Networking event - 19 October 2018

Discussion summary: Mood and psychological health

Key points

1. Charities are an essential resource and provide a vast amount of useful information to patients, professional and carers.
2. Charities can provide valuable support to families, which is not always available through statutory provision.
3. Drivers are often towards getting people out of hospital. There isn't always an MDT across the whole pathway, especially a lack of psychology.
4. Occupational therapists can't do everything. Are we taking on things that take us away from core occupational therapy interventions? Ask yourself, should we take this on; do we have the skills to take this on?
5. We are helping people to be independent and need to be patient focused. The patient is our priority. However, it's often a balance between what is best for our patients and what Commissioners and other members of the MDT want from us.
6. Timeliness of intervention is sometimes a challenge. When is the best time for rehab?
7. Share ideas and good practice, participate in debates, promote our role and skills, using RCOTSS-NP regional groups and other networks. There are lots of useful tools and ideas being used in everyday practice.
8. Use outcomes measures wisely along with functional assessments. Outcomes are seen as good for commissioning but only with correct interpretation. They need to be relevant to the person, take care and use them wisely.
9. Our assessments should always include the psychological health and social interests of our patients. Our reports should reflect our intervention in these areas. It's important for the next stage of the patient's journey and for their GPs. This may prevent people from falling through the gaps in provision.
10. Think outside the box; be innovative in your practice. Monitor your approach and communication style to achieve the best for your patients and maintain their engagement and motivation.

Brainstormed topics

- Lack of psychology and/or timely access to services.
- Psychological services who don’t work to the same remit.
- Parents looking after an adult who had a brain injury when they were a child, adjustment of roles.
- Maintaining client engagement independence v dependence and care by parents.
- Links with mental health services for working age adults.
- Managing challenging behaviour in an acute hospital setting - post surgery tumour removal, training of staff/nursing/RMN to provide 1:1. Relatives support.
- Waiting times to access services, especially in the community. Physical disability often has more access to services than those with psychological needs.
- Social care agencies offered are often mental health or learning disabilities focused.
- Lack of specialist social workers, they are more generic.
- People who fall through the gaps in services, criteria of services exclude some of our clients.
- Managing complex issues.
- Support for families and carers.
• What to do when we don't have the resources to support families/carers.
• How to engage patients with the rehab if they have low mood.
• Do we become immune to the issues?
• Time to address mood issues in the acute setting.
• Convincing people of the person's needs when it's not available in a timely manner/ do you put your intervention on hold until other professions can come on board?
• Even if they do have support is mood and psychological adjustment always discussed?
• Knowing how to access services.
• Dual diagnoses.
• PHQ9 and GAD7 not always relevant tools to use, but they are good for getting patients to think about the issues and good for providing evidence for referring onto other professions.
• Managing defensiveness from other professions especially if professions want to prove their effectiveness/intervention.
• Access to psychiatry.
• Poor motivation.
• Low mood impacts on rehab/progress and motivation.
• Work on psychological issues they may have had prior to the brain injury.
• Pre morbid diagnosis of mental health issues.
• Anxiety/persistent low mood.
• Chronic depression impacting especially if the patient does not accept they have depression.

Areas focused on during the day and the groups' thoughts

1. Lack of psychology services
   o Psychology providing reports only, interventional psychologists not always available to look at all the issues i.e. anxiety. Patients need intervention, but often psychologists are only able to assess and then provide a report.
   o Training of occupational therapists in administering tests and how they translate this into function.
   o Ongoing after care into the community.
   o Invisible symptoms are the most difficult. People struggle to come to terms with them.
   o Using the patients 'lived experience'.
   o Use the charities and their information leaflets which are free to download.
   o Use of other specialist professions e.g. nursing.
   o In-service training.
   o Regional occupational therapy groups useful for support and advice.

1. Support for families carers
   o Ask the charities for information and to come to see relatives.
   o Providing specific support/advice for carers.
   o Group for families with psychology space to sit and talk together.
   o Carers strain questionnaire on how they are feeling. Then sign post to services.
   o Social Services for a carer's assessment.
   o Education for relatives in the issues related to the diagnosis; ensure mood and psychological health included.
   o Social groups meet informally in a pub, low key chance for people to be heard.

1. Are their low level psychological therapies we as occupational therapists can deliver?
   o Embedding screening for psychological health and mood in the initial screening.
   o Screen tool, Croydon service uses a distress thermometer, looking at level of distress, leading thing for patient to work on.
   o Goal setting.
   o Solution focused brief therapy.
   o Relaxation techniques.
   o Time consuming but we need to be championing for peoples cases.
   o Identifying what we need to bridge the gap.
   o When to put your time into looking at the evidence and when to treat the patients
o Danger of doing assessments only and no time to do the intervention. People where the assessments don't match their presentation or people who do well on assessments but not in function and vice versa.

o Managing the distress of the patients on receiving the assessments results? Doing assessments because it's what we do or is it what the patient needs.

o Look at how we can improve things in the acute setting.

o Always think about the mood and psychological issues and include in our transfer and discharge reports.

o Up skilling staff on the impact of mood.

o Communication, clear referral, flagging the issues.

1. Motivation

   o Timing of intervention, when they are ready to engage.
   o Solution focused therapy, what's been better today. Think of the positives.
   o Motivational interviewing, looking at how you are communicating.
   o Consistency, how you ask the questions building up a relationship.
   o Cognitive organic motivation, fatigue, knowing this may help.
   o Motivational interviewing, find out their interests.

What specific resources do you use?

- Relaxation,
- A "tool box" we can use when needed.
- MDT approach.
- Charities - good for professionals, family and patients.
- Psychological care after stroke, stroke leaflets.
- MND, MS, Parkinson's Society information.
- Headway.
- NICE guidelines.
- Patient education.
- Groups: functional groups, breakfast group/social element/psychological wellbeing, addressing the loss, managing change, change cycle, lifestyle management groups, stress, the wake sleep cycle, primary and secondary symptoms, crisis and contingency planning, carers groups, fatigue management, behaviour, mood and social groups.
- Elements of CBT taught by psychologist.
- Think about and reflect on and adapt our approach, adapting things and thinking out of the box.
- When to give the resource information.
- Some services have follow up, some do not.
- Web sites.
- RCOTSS-NP regional meetings.
- Other profession coordinators, specifically there to support the families.
- Who gathers info about mood and psychological adjustment in their initial interviews? We should all ensure this is done. Even if it's not a specific psychological history, but more about what they used to do and their interests.
- Talking and enabling engagement, giving them space and time especially if the patient has anxiety and depression.
- Horticulture. Often only able to access these if have a mental health led service.
- Resource limitations: be creative i.e. going for a walk.
- Technology apps.
- Solution focused therapy.
- Motivational interviewing.

Assessments used

- Rivermead behavioural memory test
- BADS
• Rookwood Drivers Screen
• COTNAB
• BIT
• PHQ9
• GAD7
• COPM
• Goals
• BASDEC mood and depression
• HADS
• MOHO
• Activity and interest check list. Sue Parkinson, recovery through activity.
• End score only part of it, need to ask what difference the assessment is going to make. Also need to be aware of the other symptoms e.g. cognition.

**What specific outcome measures are used?**

• TOMS
• Goals
• Quality of life after brain injury
• GAD 7
• COPM
• Use outcomes wisely and in context of functional performance.

**Research**

It was agreed this was limited regarding occupational therapy, but there are some useful articles out there and there are guidelines and resources for occupational therapists. Topics raised included:

• Research in mild TBI Concussion / sports world may help lead in this area.
• Lots about MH and occupational therapy.
• MS: better social support increased quality of life.
• 95% have some sort of psychological issues.
• Stigma of having MS and the symptoms can lead to depression.
• Stroke association on depression and anxiety.