CASE STUDY

REPORT

Q2 July - September 2023

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TREATMENT PRACTITIONER

Background

JS referred into service in September 2022 requiring support with alcohol. JS had previously been alcohol dependent consuming 15 cans of ale for a lengthy period of time. JS disclosed that he had neglected himself and was living in poor conditions which resulted in JS losing a tenancy. At the initial assessment JS presented abstinent and prescribed relapse prevention medication. JS had been discharged from Ty cyfannol due to a violent attempt on his life resulting in life changing injuries.

Work Undertaken

Since the initial assessment JS's attendance has been exemplary, JS has always communicated well if he has been unable to attend appointments.
The initial TOPS completed with JS reflected that JS's physical, psychological and quality of life was low however this has increased since being in service.
Along JS's journey with GDAS JS has engaged in psychosocial interventions and relapse prevention groups. JS has focused on the triggers to his alcohol use and has found his own distraction techniques in order to prevent him from returning to alcohol. JS has benefitted from using a free gym pass provided by the wellbeing team within the service and now attends the gym regularly.JS disclosed significant memory issues therefore a referral to the Alcohol Related brain damage (ARBD) clinic was made.

Throughout JS's journey the keyworker has networked with other agencies that were supporting JS with mental health and housing. A community mental health referral was discussed due to the severity of JS's mental health needs. JS has now been offered a tenancy in supported housing which reduces JS's risk of vulnerability. JS has also been happy to partake in Blood Bourne Virus (BBV) testing and now understands the risks of blood borne viruses.

Outcome

The outcome of JS engaging well with GDAS has resulted in JS remaining abstinent throughout and has now been abstinent for 11 months. As a result of this JS has successfully passed his driving theory test which had been a dream goal for JS for some time. JS has stated that his mental and physical health status has improved. JS is receiving support for his mental health. JS is now settled within a supported dry house. JS has explained triggers and thoughts he has surrounding his use and has been focusing on changing his thought process throughout his engagement. JS has developed a therapeutic and trusting relationship with his keyworker which has enabled JS to overcome barriers around trusting professionals.

ENHANCED TREATMENT PRACTITIONER

The new GDAS contract permitted for the creation of specialised roles, including that of the Enhanced Treatment Practitioner and Psychology Led Practitioner. These roles aim to work with the most complex of individuals experiencing additional needs, including, but not limited to, physical health needs, trauma, adverse childhood experiences (ACES) and domestic violence. These roles have resulted in the opportunity for additional training to enhance the workers knowledge and understanding of new trends and developments within the field of substance dependency. As an Enhanced Practitioner I recently attended 'Compassionate Enquiry Training' looking at the work of Gabor Mate and his belief that the cause of addiction is suffering. This case study aims to illustrate how the development of specialised roles, and subsequent training, have created a service that is working to a trauma informed approach whilst continuing to work hard to meet the needs of each individual service user.

Through undertaking Mate's training to further develop my knowledge and understanding I have realised that, as Mate notes, trauma is a 'wound' that requires a compassionate approach to ensure that service users learn to value themselves throughout their recovery journey. If Mate's premise that suffering, and then inherently trauma, is the cause of addiction then one must acknowledge the uncomfortable truth that this leads to a complex mix of thoughts, feelings and emotions that result in trauma raising it's ugly head when one is not expecting it to do so. A simple stroll through the Park can trigger a painful memory. A conversation with a friend about the past can cause anxiety to peak. These roles are about establishing ways of supporting people with these events, without reliving the past.

Through working in an empathic caring way I have continued to develop and sustain therapeutic relationships with all my service users with a view to helping them develop new ways of coping with their complex issues that continue to impact on their recovery journey. Once we understand that trauma is not limited to the few, and that most individuals are suffering in some way, we can start to look at connection through developing and fostering these therapeutic relationships with a view to building resilience and to start planning a more fulfilling life.

Mate believes that a compassionate approach is at the heart of this and I feel that this training reinforced my work with service users by underpinning the basics of key working as a pivotal moment in treatment as, possibly for the first time, individuals experience compassion and understanding without judgement through simple acts of care such as listening and responding empathically to show value to someone. This simple act of connection for me was best demonstrated recently through my attendance at a Strategic Review to offer support and to plan treatment for the next six months with my service user. The Doctor asked MC 30162 about support and he replied without hesitation,

“I can always ring my key worker at any time. She listens. I can trust her, especially now things are difficult with my Uncle”.

This simple sentence for me, as an Enhanced Treatment Practitioner, confirmed the importance of listening and highlighted that showing compassion is the real skill when working with complex needs and trauma. Listening provides connection with a view to healing.

Case- Study- Sexual Health Nurse

32yr old female attended GDAS with partner, active treatment staff were concerned that this female could be pregnant due to an extended stomach.

Staff asked for me to chat/introduced myself to this lady and offered all the services I could provide but declined today stating she did not feel she needed this at this point.

The lady presented the next day at housing, stating she was pregnant and needed accommodation, rough sleeping coordinator contacted myself to make an appointment for the pregnancy to be confirmed. The lady attended B6West sexual health clinic at the Royal Gwent hospital within the hour where I was working and as she had met me yesterday she was relieved to see me, the pregnancy was confirmed and she was housed that evening.

Now the pregnancy had been confirmed the community midwife was contacted and an appointment at GDAS arranged as she was not registered with a GP in the Newport area.

Specialist Midwife attended GDAS and a joint consultation with the midwife and myself ensured the lady received the right medical care for both baby and her.
The multiagency approach to provide support and care worked extremely well and I am proud to be part of such a excellent service.

Successful transfer of patient - GP Shared Care (GPSC)

Approx 9 months with Transition Nurse
I took over the care of Patient A on the 23/01/23. He was hesitant to change services as he didn't want change, but with some reassurance, he agreed for a referral to be made. A referral was made on the 22/03/2023 to Aneurin Bevan Specialist Drug & Alcohol Service (ABSDAS) and was seen by ABSDAS nurse 12/04/2023.

On waiting list for 3 months before seeing ABSDAS Doctor in July 2023. His treatment was transferred over to ABSDAS GPSC (White Rose Surgery) on the 4th of October 2023 after confirming his ongoing reduction we had in place.

Patient A is a 47 year old male, living with his parents and unemployed. He first came into service in 2009 and was using £10 bags of heroin numerous times per week. He drank 2/3 double vodkas per night and suffered low mood and reported feeling very flat. Patient A was in and out of treatment with GDAS due to his poor engagement over the years.

Patient A was assessed for GPSC within GDAS in January 2023. He was on 50ml of methadone and had been giving negative urine drug screening (UDS) since 2020. His engagement was good and the GPSC contract was explained by his nurse and signed. Patient A decided to start a reduction plan of 1ml per week at the beginning of May. Patient A also reluctantly agreed for the nurse to do a referral to ABSDAS and was seen in April 2023.

At first Patient A was apprehensive about switching over to GPSC with ABSDAS as he felt happy where he was. It was evident Patient A was happy plodding along and needed more encouragement for him to make any change. The nurse reassured him and offered to attend his initial appointment with ABSDAS as this would help.
Patient A was accepted by ABSDAS who agreed to take over his script at the beginning of October 2023, by this time Patient A had continued his reduction and was down to 26ml when exiting treatment with GDAS. ABSDAS nurse and GDAS GPSC nurse communicated what dose Patient A would be require on the date of transfer and the transition was straightforward.

The day of the transfer of script, the nurse contacted Patient A to ensure he was ok and no problems with collecting his script. Patient A assured the nurse all was well and thanked them.

COMPLEX CARE

Client X is a 45-year-old male that has been receiving Mental Health support via our Complex Care Nurse and GDAS Open Access due to a relapse with substances after being abstinent for 9 months. Client X has a Mental Health diagnosis of Fixed Paranoid Delusional Disorder and is currently prescribed 10mg Olanzapine. Client X is a known previous poly drug user, specifically heroin, cocaine and benzodiazepines.

Client X was requested a referral for OST treatment and further mental health support after relapsing due to the death of his father. The Complex Care Nurse and Open Access keyworker completed an emergency prescribing referral form with Client X due to the increased risks he was displaying after the loss of his father. The Complex Care Nurse contacted the MH Practitioner at Client X's GP surgery for further support with MH, specifically trauma and the bereavement. On the day of the Panel Meeting to discuss emergency prescribing, Client X was involved in a very bad car accident. The Complex Care Nurse was contacted by the hospital to inform her that Client X had sustained significant injuries, was on a ventilator, sedated and that the situation was touch and go. The Complex Care Nurse contacted UHW to discuss the situation and requested, if possible, to attend UHW, which was agreed. The Complex Care Nurse attended, and spoke to the Consultant and Nursing staff at UHW and gave them a brief background regarding Client X. Staff at UHW were very grateful for this. While at the hospital the Complex Care Nurse met Client X's family members who had previously been estranged. The Complex Care Nurse introduced herself, informed family members what we do as a service and reassured the family members what support we would be giving as a service going forward. Client X's family members were very grateful and exchanged telephone numbers with the Complex Care Nurse so that could exchange updates regarding Client X's situation and progress.

Client X remained sedated and ventilated at UHW for 2 weeks and was then transferred to GUH for rehabilitation and to start OST treatment via ABSDAS as he was prescribed a lot of opiate based pain relief whilst in hospital. The Complex Care Nurse liaised with the team from UHW, GUH and ABSDAS to ensure that Client X received appropriate support for his substance misuse, MH and physical injuries. During this time the Complex Care Nurse relayed all information to Client X's keyworker and housing support officer so that they could develop a plan in readiness for Client X's discharge from hospital.

However, Client X's family member informed GDAS that he would be discharged earlier than expected. This was very concerning as Client X had not started OST treatment via ABSDAS and the accommodation he was going back to was unsuitable due to Client X's physical injuries. The Complex Care Nurse and Housing Support Officer attended GUH to discuss their concerns and the potential risks. Staff at GUH advised that Client X was medically fit and even though they have taken on board our concerns, they are not permitted to keep him in hospital. The housing support officer contacted his boss to discuss the situation and try to source ground level accommodation, whilst the Complex Care Nurse contacted Client X's keyworker to source OST treatment via GDAS as ABSDAS were no longer required to potentially prescribe as Client x will be discharged. The Complex Care Nurse and keyworker liaised with the prescribing team, management and Doctor by relaying all information received from UHW and GUH to source appropriate OST treatment via GDAS for Client X.

Client X was discharged from hospital and was started on OST treatment within four days. The Complex Care Nurse has also booked a review appointment for Client X regarding his mental health with the MH Practitioner for trauma counselling support and medication review, of which the Complex Care Nurse and keyworker will continue to support. Client X understands the importance of remaining compliant with his OST treatment and to attend all future appointments for ongoing support and care.

By partnership working and with the client's consent, we were able to discuss current concerns and source appropriate support for Client X's mental health and substance misuse. There have been a few barriers along the way, which caused minor delays in obtaining the correct support for Client X, but Client X is finally receiving his OST treatment and is accessing further MH support. The aim is to support Client X to remain compliant with his OST treatment, to access further support for his MH and to continue to build relationships with family members in order to further improve Client X's care and overall quality of life.

Other Comments

Quote from Wallich support worker

"The Complex Care collaborative working aspect of this role enabled us to build a rapport with the client's family to build previously damaged relationships, to support sourcing OST treatment for relapse with substances and to help source further support for his MH after a very traumatic few months. The Complex Care Nurse went above and beyond to help Client X and liaised with all services professionally and appropriately, in order for Client X to source the appropriate care and support for him going forward. I believe the keyworker, family members, The Wallich and Complex Care collaboration benefitted Client X because we were able to partnership work with other organisations to provide holistic care to tackle all needs. Overtime, Client X will access the correct mental health support and his overall presentation will improve even further which will further improve his quality of life. We were able to incorporate his wants and needs into all aspects of care to achieve a desired, positive outcome and ongoing support. Client X's attitude and engagement are positive toward his wellbeing and recovery. I believe we have all done a very good job in supporting Client X with team working and drive.

ASSERTIVE OUTREACH

Case Profile

In this case study all information and details will be anonymised. I will refer to client as Jane throughout this study. Partner will be referred to as Rob.

Jane is a 32-year-old female who came to the Complex Needs Service in December of 2022. Jane was transferred from the Criminal Justice Team. Jane is a known poly drug user, prolific shoplifter and in a high-risk domestic violent relationship. Since being with the Complex Needs Team, Jane has ceased offending, and has stopped using heroin, Jane continues her methadone prescription of 40mg.

Reasons for referral

Jane was transferred from the Criminal Justice Team to the Complex Needs Service as her order for required engagement from the court was coming to an end. It was decided that due to the complexity of her case and Jane still needing support from our organisation that she fit the criteria for our team. The aim of the referral was to maintain her prescription of methadone, continue brief interventions and harm reduction, but to also support with further appointments with probation and housing. Jane also required specialist support from Domestic violent and sexual exploitation services.

Work undertaken

At first Jane was incredibly difficult to engage as she was very distrustful of services and because of her partner, Rob. Jane is in a high-risk domestic violent relationship with Rob, who did not allow her to attend appointments with our organisation nor have a mobile phone or claim benefits, this proved difficult to engage her meaningfully. Jane is also a repeat Multi agency risk assessment conference (MARAC) which was beneficial to provide and receive information with other professionals on how to manage her case effectively. These barriers were very difficult to overcome, staff had to become innovative with the way we engaged her. I would collaboratively work with Jane's probation officer to provide support for her substance use in a safe, comfortable and familiar environment for her. This allowed me to build a good rapport with Jane. After persistence and hard work of proving what our service could provide, Jane began to seek our help without her partner's knowledge. It was often difficult to see Jane alone but over time Jane became more open with staff about her experiences with Rob, her mental health and substance use. Since, Jane has ceased her heroin use and minimised her crack use. Shortly after this her probation period came to an end, Jane ceased all offending and has not had any criminal justice involvement since.

Jane would quite often go through cycles of ending the relationship and returning. When Jane would flee this relationship, she would return to crack cocaine use and sex working. I was able to provide harm reduction advice around safer drug use, by providing brief interventions around her crack use, and sex work by regular health check-ups, including sexual health screens and BBV testing. Each time Jane would flee the relationship it became easier for her to approach staff and be open about her current situation. I was able to support Jane with referring her to an organisation that specialises in Domestic violence and sexual exploitation, and an Independent Domestic Violence Advisor (IDVA). All agencies worked together to support Jane holistically. Jane's IDVA would complete joint appointments with me to ensure that Jane was able to have access to IDVA's support safely. We would arrange appointments at the same time as her partner's, to minimise his frustration at waiting.

Jane fled the relationship for what she described as a "final" time after multiple increasingly violent domestic situations unfolded. Jane felt comfortable enough to approach staff when in crisis for support. Staff were able to comfort Jane and listen to what she needed help with. Jane requested support around housing. Staff were able to support Jane to the local council to access emergency housing, as Jane had refused refuge. There were also limited refuge spaces available. Unfortunately, the council were unable to provide the correct placement such short notice and high risks. Staff linked in other agencies and one organisation was able to offer a solution. This agency had a complex needs safe house for women experiencing exploitation and domestic violence. The risk assessment and application paperwork were completed, and Jane was accepted for this space. Jane moved in the same day.

Jane resided in this placement for several months and continued to be abstinent from substances and sex work as she had a good support system to deter her. Instead of returning to old coping mechanisms staff were able to support with developing new healthy ways of coping. Jane was very open to all support and engaged well. During this time staff were able to register client with a GP and access universal credit benefits.

However, Jane did return to her relationship with Rob and gave up her placement. The following day Jane presented to us in crisis after another domestic incident. Luckily, staff run an out of hours drop in where Jane knew she could access support. However, Jane refused refuge or temporary accommodation but was able to sofa surf at a friend's house. Jane linked in with a police officer whilst at this drop in. Unfortunately, Jane's previous placement had no free spaces and were unable to offer her another placement. Due to a fear of being street homeless and long wait lists for housing she is now back with Rob.

Summary

Although Jane continues to be in a relationship with Rob, Jane still links in with me, her IDVA, GP and domestic violent support services. Jane is now in receipt of benefits and has a mobile phone provided through the housing placement. Jane has ceased sex working and crime now that she has access to Universal Credit. I have accessed mental health support for Jane, and she is awaiting counselling. Jane has been abstinent from crack and heroin for a few weeks. Even though she has small relapses with crack, she continues to do well and knows she will not be judged for these blips. Overall, Jane's quality of life has improved.

Jane is now aware of the process for fleeing her relationship and where to go when in crisis. Jane feels comfortable enough to approach staff and knows that we will always be available to support. Jane trusts us as we have proved we are able provide wrap around support effectively and efficiently. Staff have also now built a good rapport with Rob, which in turn, enables Jane to engage better with our service.

We have a safety plan in place which Jane adheres to as she was a part of deciding this plan, as staff believe it is important for the support to be person centred.

OVER 50'S SERVICE

Introduction:
PG is a 64-year-old client who has had major trauma throughout her life. She was a victim of horrendous domestic violence (DV) with her husband, who she has divorced numerous years ago. PG was also raped after working in a bar 16 years ago and doesn't know who the perpetrator was, this affects her mentally as she never knew who it was, she is always afraid it could happen again. Previous to being referred to GDAS PG was in rehab due to her excessive drinking and came out halfway through the rehab treatment as her son-in-law passed away. Following this PG started drinking again.

Treatment:
In my initial assessment with PG she was very unstable on her legs, following this I made home visits for appointments as I felt this was safer for her as she also lived in an upstairs flat with very narrow stairs. In appointments we would use psychosocial interventions, harm minimisation, and try to start a reduction plan. PG could never remember how much she was drinking. I was concerned that she had ARBD.

Treatment Goal
Abstinence.

Summary of work completed:
I made a referral to Supporting people for PG's mental health and finances. As I felt that PG was extremely vulnerable and had no family support. PG's family refused to visit her as they blamed her for all the DV they had experienced as children. They wouldn't let her see her grandchildren as she was always intoxicated.

I was really concerned about PG's physical and mental health, so I sent an email to Adult Social Services to see if she had any support. A social worker from primary mental health contacted me and said she was due to close PG, but she was still working with secondary mental health. I emailed this support worker, and we attended a joint visit. During this visit PG was very intoxicated and we were both concerned about her health and her location with an upstairs flat.

From the supporting people referral, we then had a platfform worker on board, we started an email thread to make sure that somebody had eyes on PG regularly because of her being so ill. We all interacted really well. The plattform worker then supported her to complete a housing transfer form as she had been told previously that she couldn't move. So there was plenty of safeguarding in place. Following all these discussions I was still concerned for PG's ARDB . I spoke to my manager regarding this and we decided that PG would be best suited with a PLP to help with ARBD. On handover I linked the PLP with all other support workers so that they could all keep close contact.

ALCOHOL LIAISON

Client ML was referred via pathway to alcohol liaison service in March 2023. Due to his high admission rate (4 admissions leading to referral), problematic alcohol use and poor physical health partially caused by long term alcohol misuse.

ML has a recent history of fits and required district nurse support as he has a catheter fitted which has a common side effect of bladder infections.
It was reported during referral that he has had many previous episodes with minor changes and poor engagement.

Due to his physical health issues he lives in supported housing and has personal support to help with his daily needs, GDAS have have supported the staff to get a better understanding of alcohol misuse. ML smokes tobacco no other substances other than prescribed medication.

Initially he was reluctant to address his alcohol usage and at the time of referral he was consuming approx. ½ bottle vodka per day (14 units) and 8 cans of Stella (20 units) which was totalling units 34 a day.

ML was unhappy with the large house he was living in as when he was intoxicated, he would have fights with the other residents he didn't get along with. GDAS and Caerphilly social services worked alongside ML to explore housing options, he was then successfully moved to a smaller 2 resident supported living property.

ML opted for weekly support from GDSAS and managed to reduce his alcohol to 6 cans of beer (12 units), he can continued to engage with GDAS and has not been admitted to hospital for alcohol related health issues or unplanned detox since referral.

TRAUMA COUNSELLING SUPPORT SERVICE

Introduction:
MH was referred to the Trauma Counselling Service by the Criminal Justice team within GDAS on the 14th February 2023 as he is prescribed Buvidal and had experienced physical abuse whilst in a Children's Home.

MH has had support from GDAS since 2007 19 episodes were with Criminal Justice and the Prison Service and 1 episode with the Open Access team since 2007 to date.

Treatment:
MH attended his assessment on the 21st February 2023 and spoke about the physical abuse he experienced in the Children's Home and how let down he felt by the authorities and his parents not believing him.

He explained about the flashbacks he experiences especially the smell of meat on the B-B-Q as it reminds him of the smell of the keyworker in the Childrens Home stubbing his cigarettes out on his back. Due to the flashbacks and panic MH reported experiencing it was agreed he would have a few sessions of Counselling to work on regulating his emotions to reduce his anxiety and panic attacks and then we would do Eye Movement Desensitisation and Reprocessing (EMDR).

MH's attendance was good initially and as time got closer to him having EMDR he dropped out for a few months. Through his keyworker in Criminal Justice, we were able to let him know the door was still open for him to access EMDR when he felt ready to do so. However, in August he re-contacted and he had his first EMDR session on the 25th August 2023.

At each EMDR session the client is asked to rate the severity of disturbance (SUD) at the beginning and end of the session, and we are aiming for the score to reduce from a maximum of 10 to as close to 0 as possible. These scores are taken at the start and end of the session. We also get the client to think of a new positive thought (Validity of Cognition (VOC)) they would like to believe about themselves, and this is scored between 1 and 7 with 1 being completely false and 7 being completely true. Again, this is taken at the start and end of the session.

At the start of the session MH's SUD when recalling the image was 7½ (10 being the highest) and the score for the VOC was 2 (7 being the most positive).

MH engaged well with the session and was able to access the image of the trauma easily. Within a few sets of the hand movements, he reported his mind being "blank" and couldn't recall a thought, vision or emotion. We carried on with the hand movements and after 2 more sets he had the image of him visiting the children's home and it being derelict with the gateway covered in ivy. This was the final image he recalled on the last 2 sets of hand movements.

When the session ended, he scored his SUD as 5 and his VOC as 6. A further session has been booked to assess if we he can progress even further.

Treatment Goal:
Unfortunately, MH was not able to attend his next appointment but managed to have a telephone appointment a few weeks later.

In his phone appointment he reported that when he thinks about the image or the event he doesn't get as strong an emotional response and can "let it go, as it's as if it happened to someone else". He stated "I can put it away without it damaging me" as in the past it would be a trigger to him relapsing and committing crime.

MH reported that he has completed his drug rehabilitation requirements (DRR) following a very positive review with Probation. This was his 4thDRR but the first he has ever completed. He stated he was able to be honest with the review panel and explained what had happened in the past which he has never done and since having counselling in GDAS he feels he can "open up" and doesn't mind being emotional in sessions.

MH is interested in becoming a Peer Mentor when he is further into his recovery and is due to start learning to drive. Another EMDR session has been booked should MH want to reduce the SUD score

Outcome Measure:
SUD: 7½ down to 5
VOC: 2 up to 6

Physical Measure: "I can put it away without it damaging me"

Introduction:
AFR is a 29-year-old male who used cannabis and alcohol to deal with stress in his life, he was drinking around 40 units of alcohol every other week and smoking around 3 grams of cannabis a day. AFR reported having bad mental health problems and an history of self-harming by cutting his arms. AFR had spilt up from his kids' mother and wasn't seeing his kids at the time of starting treatment in June 2023.

AFR didn't feel that his alcohol was an issue at the start of treatment and wanted to just work on the cannabis use. A few sessions in he changed his mind and wanted support with his alcohol to reduce it to a more controllable level.

AFR started seeing his kids in the visitation centre he has one more visit there left then he can have the kids unsupervised at home, he is very happy with this.

Treatment:
AFR was informed about safe alcohol use and recommended units, he was also advised to have at least two days without alcohol.

Together we worked on a reduction plan for his cannabis use. He was asked to keep a diary of his cannabis/alcohol use and to bring it to his next appointment, he started a diary on his phone that he kept up all the way though treatment, he found this useful for him look back on and for him to track his progress.

AFR was struggling with other peoples opinions of him, this was leading him to smoke more cannabis. Together we used tools from connect five for AFR to understand that he cannot control what people say about him, but he can turn them into fact or opinions.

AFR continued to work on reducing his cannabis use, he would successfully go around two weeks without smoking it but would often have a slip up for a day or two. We are now at the stage where he has gone 8 weeks without smoking cannabis, he also took the same tools that were applied to his cannabis use and applied them to his alcohol use, he has successfully reduced his drinking and has swapped from whisky to beer. AFR is now a lot happier.