



special articles

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Service innovations: redesigning a community mental health team

AIMS AND METHOD

We describe the redesign of a community mental health team in Lanarkshire (the focused intervention team for Bellshill). Their remit is to provide focused, time-limited therapeutic intervention for patients with mild-to-moderate mental health problems.

RESULTS

The redesign involved a closer working relationship with the psychiatrist, establishing a concurrent community psychiatric nurse/psychiatric clinic, recategorisation of 'soon' and routine referrals to the team, opt-in letters and the introduction of new assessment formats.

CLINICAL IMPLICATIONS

These measures combined to provide a shorter waiting list, increased joint working and management plans for patients. Team functioning and morale improved.

General adult psychiatry is increasingly grappling with the challenge of balancing rising service demand with limited resources. The increasing workload of psychiatrists and community psychiatric nurses (CPNs) appears unsustainable in its present form. New ways of working for both psychiatrists and CPNs need to be considered (Kennedy & Griffiths, 2001). We describe a local solution. In early 2000, adult community mental health teams in the Motherwell/Clydesdale district of Lanarkshire were incorporated into resource networks. Each resource network included two main multidisciplinary teams: the assertive outreach team that provided ongoing treatment for patients with severe and/or enduring mental health illnesses (e.g. schizophrenia, bipolar and long-term affective disorders); and the focused intervention team that provided short-term interventions for mild-to-moderate mental health problems (e.g. affective disorders and first-presentation psychosis). There is much information available on the operation and access to generic community mental health teams (McEvoy & Richards, 2001), but less relating to focused intervention teams.

The Bellshill area of Lanarkshire has relatively high levels of socio-economic deprivation and poor health (Chief Medical Officer, 2001). The catchment area population is approximately 38 000. Consultant availability is approximately 0.7 full-time equivalents. The number of beds utilised by the Bellshill population varies between 5 and 7 in the local psychiatric in-patient unit. With the previous model of working, the focused intervention team for Bellshill comprised three CPNs with variable levels of access to psychiatrists and other professionals

on an *ad hoc* basis. Referrals would be received and responded to, with a high number of home assessment visits. The CPNs would conduct assessments and a relatively high proportion would be taken on the CPN case-load for treatment. Treatments offered included anxiety and depression management and schedules based on cognitive approaches. The number of sessions varied, most commonly between 6 and 10 sessions. This resulted in high case-load numbers for each CPN. Furthermore, if medical opinion was required, a referral was made to a separate clinic with a variable waiting time. The overall demand on the team exceeded capacity. This resulted in an imbalance between clinical work and other commitments, leading to reduced opportunity for development of skills. Low morale developed among the staff.

Method

The four elements of redesign of the Bellshill focused intervention team from August 2003 onwards are described below.

Consultant psychiatrist input and concurrent CPN/psychiatric clinics

Three sessions of consultant time were made available to the team. During two of these sessions the consultant psychiatrist was engaged in an out-patient clinic running at half the usual capacity, i.e. 30-min appointments instead of 15-min appointments for return appointments.



Reducing the clinic list allowed the psychiatrist flexibility in liaising with the CPN to discuss patients. This would be for patients who the CPN had just assessed and considered likely to benefit from discussion with the psychiatrist. If necessary, the psychiatrist could see the patient at the time and multidisciplinary discussion and recommendations for medication changes could be suggested immediately. The CPN clinic offered a maximum of four appointments, twice weekly. To see patients attending the CPN clinic a level of flexibility was essential at the psychiatrist's out-patient clinic. However, the position with out-patient referrals and case-load numbers indicated this would be challenging. The consequence to the psychiatrist might have been a potential backlog of out-patient appointments in an already stretched service. Our solution was for all referrals considered appropriate for focused intervention work to be discussed with all the focused intervention team members. A number of referrals previously passed on to the psychiatrist were redistributed to the CPNs for assessment at their clinic. This was done at the discretion of the senior charge nurse who, with the psychiatrist, screened the referrals to ensure appropriateness for CPN or psychiatrist assessment. Exclusions for CPN assessment might include diagnostic uncertainty, medication reviews and any other relevant referral information indicating that a specific medical assessment was required.

Previously, CPNs would assess patients and contact general practitioners (GPs) to discuss medication and other aspects of management. As GPs were not always immediately available for this feedback, considerable time could be spent by CPNs trying to contact them.

The remaining psychiatrist session was used for the extended allocation meeting and administration.

Recategorisation of referrals

Because of increasing clinical demands on the focused intervention team, CPNs had to respond to a rising proportion of 'soon' referrals. These referrals were required by locally agreed protocol to be seen within 10 working days. Referrals to the team classified as 'soon' by the referrer were previously unchallenged and were seen within the accepted 10-day limit. From August 2003, the three CPNs and consultant psychiatrist discussed referrals within the team more critically. Referrals were then recategorised in accordance with the trust criteria. This was on the basis of the clinical information available and if necessary by direct liaison with the referrer.

Opt-in letters

Before the redesign, 'soon' referrals were seen at the expense of an increasing waiting list for routine referrals. To deal with this, a system of opt-in letters was devised. This letter advised the potential patient that a referral had been received and that if they wished to receive an appointment they must return a tear-off slip indicating this.

Assessment forms and nursing notes

New assessment forms designed in collaboration with nursing staff and the psychiatrist were introduced to the team. The format of the assessment enabled standardised and comprehensive communication between the CPN and psychiatrist. Revised care plan documentation was specific to the work of the focused intervention team. This allowed significant time-saving and precisely indicated the direction and progress of treatment programmes.

Results

Impact on waiting times

The waiting times for patients allocated to the routine waiting list fell from 140 days in May 2003 to less than 60 days in December 2003 following the reorganisation of the team (Table 1). This was the result of a combination of the team being able to assess more patients within organised clinics and fewer patients being taken on to the CPN case-load. Fewer patients are being referred as 'soon', perhaps the result of referrers acknowledging that routine patients will be seen sooner.

Opt-in letters for routine referrals

There were 97 opt-in letters sent between May and December 2003; 64 were returned and 48 patients attended the clinic. The opt-in letter system alone may save over 90 h of CPN appointment time per year for this team. Approximately a third of appointments can be potentially reallocated to other patients. Despite confirming by opt-in letter, one-quarter of the patients did not attend. For those who did not attend it is possible that the nature and timing of their problems were self-limiting and resolved spontaneously. Alternatively, they may have accessed the service elsewhere (e.g. emergency departments or on-call psychiatrist at the local hospital). The spectrum of referred problems, mainly affective and stress-related disorders, was the same for those who attended and those who did not attend. Further study is required to investigate this in more detail. There is a concern that in some populations with mental health problems opt-in letters may result in the most needy, ill, psychotic or those patients most lacking insight failing to engage with services. The reason our opt-in system is feasible is that the population being accepted by the focused intervention team has mainly affective disorders which are referred on a non-urgent basis. This population is considered to have insight and a degree of responsibility to engage with the types of psychological interventions offered. The population with chronic/enduring disorders is supervised by a separate assertive outreach team.

'Soon' v. routine criteria

In the period May to December 2003, 56 referrals were designated 'soon' by the referrer and 123 routine. The



Table 1. Outcome of the reorganisation of the team

	May 2003	December 2003
Referrals per week, mean	9.4	9.4
Patients on waiting list, <i>n</i>	40	40
Waiting time for first appointment ('soon' referrals), days	10	10
Waiting time for first appointment (routine referrals), days	140	60

corresponding figures after recategorisation by the team were 42 and 136. Over the course of 7 months, only one recategorised referral has been changed back from routine to 'soon' and fears of criticism have been unfounded. Risk assessment and litigation is relevant to all mental health professionals within a multidisciplinary team (Harrison, 1997). Introducing a potentially longer waiting time for those referred with 'soon' appointments may theoretically increase this risk. However, reduced waiting times for routine patients may potentially lower the risk for this larger population.

Discussion

The changes described have helped the functioning of the team, without an increase in workload of medical or nursing staff. Within the redesign of the team, immediate access to the psychiatrist in this 'consultative' role led to a number of positive changes for patients attending CPN assessment clinics. These include multidisciplinary discussion, prompt medical opinion and immediate recommendations for medication changes. Therefore, more patients received specialist advice. There were reduced referrals to psychiatry out-patient clinics by the CPNs. Patients were not required to remain on a CPN case-load while awaiting out-patient appointment and, overall, more patients received specialist advice.

A further consequence of the redesign was the reduced proportion of referrals to psychiatric out-patient clinics from the allocation meeting. Towards the end of the redesign project the rate was 11%, in contrast to 16%

for the previous year. A resulting reduction in case-load numbers for the psychiatry clinic is ongoing.

All staff involved have noted the benefits of the changes, as have referrers to the team. This style of working is probably more in keeping with that of sustainable future practice for those working in general adult psychiatry, both psychiatrists (Kennedy & Griffiths, 2001) and CPNs.

Declaration of interest

None.

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