An Integrated Pathway for Frequent Attenders to the Emergency Department at Watford General Hospital

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Background

There is no clear definition of a Frequent Attender to the Emergency Department in England. In Scotland, a Frequent Attender is defined as someone who attends 10 times or more in 1 year, or 5 times or more within a 3-month period. Analysis of attendance at Watford A&E from 2006-2013, showed that 5% of all attendance to the department came from an average of 344 individuals attending it 10 or more times per year. A sub group of on average 22 individuals attended 15 times or more per year, accounting for 0.8% of all attendances. These attended 15 times or more per year, accounting for 0.8% of all attendances.

Figure 1: Frequent Attendances at Watford General Hospital from individuals of 2009-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Total ED Adult Attendances</th>
<th>Percentage of Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>5411</td>
<td>5.0%</td>
</tr>
<tr>
<td>2010</td>
<td>5560</td>
<td>5.3%</td>
</tr>
<tr>
<td>2011</td>
<td>5709</td>
<td>5.1%</td>
</tr>
<tr>
<td>2012</td>
<td>6221</td>
<td>6.0%</td>
</tr>
<tr>
<td>2013</td>
<td>6626</td>
<td>6.8%</td>
</tr>
<tr>
<td>Avg</td>
<td>5770</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

Development of an integrated Frequent Attender Pathway

A Frequent Attender Pathway has been set up between Watford RAID team, Watford A&E and Spectrum (the Drug and Alcohol services provider in Herts). Clinicians from these services form the core referral group and meet monthly. Referrals are made by A&E staff for individuals attending over 15 times per year or with an escalating pattern of attendance.

Reviews

Reviews of a careplan take place at 6 and 12 months, and are done by the core referral team.

Figure 2: Frequent Attender Pathway graphical representation

Early results

From March – October 2014

• 33 people have been referred
• 7 care plans are in place, all with a reduction in attendance
• 2 had a psychological intervention made at assessment and were diverted from the pathway without a full care plan. Both have had a reduction in attendance.
• 15 are currently in the assessment process
• 9 were not taken onto the pathway following early investigation after referral (due to being deemed inappropriate currently)
• 3 people have had an attendance following the intervention or careplan

Example of interventions implemented in care-plans to date

• Psychoeducation / regular contact with care coordination / professional boundaries in Emergency Department/Ambulance service
• Residential care (extreme self-neglect found at home with heavy dependence on services)
• Psychoeducation and engagement with alcohol services
• Multiagency agency consistent channelling towards alcohol services with advice to court regarding an enforced alcohol treatment programme
• Regular care coordination; DBT; encouragement through careplan to seek additional support from Acute Day Treatment Unit without overdoing
• Psychological intervention with ongoing weekly GP support

Training on professional boundary approaches in the Emergency Department

An early common finding observed during the assessment of some of the most frequently attending patients was that they were lonely individuals and were attending the Emergency Department for company. Their attendance was being unintentionally positively reinforced by ED staff acting in an ‘overly caring’ manner eg physically embarrassing them providing additional food as soon as the individual entered the department and facilitating or occasionally paying for taxis and other transport home. The RAID team have provided training to the Emergency Department on the use of behavioural methods to address unhelpful positive reinforcement of maladaptive behaviours. This training aims to get staff to treat individuals in a professional manner that is neither punitive and alienating nor overly involved.

Vignette

Vignette

40 year old unemployed divorced lady, known to mental health services. Repeatedly called ambulances complaining of shortness of breath and chest pain and was brought into hospital. On examination there were no cardiac or respiratory problems. She was well known to the ED staff, who were fond of her, and overly friendly. She tended to get a sandwich in the ED, and either make her own way home or get money for a taxi or bus from staff. She attended 14 times in the 12 months before her referral to the pathway. A professional meeting was held between the CMHT, RAID, Ambulance Service and the ED. A psychodynamic formulation was made around her poor experience of parenting as a child, and her attempts to seek a “good parenting experience” in the form of the hospital. She had developed dependent personality traits, and was seeking to deal with her loneliness by frequent attendance at the A&E department. The RAID psychologist helped the ED and ambulance service to understand the drivers behind her behaviours, and what reinforcements were happening to encourage the behaviour. A Frequent Attender Careplan was shared. Ambulance Telephone Triage or home assessment would be used to deliver attendance at A&E, and arrange for a call back from psychiatric services. If taken to A&E, a professional boundary approach was planned for attendances at A&E, where she would only be offered food at standard meal times, and told that she needed to make her own way home. She had a psychological assessment with the RAID psychologist, and regular contact with her care coordinator with a view to a longer term psychological intervention. The careplan and its rationale was shared with her. She has not attended A&E since (10 months). Her care coordinator feels that the sense of containment and boundaries she felt stopped her attendances. She is about to start psychological therapy.

Psychosocial reasons why people may frequently attend the Emergency Department:

• Health anxiety
• Previously undiagnosed psychological or psychiatric conditions which are impacting on self-management of health care, e.g. early cognitive impairment; depression and anxiety
• Substance misuse
• Social situations and symptoms
• Active alcohol and drug dependence (including addiction to opiates and other prescription medicines)
• Features of dependent personality; loneliness
• Inadequate containment of mental health conditions by community care plans leading to frequent or critical crises
• Active social problems such as homelessness; housing and financial problems, or lack of an adequate support network
• Poor coping mechanisms for long term medical conditions

Aims and Objectives

• To analyse the patterns of attendance and presenting characteristics of all people who attended Watford General Hospital 15 or more times in 2013 (results not presented in this poster)
• Development of an integrated and multi professional Frequent Attender Pathway to address the needs of individuals who have become frequent attenders (defined as attending 15 or more times per year, or with a recent escalating frequency in their pattern of attendance)
• Careplans are formulated at the interagency professionals meeting. Care plans are shared with the patient and stored in A&E; with the RAID team and with all relevant agencies to ensure consistent approaches.

Referrals

Referrals are discussed at the referrals meeting and allocated to the most appropriate team to lead the assessment and intervention. Teams leading assessments include Psychology, A&E and the Emergency Department.

Assessment

Detailed assessment of referrals is undertaken by the RAID Lea Psychology Service including direct assessment; collateral history from family, friends and other involved agencies and services. An analysis of the pattern of attendances at Watford A&E and other local Emergency Departments by the individual is made. Some referrals are diverted from the pathway following assessment, or placed on hold if the situation has changed.

Inter-agency Professionals meeting

Following assessment, a multi-disciplinary professionals meeting is held. All relevant agencies are invited (RAID, other mental health services; A&E; Physical health services; GP; Ambulance; Police; Social services; Spectrum; Housing; Voluntary Sector etc).

Careplans

Care plans are formulated at the interagency professionals meeting. Care plans address the needs of the individual in a proactive integrated manner. Care plans are shared with the patient and stored in A&E; with the RAID team and with all relevant agencies to ensure consistent approaches.

Examples of interventions implemented in care-plans to date

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Early findings requiring further investigation

• Loneliness; dissatisfaction with health care services and complaints are common characteristics of people who frequently attend
• Where the careplan is discussed with and explained to the service user there tends to be a greater reduction in attendance
• A detailed and comprehensive psychological assessment appears to be key to the success of the process
• Significant cost savings are likely to have been made across the whole health care economy (Emergency Department, GP, Ambulance service) for certain individuals. However there are potential financial costs to other providers on implementing the plan. It would be interesting to compare the overall cost savings made with the costs of a new intervention, and then to consider how the funding of such integrated schemes could be taken forward.