Preliminary Evaluation of a Psychology led RAID outpatient Follow-up clinic

Dr Mary Oldham (D.Clin.Psy) Clinical Psychologist, Birmingham Heartlands Hospital

Background: The Rapid Assessment, Interface and Discharge (RAID) model initially piloted at City Hospital (Birmingham) included a Senior Clinical Psychologist as part of the core skill mix of the original team. Since the roll out of RAID across all five acute hospital sites in Birmingham (April 2012) an additional 8a Highly Specialist Clinical Psychology post was established (October 2012). This poster presents the preliminary evaluation of a psychology led RAID outpatient follow-up clinic established as a pilot to support RAID principles of facilitating early discharge and minimising re-attendance via referral to appropriate mental health pathways and supporting the development of services that are not currently well established, e.g. MUS. The clinic was run by Mary Oldham or the Trainee Clinical Psychologist on placement with RAID representing only 0.1% of the working week. Referrals can be made by anyone in the team with appointments easily booked through a shared diary. Patients were offered an assessment and signposting or a brief intervention within 2 weeks of their discharge from hospital. It is important to note that within the wider hospital context, there is a significant lack of psychological input for the vast majority of medical specialties.

Referral guidance for RAID follow-up clinic

1. Any person requiring further psychological assessment and formulation to determine the appropriate care pathway e.g. between primary or secondary care (including suitability and motivation for psychological therapies) particularly those people with functional disorders and MUS.

2. Patients who may benefit from a brief psychological intervention of up to 8 sessions.

3. Clients who present with new incidences of self harm.

For those suitable for a brief intervention either individualised Cognitive Behavioural Therapy (CBT) incorporating Compassion Focussed, Mindfulness and Attention and Commitment training or Psychodynamic Interpersonal Therapy (PIT) was delivered.

Exclusion criteria:-

+ Patients who currently present as high risk of harm to self or others and patients who are already open to services for whom current services are well established.

Clinical Health Psychology Posts (WTE) by medical speciality within Birmingham Heartlands Hospital

(Total capacity 700 beds approx.)

Cystic Fibrosis: 1.5, HIV: 0.4, Brittle-Asthma: 0.4, Oncology: 0.5

Method:
The preliminary data presented here was sourced following a retrospective case note analysis (Mental Health and Acute Hospital records) and feedback from interviews carried out by our service user representative. Due to time restraints, hospital attendance data and case examples are only presented for small group of more complex patients.

Results

169 appointments were offered (approx. 2/52 per week).

Mean appointments 4, Median 3, Mode 1

77% of appointments offered were attended

- 12 patients attended just one appointment which in many cases was enough to facilitate access to the appropriate care pathway.
- 25 patients attended more than 1 apt.
- 7 patients did not engage. 3 were self harm referrals in the context of social stressors, 3 were frequent attenders to the hospital and 1 patient was transferred to a rehab bed and could not attend the apt. offered.
- 9 patients dropped out from agreed sessions, usually the first.

What was offered therapeutically?

CBT was delivered to 50 % of referrals and these tended to be more straightforward cases.

Self harm and MUS interventions requiring a more exploratory approach were based on Psychodynamic Interpersonal Therapy (PIT) which has evidence for use in liaison psychiatry (Guthrie et al 2001).

Referrals on from RAID psychology clinic

Neuropsychiatry
Psychiatrist
Psychiatric psychiatrist
Specialist Psychology 1/2 sessions
CMT
3rd sector
Primary Care Psychologist (WPT) services
No further mental health

81% of patients who attended at least one follow-up appointment (n=37) were not referred to any RAID service again.

MUS Case Example- Anna, 52 yrs
Referred to RAID following an admission with medically unexplained limb weakness. Further psychological assessment identified significant underlying trauma and emotional numbing. Anna likened her condition to a physical “freezing” of her emotions. She was referred on for Specialist Psychotherapy.

“My condition would not have been picked up in another acute hospital outside of Birmingham- many people present in this way and remain undiagnosed- they remain with medically unexplained symptoms. The key to RAIDs role and skills is recognising there are such conditions and there are psychological interventions and approaches to support people who have these problems.”

Discussion: This clinic was in essence a pilot to establish the most appropriate focus for liaison psychology outpatient follow-up. Through this evaluation it is evident that in the context of a hospital with extremely minimal access to psychologists, there is a danger that the clinic could be used to ‘plug the gaps’ whereas there is a demand for clinical psychology especially given that the majority of referrals were for patients with long term conditions. However, it could also be argued that the accessibility of the clinic in terms of speed of response enabled an upstream intervention to be delivered at the time of the clinician’s felt to be a vital component of the RAID model. Self harm ‘hot clinic’ were part of the original RAID model but are not currently easily provided due to 24 hour shift patterns. With approximately two appointments offered per week, the clinic formed only a very small proportion of the workload for a further Consultant Psychologist.

Complex Case—Michelle, 40 yrs

Factitious Illness Disorder – 20 years of “Hospital Hopping”

- Suspicions raised due to difficulty verifying identity including NHS number and self reported mental health history.
- Well practiced and researched admission “script” identified that raises concern enough to secure admission.
- Reports a diagnosis of schizoaffective disorder and alleged long list of medication.

Impact of Liaison Psychology Role and value of outpatient follow-up:

- Multiple telephone calls to verify information—matched with profile on mental health system for patient with 20 years of hospital history and a list of 20 fabricated identities.
- RAID Clinical psychologist built up rapport and engagement during admission resulting in attendance at outpatient clinic and a period of stability including engagement in local voluntary work placement.
- Described accessing hospital as a type of “addiction” to gain comfort, security and care. Underlying attachment disorder.

“Feels there has never been a service for her...”

- Despite continued hospital admissions nationally, liaison psychologist details now given by patient as a point of contact reducing LOS, admissions, investigations or prescriptions.

Complex/High Impact patients (MUS)

- 2/12 patients DNA’d.
- They continue to present 36/53
- ED attendance
- 6 mths pre.post.
- 12 patients engaged.
- Graph represents attendance data for 9/12 (1 patient excluded who had only recently completed brief intervention)

Description of outcomes for MUS group who engaged:

- 2 patients referred to specialist psychotherapy
- 2 patients offered a brief intervention of 5/7 sessions (no further mental health contact or acute hospital attendance)
- 2 patients referred to BHM after initial formulation work
- 1 discharged to GP with advice for GP management
- 1 patient engaged with 8 session intervention and requires continued liaison to reduce admission with care plan established for ED staff.
- 1 dropped out of therapy and continued to present with similar symptoms
- 1 continues to present nationally—see case example Michelle

References:

- Robb, et al, 200
- Self harm: The short and long term psychological and social impact of self harm in primary and secondary care
- Factitious Illness Disorder
- Primary Care Psychologist (WPT) services
- No further mental health
- 6 mths pre:post .
- ENGAGEMENTS
- Admissions
- Graph represents attendance data for 9/12 (1 patient excluded who had only recently completed brief intervention)

MUS Case Example- Anna, 52 yrs
Referred to RAID following an admission with medically unexplained limb weakness. Further psychological assessment identified significant underlying trauma and emotional numbing. Anna likened her condition to a physical “freezing” of her emotions. She was referred on for Specialist Psychotherapy.

“My condition would not have been picked up in another acute hospital outside of Birmingham- many people present in this way and remain undiagnosed- they remain with medically unexplained symptoms. The key to RAIDs role and skills is recognising there are such conditions and there are psychological interventions and approaches to support people who have these problems.”

Discussion: This clinic was in essence a pilot to establish the most appropriate focus for liaison psychology outpatient follow-up. Through this evaluation it is evident that in the context of a hospital with extremely minimal access to psychologists, there is a danger that the clinic could be used to ‘plug the gaps’ whereas there is a demand for clinical psychology especially given that the majority of referrals were for patients with long term conditions. However, it could also be argued that the accessibility of the clinic in terms of speed of response enabled an upstream intervention to be delivered at the time of the clinician’s felt to be a vital component of the RAID model. Self harm ‘hot clinic’ were part of the original RAID model but are not currently easily provided due to 24 hour shift patterns. With approximately two appointments offered per week, the clinic formed only a very small proportion of the workload for a further Consultant Psychologist.

Complex Case—Michelle, 40 yrs

Factitious Illness Disorder – 20 years of “Hospital Hopping”

- Suspicions raised due to difficulty verifying identity including NHS number and self reported mental health history.
- Well practiced and researched admission “script” identified that raises concern enough to secure admission.
- Reports a diagnosis of schizoaffective disorder and alleged long list of medication.

Impact of Liaison Psychology Role and value of outpatient follow-up:

- Multiple telephone calls to verify information—matched with profile on mental health system for patient with 20 years of hospital history and a list of 20 fabricated identities.
- RAID Clinical psychologist built up rapport and engagement during admission resulting in attendance at outpatient clinic and a period of stability including engagement in local voluntary work placement.
- Described accessing hospital as a type of “addiction” to gain comfort, security and care. Underlying attachment disorder.

“Feels there has never been a service for her...”

- Despite continued hospital admissions nationally, liaison psychologist details now given by patient as a point of contact reducing LOS, admissions, investigations or prescriptions.

Complex/High Impact patients (MUS)

- 2/12 patients DNA’d.
- They continue to present 36/53
- ED attendance
- 6 mths pre.post.
- 12 patients engaged.
- Graph represents attendance data for 9/12 (1 patient excluded who had only recently completed brief intervention)

Description of outcomes for MUS group who engaged:

- 2 patients referred to specialist psychotherapy
- 2 patients offered a brief intervention of 5/7 sessions (no further mental health contact or acute hospital attendance)
- 2 patients referred to BHM after initial formulation work
- 1 discharged to GP with advice for GP management
- 1 patient engaged with 8 session intervention and requires continued liaison to reduce admission with care plan established for ED staff.
- 1 dropped out of therapy and continued to present with similar symptoms
- 1 continues to present nationally—see case example Michelle

References:

- Robb, et al, 200
- Self harm: The short and long term psychological and social impact of self harm in primary and secondary care
- Factitious Illness Disorder
- Primary Care Psychologist (WPT) services
- No further mental health
- 6 mths pre:post .
- ENGAGEMENTS
- Admissions
- Graph represents attendance data for 9/12 (1 patient excluded who had only recently completed brief intervention)

MUS Case Example- Anna, 52 yrs
Referred to RAID following an admission with medically unexplained limb weakness. Further psychological assessment identified significant underlying trauma and emotional numbing. Anna likened her condition to a physical “freezing” of her emotions. She was referred on for Specialist Psychotherapy.

“My condition would not have been picked up in another acute hospital outside of Birmingham- many people present in this way and remain undiagnosed- they remain with medically unexplained symptoms. The key to RAIDs role and skills is recognising there are such conditions and there are psychological interventions and approaches to support people who have these problems.”