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Dhanjal, R., Hagan, T., Fletcher, H. et al. (1 more author) (2018) Developing services for people with enduring interpersonal problems: An evaluation of a complex care consultation clinic. Clinical Psychology Forum (306). pp. 14-19. ISSN 1747-5732

Developing Services for Service Users with Enduring Interpersonal Problems: Evaluation of a Complex Care Consultation Clinic

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Background

The reciprocal challenge of providing mental health care to service users with chronic interpersonal problems including complex trauma are well established (DoH, 2014). Service users presenting with such issues can therefore be (a) inappropriately held 'in stasis' by teams when a referral to a specialist service would be far more appropriate, (b) fall between the gaps between teams or (c) be inappropriately referred due to exhaustion and burnout on the part of the team. One of the key roles of specialist teams for patients with long-standing interpersonal problems is offering consultation to community and inpatient teams (DoH, 2009), as consultation creates a 'containing frame' for service users and staff teams to ensure that clear and effective care pathways are delivered based on the best evidence (DoH 2009). This paper describes outcomes from a small scale consultation pilot project conducted within an NHS Trust Specialist Psychotherapy Service (SPS). The multidisciplinary SPS team provides a range of NICE guideline (2009) indicated treatment models for patients referred with chronic interpersonal problems. The team sought to improve service provision by trialing a locality-based complex care consultation clinic within a local Community Mental Health Team (CMHT). The goals of the consultation project were as follows:

1. Improving the team interfaces

NICE (2009) guidelines highlight that service users with chronic interpersonal problems find abrupt circumstantial change challenging (often prompting risky 'acting-out' behavior) and so poorly handled transfer between teams risks iatrogenic harm. Consultation therefore sought to coordinate smoother pathways, staged team transitions and also enabling better service user involvement in decision-making about their psychological care.

2. Building intelligent kindness in staff

NICE (2009) guidelines also illustrates that staff often feel challenged and overwhelmed by the emotional needs and behaviors of service users with chronic interpersonal problems, leading to difficulties in managing often turbulent patient-professional relationships. Consultation aimed to support CMHT staff in maintaining a motivated, caring and compassionate position in relation to service users with complex interpersonal dynamics.

3. Improving understanding of the role of psychotherapy

Whilst a range of psychotherapy modalities are recommended (NICE, 2009), less national guidance is offered concerning the suitability of service users for a specific psychological intervention. Consultation therefore sought to improve understanding of the acceptance criteria for the different modalities offered by the SPS team.

This service evaluation details the outcomes achieved, reflects on the process of consultation and provides guidance to other services considering similar consultation ventures.

The Complex Care Clinic

A range of SPS staff (N = 8) delivered the consultation clinics within a local CMHT. Any CMHT staff (from support worker to medics) could book a slot to discuss a specific client for whom they thought consultation might help. The primary meeting had the aim of supporting CMHT staff, with an option for a second consultation follow-up with both the service user and staff present. The SPS used a joint consultation model, with duos reflecting different modalities. Prior to the

consultation, a detailed information search trawl of the service user's electronic clinical records was made, in order to prepare. On completion, a summary of advice and recommendations in the form of a short report was provided to the CMHT (and the client if they attended a second meeting).

Method

Issues commonly raised by CMHT staff were collated and used to form a baseline evaluation tool before starting the clinic. A total of N=36 consultation slots were offered across a 6-month period. This equated to 4 slots per clinic, initially offered on a fortnightly basis. The number of slots was adapted throughout according to staff recourses available. Prior to consultation, CMHT staff completed an evaluation form concerning prior usage of the SPS team, understanding of complex trauma, psychological formulation, stages in recovery, level of confidence, stress & anxiety and confidence around discharge (all scored using a 3 point scale; agree, disagree, not sure). The same evaluation form was completed after the consultation, as the post-consultation outcome measure. A service user satisfaction measure was used when clients attended. SPS completed a parallel reflective consultation measure focusing on collaboration. The following information was gathered on clients discussed: primary difficulty, diagnoses, type of any previous psychological therapy usage, length of service use, forensic history, safeguarding concerns, pending litigation / complaints in situ and demographics.

Results

A total of 14 clinic slots were booked by the CMHT across the six-month evaluation window, creating an uptake rate of 38.8%. CMHT professionals requesting consultation included community psychiatric nurses (n=2), social workers (n=3), psychiatrists (n=4), clinical psychologists (n=3), psychotherapists (n=6), occupational therapist (n=1) and a discharge coordinator (n=1). Four of cases involved service users that were regular users of in-patient services or were currently admitted. Only two consultations resulted in a follow-up. Table 1 summarizes the results on the outcome measure. These results indicate that consultation enabled a space to be created for staff to reflect on their work with service users with complex interpersonal needs, increased confidence in CMHT staff and also facilitated a better understanding of the role that psychotherapy might play in care plans.

Insert table 1 here please

Discussion

This project aimed to evaluate a consultation clinic whose primary functions were, (a) support colleagues within the CMHT with their work, (b) increase organizational communication, (c) develop CMHT staff skills and finally (d) increase understanding of the role of formal psychological interventions within service users care plans. The evaluation highlighted some improvements within all areas. However, it is also worth noting that in many areas, the extant level of staff member knowledge and skills were relatively high. This was clear for areas such as

sharing case work and general understanding. The data suggests a reduction in levels of staff anxiety and stress following consultation; however it is not known whether this level of reduction was sustained over time per case. The consultation clinic particularly enabled a reflective space to be established in which a worker could stand back from their work with a service user and CMHT staff were generally satisfied with the consultation service offered.

The evidence for psychological interventions/psychotherapy specifically relating to treatment complex and chronic psychological trauma remains at a developmental, rather than a consolidated, phase (NICE, 2009). Where there are added clinical complexities for example multiple diagnoses, the available evidence appears naturally more limited. Complexity increases the chances that psychological interventions may have an iatrogenic or harmful effect. Recent research (Shepherd, Evans & Cobb, 2012) has started to highlight the potential adverse effects of psychological therapies in the context of complexity. Alongside this, service users presenting with complex and long-standing interpersonal issues are known to have greater vulnerability to perceived abandonment, rejection, greater difficulty managing conflict and struggle to solve interpersonal problems during therapy (Ryle et al 1997).

There were several subthemes that arose from the responses from staff both formally and informally. These included "how to develop realistic goals for clients care" and having the support to deliver a *'therapeutic no'* to service users where psychotherapy was considered unsuitable. Saying 'no' to service users requires a degree of appropriate assertiveness from staff and to be communicated in a manner that does not invoke a rupture in existing relationships. Discharging service users with complex trauma histories involves diligent planning and discussion and the more this conversation can be informed by the case formulation, the more likely it is that the service user's emotional reaction can be predicted and normalized. The use of 'formulation' with teams

is a key component of multidisciplinary work, where the benefits have been likened to the function it serves within individual psychotherapy (Division of Clinical Psychology, 2011). Supporting this, Hollingworth & Johnstone (2014) evaluated the benefits of team formulation from a staff perspective via; informal discussion between key staff, a case notes review, meeting with the service user when appropriate followed by the development of a tentative written formulation and suggested plan of intervention. The formulation process typically drew upon cognitive, behavioural, psychodynamic, systemic and cognitive analytical frameworks. This findings from the present study can be seen as an extension to Hollingworth & Johnstone's (2014) study adding further support to the growing literature surrounding the benefits of team formulations (Whomsley, 2009). During evaluation the CMHT's adopted a multidisciplinary meeting to better support service user discharge from the service. A consultation version of the cognitive analytic model has been developed to help teams manage those clients that are unsuitable for one to one psychological therapies (Kellett et al. 2014).

Models of consultation often highlight the importance of a reflective space for individuals (and groups) in which they can step back from typical patterns and consider short and long term consequences (Carradice, 2004). The consultation offered here appeared to fulfill a similar function for staff in terms of providing space to reflect on patterns that were occurring between themselves and service users (e.g. getting drawn into rescuing, for example). Without recognition, staff teams can unknowingly reenact less helpful dynamics that unfortunately parallel the service user's world (Carradice 2013). As the SPS staff sat outside the CMHT, this enabled an opportunity to bring a more 'outside' supportive perspective on key issues.

Developing better awareness of both the risks and the expectations that can be present for service users accessing SPS also prompted the development of a cross modality assessment checklist. This considered key indicators including, emotional instability, ability to build relationships, capacity for self-reflection, reactivity to distress/increased stress, expectations for therapy, locus of control, previous usage of psychotherapy, level of internal and external resources and sense of self. The checklist was used to consider how each dimension contributes to decision making around the suitability of low to high intensity psychological/psychotherapy interventions for complex cases, where there are complex mental health / interpersonal difficulties. This is also in line with the work of (Kiff, 2006) regarding matching of complexity to intensity of psychological interventions and the mechanisms of stepped-care service delivery models (Firth, Barkham & Kellett, 2014). The development of the checklist proved a vital educative and shared tool throughout the complex care consultations.

The small sample size and the use of unvalidated measures limit both the reliability and generalizability of the findings. There are no validated measures of consultation competency available and therefore no assessment of adherence was possible and the differing duos would be likely to use differing approaches due to background and training. Given the informal nature of the service evaluation there was no rigorous data analysis performed. Future evaluation methods can effectively make use of mixed methods (particularly validated formal measures) in order to make sense of staff and service user's experiences of the process and also make use of longitudinal follow-up. There is an argument to be made for a health economic analysis of the outcomes produced (i.e. the cost savings of service users no longer being referred for therapies that would not make a difference).

It is important to note that the development of the complex care clinic was a joint venture between teams, where an openness to share experiences of the challenges of the work and to collaborate around meeting the needs of service users was crucial throughout. The consultation approach generated ongoing resource implications as two members of the PD team attended the clinic, alongside carrying out a full case notes review prior to the consultation. However, from our experience we felt that the overall organizational and clinical benefits to this approach far outweighed the resource costs. In conclusion, the present evaluation has highlighted the advantages of a multimodal consultation model for complex clients within CMHTs. Further research and development of the consultation model is indicated.

We are currently known as a Psychotherapy and Consultation Team that often work with service users who have a diagnosis of Emotional Unstable Personality Disorder / Borderline Personality Disorder. We have chosen to use less stigmatizing and more descriptive language in our writing.

Acknowledgements

As the pilot project was a collaborative venture we would like to acknowledge contributions by all those involved; Alan Bottomley, Louise Colton, Steve Day, Marcus Glennon, Ray Haddock, Anthony Poole, Sue Ridgway, Dave Saxon, Tracy Staniland, Andreas Weichselbraun and Alex Young.

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Table 1; Participant evaluation results (n=20)

	Pre implementation of complex care clinic %	Post implementation of complex care clinic %
Improving interface working across teams Sharing case work and practice Space to think about complex cases Referral to SPS Knowing when to refer into SPS	 92 25 33 44	 100 100 100 78
Build upon CMHT staff confidence and skills Good understand of complex cases Understanding stages of recovery Stress and anxiety of complex cases Preparing clients for discharge	 61 38 85 23	 67 33 67 22
Improve understanding of psychotherapy in clients' care plans Psychological formulations Criteria for undertaking formal psychotherapy Preparing clients for psychotherapy Options available for psychotherapy/ psychological work for clients	 54 15 54 15	 67 33 67 56
Overall satisfaction with clinic (n=10) Useful ideas provided Resources given were helpful Clinic provided support Clinic provided a contained / safe space Plan to take advice ideas forward	90 90 90 100 100	