# DUNDEE CASE STUDY TWO

**Person's Journey summary**

Diagnosis of emotionally unstable personality disorder, experiencing hallucinations and sleep deprivation. Significant alcohol consumption along with co-codomol use. Survivor of sexual assault with complex PTSD.
·First contact with mental services, working with psychology and Crisis Resolution Home Treatment Team (CRHTT)
·Transferred to CMHT for a short while before disengaging with services
·Re-engaged through concern family member contacting GP regarding alcohol consumption
·Pattern of inpatient admissions, detox and discharge with mental health support followed by deterioration

**Reflections**
Summary of opportunities

- Learning from the importance of and flexibility around where care is delivered and by who
- Understanding the rationalising the range of services involved in care
- Involvement of physical health
- The timing of support - ensuring there is a planned approach to when an intervention is likely to be required

Healthcare Improvement Scotland

Part 1

| | OCT 19 | | | NOV 19 | JUL 20 | | AUG 20 | NOV 21 | | DEC 21 | | MAR 22 | APR 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MOMENTS** | **Referral** | **Assessment** | **Treatment** | **Discharge** | **Family Referral** | **Treament** | **Discharge** | **Assessment** | **Treatment** | **Family Referral** | **Treatment** | **Hospital admission** | **Inpatient service** |
| **WHAT HAPPENS** | | Referral done from Women's Aid after reporting paranoia and hallucinations. She wanted a formal diagnosis and medication | Prescribed medication and supported with GAD and PTSD | Discharged into CMHT but self-discharged | Aunt contacting GP with concerns; consumption of alcohol prompted a police welfare check | Inpatient addmission prompted by high level of alcohol consumption, poor eating and sleeping along with suicidal thoughts. | Started on Accamprosate and Diazepam. Daily contact with CRHTT. Transferred to CMHT but no engagement | Assessed with sleep deprivation, provided with medication for sleep. | | Family contacted CMHT | CMHT weekly appointments along with mindfulness and grounding techniques | Physical health admission for blood transfusions. | In patient Detox |
| **SERVICE** | | Crisis resolution home team | Crisis resolution home team | Crisis resolution home team | GP<br>Duty CMHT | Duty CMHT | Crisis resolution home team | NHS Inform | Crisis resolution home team | Duty CMHT | | A and E<br>DDARS | Inpatient psychiatry |
| | | Psychology at womens aid | | | Police | | | | | | | | |
| **GOOD PRACTICE** | | | | | | | | | | | | | |
| **REFLECTIONS** | | Early intervention and harm reduction could have been introduced from the first referral. | What is the role of holistic assessments? Opportunity to look at what people need rather than if their service fits. | | | | | | | Was support for the family offered? | Not much further follow up or conversations about alcohol usage. | | |
| **IDEAS** | | | Idea: Look into assessments that take into account both SU and MH, ensuring that assessments are detailed and ask follow-up questions to gather a complete picture. | | | | | | | Idea: Ensure that there are mechanisms in place to involve and support the families of individuals receiving care, especially with their consent. | Question: How might we support CMHT staff to ask about substance use in more detail, and support them to act on the information? | | |

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Part 2

MAY 22 JUN 22 AUG 22

| Relapse | Inpatient service | Referral | Home visit | Hospital admission | Did not attend | | Referral | Emergency call | Hospital admission | Discharge |
|---|---|---|---|---|---|---|---|---|---|---|
| Continued alcohol use; not taking medication and suicidal ideation. | Admitted to Carseview | Referral to We are With You, and Richmond Fellowship support at home in place | Heightened anxiety noted and consuming alcohol again. Awaiting DDARS input. Not taking medication. | Physical health admission for blood transfusions. | Declined intoxicated | Declined as intoxicated | Met with alcohol liaison and agreed for DDARS contact, resulting in TCA referral. | 999 call made at CMHT home visit | Admitted with haematemesis. | No contact with CMHT prior to discharge. |
| Dicharge hub | | | | Ninewells | | | | | Ninewells | Ninewells |
| Inpatient psychiatry | Inpatient psychiatry | Inpatient psychiatry | CMHT | | | CMHT | | CMHT | | |
| | | | | DDARS | DDARS | DDARS | DDARS | | | |
| | | | Social work | | | | | | | |
| | | Richmond fellowship | | | | | TCA | | | |
| | | | | | | | | | | |
| | | | | | Engaging with advocacy services at this stage could support the individual with assessments, ensuring thier needs and rights are appropriately represented. | | | | | |
| | | A centralised referral hub could streamline the process for accessing services and make it make it easier for individuals to navigate and access the services they need. | | Hospital admissions not used as an opportunity to put wider support in place. | | | | | | The transition from hospital care can be challenging for individuals and they may need support pre-discharge. |
| | | | | | | | | | | Action: Develop pre and post discharge plans with CMHT to ensure a smooth transition for returning to the community after hospitalization. |

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Part 3

| SEPT 22 | OCT 22 | NOV 22 | DEC 22 | JAN 23 | MAR 23 | JUN 23 |
|---|---|---|---|---|---|---|
| **Home visit** | **Referral** | **Home visit** | **Joint working** | **Relapse** | **Assessment** | **Joint treatment** |
| Consumption of alcohol noted. | Seven day inpatient detoxification | Consumption of alcohol noted and referred to WRASAC. | TCA contacted CMHT around disclosure of co-codomol use | Sexual assault perpetrator back in contact. | Assessment | Referral to carseview fo detox<br>WAYWY referral |
| | Sexual health | Sexual health | | Kinclavin detox | Ninewells | Carseview |
| CMHT | CMHT | CMHT | CMHT | CMHT | CMHT | CMHT | CRHTT | CRHTT |
| DDARS | Kinclaven Detox | DDARS | DDRAS | DDRAS | | | | DDRAS |
| | | | | | | | | WAWY |
| | | WRASAC | TCA | Hilcrest | | | | Richmond Housing association |
| | | | | | | | | |
| | | | | | | | | |
| | | | | Trauma can be a significant trigger for mental health. | | | | |
| | Action: Develop and implement preventive measures and follow-up plans to support individuals before, during, and after rehabilitation, reducing the likelihood of relapse. | | | Action: Ensure that service providers are trained in trauma-informed care and can provide appropriate support. | | |

| MAR 23 | | JUN 23 |
|---|---|---|
| Joint treatment | | |
| Weekly support from CMHT<br>Referral to Richmond Housing Association | Carseview admisison<br>CMHT support<br>Concerns from Richmond Housing assocation<br>WAWY difficult to access | Admitted in A & E with relapse and required the crisis response treatment team<br>Discharged from Ninewalls after recovery | Abstinence and improved mental health with the holisitc support provided |
| Carseview | | Ninewells | |
| CMHT | CMHT | CRHTT | CRHTT |
| | | | DDRAS |
| | WAWY | | WAWY |
| Richmond Housing association | | | Richmond Housing association |
| | | | |
| | | | Good to have all these services engaged by care coordination is required.<br><br>Change often happens when a person acknowledges their own problems and wants to change. |
| | Lots of services are invovled and could be asking multiple questions of the individuals history which could be trigging. | A person may have relationships with multiple services, making it confusing for them in crisis knowing who to turn to. | |
| | Idea: look at developing a digital system that statutory and non-statutory can use- including past assessments, treatments, and interactions with various services, to help | Action: Clarify tiered support services, ensuring individuals have a clear point of contact and understanding how to access appropriate support when needed. | |