Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Takes your breath away: a case study of systemic formulation of COPD, Panic and Frequent Attending

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Introduction

Chronic Obstructive Pulmonary Disease (COPD) is commonly associated with frequent ED re-attendance (Paul et al., 2010; Kirby et al., 2011). A UK study found 1 in 5 patients with COPD are clinically depressed and 1 in 3 patients have an anxiety disorder (Cleland et al., 2008). It has been shown that catastrophic thoughts in patients with COPD are more severe in places the individual perceives to be unsafe and patients tend to avoid these places (Sutton et al.,1999). A systematic review by Dickens et al., (2014) found a 30% reduction in urgent care use by patients with COPD who had a 'complex intervention' including psycho-education and relaxation.

Case Study: Irene*

- Retired carer, living alone for the first time bungalow for over 55's.
- Divorced and a mother of 6—family 'feuds'
- End stage COPD, (continues to smoke 5-10 cigarettes per day.)
- Diagnosed with Anxiety and Depression
- Pharmacologically treated with a variety of anti-depressants.
- Cognitively intact; ACE-3 98/100

- 7 previous RAID referrals in previous 12 months.
  Resulting in:
- Referral to primary care x 2 for IAPT pathway.

- Psychoeductation and low intensity CBT while an inpatient.
- Reviews and increase of anti-depressant.
- Referral to older adult Community Mental Health Team (CMHT)
- No engagement due to repeat admissions.

PLAN

Assessment

- Analysis of hospital presentations and admissions (Figure 1)
- Patient's psychological and social status assessed to inform and develop an:

Interactive Formulation of patient's behaviour and system response (Figure 2)

Intervention: Liaise with systems involved and make recommendations based on formulation to improve well being and reduce unnecessary admissions (Figure 3).

Pattern of Hospital admissions

Irene has been admitted 18 out of the 22 times she has presented to hospital (82%).

15/18 discharge summaries stated:

- 'no acute medical problem'
- 'no change'
- 'no acute exacerbation'

Across the admissions Irene had an average stay of 8 days (range 1-14 days). 150/365 days as inpatient (41%) with only 13 days in with infection.

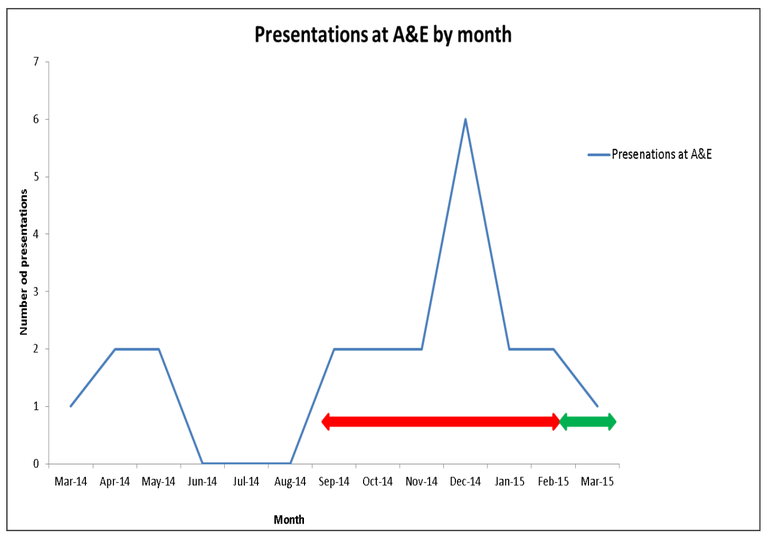


Figure 1

Cost assessment estimate through liaison with hospital informatics of previous years attendances: **£45,139**

Conclusions: Likely to be admitted if she attends ED leading to costly social admissions, reinforcing attendance behaviour.

RAID Assessment on the ward

- No objective evidence of anxiety or depression evident on assessment.
- Doesn't like living alone, feels safer in hospital.
- Refuses to consider residential care.
- Family are not visiting.

Discussed pattern of readmissions, elicited specific thoughts and patient acknowledges 'It's all just panic' but threats of self harm if suggestions of potential benefits of considering accommodation when faced with discharge.

Intervention: Liaison and intervention with involved systems

The aim is for containment within the community to reduce unnecessary hospital presentations and admissions. The intervention strategy included:

- ⇒ Psycho-education on ward for staff and patient
- ⇒ Reinforced previous anxiety management techniques (esp. controlled breathing)
- ⇒ Liaison with services involved –GP, MHT, Community Respiratory Nurses
- ⇒ Multi-agency, multi-discipline involving Irene and family meeting recommended to enhance community support and minimise re-attendance.
- ⇒ Shared formulation with Irene, ED and community teams and GP.
- ⇒ Recommendations for admission criteria and conservative management in hospital (A copy in notes and on hospital data systems).

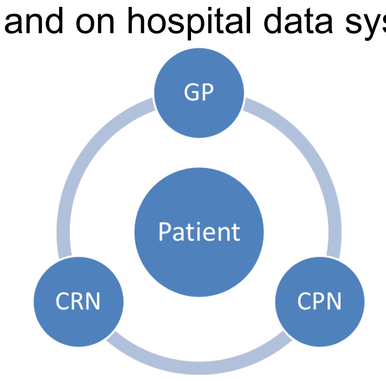


Figure 3

Outcome

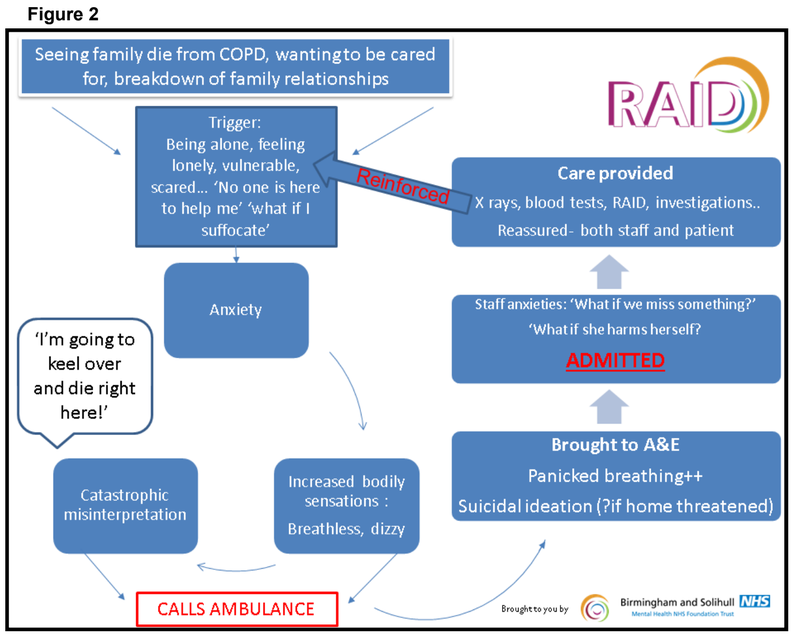
Initially there was an on-going continuous cycle of responding and reinforcement from the system. Irene* continued to refuse supported accommodation or a care home.

There was an eventual agreement of discharge to care home, at which time the frequent presentations stopped. There has been on-going interventions with care home staff to ensure continued successful management of anxiety and panic attacks.

Irene's case is an example of how RAID teams can intervene with costly patients who frequently use hospital services.

*Name changed to preserve confidentiality

Figure 2



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