Care pathways or mazes? Signposting for the lost

Dr. Rob Jackson, Lead Psychiatrist, Substance Misuse Care Group, Sussex Partnership NHS Trust (West)

rob.jackson@sussexpartnership.nhs.uk

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A patient's journey through different services – confusion or collaboration?

Patient ping pong (or client croquet)

Care: pathway or maze?

- 2 typical scenarios for opiate misusing clients
  - Prepared for NPfIT guidance 2004
- Arrest referral client:
  - Minimum 12 agencies, typically 45 care steps
  - Potentially another 11 agencies
- Substance using mother, pregnant:
  - Typically 17 agencies/people, 80 care steps
  - Potentially another 10 agencies even without MH care
- Dual diagnosis client:
  - Many more than the above!

Pity the poor patient

- What is patient ping-pong?
  - “I can’t stop drinking, and I hear voices.”
  - CMHT: “Come back when you’re sober.”
  - Sub mis team: “Come back when the voices have stopped.”
  - ***Coherent care, not!***
- And pity the poor GP or other referrer too.

Goals of this presentation

- Knowledge of organisational & care pitfalls created by multiple teams and eligibility criteria
- Skills: collaboration and joint care planning, reading & developing care pathways
- Attitude: focus on patient care and safety; limit-setting and risk management, but without rejection or buck-passing
- Awareness of the patient's need for coherent care above all else

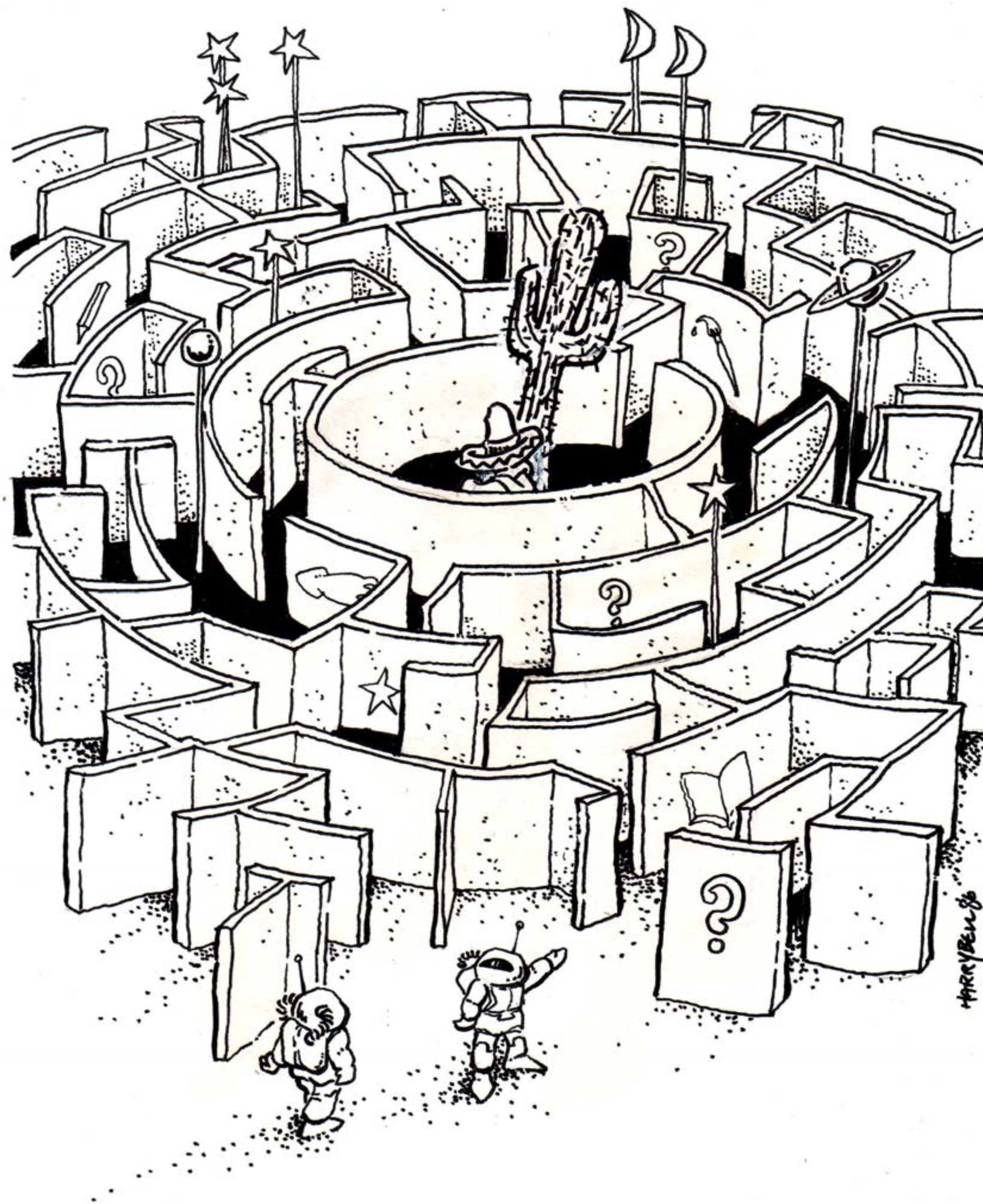
Topics to be covered

- Team proliferation in general – risks of splitting
- Dual diagnosis as a specific example
  - Risks – good care – pitfalls – care pathways
- Team dynamics and relationships
- Confusion or collaboration at team level
- Coherent planning, development of policies, care paths & eligibility criteria: don't set teams up to squabble
- Change management and support for teams

Which team meets what need?

- Recent trends to increasing specialisation and fragmentation in UK
  - 50s/60s: first community services
  - 70s/80s: CMHTs; rehabilitation; substance misuse
  - 90s: CMHTs for elderly; assertive outreach; crisis response
  - 2000s: early intervention; community forensic; sub mis DRR/DIP (forensic) teams; OPMH liaison
- Who's in charge? Who agrees who does what?
- Risk of the patient slipping through the net
- Minimising risk using care pathways; the "therapeutic team"

A typical care pathway



Sources of confusion

- Eligibility criteria not agreed; care paths don’t map
- Unrealistic expectations of other teams
- Team conflicts/rivalries
- Problems timetabling/attending care plan meetings
- Delays
- Letters not being copied
- Different info systems, assessment tools
- Covert or overt rejection of “difficult” patients
- Stigmatisation of certain patient groups

Mental health vs. addictions care

	Mental health care	Addictions care
Pt culpability/ responsibility	Partial or even minimal (external locus of control)	Maximised/encouraged (internal locus of control)
Documentation	Care Programme Approach	Models of Care
Sanctions	Restrict, observe, MHA	Contracts, discharge
Mental Health Act	Available if risks justify	Unavailable (at least in 83 Act)
Long-term medication	Often needed/ encouraged	Usually discouraged

Ingrid Barker, 1998: four care models for comorbid (dual diagnosis) patients

- **Consecutive:** one service first, then the other
- **Parallel:** liaison between separate services – depends on rapport
- **Shared care:** combined clinics via specific liaison posts
- **Specialist teams:** expensive; only justified for large populations

Care model conflict in dual diagnosis: cat's cradle or dog's breakfast?

- Mental health acronyms: NSF, MHA, CPA, CMHT's, AOT's, CRT's
- Substance misuse acronyms: NTA, DAAT, DTTO's, DRRs, SCAN, SMMGP
- 2 primary Govt depts: DH, HO; different agendas
- Both agendas risk-driven – but different risks
- Can the cogs of the 2 engines be in synchromesh?

How common is DD?

- Royal College of Psychiatrists Research Unit 2002:
  - Estimated 1/3 of MH patients in UK also have sub mis problem
  - Estimated ½ of sub mis patients also have MH problems (incl. personality disorder)
  - "The label of having dual diagnosis itself can lead to the individual experiencing prejudice and stigma, and may even act as a barrier to care."

DH/NTA funded CoSMIC study (Weaver 2002):

- 74.5% drug service users had MH problems*
- 85.5% alc service users had MH problems*

  * - mostly affective disorders (depression) or anxiety

- Almost 30% drug service users, & over 50% of alcohol, had multiple morbidity (>2 problems)
- 44% of mental health service users reported drug use &/or had drunk to risky levels in the past year
- 38.5% of drug users with a psy disorder were not in treatment for the problem

Implications for service users

- Significantly poorer social functioning
- Greater need for intervention
- More unmet need, even when already getting extra help (pushed to back of queue when risks should suggest the front)
- Comorbidity often not picked up – need for better staff training, assessment & recording
- Both CMHTs and CSMTs should be able to deliver the opposite sort of help at low level if required
- Severe MH – intensive joint working, led by MH ("mainstreaming" – see DH's DD Good Practice Guide)

Specific risks (CRU report):

- More likely to have –
  - Increased likelihood of suicide
  - More severe mental health problems
  - Homelessness & unstable housing
  - Increased risk of being violent
  - Increased risk of victimisation
  - More contract with the criminal justice system
  - Family problems
  - History of childhood abuse (sexual/physical)
  - More likely to slip through net of care
  - Less likely to be compliant with medication and other treatment

Louis Appleby in Safer Services:

- "Suicide and homicide cases have high rates of alcohol and drug dependence and misuse. Increased alcohol and drug misuse frequently occurs in the period leading to suicide or homicide, often in the absence of more direct indications of clinical relapse."

Franey and Quirk, 1996:

- "…People with dual diagnosis are recognised to be especially needy and vulnerable yet they are more likely than those with either drug or mental disorders alone to be excluded from mainstream treatment services. Services are often ill-equipped to deal with the needs of this client group."
- Risk of ***patient ping-pong***

Good dual diagnosis care

- Skills:
  - Assessments
  - Risk assessment
  - Risk management especially re compulsory admission
  - Joint/shared care planning
  - Ability to set limits & retain control in face of chaotic behaviour
- Attitudes:
  - Not rejecting or judgemental
  - Accepting that motivation can be a long-term goal; not downhearted by relapse – accepting that substance misuse is not easy for the individual to get into perspective
  - Holistic, multi-axial thinking

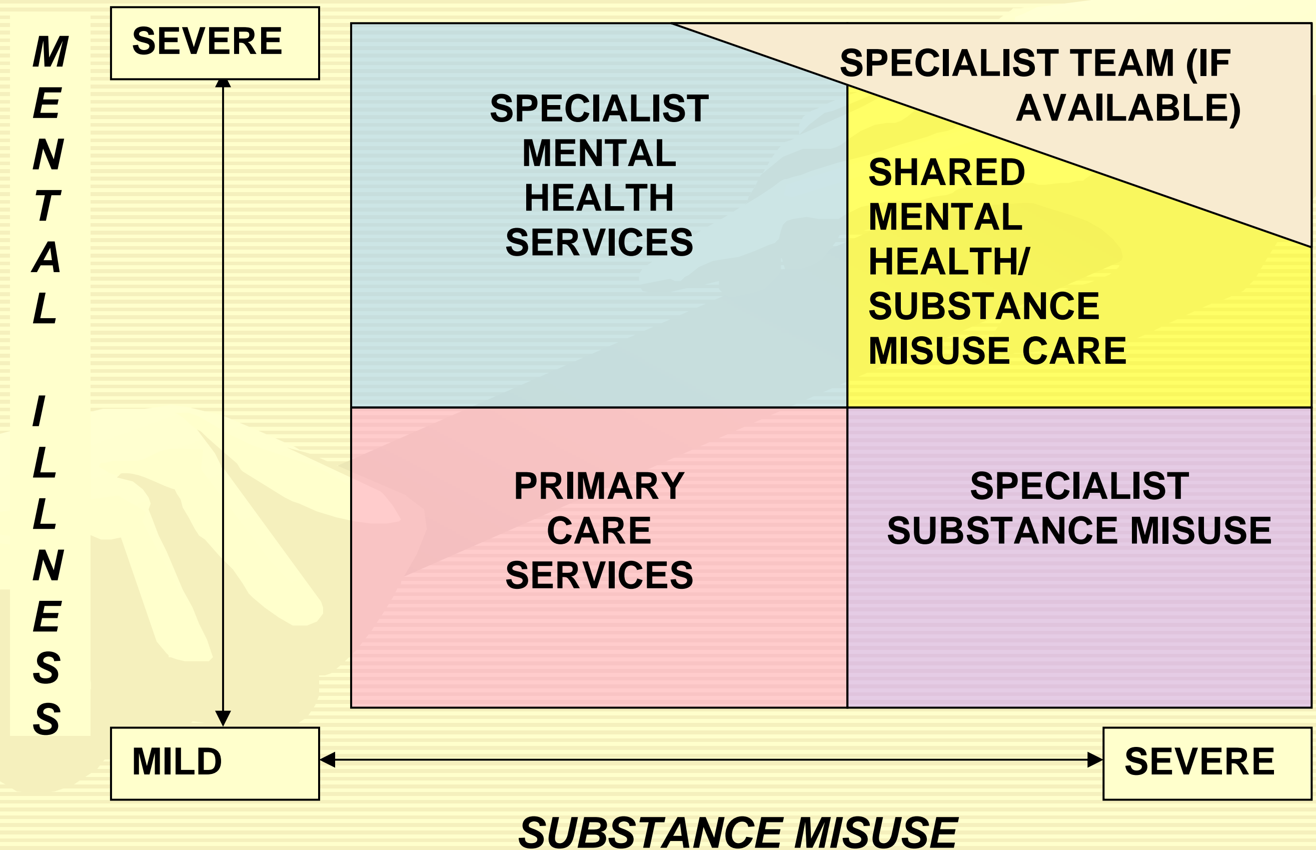
Why assess risk?

- To MANAGE it
  - Keep the patient/client, family, children, acquaintances, road users, and ***ourselves*** as staff, ***safe*** both short and long-term
  - ***Including deciding on admission, incl. via MHA 83***
- To provide structure & boundaries for a complex task
- For medico-legal/defensive reasons
  - To prove we have done the right thing for high-risk clients

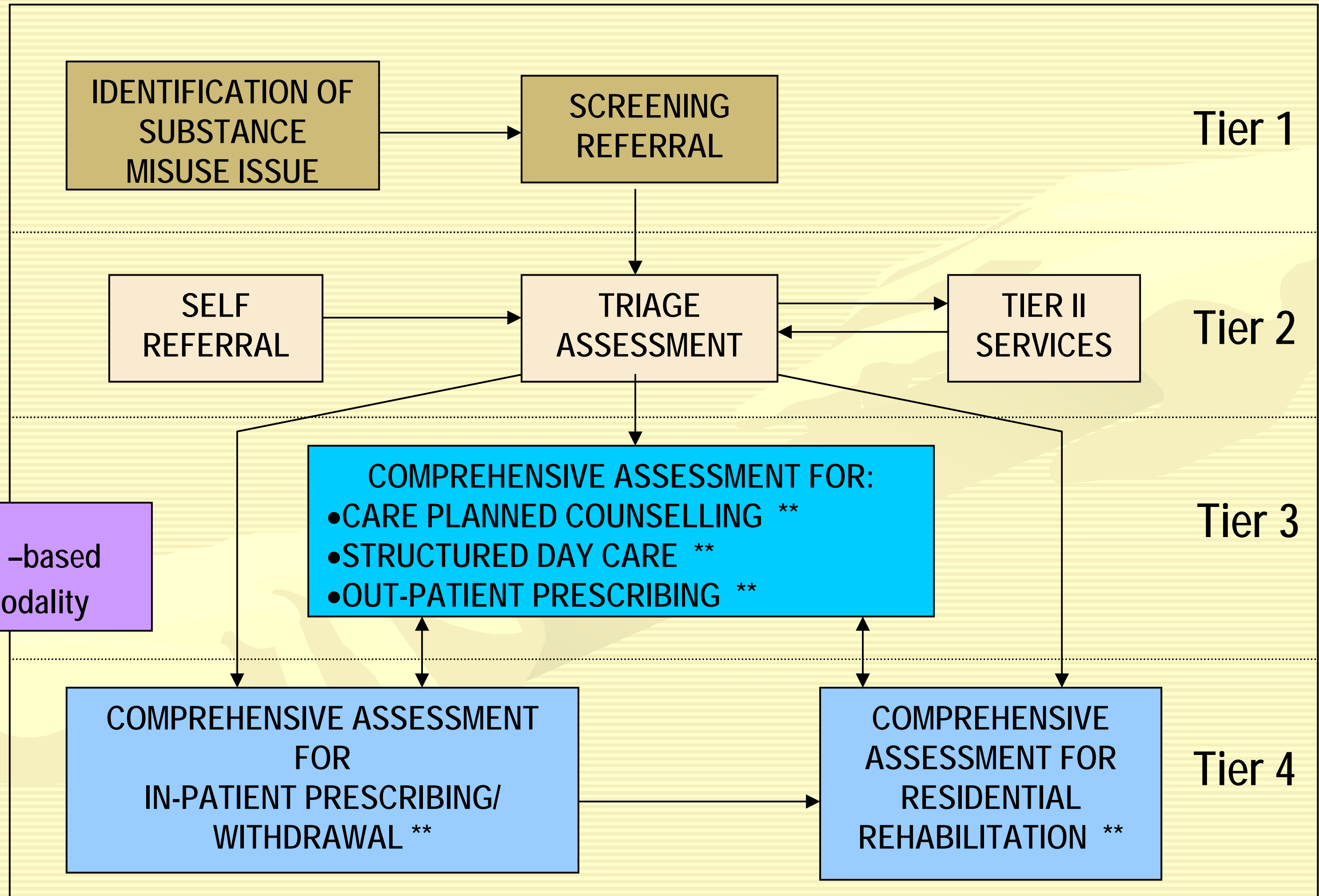
Risk management & care planning

- Ideally using combined/holistic risk tools
- Immediate risks
  - Biopsychosocial model
- Longer-term risks
  - long-term planning
- Shared care: can it be integrated?
  - “Virtual team” for each patient
  - Joint assessments (or joint assessments, think!)

Who provides what care?



An integrated care pathway model (tiered care)



W Sx DD ICP – key points

- Promotes shared assessments at all stages
  - triage or comprehensive assessment w CMHT
  - CPA reviews with both teams present encouraged
- Flexible
  - if SM or MH eligibility criteria not met, allows single-team care
  - if both problems need specialist care, should be shared

How are the approaches best combined?

- Mental health: graded return of responsibility even if removed by admission or MHA: "care" a 3-way partnership – professionals, user, carers
- Sub mis: motivation, social inclusion, max personal responsibility from the start: substitute prescribing only in opiate dependence
- DD: Balance between treatment approaches
- Acceptance of long-term, cyclical nature of motivational work

Principles of treatment of Dual Diagnosis

- Assertive outreach
- Close monitoring
- Integration
- Comprehensiveness
- Stable living situation
- Flexibility
- Stage-wise treatment
- Long-term perspective
- Optimism

Integrated care summed up

Overt message	Hidden message	Comment
Come back when you're sober/when the voices have stopped (or) go to the other lot down the road	You get up my nose, & I'm not sure I'd know what to do with you even if you did come back here	The natural but untrained response from a worker trained in only 1 modality
Here's some Valium, now	Let's both be out of control together	The worst fear of the untrained worker with no limit-setting skills
Here's an appointment for 11 tomorrow – it'd be really great if you could manage not to be stoned or drunk	I just might be able to help you get life together & get some self-respect	The non-rejecting, balanced & therapeutic response

Types of joint assessment

- Specialist team to undertake both roles? (e.g. dual diagnosis team)
- Specialist workers with specific skills within generic teams? (e.g. MH worker in SM team, or DD worker in MH team)
- Joint assessment or care planning by “virtual teams” who meet for individual patients’ care plans (the most commonly advised model)

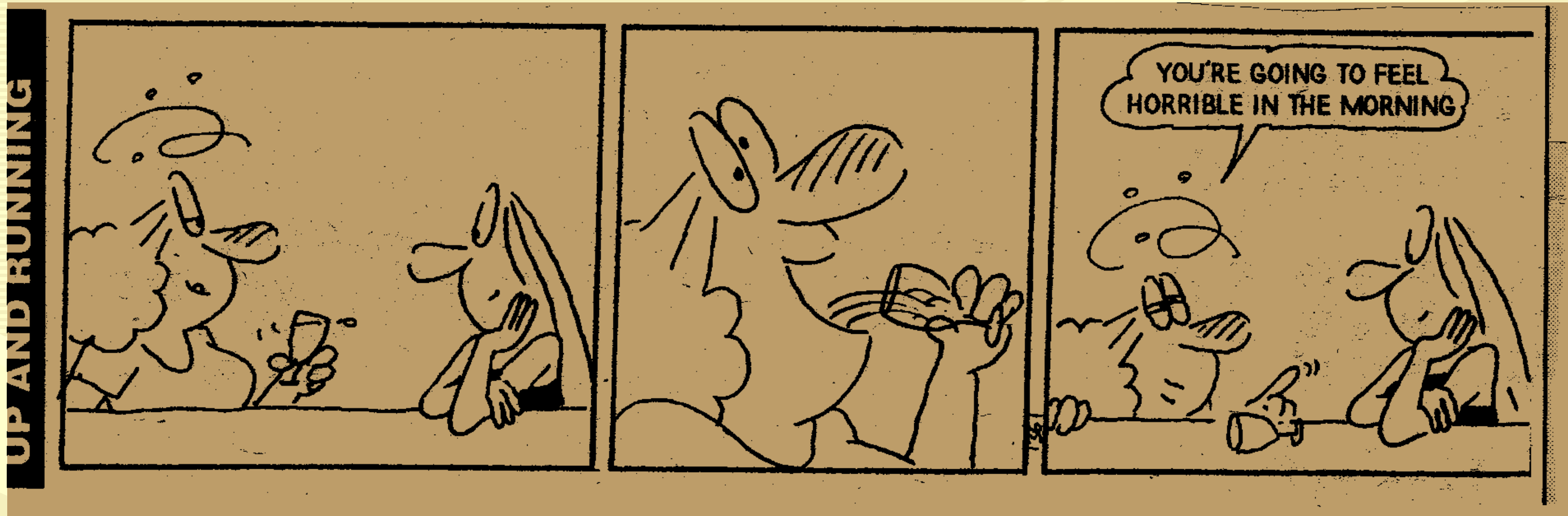
Practical problems locally

- Timetabling: next gap weeks away?
- Training both sides (cf. Maslin '01):
  - misplaced assumptions about what is specialist ("that's ***their*** problem" – no respect for eligibility criteria)
- Limit-setting:
  - balancing demand & safety in managing crises
  - ensuring eligibility criteria at team level don't ignore high-risk patients
  - risk of stigma, esp. with PD patients

Failings of in-patient practice (Barnaby, Drummond, '03)

- 200 consenting acute IPs out of 364: 97 with AUDIT scores (≥8) showing hazardous drinking
- Of 200, 1 had full alc Hx, 54 partial. Other 146 had no record. 148 had no drug use record.
- DH DD Good Practice guidelines failed ("…to overlook or neglect substance misuse in the course of mental health treatment will result in poor treatment outcome…") – urgent training need

Attribution of risk & blame…



Practical problems nationally

- Guidelines at odds
  - DoH Good Practice Guide encourages "mainstreaming" (at least for severe MH pts with DD)
  - Appleby strongly urges assertive care for high-risk DD clients
    - yet Sainsbury Centre for Mental Health criteria for HTTs/CRTs used to discourage involvement with "primary diagnosis of alc or drug mis" (can be taken to mean "any diagnosis"…)

Tiered or stepped care

- Tiers of care are similar to steps in stepped care
- Increasing specialism as the “steps” climbed
- One team’s specialism is another team’s non-specialist or external agency
- One team’s idea of how the care path should work may not be the same way as another’s
- Who checks they work the same way from both perspectives?

Local planning processes

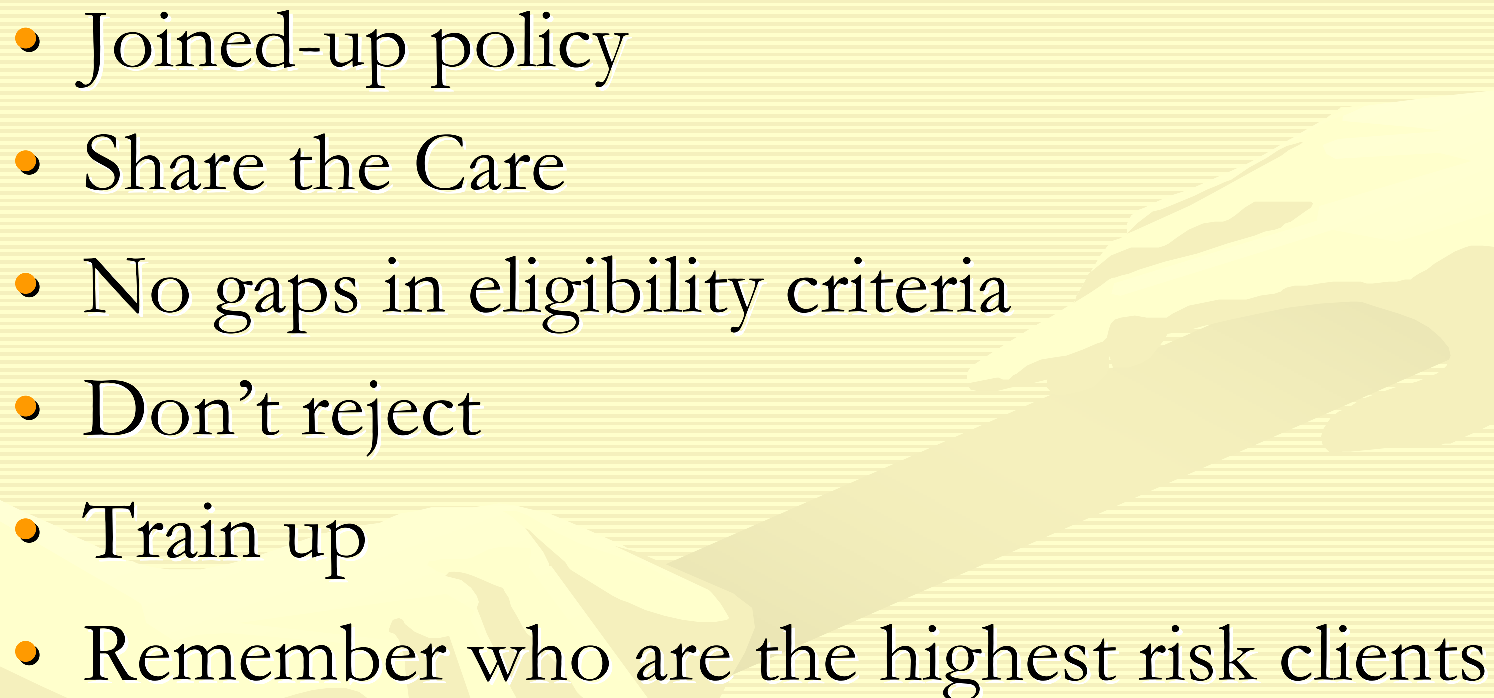
- Who writes the policies?
- Does anyone agree the eligibility criteria and review how they dovetail? Who is allowed to get away with tight exclusion criteria?
- Who refers to whom? How are the care pathways seen as working? What are the steps in care?
- Is there a manager or clinician with some clout who looks at policy/guideline development in all relevant teams? If so, do they have time to notice the inconsistencies?

Team proliferation and risks: who sees whom?

- First presentation with hallucinations & paranoid ideas, aged 25: occasional recent cocaine use, but no opiates
  - Early intervention team? – maybe
  - Crisis response team? – maybe
  - Core CMHT? – maybe
  - Substance misuse advice? – maybe
- **Who decides?**

Some principles

- Joined-up policy
- Share the Care
- No gaps in eligibility criteria
- Don’t reject
- Train up
- Remember who are the highest risk clients



Conflict or collaboration between teams

- "There is much talk about the need for better co-ordination, for collaboration, for teamwork. Yet services continue to be fragmented, intergroup rivalry and conflict are rife, and attempts to address these difficulties are met more often with frustration and failure than with success."
  - Vega Zagier Roberts, "The Unconscious at Work: Individual and Organisational Stress in the Human Services", chapter 20

Three team rivalry scenarios: 1

- Non-stat housing agency to help long stay psychiatric hospital leavers: "New Start"
- Referrals more from housing than from hospital, surprisingly; turned down most as narrow criteria not met
- Initially, declined joint assessments as feared being dumped on; saw statutory agencies as paternalistic
- Worried about "lost" (unreferred) clients, but feared chasing referrals in case they were swamped/exploited
- Eventually overcame worry, accepted equal role in joint assessments – scheme eventually very successful

2: Professional role conflict

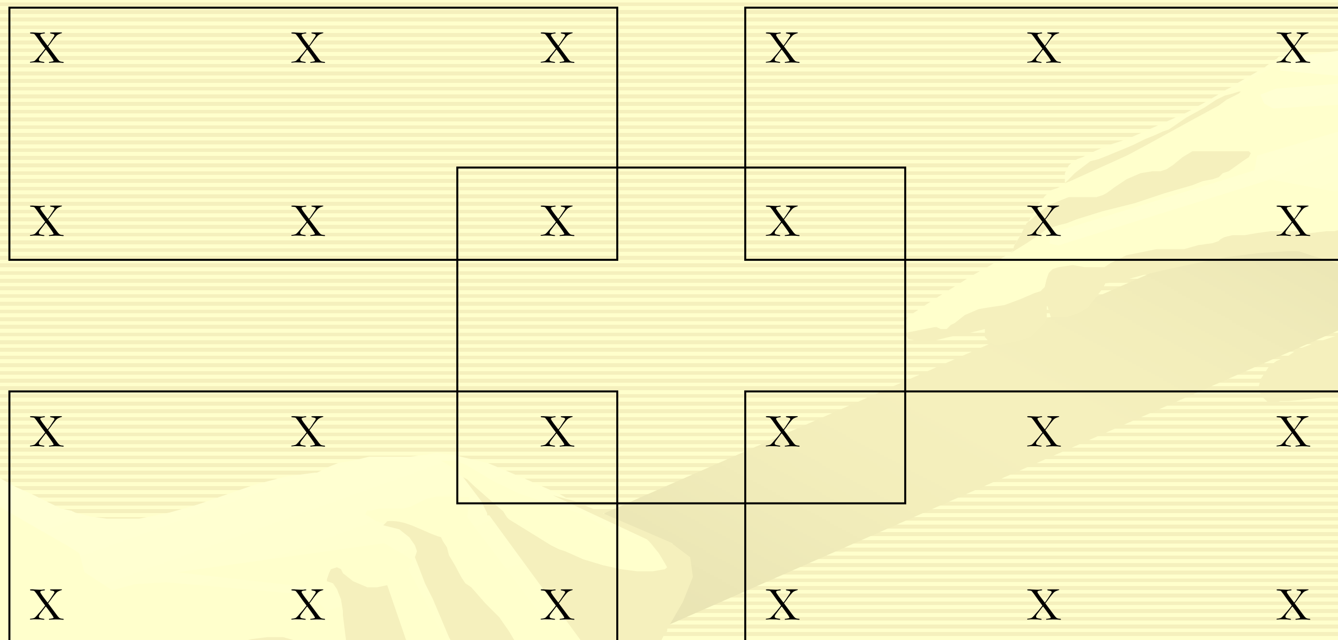
- DGH nurses (ward-based) vs OT's, physios & others (visitors to the ward, managed elsewhere)
- Overworked nurses saw OT's as "swanning in" to run groups: OT's resented nurses not getting pts ready in time (still busy being bathed etc)
- Enlarge boundaries of ward team so OT's & others helped finish bathing & felt shared responsibility
- However, mgt not handed to ward sister so report not implemented: negative "what do you expect?" response from nurses

3: Skill mix and intergroup relations

- “Bradley Lane”: CMHT plagued by interdisciplinary rivalry
- Psychiatrists, psychologists, SWs: therapy for least disabled pts
- Nurses, OTs: groups/activities for chronic pts: resented “low status” work
- New team manager wanted team cohesion: agreed on “generic” work pattern
- 1 nurse agreed to do evening group but was forbidden by external nurse manager: morale dropped, 3 staff left
- Group was abandoned, without anyone else being nominated: “they won't let us do anything anyway”
- Team abandoned individual skills & only did what all could manage

Divided loyalties in shared group/team membership

- Intergroup system (from Miller & Rice, 1967):



Which loyalty is first?

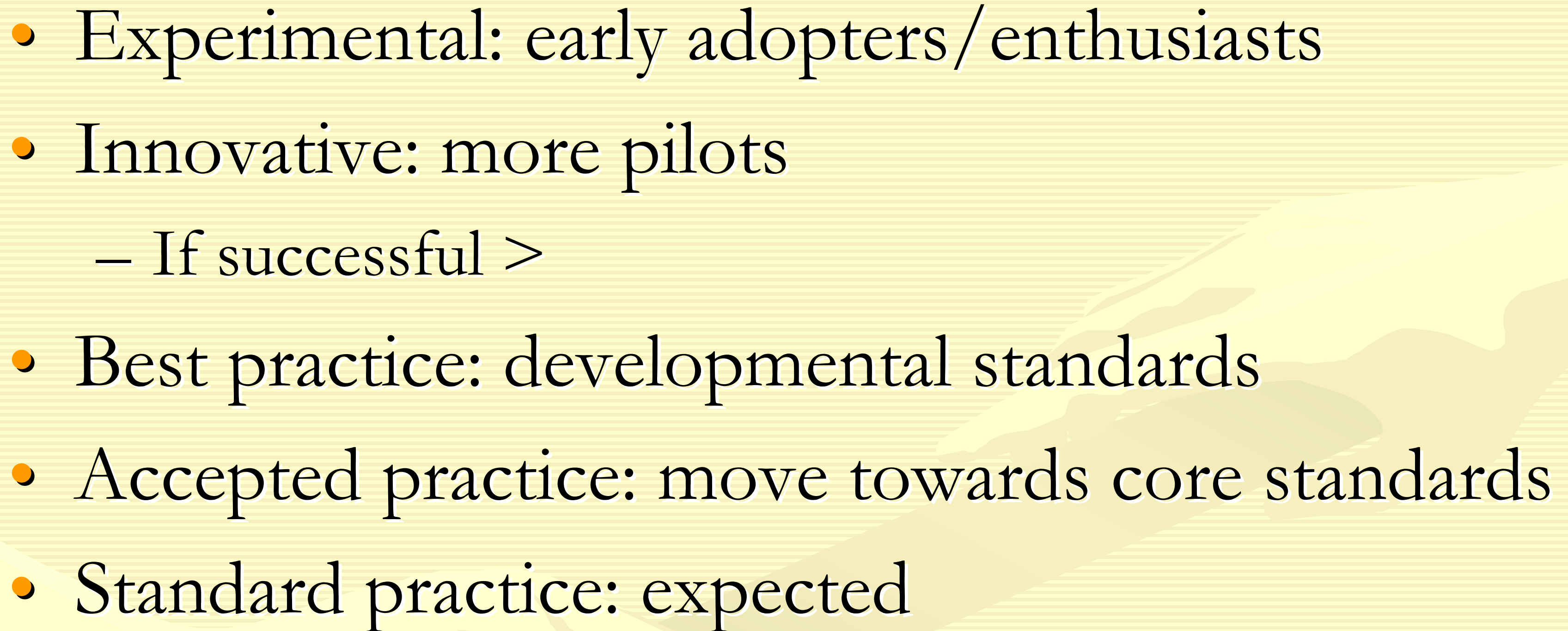
- In joint assessment teams:
- Is it your agency of origin?
- Your profession?
- Or the new group to which you are outposted (to the extent of losing original loyalty)?
  - e.g. CMHT members forgetting to be nurses, SWs or doctors for fear of rekindling rivalry – or forgetting to ask your line manager as well as your team manager when you innovate

Successful collaboration in a virtual team: what's needed?

- Clearly defined task
- Task in the interest of the home-agencies as well as the client
- Important enough for commitment and resources to be allocated
- Group membership task-related, so each member has a specific role
- Authority sanctioned both from inside and out

Stages of organisational change

- Experimental: early adopters/enthusiasts
- Innovative: more pilots
  - If successful >
- Best practice: developmental standards
- Accepted practice: move towards core standards
- Standard practice: expected



Example of innovation: early intervention service, Worcs.

	National	3 yrs EIS, '03-06 (n=78)
Duration of untreated psychosis	12-18 months	5-6 months
% of FEP pts admitted	80	41
% FEP using MHA	50	27
Readmission %	50	27.6
% engaged at 12m	50	100 (79 well engaged)
% with family involved satisfied	49 56	91 71
% employed	</= 20	55
% suicide attempted completed	48	21 0

Practical lessons in changing working patterns

- Consult widely, including key opinion-formers early on (who may not be the most senior people)
- Get some Luddites involved as well as enthusiasts: the end product will be more workable; you will have made your argument more cogent to win them over
- If necessary let them feel they own the idea
- Ensure the external reps are senior enough to be listened to in their own agency, or give them power to match responsibility in the specific area/role
- Size isn't everything: consult small agencies too, or they may fear a take-over & withdraw

Writing new clinical guidelines

- Try to keep the language plain, even if the concepts are complex
- It’s OK to borrow external ideas, but if you do, let the owner know
- Don’t worry if the first few drafts get “I’m not sure about…” or “What if…” – that’s what word-processors are for

Don’t be a bulldozer – be a bus

- Authoritativeness is better than authoritarianism
- Motivational thinking applies to changes in care systems too. Others have to make their own decisions, and are more likely to do so positively if shown alternatives rather than pushed.
- Or, in TA terms: “Because I say so” is critical-parent, and brings out rebellious-child in the listener. Wise and well-informed adult is ideal.
- Buses take people with them, and go further than bulldozers in the long run anyway.

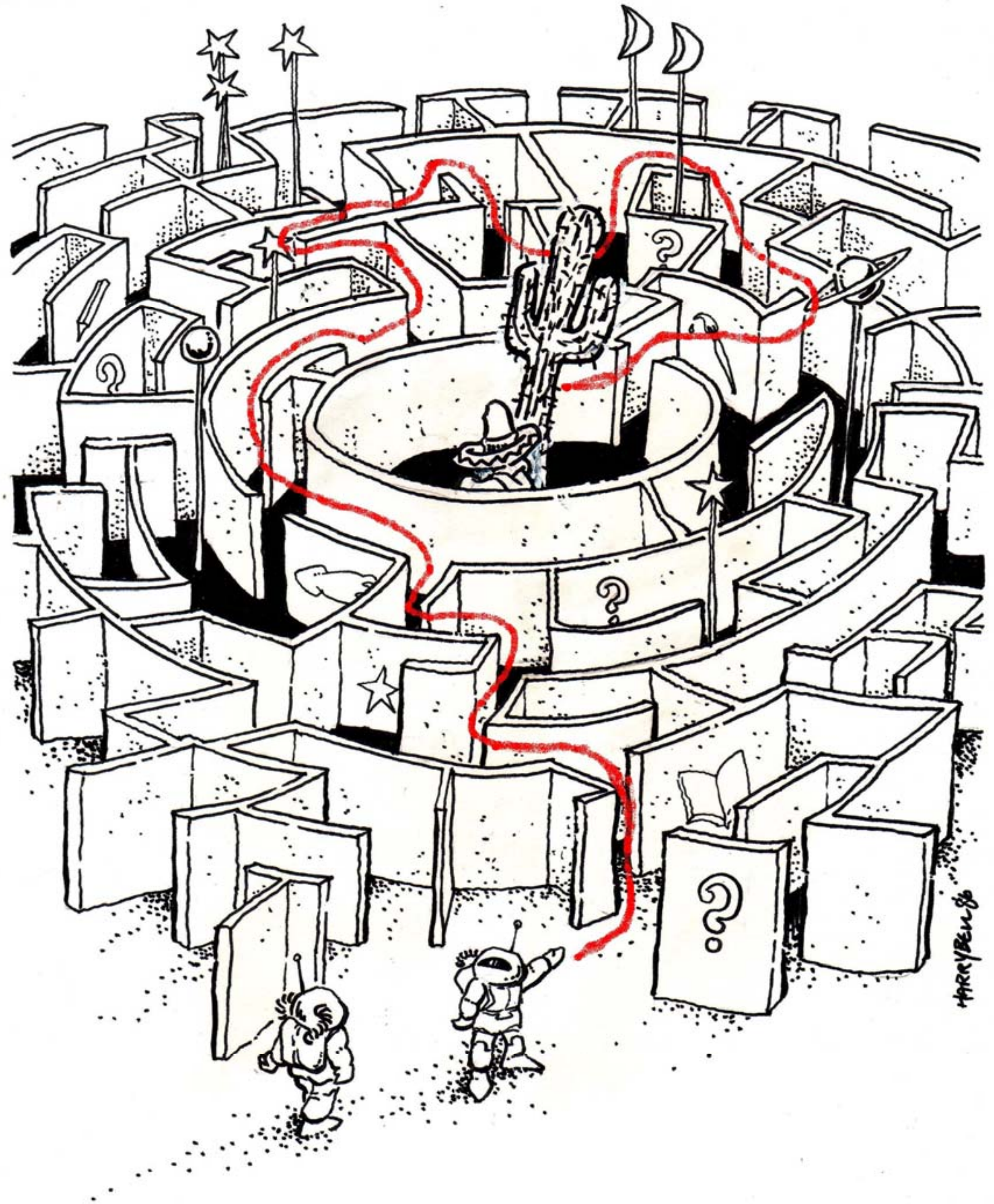
Joined-up planning

- Commissioners and service managers need to ensure:
  - Care pathways are clear
  - Stepped care process is clearly understood
  - Each team knows where they stand in terms of steps of care
  - Expected activity levels/workload match demand/need and resource
  - Pressure points where there is too much work are identified and supported

Implementing collaboration

- Agree to keep in touch
- Timetabled assessment slots?
- Get to know each other's teams' skills, strengths and limits
- Develop shared crisis management strategies
- Loyalty in virtual teams: it's to the **PATIENT** and his or her safety and well-being, not one or other team or profession. Then the care may make sense.

… with a way through



Concept of the therapeutic team

- Therapist/patient therapeutic alliance depends on empathy, genuineness, warmth
- Same qualities variably present in teams
- Don't be defensive with your colleague teams
- Know your own team's strengths: they are more important than its gaps/weaknesses
- Spot the patients where a stitch in time saves nine
- Be therapeutic to your fellow services/teams as well as patients

References and links

College Research Unit on dual diagnosis (3 papers within this link):

http://www.rcpsych.ac.uk/crtu/centreforappliedresearch/completedprojects/dualdiagnosisinfo.aspx

The Unconscious at Work: Individual and Organisational Stress in the Human Services – ed. Anton Obholzer, Vega Zagier Roberts, and James Krantz; Routledge 1994

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Department of Health (2002): Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. London: The Stationery Office.