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A community mental health team: assessment of urgent referrals

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The Southsea Mental Health Team serves a geographically-defined catchment area of 80,000 adults under the age of 65. The area lies on the south coast of England, merging on its northern boundary with the naval city of Portsmouth. There is a variety of housing types including council housing estates, private housing and a significant number of large houses in multi-occupancy use as flats, bedsits or bed and breakfast accommodation.

In March 1986, the service was divided into three autonomous but interlinking teams in order to allow each part of the service to develop cohesive policies and services – the acute, continuing care, and inpatient teams. In August 1987, the acute team moved out of scattered offices in St James psychiatric hospital in Portsmouth into Cavendish House, a large Edwardian house located centrally within the catchment area. The team comprised one consultant psychiatrist, one part-time senior registrar, one registrar/SHO in psychiatry, five community psychiatric nurses, one occupational therapist, one part-time clinical psychologist, one social worker, a team manager and assistant manager, and three clerical staff. All these, with the exception of the community nurses and occupational therapist, also had involvements with the other strands of the Southsea Mental Health Service.

A 'duty officer' system was established which dealt with urgent referrals to the service between the hours of 9 a.m. and 5 p.m. The duty officer could be a community psychiatric nurse, occupational therapist, social worker or psychologist organised on a daily rota. However, if a general practitioner wished a domiciliary visit by the consultant psychiatrist, this could be requested in the usual way. Access to the duty officer could be by referral by any health professional, self-referral or through friends or neighbours. Contact could be made by telephone or in person. The service was discussed in advance with general practitioners and other primary care team members. Publicity was also displayed within GP surgeries. Once contact had been made, the clients were either seen at home, at Cavendish House or elsewhere as seemed most appropriate. After initial assessment, referral to medical staff or other agencies was arranged if necessary. The system thus comprised aspects of a psychiatric emergency clinic such as the one which existed in Southampton (Smithies, 1986) and those of a crisis intervention service based on domiciliary consultations such as the service in Barnet (Scott, 1980).

The study

The study described here aimed to answer a number of questions – who are the people who would be reached by such a service and what are their problems? What kinds of help do they require? Do those referring themselves differ from those referred by GPs? How do the local GPs perceive the usefulness of such a facility?

A form designed specifically for this study was completed by the duty officer for every client who made contact over the 12 months starting 1 September 1987. As well as allowing evaluation of the service this form also fulfilled the need for clinical record keeping. A survey of GPs' opinions of the service was carried out using a questionnaire.

Findings

Over the year 293 contacts were made, with a steady increase in numbers from 10 per month to a maximum of 38 per month. These were initially evenly distributed throughout the week but towards the end of the study a weekend service was initiated by the continuing care team and the numbers of weekend contacts decreased (42% of weekend contacts had previous involvement with the continuing care team compared with only 6% of people seen on weekdays); 54% were seen at home and 30% at Cavendish House. Of the clients, 39% were male; 68% were single, divorced, widowed or separated. The average age of the clients was 37 years (age range from 17 to 71 years) and 18% were under 25. Twenty-nine per cent were living in bedsits, hostels, group homes or bed and breakfast accommodation; 49% were unemployed; 77% of clients had had previous contact with mental health services. Approximately half of the workload was accounted for by 26% (49) of the people who had on average three contacts each.

Referral sources

Of all clients, 31% were self-referred and 29% were referred by their general practitioner. In 10% the request for help came from a friend or relative, and 11% were referred by a community psychiatric nurse or social worker. The remainder of referrals came from the police, probation officers, psychiatrists and a variety of other sources.

Main problem

This was assigned by one psychiatrist (HM) who examined the duty officer assessment forms and the categories are necessarily broad. For most clients it was possible to identify a single main problem area, although for some it was necessary for more than one problem area to be designated. For example, a significant proportion of those threatening self-harm were also depressed. The main problem(s) were depression (44%); relationship problems (25%); anxiety (19%); actual or threatened self-harm (18%); delusions or hallucinations (12%); alcohol problem (7%) and drugs problem (6%).

Action taken

Possible courses of action (not mutually exclusive) were divided into the following categories – practical support (e.g. arranging for a neighbour to stay, obtaining medication from the chemist); counselling; immediate admission to psychiatric hospital; referral to other agencies, e.g. psychiatrist. Of the clients, 24% were offered practical support and 46% given counselling at initial contact. In 29% further counselling sessions were offered; 11% were admitted immediately.

The following sub-groups were selected for further study.

Actual or threatened self-harm

This group comprised nearly a fifth of all referrals. There was a smaller percentage of self-referrals and a corresponding increase in referrals from other sources. Half of the referrals from police or probation services were because of actual or threatened self-harm. A smaller number of this group were referred to a psychiatrist (8% compared with 20%) although this may be partly explained by the increased admission rate (22% compared with 9%). Over half were judged to be depressed.

People recently moved into the area

Over a quarter (27%) had lived in the area for a year or less and of these 46% were living in hostel, bedsit, guest house or group home accommodation. There was no increased likelihood of previous psychiatric care.

Self-referrals

These did not differ significantly from the rest of the referrals. There was a trend for those under 25 or over 65 to refer themselves more often and a corresponding decrease in GP referrals.

Referral to psychiatrist

After the initial assessment 18% were referred for further assessment by a psychiatrist. In other cases the duty officer may have discussed the client informally with the psychiatrist. Those with delusions or hallucinations were more likely to be seen subsequently by a psychiatrist as were referrals from police and probation services. There was no difference between numbers of GP referrals and self-referrals seen by a psychiatrist.

GP involvement

One of the more contentious aspects of the service was the degree of confidentiality offered. It had been decided that contact would only be made with the general practitioner if the client agreed: 31% indicated that they did not wish their GP informed (36% of men and 27% of women). This could lead to problems, particularly where the GP was already involved. Clients under 25 were least likely to wish their GP informed. Only a small number who were referred by their GP did not want him or her informed of the outcome (6%). This was one aspect of the service which was kept under close review and on one occasion, after discussion with the client involved, the GP was informed against her wishes.

GP satisfaction

A questionnaire was distributed to all GPs who referred to the service. Replies were received from 25 GPs (46%). This low response rate is partly explained by the fact that some of the GPs rarely referred to the Southsea sector because of catchment area boundaries.

In an initial structured section GPs were asked to respond using a visual analogue scale. In response to the question "How essential do you feel the duty officer service is?", the mean score as indicated on a 10 cm line was 7.9 (range 4.8–10), thus indicating that most GPs thought the provision of such a service to be desirable. A similar response was received in reply to the question "How satisfied are you with the service?" – mean score of 7.6 (range 4.7–10). However, the GPs' views on the adequacy of the communication varied much more widely and there was a lower level of satisfaction with this aspect of the service. The mean score was 6.3 with a range from 0.3–10. This was reflected in some of the disadvantages mentioned later in the open section of the questionnaire, e.g. "Poor communication allows 'game

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play' by patient". Other disadvantages mentioned were the risk of creating dependence, possible duplication of effort and therefore poor use of scarce resources. Several GPs felt that they themselves could have dealt with some problems more effectively. However, 13 GPs said they perceived no disadvantages. Of the GPs, 20 specifically mentioned immediate access and speed of response as advantages. Other advantages mentioned were improved communication, the ready availability of advice, and the confidentiality of the service.

Comment

The service appeared to fulfil a need and its use by clients and referrers was increasing. From the number of clients who were admitted directly to hospital, and from the level of threatened or actual self-harm, one might expect that many of these clients would previously have been seen urgently on domiciliary visits by a psychiatrist and this was reflected in a reduction in the number of requested domiciliary visits, (79, compared with 125 for the preceding 12 months).

The finding that 78% of clients had previous contact with mental health services is in accord with a recent study of self-referrals to the Mental Health Advice Centre in Lewisham (Boardman & Bouras, 1989). These figures may change as the service is more widely publicised. A further project to assess consumer satisfaction is under way.

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Your supported lodgings

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Supported lodgings are an important means of achieving the successful rehabilitation and resettlement of the chronically mentally ill into the community (Anstee, 1978, 1985). In a survey of 15 psychiatric hospitals in England and Wales, it was estimated that 9.3% of the long-stay patients (i.e. in-patients from one to five years) under 65 years of age were ideally suited to less supervised accommodation outside the hospital. In Gloucestershire the Supported Lodging Scheme is provided by the Psychiatric Social Services Department. It was started to enable 'new' and 'old' long-stay patients at Coney Hill and Horton Road hospitals to be settled in the community. Now any psychiatric or mentally handicapped patient can also enter the scheme if appropriate.

The lodgers had often spent a long period in hospital before placement which, together with their illness, may have diminished their life skills. It has been helpful to provide new lodgers with an explanatory booklet called *Your Supported Lodgings*, giving guidance not only on the supported lodgings but on other community services and how to use them. This booklet contains the following information and is completed by the supported lodgings officer with each patient before discharge.

The address is given of the supported lodgings and the name of the landlord/landlady, who must provide bed, breakfast, and evening meal Monday to Friday, plus full board Saturday, Sunday and Bank Holidays, together with washing facilities. Lodgers must stick to the house rules, especially those on