

Effective Interventions Unit

Integrated Care Pathways Guide 6: Drug Misuse in Acute Psychiatric Settings

WHAT IS THE PURPOSE OF THIS GUIDE?

This is the sixth in a series of guides on developing and implementing Integrated Care Pathways (ICPs). This guide sets out the processes involved in providing care and treatment to drug misusers within an acute psychiatric setting which is consistent, evidence-based and appropriate to the needs of the individual.

WHO SHOULD READ IT?

Those involved in commissioning, planning, delivering and evaluating in-patient mental health services. It is primarily targeted at nursing, social work and medical staff working in acute psychiatric units that do not regard themselves as specialists in the treatment of drug misuse.

DEFINING THE POPULATION

In 2000/2001 there were 33962 admissions to psychiatric hospitals in Scotland, over 1700 of these had a drug related diagnosis (ICD-10) of which 262 (14.8%) had a concurrent diagnosis of schizophrenia.¹

A survey of over 200 homeless people in Glasgow found that 44% met the criteria for at least one mental health diagnosis (excluding substance misuse). Of these, 45% experienced disorders of anxiety and/or depression. A quarter of the total survey population showed evidence of drug dependence but in the 25-34 year age range this rose to 70%. 18% of the total sample was dependent on heroin.²

The Office for National Statistics recently reported that those who were dependent on drugs (other than cannabis) were around five times more likely to have ever attempted suicide than those who were non-drug dependent (20% compared with 4%).³

This Guide contains information on:

- Defining the population
- The scope of the pathway
- Who should be involved?
- Defining the desired outcomes of care
- Identifying key indicators
- Mapping current practice
- Identifying potential failure points
- Reviewing evidence of good practice
- Designing the pathway
- Flowchart and menu of documents
- Checklist
- Next Steps and Other Resources

SUMMARY OF EVIDENCE

On average, 34 people are admitted every week to psychiatric hospitals in Scotland with a **drug related diagnosis**. Of this number, 5 will have a concurrent diagnosis of **schizophrenia**, 15 will suffer from anxiety and/or depression and 7 are likely to have **attempted suicide**.

In 2002 the Scottish Executive produced *Mind the Gaps*, a report on service provision for people with **mental health and substance misuse** problems. This stated that:

"The provision of care for both substance misuse and mental health problems has long been recognised as requiring a broad range of participants. If a smooth passage through services for the client is to be achieved, not only must the providers share a broadly similar understanding of what types and sequences of care are appropriate, but they must also be able to apply these flexibly and jointly across professional and organisational boundaries."

THE SCOPE OF THE PATHWAY

Every ICP needs an identified start point and end point. An ICP for the care of people with drug problems in acute psychiatric settings should begin on the day of **admission to acute psychiatric in-patient wards** and end when the patient is **discharged from the ward**.

The term **co-occurring substance use and mental health problems** is used to define the client group, acknowledging that not all mental health problems have been diagnosed, nor are all forms of substance use considered to be problematic,⁴ and only the minority of cases are admitted to hospital. An effective response would be to provide an integrated approach to the management of problems that arise as a result of these co-existing conditions.

¹ Data from SMR04 forms April 2000 – March 2001, Information & Statistics Division (ISD), Common Services Agency

² Kershaw A, Singleton N & Meltzer H (2000) *Survey of the health and wellbeing of homeless people in Glasgow*. London

³ Office of National Statistics (2002) in Scottish Executive (2003) *Mind the Gaps* (p36)

⁴ Scottish Executive (2003) *Mind the Gaps*

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WHO SHOULD BE INVOLVED?

ICP Guide 1 (Definitions and Concepts) states that a steering group should be developed for each pathway. This should consist of frontline workers, clients and others with particular **expertise** in this area. The table below suggests the professions or organisations that should be represented on the group

QUESTION

Has a similar ICP been developed in another area? Who would be the best person to speak to about its development and evaluation?

WHO?	WHY?
Consultant psychiatrist	Ultimately clinically responsible for the care of all patients in the ward.
Pharmacist	Medication reviews will be an important feature of this ICP, on admission, during their stay and at discharge.
Ward nursing staff	Carry day-to-day responsibility for delivering care and maintaining the safety of the patients and others around them.
Community addictions workers	Often the main care provider for managing substance misuse issues prior to and following this episode of in-patient care.
Community Mental Health Team Member	Often the main care provider for managing mental health issues prior to and following this episode of in-patient care.
Service user group	Collectively will be able to provide a unique perspective of the needs of the client at different stages of the ICP. May also be in a position to offer a point of contact for clients during hospitalisation.
Others?	Who else locally has had, or could have, a role to play in developing evidence-based processes of care for people with co-occurring substance use and mental health problems?

DEFINING THE DESIRED OUTCOMES OF CARE

The outcomes of care should primarily reflect the reasons for admission. These should include:

- the maintenance of a safe environment for the client, other patients, staff and visitors
- the effective management of symptoms related to the client's problem(s)
- the resolution of the acute phase of difficulty that they have been experiencing
- involvement of the client in decisions relating to the current and future management of their problems
- a plan to provide effective on-going care management in the community, if required

Who will be the ICP Facilitator?

Should one of the above take on the role of Facilitator or should it be someone with a clinical governance or quality assurance role?

IDENTIFYING KEY INDICATORS

Identifying and monitoring a number of key indicators will assist in ensuring that the **desired outcomes of care are being realised**. Pragmatically, it is best to limit the number of key indicators to between 4 and 6 for each pathway. It is vitally important to ensure that all those involved in the development and implementation of this ICP are given the opportunity to contribute to the identification of key indicators.

Key indicators for this ICP might include:

- making the right diagnosis
- effective management of withdrawal symptoms
- maintaining safety of patients and others
- reduce risk of overdose/withdrawal
- consistency of approach
- communication

REMEMBER...

The goals of treatment should reflect the client's changing needs. Key indicators are often referred to as **milestones** as they should be spread throughout the course of the ICP.

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MAPPING CURRENT PRACTICE

The ICP Development Group will need to identify the current processes of care in their area (see **Process Mapping** in Guide 2). Following this exercise there are a number of questions that should form the basis of an analysis of current practice. From your process map can you identify:

- what information is collected during or prior to admission regarding the person's drug use?
- what processes are used to assess:
 - nature and level of dependency?
 - risk to self and others?
 - motivational state and stage of change?
- what processes are in place to ensure adequate and appropriate communication with other agencies?
- how are the goals of care established?
- what arrangements are routinely made regarding follow-up?
- when are these arrangements made?
- what is the nature and extent of evaluation of an individual's care experience?
- what is the nature and extent of service evaluation?

IDENTIFYING POTENTIAL FAILURE POINTS

The collective experience of the ICP Development Group will help it to foresee difficulties or barriers that might affect the effectiveness of the ICP. Depending on the nature of these, the Group may be able to remove or avoid many of these obstacles before implementing the ICP. Those that remain should be monitored and feature as a key part of the evaluation process. Potential failure points might include:

- variations in knowledge, experience and attitudes and behaviours of in-patient staff
- inconsistency of staff (keyworkers) due to shift rotas, holidays and staff moving between areas
- client being discharged earlier than planned due to the demand for in-patient beds
- client's presentation changes to the extent that it requires a change in management plan
- the client's goals change and he or she decides not to pursue this particular course of treatment

REVIEWING EVIDENCE OF GOOD PRACTICE

When reviewing evidence from other services it is often useful to have a template by which to measure the extent to which a particular service or approach matches what you are seeking to provide. The checklist below is based on the key elements of Integrated Care as defined in **Integrated Care for Drug Users: Principles and Practice** (EIU, 2002) and relates to the treatment and care of drug users in acute psychiatric settings.

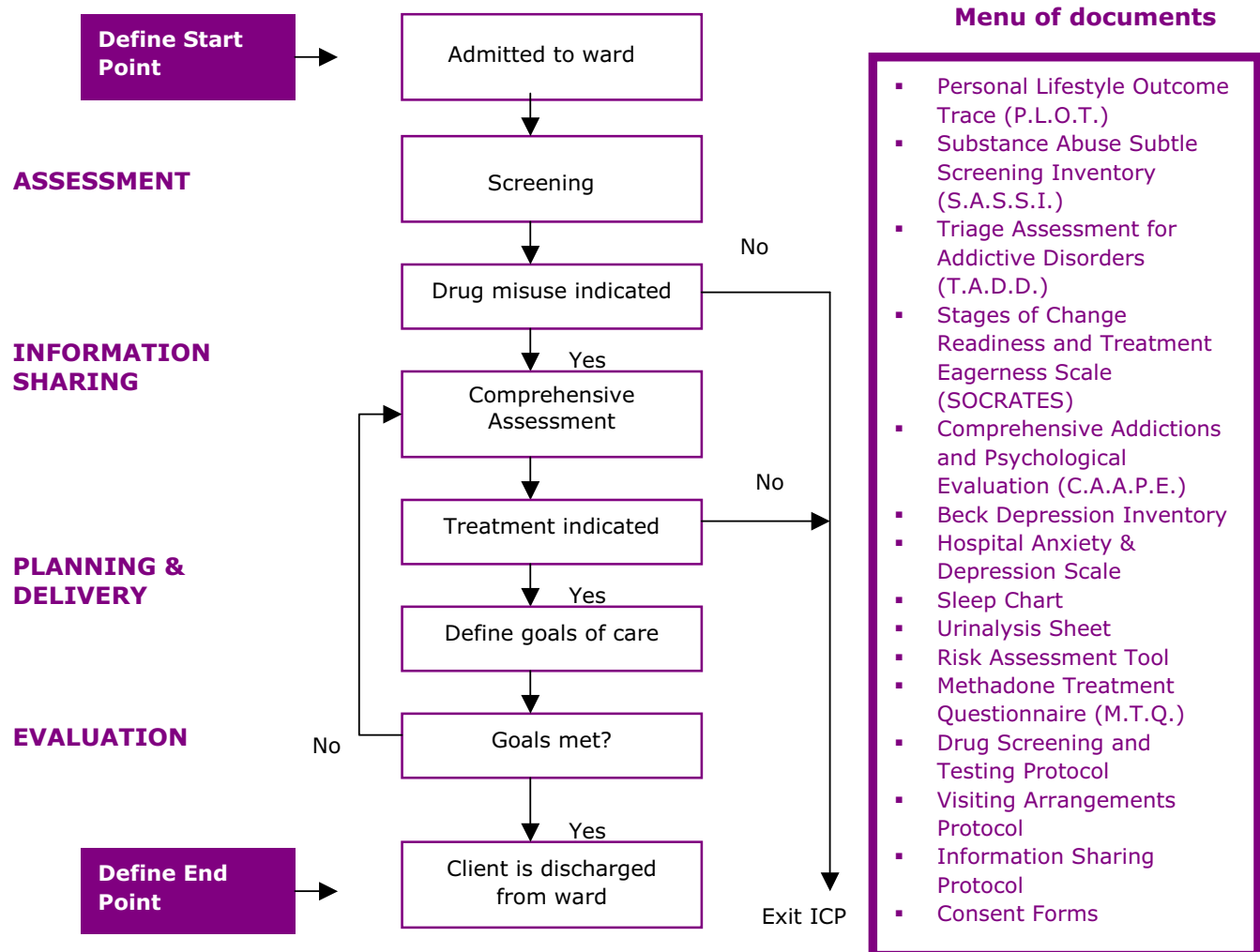
Key Element	Descriptor	Tick
Accessibility	The ICP accommodates the needs of people with moderate to severe mental health and substance misuse problems.	✓
Assessment	The assessment process involves the use of validated screening and assessment instruments for mental health and substance misuse.	✓
Planning & delivery	The different elements of the care plan are compatible with the client's ongoing care in the community.	✓
Information sharing	There is evidence of an open and transparent process of information sharing between the different agencies and the client.	✓
Monitoring	There are defined indicators and evidence of a process of collecting this information in a systematic manner.	✓
Evaluation	There is evidence of a robust, objective process of data analysis against the stated goals of the ICP.	✓

DESIGNING THE PATHWAY

Each ICP should be based on evidence of effective practice and local needs assessment (see **Guide to Needs Assessment**, EIU, 2003). The actual structure of the pathway will be influenced by the availability of resources locally, in particular the range and capacity of services and the skills, knowledge and experience of staff within the different organisations involved.

FLOWCHART AND MENU OF DOCUMENTS

The flowchart below provides a framework that can be adapted and built upon to reflect these local factors. The menu of documents suggests a number of simple assessment tools from **Digest of Tools Used in the Assessment Process and Core Data Sets** (EIU, 2003), information collection forms and protocols. In-patient and community mental health services and local drug agencies might consider using these types of documents as part of a Single Shared Assessment and care management process.



NEXT STEPS AND OTHER RESOURCES

All EIU documents referenced in this Guide and planned future ICP Guides and ICP dissemination events can be viewed on the EIU website: www.drugmisuse.isdscotland.org/eiu
The EIU welcome comments on their work outputs.