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ORIGINAL RESEARCH

Are psychiatric team meetings patient centred? A cross-sectional survey on patient views regarding multi-disciplinary team meetings

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Objectives. The system of weekly psychiatric ward rounds is being challenged and multi-disciplinary team meetings (MDTMs) involving inpatients have been developed. These aim to improve integration between medical and social services and increase patient involvement in their care. However, such large meetings are potentially threatening to the patient. This survey aimed to examine inpatient experience of MDTMs and identify factors that significantly alter this experience.

Methods. In this cross-sectional survey we assessed patient opinion regarding patient inclusive MDTMs in a psychiatric inpatient unit. A total of 27 participants (response rate 90%) were included. We utilised descriptive statistics and Fisher's exact test for non-parametric data where appropriate.

Results. In all, 85% ($n = 23$) of patients identified the consultant psychiatrist as a member that they would like to have present at the MDTM. The ward nurse was identified by 63% ($n = 17$) of patients. In all, 48% ($n = 13$) of patients reported feeling anxious/threatened at the MDTM. In all, 70% ($n = 19$) of patients stated that they would have felt less threatened at the MDTM if there were fewer people in attendance. A significant number of voluntary patients ($n = 11$) felt threatened/anxious at the MDTM compared with involuntary patients ($n = 2$) ($\chi^2 = 4.921$, df = 1, $p = 0.026$).

Conclusion. The central findings of this study are that patients would prefer fewer people at the MDTM and would feel less threatened/anxious if they participated in selecting those in attendance. These findings suggest that greater patient involvement in preparation for the MDTM could result in a less anxiety filled experience for them.

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Key words: Clients, multi-disciplinary team meeting, patients, psychiatry, service users, staff attitudes.

Introduction

Nearly 30 years ago 'Planning for the future' recommended the establishment of multi-disciplinary teams (MDTs) in mental health care (Deptartment of Health, 1984). Further to this, the traditional ward round system has been challenged and multi-disciplinary team meetings (MDTMs) involving the patient have been developed in certain hospitals. While ward rounds in the acute hospital setting remain an essential component for routine patient care and treatment they have never been without a certain level of conflict (Price, 2005). Over the past decade, policy and guideline initiatives within the United Kingdom related to the conduct of ward rounds have been established, and a 'code of good practice' has been outlined (Wolf, 1997). The code includes the patient's right not to attend and the need for the number of professionals to be kept to a minimum. In Ireland, the Vision for Change document does not provide clear operational guidelines for inpatient ward rounds (Expert Group for Mental Health Policy, 2006). The difference between the traditional ward round and MDTMs is that MDTMs aim to improve collaboration between team members and improve patient outcome. MDTMs are in keeping with a person-centred health system that was described in an Irish Department of Health document, the Health strategy 2001, as one that 'identifies and responds to the needs of the individual, is planned and delivered in a coordinated way, and helps individuals to participate in decision making to improve their health' (Department of Health, 2001). However, MDTMs with patient involvement do not necessarily solve, and may even exacerbate, a number of the problems cited with the traditional ward round. While MDTMs allow for greater involvement of the patient in their care and greater collaboration between team members, such a large meeting is potentially threatening. While MDTMs are designed to create a sense of 'multi-party egalitarian co-operation', some believe that it further disempowers the patient (Mohr, 1995). Health and social care integration

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has been found to be important in creating a power balance between professionals (Tousijn, 2012) but our question is; does it do the same for the patient? This question is asked within the contemporary setting of increasing patient involvement in deciding the structure of mental health services (Tait & Lester, 2005) and the direction of psychiatric research (Faulkner & Thomas, 2002).

The aims of this study were to establish the current practice around MDTMs in St. Columbas' Psychiatric Hospital, Sligo, Ireland, to elicit patient reactions to MDTMs and to identify how many team members would preferably be in attendance. We also sought to identify which team members would ideally be present and whether this would alter patient experience. We did not seek to perform a direct comparison to traditional ward rounds.

Methods

This cross-sectional survey was conducted over a period of 1 week in May 2011, in the psychiatric inpatient unit at St. Columbas' hospital, Sligo, Ireland. In St. Columbas' hospital, all members of the team met together with each inpatient twice weekly for a MDTM. The MDTM included a consultant psychiatrist, junior doctor, ward nurse, community mental health nurse/s, occupational therapist, social worker and occasionally nursing or medical students. Patients were also seen on an individual basis with various members of the team throughout the week.

St. Columbas' hospital is the psychiatric inpatient setting for the Sligo, Leitrim, South Donegal and West Cavan catchment area, serving a population of ~90,000. St. Columbas' Hospital was on a separate hospital site to Sligo General Hospital, providing the advantage of having its own grounds. There were two acute wards, one for male and one for female patients. There were 30 acute beds, 15 each for male and female patients. There was a high security ward with 10 beds that facilitated both acute and long-stay patients. This has since been changed to a high observation ward.

All inpatients that were older than 18 years of age, who retained decision-making capacity and had a Mini Mental State Examination >27/30 (Folstein *et al.* 1975) were invited to participate in the study. In all, 30 patients fulfilled these criteria. Data was collected using a 19-item newly constructed, self-administered questionnaire (see Appendix 1). All participants were provided with a letter of information, signed consent was obtained from each of the participants, a postbox was provided for the finished questionnaires and anonymity was assured. Demographic data including gender, age and nationality was collected along with clinical information relating to the patients' admission status and their duration of inpatient hospitalisation. A free text comments section was included at the end of the questionnaire.

Statistical analysis was performed using the Statistical Package for Social Sciences 18.0 for Windows (SPSS Inc., USA). We utilised the Student's *t*-test for parametric data and Fisher's exact test for non-parametric data where appropriate. All statistical tests were two-sided and the α-level for statistical significance was 0.05.

Results

A total of 27 patients were included in this study giving a response rate of 90%. In all, 59% ($n = 16$) of participants were male with 41% ($n = 11$) being female. In all, 70% ($n = 19$) of inpatients were voluntary admissions while 30% ($n = 8$) were involuntary admissions to hospital. In all, 48% ($n = 13$) of participants were inpatients for more than 4 weeks, with 41% ($n = 11$) admitted between 1 and 4 weeks and 11% ($n = 3$) admitted for <1 week. The mean age of respondents was 44 years (S.D. = 16.58).

In all, 93% ($n = 25$) of patients reported that they were informed of the first MDTM at which they were invited to attend, while 7% ($n = 2$) stated that they were not forewarned. In all, 93% ($n = 25$) of patients were informed of the MDTM by a nurse, while only 11% ($n = 3$) were informed of the MDTM by a doctor. Patients were informed in advance at a median time of 2.5 hours (range 1–96 hours) of the MDTM. Fewer patients were informed of subsequent (MDTMs) at which they were invited to attend (77%, $n = 21$). In all, 67% ($n = 18$) of patients knew who would be at the meeting; however, 63% ($n = 17$) did not know how many people would be there. A substantial majority of patients attended the MDTMs (96%, $n = 26$). In all, 70% ($n = 19$) reported that they would have found the MDTM less threatening if there were fewer people present. A comparison of voluntary and involuntary patient's experiences of participation in the MDTMs is shown in Table A1.

Table A2 shows the percentage of patients who preferred respective members of the MDT to attend or not to attend the MDTMs. The consultant psychiatrist was identified most frequently by the patients as an individual who they would like to attend the MDTM (85% of patients, $n = 23$ responses), while no patients stated that they did not want the consultant psychiatrist to attend. Administrative staff were most frequently (40.7% of patients, $n = 11$ responses) identified as members of the MDT who patients did not want to attend the MDTM. Voluntary patients most frequently identified the consultant psychiatrist (94.7% of voluntary patients, $n = 18$) as a team member who they would like to attend the MDTM, while involuntary patients most frequently identified the consultant psychiatrist, social worker and occupational therapist (62.5% of involuntary patients expressed a preference for each respective team member, $n = 5$ for each) as team members who they would like to

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attend. In all, 52.6% (n = 10) of voluntary patients identified administrative staff as a team member who they would not like to attend the MDTM [identified by 12.5% (n = 1) of involuntary patients]. In all, 42% (n = 8) of voluntary patients did not want an addiction counsellor to attend, while 37% (n = 7) expressed a preference each for the psychologist and for a medical student not to attend.

In all, 48% (n = 13) of patients reported that they felt anxious and threatened at the MDTM, while 30% (n = 8) reported feeling reassured and comfortable at the MDTM. In all, 22% (n = 6) of patients stated that they had a neutral emotional response to the MDTM. A comparison of those who felt anxious and threatened with those patients who felt reassured and comfortable at the MDTM along with their experience of the MDTM and their demographic and clinical correlates is shown in Table A3.

Free text comments section

In all, 33% (n = 9) of the patient group provided additional comments at the end of the questionnaire of which 11% were favourable, 78% were critical, 11% contained both favourable and critical comments. The majority of the comments (78% and n = 6) reflected the results above regarding a need for fewer team members:

> Find it difficult to relate to people at the MDT. Feel more secure talking on a one-to-one basis.

> When feeling bad, too many people doesn't help. You can't feel relaxed to answer the questions or add extra information.

> Although there are quite a few professionals attending my meeting I try to focus on the CPN, nurse and psychiatrist. This makes me less anxious.

Some demonstrated that they would like to give explicit consent:

> I would like to be asked beforehand.

Others were unclear on the aim of the meeting:

> I can understand why so many people are involved in a patient's care but no one other than the psychiatrist/ward nurse ever actually says anything-surely they can discuss you after you've met with fewer people?

Discussion

To our knowledge, this is the only study investigating patients' views of their participation in MDTMs in Ireland. Most past literature pertains to ward rounds, (Department of Health, 1984; McIntyre *et al.* 1989; Foster *et al.* 1991; Wagstaff & Solts, 2003) and while MDTMs incorporate a different method of decision making, they share certain characteristics that have previously been criticised in ward rounds, including the numbers of individuals present and feelings of power imbalance. One study assessing the views of consultant psychiatrists found that the majority of responders saw the ward round as 'a compromise between professional efficiency and patient satisfaction' (Hodgson *et al.* 2005). In a study of staff attitudes about ward rounds by Fiddler *et al.*, it was found that meetings were 'severely overcrowded' (Fiddler, 2010). This dissatisfaction is reflected by patient studies, where problematic areas in relation to inpatient ward rounds, have included large teams and lack of an appointment time (White & Karim, 2005). Similar areas of patient concern with MDTMs have been identified in this study, which suggests there is a need to adapt MDTMs to minimise such problems.

In this study, admission status was found to significantly affect subjective experience of the MDTM. Contrary to expectation, a greater number of voluntary patients reported negatively and more involuntary patients gave a positive report. Gender, duration of admission and level of notification before the meeting were found to be insignificant factors in determining a patients' response to the MDTM. Perhaps notification before the meeting was not a significant factor owing to a lack in the quality and quantity of information given. While not assessed in sufficient detail here, the wide range (1–96 hours) in advance warning and the additional comments relating to consent and understanding the aim of the meeting imply that standardised preparation could render this factor more significant. In the additional comments, it was found that some patients did not understand the aim of the MDTM. This may relate back to lack of explanation before the meeting. In 'The discipline of teams' the best teams are speculated to be those that invest a lot of time in agreeing on a purpose (Katzenbach & Smith, 1993) so more emphasis on patient preparation may be beneficial.

Patients were given the option of all potential members, as recommended in 'A Vision for Change', (Expert Group for Mental Health Policy, 2006) when choosing who they would or would not like to attend the meeting. We did not have the scope in this study to ask patients which members they felt were more important as a whole. Rather, we asked as to who the patients found valuable at the weekly meetings in which they themselves are involved. It was quite clear with regard to certain members as to whom patients would or would not like to have present. The presence of many other members remains uncertain. It was found that most patients wanted their consultant psychiatrist, ward nurse or CMHN present. This is possibly owing to their level of clinical interaction with the patient during or before their hospitalisation. Administrative staff was most frequently chosen as a group that patients would prefer not to attend. Perhaps

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this is owing to their lack of previous interaction with the patient or to the absence of a formal introduction or explanation of their presence at the MDTM. This presence of unknown individuals at the MDTM may also affect perception of the size of the meeting making it seem larger, as found in a study by Labib *et al.* (2009).

Significant findings included an association between the number present and a subjectively negative experience for patients at the MDTM. This indicates that the patients perception of and the actual meeting size may both impact on their experience of the event. Previous studies on optimising ward rounds have shown conflicting results regarding number of staff present. White & Karim (2005) found that the number of people present was a significant factor. In contrast, a study by Labib *et al.* (2009) found that patient opinion regarding the number of people present is associated with patient satisfaction with the ward round, even though the actual number of people present is not.

Patients have been shown to find ward rounds uninformative and stated that they can provoke anxiety and distress (Ballard & McDowell, 1990). Here there was a significant association between those who would feel less threatened/anxious and between those who would feel more comfortable should the size of the MDTM be reduced. A substantial proportion of those who already felt comfortable/reassured also said that they would feel more comfortable with only certain team members at the MDTM. This indicates that an optimisation of the number of professional participants in patient-attended MDTMs may be beneficial for all patients and would suggest that there is a greater need for patient involvement in this process. To reduce numbers at the meeting, members could all meet the patient individually, hold an MDTM without the patient and then have a smaller number of team members discuss objectives with the patient. This would take time and it has been found that changes take longer to implement when there are conflicting demands on the time of team members (Rix & Shepphard, 1990). However, it could lead to greater effectiveness overall, as an inadequate picture of the patient can be formed in an intimidating setting.

Strengths of this study include high response rate from a sample of hospital inpatients. This improves the reliability and the generalisability of the study findings. Patient-attended MDTMs are a relatively novel concept that certainly would not be standard practice in many MDTMs within Irish mental health care. To our knowledge, this survey is the first within Ireland to ascertain patients' attitudes about such meetings and their experience of attending them. It thus provides previously undocumented comment and insights into this relatively under utilised form of patient engagement.

Limitations of the study include a small sample size and the use of a self-administered, non-validated questionnaire, which could have caused measurement and observer bias in our study. As a cross-sectional survey, there is a lack of longitudinal design that would allow for better judgement of the effects of advance warning and information about the MDTM. It would also more confidently identify an association between such an approach and patients' expectations of the MDTM. No direct comparison was made with traditional ward rounds. A number of factors that were not explored in this study may have been confounding factors in a patients' experience. A previous study on MDTMs examined the importance of room size, seating arrangements, display configuration and variations in preparing and presenting medical information along with team size and how these influenced conversational dynamics (Li & Robertson, 2011). The limited information on the clinical status and diagnoses of the participants at the time of the study may have acted as an additional confounding factor. Further, the emotional responses of the patients to the MDTM could have been affected by mental illness. Someone who is actively depressed, for example, may display different emotional responses to someone who is anxious or who is highly distressed but without evidence of a clinical disorder. We did not examine if patients' responses to the MDTM were influenced by their prior exposure to MDTMs, preventing us from assessing if they became more accustomed to the MDTM format in relation to prior attendance. However, the majority of patients had a duration of hospital stay greater than 1 week, indicating that they would have had multiple opportunities to attend.

Conclusion and recommendations

The aim of MDTMs is to create greater team work and empowerment of the service user. Studies such as this are necessary to assess whether the MDTM is meeting its objectives. A main finding that is postulated in this study is the need for fewer team members at each MDTM with the patient. We believe that understanding both staff and patient views of MDTMs is central to good patient care and efficient running of psychiatric services. Therefore, future research investigating staff attitudes to patient participation in MDTMs would be merited for comparison with this survey, which could highlight areas of contention and areas for change that may be agreeable to both parties. This study highlights an overlooked area of inpatient care that should provide impetus for further study in this area with a view to establishing guidelines for the optimal organisation of patient-involved MDTMs.

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Appendix 1

Table A1. *Comparison of voluntary and involuntary admissions and their experiences of the MDTM*

	Voluntary patient (n = 19) N (%)	Involuntary patient (n = 8) N (%)	χ^2	df	P value[a]
Duration of hospital admission					
<4 weeks	5 (15.7%)	0 (0%)	12.243	1	0.001*
>4 weeks	14 (84%)	8 (100%)			
Advance notification of the MDTM			2.466		
Yes	19 (100%)	7 (87.5%)		1	0.296
No	0	1 (12.5%)			
Were you told who would be attending the MDTM					
Yes	13 (78%)	5 (62.5%)	0.089	1	0.550
No	6 (22%)	3 (37.5%)			
How many people would be suitable to attend the MDTM?					0.014*
<3	15 (74%)	2 (12.5%)	7.026	1	
>3	4 (21%)	6 (75%)			
Felt threatened/anxious at MDTM (n = 21)**			4.921		0.026*
Yes	11 (58%)***	2 (25%)***		1	
No	3 (16%)	5 (62.5%)			
MDTM would be less threatening if fewer people were in attendance				1	0.004*
Yes	18 (95%)	3 (37.5%)	10.671		
No	1 (5%)	5 (62.5%)			

MDTM, multi-disciplinary team meeting.

[a]Fishers exact test.

*$p < 0.05$.

**n = 6 or 22% stated that they were emotionally neutral during the MDTM.

***Percentage of total number of voluntary or involuntary patients.

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Table A2. *Patient preference for each member of the MDTM to attend or not to attend the MDTM*

	Who would you like to attend the MDTM [percentage of patients who identified each individual (n = number of responses for each individual)]	Who would you not like to attend the MDTM [percentage of patients who identified each individual (n = number of responses for each individual)]
Consultant psychiatrist	85% (23)	0% (0)
Junior doctor	37% (10)	11.1% (3)
Ward nurse	63% (17)	7.4% (2)
Social worker	37% (10)	18.5% (5)
Occupational therapist	18.5% (5)	18.5% (5)
Psychologist	22.2% (6)	25.9% (7)
Key worker	26% (7)	7.4% (2)
Community mental health nurse	48% (13)	22.2% (6)
Addiction counsellor	3.7% (1)	37% (10)
Medical student	18.5% (5)	29.6% (8)
Administrative staff	3.7% (1)	40.7% (11)
Staff from supported accommodation	3.7% (1)	33.3% (9)
Friend/relative	18.5% (5)	29.6% (8)
No specific individual	0% (0)	29.6% (8)

MDTM, multi-disciplinary team meeting.

Table A3. *Demographic and clinical correlates and experience of the MDTM in those who felt anxious/threatened and in those who felt reassured/comfortable at the MDTM*

	Felt anxious/ threatened at the MDTM (n = 13) N (%)	Felt reassured/ comfortable at MDTM (n = 8) N (%)	χ^2	df	P value[a]
Gender					
Male	6 (46%)	4 (50%)	0.029	1	0.608
Female	7 (54%)	4 (50%)			
Admission status					
Voluntary	11 (85%)	3 (37.5%)	4.947	1	0.041*
Involuntary	2 (15%)	5 (62.5%)			
Duration of hospital admission					
<4 weeks	7 (54%)	2 (25%)	1.683	1	0.201
>4 weeks	6 (46%)	6 (75%)			
Advance notification of the MDTM					
Yes	13 (100%)	7 (87.5%)			
No	0 (0%)	1 (12.5%)	2.466	1	0.116
Prior knowledge of number attending the MDTM				1	
Yes	4 (31%)	4 (50%)	0.777		0.336
No	9 (69%)	4 (50%)			
Did you feel that there were too many people there					0.041*
Yes	11 (85%)	3 (37.5%)	4.947	1	
No	2 (15%)	5 (62.5%)			
Prefer MDTM with three or fewer people in attendance					
Yes	11 (85%)	3 (37.5%)	4.947	1	0.041*
No	2 (15%)	5 (62.5%)			
More comfortable if only those who you would like to attend were at the MDTM					
Yes	13 (82%)	5 (62.5%)	5.668	1	0.042*
No	0 (0%)	3 (37.5%)			

MDTM, multi-disciplinary team meeting.
[a]Fishers exact test.
*$p < 0.05$.

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Appendix 2

Patient views re: Multi-disciplinary team meetings
Sligo mental health services
Dr Abba Aji, Cornelia Carey
Survey Consent Form

This survey requires you to answer questions regarding your background and how you feel about the weekly multi-disciplinary team meetings conducted by your team in St. Columbas'. The survey takes about 10–15 minutes to complete. The weekly multi-disciplinary meetings are an important component of your treatment plan. As it is the team comprises of nurses and other health professionals and it is arranged by your consultant psychiatrist. This survey aims at improving this weekly meeting based on your personal experience. Your participation is completely voluntary, and your responses will be completely anonymous. The data I collect will be analysed at the group level only. You do not have to answer any question you would rather not answer. There are no consequences if you decide not to complete the survey.

Demographics

Age ☐ Nationality ☐ Gender ☐ ☐
F M

- Length of current admission:

  Less than 1 week ☐ 1–4 weeks ☐ More than 4 weeks ☐

- Admission status:

  Voluntary ☐ Involuntary ☐

Questionnaire

1. Were you informed in advance of the first multi-disciplinary meeting?

   Yes ☐ No ☐ Unsure ☐

2. If yes, how far in advance were you informed?

   ☐ Hours OR ☐ Days

3. Who told you about the meeting? (can choose more than one)

   Nurse ☐ Patient ☐

   Doctor ☐ Relative ☐

   Other (please specify)

   _____

4. Were you informed in advance of each multi-disciplinary meeting after that?

   Yes ☐ No ☐ Unsure ☐

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5. If yes, how far in advance were you informed?

☐ Hours OR ☐ Days

6. Did you know how many people were going to be present?

Yes ☐ No ☐ Unsure ☐

7. Were you told who would be there?

Yes ☐ No ☐ Unsure ☐

8. Who told you how many people would be there? (can choose more than one)

Nurse ☐ Doctor ☐

Patient ☐ Relative ☐

Other (please specify) _____

9. Who were you told would be there? (can choose more than one)

Consultant psychiatrist ☐ Community mental health nurse ☐

Junior doctor ☐ Social worker ☐

Ward nurse ☐ Occupational therapist ☐

Medical student ☐ Other (please specify) _____

10. Did you attend the meeting?

Yes ☐ No ☐ Unsure ☐

11. How did you feel about the meeting? (choose one)

Threatened/anxious ☐ Neutral ☐ Comfortable/Relaxed ☐

Other (please specify) _____

12. Did you feel that there were too many people there?

Yes ☐ No ☐ Unsure ☐

13. What number would you find suitable at a team meeting?

1–3 ☐ 4–6 ☐ 7 or more ☐

14. Who would you like to be there? (can choose more than one)

Consultant psychiatrist ☐ Community mental health nurse ☐

Junior doctor ☐ Ward nurse ☐

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Occupational therapist	☐	Social worker	☐
Psychologist	☐	Addiction counsellor	☐
Key worker	☐	Administrative staff	☐
Staff from Garden centre	☐	Staff from supported accomodation	☐
Relative/friend	☐	Medical student	☐

15. Who would you like NOT to be there? (can choose more than one)

Consultant psychiatrist	☐	Community mental health nurse	☐
Junior doctor	☐	Ward nurse	☐
Occupational therapist	☐	Social worker	☐
Psychologist	☐	Addiction counsellor	☐
Key worker	☐	Administrative staff	☐
Staff from Garden centre	☐	Staff from supported accommodation	☐
Relative/friend	☐	Medical student	☐

16. Would you find the meeting less threatening if there were fewer people there?

Yes ☐ No ☐ Unsure ☐

17. Would you find the meeting more comfortable if only the people you have specified in q14 were present?

Yes ☐ No ☐ Unsure ☐

18. Would you find the meeting more useful if only the people you have specified in q14 were present?

Yes ☐ No ☐ Unsure ☐

19. Additional comments

_____

_____

_____

Thank you for completing this survey

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