SCI PATHWAY AND TRANSFORMATION RECOMMENDATIONS FOR ADULTS WITH SCI who have PSYCHOLOGICAL and MENTAL HEALTH NEEDS

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Context

NHS England brought together the eight spinal cord injury centres across England to develop a set of recommended standards for patients presenting with a traumatic or non-traumatic spinal cord injury. The set of standards have been developed to ensure a consistent pathway and clinical care for SCI patients from diagnosis to lifelong care. The standards in this document accompany and are to be read alongside the Standards for Specialist Rehabilitation of Spinal Cord Injury.

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1. Executive Summary

This document provides information on current service and delivery models for psychological and psychiatric care for people with spinal cord injury (PwSCI) in the eight spinal cord injury centres (SCIC) in NHS England. It draws on the Spinal Injury Psychologists Advisory Group's analysis of worldwide best practice and the associated evidence base. Four proposals are made: a complexity and matched care intervention pathway, an associated MDT education training curriculum, a pathway to ensure parity of admission for people with complex mental health, and recommendations for psychological health assessment and outcome measures. There are nineteen linked recommendations to ensure unity of service model across the SCICs and parity of provision and access. The recommendations are across the pathway from first episode of care after sustaining an injury, transition into the community, follow up, and secondary SCIC care.

2. Background and Current Provision

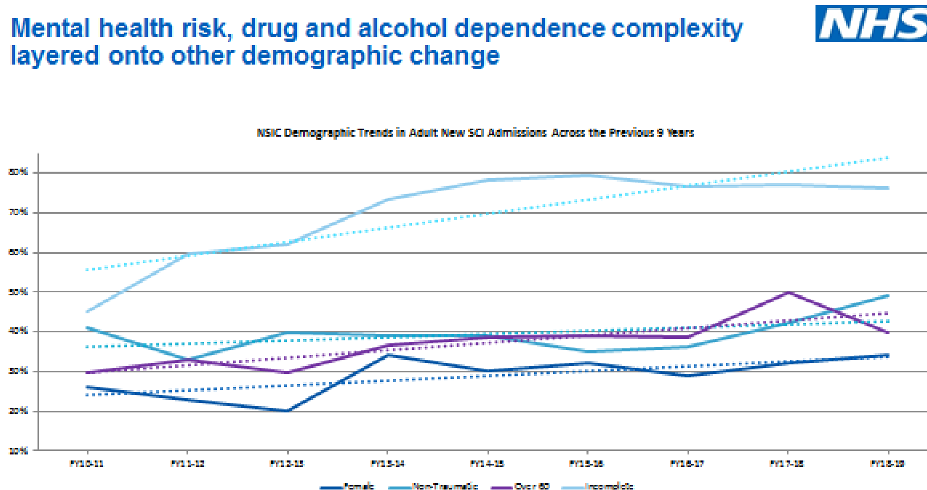
The working group recognised the breadth and complexity of need and range which encompasses patients with complex severe and enduring mental health, traumatic brain injury (TBI), dementia and neurodevelopmental needs. The group had members with a range of professional, lived and SCIC experience (Appendix A).

The group was informed by a range of information:

- recent draft psychological standards written by the Spinal Injury Psychologists Advisory Group (SIPAG), an umbrella organisation of the 12 SCICs across the UK and Ireland, based on a worldwide evidence base of 32 papers from 2005, see references for information
- published guidelines from the Paralyzed Veterans of America and Consortium for Spinal Cord Medicine Clinical Practice Guidelines for the Management of Mental Health Disorders, Substance Use Disorders, and Suicide in Adults with Spinal Cord Injury (2020)
- 2015 Mental Health service standards of the Clinical Reference Group (CRG), with the aim to operationalise these in the current context
- a survey of the psychology services and care provided by the 8 SCICs, conducted by the Chair prior to the commencement of the group which informed its aims and objectives

The group used the following to guide its remit:

2.1 Mental and psychological health complexity has increased substantially since the inception of most SCIC services (2010 onwards data):



2.2 Mental and psychological health needs are under recognised:

"Mental health and Substance Use Disorders (SUD) are under recognised and undertreated in individuals with SCI and that under recognition may occur because SCI is a catastrophic injury that blurs the lines between normal emotional responses and mental health disorders. Undertreatment may stem from poor recognition, as well as failure to use rehabilitation as a window to intervene in mental health and SUD conditions. Treatment of mental illness and SUDs is becoming more integrated into regular medical and trauma care. This is a trend that should be followed in SCI rehabilitation because it can be more effective and consistent with mental health treatment preferences in individuals with SCI" (PVA and Consortium for Spinal Cord Medicine Clinical Practice Guidelines for the Management of Mental Health Disorders, Substance Use Disorders, and Suicide in Adults with Spinal Cord Injury, 2020)

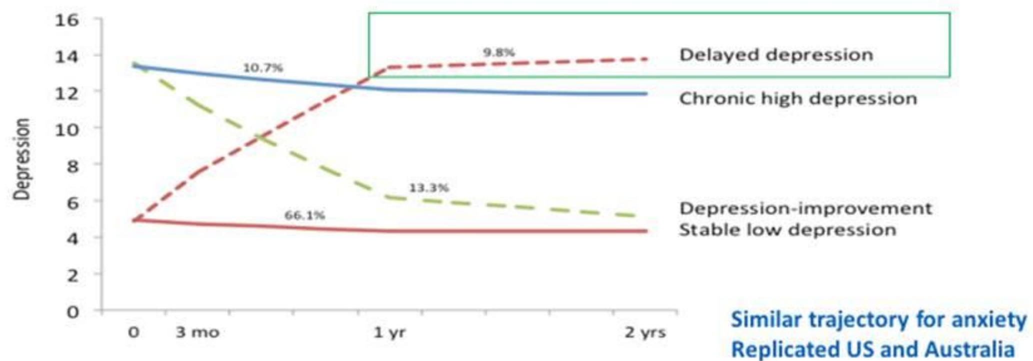
2.3 Adjustment to spinal cord injury is not a linear process:

There is a need to provide assessment, and where needed, psychological and/or psychiatric treatment for all patients with a first-time inpatient admission to a SCIC.

There is a need to follow up patients as symptoms of depression and anxiety might not present during first inpatient admission, and chronic difficulties can arise over time. The below trajectory profile is also found for symptoms of anxiety.

Bonnano, Kennedy, Galatzer, Lude and Elfstrom (2012)

NHS



17 | Duff, 08.05.19, NSIC@Stoke Mandeville – Maximising Potential, Enabling Lives

2.4 There is a wide variety of psychological and psychiatric provision across the SCICs:

All SCICs have psychological services, with a range of staffing resource from 1:15 to 1:100 for newly injured SCI beds with Sheffield, Salisbury, Southport and Stoke Mandeville having the lowest provision (Appendix B). Psychological services are largely staffed by clinical psychologists, some services also include counselling psychologists.

Seven out of 8 SCICs have a liaison psychiatry model to support the SCIC, with a variety of providers, some of these services are resident on site (Appendix B). One SCIC (Stanmore) has inhouse liaison psychiatry support as part of its' psychosocial support service model.

Some psychology services are able to provide outreach consultation prior to SCIC transfer to plan admission, most are unable to do this.

Only one SCIC was able to provide in person psychological/psychiatric assessment prior to admission and some outpatient follow up, Stanmore.

2.5 The need for a system wide approach to categorising and assessing psychological health needs and rehabilitation outcome:

The psychological health outcome measures, suggested by SIPAG in 2014, were not able to be implemented due to database constraints. These were subsequently revised by SIPAG and became part of the current review.

There was recognition that the current identification of mental health (MH) on the database needed revision.

2.6 There is a need to increase knowledge of MH needs across the system, to ensure appropriate treatment for people with serious and enduring MH and accessible inpatient psychiatry beds for PwSCI:

People with serious or enduring mental disorders (schizophrenia, bipolar affective disorder, autism spectrum disorder, and severe personality disorders) are many more times likely to have traumatic injuries, including spinal cord injury, either by accident or deliberately. However, people with such complex needs are often unable to be managed at spinal cord injury centres. Conversely people with spinal cord injury and complex or very complex mental health needs are unable to be managed in inpatient psychiatric facilities. Barriers include, but are not limited to, a lack of:

- accessible mental health units
- training amongst staff in caring for SCI in mental health units and of caring for complex mental health needs in SCICs
- working relationships between spinal cord injury services and mental health services
- awareness and confidence in managing the legal requirements of people subject to the Mental Health Act

3. Aims and Objectives

The aim of the group was to identify a common model that could be used across the 8 NHS England SCICs and include representation from a range of professional groups and SCICs as outlined in Appendix A. The group had 11 meetings and agreed:

3.1 To develop a pathway to provide matched collaborative care pathway (see glossary in appendix C for definition) and a measure of complexity for use across SCICs to cross compare the psychological and mental health of patients and tier psychological / psychiatric provision by need. To take a data snapshot of SCIC admissions using this measure

3.2 To review SCIC admissions for people defined as having a MH need from April 2018 to October 2020 and develop an outreach pathway which incorporates psychological and psychiatric assessment and admission recommendations

3.3 To develop a multidisciplinary (MDT) education curriculum to meet the diverse psychological and mental health needs in recognition that psychological care is provided by all members of the MDT. The curriculum would complement the matched care pathway in recognition that the efficacy of individual and group psychological and psychiatric treatment is impacted by the individual's wider healthcare experience

3.4 To provide consultation to the other transformation groups and agree psychological health outcome measures for Preadmission, Rehabilitation and Discharge phases, Follow Up and Lifelong care

3.5 To make recommendations for future development

4. Guidelines and Pathways

4.1 Definition of psychological and mental health needs

This guidance is for PwSCI who have pre-existing or newly emergent complex psychological / mental health needs that significantly impact upon the potential of a positive rehabilitation outcome, impair or impact on functioning of the individual or increase risk to self or others. Psychological complexity includes a range of additional needs which might include but are not exclusive to mental health or a diagnosable psychiatric disorder such as substance use, learning disability, neurodevelopmental disorder, traumatic brain injury / cognitive impairment / dementia, or needs developed as a consequence of SCI such as pain, trauma, complex adjustment, and psychosexual needs.

PwSCI who present with complex psychological / mental health needs should be offered assessment and treatment intervention to optimise rehabilitation outcome. It will be a matched care model delivered through a person centred approach, provided across the lifespan, and be aligned to the individual's needs for example in terms of information provision for cognitive difficulties. It will include collaborative shared decision making, advocacy, formulation and intervention within the care environment to ensure wellbeing and prevent secondary complications across the care pathway. Service provision will work in partnership with PwSCI who are expert by experience using co-production.

4.2 Complexity Pathway and SCIC admissions

A complexity pathway was developed and copyrighted by the National Spinal Injuries Centre Stoke Mandeville following the tariff review in 2014 which had been adopted by some SCICs. The group revised the pathway and recommends its introduction across inpatient SCICs. See glossary, Appendix C, for abbreviations.

Figure 1. SCI Psychological Health and Wellbeing Matched Collaborative Care Intervention Pathway

This is a framework for providing matched collaborative care (see glossary) psychological assessment and treatment following SCI for all first-time admissions to a SCIC and is based on complexity of past and present needs.

There are also a range of psychological **COMPLEXITY MODIFIERS** which may mean that intervention needs to be increased to the next level. These may include but are not exclusive to: quality of social support or relationship difficulties with family / spouse / significant other; unstable housing; psychosexual difficulties impacting upon self-esteem; previous attachment difficulties or trauma e.g. through migration or adverse childhood events; negative experience of authority.

FOUNDATION psychosocial health needs:

- Psychological Health:
  - All first-time admissions to SCIC to have **psychological health screen on admission and prior to discharge**
  - **Full psychological assessment to be started within 10 days of admission to SCIC, psychological review prior to discharge**
  - **Group based intervention** led and supervised by SCIC Psychological Health Service in partnership with peer worker, rehabilitation assistant, OT/PT as required
  - **Psychosexual Counselling** support as required
- Self-Management Skill Development:
  - **Holistic assessment** of patient knowledge and skill at outset of rehabilitation and reassessment prior to discharge for outcome and any residual knowledge / skill needs
  - **Collaborative goal orientated programme** involving patient, family and whole MDT
  - **Patient Education** – either group or individual depending on need
  - **Peer support** as required
  - Self-advocacy skills
- Wider system:
  - **Family Counselling** support / signposting to local services as required

	Matched Collaborative Psychological Care Assessment and Intervention Pathway:						
	Clinical Presentation	**Preadmission Outreach and previous Mental Health (MH)**	**Psychological Therapy Contact**	**MDT Skills and Consultation**	**Referral / treatment from Specialist co-located service for additional need:**	**Keyworker and Goal Planning**	**Discharge Planning**
1 BRIEF INTERVENTION	<u>Past:</u> No previous MH or previous MH needing intervention in primary care <u>Present:</u> Predominant presentation of symptoms below clinical threshold for depression/ anxiety or adjustment Subthreshold Sx of mood or anxiety (PHQ9 <10; GAD7 <10) Some difficulty coping – ADAPSSsf profile to guide intervention Well-circumscribed and understandable anxieties e.g. fear of falling when transferring No active suicidal ideation or self harm risk, passive suicidal ideation may be present <u>Cognitive Issues</u>: No cognitive issues	May have had positive Outreach screen. SCIC extended preadmission liaison not usually required.	Initial assessment and treatment intervention usually time limited eg 1-3 sessions, then may become periodical and relating to rehabilitation concerns. Group intervention will augment individual.	Level 1 MDT psychological care skills. Consultation usually takes place as standard in planned MDT meetings and needs review through attendance at goal planning meetings. Extended consultation not usually required.	Not usually required	MDT member Keyworker Usual frequency of goal planning meetings	May need onward referral via GP to IAPT or mentoring support Contact and discharge summary on IDR

BASCIS British Society of Physical & Rehabilitation Medicine MASCIP

2 ROUTINE INTERVENTION	<u>Past</u> No previous MH or previous MH needing intervention in primary care Other pre-morbid condition such as learning disability or dementia or current co-morbid condition such as TBI which complicates adjustment And / or above in association with: <u>Present:</u> Predominant presentation of symptoms above clinical threshold for depression/ anxiety or adjustment Mild Sx of mood or anxiety disorder, above threshold (PHQ9 10-15; GAD7 11-14) ADAPSSsf profile to guide intervention, may need full scale ADAPSS Symptoms of PTSD may be present No active suicidal ideation or self harm risk, passive suicidal ideation may be present Pre-injury regular excessive alcohol use or dependence	May have had positive Outreach screen. SCIC extended preadmission liaison not usually required unless screen identified additional needs that could impact on rehabilitation engagement eg TBI, substance use	Regular individual treatment intervention, following assessment which is augmented by group intervention. Cognitive assessment needed for positive screen and management advice provided to the team.	Level 2 MDT psychological care skills. Consultation usually takes place as standard in planned MDT meetings and needs review through attendance at goal planning meetings. Some minimum extended consultation might be required.	Consultation may be required eg discussion with liaison psychiatry / substance use where non-response to interventions e.g. PTSD or if complex discharge needed and to minimise risk of relapse of alcohol / drug misuse	MDT member most usually Keyworker or may be SCIC psychologist if interpersonal issues affect adjustment / supervision provided by SCIC psychologist if not Keyworker. Usual frequency of goal planning meetings	May need onward referral via GP to IAPT or mentoring support Contact and discharge summary on IDR

	Cognitive Issues: Mild cognitive impairment impacting upon rehabilitation e.g. difficulty with SCI education or carry-over between PT/OT sessions Borderline intellectual disability (IQ >70; mental age of 12) impacting upon rehabilitation; or mild intellectual disability (IQ >50, mental age of 9-12)						
3 **COMPLEX**	May have previous contact with MH / GP services or other services for pre-morbid condition History and risk (but no active or recent presentation) of self-harm or imminent risk to self or others; and / or chronic mental health difficulties with acute relapse; active issues with substance use; severe interpersonal difficulties / behaviours that challenge Risk of relapse and / or self-neglect Moderate Sx of mood or anxiety disorder (PHQ9 15-20; GAD7 15-18)	Positive Outreach screen including previous MH needs identified. SCIC extended preadmission liaison required which may include requesting local liaison psychiatric report / liaison with previous CMHT contact / neuropsychological screening leading to SCIC planning care such as personal safety planning.	Significant individual treatment intervention, following assessment which is augmented by group intervention. SCIC psychologist to provide or refer for extended neuropsychological assessment. SCIC psychologist to provide management advice to the team.	Level 2 MDT psychological care skills. Significant consultation required outside of MDT and goal planning meetings. SCIC psychologist actively involved in team risk management/ safeguarding and is link for liaison with MH services can be required to provide consultation in crisis situations. Risk managed through psychological	Psychiatric Significant liaison including: - preadmission consultation as required - regular risk review including safety netting and medicines optimisation. Substance Use – Intervention as per local service Neurology / Dementia care – Assessment and intervention as per local service	SCIC Psychologist Keyworker / supervision provided by psychologist if MDT member is the Keyworker. Goal planning meetings usual intensity, may include support in between	Significant discharge planning and liaison which may include active psychiatric involvement to ensure smooth handover to community services. Discharge Letter written with recommendation s and onward referral

	ADAPSSsf profile to guide intervention, may need full scale ADAPSS Ongoing alcohol misuse or craving for alcohol; H/O regular substance misuse; evidence of prescribed drug addiction Stable but serious mental illness: schizophrenia, bipolar affective disorder, eating disorder, personality disorder <u>Cognitive Issues</u>: Significant cognitive difficulties eg. 6CIT ≤ 8 or AMTS < 8 or MOCA <20; in people with tetraplegia: MOCA-Blind <15 Moderate intellectual disability (IQ >35; mental age of 6)			consultation with team and provision of adequate support structure.	<u>NeuroPsychologist</u> – Assessment and intervention as per local service Other:		
4 **HIGHLY COMPLEX**	Likely to have previous substantial contact with MH or other services for pre-morbid condition Recent /active self-harm or risk (which could be imminent) to self or others; chronic mental health difficulties with acute relapse; active issues with substance use; behaviours that challenge severe interpersonal difficulties/those with high levels	Positive Outreach screen including previous MH needs identified. SCIC extended and substantial preadmission liaison required which may include requesting local liaison psychiatric report / liaison with previous CMHT contact /	Substantial and frequent individual treatment which at times of crisis may be more often than once a week. SCIC psychologist to provide or refer for full neuropsychological assessment. SCIC psychologist to	Level 2 MDT psychological care skills. Substantial and frequent consultation outside of MDT and goal planning meetings. Often weekly or more frequent at times of crisis.	<u>Psychiatric</u> -substantial, active and regular liaison response. -medicines management -active risk management <u>Substance Use</u> – Intervention as per local service	SCIC Psychologist Keyworker / supervision provided by SCIC psychologist if MDT member is the Keyworker.	Complex, substantial liaison with community staff pre discharge and may include active psychiatric involvement to ensure smooth handover to community services.

	of social deprivation which affects patient engagement and safety. Severe Sx of mood or anxiety disorder (PHQ9 >20 or GAD7 >18) ADAPSSsf profile to guide intervention, may need full scale ADAPSS History of injecting drug use; history of substance dependence; methadone prescription Unstable serious mental illness Cognitive Issues: Delirium not responding to standard treatment	neuropsychological screening leading to SCIC planning care such as personal safety planning.	provide management advice to the team.	SCIC Psychologist leads in team risk management/ safeguarding is link for liaison with MH services and team requests consultation in crisis situations	Neurology / Dementia care – Assessment and intervention as per local service NeuroPsychologist – Assessment and intervention as per local service Other:	Goal Planning meetings often more frequent including liaison in between meetings	Discharge Letter written with recommendations and onward referral

The group conducted a data snapshot review of SCIC admissions using the above complexity definitions to gain insight into the percentage of patients in the system who had complex or highly complex needs (raw data in Appendix D). Data was received from 6 SCICs in December 2020:

Highly complex - 22%	Likely to have previous substantial contact with MH or other services for a condition prior to SCI Recent / active self-harm or risk (which could be imminent) to self or others; chronic mental health difficulties with acute relapse; active issues with substance use; behaviours that challenge severe interpersonal difficulties / those with high levels of social deprivation which affects patient engagement and safety Severe Sx of mood or anxiety disorder (PHQ9 >20 or GAD7 >18) ADAPSSsf profile to guide intervention, may need full scale ADAPSS History of injecting drug use; history of substance dependence; methadone prescription Unstable serious mental illness Cognitive Issues: Delirium not responding to standard treatment
Complex - 22%	May have previous contact with MH/GP services or other services for a condition prior to SCI History and risk (but no active or recent presentation) of self-harm or imminent risk to self or others; and / or chronic mental health difficulties with acute relapse; active issues with substance use; severe interpersonal difficulties/behaviours that challenge Risk of relapse and / or self-neglect Moderate Sx of mood or anxiety disorder (PHQ9 15-20; GAD7 15-18) ADAPSSsf profile to guide intervention, may need full scale ADAPSS Ongoing alcohol misuse or craving for alcohol; H/O regular substance misuse; evidence of prescribed drug addiction Stable but serious mental illness: schizophrenia, bipolar affective disorder, eating disorder, personality disorder Cognitive Issues: Significant cognitive difficulties eg. 6CIT ≤ 8 or AMTS < 8 or MOCA <20; in people with tetraplegia: MOCA-Blind <15 Moderate intellectual disability (IQ >35; mental age of 6)

This is possibly elevated and slightly unrepresentative of admissions in a non COVID year as the most complex patients remained in SCIC care and were not discharged during the COVID-19 pandemic. The NSIC using the above complexity has found 26% of its admissions to have complex / highly complex needs FY19-20; 29% FY 18-19.

Recommendation:

1. Implementation of the matched collaborative care pathway across SCICs
2. Yearly audit of implementation and complexity of patients in SCICs by SIPAG / peer review.
3. It is anticipated that some services will be noncompliant with 1 because of their comparative low resourcing (Appendix B). Where service gaps are identified, action plan to be implemented

4.3 MH need and outreach pathway

We are grateful to Andy Coxon for his support in achieving this aim (Appendix E for data).

Admissions, defined as having a MH need from the database, were reviewed by 8 SCICs. The findings were:

- The MH category on the database is a catch all term and centres found it referred to people with learning disabilities, who had a TBI, older adults with dementia, people with neurodevelopmental needs as well as people with severe and enduring MH and associated risk of self-harm. The group recommends that this be amended to reduce confusion about patients who are declined services.
- A deep dive into the available data revealed:
  - There was a greater delay for admission for people with an identified MH need on the database for all SCICs apart from one centre.
  - There was a difference between the percentage of admissions for people with an identified MH need compared to those who did not have a MH need in 5 SCICs
  - One SCIC compared their database data entry for MH - there was missing data for 38% of admissions (58% had data entry of no MH).
  - One SCIC compared its database data with the complexity assessment by the SCIC clinical psychologist after admission. They found 8 patients who had highly complex / complex needs whose needs were not identified by referrers (18 patients were identified with a MH need for this SCIC).
  - Two SCICs compared their pathway of formal assessment / consultation by the SCIC psychologist / psychiatrist prior to admission and found that this had not been followed and patients had been declined prior to formal assessment.

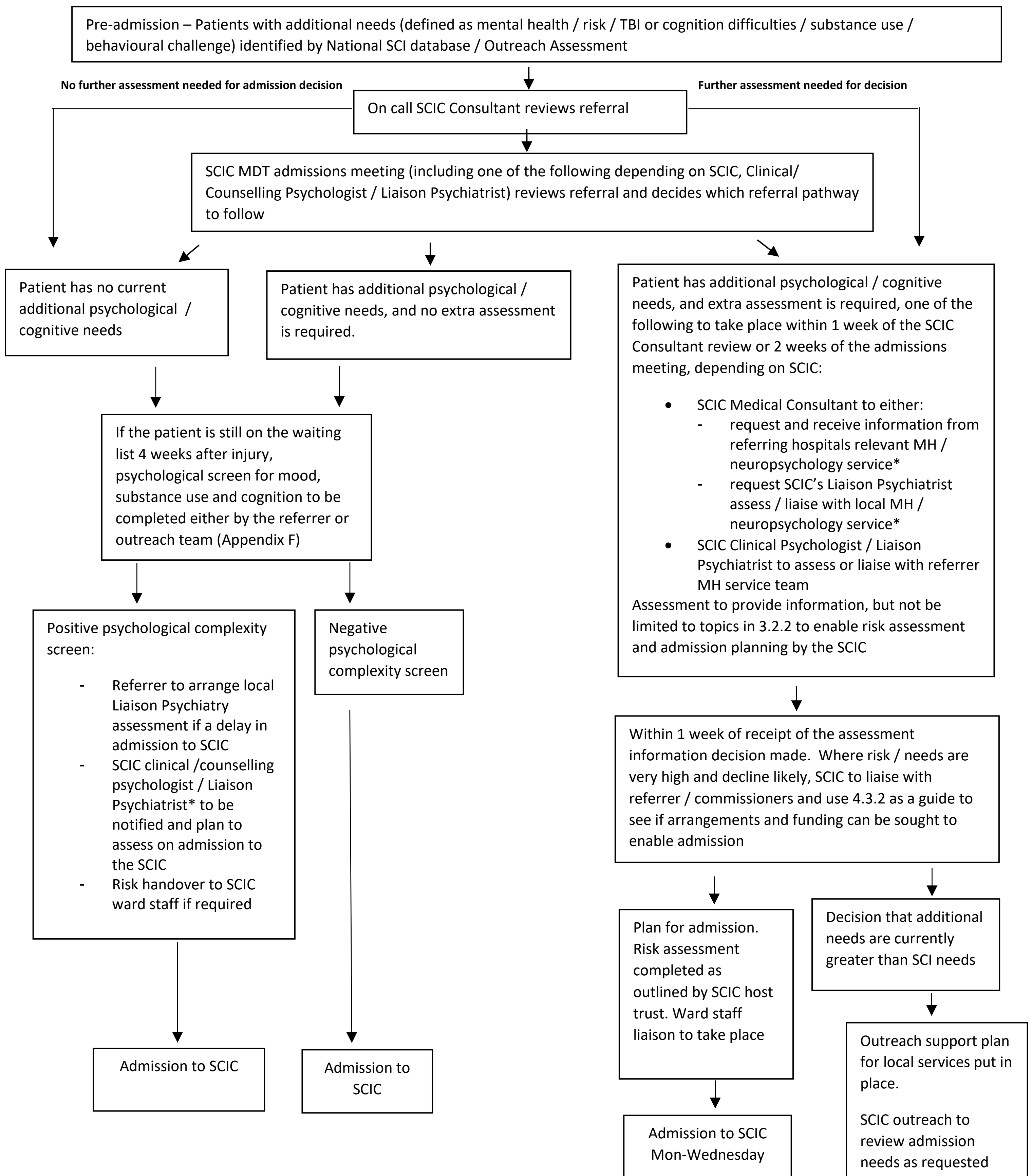
On the basis of the above, and in recognition of the need to develop clearer admission criteria with transparency of information about a reason for decline, the group developed an outreach flowchart. The flowchart recognises that there may be specific safety, training, and environmental limits for the SCIC in accepting an admission, or that the patient may not yet be ready/psychiatrically stable enough for active rehabilitation. It gives recommendations for the assessment and local service liaison that could facilitate SCIC admission.

The group, in liaison with workstream 1, recommended the following acceptance criteria to complement the flowchart:

Patients with significant MH needs – a decision not to admit to SCIC should only occur after review from the MDT including consultation with those who provide psychological service in the SCIC and when someone's pre-existing psychological needs might compromise their safety or the safety of other patients. Active steps to be taken, such as employment of additional 1:1 nursing observation (by HCA or RMN), to enable an admission and an action plan outlining admission needs should be provided, including a plan to meet their psychiatric or cognitive needs. Where observational or psychiatric support is required beyond that available at the SCIC the persons local referrers/CCG may be required to fund or provide staff (see SCIC Psychological and Mental Health Outreach Flowchart).

4.3.1 SCIC Psychological and Mental Health Outreach Flowchart

Figure 2. SCIC Psychological and Mental Health Outreach Flowchart is intended as an overlay to the SCIC's usual admission process for people who have psychological and mental health needs identified on referral or at Outreach assessment.



*Relevant MH service will in most instances be the referrer's Liaison Psychiatry service, but could instead include depending on local arrangements the referrers clinical psychology / or health psychology service

4.3.2 Additional Information for formal assessment:

- Current and past psychiatric diagnoses, CMHT / crisis involvement / MHA section and contact information for community teams
- Whether the patient is able to learn and retain rehabilitation and care information, follow direct care instructions and initiate / instruct on care, participate in active physical rehabilitation?
- If there has been any of the following with information about the behaviour, frequency and triggers:
    - Self-harm
    - Absconding
    - Aggression / Violence
    - Refusal of care
    - Active psychosis
    - Substance use
- Requirement for additional nursing / other resource for admission
- Current medication
- Recommended timeframe for psychological / psychiatric assessment after transfer
- Neuropsychological assessment to be requested if there is a positive screen on the 6CIT / AMTS / MOCA possible significant brain injury or ageing cognitive decline identified

4.3.3 Additional aspects that may reduce risk and enable admission to SCIC where a decline for admission is being considered.

SCIC, referrer and commissioner to liaise and seek local area funding where needed and outline whether provision of the below would enable admission:

- Contracted period of admission with extension possible after progress review, alongside for safety either:
    - local hospital repatriation bed identified
    - local area psychiatry bed held open for patient
- Local area to continue to hold and be:
    - Mental Health Act Responsible Clinician and manage the MHA section
    - CPA local care co-ordinator
- Local area to provide funding for RMN staffing, as required
- SCIC to consider environmental, security and relational safety and:
    - arrange for the patient to be open to local CMHT / Liaison Psychiatry for crisis need
    - provide SCI psychological and Liaison Psychiatry treatment and specify the framework for the support between the SCIC clinical psychologist/liaison psychiatrist and local liaison psychiatry / continuity of care from CMHT and care co-ordinator
    - identify robust local MH agency staff, with back up resource identified
    - identify environmental needs, equipment and training such as ligature cutters

Recommendation:

4. Amendment of the database to re-categorise MH into the below. Although most self-harm attempts occur in the context of other MH needs, it is suggested that this is a separate category to capture the frequency and additional pre-admission needs of this group:
    - Self-harm / suicide attempt / neglect
    - Severe and enduring MH / psychosis / schizophrenia
    - Depression / anxiety
    - Substance use
    - Neurodevelopmental diagnosis
    - Dementia
5. Implementation of the outreach flowchart, Figure 2
6. Yearly audit of flowchart in SCICs by SIPAG / peer review
7. It is anticipated that some services will be noncompliant with 5 because of their comparative low resourcing (Appendix B). Where service gaps are identified, action plan to be implemented

4.4 MDT staff development and training curriculum to meet the identified need

The group recognised the inter-relationship between specialised psychological and psychiatric treatment and the daily emotional support provided to patients by members of the MDT in their treatment and care. The group drew on a stepped model used in Improving Access to Psychological Services (first line community treatment), cancer care, burns, and other physical health services.

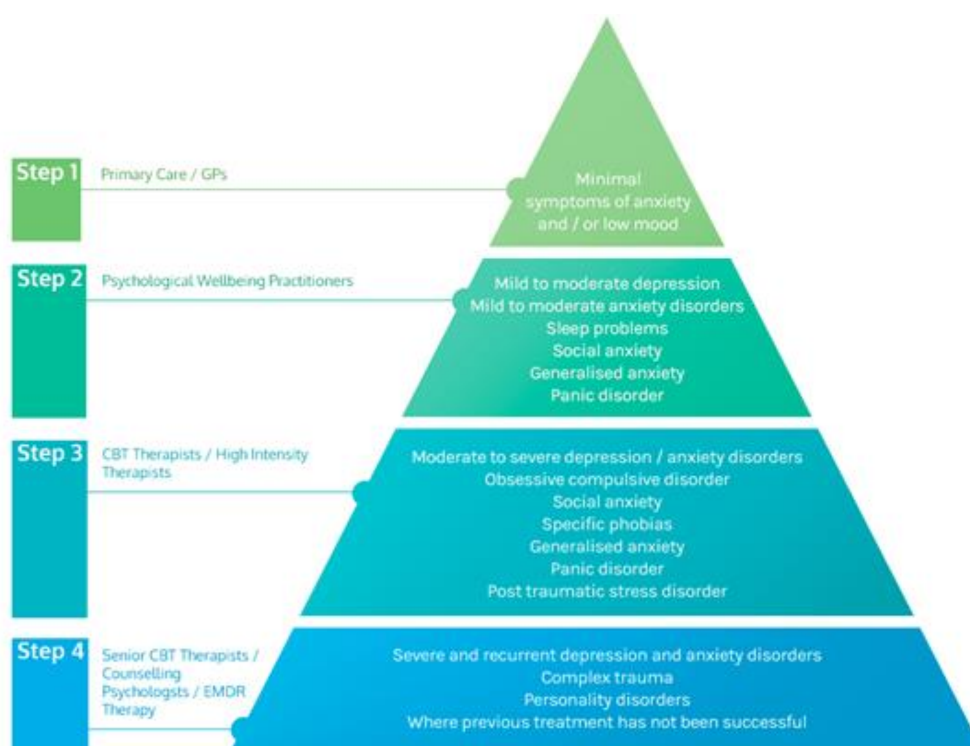


Figure 3. SCI MDT Education Curriculum

The group used the above generic stepped framework to develop a SCI specific curriculum for MDT staff, identifying basic (level 1) skills that are needed by all staff working in the SCIC, with some staff in each clinical area needing advanced (level 2) skills. The SCI MDT curriculum recognises the psychological first aid and generic emotional skills support provided by members of the MDT, which complements the specialist individual and group psychotherapy matched collaborative care assessment and treatment framework, Figure 1. The below curriculum draws on and includes the **Mental Health Core Skills Education and Training Framework,** Skills for Health Mental-Health-CSTF.pdf (skillsforhealth.org.uk)

Level 1		
Subject	**Content**	**Objectives**
• *Being in hospital*	– The meaning of hospital for patients – What a hospital can look and feel like to patients – The effects of the above – From person to patient (pros and cons) – Helping a patient to maintain their identity – Why sleep is important – The normal sleep cycles – Effect of admission to hospital on sleep – Sleep strategies for the patient – What night staff can do to help – Cognitive Fatigue / fatigue and SCI – Active listening skills – hearing what is beyond the statement and how to respond	– To understand how hospitalisation can affect a patient and their family – To understand sleep, be able to support the patient to improve their sleep and change own behaviour that might be affecting the patient's sleep
• *Interaction between physical and mental health (biopsychosocialspiritual model)* • *Understanding the patient (simple formulations)*	– What is the biopsychosocial spiritual model? – Why it is important to consider in the hospital ward – Mood and thoughts can affect physical symptoms – Is the patient exaggerating or could it be something else? – What is a formulation – Why are they important when working with a patient? – How you can use them in your work with patients – A framework for understanding diagnosis, prognosis and common reactions – The role of hope (that it is not denial) and pendulum that people experience as they approach what SCI means, back away (avoid) and then approach again	– To understand the biopsychosocial spiritual model and the implications for working with patients – To recognise that every patient is different and therefore treated as individuals and without judgement – To understand what a formulation is; its role and how to develop and communicate a basic formulation

	– Context and coping with behaviours that challenge **Mental Health Core Skills Education and Training Framework** Subject 12 and Ref: Y/602/6374 Level 1 Introduction to mental health Violence and aggression: short-term management in mental health, health and community settings (nice.org.uk)	
• *Depression*	– What is depression? – Causes of depression – Symptoms of depression – Effects of depression – Working with the patient who is depressed **Mental Health Core Skills Education and Training Framework** Subject 4, 5, 11, 13 and Ref: Y/602/6374 Level 1 Introduction to mental health	– To understand depression, its causes and effects. – To feel confident working with a patient who is depressed
• *Anxiety*	– What is anxiety? – Causes of anxiety – Symptoms of anxiety – Effects of anxiety – Working with the patient who is anxious **Mental Health Core Skills Education and Training Framework** Subject 4, 11, 13 and Ref: Y/602/6374 Level 1 Introduction to mental health	– To understand anxiety, its causes and effects. – To feel confident working with a patient who is anxious
• *Risk assessment*	– What is self-harm and what is suicidal intent – How do you know a patient is suicidal? – Assessing a suicidal patient – The words to use – Action to take – The myth that talking to a suicidal patient will make it more likely that they will attempt to end their life – Effect on you when a patient is suicidal & how to manage these feelings and afterwards **Mental Health Core Skills Education and Training Framework** Subject 2, 3, 5, 7, 11, Ref: R/602/6194 Level 1 Awareness of protection and	– To be able to assess a patient who is thought to be at risk of suicide – To be able to respond with appropriate actions to ensure the safety of the patient – To be able to recognise and understand the impact on the clinician and to ensure self-care

	safeguarding in health and social care (adults and children and young people), early years and childcare and Ref: A/601/8574 Level 2 Principles of safeguarding and protection in health and social care	
• *Pain on the ward*	– What is pain (biopsychosocial and basic pain mechanisms)? – Acute and chronic pain – Culture and pain and expression of pain – What can increase a patient's pain – Can we tell how much pain patients are in? – How to assess pain – How to respond to pain **Mental Health Core Skills Education and Training Framework** Subject 3	– To have a basic understanding of pain mechanisms – To understand the difference between acute and chronic pain – To understand that pain is always a mix of physical and psychological – To understand what affects pain – To be able to assess and respond to patients' pain
• *Cognition*	– Memory, attention, dysexecutive difficulties – What to look for in rehab	– To be able to recognise signs of memory, attention, dysexecutive difficulties – To know how to refer – To know how to make basic adaptations to a care environment
• *Alcohol and substance use*	– What this is alcohol and substance use and how to recognise – Behaviours that may be associated with this – Different approaches abstinence/relapse prevention – When you feel conflicted e.g. smoking/bed rest, boundaries when someone tells you about substance use **Mental Health Core Skills Education and Training Framework** Subject 13	– To have a basic understanding of alcohol and substance use and what this looks like in rehab environment – To practice verbal replies to verbal and physical behaviours that challenge, role of consistency across MDT
• *Severe and enduring mental health*	– Basic MH knowledge and awareness – Behaviours that might be associated with this – Taboos and myths – Risk Assessment – Basic information and limits on the Mental Health Act, holding powers etc **Mental Health Core Skills Education and Training Framework** Subject 6, 7, 13, 16	– To have a basic understanding of MH needs and what this looks like in rehab environment – To know how to adapt the care environment/intervention/therapy to accommodate – To be able to have a risk conversation

• *Culture and language*	– Different language and use of interpreters – Different culture – Same language, different culture **Mental Health Core Skills Education and Training Framework** Subject 5 and Ref: H/602/3039 Level 2 Principles of diversity, equality and inclusion in adult social care settings	– To have attended local Trust level awareness – To be aware of local SCIC demographics and need – Unconscious bias and inclusion examples
• *Managing difficult interactions with patients and families*	– Understanding the patient and the family and their stress/mood – What is anger and how much anger do we tolerate – Noticing an escalating situation – What helps and what does not help – Managing your own reactions to others' stress – Difficult conversations feel difficult, this is normal – Plan (but don't over plan) what you need to say – Spend some time reflecting on how the subject affects you – Confidential, uninterrupted space – Consider environment (e.g. no desk between you; same height chairs) – You and the patient must have plenty of time **Mental Health Core Skills Education and Training Framework** Subject 8 and 9 Violence and aggression: short-term management in mental health, health and community settings (nice.org.uk)	– To be able to have an effective difficult conversation with a patient/their family
• *Self-management and adjustment model*	– Motivation for goals and what helps people to adhere – Specific goals / targets, who, what, where, when – Goals and care planning – Participation and impact on adjustment – work, quality of life, implicit expectations **Mental Health Core Skills Education and Training Framework** Subject 14 https://skillsforhealth.org.uk/wp-content/uploads/2021/01/Person-Centred-Approaches-Framework.pdf	- Be aware of basic principles of adherence, factors that facilitate and diminish it - Have basic knowledge of motivational interviewing/health coaching and how to engage people in positive decision making - Be able to set specific goals and targets in own clinical area

	https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf Violence and aggression: short-term management in mental health, health and community settings (nice.org.uk)	
• *Sexuality*	– PLISSIT model (Permission, Limited Information, Specific Suggestions, Intensive Therapy – skilled in P and LI) – Basic sexual responsiveness by level of SCI – Signposting people to more specialist support – Understanding of how to apply the clinical practice guide - Sexuality and Reproductive Health in Adults with Spinal Cord Injury: a clinical practice guideline for health professionals (2010). Consortium of Spinal Medicine and Paralyzed Veterans of America	- To have basic knowledge of physical sexual responsiveness by level of injury - To be confident in how to answer a question about options available - To be able to signpost to services
• *Self-care*	– Stress, depression, anxiety – Busy job and burn out – Unhelpful responses and behaviours – Helpful responses and behaviours – When to get more support – Mentoring and clinical supervision - how to use	- To be able to identify signs and symptoms of stress and be aware of triggers - To be aware of and able to discuss impact of a clinical case on own self care
Level 2		
Subject	**Content**	**Objectives**
• *A framework for understanding the patient*	Understanding the patient: CBT principles – Hot cross bun (thoughts; emotions; behaviour; physical symptoms) – Hot cross bun and the patient/relatives – Understanding a patient’s responses: Examples of patients’ hot cross bun – Understanding ‘odd’ behaviour: Examples – Recognising a downward spiral / unhelpful thoughts	– Have a basic understanding of the relationship between thoughts, emotions, behaviour and somatic symptoms/feelings – Understand what could be underneath / driving patients ‘odd’ or unwanted behaviour – Develop basic skills in helping patients to consider alternative thoughts
• *Self-management (patient)*	– Medical vs self-management model – Values – Kolb’s Learning Cycle – Integrating patient education with SMART goals https://skillsforhealth.org.uk/wp-content/uploads/2021/01/Person-Centred-Approaches-Framework.pdf	– To be able to help the patient set SMART goals – To understand what values are and how they are related to goal setting

	https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf	
• *Cognition*	- How to recognise delirium - Mental Capacity Assessment (MCA) - Memory, attention, dysexecutive difficulties – what to look for in rehab and how to adapt the environment **Mental Health Core Skills Education and Training Framework** Subject 16	- To be able to adapt care environment to meet cognitive needs - To be aware and able to write personal safety plan - To be able to complete a MCA
• *Screening for psychological distress and how to support other staff*	– Mental Health First Aid principles – Reflective practice and supervision	- To be able to signpost staff - Co-facilitate reflective practice session with a qualified psychological practitioner taking the lead
• *Sexual Health*	– PLISSIT model (Permission, Limited Information, Specific Suggestions, Intensive Therapy – skilled in P and LI as level 1 (basic) and SS and level 2 (advanced) – Basic sexual responsiveness by level of SCI – Signposting people to more specialist support – Understanding of how to apply the clinical practice guidelines - Sexuality and Reproductive Health in Adults with Spinal Cord Injury: a clinical practice guideline for health professionals (2010). Consortium of Spinal Medicine and Paralyzed Veterans of America	- To have basic knowledge of physical sexual responsiveness by level of injury - To be confident in how to answer a question about options available - To be able to signpost to services - To be able to make specific recommendations and support patient to trial these
• *Team working in MDT*	– Hot Cross Bun and you/the team – Individual clinician's vs MDT vs IDT: What are they and pros and cons – What causes problems in a team – Signs when things aren't working – What to do when things aren't working (including support available in the Trust) – Difficult conversations in a team – Signs when a team is working well – What helps a team to function well? – Hierarchies, respect & opinions	- To be able to co-facilitate team discussion with a qualified psychological practitioner taking the lead

Recommendation:

8. Adoption of the pathway model, Figure 1, to align SCICs with other physical healthcare services
9. Support for SCICs to transition to Figure 1 supported by the implementation of the curriculum in Figure 3 for training and skill development for MDT staff
10. The most efficacious approach for training would be to develop an online skills package which could be developed and utilised by all 8 SCICs psychological care teams, and minimally personalised by them as needed. Resource funding would need to be identified for this and a host website. The Back Up Trust website or Health Education England is a potential location for this skills package. Such training could also be accessible to staff in DGHs and MTCs caring for patients with SCI not admitted to SCIC.

4.5 Psychological Health screen and recommended measures (Appendix F)

4.5.1 Psychological health short form screen to be completed with all PwSCI 4 weeks after injury (included in the output from workstream 1)

4.5.2 All newly injured PwSCI who have a first admission to SCI Centre, to be administered a full psychological screen to gain baseline assessment and outcome data:

- within 4 weeks of SCIC admission
- within the final 4 weeks of SCIC admission prior to discharge

4.5.3 At outpatient review by SCIC Centre, outpatient staff to complete a short form psychological health screen at the same time point as other outcome assessments such as SCIM and ASIA, with referral to community services for someone with a positive screen

4.5.4 All secondary rehabilitation admissions of PwSCI to a SCIC be administered a short form psychological health screen. Referral to be made to the SCIC psychological services for full assessment if there is a positive screen.

Recommendation:

11. Implementation of psychometric screen across all parts of the pathway and for all levels and completeness of SCI
12. Outcome comparison by SCIC and tracking of group trajectory profiles by complexity. Revision of matched intervention as required
13. It is anticipated that some services will be noncompliant with 11 and 12 because of their comparative low resourcing (Appendix B). Where service gaps are identified, action plan to be implemented.

4.6 Future Development

Recommendation:

14. Support to consult, finalise and publish the evidence based SIPAG standards for psychological care which incorporates broader psychological and personalised care needs (Figure 3), addressing service standards for sexuality, peer support, vocational needs and family/carer support, and where this can be provided across lifespan and pathway for adults PwSCI
15. All SCIC psychology services to be resourced similarly and to at least the staffing of the current best ratio (London SCIC, Appendix B) and in alignment with the specialist provision of the SCIC compared with other SCI providers in the network such as neurorehabilitation services
16. Development of SCIC outpatient services with the following being recommended:
    - 40% of first-time inpatient admissions are likely to have transition psychological need (Saleh, Duff et al, 2020; Saleh, Duff et al (under editorial review). This does not include patients with significant psychological / psychiatric need who are referred to CMHT for ongoing care following discharge – recommended that a psychological outpatients assessment clinic be developed to assess patients within 18 months of discharge and signpost to community services / peer mentoring
    - it is likely that 60% -70% of people presenting with persistent pain will need an associated psychological review (Siddall et al, 2003, estimate pain prevalence in 81% of the SCI population – recommended that an outpatient MDT clinic including psychological review but developed
17. Traumatic Brain Injury provision within SCICs to be improved. Whilst SCICs can manage the needs of those with mild TBI, those with more severe injuries often fall in the gaps between neurorehabilitation and spinal cord injury rehabilitation. Future development should focus on:
    - Scoping local services and developing links, providing an integrated pathway for those with moderate TBI and spinal cord injury by embedding neuro-rehabilitation expertise within SCICs and vice versa, including joint training events, rotational arrangements for therapists and nurses in the first instance
    - progressing to the employment of staff skilled in managing moderate TBI in SCICs
18. Psychiatry provision to be improved, SCIC to:
    - foster links with local specialist mental health services, particularly liaison psychiatry services
    - have service level arrangements with or embedding liaison psychiatry services within spinal cord injury services
    - improve training of staff to better manage mental health complexity on spinal cord injury units through adoption of Figure 3
    - arranging collaborative and parallel working practices for people with co-occurring complex mental health and spinal cord injury rehabilitation needs such as repatriation arrangements
    - agreeing responsible clinician arrangements with local specialist services for people detained under the Mental Health Act

19. Wheelchair accessible access to mental health units for PwSCI

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6. Appendices

Appendix A: Working Group Membership

Name	Position	SCIC
Dr Jane Duff (Chair)	Consultant Clinical Psychologist and NSIC Head of Service	NSIC, Stoke Mandeville
Staff Nurse Lillie Birch	Senior Nurse	MCSI (Midland Centre for Spinal Injuries), Oswestry
Dr Suzanne Clarke	Clinical Psychologist	NWRSCIC, Southport
Dr Ram Hariharan	Medical Consultant	Princess Royal SCIC, Sheffield
Mary Hutchinson	Occupational Therapist	Pinderfields SCIC
Dr Sally Kaiser	Clinical Psychologist	MCSI Oswestry
Dr Christina Kalovidouri	Clinical Fellow	MCSI Oswestry
Andy Masters	PPV	--
Dr Anitha Naidoo	Locum Consultant Spinal Injuries Rehabilitation	NSIC, Stoke Mandeville
Dr Parashar Ramanuj	Consultant Psychiatrist and Clinical Lead	London SCIC, Stanmore

Appendix B: Current SCIC Service

BSRM recommendations for a level 1a service range from 8:1 to 6:1

	Specialised rehabilitation service WTE Per 20 beds			Local specialist rehabilitation service WTE Per 20 beds	
	Hyper-acute	**Level 1a**	**Level 1b**	**Level 2a**	**Level 2b**
Medical Staff - Consultants accredited in rehabilitation medicine	3.0-3.5	2.5-3.0	2.0	2.0	1.5
Medical staff – Junior (Training grades above FY1 or Trust grades)	3.0-3.5	2.0-2.5	1.5-2.0	1.5-2.0	1.5-2.0
Nurses	45-60	40-50	35-40	35-40	35-40
% Qualified nursing staff (Band 5 or above) (Depending on acuity of caseload)	65-75%	50-60%	45-50%	45-55%	45-55%
% Nurses with specific rehab training		At least 45%	At least 40%	At least 40%	At least 30%
Therapy Staff					
Professionally qualified physiotherapists (Depending on proportion of patients with tracheostomy or requiring 2:1 therapy)	6.0-7.0	6.0-7.0	5.5-6.5	5.5- 6.0	4.5-5.5
Professionally qualified occupational therapists	5.5-6.5	6.0-7.0	5.5-6.5	5.5- 6.0	4.5-5.5
Professionally qualified speech and language therapists (Depending on proportion of patients with tracheostomy)	3.0-4.0	3.0-3.5	2.5-3.0	2.0-2.5	1.5-2.0
Professionally qualified clinical psychologist/counselling (Depending on whether patients with severe behavioural problems are accepted)	2.5-3.0	2.5-3.5	2.5-3.5	1.5-2.5	1.5-2.0
Social worker / discharge co-ordinator	1.0-1.5	1.5-2.0	1.5-2.0	1.5-2.0	1.0-1.5
Dietitian (Depending on the proportion of patients on enteral feeding / complex nutrition needs)	1.0	1.0	0.5-1.0	0.75-1.0	0.5-0.75
Clerical staff	3.0 WTE, but dependent on caseload and throughput				

Note:
These staffing levels support both the inpatient activity and associated out-reach work including pre-admission assessments/pre discharge home-visits, case-conferences etc. related to each inpatient episode but does not include general out-patient clinics.
Additional resources are required if the services also offers community rehabilitation services.
Additional staff eg technicians, engineers, prosthetists etc may also be required depending on the caseload.

Clinical Psychology Staffing at the time of the first report, January 2020, and updated for SCI Network Board 16th December 2021

SCIC	Adult database beds January 2020	WTE and Beds:staff ratio Jan 2020	Adult database beds, December 2021	WTE, Beds: staff ratio and Service constraints Dec 2021	Staffing for provision to be equivalent to Stanmore (wte gap)
London SCIC, Stanmore	33	2.2 (in addition, 0.7 wte Liaison Psychiatry as part of psychosocial service = total 2.9) 15:1	33	2.2 (in addition, 0.7 wte Liaison Psychiatry as part of psychosocial service = total 2.9) 15:1	N/A
Yorkshire SCIC, Pindersfield	32	1.2 27:1	32	1.2 wte, 27:1 ML and secondment, no provision	2.13 wte (0.93 wte)
Midlands SCIC, Oswestry	44	1.5 29.3:1	44	1.5 wte, 29.3:1	2.9 wte (1.4 wte)
Golden Jubilee Centre, Middlesborough	24	0.8 30:1	24	0.8 wte, 30:1	1.6 wte (0.8 wte)
NSIC, Stoke Mandeville	93 (prior to St Joseph closure 109)	2.87 32.4:1 (previously 38:1)	93	3.26 wte, 28.5:1	6.2 wte (2.94 wte)
NWRSCIC, Southport	51	1.37 37.2:1	51	TBC - 1 wte Vacancy Clinical Psychologist, 0.37 Counsellor in place, 0.4 wte advert	3.4 wte (2.1 wte)
Duke of Cornwall, Salisbury	42	0.78 54:1	39	1.38, 30:1 (long term absence 0.78)	2.8 wte (1.42 wte)
Princess Royal SCIC, Sheffield	60	0.6 100:1	60	TBC - Vacancy (overview provided by Trust Head of Psychology)	4 wte (3.4 wte)

SCIC Co-located Service Information, January 2020

SCIC	Description
NSIC, Stoke Mandeville	Liaison Psychiatry on site provided by MH Trust under honorary contract arrangement Local agreement with substance use service. Older adults dementia / neurology services on site with dementia specialist nurse LP - 2 sessions a month dedicated to NSIC and 8-8 for immediate risk as with rest of DGH
Midlands SCIC, Oswestry	Off site RAID/Liaison service. Provide 24/7 telephone support to team. Within working week Psychology Team normally manage requests and liaise with RAID team when needed. Other services are not provided within trust/SLA & would require specific referral to outside organisations.
Princess Royal SCIC, Sheffield	On site Liaison Psychiatry (Mental Health Trust staffing). The team can refer to Liaison Psychiatry, Older Peoples Liaison Psychiatry and Neuro-Rehab Consultants. Alcohol Liaison Team attached to Psychiatry, but no substance misuse team for patients out of area, only those who are from Sheffield.
Yorkshire SCIC, Pindersfield	LP onsite. Also new MH Liaison workers available. Dementia, substance use team all available on site.
London SCIC, Stanmore	Onsite Liaison Psychiatry based in SCIC x1.5 Consultant + 1 Physician Associate) - also provides a service to rest of hospital. Part of SCIC psychosocial care service, admissions allocated according to need.
NWRSCIC, Southport	LMH team available by referral within Trust (provided by different Trust). Dementia team within the Trust. HALT team cover substance misuse also Trust resource.
Golden Jubilee Centre, Middlesborough	Liaison psychiatry with SLA
Duke of Cornwall, Salisbury	No information provided

Appendix C: Glossary

ADAPSSsf - Appraisals of Disability: Primary and Secondary Scale short form

AMTS – Abbreviated Mental Test Score

CMHT – Community Mental Health Team

DGH – District General Hospital

GAD-7 – General Anxiety Disorder (Assessment) – 7 items

GP – General Practitioner

H/O – History of

IAPT – Improving Access to Psychological Therapies

IDR – Interdiscplinary Discharge Report

IQ – Intelligence Quotient

Matched Care – "The three main models (collaborative care, matched care and stepped care) are summarised by NICE Clinical Guideline 91: Depression in adults with a chronic physical health problem (National Institute for Health and Care Excellence, 2009). Stepped care involves starting all people at the lowest level intervention and stepping up to the next level if they do not adequately respond. Matched (or stratified) care includes an initial triage so that people start on the most appropriate step, which may be the highest level. Stepped or matched care can be part of collaborative care, a model for the management of chronic disease. Collaborative care has four components: collaborative identification of problems; goal-planning; self-management training and support to facilitate intervention plans, behaviour change and emotional coping; and active monitoring and follow-up" 2.12, National Clinical Guideline for Stroke (2016), Royal College of Physicians: Intercollegiate Stroke Working Party.

MDT – Multidisciplinary Team

MH – Mental Health

MHA – Mental Health Act

MOCA – Montreal Cognitive Assessment

MTC – Major Trauma Centre

NSIC – National Spinal Injury Centre

PHQ -9 – Patient Health Questionnaire – 9 items

PLISSIT – Permission, Limited Information, Specific Suggestions, Intensive Therapy Model

PPV - Public Patient Voice

PTSD – Post Traumatic Stress Disorder

PwSCI – Person with Spinal Cord Injury

RMN – Registered Mental Health Nurse

SCI – Spinal Cord Injury

SCIC – Spinal Cord Injury Centre

SIPAG – Spinal Injury Psychologists Advisory Group

SUD – Substance Use Disorder

Sx - symptoms

TBI – Traumatic Brain Injury

6CIT - 6 Item Cognitive Impairment Test

Appendix D: Snap shot of application of Figure 1 for Psychological Complexity, December 2020

SCIC	SCIC newly injured beds, N	% of Highly complex / complex inpatients at the SCIC	Highly complex N (%)	Complex N (%)	To be assessed
			Previous substantial contact with MH or other services for pre-morbid condition Recent /active self-harm or risk (which could be imminent) to self or others; chronic mental health difficulties with acute relapse; active issues with substance use; behaviours that challenge severe interpersonal difficulties/those with high levels of social deprivation which affects patient engagement and safety.	Previous contact with MH / GP services or other services for pre-morbid condition History and risk (but no active or recent presentation) of self-harm or imminent risk to self or others; and / or chronic mental health difficulties with acute relapse; active issues with substance use; severe interpersonal difficulties / behaviours that challenge	
Yorkshire SCIC, Pindersfield	20	65%	9 (45%)	4 (20%)	1
Princess Royal SCIC, Sheffield	25	36%	1 (4%)	8 (32%)	4
NWRSCIC, Southport	28 (usual 51)	47%	5 (18%)	8 (29%)	
Midlands SCIC, Oswestry	44	34%	5 (11%)	10 (23%)	
NSIC, Stoke Mandeville	61	67%	3 (49%)	11 (18%)	
London SCIC, Stanmore	24	11%	1 (4%)	2 (9%)	

Appendix E: MH Data from Andy Coxon for delays by SCIC

	No Mental Health Comorbidity Present					Percentages	
	(n)	Average Referral to Status (days)	Average Referral to Admission (days)	Inappropriate	No SCI	Inappropriate	Declined
Salisbury	401	31.75	41.08	84	7	20.9%	2.2%
Stanmore	575	45.26	59.13	179	12	31.1%	9.2%
Stoke Mandeville	702	43.49	66.29	193	13	27.5%	4.0%
Oswestry	474	25.93	33.50	66	15	13.9%	5.5%
Southport	568	27.25	37.62	134	40	23.6%	9.7%
Sheffield	650	50.21	50.93	65	19	10.0%	7.4%
Wakefield	333	24.36	18.51	27	22	8.1%	8.4%
Middlesbrough	197	9.39	10.73	55	21	27.9%	1.0%
Total	3900	35.50	43.26	803	149	20.6%	6.4%

	Mental Health Comorbidity Present					Percentages	
	(n)	Average Referral to Status (days)	Average Referral to Admission (days)	Inappropriate	No SCI	Inappropriate	Declined
Salisbury	37	33.05	54.93	12	2	32.4%	2.7%
Stanmore	46	42.72	88.20	19	2	41.3%	4.3%
Stoke Mandeville	60	41.78	69.24	27	0	45.0%	3.3%
Oswestry	50	35.58	44.91	7	0	14.0%	6.0%
Southport	67	38.97	47.88	15	6	22.4%	6.0%
Sheffield	42	69.70	48.00	5	0	11.9%	9.5%
Wakefield	22	23.45	24.50	5	4	22.7%	4.5%
Middlesbrough	28	9.15	17.64	13	3	46.4%	0.0%
Total	352	37.88	47.95	103	17	29.3%	4.8%

	Total	MH %age of total admissions	Delay in days	Number of additional possible admissions each year re psychological resource		% difference between no MH and MH	
Salisbury	438	8.4	5	12	2.70%	11.50%	2.7%
Stanmore	621	7.4	22	19	3%	10.20%	4.3%
Stoke Mandeville	762	7.8	3	27	3.50%	17.50%	3.3%
Oswestry	524	9.5	12	7	1.30%		6.0%
Southport	635	10.5	11	15	2.30%		6.0%
Sheffield	692	6.1	-2	5	0.70%		9.5%
Wakefield	355	6.2	6	5	1.40%	14.60%	4.5%
Middlesbrough	225	12	7	13	5.70%	25.80%	0.0%
							4.8%

Key - April 2018 to date

(green) higher for MH comorbidty than non MH

Declined is patient declined admission

Inappropriate is SCIC deemed inappropriate

Comorbidity	Group
Mental Health	MH
Cardio Vascular, Muscular Skeletal, Mental Health	MH
Cardio Vascular, Abdominal, Muscular Skeletal	Non MH
None	Non MH
NULL	Excluded

Appendix F: Psychological Health Screen Measures

PRE-ADMISSION TO SCIC – SHORT FORM SCREEN

Psychological Health Screen to be completed for all patients 4 weeks after SCI:

Mood

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use " ✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3
5.Thoughts you would be better off dead or hurting yourself in some way	0	1	2	3

- QU: 1 and 2 - a summed score of 4 or greater is considered a positive screen
- QU: 3 and 4 - a summed score of 4 or greater is considered a positive screen
- QU: 5 – any response above 1 is a positive screen and patient needs further assessment, referrer to arrange with local services.

Substance Use:

- How often have you had 6 or more drinks containing alcohol on one occasion in the past year: Less than monthly / monthly / weekly / daily or almost daily – weekly or more positive screen

- How often in the past year have you used an illegal drug or a prescribed medication for a non-medical reason: Less than monthly / monthly / weekly / daily or almost daily – monthly or more positive screen

A positive psychometric screen is weekly for alcohol use of 6 drinks or more and monthly for drug misuse – refer to local services or SCIC Psychological service if patient is to be admitted to the SCIC

Cognition:

Pre-existing or current cognitive impairment?

If yes, for adults complete a recognised cognitive test such as 6CIT, AMTS or MOCA. Where needed complete the local hospital delirium screen.

ON ADMISSION TO AND DISCHARGE FROM SCIC – FULL PSYCHOLOGICAL HEALTH SCREEN

MOOD

PHQ - 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ-9 total score

Interpretation: positive endorsement and referral for full psychological assessment for any score of 5 or above:

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

GAD-7 total score

Interpretation: positive endorsement and referral for full psychological assessment for any score of 7 or above:

0-5 Mild anxiety

6-10 Moderate anxiety

11-15 Moderately severe anxiety

15-21 Severe anxiety

COPING AND ADJUSTMENT

The Appraisals of Disability: Primary and Secondary Scale short form (ADAPSSsf)
Dean RE and Kennedy P[1] (2009). Measuring Appraisals following Spinal Cord Injury: A Preliminary Psychometric Analysis of the Appraisals of Disability. Rehabilitation Psychology, 54, 222-231, for further information on use and psychometrics contact bht.nsicpsychology@nhs.net.

INSTRUCTIONS:

We are interested in the thoughts people have about their spinal cord injury. Using the following scale, rate the extent to which the following statements reflect your **current** perceptions of your injury by circling your responses.

F D	Since my injury life is more frightening for me	STRONGLY DISAGREE 1	MODERATELY DISAGREE 2	MILDLY DISAGREE 3	MILDLY AGREE 4	MODERATELY AGREE 5	STRONGLY AGREE 6
O D	I cannot believe that this has happened to me	STRONGLY DISAGREE 1	MODERATELY DISAGREE 2	MILDLY DISAGREE 3	MILDLY AGREE 4	MODERATELY AGREE 5	STRONGLY AGREE 6
D R	I will continue to live my life to its full capacity	STRONGLY DISAGREE 6	MODERATELY DISAGREE 5	MILDLY DISAGREE 4	MILDLY AGREE 3	MODERATELY AGREE 2	STRONGLY AGREE 1
N P D	I am going to miss out on so many aspects of my life	STRONGLY DISAGREE 1	MODERATELY DISAGREE 2	MILDLY DISAGREE 3	MILDLY AGREE 4	MODERATELY AGREE 5	STRONGLY AGREE 6
G R	This experience has made me a stronger person	STRONGLY DISAGREE 6	MODERATELY DISAGREE 5	MILDLY DISAGREE 4	MILDLY AGREE 3	MODERATELY AGREE 2	STRONGLY AGREE 1
P A	There are many things that I can do to change my situation	STRONGLY DISAGREE 6	MODERATELY DISAGREE 5	MILDLY DISAGREE 4	MILDLY AGREE 3	MODERATELY AGREE 2	STRONGLY AGREE 1

TOTAL =

SCORES ABOVE 22: ADMINISTER ADAPSS FULL SCALE VERSION during Psychological Assessment

The Appraisal of Disability: Primary and Secondary Scale (ADAPSS full scale)

Dean RE and Kennedy P (2009). Measuring Appraisals following Spinal Cord Injury:
A Preliminary Psychometric Analysis of the Appraisals of Disability. Rehabilitation Psychology, 54, 222-231, for further information and psychometrics contact bht.nsicpsychology@nhs.net.

We are interested in the thoughts that people have about their spinal cord injury and how these thoughts may change over time. Using the following scale, please rate to what extent the statements below reflect ***your current perceptions of your spinal cord injury*** *by* ***clearly circling*** *the appropriate response. Please respond as quickly as possible as first responses are usually more accurate.*

1. **(NPD)**	This is something that will significantly change the rest of my life	**Strongly Disagree** **1**	**Moderately Disagree** **2**	**Mildly Disagree** **3**	**Mildly Agree** **4**	**Moderately Agree** **5**	**Strongly Agree** **6**
2. **(PA)**	There are many things that I can do to change my situation	**Strongly Disagree** **6**	**Moderately Disagree** **5**	**Mildly Disagree** **4**	**Mildly Agree** **3**	**Moderately Agree** **2**	**Strongly Agree** **1**
3. **(PA)**	I am the same person I have always been	**Strongly Disagree** **6**	**Moderately Disagree** **5**	**Mildly Disagree** **4**	**Mildly Agree** **3**	**Moderately Agree** **2**	**Strongly Agree** **1**
4. **(NPD)**	I am going to miss out on many aspects of my life	**Strongly Disagree** **1**	**Moderately Disagree** **2**	**Mildly Disagree** **3**	**Mildly Agree** **4**	**Moderately Agree** **5**	**Strongly Agree** **6**
5. **(PA)**	The more that I learn about this situation the better I am able to cope	**Strongly Disagree** **6**	**Moderately Disagree** **5**	**Mildly Disagree** **4**	**Mildly Agree** **3**	**Moderately Agree** **2**	**Strongly Agree** **1**
6.	Since my injury I find it harder to	**Strongly Disagree**	**Moderately Disagree**	**Mildly Disagree**	**Mildly Agree**	**Moderately Agree**	**Strongly Agree**

(OD)	control my emotions	1	2	3	4	5	6
7. (OD)	This is too much for anyone to deal with	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
8. (PA)	I am eager to manage my future	**Strongly Disagree** 6	**Moderately Disagree** 5	**Mildly Disagree** 4	**Mildly Agree** 3	**Moderately Agree** 2	**Strongly Agree** 1
9. (FD)	The world is now a more hostile place	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
10. (FD)	Everyday is now a battle	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
11. (GR)	The ordinary things in life are now more valuable to me	**Strongly Disagree** 6	**Moderately Disagree** 5	**Mildly Disagree** 4	**Mildly Agree** 3	**Moderately Agree** 2	**Strongly Agree** 1
12. (NPD)	This is negatively affecting everyone in my life	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
13. (PA)	My past experiences help me to deal with this situation	**Strongly Disagree** 6	**Moderately Disagree** 5	**Mildly Disagree** 4	**Mildly Agree** 3	**Moderately Agree** 2	**Strongly Agree** 1

14.	This experience has made me a stronger person	Strongly Disagree 6	Moderately Disagree 5	Mildly Disagree 4	Mildly Agree 3	Moderately Agree 2	Strongly Agree 1
15. (FD)	I am frightened of what will happen to my physical health	Strongly Disagree 1	Moderately Disagree 2	Mildly Disagree 3	Mildly Agree 4	Moderately Agree 5	Strongly Agree 6
16. (NPD)	I can never forget that I am in a wheelchair	Strongly Disagree 1	Moderately Disagree 2	Mildly Disagree 3	Mildly Agree 4	Moderately Agree 5	Strongly Agree 6
17. (GR)	I am more resilient	Strongly Disagree 6	Moderately Disagree 5	Mildly Disagree 4	Mildly Agree 3	Moderately Agree 2	Strongly Agree 1
18. (FD)	It is hard for me to see what my future will be like	Strongly Disagree 1	Moderately Disagree 2	Mildly Disagree 3	Mildly Agree 4	Moderately Agree 5	Strongly Agree 6
19. (DR)	I am not going to let this beat me	Strongly Disagree 6	Moderately Disagree 5	Mildly Disagree 4	Mildly Agree 3	Moderately Agree 2	Strongly Agree 1
20. (FD)	Too much focus is on my physical and not my emotional needs	Strongly Disagree 1	Moderately Disagree 2	Mildly Disagree 3	Mildly Agree 4	Moderately Agree 5	Strongly Agree 6
21. (DR)	I am independent	Strongly Disagree 6	Moderately Disagree 5	Mildly Disagree 4	Mildly Agree 3	Moderately Agree 2	Strongly Agree 1
22. (GR)	We are now closer as a family	Strongly Disagree 6	Moderately Disagree 5	Mildly Disagree 4	Mildly Agree 3	Moderately Agree 2	Strongly Agree 1

23. (OD)	I cannot accept my situation	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
24. (FD)	Everyday life is frustrating	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
25. (FD)	I have less choice over the things that matter to me	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
26. (OD)	I cannot believe that this has happened to me	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
27. (DR)	I will continue to live my life to its full capacity	**Strongly Disagree** 6	**Moderately Disagree** 5	**Mildly Disagree** 4	**Mildly Agree** 3	**Moderately Agree** 2	**Strongly Agree** 1
28. (FD)	Other people see me as less of a person	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
29. (GR)	I now have a more positive view of disability	**Strongly Disagree** 6	**Moderately Disagree** 5	**Mildly Disagree** 4	**Mildly Agree** 3	**Moderately Agree** 2	**Strongly Agree** 1
30. (NPD)	The lack of movement totally dominates my life	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6
31. (FD)	I feel more vulnerable	**Strongly Disagree** 1	**Moderately Disagree** 2	**Mildly Disagree** 3	**Mildly Agree** 4	**Moderately Agree** 5	**Strongly Agree** 6

32. **(OD)**	I often think of the things that I am unable to do	**Strongly Disagree** **1**	**Moderately Disagree** **2**	**Mildly Disagree** **3**	**Mildly Agree** **4**	**Moderately Agree** **5**	**Strongly Agree** **6**
33. **(DR)**	I can overcome this	**Strongly Disagree** **6**	**Moderately Disagree** **5**	**Mildly Disagree** **4**	**Mildly Agree** **3**	**Moderately Agree** **2**	**Strongly Agree** **1**

SCORING SHEET

To score answers on the ADAPSS, each subscale can be calculated by summing the scores for each item.

For each question on the ADAPSS, a code is given to indicate to which subscale the item is allocated:

(FD) **Fearful Despondency (9 items - maximum score 54)**

(OD) **Overwhelming Disbelief (5 items - maximum score 30)**

(DR) **Determined Resolve (4 items - maximum score 24)**

(GR) **Growth and Resilience (5 items - maximum score 30)**

(NPD) **Negative Perceptions of Disability (5 items - maximum score 30)**

(PA) **Personal Agency (5 items - maximum score 30)**

Enter the total amounts into the table below and see overleaf for cut-off criteria.

	FEARFUL DESPONDENCY (FD)	OVERWHELMING DISBELIEF (OD)	DETERMINED RESOLVE (DR)	GROWTH & RESILIENCE (GR)	NEGATIVE PERCEPTIONS OF DISABILITY (NPD)	PERSONAL AGENCY (PA)
TOTAL						

CUT OFF CRITERIA

	VERY LOW **9-18**	**LOW** **19-28**	**NORMAL RANGE** **29-44**	**HIGH** **45-50**	**VERY HIGH** **51-54**
FEARFUL **DESPONDENCY** **(FD)**	SCORES BETWEEN **9-18** INDICATE LOW LEVELS OF FEARFUL DESPONDENCY	SCORES BETWEEN **19-28** INDICATE LOWER THAN AVERAGE LEVELS OF FEARFUL DESPONDENCY	SCORES BETWEEN **29-44** REPRESENTATIVE OF NORMAL POPULATION	SCORES BETWEEN **45-50** INDICATE HIGHER THAN AVERAGE LEVELS OF FEARFUL DESPONDENCY	SCORES BETWEEN **51-54** INDICATE HIGH LEVELS OF FEARFUL DESPONDENCY AND **MAY REQUIRE ATTENTION**

	VERY LOW **6-8**	**LOW** **9-12**	**NORMAL RANGE** **13-24**	**HIGH** **25-27**	**VERY HIGH** **28-30**
OVERWHELMIN G **DISBELIEF** **(OD)**	SCORES BETWEEN **0-8** INDICATE LOW LEVELS OF OVERWHELMING DISBELIEF	SCORES BETWEEN **9-12** INDICATE LOWER THAN AVERAGE LEVELS OF OVERWHELMING DISBELIEF	SCORES BETWEEN **13-24** REPRESENTATIVE OF NORMAL POPULATION	SCORES BETWEEN **25-27** INDICATE HIGHER THAN AVERAGE LEVELS OF OVERWHELMING DISBELIEF	SCORES BETWEEN **28-30** INDICATE HIGH LEVELS OF OVERWHELMING DISBELIEF AND **MAY REQUIRE ATTENTION**

	VERY LOW **21-24**	**LOW** **15-20**	**NORMAL RANGE** **12-14**	**HIGH** **9-11**	**VERY HIGH** **4-8**
DETERMINED RESOLVE **(DR)**	SCORES BETWEEN **21-24** INDICATE LOW LEVELS OF DETERMINED RESOLVE AND **MAY REQUIRE ATTENTION**	SCORES BETWEEN **15-20** INDICATE LOWER THAN AVERAGE LEVELS OF DETERMINED RESOLVE	SCORES BETWEEN **12-14** REPRESENTATIVE OF NORMAL POPULATION	SCORES BETWEEN **9-11** INDICATE HIGHER THAN AVERAGE LEVELS OF DETERMINED RESOLVE	SCORES BETWEEN **4-8** INDICATE HIGH LEVELS OF DETERMINED RESOLVE

	VERY LOW 25-30	LOW 19-24	NORMAL RANGE 12-18	HIGH 9-11	VERY HIGH 6-8
GROWTH & RESILIENCE **(GR)**	SCORES BETWEEN **25-30** INDICATE LOW LEVELS OF GROWTH AND RESILIENCE AND **MAY REQUIRE ATTENTION**	SCORES BETWEEN **19-24** INDICATE LOWER THAN AVERAGE LEVELS OF GROWTH AND RESILIENCE	SCORES BETWEEN **12-18** REPRESENTATIVE OF NORMAL POPULATION	SCORES BETWEEN **9-11** INDICATE HIGHER THAN AVERAGE LEVELS OF GROWTH AND RESILIENCE	SCORES BETWEEN **6-8** INDICATE HIGH LEVELS OF GROWTH AND RESILIENCE

	VERY LOW 6-11	LOW 12-18	NORMAL RANGE 19-26	HIGH 26-28	VERY HIGH 28-30
NEGATIVE PERCEPTIONS OF DISABILITY **(NPD)**	SCORES BETWEEN **6-11** INDICATE LOW LEVELS OF NEGATIVE PERCEPTIONS OF DISABILITY	SCORES BETWEEN **12-18** INDICATE LOWER THAN AVERAGE LEVELS OF NEGATIVE PERCEPTIONS OF DISABILITY	SCORES BETWEEN **18-26** REPRESENTATIVE OF NORMAL POPULATION	SCORES BETWEEN **26-28** INDICATE HIGHER THAN AVERAGE LEVELS OF NEGATIVE PERCEPTIONS	SCORES BETWEEN **28-30** INDICATE HIGH LEVELS OF NEGATIVE PERCEPTIONS OF DISABILITY AND **MAY REQUIRE ATTENTION**

	VERY LOW 26-30	LOW 18-25	NORMAL RANGE 12-17	HIGH 9-11	VERY HIGH 6-8
PERSONAL AGENCY **(PA)**	SCORES BETWEEN **26-30** INDICATE LOW LEVELS OF PERSONAL AGENCY AND **MAY REQUIRE ATTENTION**	SCORES BETWEEN **18-25** INDICATE LOWER THAN AVERAGE LEVELS OF PERSONAL AGENCY	SCORES BETWEEN **12-17** REPRESENTATIVE OF NORMAL POPULATION	SCORES BETWEEN **9-11** INDICATE HIGHER THAN AVERAGE LEVELS OF PERSONAL AGENCY	SCORES BETWEEN **6-8** INDICATE HIGH LEVELS OF PERSONAL AGENCY

PAIN – Shortened ISCoS Basic Pain Data Set

Have you had any pain in the last seven days, including today?	YES		NO	
Does your pain interfere with your ability to get on with your rehabilitation?	YES		NO	

If "No" has been answered to both of the above questions do not administer the following questions

	Answer (0-10)
How would you rate your average pain intensity in the last week? (0=No pain, 10= As bad as you can imagine)	
In general, how much has pain interfered with your **overall mood** in the last week including today? (0=No interference, 10=Extreme interference)	
In general, how much has pain interfered with your **day-to-day activities** in the last week including today? (0=No interference, 10=Extreme interference)	
In general, how much has pain interfered with your ability to **get a good night's sleep** in the last week including today? (0=No interference, 10=Extreme interference)	
Overall, how satisfied are you with your pain management? (0=Not satisfied at all, 10= Completely satisfied)	

Where is the worst pain you have? (Please tick all that apply)

Head		**Neck**		**Shoulders**		**Arms**		**Hands**		**Chest**		**Abdomen**	
Back		**Buttocks**		**Hips**		**Upper Leg/Thigh**		**Lower Legs**		**Feet**			

When did this pain start? (dd/mm/yyyy)	

<u>Psychological Impact of Pain</u>

Read each item below and tick the box that indicates how much, on a four point scale, you agree with each statement. Please ensure you answer all questions.

Column 1 = **Not at all**
Column 2 = **To a slight degree**
Column 3 = **To a moderate degree**
Column 4 = **All of the time**

When I'm in pain…

NB: ANSWER ALL QUESTIONS	1	2	3	4
I keep thinking about how badly I want the pain to stop				
It's terrible and I think it's never going to get any better				
I become afraid that the pain may get worse				
I anxiously want the pain to go away				

FOLLOW UP – SHORT FORM SCREEN to be completed as part of SCIC review

Mood

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Interpretation:

Sum questions

- 1 and 2 - a score of 4 or greater is considered a positive screen, refer to local services or SCIC Clinical Psychology service if patient is admitted to the SCIC
- 3 and 4 - a score of 4 or greater is considered a positive screen, refer to local services or SCIC Clinical Psychology service if patient is admitted to the SCIC

Substance / Alcohol Use

- How often have you had 6 or more drinks containing alcohol on one occasion in the past year:
  Less than monthly / monthly / weekly / daily or almost daily

- How often in the past year have you used an illegal drug or a prescribed medication for a non-medical reason:
  Less than monthly / monthly / weekly / daily or almost daily

A positive psychometric screen is weekly for alcohol use of 6 drinks or more and monthly for drug misuse – refer to local services or SCIC Psychological service if patient is admitted to the SCIC

PAIN – Shortened ISCoS Basic Pain Data Set

Have you had any pain in the last seven days, including today?	YES		NO	
Does your pain interfere with your ability to get on with your rehabilitation?	YES		NO	

If "No" has been answered to both of the above questions do not administer the following questions

	Answer (0-10)
How would you rate your average pain intensity in the last week? (0=No pain, 10= As bad as you can imagine)	
In general, how much has pain interfered with your **overall mood** in the last week including today? (0=No interference, 10=Extreme interference)	

In general, how much has pain interfered with your **day-to-day activities** in the last week including today? (0=No interference, 10=Extreme interference)	
In general, how much has pain interfered with your ability to **get a good night's sleep** in the last week including today? (0=No interference, 10=Extreme interference)	
Overall, how satisfied are you with your pain management? (0=Not satisfied at all, 10= Completely satisfied)	

SECONDARY SCIC ADMISSION – SHORT FORM SCREEN

Mood:

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Interpretation:

Sum questions

- 1 and 2 - a score of 4 or greater is considered a positive screen, refer to local services or SCIC Psychological service if patient is admitted to the SCIC
- 3 and 4 - a score of 4 or greater is considered a positive screen, refer to local services or SCIC Psychological service if patient is admitted to the SCIC

Substance / Alcohol Use

- How often have you had 6 or more drinks containing alcohol on one occasion in the past year:
  Less than monthly / monthly / weekly / daily or almost daily

- How often in the past year have you used an illegal drug or a prescribed medication for a non-medical reason:
  Less than monthly / monthly / weekly / daily or almost daily

A positive psychometric screen is weekly for alcohol use of 6 drinks or more and monthly for drug misuse – refer to local community services or SCIC Psychological service if patient is to be admitted to the SCIC