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Service innovations

Multi-disciplinary team assessments: a method of improving the quality and accessibility of old age psychiatry services

The increase in older people in the UK will increase the need for mental health services to run efficient, high-quality services. Multi-disciplinary team assessments, although not new, provide a method of increasing the capacity to see referrals. Two similar systems of multi-disciplinary team assessments from North Yorkshire are reported with evidence of improvement in quality.

The UK has an ageing society. The proportion of people aged over 65 is increasing rapidly, but most striking is the increase in the population aged over 80. The incidence of mental illness increases with age. This is reflected primarily in the incidence of dementia, with about 5% of the total population aged 65 and over suffering from this disorder, rising to 20% of the population aged 80 and over. Depression is also common, with 10–15% of the population aged 65 and over suffering from depression at any one time. Therefore, up to 20% of the over 65s may be suffering from a mental illness, which is at least 500 people in an over-65 catchment area of 10 000.

With this high prevalence of mental illness in the community, mental health services and primary care trusts need to determine how affected individuals are assessed and treated. The National Service Framework for Older People (Department of Health, 2001) emphasises the role of primary care in diagnosing and caring for older people with mental illness, but older persons' mental health services have a major role in supporting and developing primary care services in this role.

There still remains a large number of mentally-ill people who need assessment and treatment by specialist services. These services have developed differently throughout the country but broadly, as with younger adult services, use a community mental health team (CMHT) model. There are two models of working processes in CMHTs:

1) The traditional model. In this, the members of the CMHT are referred patients separately and assess them separately, bringing problems back to the team.
2) Team referral model. In this, the referrals from primary care are allocated at a team meeting, so that all members of the team see the information regarding the referral.

In the traditional model, the consultant old age psychiatrists are clear who their patients are and what specific treatments they are providing. They can only provide input, however, to the patients who they see, which is a small proportion of those referred to specialist services. In the team referral model, the consultant can have more input into what is happening within the team, but it denies the general practitioner (GP) the right to refer to individual team members. This approach is consistent with the Mental Health Policy Implementation Guide on CMHTs (Department of Health, 2002), where there is one point of access for secondary care. Younger adult CMHT services have developed more of a team referral model, but many older persons' services have resisted such developments. It is vital for future service delivery that a model is developed where the full skills of the multi-disciplinary team are used but, in view of the frequency of medical interventions required, there is adequate medical overview of as many team referrals as possible.

We report an extension to the team referral model for older persons' services in which, in two different parts of North Yorkshire, slightly different systems are used to provide a multi-disciplinary assessment of patients following a team referral.

Thirsk and Wensleydale model – the joint assessment clinic

In this model, all referrals are sent to the CMHT, discussed and then allocated. Different CMHT members work together in all the clinics and patients are seen for an hour by one or two members of staff, either in the clinic or at home. Following this, there is a half-hour discussion between all clinic workers about the referrals seen in the previous hour. A treatment plan is then made and, if necessary, other members of the team will see the referred patient. As a result, there is rapid assessment,

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improvement in joint working and an improvement in team cohesion. Patients are potentially assessed by a few different members of the team and a full multi-disciplinary care plan can be organised immediately without any need for inter-team referrals and further waits.

After the first 29 patients were seen, this service was evaluated by sending a questionnaire to all patients and carers, all GPs making the referrals and all CMHT members. Each group were asked questions about the length of time patients wait to be seen and the completeness of the assessments. The GPs and CMHT members were also asked about the adequacy of the written assessment letters, their view of the joint assessment clinic and whether it has improved the service. All questions were answered on a scale of 1 to 5 (very unhappy to very happy).

The response rates were 78% for CMHT members, 83% for patients and carers, and 93% for GPs. The results of the time patients wait to be seen showed that GPs had a mean rating of 5.0, CMHT members 4.7 and patients 3.8 on the 1 to 5 scale. The figures were 4.3, 4.4 and 3.9, respectively for completeness of assessments. For happiness of GPs and CMHT staff with the written assessment, the scores were both 4.3, and for general happiness with the clinic, 4.0 and 4.9. For whether the introduction of the clinic had improved the service, the scores were 3.6 and 4.9, respectively.

General practitioners were not consulted about this change in service, but were clearly very happy with it on average. The patients had nothing to compare it with, but were none the less happy with the service. Of particular significance, the members of the CMHT were extremely happy with the changes. As a result of the use of more staff for assessments, the waiting lists have now disappeared.

The joint assessment clinic was part of a new service development that included a new team. This resulted in the team developing the service and having start-up enthusiasm, which may have had a positive effect. The conclusions from this evaluation have been that assessments are considered to be thorough and assessment letters are good. General practitioners and CMHT members are happy with the clinic, and consider that it has improved the service and reduced waiting times. The clinic has therefore been welcomed by all, and has resulted in more multi-disciplinary input.

Whitby Model — joint domiciliary assessments

Multi-disciplinary assessment has been in use in Whitby for 6 years. The weekly referral meeting allocates two members of the team to see each patient (and carer) at home over the next week, reporting back to the next referral meeting. The care plan is confirmed and any other extra elements (e.g. a trial of medication or a further assessment involving another speciality) are added. A significant development over the past 3 years has been a greater demand for cholinesterase inhibitors by local GPs. The team decided that these referrals should be dealt with like all the others, as it was likely that all disciplines would be valuable in this 'early intervention' process for dementia care.

The gap between the date referred and date seen has been reduced from 21 days to 14 days over the past 3 years, despite an overall rise in referrals of 50% in the same time period. The service was also evaluated using a questionnaire survey of GP satisfaction, with a response rate of 79%. All the respondents were aware of the multi-disciplinary assessment system, and 85% valued it. There were similar responses to ongoing interventions and support for carers. When asked about access to the team, 80% reported this as 'easy' compared with 15% who had 'problems'. On response times, 85% considered them to be satisfactory, with 15% considering responses 'very prompt'. However, GPs appear to prefer even quicker responses, with 45% suggesting one week and 15% each suggesting 3 working days and 10 days, respectively.

When asked about the quality of information following initial assessment, 58% considered this to be 'good' and a further 32% 'adequate'. Overall satisfaction with services produced a response rate of 16% being excellent, 68% good, 16% satisfactory and 0% poor.

Although the team developed this service and were therefore enthusiastic for it to work, they had been running the joint domiciliary assessments for about 3 years before this evaluation, so the benefits were not part of a 'start-up effect'.

Conclusion

Multi-disciplinary team assessments are not new to psychiatry. There is considerable variation throughout the country in implementing such processes, but it is often primarily done in child and adolescent services and the younger adults' mental health services. The need to change and develop team systems of working in older persons' services is paramount due to the pressures on mental health professionals from demographic changes and the introduction of anti-dementia drugs.

This paper has described two different approaches to multi-disciplinary team assessments in old age mental health services that have been evaluated and shown to improve the service. They were developed and evaluated separately, but use the core concepts of team referrals, the use of non-medical members of the team to do the assessments and the use of team discussions of assessments to gain further multi-disciplinary input. They differ in the timing of the team discussions, one organising all discussions to take place immediately after the assessment and the other at the next routine meeting. There are relative merits of each approach, but they both need different organisation arrangements. Of particular note is that they have both succeeded in increasing the capacity for assessing older people, resulting in a removal of all waiting lists at a time when referrals have increased. This appears to have been done without lowering the quality of the assessments. It is possible that some of the effects

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might have been due to the enthusiasm of the teams, but the new assessment processes encouraged this enthusiasm.

Whether such quick assessments of more patients has an impact on other parts of the service is not known, and requires further research and evaluation.

Declaration of interest

None.

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Service innovations

An outreach support team for older people with mental illness — crisis intervention

AIMS AND METHOD
We describe activity and outcome concerning a consecutive series of older community patients referred to an outreach support team while waiting for acute psychiatric admission.

RESULTS
Forty patients on an admissions waiting list who were referred to the outreach support team were followed up. Each patient was reassessed for admission by the responsible medical officer when an in-patient bed became available. Thirty patients who would have been admitted (if a bed had been available at the time of the first assessment) remained at home and did not need hospitalisation.

CLINICAL IMPLICATIONS
This study suggests that intensive domiciliary support might offer an acceptable form of crisis intervention for older people with mental illness. Further research is needed before generalisation of these findings can be recommended.

The Cheshire and Wirral Partnership NHS Trust has approximately 57 000 Wirral residents aged 65 and over. The population is serviced by three-and-a-half whole-time equivalent consultants and three community mental health teams. Each team is led by a senior registered mental nurse and has a case coordinator. There are 15 community mental health nurses, three occupational therapists (and two assistants), two physiotherapists and four nursing auxiliaries/support workers. A functional day hospital supports the community teams. It is staffed by a nurse manager, a staff-grade doctor, three primary nurses, two associate nurses and two support workers. There are 24 acute functional beds and 30 acute organic beds servicing the population.

The outreach support team was established in November 1999 because of winter bed pressures within the acute geriatric wards at the local District General Hospital. These pressures led to the closure of 20 acute psychiatric beds for older patients. The team has three aims: to provide additional support to community mental health teams (CMHTs) for older, community patients experiencing crisis – irrespective of the nature of their mental illness; to reduce acute admissions and to facilitate early discharge from psychiatric in-patient care. The team is based within a day hospital facility and is staffed by six support workers with clinical work coordinated by a registered mental nurse.

The team provides services over a 12-hour day and operates 7 days a week. The activities of the team vary according to individual patient needs. They include monitoring the mental states of patients, monitoring fluid and dietary intake and compliance with medication assisting with physical care, supporting carers, helping patients with basic target setting and assisting patients in developing new coping skills. The patient is usually visited once or twice per day, but visits may take place more frequently if necessary. Most visits involve just one member of the team, but occasionally two or three staff are needed on a visit. Care is taken to try to prevent patients becoming dependent on the service. Referrals are accepted from consultants, CMHTs and in-patient units. Patients may have functional or organic disorders, and the service is available for any patient in crisis. The day hospital provides additional respite (daytime) support for functional patients and the in-patient units provide occasional day respite services for organic cases.

During its first 5 months, the outreach support team witnessed the referral of 59 patients, receiving 668 visits/units of activity. It must be emphasised that the team was establishing itself over this period, and was busy developing protocols and referral criteria while also engaged in clinical work. Of the 59 patients handled, a sub-group was referred for transient home support while on a waiting list for in-patient treatment. It was noted

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