Psychiatric Bulletin (1991), **15**, 415–416

Audit in practice

Multidisciplinary involvement in hospital discharge

A regional survey of current practice in general adult psychiatry

COLIN COWAN, Registrar in Psychiatry, Reaside Clinic, Bristol Road South, Rednal, Birmingham B45 9BE

The multidisciplinary team approach is considered by the Royal College of Psychiatrists to be a valuable instrument in modern psychiatric practice (Rawnsley, 1984). In addition, it is assumed by the 1983 Mental Health Act in Section 117 concerning joint Health and Social Service responsibility for statutory aftercare and in Sections 57 and 58 where consultation with other disciplines by the second opinion doctor is required. The benefits of this way of working include a broader perspective in care provision, consistency of approach, continuity of care, and improved communication between disciplines (Pollock, 1986).

A recent development in multidisciplinary working has come in the form of *Guidelines for Good Medical Practice in Discharge and Aftercare Procedures*, circulated by the Royal College of Psychiatrists in 1989 as a response to the Spokes Enquiry (DHSS, 1988) and recommending the use of forms for recording plans for aftercare made jointly between the representatives of the medical, nursing, occupational therapy, clinical psychology, and social work professions attending a formally arranged discharge and aftercare meeting. This study aims to evaluate the current extent of multidisciplinary working in general adult psychiatry in one regional health authority.

The study

The 91 consultant psychiatrists on West Midlands Regional Health Authority's list of consultants in post whose major specialty was mental illness were circulated with a questionnaire asking which of six professional groups (junior medical staff, nursing (ward-based), nursing (community), occupational therapy, clinical psychology, and social work) had a representative assigned to their regular ward review (or discharge meeting if held separately) and which of the groups were represented at the last meeting in which a patient was actually discharged. The date of completion and the name of the hospital were also requested. All questionnaires were sent out together at the end of March 1990.

Findings

Out of the 91 questionnaires sent, 70 were returned (77% of the total). Three consultants did not have any regular meeting at which arrangements for discharge were made (hereafter referred to simply as 'discharge meetings') and of the remaining 67 a further four were rejected, two because the responses were stated on the form as being based on a rehabilitation unit rather than a general adult unit and two because the questionnaires were completed over three weeks later than the date by which all the rest had been completed (10 April 1990). This left 63 valid replies, constituting 90% of the replies received and representing 69% of all general psychiatrists in the region. Results were analysed for each of the professional groups in terms of the proportion of all discharge meetings surveyed: (a) to which a representative was assigned, and (b) at which a representative was actually present. In the single instance where a positive response was made regarding a particular group having an assigned representative but a qualifying comment added (in this case "sometimes"), a negative response was counted.

Junior medical staff and ward-based nursing staff were universally assigned and were present in virtually all discharge meetings. Social workers had an assigned representative at 58 (92% of total) discharge meetings and a representative present at 51 (81%), occupational therapists were assigned to 45 (70%) discharge meetings and were present at 35 (56%), and community nurses were assigned to 38 (61%) of discharge meetings and represented at 30 (48%). The least represented group was clinical psychology with 11 (17%) discharge meetings having a representative assigned and only seven (11%) having one actually present.

The completeness of the team assigned to consultants and that actually represented at the last

discharge meeting was also analysed. Only seven out of the total 63 teams had a full complement assigned and only four were fully represented at the last discharge meeting. Twenty-four had five groups assigned, 22 had four assigned and six had three assigned; only 16 had five groups represented, 25 had four groups and 12 had three. Four had only two groups assigned (invariably junior medical and ward-based nursing staff) and six had only two groups represented.

Comment

This 'snapshot' view of attendance can give only an impression of the longer-term picture, although a significant one in view of the fact that a patient was actually discharged at every review and that seasonal distortion due to holidays was unlikely during the period in question. There is, however, no indication of whether participants stayed for the entirety of the meeting nor of whether they were present at the time discharges were arranged and no indication is given of the attendance rate of consultants.

The results demonstrate the generally restricted nature of multidisciplinary team-working across the West Midlands and the marked variability between units; even if clinical psychology had been excluded from the questionnaire, only 43% of consultants would have reported a full team assigned and 29% a full team actually present. The fact that 68% of discharge meetings had fewer than five of the six groups represented and 29% had fewer than four indicates particular problems in making plans for vulnerable patients requiring a high degree of multidisciplinary teamwork.

It would appear that the assumption that all major clinical disciplines will be represented at the discharge and aftercare meeting referred to in *Guidelines for Good Medical Practice in Discharge and Aftercare Procedure* is not currently applicable to the majority of general adult psychiatric units in this region at least. Formal arrangement of each individual discharge and aftercare meeting would be essential in such units if multidisciplinary working is to proceed along the lines envisaged in the guidelines, possibly leading to delays in discharge. Where the problem is caused by poor co-operation or communication between the various disciplines, time invested in improvement would yield long-term dividends but where low staffing levels are at fault, solutions seem unlikely without remedying the basic problem.

Acknowledgement

I would like to thank Dr Ashraf Kahn for his encouragement and support with this project.

References

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1988) *Report of the Committee of Enquiry into the Care and Aftercare of Miss Sharon Campbell.* (Chairman, John Spokes). Cmd440. London: HMSO.

POLLOCK, L. (1986) The multidisciplinary team. In *Rehabilitation in Psychiatry* (eds, C. Hume & I. Pullen). Edinburgh: Churchill Livingstone.

RAWNSLEY, K. (1984) The future of the consultant in psychiatry. *Bulletin of the Royal College of Psychiatrists*, **8**, 122–123.

ROYAL COLLEGE OF PSYCHIATRISTS (1989) *Guidelines for Good Medical Practice in Discharge and Aftercare Procedures.* Council Report Number 8.

Samuel Tuke (1784–1857)
Quaker philanthropist and merchant of York; treasurer of the Retreat; grandson of William Tuke, founder of the Retreat, and father of D. H. Tuke.