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| **PROTOCOL  for  PROFILES   of  PEOPLE**  **home-less & health-less**permanent situation  [***protocol***](http://www.smes-europa.org/PROFILES%20protocol.docx) |
| **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?*** |
| **1.**      **BACKGROUND and environment / context  of** profile of the person in relation to : the condition of ‘***dignity’ and 'health***' in which these people live.   What kind of interrelation between these dimensions:   **-   time**, in relation to the chronic situation;  **-   abandonment**, in relation to the breakdown of any relationship and link;  **-   refusal** , in relation to any institutional offer of care and assistance services?     Arthur, 43 years of age. Educated confectioner. In the past worked in a butchery. Brother emigrated, A. would like to have some contact to him. Parents live in other part of Poland. A. contacts them sporadically, accepts some material support from them but otherwise does not miss them or is not willing to return to them. Two daugters of 21 and 11- not contactes for several years now. Daughters either from a wife or a partner – no info. Homeless from 2005. From 2013 in Caritas shelter.        **2.**      **HEALTH:  physical  and  psychic conditions.** All additional information on the health situation,  information on hypothetic or declared diagnoses  including:  -  interaction between mental and physical condition;   -  influence of the health condition on the lifestyle of a person;  -  history of interruptions and resumptions of medical services provided to the person,  -  orientation and opinions  of the medical  players  in respect to the person;   -  interdependence of psychosocial distress in cases where two people of the same family circle are involved     Physically seemingly healthy – according to hospital tests in 2013. Brain tomography (2013) – correct. 6 stays in psychiatric hospitals in Warsaw in 2013, including one stay at a detox unit.  Diagnosed with:   * Alcoholic delusions * Mixed personality disorders * Dissociative disorders * Adaptive disorders    Prescriprions: Pernasyne, Pridinol, Neurotop, Hydroxizinum, Convulex, Deprexolet, Propranolol.  Arthur stops taking drugs shortly after leaving hospital. At the shelter the alcohol addiction diagnosed by addiction therapist. A. took alcohol for the first time at the age of 6 (vodka). Longest period of perpetual drinking – 5 months. Multiple detoxications. In 2013 he drank after 22 weeks of abstinence , because he “heard voices”. In 2014 judged as handicapped for 3 years. Entitled to a monthly benefit for the time of “work incapacity” – 120 euro. In the meantime he took temporary jobs like cleaning, arranging wares at supermarkets. In 2015 attempted stable work and resigned the benefit. Gave up work after few weeks. Returned to benefit.  Arthur functions correctly in the shelter. Accepted by inhabitants of his sleeping room despite his long hours of sleep and the fact that he speaks loudly while asleep. No close relationships with other inhabitants. Does not communicate if not accosted. Sits alone in the smoking space, watches tv, works in the kitchen and in the public showers run by the shelter. From time to time spends a few days in a roll in bed claiming “being ill”.      3.       **INTERVENTIONS  description  :**  presentation and evaluation of the history of interventions with their difficulties, successes, failures, including the circumstances of the person’s first contact with the organized assistance; clarification of the objectives of the intervention in its various stages; description, if needed,  of specific operational solutions; stating the reasons for compulsory sanitary treatment . -   What kind of intervention – in health + social field - success of non-success depends of …; -   Highlight the correlations between the objectives to be pursued, programmed interventions and outcomes...  –    Innovative practices     While in the shelter Arthur has never shown any initiative towards returning to independent life. Once in a while the social worker tried to mobilize him and facing failure asked again and again the shelter psychologist and addiction therapist to find a way. To little avail. Arthur is a difficult client. He mostly shunned the interviews with psychologist, and refused to go to the psychiatrist claiming that the drugs prescribed for him by psychiatrists in the past have only harmed him inducing psychotic experiences (like “voices”). Social worker suspected simulation on Arthur’s part aimed at obtaining the benefit and avoiding paying alimonies for his daughters’. In 2016 another psychiatrist on a visit to the shelter did not diagnose any concrete psychiatric ailment. Arthur complained at the time to suffer visual and listening hallucinations. Arthur did not drink alcohol since 2013. Presently Arthur goes to visit the psychiatrist not alone but attended by psychologist – whose role is to support him on the way and make meaningful communication possible betrween the two parties. First visit occurred in September 2107, second in October. Arthur abandoned taking the first prescribed drug – Pernasyne – after 2 weeks claiming it causes frightening hallucinations. He was then visibly agitated, running in and out of the shelter, but always returning. Next drug he was prescribed is Olanzapine. We are waiting for the results. The positive change is the fact that the attended visits are taking place at all and that the psychiatrist agreed to the presence of psychologist during the visits. Arthur is not at all disturbed by the psychologist’s presence. We plan to make some psychological tests on Arthur and have him tested with brain tomography. The psychiatrist seems now to concur with psychologist on possible diagnosis – paranoid schizophrenia.      **4.      WORKERS & NETWORK:**  -  One or many actors?    -   Does the networking and cooperation between actors exist or not?  -   What kind of collaboration between public and private sector?  -   What kind of multidisciplinary performing synergies between social, health services and... others?  -   What kind of co-working and co-responsibility between Institutions - Associations - Administrations? -  What are the institutional and legal barriers and limitations to providing adequate assistance (cumbersome, poorly      defined procedures, “vicious circles”; resources and financing).  -   What obstacles could be overcome by “creativity” of the operators in the face of the unhelpful of confusing legislation?      Networking has always been the weakest aspect in assistance given to Arthur. After leaving the hospital he was left to his own devices and then to the assistance from the shelter staff with little knowledge of what happened during the hospitalization. The only thing at their disposal was the excerpt Arthur was given when leaving the hospital. He refused to take drugs or to go to the psychiatrist while at the same time causing few problems and being cooperative as far as practical functioning in a shelter went. Thus he avoided being much seen or heard of and stagnated as a result. His positive attitude to make now assisted visits to the psychiatrist may stem from the fact that he lacked money after the benefit ceased to be paid in March. In the psychologist’s opinion his inability to gather necessary documents and reapply for the benefit is indicative of the genuineness of his sickness.          5.       **PROPOSALS:** What proposals of possible and innovative interventions when the solution of complex situations seem impossible?  -   What pathways,  what specific priorities could be taken for priority recommendations?  -  Make the proposals as concrete as possible and  avoid generalities.     It seems necessary to continue the visits to one psychiatrist, to do the tests and complete the dossier on his state of psychiatric health. He will probably obtain the handicapped person certificate and the benefit, but it will not solve his problems. At the moment Arthur seems unable to leve on his own. The family is reluctant to take him back, and he himself is not seeking contact with them Just recently he refused to see his mother who has come a long way to Warsaw to visit him while having precious little to offer. Perhaps some form of protected housing would meet his needs and capacities – protected meaning with regular support. Also employment in his case would have to be “protected” in some way. He is capricious in this respect. Just recently he goes eagerly to arrange the wares at the building supermarket. Perhaps because the present colleagues suit him. He has a problem with taking drugs but it takes so long to really diagnose him and prescribe something adequate without too much side effects. Having stated the longevity and at times randomness of the help he received so far we cannot forget that at the shelter he got rid of his more acute symptoms, has a day structure, something to do, and a rather positive human environment. There is at the moment practically no better place for him to be.          6.      PERSONAL FACTORS INFLUENCING the launching and continuation of assistance process:  -  possible stigmatization of person taking charge or applying for assistance;  -  sources of stress and burn-out for assistance workers;  -  changes in staff during assistance process; clashing cultural aspects.            7.      **OVERALL ASSESSMENT OF THE CASE**: strengths and weaknesses of the support net and/or interventions provided;  -  synthetic judgment: the person's condition has improved/worsened or remained unchanged?      (in relation to the assumed objectives relevant ethical issues related to the work;  -   final thoughts, free.            ***OPTIONAL:*Complementary elements** on the situation of gradual degradation in terms of both physical and mental health        **DIVERS: ....** |