Enhanced Psychosocial Service in Palliative Care

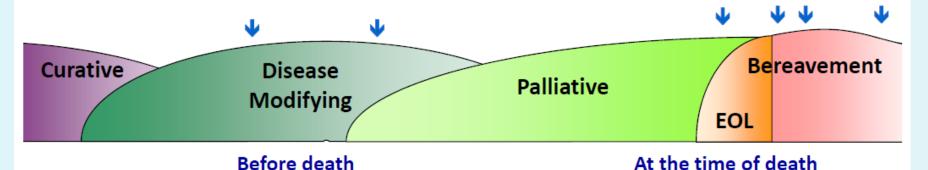
HA Convention 7 May 2014

WHO Definition of Palliative Care

- relief from pain and other symptoms;
- o affirms life;
- neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- o offers a support system to help patients live as actively as possible
- o offers a support system to help the family cope
- team approach
- enhance quality of life
- is applicable early in the course of illness

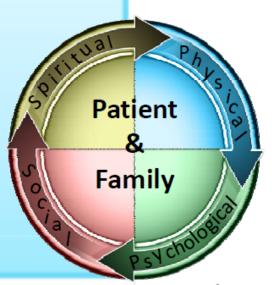


Characteristics of Psychosocial Care



 Interconnection of physical, psychological, social & spiritual aspects

- Need-based
- Key time points of psychological stress
- Targeting patients and family caregivers
- Multidisciplinary involvement
- Collaboration with community service providers and volunteers



After death

Palliative Care Units under the HA



Background

- 2009: Trent Bereavement Audit identified service gaps
- 2010: Multidisciplinary working group (doctors, nurses, MSWs, CPs) under CCPC - Structured Psychosocial Care Model
- 2011: Presentation of an annual plan & service framework at SMM
- 2012: Enhanced Psychosocial Service with additional manpower in MSW, CP and PCA

Structured Psychosocial Service

- Strengthening of psychosocial team in PC
- •Risk identification and engagement of patients and main caregivers
- oIntensified intervention for high risk group

(SBPC Meeting 2012)

L4 Dx of Psychopathology

L 3 Identify & diagnose persisting distress

L2 Early Identification of psychosocial distress

L1 Recognition of needs

Stepped Care Model

- Level of care
 - matched to patients' needs
 - stepped up or down according to needs
- More efficient use of resources

Improved access to psychosocial care

Psychology Assistants

- Based on IAPT model, UK
- Pioneer model download low-intensity work
- systematic training organized by COC(CP);
 HOHR(T&D) Team
- Regular supervision by CPs in local palliative care setting

Improved access to psychosocial care

Roles of Psychology Assistants:

- o psychosocial needs/ risks identification
- Basic psycho-education
 e.g. coping with illness
- Low intensity psychological work
- Documentation of outcomes

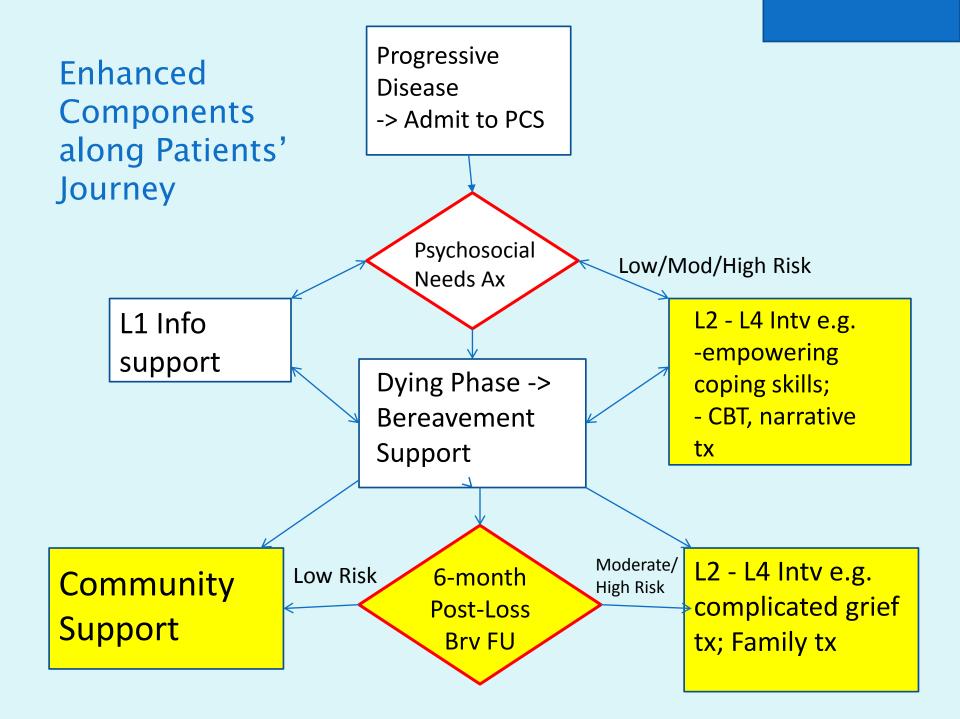


Manpower

In 7 clusters,

- o8 MSWs
- o5 CPs
- o8 PCAs

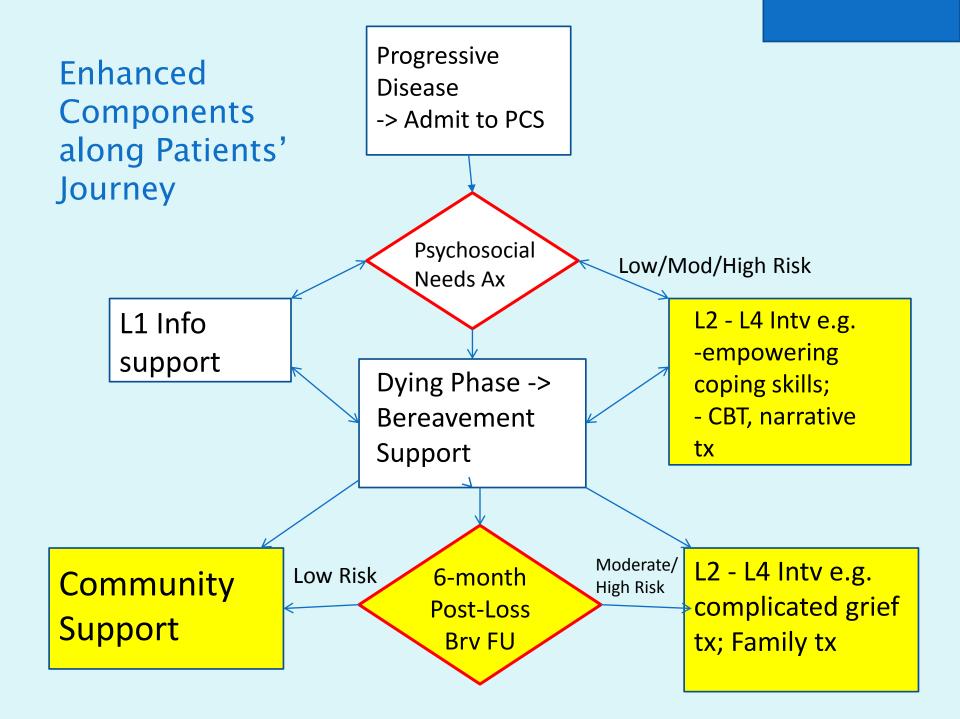
Outcome

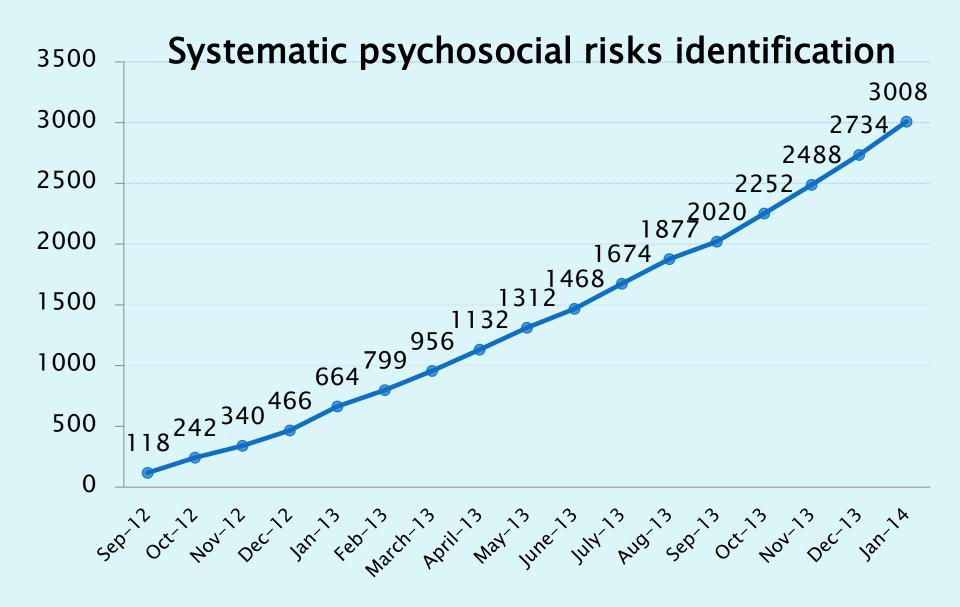


ALIGNED AX BY MSWs

- Living condition
- Financial condition
- Caring agent
- Family relationship
- Patient perceived social support

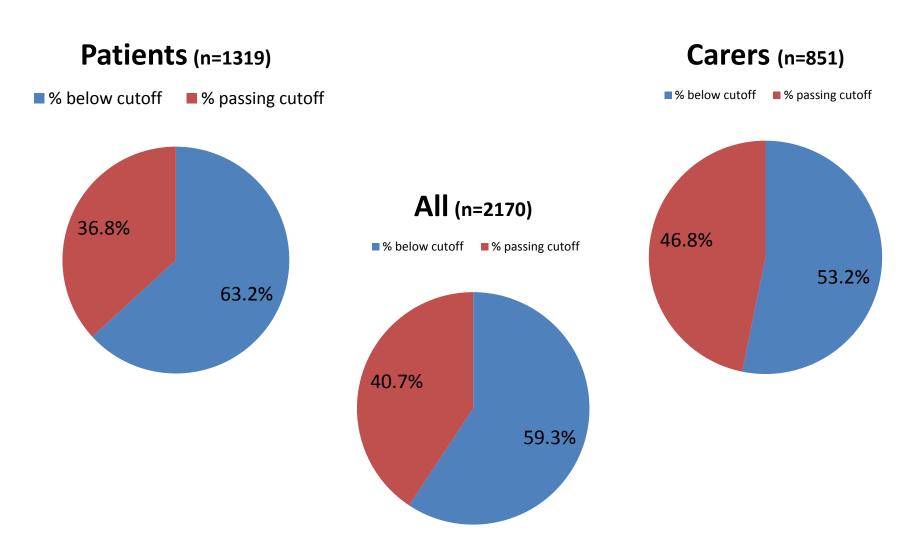
- Community support
- Reaction towards illness
- Bereavement risk factors
- Problem identification
- Needs for FU action

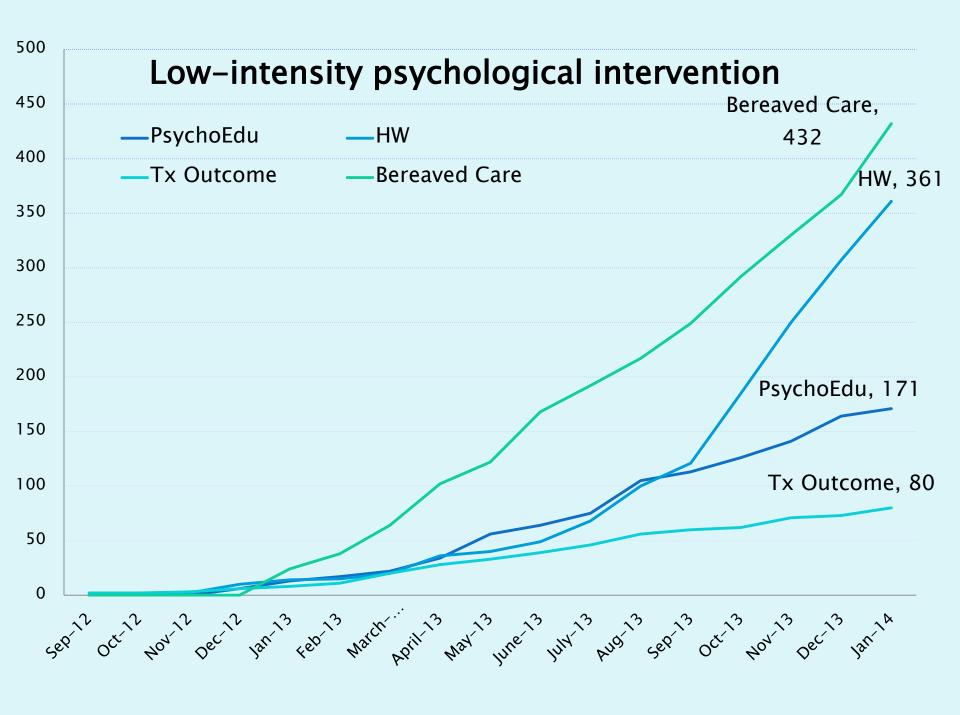




% of Patients & Carers At Risk

% passing cutoff on any 1 of the subscales of standardized questionnaires





Enhanced Service Intensity

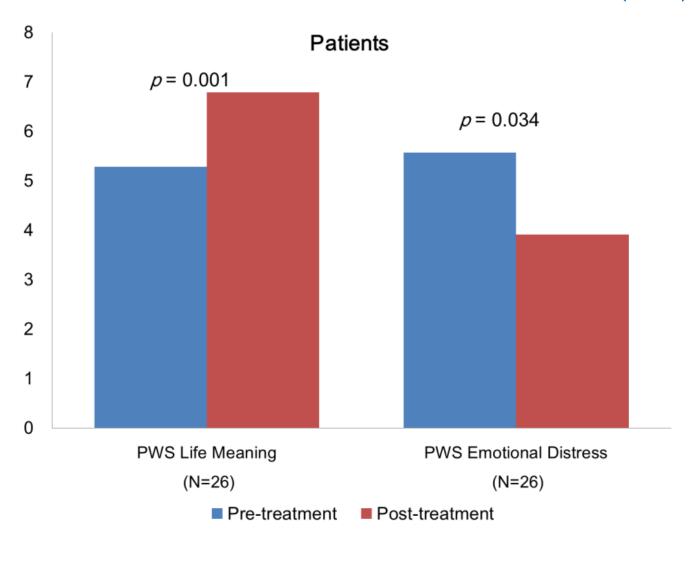
MSW:

Baseline attendance (2009): 2

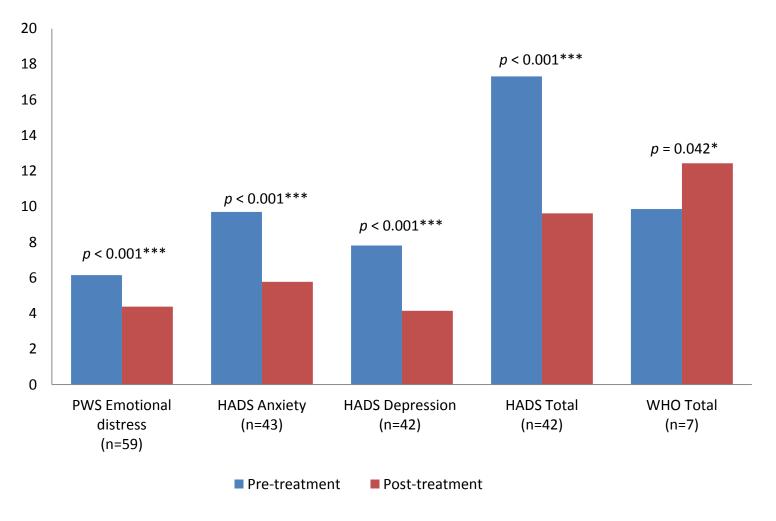
Program target: 6

Actual attendance: 9

Pre- & Post-treatment Scores (CP)







Conclusion

Benefits of the program

- Systematic detection of psychosocial risk at critical time points (entry to service, time of death, 6 months post-loss)
- Improved access and early engagement of patients and main caregivers
- Interdisciplinary collaboration through protocol driven referral to specialist care
- Intensified intervention for patients and families with elevated risk
- Reduced distress and improved well being of patients and caregivers

"Do not protect yourself from grief by a fence, but rather by your friends." – Czech proverb

THANK YOU.