consultant psychiatrist, a junior psychiatrist in training, two community psychiatric nurses (CPNs), a clinical psychologist and a social worker.

The main aims of the CMHT were:

(a) to provide a comprehensive service for the mentally ill, working with relevant organisations
(b) to promote good mental health practice
(c) to participate in the education of the general public to develop positive attitudes to mental health.

Because only 7% of mentally ill patients in primary care may be seen by a psychiatrist (Goldberg & Huxley, 1980), communication between CMHT members and relevant community health care workers seemed an important area to investigate in evaluating these aims.

The study

A brief two section questionnaire was designed. The first section asked how available each CMHT member was to discuss patients or problems. Respondents indicated on 1–7 scales how available each member was to discuss:

(a) patients with dementia
(b) patients with other mental illnesses.

The second section asked for ratings of general satisfaction with the mental health service. Respondents indicated, again on 1–7 scales, their satisfaction with the service to:

(a) patients with dementia
(b) patients with other mental illnesses
(c) the service overall.

If respondents had insufficient contact with any CMHT member to rate their ability or rate satisfaction with the service they could indicate "no contact".

The study involved four stages:

Stage A Before establishing the CMHT, a copy of the questionnaire was sent to every general practitioner, district nurse, health visitor, social worker and neighbourhood manager in the sector (in Northallerton Health Authority district nurses and health visitors are organised administratively into areas called neighbourhoods, each with a neighbourhood manager). Those who did not respond at first were sent another copy.

Stage B As a result of stage **A** members of the CMHT agreed that certain areas of practice should have particular emphasis and agreed to alter their work accordingly.

Stage C After nine months the members of the CMHT were asked how they had altered their work practices.

Stage D The questionnaire was sent out to the same health care professionals as in **A**.

There were therefore two aims in the study: to compare the responses to the questionnaire over the first nine months of the CMHT and to see whether changes in practice agreed upon were both carried out by the CMHT members and perceived by the questionnaire respondents.

Test–retest reliability was assessed by asking respondents in the Thirsk area to repeat the questionnaire after about one week. Seven GPs, eight neighbourhood professionals and five social workers responded.

Mean ratings by groups of professionals were compared using the Mann Whitney U Test. Some results were divided into three geographical areas for further comparison: the central area of Thirsk, the intermediate area of Bedale, and the outlying area of Wensleydale.

Findings

Reliability

The results of the 'general satisfaction' scores on the test–retest reliability for dementia, other mentally ill patients and overall service were that 50%, 55% and 55% respectively scored exactly the same on the seven point scale after one week and 80%, 85% and 85% respectively scored within one point. The reliability of the 'availability for discussion' questions was similar.

Stage A – 1st questionnaire

Response rates were: 92% for general practitioners (n = 23), 100% for neighbourhood professionals i.e. district nurses, health visitors and neighbourhood managers (n = 23), and 73% for social workers (n = 19).

Satisfaction with the service. For the service to patients with dementia, GPs were significantly more satisfied than neighbourhood professionals ($U = 55$, $P < 0.005$), and social workers, ($U = 13$, $P < 0.005$). For the service to patients with other mental illnesses, there was a non-significant trend for GPs again to be the most satisfied of the three professional groups. For the service overall, GPs were again significantly more satisfied than neighbourhood professionals ($U = 38$, $P < 0.0005$), and social workers ($U = 13$, $P < 0.005$).

Availability for discussion. There were no statistically significant differences between the scores for each CMHT member's availability to discuss patients or problems. GPs felt that the consultant psychiatrist and clinical psychologist were most available, and that team members were slightly less available to discuss patients with dementia than those with other mental illnesses.

Compared with the GPs, most of the scores indicated that neighbourhood professionals and social workers considered each team member was less available to discuss patients. There was a trend for social workers to rate team members as less available to discuss patients with dementia than those with other mental illnesses. There was a geographical trend of lower scores for availability to discuss patients in the more outlying area of Wensleydale, especially as rated by neighbourhood professionals.

Stage B – Planned practice changes

After discussion of the above results by the CMHT the following areas of practice were agreed on as requiring particular emphasis:

(a) to improve the service to patients with dementia
(b) to improve the service to outlying areas
(c) specific members to improve communication with primary health care team members as follows: the consultant psychiatrist with GPs throughout the sector; one CPN with neighbourhood professionals in Thirsk; the clinical psychologist with neighbourhood professionals in Bedale; the other CPN with neighbourhood professionals in Wensleydale.

Stage C – Changes in practice

CMHT members, when asked what changes they had made to their practice during the study period, reported the following: the consultant psychiatrist felt that he had improved communication with general practitioners throughout the sector and had increased his emphasis on the service to dementing patients, the social worker felt she had established a liaison with other social workers, the Thirsk CPN reported no change in her practice during the nine months, the clinical psychologist continued regular meetings with neighbourhood professionals in Bedale which had already been taking place, the Wensleydale CPN felt he had improved communication with GPs in Bedale, GPs and neighbourhood professionals in Wensleydale, and with residential homes.

Stage D – Comparing questionnaires

Response rates to the second questionnaire were: 91% for GPs (n = 21), 78% for neighbourhood professionals (n = 18) and 77% for social workers (n = 17).

Satisfaction with the service. For the service to patients with dementia, GPs, neighbourhood professionals and social workers were all significantly more satisfied ($P < 0.5$ in each case, $U = 150$, 50, 11 respectively) after the nine month study period. For the service to patients with other mental illnesses, there was a non-significant trend for each of the three professional groups to be more satisfied after the study period, and for the service overall each professional group was more satisfied afterwards (neighbourhood professional improvement significant at ($P < 0.05$, $U = 61$).

Availability for discussion. In general, changes in this area were small over the study period. General practitioners rated a trend for all CMHT members

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except the clinical psychologist to be more available to discuss patients after the nine months. The improvement for the consultant psychiatrist, who had been asked to concentrate on communication with GPs, related most to the central area of Thirsk where it was significant for discussion of patients with dementia ($U=23$, $P<0.05$) and other mental illnesses ($U=19$, $P<0.05$).

None of the changes in ratings by neighbourhood professionals achieved statistical significance. They rated that, of all CMHT members, only the CPN was consistently more available to discuss patients after the nine month period (non-significant trend). Regarding team members with tasks to liaise with specific neighbourhood professionals, Thirsk neighbourhood professionals rated the Thirsk CPN as being almost equally available for discussion before and after the study, Bedale neighbourhood professionals rated the clinical psychologist as slightly less available, whereas the Wensleydale neighbourhood professionals found the CPN to be slightly more available after the study period. None of the changes in ratings by social workers achieved statistical signifiance, but there was a trend for each CMHT member to be more available to discuss patients after the study period and the improvement was particularly marked for availability to discuss patients with dementia.

Comment

It is important to bear in mind the possible errors and biases which may influence the results of this study. For example, the questionnaires were sent out by the consultant's SHO; some of the statistical analysis is made less robust by relatively small numbers when individual neighbourhoods were compared; and the study analyses only the opinions of health care professionals, which may not necessarily be extrapolated to excellence in patient care.

Notwithstanding the above, this study proved a simple and useful method for comparing the progress in attitudes and communications with the CMHT over its first nine months. It shows a general improvement in both these areas. It was of particular interest to look at how planned changes in practice by the CMHT after the first questionnaire compared with the changes in questionnaire ratings.

The first aim was to improve the service to patients with dementia, and all three categories of professionals rated this as significantly improved after the nine months.

The second aim was to improve the service to outlying areas (that is, Wensleydale): general satisfaction improved, but not significantly; of CMHT members, only the Wensleydale CPN was consistently rated as more available for discussion by the end of the study.

The third aim was to improve communication with specific primary health care team members: there were no significant differences, but trends occurred such that members who described changes in their practice achieved improved ratings, whereas members who said they had not altered their practice were rated similarly at the beginning and end of the study period.

In conclusion, this study has shown the value of a brief questionnaire in the study of communication between members of a CMHT and relevant community health care professionals, and the sensitivity of the questionnaire to changes in the practice of CMHT members.

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