

## A STUDY OF TWO COMMUNITY MENTAL HANDICAP TEAMS IN SCOTLAND

D. A. COOPER <sup>1)</sup> and K. G. BONHAM <sup>2)</sup>

### INTRODUCTION

In recent years there has been a dramatic change in the philosophy regarding what constitutes appropriate provisions for mentally handicapped people in Britain. The conceptual shift towards emphasis on community resources has been reflected in recommendations for service planning, one of these recommendations being the establishment of Community Mental Handicap Teams (National Development Group 1976, 1980; Development Team for the Mentally Handicapped, 1978). The Development Team for the Mentally Handicapped (1978) stated that although many of the needs of the mentally handicapped and their families were being met by various professionals, "the help is frequently unco-ordinated and fragmented, and insufficiently related to the needs of the family". These authors envisaged the development of Community Mental Handicap Teams (CMHTs) as providing a co-ordinated multidisciplinary approach to specialised support and assessment services for mentally handicapped people and their families. In this report, the Development Team specified certain functions which the CMHT should embrace. These functions included, for example, specialist counselling and support for families in adjusting to having a mentally handicapped member, specialist advice on day-to-day care and management of a handicapped person, and help for particular difficulties such as behaviour problems.

The regular members of such a team would, according to this report, be:

Nurses trained and experienced in mental handicap,

Social Workers,

Consultants in Mental Handicap,

Clinical Psychologists,

Occupational Therapists, Physiotherapists and Speech Therapists.

Others who would be involved to varying degrees would include specialist Health Visitors, Paediatricians and General Practitioners.

The same authors reaffirmed their convictions in their third report (Development Team for the Mentally Handicapped, 1982) in the statement "We regard the establishment of Community Mental Handicap Teams as one of the most important ways of promoting well co-ordinated local services for mentally handicapped people and their families".

The development of this type of service has been welcomed by independent groups such as the Campaign for Mentally Handicapped People (Plank, 1982).

In many areas, the CMHT now forms part of the service provision for mentally handicapped people and their families, and elsewhere new teams are being planned and developed. It can be most useful for those in the process of establishing new CMHTs to know something of the work of similar existing services. Furthermore, as a relatively recent development of service, the CMHT warrants evaluative study.

1) Greater Glasgow Health Board, Glasgow

2) Merchiston Hospital, Brookfield by Johnstone, Renfrewshire, Scotland. All correspondence to this address.

This paper presents an analysis of the work of two Scottish CMHTs, based at St. Joseph's Hospital, Midlothian, and at Merchiston Hospital, Renfrewshire. The conception, development and running of the Midlothian Team has been described in detail recently in the literature (Davies, 1986). The aims in our study were to examine the use of these services and from this to comment on further service planning.

## STUDY DESIGN

The CMHT at St. Joseph's Hospital serves a suburban and semi-rural population of approximately 82,000. It was set up formally at the beginning of 1983, with input as follows:

Consultant Psychiatrist	3 sessions per week
Community Nurses	30 sessions per week
Psychiatric Registrar	1 session per week
Clinical Psychologist	2 sessions per week

In addition, a senior member of the Area Social Work Department attended the weekly team meeting to advise and liaise, and the team also had access to a Speech Therapist and an Occupational Therapist when their special skills were needed.

A primary function of the weekly team meetings was to allocate new referrals to the people felt to be most appropriate as key workers. Referrals were also discussed after their initial assessment in order to formulate more definitive management strategies. In addition, the meetings served as a forum for multi-disciplinary discussion on ongoing cases, particularly those where the problems were complex or multifaceted. In this way, the team meetings fostered cohesion and co-ordination.

The catchment population for the CMHT at Merchiston Hospital is about 380,000, again distributed in a suburban and semi-rural area. This CMHT was established in May 1985 with the following time commitments:

3 Consultant Psychiatrists	4½ sessions per week total
Senior Registrar	2 sessions per week
Community Nurse	5 sessions per week
Clinical Psychologist	2 sessions per week
Social Worker	3 sessions per week
Associate Specialist (from August, 1985)	½ session per week
Second Community Nurse (from September, 1985)	1 session per week

The Assistant Director of Nursing also attended the monthly team meetings, which served similar functions to those described above for the St. Joseph's Team.

Data was collected on all new referrals to St. Joseph's CMHT during the 18 month period from January, 1983 to the end of June, 1984. Information was gained both from case records and also directly from team members. For the Merchiston study, survey forms were completed for all new referrals to the CMHT during the first six months of its operation. Referrals were deemed to be 'new' if there had been no previous contact with that individual, or if at least six months had elapsed since last contact with the hospital's community services.

## RESULTS

### 1. Those Referred

During the 18 month period studied at St. Joseph's, there were 34 new referrals to the Community Team, 18 males and 16 females. There had been no previous contact with 27 of these. Referrals were made at a fairly constant rate of about 2 per month. (Histogram 1). Those referred ranged in age from 5 years to 74 years, with mean ages of 26 years for males, and 29 years for females. (Histograms 2 and 3). The modal age range for both sexes was 21 to 30 years.

Although the degree of handicap was not formally assessed in all cases, there was representation of all levels from borderline handicap downwards in both studies.

The number of new referrals to Merchiston Hospital CMHT was 25, 14 males and 11 females. Histogram 4 shows the trend of increase in the referral rate over the six months studied. Mean ages at referral were 26 years for males and 25 years for females, with modal age ranges 11 to 20 years for both sexes. (Histograms 5 and 6).

Table 1 shows an analysis of the places of residence of those referred. In both studies, two thirds of the referrals were living in a family group, either with natural parents, foster parents or a sibling.

**Table 1:**  
Place of Residence at Time of Referral

<i>Place of Residence</i>	<i>St. Joseph's</i>	<i>Merchiston</i>
Both natural parents ± sibs.	13	14
Single parents ± sibs.	7	2
Foster parents	1	0
Sibling + spouse	1	1
Alone	1	0
Friend	1	0
Lodgings	2	0
Special accommodation for handicapped	3	8
General psychiatric hospital	1	0
St. Josephs Hospital (referred just prior to discharge)	4	0

### 2. Reasons for Referral

The problems presented and intervention requested were diverse but may be categorised as in Table 2. As shown in this table, only one third of referrals to both CMHTs were made specifically for the assessment and treatment of behavioural or psychiatric problems, what one might call "illness", whilst two thirds concerned residential placements, training issues and community support.

**Table 2:**  
Reasons for Referral

<i>Reasons for Referral</i>	<i>St. Joseph's</i>	<i>Merchiston</i>
Behavioural Problems	7	7
Neurotic symptoms	4	1
Long term support and practical help at home	7	8
Assessment and help to find residential placement	6	3
Requests for relief admissions	5	2
Assessment and advice on A.T.C. programme	2	4
Request for day care	1	0
Request for night sitter service	1	0
Intellectual assessment for court case	1	0

**3. Referring Agents**

The sources of referral are shown in Table 3. It is of note that over three quarters of the referrals to each CMHT came from various community based agents and less than one quarter from hospital staff.

**Table 3:**  
Referring Agents

			<i>St. Joseph's Hospital in Roman script</i>	<i>Merchiston Hospital in Italics</i>
M.H. inpatient team	4 1	} Hospital based health service	}	}
General psychiatrist	3 0			
Clinical psychologist	1 0			
Paediatrician	0 4			
		8 5		
G.P.	9 3	} Community based health service	}	}
School M.O.	2 3			
Community health doctor	1 0			
Health visitor	1 0			
		13 6		
Social worker	7 4	} S.W. dept.	}	}
A.T.C.	4 4			
		11 8		
Relative	1 0	} Community based agents	}	}
Solicitor	1 0			
Voluntary agencies	0 6			

#### **4. Duration of Contact**

Six months after initial referral, active contact had ceased in only one quarter (9) of the St. Joseph's cases. Involvement continued for more than a year with the majority (20) of their referrals. Two of the referrals were not actually seen by team members, the request for help being re-directed after liaison with the referring agent.

In contrast, Merchiston CMHT tended to discontinue active involvement after a shorter period of time. The length of contact was less than six months in two thirds (16) of their referrals.

#### **5. Interventions Offered**

Both teams relied principally on the assessment and management of referrals in the handicapped person's own environment and both were ready to respond to crisis situations at short notice. Overall co-ordination for individual referrals was the responsibility of the nominated key worker, but it was not uncommon for several professionals to be involved in the management of a referral over a period of time.

The following examples are illustrative:

##### **Case 1**

A 52 year old mildly handicapped woman was referred because of neurotic anxiety/depressive symptoms and self injurious behaviour. She was receiving low-dose antidepressant treatment and an anxiolytic from her General Practitioner. She and her family (other members of which were also mentally handicapped) were already known to some members of the Team.

A Community Nurse and a junior Psychiatrist initially assessed her at home. The Psychiatrist continued to see her as an outpatient and the Clinical Psychologist assessed her suitability for relaxation training. These measures met with little success, and both the self injurious behaviour and family tension increased. The case was again brought back for Team discussion and it was agreed that a short term admission to St. Joseph's Hospital was appropriate to relieve the family situation and for more detailed assessment of her mental state.

After thorough inpatient assessment, she was not considered to be suffering from a primary depressive illness, and antidepressant medication was withdrawn. Attention focussed on her need for purposeful daytime activity. The Community Nurse arranged a job for her in the hospital laundry, to which she responded enthusiastically. She was discharged home and continued her part-time laundry work. The self injurious behaviour ceased and her neurotic symptoms improved significantly. Follow up was continued by the Community Nurse.

##### **Case 2**

A 24 year old mildly handicapped woman living with her mother was referred to the CMHT by the Manager of an Adult Training Centre (ATC). The index problem was disruptive and aggressive behaviour, both at home and at the ATC. The woman was already known to one of the CMHT Consultants, as she had been an inpatient in a local psychiatric hospital some years earlier. Although it was appreciated that this lady had been involved previously with the psychiatric services and was being prescribed anxiolytic medication by her General Practitioner, it was decided by the Team that the referred problem would be best addressed from the viewpoint of a Psychologist with special experience in mental handicap.

The Psychologist worked initially with the ATC staff, and developed a behaviour modification programme. This led to no significant improvement. Following discussion with other Team members, the Psychologist linked with the patient's

local Social Worker in joint home visits. A Community Nurse was also involved at this stage. Although the aggressive outbursts continued, and she was suspended from the ATC following an outburst, the Team supported the principle that this lady should remain in the community and not be admitted to either the mental handicap or psychiatric hospital. Slow progress was made in directing her towards more appropriate behaviour and independent living, and in helping her mother both to accept the change and to manage the difficult behaviour more effectively.

Unfortunately, her mother then suffered a severe cerebrovascular accident requiring a long period of hospital care. Whereas in similar circumstances mentally handicapped offspring might be admitted to a mental handicap institution, in this case the team work already completed enabled swift and effective community support to be implemented. She was maintained in the family home with domestic assistance, and other family members were counselled by team members to foster her growing independence. Soon afterwards, the local Social Worker found her a small house of her own, where she continues to live with minimal support under her Social Worker's supervision. She has returned to the ATC on a part-time basis and aggression is no longer a significant problem.

### **Case 3**

A 17 year old man with moderate mental handicap was referred to the CMHT following a joint case conference attended by staff from his Adult Training Centre and the hostel where he resided. The concerns were that he was not making the progress anticipated at the ATC and that he appeared overly dependent at the hostel.

The case was passed to the Team's Psychologist, who reviewed the young man's programme with the ATC staff, discussed his level of functioning with the hostel staff, and also made an independent assessment of his capabilities. From this, it became clear to the Psychologist that there was a major difference between the expectations of the ATC and the hostel, and that the ATC programme was attempting to train in areas which were both too complex and also inappropriate to his abilities. A more domestic and practical programme was devised and implemented both in the ATC and in the hostel.

The Psychologist followed up the case for another three months, during which time notable progress began. There was no need for further intervention by the CMHT.

## **DISCUSSION**

One could describe a CMHT as a group of professionals, by implication multi-disciplinary, who provide a service to help mentally handicapped people living in the community, the particular skills offered and range of problems dealt with being dependent to a significant extent upon the training background of the team members. The basic system of community team operation used at St. Joseph's was adopted at Merchiston. The membership of these two teams was comparable, being based essentially upon nursing, psychiatry, psychology and social work, and thus in keeping with the spirit of the recommendations set out by the Development Team for the Mentally Handicapped (1978).

At St. Joseph's, there was felt to be a good balance of time allocation from the various members, whilst the development of the Merchiston team brought to light areas of deficit, notably in the community nurse complement. In addition, the size of the Merchiston Team's catchment area seemed too large for one CMHT

to manage optimally. Nevertheless, we hope that the case examples and the following discussion on them are illustrative of what can be achieved by such Teams.

Whilst there have been objections, with some justification, to CMHTs having a hospital site as their administrative base, we suggest that Case 1 reported above serves to illustrate the advantages of having close administrative, if not geographical, links with specialist residential facilities. In this case, the fact that some staff were members of both the CMHT and the inpatient team was advantageous in ensuring continuity of care and also smooth co-ordination of the community and inpatient services.

Case 2 also exemplifies a situation where concurrent membership of the CMHT and the inpatient team enabled staff to make an informed decision on what type of service would be most beneficial for the individual handicapped person. The position of these CMHTs in standing astride the gap between hospital and community provided the CMHT members with knowledge of the strengths and limitations of both inpatient and community services. In this case, the easiest response to mother's incapacity would have been to admit the handicapped woman to hospital. However, the CMHT members were in a position to judge that it would be more constructive to utilise the resources of the community instead. Also demonstrated in Case 2 is the importance of maintaining strong links between the CMHT and the local Social Work Departments. In this example, such collaboration facilitated the speedy rallying of community support services and the provision of suitable alternative accommodation.

Unlike the previous two examples, Case 3 required involvement by only one CMHT member. This illustrates how effective intervention need not incur much cost to time and labour. Although operating without a co-worker from the Team, the Psychologist was nevertheless acting as an agent of the CMHT, with the group credibility and backing of the multi-disciplinary Team. In this case, the Team representative filled an important role as an external arbiter to different community agencies. Case 3 also demonstrates how problem orientated assessment can lead to constructive changes in management, a point of note given the number of referrals made for assessment purposes.

The case examples also illustrate the resources inherent in the multi-disciplinary composition of the CMHTs. The team can choose the most appropriate members to be involved in the management programmes of individual referrals according to the members' particular skills and interests. The representation of different disciplines also enriches team discussion on referrals by providing viewpoints from a variety of angles. This is particularly productive in complex cases where the presented issue is only one facet of a problem situation. Here, the team meetings provide an excellent forum for the collation of information and ideas on different aspects of the situation.

Given that CMHTs vary according to their membership, we would suggest that their mode of operation and resultant referral statistics could show variation according to the central cluster group of the team. With the two teams studied here, of comparable composition and functioning in geographically separate but similar areas, there are striking similarities between the two sets of referral data. We appear to have received a group of referrals comprising one third with psychiatric and psychological problems and two thirds with issues relating to training, accommodation or general support (Table 2). Thus, these CMHTs were

being used as a general psychiatric agency for about one third of the referrals, whilst having, for the remainder, a wider role which differed significantly from the traditional psychiatric model. Given the nature of the problems dealt with, it would be difficult to quantify the success of CMHT intervention in terms of a "cure" rate or similar measure. The basic problems inherent in being mentally handicapped cannot be solved or cured as such by this form of intervention — the main aims of the CMHTs were to alleviate those problems which were amenable to change, to promote the personal progress of mentally handicapped individuals, and to provide a specialist part of the resource network supporting mentally handicapped people and their families in the community.

One area of difference between the two study groups lies in their referral rates (Histograms 1 and 4). Over 18 months at St. Joseph's there were 34 new referrals, compared with 25 over a 6 month period at Merchiston. However, Merchiston serves a population which is over four times larger than that served by St. Joseph's, which means that the referral rate per capita to Merchiston was only about half of that to St. Joseph's CMHT. Moreover, whilst the new referrals to St. Joseph's occurred at a fairly steady rate, equivalent to 2.3/100,000 population/month, those to Merchiston showed a trend of increase over the study period, progressing to a rate comparable to that of St. Joseph's by the end of the six months studied. We suggest that this occurred because there was little explicit community commitment at Merchiston prior to the inception of the CMHT, whereas St. Joseph's had had a long history of community involvement before the formalisation of the community team. As the referral rate to Merchiston CMHT remained at about the same level after the end of the study period, we would suggest that these findings go some way towards expunging the concern that a health service which explicitly extends its commitment into the community will be caught up by an almost infinite expansion of demand. No such 'bottomless pit' was uncovered in our studies: rather the St. Joseph's referral figures and the figures from the latter part of the Merchiston study indicate new referral rates levelling out at about 2/100,000 population/month. Another difference between the two teams was found in the figures for duration of contact with the CMHTs. Six months after initial referral, almost three quarters of the St. Joseph's group were still being actively followed up, compared with only one third of the Merchiston referrals.

It seems likely that this difference between the two teams occurred largely as a consequence of differing team composition and members' time commitments. Thus, prolonged follow up in the absence of active acute problems was common practice for St. Joseph's CMHT, most of this work being undertaken by the community nurses, who provided the vast majority of the sessional input to the work of the team. Merchiston CMHT, on the other hand, received comparatively little community nurse time to cover their larger catchment population and its mode of action was directed towards discontinuation of involvement when the index problems had been dealt with.

The points discussed above may be drawn together in considering CMHT workload more generally and we would offer our findings as a tentative guide to the prediction of required service provision in other similar geographical areas. We suggest that our referral rates provide useful guidelines, particularly as the Merchiston rate rose latterly to a level comparable to St. Joseph's. The other variable contributing with referral rate to the overall workload, i.e. duration and frequency of contact, is dependent to some extent on the style of operation adopted by the CMHT. This has been illustrated by the differing practices of these

two teams with regard to discontinuing contact. Thus, depending on the preferred style of CMHT operation, and follow-up policy in particular, the material presented on either St. Joseph's or Merchiston CMHT could be used as a guide to likely workload for other teams of similar basic composition, i.e. teams based on nursing, psychology, psychiatry and social work.

Of course, some CMHTs will have a regular active commitment from a wider range of professional disciplines and, as already discussed, we would expect that their workload might differ from that of our teams. For example, a CMHT which includes a regular speech therapy commitment will be likely to attract a different spectrum of referrals, the recognised composition of the team affecting referral behaviour and thus workload.

The profile of referring agents (Table 3) showed that only one of our total of 59 referrals came directly from a family member and yet, in contrast, we noted that two thirds of those referred were living in a family group. It is also interesting that no handicapped person made a self-referral to these community teams. The referring agents were diverse, falling into thirteen categories in the pooled survey data (Table 3). This emphasises both the multiplicity of agencies involved with the mentally handicapped and also the wide range of professionals who were aware of the CMHT services.

Another point of interest is that over three quarters of the sources of referral were community based agents. This observation should be qualified, however, by noting the difficulty in pinpointing the individual who actually initiated the process leading to official referral. What is clear is that neither key relatives nor the handicapped people themselves were making direct approaches to the CMHTs, with the single exception of one mother in the St. Joseph's study group.

This last observation is striking in view of the fact that both these CMHTs sought to be only one stage removed from the problems of the mentally handicapped, wishing to accept direct referrals from relatives and other carers, and from the handicapped themselves. This policy can be advocated as a means of promoting efficient pick-up of problems. It both simplifies the route to obtaining help for those who may not know how to proceed otherwise, and it also prevents the loss of referrals which can occur in a multi-stage referral process, perhaps through inappropriate filtering. Other CMHTs might choose not to offer such a direct referral facility, anticipating that if referrals are accepted only from other professionals, then the number of inappropriate referrals will be minimised. However, we believe that this latter system would give a CMHT less leeway to define and shape its own role, which we would see as being undesirable.

CMHTs exist to provide a service for the mentally handicapped in the community. It is important, therefore, that all relevant members of the community are aware of its functioning, and the CMHT should take positive steps to ensure that such awareness exists. The list of referring agents in Table 3 probably includes the majority of professional groups who should be informed about the CMHT. We advocate that relatives, other community carers, and the mentally handicapped themselves, should also form a major focus for the dissemination of information about the CMHT. From the cultivation of such awareness in those closest to the problems of the mentally handicapped, we would expect to promote not only the efficiency of pick-up, as discussed above, but also the function of the CMHT as a central resource system for the mentally handicapped.

## SUMMARY

This paper reports on a study of two Scottish Community Mental Handicap Teams (CMHTs). The work of these teams was considered with particular reference to the characteristics of new referrals received. A number of interesting similarities were noted and discussed. These included the finding of a referral rate reaching an average of about 2/100,000 population/month for both teams, which could be a useful guide in the planning of new CMHTs in similar areas. Questions concerning team membership, mode of operation and appropriate referral processes were addressed in the context of considering the role of the CMHT and its effectiveness. Suggestions were put forward for the further development of such services.

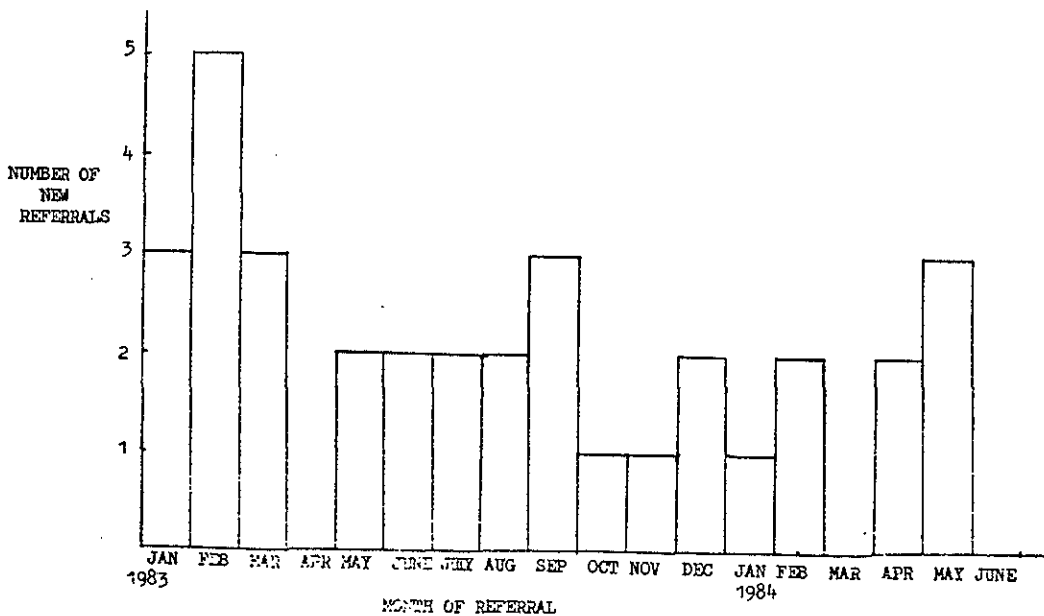
## Acknowledgements

We would like to express our thanks to all members of St. Joseph's and Merchiston Community Mental Handicap Teams for their help in providing information for this study and to Mrs. Jan Howitt and Mrs. Martha MacLeod for their patient typing.

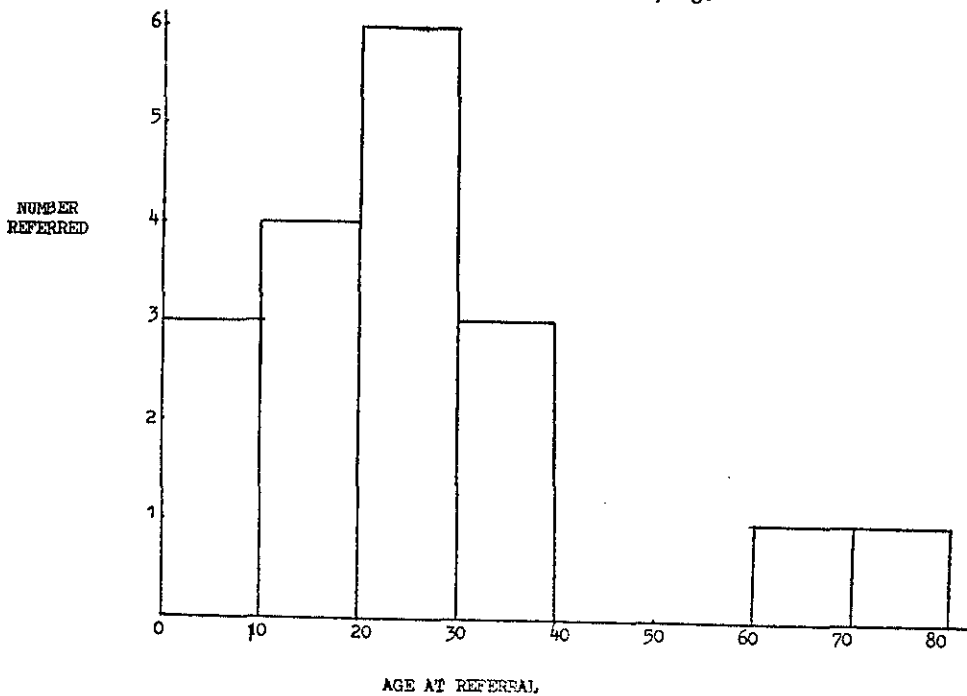
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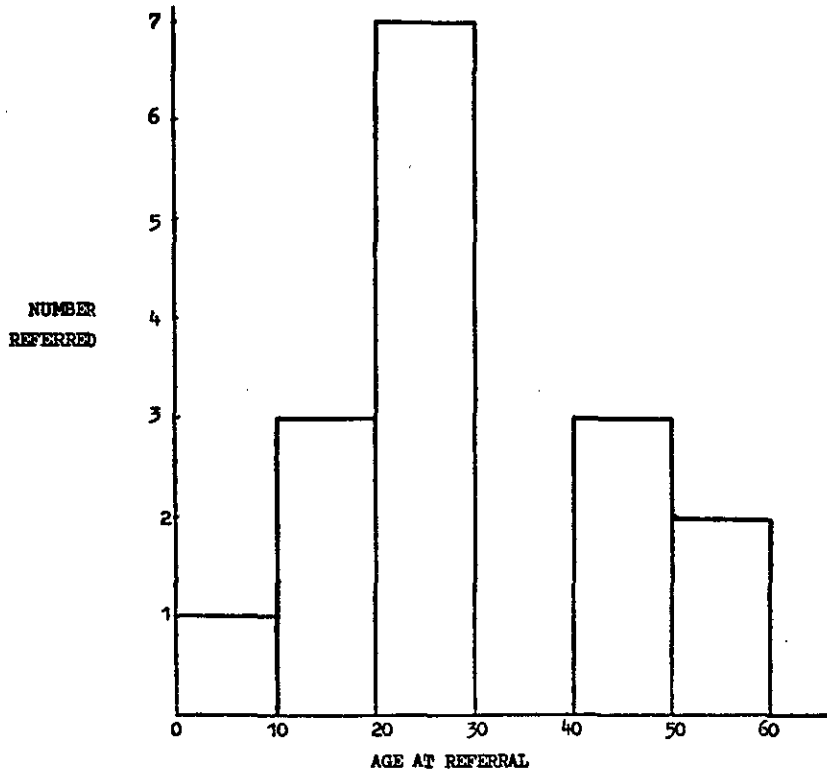
**Histogram 1:**  
St. Joseph's CMHT - Referrals by Month



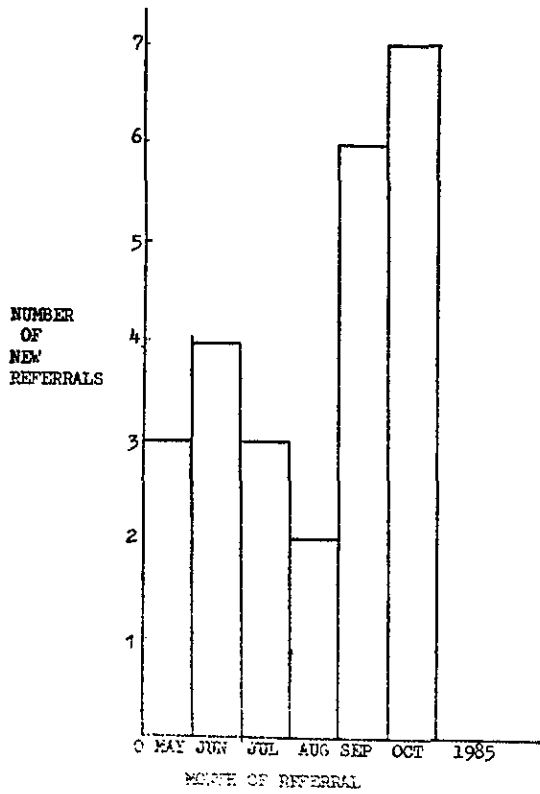
**Histogram 2:**  
St. Joseph's CMHT - Male Referrals by Age



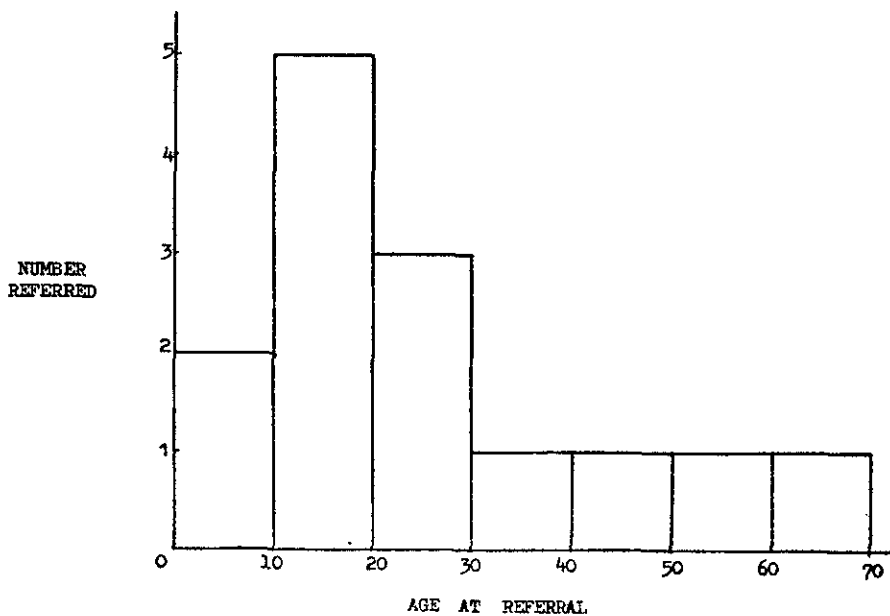
**Histogram 3:**  
**St. Joseph's CMHT - Female Referrals by Age**



**Histogram 4:**  
**Merchiston CMHT - Referrals by Month**



**Histogram 5:**  
Merchiston CMHT - Male Referrals by Age



**Histogram 6:**  
Merchiston CMHT - Female Referrals by Age

