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|  | **PROTOCOL for redaction of PROFILES of study case's  for D-&-WB workshops inter-vision & evaluation  about : background - health - intervention - network - proposals**  When the solution of complex situations seems impossible*:   how to listen  for a deepest  understanding ?* When the body speaks through his silence and his wounds:   *who will listen and hear before intervening* |
| ***N.B. The PROFILE more than a PHOTO is a RADIOGRAPHY which will facilitate the comprehension of the inter - action  and the causes. NOT MORE than 2 pages. Attention please PROTECT PRIVACY OF EACH ONE*** | |
| 1. **BACKGROUND and environment / context  of**   T is a fifty seven year old male. He grew up in the midlands and still has a lot of family who live near where he currently resides with Midlands Simon in their Emergency Accommodation (EAS). He reported that he was very close to his mother as a child but had a fractured relationship with his father. His sister, a retired psychiatric nurse, would have stated to staff at Midlands Simon that T was a difficult child and described him as “the black sheep of the family”. She stated that if he had been a child today, he would probably have been diagnosed with something and received help. He had a diagnosis of Dyslexia later in life which would support this information. As a result of his behaviours as a child, T and his sister would both have stated that their father was physically abusive to T. Due to his drinking in adulthood, and his previously unstable mental health, relationships within the family have broken down over the years. He was married with two children who he has no contact with (their decision). The loss of relationship with his children in particular has been very hard for him. His parents are deceased but he sees some of his siblings regularly. The relationships with some of his siblings has improved during his time at Midlands Simon EAS.  T has lived at Midlands Simon EAS for two years and two months. The average stay at the EAS is six months. T needs a lot of daily support and it has been difficult to help him come to terms with the fact that he is too vulnerable to live independently in the community. The level of support needed meant that T could not access the private rental market or live independently in social housing. | |
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| 1. **HEALTH:  physical  and  psychic conditions.** | |
| T has a diagnosis of Schizophrenia and alcohol induced dementia/Korsakoff Syndrome (Wet Brain). He attends the local mental health services (ReNua), where he receives a depo-injection every three weeks and sees the resident psychiatrist every three months. He is currently stable regarding his mental health but his dementia has been progressive over the past two years and staff at the EAS would have observed an acceleration in that deterioration in the past several months.  This has had a significant impact on T’s daily life. He is no longer able to take care of his own finances, he has become vulnerable to other individuals in the local community taking advantage of him or influencing his behaviours (such as being encouraged to argue with staff at Midlands Simon about his finances, encouragement to smoke cannabis etc;…). In the past six months, T has also needed some assistance with personal hygiene. His medication needs to be distributed to him by staff.  Midlands Simon staff would have voiced concerns to T’s doctor and psychiatrist. They are both of the opinion that no more can be done for T from a medical perspective than is currently being done.  Before T came to live at the EAS, he was living in a different county and was drinking heavily. There is a high probability that there was interruption in his care during this time. | |
| 1. **INTERVENTIONS description**   The Regional Settlement Service (RSS) team of Midlands Simon Community and the community liaison nurse were instrumental in securing T a place at the EAS.  Due to T’s dual diagnosis of alcohol addiction and mental health issues, it has sometimes been difficult to have a co-ordinated response to T’s needs due to the fact that these services work independently of each other. In addition, staff at the EAS found that it took persistence on their behalf to get the medical professionals involved to recognise the deterioration that staff were seeing on a daily basis.  During the two years That T has resided at the EAS, he has had the same keyworker advocating for him along with the whole EAS team and our team manager. This intervention in T’s life, has been the first stable positive living environment that T has experienced for many years in his life. Although he has a long history of dealing with his medical providers, the introduction of a more holistic approach to T’s care, encouraged by Midlands Simon, has been very beneficial towards being able to find a suitable place for T to live.  T has severe disruption to his short term memory, so having the continuity of a keyworker who had sufficient time to build a working relationship with T has given him a sense of security. This is important because life can sometimes be very confusing for him. | |
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| 1. **WORKERS & NETWORK:**  There was a multidisciplinary approach between the community liaison nurse and the regional resettlement service to access emergency accommodation. The EAS staff liaised with mental health service, addiction service and an independent Clinical Psychologist to assess T’s needs going forward. Reports from these services supported Midlands Simon’s application to Tusla ( the governmental Department of Health) to secure funding for care of T in a 24 hour residential setting for the remainder of his life.   Staff at the EAS would be of the opinion that the practice of services working in isolation of each other is a significant stumbling block when working with complex cases where there is dual diagnosis. | |
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| 1. **PROPOSALS**   . • Access to Clinical Psychologist within organisations for assessment of needs in complex cases.  • Promotion of multi-disciplinary approach between mental health and addiction services. | |
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| 1. Personal factors influencing | |
| • Attitude by some of the medical profession that T’s dementia was self-inflicted through alcohol, therefore less sympathy  for his situation.  • Inappropriate length of time spent in Emergency accommodation due to lack of appropriate living accommodation.  • Extra stress on staff as they tried to provide dignified care for T in an inappropriate environment.  • Continuity of care as stablising factor in T’s time at emergency accommodation | |
| 1. **Overall assessment of the case**:   There was rapid response to initial need for emergency accommodation by RSS and CLN.  The complex needs of T and the deterioration in his cognitive abilities were challenging for staff, who generally work alone to support six clients simultaneously.  The fragmented care of various services was unhelpful when trying to provide a hoslistic solution to T’s situation.  The lack of a suitable community supported living environment has resulted in T having to enter nursing home care at an unsuitably early age. | |
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***OPTIONAL:* Complementary elements** on the situation of gradual degradation in terms of both physical and mental health   
 **DIVERS: ....**

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| http://www.smes-europa.org/smeseulogobase.jpg | **RESUMING the PROTOCOL  of STUDY’s CASES**  *background - health - intervention - network - proposals* |

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| |  | | --- | | When the solution of complex situations seems impossible, how to intervene? | |

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| **Fictitious name** | Tom | | | | Codex D&W: | |
| **Gender** | M | F | Male | | | |
| **Age** | known: 57 | | | hypothetic: | | |
| **Permanence time on the streets** *(in months)* | known: | | | hypothetic: 10 years | | |
| **Permanence time on the shelters** *(in months)* | known: 2 years and 2 months | | | | | |
| hypothetic: | | | | | |
| **Hygienic conditions** | Acceptable X | | | bad | | very bad |
| **Health conditions** | acceptable | | | bad | | very bad |
| diagnosis declared: Dyslexia, Korsakoff Syndrome, muscle tremors | | | | | |
| diagnosis hypothesized: | | | | | |
| **Mental Health Conditions** | diagnosis declared: Schizophrenia | | | | | |
| diagnosis hypothesized: | | | | | |
| **Causes / factors of loss** | housing: Maritial breakdown | | | | | |
| health: Excessive alcohol and drug use | | | | | |
| **In charge of** | social services: Tusla | | | | | |
| health services G.P. | | | | | |
| mental health services: ReNua | | | | | |
| **Collaboration of people** | with a request: Clinical Psychologist | | | | | |
| Collaborative: Emergency accommodation, RSS | | | | | |
| indifferent: Some family members | | | | | |
| oppositional: Tusla (initially turned down funding for residential care but decision was overturned on appeal from Midlands Simon) | | | | | |
| **Interventions** | net-working: Midlands Simon | | | | | |
| individualists: Clinical Psychologist | | | | | |
| complementary: | | | | | |
| occasional: Family | | | | | |
| sustainable: Residential setting secured for long term care | | | | | |
| **Pathways** | alternative: No feasible alternatives available due to health deterioration. | | | | | |
| possible: | | | | | |

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