Prioritising referrals to a community mental health team

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SUMMARY
Background. *Current national policies encourage prioritisation of people with severe mental illness (SMI) as well as the development of a primary care-led National Health Service. Where resources for mental health are limited, there is a potential conflict between the needs of people with SMI and the much more common depressive and anxiety disorders that form the bulk of the mental health workload in primary care.*
Aim. *To describe the re-organisation of a community mental health team in order to prioritise people with SMI.*
Method. *The number and type of referrals received in the 12 months before and after re-organisation were compared, and general practitioners' (GP) views on the changes sought.*
Results. *There was a significant reduction in GP referrals of patients with less severe disorders in the second year. In both years the proportion of patients with a possible psychotic diagnosis or risk of self-harm was much higher among referrals from within the psychiatry department (92% of referrals) than among GP referrals (20% of referrals). Using data from a postal survey, 46% of referring GPs reported a significant improvement in the service provided to patients with SMI, but 34% reported a deterioration in services for other patient groups. GPs were more likely to be satisfied with the service for people with SMI than with the service for other patient groups.*
Conclusions. *Improvements in the service provided for those with SMI can be achieved, but this may be at the expense of services for other patient groups. Primary care groups will need to consider this potential conflict in setting priorities for mental health.*

Keywords: *mental health care; severe mental health; prioritisation.*

Introduction

COMMUNITY psychiatric nurses (CPNs) were first appointed in the 1950s to provide after-care for patients discharged from the mental hospitals. Their numbers have grown rapidly since then,[1] with CPNs increasingly becoming based in primary care or within multidisciplinary community mental health teams (CMHTs).[2] There have also been changes in the type of work undertaken, with CPNs receiving more referrals directly from general practitioners (GPs)[3] and non-medical sources,[4] and working in different ways to hospital-based CPNs.[5] A national survey of primary care-based counsellors found that CPNs were the professional group most likely to be undertaking this work, with 12% of all practices surveyed having a CPN counsellor.[6]

This change in emphasis has raised concern that more severely ill patient groups may be neglected. In a national survey of CPNs, only 27% of the total caseload was made up of people suffering from schizophrenia, and one-quarter of CPNs saw no patients with schizophrenia. Similarly, CPNs in Salford[7] saw fewer patients with psychotic illness and spent less time with patients with severe mental illness (SMI) than with those suffering from anxiety or depression. The shift towards the development of CMHTs does not appear to have adequately addressed these concerns, with a continued lack of emphasis on the care of those with more severe mental illness.[8,9]

Concern about such changes in working practice has been accompanied by the public perception that community care is failing.[10,11] This appears to have led to a shift in national policy towards the prioritisation of those with SMI,[12,13] but, in the absence of additional funding for mental health, affording higher priority to those with SMI is likely to mean a reduction in service to those with a less severe illness. This creates an inevitable tension with the demands of primary care, where neurotic disorders are more common and time-consuming for GPs than the small number of patients with SMI per practice.[14,15]

A number of authors have suggested how these tensions might be addressed.[16] CMHTs are encouraged to agree referral criteria with local practices, to ensure information is available about other mental health resources, and develop a practice liaison model involving a link between one member of the CMHT and each practice. Primary care teams are encouraged to develop registers of patients with SMI and agree procedures for care planning and review.[17] Few studies to date have evaluated the impact of any such changes on the workload of CMHTs or CPNs.

This study describes the work of a single CMHT covering a population of approximately 40 000 in a deprived inner-city area; part of a health district reported to have the highest level of need for mental health services in England.[18] At the start of the study period, the CMHT consisted entirely of CPNs. They had worked autonomously for several years, accepting the majority of referrals from primary care but also carrying large caseloads of patients with SMI. A separate community rehabilitation team accepted referrals from secondary services and worked with much smaller caseloads.

We report the measures taken to prioritise people with severe mental illness while developing links with primary care. The impact on referral patterns is described using routine referral data collected before and after the changes. The views of referring GPs are also reported.

Method

During 1995 and 1996, data were collected on all referrals to a CMHT covering one geographical sector within central Manchester. Medical and non-medical referrals were preserved as separate streams but recorded and discussed at a single sector allocation meeting. Information was collected on source of referral, patient demographics, and type of referral. A checklist was developed of items within the referral letter that might indicate a psychotic illness (for example, hearing voices, past history, paranoid ideas, suggestion of hyperactivity) or possible suicide risk (recent self-harm, suicidal ideation). All referral letters were rated by the author as possible psychotic illness, possible suicide risk, or neither of the above. In order to assess reliability of these

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ratings, 50 referral letters were re-rated blind by an independent researcher, with 100% agreement between raters.

At the end of the study period, all referring GPs were asked for their views about the service by postal survey. The GPs were asked to distinguish between the service provided to patients with 'major mental illness; for example, schizophrenia or manic depression', and the service provided for patients with 'other mental health problems; for example, depression/anxiety'. For each category, GPs were asked about perceived changes in the service during the study period (rated as improved, not changed, deteriorated) and for their current levels of satisfaction with the service (dissatisfied, neutral, satisfied) on the following items: direct liaison with professionals, written communication, access to services in an emergency, access to services in a routine situation, and overall quality of service. General comments were also invited.

Interventions

During 1995, the details of all referrals to CPNs, the community rehabilitation team, and medical staff were recorded. An audit of the caseloads of the two teams showed that many of the patients seen by CPNs were as severely ill as those seen by the community rehabilitation team.[19] A gradual transition was made towards a single CMHT with a single referral mechanism. Two additional members of staff were employed and staff were encouraged to receive training in psychosocial interventions for patients with SMI.

In light of the referral data from the first year, the audit of caseloads, and the national priority given towards SMI, it was decided at the start of 1996 to limit the work undertaken by the team with patients who would not be considered as suffering from SMI. This involved the following interventions, implemented during the first three months of 1996:

- A letter was sent to all GPs explaining the need to prioritise patients with SMI, explaining the type of referrals considered appropriate, and inviting further discussion.
- This was followed up by personal visits to most practices by the author. GPs were provided with feedback about their referral patterns during the previous year and the reasons for prioritising work with the severely mentally ill population explained.
- The author and a team member were invited to speak at the local GP postgraduate meeting. Data on referral patterns over the past year were presented plus statistics on the high level of need in the area. A full discussion took place about appropriate referrals and other potential sources of help.
- A member of the CMHT took on the role of link worker with each of the local practices. This involved monthly visits to practice meetings as a point of communication. The practices were provided with feedback about their patients registered on the Care Programme Approach and information about local mental health services. Individual patients could be discussed to decide if referral was indicated.
- A small number of referrals that were considered inappropriate were refused. This was always done by the author in writing, with suggestions for other management and an invitation to contact JH if the referrer wished to discuss this further.
- No attempt was made to influence the type or number of referrals to psychiatrists.

None of the referring GPs were fundholders at the time of the study.

Results

Referrals to community team

A total of 140 referrals to the community team were received in 1995 and 111 in 1996, including 13 that were turned down in 1996. In all, 74% of referrals were from GPs in 1995 and 66% in 1996; most of the remainder being from within the psychiatry department. The mean monthly referral rate from GPs was 8.6 in 1995 (range = 3 to 12) and 6.1 in 1996 (range = 3 to 10). Using the Wilcoxon matched pairs test to compare referrals for each month in 1995 and 1996, a significant reduction in referral rates to community staff was seen during 1996 ($P = 0.01$). One hundred and eighty referrals from GPs to psychiatrists were received in 1995, and 197 in 1996. No significant difference was seen in monthly referral rates to psychiatrists for the two years.

Referrals that were rated as the patient being possibly psychotic or a possible suicide risk were combined into a 'priority' category. For both years, the proportion of referrals in the priority category was much higher from the psychiatry department (95% in 1995 and 90% in 1996) than from the GPs (15% in 1995 and 26% in 1996) ($P<0.001$) (Table 1). The reduction in referral rates in 1996 was accounted for entirely by the non-priority cases with a small but non-significant increase in the number of priority referrals from GPs in 1996.

GPs' views

A total of 40 GPs referred to the service during the study period, of whom 12 (30%) were single-handed and 28 (70%) worked in group practices. Thirty (75%) GPs returned questionnaires. One-third of single-handed GPs did not return questionnaires, as compared with 18% of GPs in group practices. This difference was not statistically significant.

Most GPs felt that the service for patients with SMI had either improved (46%) or had not changed (39%). The greatest improvements were felt to be in communication with professionals, both in person and in writing (45% reporting improvement), and in the overall quality of the service (Table 2). GPs perceived little change in access to services for patients with SMI. In contrast, few GPs reported improvements in the service for other patient groups, and most felt that access to services for other patient groups had deteriorated. A total of 59% of GPs reported no change in the quality of service for other patient groups, and 34% felt that the quality of service for other patient groups had deteriorated. On all five aspects of service delivery, the ratings of change were much more positive for patients with SMI than for other patient groups.

General practitioner ratings of satisfaction with current services showed a similar pattern (Table 3). GPs were most likely to be satisfied with communication with professionals and were dissatisfied with access to services for both patient groups. In all, 38% of GPs reported dissatisfaction with the overall quality of service for patients not in the severely mentally ill group, as compared with 18% for the severely mentally ill group ($P = 0.001$). There was a tendency for GPs to be more satisfied with all aspects of the service for patients with SMI than for other patient groups, although this was only statistically significant in relation to direct liaison with professionals and access to services in an emergency ($P<0.05$).

Discussion

The absence of a true control group limits the ability of the study to establish a causal relationship between the interventions described and the change in referral rates. The association is strengthened by the fact that the more commonly observed trend

Table 1. Type of referral by source.

Source of referral	1995 Priority[b]	1995 Non-priority	1996 Priority	1996 Non-priority	Total[a] Priority	Total[a] Non-priority
General practitioner	15 (15%)	82 (85%)	19 (26%)	54 (74%)	34 (20%)	136 (80%)
Psychiatry services	35 (95%)	2 (5%)	34 (90%)	4 (10%)	69 (92%)	6 (8%)

[a]Fisher's exact test, P<0.001; [b]priority cases included suggestion of psychotic illness or mania or risk to self (see text).

Table 2. GPs' views of change in service during study period.

	Services for patients with serious mental illness (e.g. schizophrenia/manic depression)			Services for patients with other illnesses (e.g. anxiety/depression)			P-value (Wilcoxon matched pairs test)
	Deteriorated	No change	Improved	Deteriorated	No change	Improved	
Direct liaison with professionals	2 (7%)	14 (48%)	13 (45%)	4 (14%)	19 (65%)	6 (21%)	0.005
Written communication	2 (7%)	14 (48%)	13 (45%)	2 (7%)	23 (79%)	4 (14%)	0.011
Access to services in an emergency	7 (24%)	12 (41%)	10 (35%)	9 (32%)	17 (61%)	2 (7%)	0.008
Access to services in routine situation	9 (30%)	17 (57%)	3 (10%)	15 (52%)	14 (48%)	0 (0%)	0.033
Overall quality of service	4 (14%)	11 (39%)	13 (46%)	10 (34%)	17 (59%)	2 (7%)	0.004

Table 3. GP satisfaction with current service.

	Services for patients with serious mental illness (e.g. schizophrenia/manic depression)			Services for patients with other illnesses (e.g. anxiety/depression)			P-value (Wilcoxon matched pairs test)
	Dissatisfied	Neutral	Satisfied	Dissatisfied	Neutral	Satisfied	
Direct liaison with professionals	3 (10%)	10 (35%)	16 (53%)	8 (28%)	10 (34%)	11 (38%)	0.038
Written communication	4 (14%)	11 (38%)	14 (48%)	5 (17%)	14 (48%)	10 (34%)	0.102
Access to services in an emergency	12 (43%)	8 (29%)	8 (29%)	15 (54%)	10 (36%)	3 (11%)	0.029
Access to services in routine situation	13 (45%)	11 (38%)	5 (17%)	17 (59%)	10 (35%)	2 (7%)	0.058
Overall quality of service	5 (18%)	13 (48%)	9 (33%)	11 (38%)	13 (45%)	5 (17%)	0.001

is for referral rates to CMHTs to increase with time[9,20] and the absence of any change in referral rates to psychiatrists during the same period.

The study is also limited by the lack of specificity of the interventions. It is not possible to say whether the changes in referral pattern and GP satisfaction were attributable to the development of a link-worker role, the appointment of two extra members of staff, or the change in emphasis of the team. Further research is needed to clarify the contributions of these components.

In an ideal world, the changes in service would have been negotiated in detail between purchasers and providers of care with the opportunity for full consultation. In reality, the contracting process at that time did not appear sensitive enough to allow for such an approach, and the changes were driven by the desire to improve services for patients with SMI and to reduce pressure on inpatient beds. While GPs were widely consulted and kept informed of the changes, our service model may be criticised for not being primary care-led. We were also able to implement change more easily in the absence of any GP fundholders in the sector.[21]

The possible presence of a psychotic illness has been used as a proxy for SMI. This is clearly an over-simplification, but there is no current consensus on the definition of SMI.[22] While patients with a psychotic illness would always be considered a priority for our CMHT, many patients with other diagnoses are also accepted for services. The small numbers of patients who were not accepted by the CMHT were mainly those with no indication of mental illness. For example, some patients were referred because they were 'very upset' or 'in need of support'. In these cases, GPs were invited to refer back to the service if clear signs of mental illness emerged or symptoms did not improve with time or other treatment.

The CMHT staff believe that the reduction in referral rates has increased their capacity to provide focused care for patients with SMI, and the GP ratings support this view. Debate continues about the most effective models of service delivery for patients with SMI,[23] but a number of factors relating to the organisation of services appear to be important in predicting improved outcomes. These include a multidisciplinary team approach,[24] small caseloads with assertive follow-up,[23] and appropriate training — particularly in psychosocial interventions[5,25] — all of which were incorporated into our service re-organisation.

Although few referrals were turned down, local GPs are clearly dissatisfied with the service available for patients who do not have SMI, and many feel the service available for these patients has deteriorated at the expense of an improved service for those with more severe illness. This highlights a potential policy conflict that has been commented on by others.[16,26,27] Well coordinated and efficient community care for patients with SMI requires a clear focus and prioritisation of this group,[2] but a primary care-led National Health Service may chose to prioritise different patient groups, particularly the more prevalent neurotic

disorders that form a large part of the workload in primary care.[14] With the advent of primary care groups, the need to reconcile these competing priorities is likely to become more acute.

Three broad strategies have been proposed to address this potential conflict: locating mental health professionals within primary care, developing consultation/liaison models of working, and improved training in mental health for primary care teams. Establishing CMHTs in primary care has been shown to increase GP satisfaction with services,[28] but also results in an increase in referral rates for patients with depression and anxiety[20] and no apparent improvement in the ability of GPs to detect and manage mental illness.[28] Many practices have employed additional mental health workers[6,29] but the treatments offered have not always been of proven benefit. For example, the growth in practice-based counsellors represents a considerable diversion of mental health resources without any clear research evidence for the efficacy of counselling.[30] Priority should be given to employing staff who can offer treatments of proven efficacy, such as cognitive and behavioural therapies.[31]

Much of the research on consultation/liaison models has concentrated on visits to general practice by psychiatrists,[32,33] but it is questionable whether this model is practicable across a whole service, with 12 times as many GPs as psychiatrists nationally. A liaison or link-worker role for non-medical community staff has also been proposed,[16] and this was the model we adopted. Further research is needed to examine the impact of such a change on the work of the primary care team.

Better training for primary care staff in dealing with mental illness is also important. Training packages already exist for GPs[34,35] and practice nurses,[36] but uptake is variable. If high-referring practices could be supported in treating more of their own patients without recourse to referral, this should free up time to provide more specialist care for those most likely to benefit.

Even with such a reduction in referrals, however, there is little capacity within our CMHT to take on patients who do not have SMI. Nationally there appears to be wide variation in access to community mental health services for patients without SMI,[37] with higher proportions of patients with SMI on the caseloads of teams in urban areas.[2] The GPs surveyed were not asked to state a preference for better services for patients with SMI or other patient groups, as this was thought to present a false dichotomy. In practice, most appear to accept the need to prioritise the more severely ill, but feel the resources committed to mental health in the most deprived inner-city areas remain inadequate. This suggestion is emphasised by the very small number of referrals from within the psychiatry department of patients who did not show signs of major mental illness or risk to self. It seems likely that many patients with long-term and disabling neurotic illnesses are being denied the opportunity of a multidisciplinary approach because of limited resources.

Conclusion

The data presented suggest that it is possible to improve the service available for patients with SMI through a number of organisational changes. However, the re-organisation appears to have been achieved at the expense of the service to other patient groups. If the potentially conflicting demands of primary and secondary care services are to be resolved, primary care teams need greater assistance in dealing with patients with less severe illness. This may involve greater emphasis on training and further development of liaison roles. If existing mental health services are already dealing with an almost exclusively severely ill population, additional resources are likely to be needed to meet the needs of other patient groups.

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