Guidelines are presented that help to make psychiatric intake conferences more efficient and productive. The emphasis is placed on having designated personnel meet individually with the patient as well as review the patient's chart prior to the formal intake conference. Thus, the personnel is able to spend more time on formulating a diagnosis and treatment plan than on reviewing the past history of the patient. Information presented at such conferences should consist more of unique contributions from the personnel (e.g., observations, impressions, testing, etc.) than of redundant material commonly known by the personnel assigned to the patient.

The importance of including many staff members in the process of patient evaluation, disposition, and treatment in a psychiatric hospital has been well summarized by Jones. The goal may be to obtain as much input as possible from as many staff members as possible, but certain problems are created by the traditional, relatively unorganized ways of collecting and presenting such data. Nowhere are these problems more apparent than with the patient intake conference in a psychiatric hospital.

More specifically, patient intake conferences are often unstructured meetings during which every staff member is allowed or even encouraged to present every piece of information that they have obtained about a patient. Yet the nondiscriminative presentation of all material does not guarantee better diagnoses and treatment plans. The careful presentation of relevant material necessitates a clearly defined leader who is able to effectively moderate presentations and discussions in accordance with the goals of the meeting, by changing the topic or ending the discussion when necessary.

Maxmen, Tucker, and LeBow have presented five general functions of a patient staffing conference:

1. Presentation of new patients, discussion of their histories, and formulation of tentative treatment plans.
2. Discussion of current problems with patients and modifications, when necessary, in treatment plans.
3. Periodic review of treatment plans of “nonproblem” patients.
4. Discussion of case histories, treatment plans, and psychopathology for the purpose of education.
5. Discussion of unit-wide problems which affect several or all patients.

These goals must be kept in mind when information is presented; otherwise staff time may be inefficiently used. The professionals at a patient conference should be concise, well organized, and provide a relatively unique contribution based on his or her discipline. If certain information is equally accessible to most staff members, then the other staff members most likely already have the same information either from direct contact with the patient or through a reading of the patient’s chart. Physicians, nurses, psychologists, social workers, and other personnel do have specialized training that allows them to make unique observations and recommendations. Thus, the emphasis should be on eliciting new information from staff members that would help in the conceptualization and treatment of the problem, and not on presenting a complete case history of the patient.

Occasionally staff conference leaders are either too dominating or too passive in conducting the meeting. Leaders should present a quick summary of the relevant information regarding a patient and should help other participants to remain task oriented to providing new information or observations at a steady pace. Individuals must be given the opportunity to make contributions but not to monopolize the conference.

There is a dearth of research related to staffing guidelines. One study does provide some relevant background information. A total of 24 intake staffing conferences from three neuropsychiatric units were tape-recorded and analyzed. Not surprisingly, the unit which had the most favorable release rate and remission indices was also judged to have the most efficient staffings. The more efficient meetings were characterized by a number of variables: (1) an average of 15 minutes was spent on each patient as compared to an average of 30–40 minutes on the other units; (2) significantly less time was spent discussing the patient’s social and medical history; (3) significantly more time was spent on diagnosis and disposition-treatment plans; (4) the leader (usually a physician) had a clearly defined role of presenting concise background information as well as his observations and recommendations, and of eliciting specific, relevant comments from other staff members; (5) the psychologists, social workers, and nursing staff spoke less than the leader (physician) and added only new information and/or specific recommendations; and (6) staff personnel were prepared to discuss cases since they had already reviewed the patients’ charts.

The findings of this study were used to form the basis of specific guidelines in conducting patient intake conferences. Perhaps the most significant feature of such guidelines is the change in the goals of the meet-