Members of a community mental health team

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The aim was to find out if professions differed in their contributions to the workload of two multi-professional community mental health teams. Both teams aimed to provide community mental health care in London, targeting those with severe mental illness and using the care programme approach. Junior psychiatrists had fewer contacts than other professionals but medical staff tended to contribute more to assessments. Community mental health nurses tended to have the most contacts. Community mental health team planners should be aware of inter-professional differences when designing teams.

Community mental health teams (CMHTs) are being established in many centres but there is little information to guide service planners on the best constitution of such teams. One approach is to have a member of all relevant mental health professions, e.g. psychologist, social worker, occupational therapist, community mental health nurse (CMHN) or psychiatrist (Morgan, 1993). However, if the number of members in the team is smaller or larger than the number of professions the criterion of multi-disciplinarianism alone will not be sufficient to allow rational planning.

What other criteria could be used? Obviously the purposes of CMHTs differ and different criteria may be appropriate for different teams. For example, one team, might aim its service at providing rapid mental health assessments with multiple referral to other agencies for providing services. For this team, workers who are skilled or adept at large numbers of assessments may be more efficient; thus a psychiatrist may be more appropriate than a psychologist. Of course many individual practitioners would not accept this assumption, for example a psychiatrist trained in psychodynamic psychotherapy may be more suited to providing talking treatments and supervising others and a psychologist with wide experience in needs assessments more suited to assessments of new referrals. Another team may be directed towards the support of people with chronic, severe psychosis, who previously had frequent and chaotic service use; here a psychologist who could aim for a small, but crucial behavioural change over an extended period, e.g.

in dangerous smoking behaviour, may be more useful than a psychiatrist.

Most CMHTs will have most members of the team practising generically as mental health workers with only specific tasks allocated to specific professionals, e.g. formal psychometric testing by a psychologist (Ovretveit, 1993). Nevertheless the profession of origin may affect performance in the team, however explicit the team's commitment to generic working. By examining the record of teams the contribution to different tasks such as assessment or provision of community groups by profession can be noted and this information used in future team planning. Focusing on those with severe mental illness is a common aim of many CMHT and the degree to which team members achieve this focus is another dimension to guide team planners.

The study

All team contacts, from June to December 1994, with clients of two London community multi-disciplinary teams were recorded on a database. The teams were chosen because of the comprehensiveness and accessibility of the activity data they had collected. Both teams took referrals from statutory services, non-statutory services and self-referrals. Both teams invited joint working with the referring agency where appropriate. Two clinical workers were usually assigned to each case taken on initially, with either one or both workers continuing according to decisions made at the twice weekly multidisciplinary (including consultant) review meetings. Both teams had priorities of seeing people with major mental illness and providing packages of care in the community, but including hospital-based psychiatric services. Table 1 shows the professional make-up of the two teams. Simple activity codes were used allowing assessment and on-going and group treatments to be distinguished.

The amount of clinical time available for each individual post holder was assessed taking into account:

(1) Time in each post for team clinical work (as opposed to management or research or

work for another team). Each post holder was asked for this time and responses of the post holders checked with the team manager.

(2) Joining the team – the first month was not included as few cases were seen initially. Totals were adjusted proportionately to allow valid comparisons to be made with established staff.

(3) Leaving the team – totals were adjusted proportionately to the amount of time the post was occupied, if a team member left the team before the period of study ended. If two individuals held the post during the period of study, their activities were summated. The amount of time for each post is shown in Table 1.

Diagnoses were reached during the multi-professional team meetings or in other consultation with the psychiatric team members. Severe mental illness is defined here as the main diagnosis for the clinical episode being schizophrenia (ICD–10; F20), delusional disorder (F22 and F24), unspecified non-organic psychosis (F23, F28, F29), bipolar affective disorder (F30, F31) or severe depressive disorder (F32.2, F32.3, F33.2, F33.3).

Findings

In total, 2408 face-to-face contacts were recorded by all team members. The consultant activities differed considerably between the two teams – in team B the consultant had only two sessions and acted as a consultant (i.e. expert advisor) to review meetings, a role suggested by Onyett (1992), whereas in team A the consultant had five sessions with much hands-on clinical activity. To allow comparison between the two teams, the consultant's contribution in team A has been excluded from the team's total workload. It has been included in Fig. 1 to allow comparison within team A, so that team A's summed percentages are greater than 100%.

Overall, the CMHNs had the most face-to-face contacts, followed by the consultant (Fig. 1).

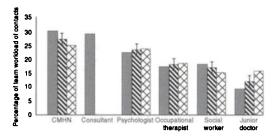Figure 1. Total contacts by profession. ■, team A =1125; ☒, team B=1283, ▨, weighted mean of both teams
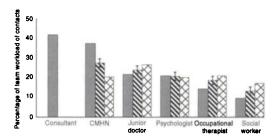

Figure 2. Percentage of teams' assessments by profession. ■, team A=457; ☒, team B=426; ▨, weighted mean of both
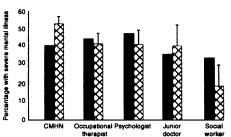

Figure 3. Diagnostic casemix by profession for team B. ■, episodes (n=201); ☒, contacts (n=1283)

Consultant figures may be misleading as there are only two posts, i.e. 0.8 whole time equivalent in total. Psychologists and occupational therapists were intermediate, with the social workers then junior psychiatrists behind. Excluding group contacts, the ordering of the professions was not changed. Medical staff see relatively more assessments (Fig. 2), especially the consultant in team A.

Diagnostic case mix data were available for only team B, which routinely collected the ICD–10 diagnosis (Fig. 3). An episode is a period of open case management, so that the number of

Table 1. Constitution of teams – expressed as fractions of whole time equivalents

	Team A	Team B
Community mental health nurse	1+1	1+1+1
Consultant	0.5	0.2
Occupational therapist	0.6+0.5	1+0.5
Junior psychiatrist	0.6+0.3	0.6
Psychologist	0.8	0.5+0.5
Social worker	0.5	0.9
Total	5.8	7.2

open episodes for each team member is the case-load. This showed that while each profession took on roughly 40% of cases with severe mental illness, CMHNs spent more than 50% of their time with those patients, while social workers spent less than 20%.

Comment

An obvious limitation of this study is the crudity of the measure of staff activity. For example, multiple brief visits by a CMHN may be less useful than a single, prolonged and carefully planned family meeting by a social worker. Both may be useful interventions in different clinical situations and the number of contacts or assessments is only a process (rather than clinical outcome) measure of useful contribution to the team's work. It would be desirable to analyse more detailed measures of the content of the clinical activity such as the number of significant others seen or the duration of the contact. One serious practical drawback of this would be the increased load on clinician's time in collecting such data.

The differences detected here may be due to personal factors, e.g. enthusiasm, commitment to the team's aims rather than professional factors as only 20 workers in two teams were monitored. Clearly this limits the generalisability of the results. However, the two teams gave remarkably similar patterns of activity distribution between the professions (apart from the consultant figures where different roles were adopted). Thus it is likely that professional factors also operate and from these more general conclusions may be drawn.

CMHNs emerge as having the most total contacts. This may reflect the fact that all the posts were of 1.0 whole time equivalent which reduces the impact of clinical review, business and staff support meetings. Teams with the limited but not unfashionable aim of maximising face-to-face clinical contacts for the least cost should consider emphasising CMHNs in their make-up.

Junior psychiatrists make a low contribution generally but contribute more significantly to assessments, as do the consultants. They and their teams may feel that their diagnostic skills are best used in seeing large number of new patients rather than in carrying out specific therapies or providing monitoring. This result may be expected for junior psychiatrists who

may only be in the team for six months, making certain forms of treatment problematic, e.g. long-term supportive psychotherapy. Consultant contact numbers are small, making conclusions difficult but they are often in teams for longer and may be the longest serving member of a team, making them well-placed to take a long-term view of treatment; it may be that their tendency to make relatively more assessments than treatment contacts reflects the fact that they see patients less often but over a longer period. A team geared towards assessments should consider maximising the psychiatric staffing input to it.

The severely mentally ill case-load was evenly spread between professions, suggesting that all were equally willing to take on referrals of such patients. The junior psychiatrists and CMHNs spent more of their contacts with severely mentally ill patients than the proportion of their case-load with such diagnoses, while the opposite was true for occupational therapists, psychologists and the social worker, although differences were small. While only one team's case-load is analysable in this way, it does suggest that the more 'medical' professionals are less easily distracted towards neurotic and personality disordered patients. Managers designing teams to fulfil commissioners' contracts should be aware of these findings.

Acknowledgements

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References

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