Innovation at Phénix, Belgium:

A Welcome and Orientation Phase (PAO)

after only two days of training course!

(Morgane Dedecker, www.asblphenix.be)).

What have you done after return of your internship at the COD ?

We left in December 2013 for the Ceis of Modena (Italy) wondering about how to work with addicted persons with dual diagnosis, in our daycare therapeutic community. Visiting the COD, we were amazed by the period of 3 months observation in community, while in Namur (Belgium) observation was limited to 2 interviews of 1 hour by a single professional who gave his opinion to get the patient in the center or not (see GP "*be clear regarding dual diagnosis patients*" in Newsletter n ° 13).

At return of the Ecett course in Italy, we wanted to introduce a period of observation at Phénix. The circuit followed by patients in Italy was therefore presented to the team. We then formed a working group with two of the three interns who visited the COD in Modena: an educator (Marcel), the social worker (Morgane), Coordinator of care trajects (Anne Sophie) and the referent of admissions to the welcome phase (Thibaut). The idea was to reduce the waiting time for admission to the daycare centre and giving time for the observation of new patients in a community setting. We thought that giving more time to the new patient before admission to the daycare center, would reduce the pressure on the patient and on the head of the admission service.

What innovation did you therefore made in Phoenix?

It was decided to open at Phénix a “welcome and orientation phase” (PAO) in December 2014, thus one year after the internship in Italy. The PAO phase leaves time for observation of the person at its own pace, to propose rules and expectations adapted to their capacities. It is important that the person feels well, in terms of staff availability and treatment modalities. One of the problems brought by this new approach is the increase of rules override in community and disturbances at the level of therapeutic activities. So we had to give support to the elder patients who had a "sponsorship" function to the newcomers. Saw the larger number of arrivals and therefore overriding behaviour of the rules, it is necessary to avoid that destabilized “elder” residents would take distance from the new ones and fold together. We had to restrict the access to some activities because there were too many new patients who wanted to participate at all of them.

One month after the admission in PAO, our team meets and we speak about the person, our observations and there is an assessment with the representative of the community, the care trajects coordinator and the social service and each gives his opinion. We review all therapeutic and group life moments where one could observe the patient. After the team assessment, we talk about this with the patient who says what he wants, what puts him in still trouble, etc. If there is a dual diagnosis, one sees with the patient if he is "applicant" for the the day centre dynamic, if he is ready or if he prefers a different orientation. Indeed, community dynamic is not necessarily the best choice for everyone. The PAO is therefore a considerable period in order to take a decision and see whether we need to adopt a particular attitude towards a patient with special needs.

The visit od COD confronted us with a tricky problem: the management of shared professional secrecy, it means how we were going to inform the group of the reasons for which some patients (with dual diagnosis) were entitled to special rules. We don't like to give people a "psy" label. Finally, after discussion with our medical team, it was decided not talking about diagnose, but only behaviours and emotional difficulties justifying special provisions. We bring the patient to understand what puts him in difficulty and to talk about it with the group. Without spéaking of pathology, the group can understand that one new participant has such difficulty in facing such situation, they respect it and accept whether we work differently with some members of the group. When the team clearly names the difficulty, the group admits the difference of this person without stigmatizing him/her. If psychiatric complications occur, we talk with the doctor who will speak with the patient and he will talk, thereafter, to the group so that everything goes well.

How did you manage the communication with the team so that this innovation was accepted? The fact that the Director of Phoenix accompanied us in Modena has made easier the transfer of the good practice. We felt supported. After the internship, we wrote a report on the management of dual diagnosis at COD and it was presented to the team. Some colleagues were reluctant to shorten the time limits for entry because they feared not being sufficiently informed about these patients. They were afraid that these entries would happen too fast and that it would go wrong, that there would be too many unstable people because all patients are in the same day center and it could induce an imbalance in the group dynamics.

Have you already assessed if this innovation is satisfactory?

Several evaluations have already been made from the point of view of the team and the patients. These were based on field observations, we have noted what happened in the group dynamics.

The PAO became true just over a year after our internship at COD, and today, this innovation already returned in the normal operation of the team. Generally the colleagues who were initially reluctant to this new operation were convinced, so much that some have forgotten that the PAO is a transfer from an Ecett course at COD in Modena.

<u>Advantages of the PAO:</u>

- reduction in the waiting time for applicants to enter the day centre.

- Decrease of pressure on the patient and on the person in charge of admissions when they are facing difficult situations.

- opportunity to negotiate milder rules and expectations when it is justified.

<u>Difficulties related to the PAO:</u>

- fast PAO admissions bring more override of rules and this induces more stress and requires management efforts by the rest of the group.

- the group sees many more people because the entries are faster and it is difficult to accommodate so many people who need explanations of all the rules. This creates more stress for the group. However the group should no be exhausted by this new way of working. It may be necessary to limit the number of newcomers to avoid saturation of the group

● The administrative team has more work because some newcomers are quite unstable (absences) and that one hase to call their relatives to keep the link.

Possible improvements:

● One must make sure to keep this period as a reflection and observation time, although many newcomers are caught up in the movement of the group and become very participatory. This involvement may decrease the 'observation' aspect of this period.

● We had to establish a " PAO referent " role for the staff who provides the link with the patient before admission in the day centre. It is necessary that the newcomer knows who can help him in case of difficulty. The person who enters the PAO should feel secure about having his referent and not feeling alone, because he has to wait one month before confirmation of his admission in the day centre and the designation of his referent.

What has been the cost of this innovation? It costed nothing because we changed the work organization of admission and welcome services. Staff available for the PAO are simply service colleagues. Finally, there are less participants who stagnate in welcome phase and so, this creates no additional cost.