Taking Responsibility

The Cambridge “full care” locality
PD service: A report back at three years.

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Areas covered

- Context – historical/geographical
- Structure of the service
- Underlying philosophy
- Findings/issues emerging

Geographical context

- Cambridgshire – population ~900K
- Cambridge, Huntingdon, Peterborough, Isle of Ely, Fenland

Historical context

- 2003 “no longer a diagnosis”
- ~12 community pilot sites – Cambridge “Complex Cases” PD service
- Core “lifeworks” support +/- skills, arts psychodynamic group and individual
- 2010 – Coalition strategy, ending of ring fenced funding.

Critique of “Complex Cases”

- Didn’t take “responsibility” – i.e. CPA
- Saw few patients intensively
- Unclear parameters for acceptance
- Inequity of access (Cambs only 8 years)
- “lottery” – long term intensive to small group
- Extended intense input; some improved, some did not

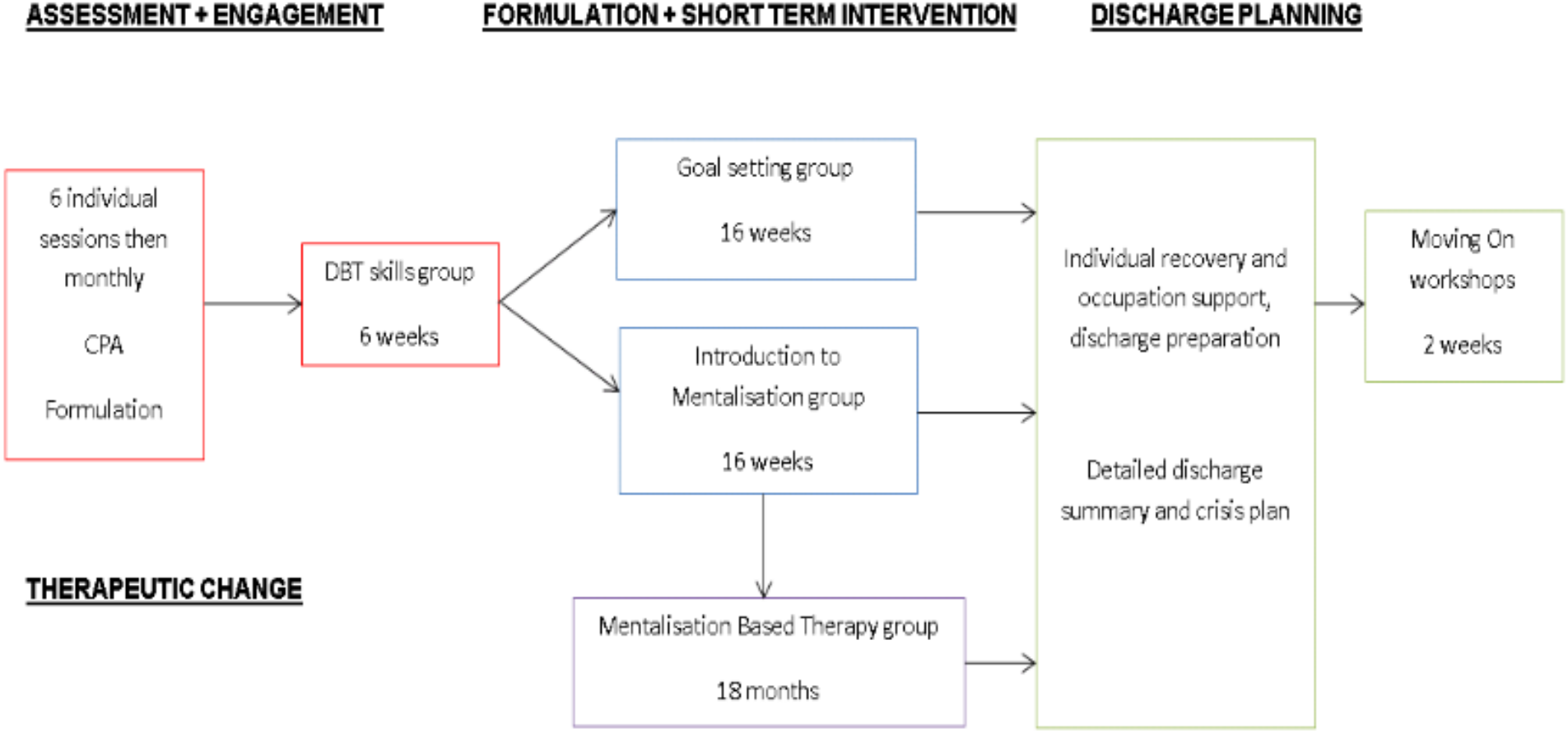
PDCS

- 17% top sliced from community team budget
- ~25 member team
- Working across 4 sites across the county
- ~8 month treatment programme (proposal was 2 years; needed more FPEs)
- Commissioner driven and tailored

8 month treatment programme

1. 6 weeks 1:1 care coordination
    - paperwork, care plan
    - crisis plan
2. 6 weeks DBT skills (distress tolerance module)
3. 4 months of group work
    - either MBT skills group
    - or “Goal Setting” OT group
4. 2 weeks “moving on group” and Discharge back to GP

Personality Disorder Community Service – flow diagram



CRISIS MANAGEMENT

Open clinic daily (face to face when needed)

Liaison with all external agencies, emergency services, GPs, CRHTTS, Liaison Psychiatry, Housing, inpatient wards (including out of area), Social Care

Philosophical underpinning

- Anti-”lottery”; equity of access
- Fordist/industrial conveyor belt activity
- Maximisation of resource impact
- Pragmatic provision for (cluster 7/8).
- Team not individual responsibility
- No long term follow up
- Provision of a treatment “dose” to the greatest possible number
- Explicit/reliable time-limited treatment for the chaotic, attachment disturbed and impulsive

Focus on greatest need

- Pragmatic limitation to cluster 7/8
  - Decision following deluge of referrals
  - Legitimised in terms of targeting the highest risk/most active people
- Triage of referrals takes out about 30%
- No ASPD service; borderline only
- Pragmatic decision based on evidence, levels of referrals, and premises

Industrial conveyor belt activity

- Cohort model
  - On cohort 9;
  - Each cohort has ~42 people; staggered entry
  - Each care coordinator has 25-30
- Rigorous challenge of developing co-dependency
- Maximisation of resource impact
- Dose management; discharge and re-referral

Team not individual responsibility

- Reduction in care coordinator role
  - CPA; risk assessment/crisis plan; MHA stuff
  - Everything else done by “duty team”.
- Reduction in burn out and adverse enactment
- More efficient use of resource
- Able to provide planned treatment groups whilst also giving flexible response to phases of acute need and social care demands
- Duty team expansion of role

No long term follow up

- Discharge back to GP after treatment dose
- Notwithstanding continuing/escalating risk

Rationale

- Lack of effectiveness
- reducing individual resilience; promotion of dependency
- Intermittent reinforcement.
- unsustainability

Evidence based treatment dose

- 4 therapy components
  - Attachment – initial sessions
  - DBT – distress tolerance module
  - MBT ***skills*** for more psychologically integrated
  - OT based more basic skills for the socially isolated / functionally impaired
- Support component
  - Duty team are coordination
  - Open clinic
  - Crisis meetings

Treatability vs outcomes

- 'Conveyor belt' programme allows for evaluation at set time points
- T1 – assessment; T2 – before groupwork; T3 – end of groupwork / discharge
- Measures of 4 domains; BPD pathology, self harm rates, social functioning, wellbeing
- Dedication needed to get high returns!
- Analysis of match pairs shows significant reductions in BPD pathology, anxiety & depression, self harm, plus increases in wellbeing
- Re-referral rates approx. 18% - does this indicate effectiveness??

18 month MBT programme

- Only for some who have completed MBT skills group
- Selection based on assessed capacity to develop curiosity, a level of functioning social network, ability to consider 'other' perspectives, commitment to delay or suspend use of suicidality to manage emotion
- Resource only to provide this to approx. 20% of total caseload, with resulting fears of not being 'good enough'

Emerging issues

- Treatability of cluster 7/8
- Case-work drag
- Decline in severity and waiting lists
- Resumption of “diagnosis of exclusion”
- Other system changes

Treatability of cluster 7/8

- High levels of drop out ~50%
- Follow on MBT therapy (18 month programme) numbers declining

??? Wisdom of focussing on cluster 7-8;

??? Patient group too chaotic to be able to tolerate treatment (PCLR with ASPD)

Increasing case work drag

- Locality team “fire-fighting” problem
- Increasing expectation to provide locality team functions
    - Medication reviews
    - Perinatal care
    - Risk based follow up
    - SG/MARAC/CIN activities
    - FU of hospital discharges
    - Cluster C service
    - ASPD

Severity and waiting lists

- ?? Clinical impression of reduction in crises and severity (blood/police in waiting room)
- Reduction in waiting lists
  - In part "opt in"
  - In part PDCS triage/asst/treatment of

    ~ 1250-1500 of 2000 in county (at 10% prevelance)
- > Recent lowering of threshold – how do you identify the 'sweet spot' of treatability?
- Requires skilled assessment – resource intensive

New exclusionism

- Initial wave of PDs “on the books”
- Differential practice between teams
- Performance management of largest to discharge all PD and refer all PDCS
- One way street for co-morbidity

Other system issues

- Cambridge “3/3/3” model supportive; open admissions for some
- Concept of “chronic high risk” and CRHTT
- Development of self referral portal
- Complex cases and I/P graduates
- Joining up with emergency services

Discussion issues

- Radical design
- “Calm management” hypothesis vs “problem elsewhere”
- Paradoxical role of duty – ?increasing instability and dependency
- Re-referal of 18% > ?effectiveness

thank-you

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