Improving referral information in community mental health

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This article explains how a questionnaire to improve the quality of information about clients referred to a community mental health team was devised. The questionnaire was drawn up with the help of the local advocacy service and service-user representatives, and led to improved information that enabled us to improve our service to clients.

The quality of information on some referrals to the community mental health team (CMHT) caused difficulties for both those clients and professionals dealing with the referral. The team wanted to improve the information they received to help in decision-making. For example, in the allocation process, the team wanted to include people for whom the service is suitable and to help direct others to services more appropriate for their needs.

The team decided to improve the information supplied by adopting a questionnaire for clients to complete before assessment. This was developed and piloted in our clinical psychology service.

The CMHT is multidisciplinary and consists of psychiatry, nursing, psychology, occupational health, social work and secretarial staff. Before this initiative, referrals were discussed and allocated based on what was considered the most appropriate intervention. This depended largely on information in the referral letter. However, in some letters, the information was relatively poor, which often led to the referral being put on hold while team members made a series of telephone calls and letters to collect more information. This was often frustrating for staff and certainly not helpful to the people referred.

Additionally, decisions may have been made to allocate services on the assumption that referral information was accurate when it was not. Some clients may, therefore, have missed being referred to other, more suitable services at the outset.

Team members had expertise in modernisation, which involved ‘plan-do-study-act’ (PDSA) cycles (Langley et al, 1996). The team identified poor information in some referrals as an improvement hotspot. A PDSA cycle was used to tackle this.

Planning component of PDSA cycle

To improve the information about clients and the service they received, the team decided to use a self-assessment questionnaire (SAQ). This was developed collaboratively by the local department of psychological services, advocacy service and service-user representatives, and designed to enable people who have been referred to complete it before being seen for assessment. A PDSA study of 50 consecutive referrals to the department of psychological services gave a favourable response, with the opt-in rate to that service improving from 54 per cent to 64 per cent. Also, clients viewed the SAQ favourably.

The SAQ consists of 20 areas, including clients’ problems and their longevity and perceived cause, background details (such as employment status), health details (such as sleep and eating habits) and details of any prescribed medication. Clients were also asked to complete a hospital anxiety and depression scale (HADS) (Zigmond and Snaith, 1983).

A covering letter asked clients to return the SAQ in...
a stamped addressed envelope provided within three weeks. It advised them to contact the team if they needed help with the SAQ and stressed that they would still be offered an appointment if they did not complete it. They were also given information on confidentiality.

The SAQ was sent to 50 people consecutively referred to the team. The input to clients was decided when their information was received. There were no major problems with the new procedure.

**Study component of the PDSA cycle**

From the 50 questionnaires sent out, 40 replies were received (80 per cent return rate). Ten people did not return the SAQ and made no contact with the team. Of the 40 returns, four people returned the SAQ uncompleted but wished to be seen.

In all, 36 completed SAQs (72 per cent) were returned. There was an excellent completion rate of the 20 areas of the SAQ: 11 areas were completed by all 36 clients; five were completed by 35; one area was completed by 33; and another by 30. The two least-completed areas were ‘suggestions’ about the questionnaire (completed by 20) and ‘issues not covered’ in the questionnaire (completed by eight).

The sample consisted of 25 men and 25 women with a mean age of 36.68 years (sd=11.43). The mean longevity of problems was 8.25 years (sd=8.90) and the most frequently reported were depression (16 out of 36; 44.4 per cent), anxiety (nine; 25 per cent) and anger, obsessive compulsive disorder and post-traumatic stress syndrome (each reported by two clients; 5.5 per cent). The HADS scores were mainly typical for clients referred.

The team felt the questionnaire improved the quality of information before face-to-face assessment and consequently improved the service.

The improved information helped the team in the planning and prioritisation of waiting lists for therapy. The team also improved client choice and treatment options because better information helped with planning the most appropriate options. For example, it helped the team identify clients who might benefit from self-help literature while they were waiting to be seen.

The team felt the SAQ had improved attendance rates, possibly because it engaged people before they were seen and sifted out those who did not wish to be seen. Extra information meant decisions about interventions could be made more quickly. These factors were seen as being important in improving attendance, as those who were more likely to attend were probably identified in the SAQ process.

The team wanted to ensure that the use of the SAQ was fair and ethical and that it improved the outcome for clients: decisions made using it were compared with those made for 50 consecutive clients referred using the previous procedure (Table 1).

<table>
<thead>
<tr>
<th>TABLE 2. POSITIVE AND NEGATIVE COMMENTS ABOUT THE QUESTIONNAIRE</th>
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<tbody>
<tr>
<td><strong>16 people gave positive statements including:</strong></td>
</tr>
<tr>
<td>• ‘It was no problem.’</td>
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<tr>
<td>• ‘It was easy to understand.’</td>
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<tr>
<td>• ‘The questions were straightforward.’</td>
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<tr>
<td>• ‘Good that questions are asked before I’m seen.’</td>
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<tr>
<td>• ‘Gives a good knowledge of my background.’</td>
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<tr>
<td>• ‘Should help you understand my condition.’</td>
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<tr>
<td><strong>Four people gave negative statements, including:</strong></td>
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<tr>
<td>• ‘How confidential is it?’</td>
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<tr>
<td>• ‘It was a burden.’</td>
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<tr>
<td>• ‘There were too many questions.’</td>
</tr>
<tr>
<td>• ‘I had to motivate myself to complete it.’</td>
</tr>
</tbody>
</table>

**Were clients satisfied with the SAQ?**

The final question in the SAQ was: ‘Our team is trying to improve the way we ask questions. Please tell us how you felt about completing this, and feel free to make suggestions for improvement.’ Responses were grouped as either ‘positive’ or ‘negative’. Sixteen people gave a total of 23 positive statements and four gave a total of five negative statements (Table 2).

The team felt the responses gave a good outline of clients’ background and problems (sometimes not indicated in the referral letter) and helped practitioners relate to clients before seeing them.

**Act component of the PDSA cycle**

It was felt that the SAQ had improved the team’s service to clients. The data was discussed within the team and in wider forums attended by mental health workers and service users. It was felt that the SAQ was useful for identifying risks that may not be mentioned in referral letters. Clients’ SAQ responses indicated problems that had not been included in their referral letters, concerning sleep and lack of knowledge about their medication.

Areas for action included:

- To continue using the SAQ;
- To improve the team’s use of self-help leaflets (for example, leaflets on improving sleep as well as more ‘traditional’ leaflets on depression and anxiety);
- Better information for clients about medication;
- To lessen the waiting time for initial face-to-face appointments following completion of the SAQ;
- To discuss our findings with the relevant referral agencies to further improve referral information.

**Conclusion**

Developing the questionnaire through the PDSA cycle has been a clear success. The team has discussed the data and believe the SAQ is beneficial for both clients and staff. The SAQ approach is adaptable for other CMHTs and other areas of mental health work.

**References**
