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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Evaluation of collaborative care planning in mental health treatment centres: a review from patient, provider and administrator perspectives

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Abstract

Background and context: Patient safety protocols in mental health are often given less importance than they merit. Procedures to enhance the culture of safety in mental health facilities can benefit not only patients and their families, but also providers and administrators. The Patient Safety Movement Foundation's Actionable Patient Safety Solutions around mental health highlight the importance of tools such as collaborative care planning and comfort care kits.

Aim: This article aims to provide an insight into patient and clinician experiences using the collaborative care planning and comfort kits outlined in Actionable Patient Safety Solutions.

Conclusions: Collaborative care planning and the development of elements such as comfort care kits have the potential to improve patient experiences, outcomes and safety. From the organisational point of view, Actionable Patient Safety Solutions have the potential to improve cost effectiveness and structural efficiency.

Implications for practice:

- Collaborative care planning has been shown to reduce the incidence of patients harm and suicide
- It is low cost and can easily be tailored to specific contexts
- There is significant potential for a reduction in organisational inefficiencies, clinically, structurally, and financially with the adoption of a collaborative care planning model
- Understanding the firsthand perspectives of patients and clinicians themselves can offer significant insight for implementation in other settings

Keywords: Patient safety, mental health, quality, collaborative care, preventable deaths, comfort kits

Background

Patient safety in mental health is often neglected in research when compared with other medical specialties (Dewa et al., 2018). Although many patient safety issues are common to physical and mental health care, the latter entails distinct risks and should therefore be recognised as requiring its own set of standards to ensure quality of care (Brickell and Mclean, 2011). While medication and communication errors, for example, are present in physical and mental health care settings, issues that are far more commonly seen in mental health, including self-harm, use of restraint, death by suicide and

seclusion, are lacking in research and in identification of implications and recommendations (Brickell et al., 2009, Dewa et al., 2018). The potential for aggression and self-harm is innate to some psychiatric disorders themselves, and therefore needs to be considered when developing safety protocols for these patients (Dewa et al., 2018).

The gap in current and preferred practice is evidenced by an average of 1,500 deaths by suicide in US psychiatric units per year (Mills et al., 2013). There is also evidence to suggest that psychiatric settings account for around one in four incidences of unsafe care across the medical field (Chang, 2005). In addition to these safety concerns, research shows that stigmatisation and inadequate treatment facilities deter patients from seeking treatment in the first place (Mascherek and Schwappach, 2016).

In addition to the lack of bedside evidence, research around mental health treatment lacks a framework of clear terminology and definitions (Brickell et al., 2009). Therefore, the classification of psychiatric patient safety incidents becomes difficult, hampering the development of policy and improvement guidelines and effectively forcing the sector to rely on acute care guidelines, which are inadequate when applied to psychiatric safety (Brickell et al., 2009).

This critical reflection offers insight into the environments that may lend themselves to patient harm and suggests solutions, such as collaborative care planning to eliminate the risks for patients, family members and staff. It concentrates specifically on the pilot institution in Canada, which adopted and trialled collaborative care planning and the comfort kits. The organisation piloted the comfort kits across the acute, tertiary and urgent community areas between August and October 2019.

The Patient Safety Movement Foundation

The Collaborative Care Planning Tool from the Patient Safety Movement Foundation has been developed in partnership with patients, family members and healthcare professionals to encourage patient involvement in care, increase awareness of patient safety protocols designed to improve psychiatric outcomes, and serve as a guideline that can be implemented universally and also tailored to specific contexts.

Aims

This article evaluates the extent to which the Collaborative Care Planning Tool featured in the foundation's Actionable Patient Safety Solutions (APSS) has proved advantageous from patient, clinician and administrator perspectives.

Methods

In this multiperspective framework study, a variety of administrators and clinicians were contacted via the Vancouver Coastal Health and Patient Safety Movement Foundation networks to offer the opportunity to provide insight into collaborative care planning tools adopted in their institutions. Those who responded via email were asked a series of questions, as documented in the 'clinician perspective' section below. These questions were specifically designed to prompt clinical insight regarding the universality, adaptability and benefits of the tools. Ethics clearance was obtained for all participants. The names used in the article are those of real individuals who consented to use of their names for the purposes of this article.

The decision to include just one patient perspective stems from the unique combination of the individual's personal treatment and recovery within the pilot location, coupled with their activism in advocacy and involvement in the Patient Safety Movement Foundation's Actionable Patient Safety Solution around collaborative care planning thereafter.

Patient perspective

From the patient perspective, individuals generally experience a heightened sense of fear and anxiety when having to deal with mental illness, especially when systems are not organised to optimise the

experience and effectiveness of treatment (Gilburt et al., 2008; Csipke et al., 2016). For example, psychiatric patients may experience a loss of autonomy in their care, indicating that a 'one size fits all' approach is not appropriate (Tambuyzer et al., 2011). Additionally, patients may not be able to find the words or expressions to explain their experiences of challenges or pain. The invisibility of traditional clinical symptoms in mental health patients further highlights the need for a human connection in care to aid in understanding of the underlying issues that are not immediately apparent (Cutcliffe, 2013). The traditional mechanisms for assessing 'invisible' symptoms, such as pain scales, can be inadequate in mental health conversations. Instead, personalised techniques, such as expressive writing, have been shown to aid the recognition and absorption of painful experiences (Cooper, 2013). Cooper suggests writing is a beneficial component of treatment as it has been shown to help patients gain distance from a negative experience via their stories. Motivational interviews also offer a way for patients to articulate their needs and for clinicians to respond in an individual-specific manner, thanks to the collaborative, person-centred nature of this method (Barwick et al., 2012). These techniques and others allow patients and family members to generate questions like 'What is happening?' 'How long will this last?' and, most importantly, 'How can I be involved in my own recovery?' Research has shown that patient and family involvement is positively associated with better outcomes (Kaas et al., 2003). The patient perspective in mental health care quality initiatives, therefore, can help clinicians learn how to connect more effectively with the patient and those close to them, allowing for better care planning and patient outcomes.

Patient perspective: Taylore's story

'During a long-term (four-month) inpatient stay, I was introduced to collaborative care planning for the first time. My team consisted of a psychiatrist, psychologist, general practitioner, pharmacist, recreational therapist, occupational therapist, social worker, dietitian, patient coordinator, and the unit head nurse and me around a conference table. Even though I was in the depths of severe depression and had a very recent suicide attempt, I was told I had a clear choice – to participate in my care and my recovery journey, or not. I decided to take full advantage of everything that was offered to me. The daily varying levels of energy would determine what I was able to do mentally, emotionally and physically. Over the first week, I would have conversations with two professionals every day, and asked if someone could take notes for me. This not only gave me a sense of control but also a sense of responsibility and ownership in my care. If I didn't care about getting better, why should anyone else? The motivational interviewing gave the team a well-rounded picture of who I was, what underlying issues there were and how best to proceed in getting me well and back in the world as a functional human being.

'From the beginning of my inpatient stay, my goals and my wishes were central objectives in my team's activity. It wasn't about "patient stabilisation and being compliant"; the focus was, "Who is Taylore and how can we get her to where she wants to be?" I went back to the unit five years after my discharge, to say thank you for helping me recreate my life, for their gentle, compassionate guidance, and allowing me to have my voice. For without that, I would not be the person I am today - happy, healthy and able to withstand many life challenges of the past 15 years. I have taken the tools I learned then and use them every day. I am truly grateful to the women and men who let me fall and were there to catch me. Before admission, I asked what I could bring to the unit. When I arrived, the usual things were taken away (razors and other sharp objects that I could harm myself with). I also brought what could be seen now as my own comfort care kit: a stuffed penguin, my favourite blanket, picture of my cats, crayons and a colouring book. I was very glad to have a few of my own things as they kept me connected to my life outside the unit, gave me hope and motivated me to get well and back to my life.'

Clinician perspective

The Mental Health Actionable Patient Safety Solution (APSS) was co-produced by a workgroup consisting of clinicians, administrators, patients, and family members. The APSS was co-chaired by one

mental health clinician and one patient. This APSS provides a general yet comprehensive articulation not only of patient safety hazards common in healthcare today, but of tactics to mobilise leadership, staff, patients and tools available to optimise patient safety and prevent avoidable harm.

We asked two clinicians about their experience with the APSS. Documented below are their responses.

1. How were you able to make this APSS specific to your needs and to your organisation?

'Some sites appreciated the flexibility of the APSS, which enabled them to make modifications to align with their specific population' (Monica McAlduff, regional tertiary director, mental health and substance use, Vancouver Coastal Health).

'By rewording the questionnaires and incorporating the kits into the trauma groups for an early introduction to grounding, people were able to add to the process and incorporate their own feedback' (Dr Colleen Allison, registered psychologist and clinical lead for psychotherapy, mental health and substance use, outpatient services, Vancouver General Hospital).

2. How were you able to incorporate and build comfort care kits for your organisation?

'Foundation donations helped cover the initial cost of the kits. From there, patients assisted in kit making' (MM).

3. What aspects of the APSS have been particularly useful in your setting?

'The detailed explanation of the value of implementing the comfort kits in addition to the step-by-step description of the research behind the kits have been helpful, especially for those who may not be used to collaborative care planning' (MM).

'It provides a starting place for brainstorming' (CA).

4. What does an investment in the comfort care kits provide for clinicians?

'The investment serves as a preventive measure, which has saved our organisation financial resources in the long run by, for example, saving staff time off due to injury' (MM).

'This is a tangible way that clinicians can demonstrate their ideas more effectively to diverse audiences' (CA).

5. How have clinicians collaborated with patients in mental health planning?

'Each area in collaborative care planning assesses the patient's needs as well as the unit's needs, to determine the best place of readiness for all parties involved' (MM).

'To ensure sustained commitment and readiness and to avoid anxiety or strain, the clinicians and patients review additions to the kits weekly' (CA).

6. What were some needs/gaps in your organisation that this APSS seemed to address?

'We noticed patient empowerment being cultivated through use of the APSS, which therefore encouraged the patient to be more directive in their care. The APSS provided a direct, simple, and sustainable source for patient and provider communication. Here, the patient is the driver' (MM).

'We were able to enhance visualisation techniques used for grounding and mindfulness' (CA).

'Overall, feedback from clinicians highlighted the positive staff reception for the comfort care kits as they could see tangible benefits to patients and the care team' (MM).

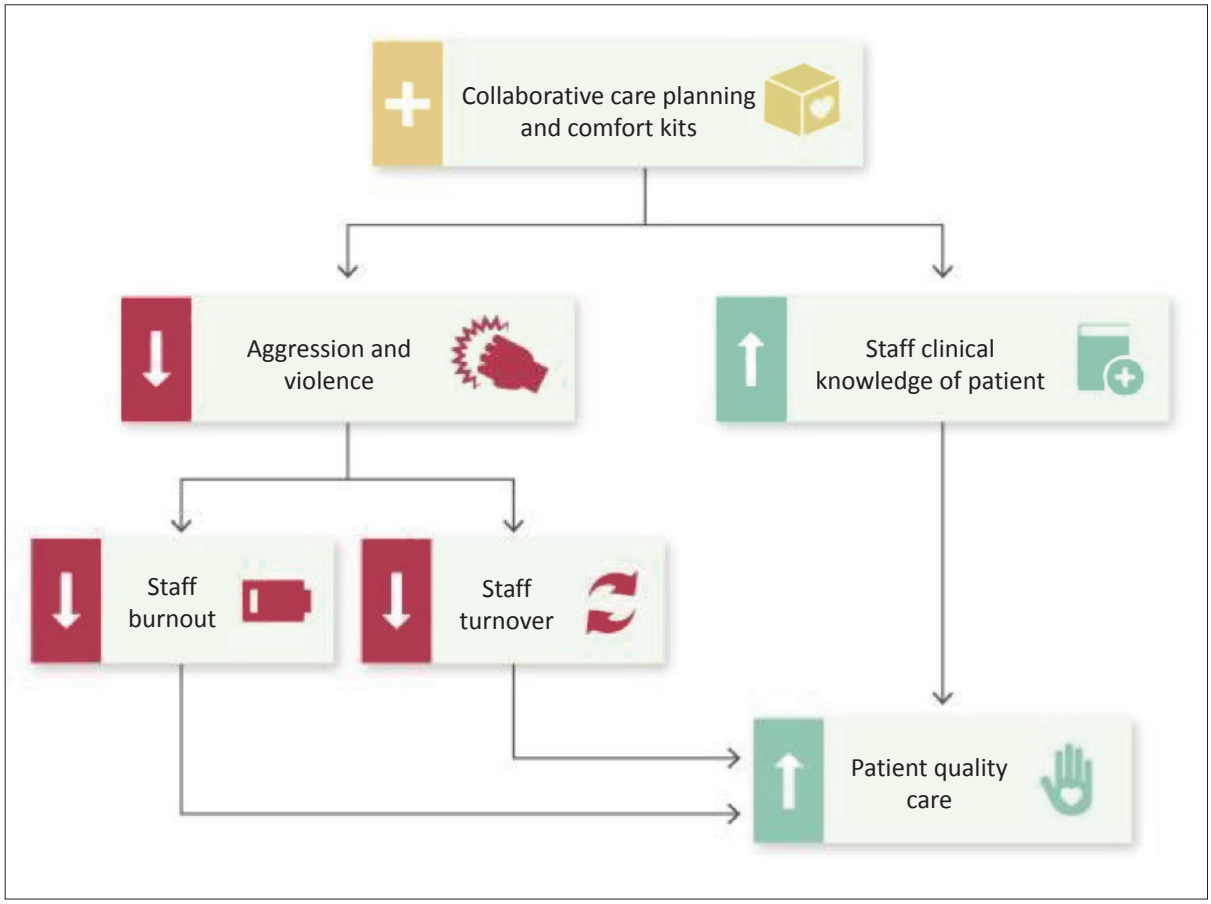
Administrator perspective

Healthcare administrators concerned with improving the quality of care for patients and increasing safety for staff (Figure 1) benefit from the collaborative care planning and comfort kits involved in the APSS because:

- There's a structured definition and process
- Metrics are included to track improvements in quality of care after APSS introduction
- The APSS outlines education methods for staff, patients and families

The APSS provides a guideline for introducing collaborative care planning into a variety of contexts across hospitals, including open and secure inpatient wards, outpatient settings and ambulatory assessment clinics. The flexibility of collaborative care planning allows interventions to be used in group settings as well as in one-to-one patient and clinician work.

Figure 1: How introducing collaborative care planning and comfort kits positively affects the quality of patient care



Administrator perspective

'The included metrics have made it easy for staff at any level to test collaborative care planning and comfort kits in their area. It is a way of removing another barrier of implementation.

'As administrators, we want the best health outcomes for our patients and their families and also want our staff to be safe and have the tools available to care for their patients. Collaborative care planning and comfort kits offer both these benefits for a lower cost and with fewer roadblocks to implementation than other similar interventions.

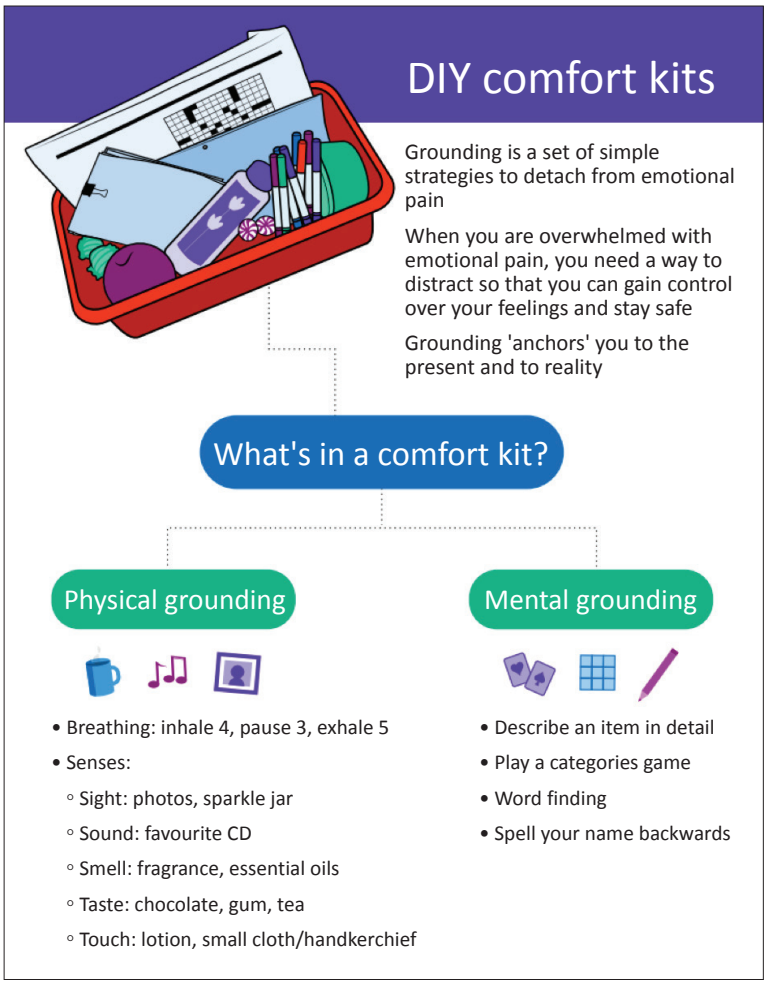
'The APSS can be moulded across the cultural differences and funding challenges faced in many hospitals. Because we can be creative in our implementation, we can launch this intervention more quickly than many others and therefore get its benefit to patients right away.

'The APSS function is about minimising the barriers that staff may face when wanting to try something new on their unit.'

The APSS is inexpensive, flexible and quick to implement. Starter comfort kits implemented at the original Canada public hospital sites cost $2CAD (£1.20) each and consist of a box containing colouring

pencils, crossword, word search, colouring mandala, gum, Velcro® and bubblewrap (see Figure 2). Patients retain this kit, meaning a $2 investment per patient/per admission. The APSS flexibility allows sites to work within their boundaries and does not necessitate large changes to infrastructure or programming. Collaborative care planning draws on the existing clinical skills of staff and physicians, meaning it can be inserted into existing group and clinical work. A champion model that supports keen staff to incorporate collaborative care planning into their work allows for units to implement it quickly.

Figure 2: The APSS comfort kit box



Discussion

There is currently insufficient research to inform the creation, dissemination and implementation of strategies to minimise adverse events for mental health patients (Dewa et al., 2018). While topics such as a culture of safety and medication safety apply in both mental and physical health care (Shields et al., 2018), areas such as patient engagement and collaborative care are especially important in mental health treatment plans. A significant current barrier is the lack of diversity of perspectives when setting priorities (Brickell and McLean, 2011). The collaborative care planning emphasis within the APSS integrates the unique needs of the individuals involved, positions the patient at the centre of their care, and considers the expertise and time constraints of all parties. This approach anticipates potential risks and barriers, captures and addresses the apprehension of all involved, and leverages the skills, capabilities and capacities of all participants.

Use of the APSS provides a treatment route for mental health patients that consistently encourages the patient to take a role in their own treatment, with the reassurance that they are part of a team. Thus,

the patient is able to better communicate with their care team through the activities performed using the APSS. The teambuilding and trust nurtured in this way not only makes the team more effective as a whole, but also helps the patient to adopt these values independently and sustainably.

As cost pressures continue to rise in healthcare facilities, budgets remain at the forefront of concern. The APSS content is free for users and inexpensive to implement in a variety of settings, from larger healthcare systems to smaller community hospitals. These low costs, allied to the versatility of such a resource, offer the potential to help significant numbers of patients.

The typical treatment pathways for physical conditions are often inadequate when applied to the behavioural health sphere. This analysis demonstrated that activities embracing patient empowerment – cultivated through integration of collaborative care planning as outlined in the APSS – encourage patient autonomy and engagement, and continuously reinforce patient-centredness in care. In conjunction with helping patients become more active and heard in their recovery, the careful evaluation of the capacities and needs of the professional team nurtures a team relationship in which each individual feels empowered and comfortable with the collectively built care plan. The collaborative care planning technique featured in the APSS encourages equal input from all parties into the care plan to effectively sustain efforts, foster an environment of tolerance and promote active engagement from all individuals.

Conclusion

A patient may not expect their stay in a hospital to be enjoyable but the methods of collaborative care planning, such as the development of comfort care kits, have the potential to improve patient experiences, outcomes and safety. From the organisational point of view, the APSS has the potential to improve cost effectiveness and structural efficiency. The more patients are able to use their comfort kits, the better equipped they can become to reduce their moments of stress and consequently to reduce escalation and severity of mental health symptoms. This can result in a possible reduction of length of hospital stay and even reduce the need for future admission.

While collaborative care planning has been in existence for quite some time, patients are still experiencing avoidable harms in hospitals due to structural inefficiencies. This tool should be further researched and those adopting it should consider the need to tailor it to an organisation's specific culture.

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