

Feature

What's your emergency?



Sifo Cracitor/Corbis

It's 2 AM and a man with bipolar affective disorder rings 111 complaining of insomnia and unbearable agitation. He feels like he's heading for a mental health crisis but is struggling to communicate his concerns. With only a blank sheet of paper to guide his treatment, the call handlers and clinicians are left with little option but to despatch an ambulance and bring the man to his local accident and emergency (A&E) department.

"Situations like this happen all too often", says Julia Riley, a palliative care consultant at The Royal Marsden, about this hypothetical scenario. "If a crisis happens out-of-hours the default position is A&E even though that's not always the best option. But for emergency teams it's often their only option because of the lack of information they have about the patient."

Riley is clinical lead at Coordinate My Care, an NHS clinical service for London and Surrey Downs that creates urgent care plans for patients that can help to more effectively guide emergency treatment. Once created, these personalised plans are shared securely across health and social care providers so that more appropriate solutions can be sought. The service was established in 2010 for end-of-life patients and by the beginning of next year it will be available for patients with mental health disorders.

"If emergency services such as A&E staff or the ambulance service had access to an urgent care plan for mental health patients", she says, "I think many crises could be avoided." It would be of benefit, she adds, to anyone with multiple, complicated drug regimens or to people who are vulnerable to brittle emotional crises or extreme emotions during crises, especially those who cannot advocate for themselves. The urgent care plans will detail a patient's medical requirements as well as contact details for, say, their family members. "If a patient was reassured that help was at hand they might settle without the need to be admitted to A&E, which would serve only to increase their anxiety."

Some patients will need to go to A&E, but here Coordinate My Care can provide the treating clinician with the patient's current drug regimen and crisis treatment actions. "If the patient had bipolar and acute depression, maybe they are suicidal, the urgent care plan might say double their dose of drug 'x' and here are the contact details for their mental health team in the morning."

The system, Riley says, is a little clunky at the moment. It is undergoing a makeover and will be redesigned on a new platform by September this year. "By September, accessing the system will be as easy as going on Amazon", she says. "By the end of November clinicians and patients will be able to access their urgent care plans on their smartphones."

Number crunching for the palliative care service show that Coordinate My Care is cost-effective—as well as ensuring that

80% of patients died in their preferred location, it saves the NHS £2100 when the increased community costs were offset against savings in ambulance trips and hospital admissions. That the system has already been paid for—and that much of the heavy lifting around consenting, data sharing, clinical governance, and security has been done—makes the financial argument for rolling-out to mental health patients more appealing. But because of the complex and continuous nature of psychiatric care, says Alex Thomson, a liaison psychiatrist and clinical network lead for psychological medicine at Central and North West London NHS Foundation Trust, the cost-benefit analysis is not quite as clear for mental health.

"In principle, the idea of having communication and shared, advanced care planning is potentially beneficial", he says. "But out-of-hours mental health services already have access to the electronic records used by community mental health teams and I'm not convinced that an IT solution can completely compensate for gaps in mental health services."

As such, having coordinated care can help with the immediate crisis but won't, he says, necessarily prevent a patient's situation from getting to a crisis. "In A&E we can't start mental health treatments or bring people back for ongoing care", he says. "We can plug a gap but really we need to refer to a treatment team or a community mental health team and often there's still a long waiting list to actually start treatment." It also won't replace the human element of needing skills to deal with mental health crises. "In a mental health crisis, the element of interpersonal contact is crucial. Of course medicines have a role to play but a therapeutic encounter with a compassionate health-care professional is more likely to prevent crises escalating than changing the dose of drugs."

He also stresses the need to ensure that the system is not a standalone one, and that health professionals are not forced to enter information about care plans, which he says should be getting made anyway, into two separate systems. "Increasing the time it takes to see each patient reduces the total number of patients mental health services can help", he says, "It can also increase the risk of misunderstanding if care plan information gets out of sync on different systems. Coordinate My Care should pull care plans off existing record systems." Coordinate My Care, says Riley, will have the ability to be interoperable with any system from April, 2016.

Patient confidentiality is also a concern. Police, for instance, will not be given access to information in care plans after patient groups indicated that it would make them less comfortable. Thomson adds that some patients might be reluctant to share information more widely than is necessary, even within the health system. "The information in these

plans can be quite personal”, he says, “and let’s face it, there’s still a lot of stigma and misunderstanding associated with mental health conditions even among health professionals.”

Management of this system for patients with mental health disorders, says Hugo de Waal, a psychiatrist and clinical director for dementia at the South London Health Innovation Network, will not only be about protecting information, but improving the flow of it to patients. de Waal has been advising Coordinate My Care about the service’s roll out later this year to patients with dementia. The service’s urgent care planning for dementia is being developed in close collaboration with MyBrainBook, a separate initiative from de Waal and colleagues at the South London Health Innovation Network that aims to put people with dementia and their family carers at the centre of their care planning process, including urgent care planning and helping anticipatory care for physical co-morbidities often seen in dementia.

Speaking about the anticipated roll out of Coordinate My Care to patients with mental health disorders, with which he is not involved, de Waal says: “Mental health patients have to understand the benefits but also the limitations of the service. Drafting an urgent care plan in psychiatry is more difficult than with, say, end-of-life care where patients decide on palliative interventions and place of dying. These are fairly circumspect preferences, whereas for mental health care they are more complex.”

A patient, he says, might have previously been sectioned under Section Two of the Mental Care Act. “They might

say ‘it was a nightmare and I didn’t get the care I wanted or needed. Can we please avoid that at all costs?’ It makes sense at the time—and it’s the stated aim of any decent psychiatric service—but if the decision is made by the usual process and the care plan is over-ruled and the patient is again sectioned, then the patient’s previously expressed preferences are utterly meaningless.”

Riley is not perturbed by the complexities of the challenge. “To my knowledge nothing like Coordinate My Care has been done before”, she says. Madrid and Hong Kong, she adds, are the only other places in the world with systems that link planned with emergency health care, though Madrid’s is not as technologically complex, based on a largely email system, and Hong Kong has the technology “but doesn’t have the care planning. Coordinate My Care is about the wrap-around teaching and training process as well as the IT”, says Riley.

“The whole programme”, she continues, “is all about anticipatory care rather than reactive care. It means a culture change as it’s not how doctors and nurses have traditionally been trained. We’ve seen with palliative care that we get outcomes that are repeatedly good and I don’t see why that won’t be the same in mental health. Our main aim is to improve patient care and stop people falling through the gaps in services. As we’ve done with palliative care and are doing with dementia, we’ll make sure that the system in mental health will not veer from this central tenant of improving care.”

Dara Mohammadi

Essay

A labour of love

As a child I was lucky to live next door to a great art teacher called Jane, who was friends with my mum and gave me lessons from a very young age. I loved it, and my passion grew from there. My grandpa, who was a farmer, entered one of my paintings into a competition at his local market show in Cricklade. I won a rosette, and I was so happy that I knew I wanted to be an artist right then. At secondary school, Jane introduced me to the impressionists, Magritte and other surrealists, Lucien Freud, Stanley Spencer, and Francis Bacon who still influence me today. At 14, I got an art and sport scholarship to a boarding school called Millfield. The school had a dyslexia unit, which would be a help to me, as well as a very good art department. It was also the school my dad went to. He’d had a great experience, so there were high hopes for me to do the same.

Unfortunately, although Millfield is a great school, I didn’t see that at the time. I hated being away from my home and family. I fell in with a bad crowd, and by the end of my time there, though I had got straight A grades for my subjects, I

started to develop severe paranoia due to smoking cannabis through my teenage years.

I started an art foundation course in Bristol and there was a lot of self-expectation, finally being back where I wanted to be. I had been thinking about being back home for years, and was infatuated with all things about Bristol at that age: drugs, drum and bass, and graffiti! I started spray-painting seriously, and came up with stencils based on Banksy that I sprayed around Bristol. I came up with a tag called Hardie, an abbreviation of my second name. But things began to go off the rails. I started to see prophetic meanings in graffiti including my own tag and felt grandiose and immense elation that made me perceive in a new way and was very spiritual. I thought I could change the world but when I told others they thought it was strange. I lost touch with day-to-day things that keep you grounded and my thoughts spiralled because I was trying to find a reason or crux to existence. I couldn’t sleep for days on end thinking. The elation turned into existential despair as I couldn’t find a reason and started



George Hardie