MODEL INTERVENCIÓ COMUNITÀRIA: APLICACIÓ I RESULTATS A GAL·LES

XV JORNADES CCPC

ENTENENT I ACOMPANYANT LES CONDUCTES ENS PREOCUPEN

Dra Maria del Mar Adrover Amengual

Consultant Psychiatrist Intellectual Disability, National Health Service of Wales

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Declaració de Polítiques i Bones Practiques per a adults amb DI
Govern Gal.les

"Totes les persones amb DI son ciutadans de ple dret, amb igual status i valor que els altres ciutadans de la mateixa edat

Tenen els mateixos drets a: Viure una vida sana, productiva i independent amb els suport i intervencions adequades per a desenvolupar el seu maxim potencial.

Ser individus i poder decidir questions cotidianes i importants de les seves vides , amb assessorament i suport sensat sempre i quan sigui necessari "

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Vivir les seves vides dintre la seva comunitat, mantenent els vincles i conexions socials i familiars que son importants per a la persona.

Disposar del suport de las comunitats de les que formen part i acces a serveis generals i especialitzats que respondran a les seves necesitats individuals, circumstancies i preferencies ".

LEARNING DISABILITY ADVISORY GROUP (LDAG)

"Grup Assessor de DI"

- Health Inequalities

(Desigualtats en Salut)

- Transforming Care

(Transformant l'Assistencia)

- Self-Advocacy

(Auto-Determinació)

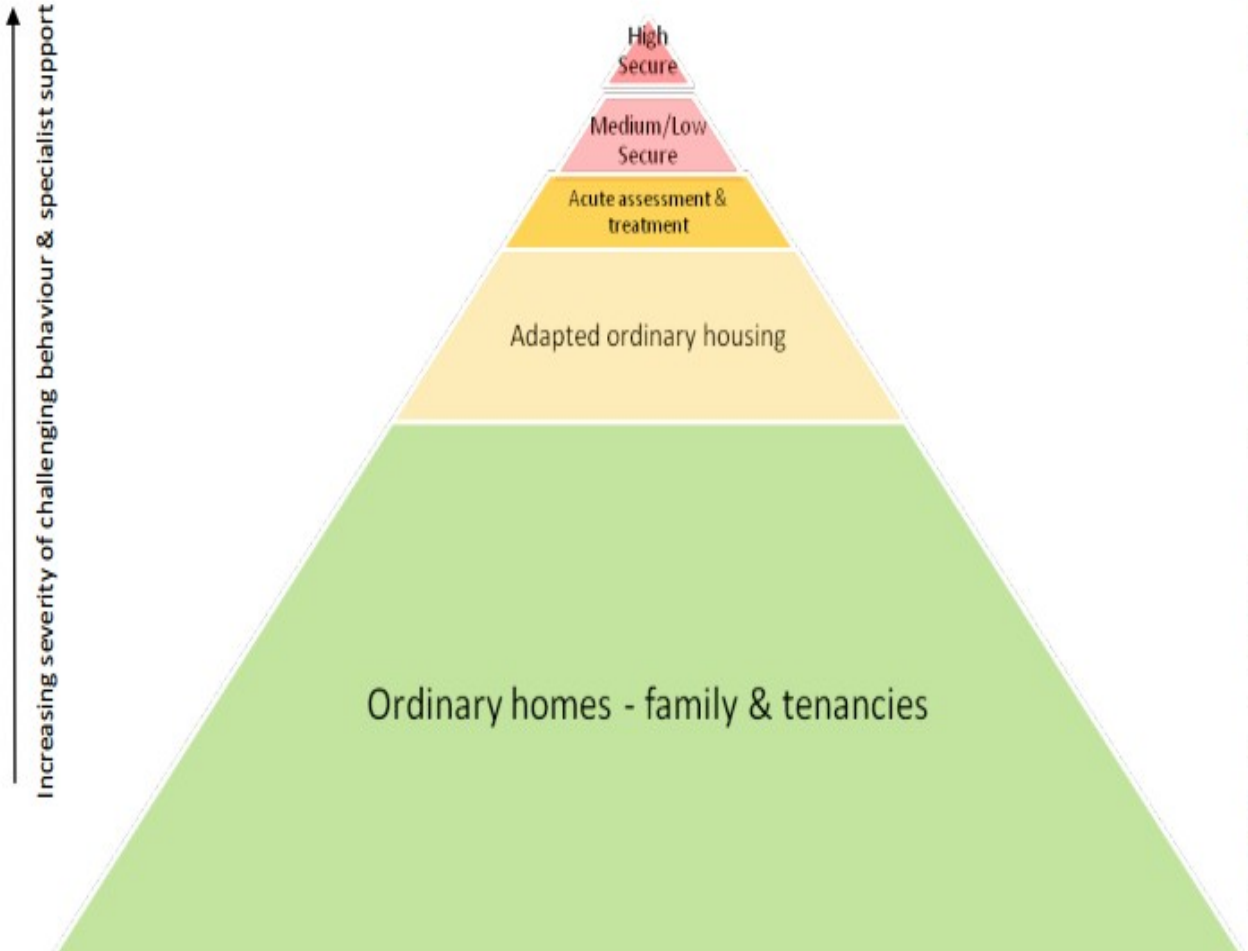
Serveis Communitaris

1. Serveis de Vivenda i Families
2. Centres de dia i Serveis de Respir (planificat o emergencies)
3. Educacio i Treball
4. Govern Wales- underpinning
   - Salut
   - Serveis Socials
   - Tercer Sector i Voluntariat

Vivenda

- Model de Supported/Residential accommodation (Vivenda amb Suport)
- Model de “Core and Cluster”
- Vivenda propia
- Familia: Propia o “Shared Lives”- families d’acollida

Figure 1 Recommended Structure of Optimum Service Provision in Wales for Children & Adults with Learning Disabilities &Challenging Behaviour



SECURE [NHS]– (very few people) Hospital forensic short and long stay

AATU [NHS] – small scale, short stay

ADAPTED HOUSING [Mainly Social Care with some NHS input] – specialist accommodation services, residential schools, full implementation of PBS model by highly trained staff from this level upwards

ORDINARY HOMES [Social Care] supported living, 3rd sector support providers, mainstream schools, family-based care, specialist support from outreach behavioural specialist teams and social services community support teams. All staff able to implement PBS with support from community and behavioural teams

Principis clau (Overarching principles)

- El Servei s'adapta a la Persona
- La vivenda es una part del projecte de vida de la persona
- La persona ens ajuda a decidir el Servei (Co-production)
- Presencia comunitaria
- Suport:
  - Promou l'Autonomia de la persona, treballant amb ella per a aconseguir una major independencia (menor Dependencia)
  - Assegura que la persona es senti segura i acompanyada

"Meaningful lives"

Supported Accomodation

- 3-4 persones per casa
- Tot el ventall de complexitats de persones amb Discapacitat Intellectual
- Ratios personalitzats

Equip estable “CORE Team”

COORDINADOR d’equip

Instrument de Planificacio del recurs de vivenda amb suport “Accomodation Planning Overview”

We all need somewhere nice and a safe place to live

As adults many people move out of their family home

They leave their home with mam and dad

A lot of adults move to a new home

In the new home staff are there to help

Altres models de vivenda

- Core and Cluster
  - Pisos o estudis individuals a un lloc amb espais comunitaris
  - Entre 16 o 18 pisos/estudis
  - Suport individualitzat planificat- certes hores al dia
  - Acces a suport les 24 hores si es necessita

- Vivenda propia
- Familia: Propia o “Shared Lives”- families d’acollida

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Pla de Gestio de Cas

This part of the care and treatment plan records the outcomes which the provision of mental health services are designed to achieve, details of those services that are to be provided, and the actions that are to be taken with a view to achieving those outcomes.

*The planned outcome(s) included in the following part of the plan must relate to **one or more** of the areas listed, and include an explanation of how each outcome relates to each area. Outcomes also may be achieved in other areas, and are to take into account any risks identified in relation to the relevant patient. This part of the plan should also set out details of the services that are to be provided, or actions taken, to achieve the planned outcomes, including when, and by whom those services are to be provided or actions taken.*

Outcomes to be achieved must be agreed in relation to at least one of the following areas:	Outcome to be achieved	What services are to be provided, or actions taken	When	Who by
a) accommodation *b) education and training*	Move into supported accommodation	• Xxx requires 24hr supported accommodation that can provide specialist care for people with mild Intellectual Disability and Autism, if possible with particular focus and expertise on Pathological Demand Avoidance Syndrome. Once suitable accommodation has been indentified and agreed the Community Learning Disability Team will be involved in Network training sessions which will focus on individualised interventions for Xxx.	1 month	Xxx, Kelly Vaughan, Health team members as appropriate
c) finance and money	To attend further education courses	• Xxx requires support to identify appropriate courses and support to access them.	Once settled in the new supported accomodation	Xxx, Kelly Vaughan, Health team members as appropriate
d) medical and other forms of treatment, including psychological interventions	For Xxx to continue to manage her own finances	• Xxx's benefits to continue to be paid into her personal bank account, for her carers, health team members and social worker to give prompts to ensure that Xxx's money is not being exploited	Ongoing	Xxx, Kelly Vaughan, Health team members as appropriate

CTP
Pla de Gestio de Cas

	• This might need to be reassessed once in the community if there were concerns about Xxx's ability to manage her own finances and/or if the risk of being exploited could not be prevented		
To maintain Xxx's mental health by monitoring her medication and mental health	• Xxx is currently an impatient at Hafod y Wennol, Assessment and Treatment Unit under Section 3 of the Mental Health Act; she is under Section 117 after care. Xxx requires regular psychiatric review and review of medication. • Support for Xxx to manage her anxieties • Support to Xxx and her family with her diagnosis of Autistic Spectrum Disorder	Ongoing Ongoing Ongoing	Psychiatry and Nursing Nursing with support from psychology Psychology with support from nursing and psychiatry

CTP
Pla de Gestio de Cas

	Outcome to be achieved	What services are to be provided ,or actions taken	When	Who by
e) parenting or caring responsibilities	N/A	N/A	N/A	
f) personal care and physical well-being	Xxx to maintain good physical health	• Staff at Hafod y Wennol to support with Physical health needs	As Required	Health team
g) social, cultural and spiritual	Xxx to access social opportunities once she is discharged from HYW	• This will depend on the local resources available	Once she is settled in supported accommodation in the community	Xxx, Kelly Vaughan, carers
h) work and occupation	N/A at present	N/A at present	To be reviewed once settled in supported accomodation	
Outcomes to be achieved may also be agreed in relation to other areas	Continue to maintain relationship with her family	• Regular visits from her family at HYW	Ongoing	Xxx, Family

CTP
Pla de Gestio de Cas

Name of relevant patient

The following thoughts, feelings or behaviours may indicate that xxx is becoming more unwell and may require extra help from the care team (these are sometimes called relapse signatures):

Increase in anxiety levels to include:

- Increased visits to her GP
- Increased phone calls to: CLDT, Care Management Team and Psychiatrist secretary.
- Presenting herself to the crisis team, phoning emergency services
- Loss of appetite, vomiting, increase in agitation, shouting to self and at others, seeking reassurance through repetitive questions, absconding, poor sleep .

Name of relevant patient

If xxx feels that his or her mental health is deteriorating to the point where he or she requires extra help or support, the following actions ought to be taken (this is sometimes known as a crisis plan and must include the details of services to be contacted):

- Support from Hafod y Wennol
- Maintain communication between MDT (Hafod y Wennol staff, CLDT, social worker)

Name of relevant patient

The views of xxx on this care and treatment plan, the mental health services that are to be provided, and any future arrangements that ought to be considered, are:

xxx would like to move to live into supported accommodation

Record any views that the relevant patient wishes to be included (including past and present wishes and feelings about the matters covered by the plan), and include any statements about any future arrangements which may apply. If the patient does not have any views or statements on these matters, or the patient's views cannot be ascertained, this ought to be recorded also.

This care and treatment plan has:

* been agreed with xxx *Name of relevant patient* and is recorded in accordance with section 18(2) of the Mental Health (Wales) Measure 2010

* not been agreed with _____ *Name of relevant patient* but the outcomes have been determined by the mental health service provider(s) and are recorded in accordance with section 18(6) of the Mental Health (Wales) Measure 2010

** delete as applicable (one, but not more than one, statement must apply)*

So far as it is reasonably practicable to do so, the following mental health service provider(s) must ensure that the mental health services set out in this care and treatment plan are provided:

ABMU LHB on behalf of Cwm Taf Health Board

Enter the name of the Local Health Board and/or the Local Authority who are responsible for

Equip de support- Core Team

- El personal de suport coneix be a la persona
- Formacio del personal de support
  - Formacio basica(SCP/SA/RPR)
  - Formacio per necessitats especifiques (Epilepsia/Autisme/Demencia/Persones/PMLD)
  - Formacio amb enfoc individualitzat de la persona atesa
  - Equips resilients

Marc d’igualtat en Salut
“Health Equality Framework “

- Control de Salut Annual- ID Annual Health Check- obligatori
- Passaport de Salut (Health Profile)
- Infermeria de DI d’Enllac
- Metge de Primaria consultor- Area d’interes: Disacpacitat Intel.lectual

- Servei de Salut Mental i Discapacitat Intelectual
- CLDT-Equip de Salut de Discapacitat Intel.lectual
- LDIST- Equip de Suport Intensiu de Discapacitat Intel.lectual
- Unitats de Valoracio i tractament

- Pathways- Fulls de Ruta: Practiques Restrictives/Demencia/Transicio/Salut Mental/Epilepsia

- Advocacia

- Universitat de South Wales/Universitat de Swansea/Universitat de Bangor: Formacio de Profesionals del camp de la DI

Per que necessitam Serveis Especialitzats?

- Persones amb DI I Conductes que ens preocupen: risc de rebre intervencions abusives o restrictives i exclusio social

- ¿Que son intervencions abusives o restrictives?
- ¿Que es exclusio social?

- No oblidar: alteracions de conducta, definicio que ve determinada per la nostra normativa social
- No oblidar: que es el que se'ns esta communicant?

Psiquiatria de Discapacitat Intel.lectual

- Valoracio de Salut mental
- Prescripcio i monitoritzacio de farmacs psicotrops
- Monitoritzacio de farmacs psicotrops: Auditoria clinica
- Consultes de De-prescripcio (amb el suport de Farmacia Hospitalaria)

Fàrmacs

Revisió regular farmacs

Evidencia de que son efectius

Monitoritzar efectes secondaris

Guies individualitzades per “medicació de rescat”

Treballar conjuntament amb fàrmacia hospitalària:

- Dosis màximes indicades
- Protocols de contenció química
- Polifàrmacia
- Auditories de prescrició farmacològica

Intervencions cont.

- Suport Conductual Positiu (registres, monitoritzacio per a “informar”)
- Intervencions basades amb experiencies de Trauma- Trauma informed care (Serveis de Salut/Educatius/Socials)
- Reduccio de Practiques Restrictives: Opcio menys restrictiva -Least Restrictive option

Pla strategic del Welsh Governement

- Grup assessor Ministerial de Discapacitat Intel.lectual: inclusiu i accessible
- Enfoc: Resultats mesurables
- Observatori Nacional de Discapacitat Intel.lectual

RECOMENACIONS

- El suport efectiu i segur (minimitzacio de riscs) de les persones amb conduvtes que ens preocupen es pot oferir des de la comunitat (model integrat)

- Els Hospitals i les Residencies no son alternatives aceptables per a proporcionar atencio integrada i exhaustiva a prop de casa.

- Les Intervencions realitzades com part dels Plans de tratament s'han de basar en un ENFOC CLAR, FORMULACIÓ COMPLETA DEL CAS I DIAGNÓSTIC CONSENSUATS

- Objetius principals de les intervencions : basats en la qualitat de vida i en la protecció de drets humans

- Enfoc continuat al llarg de tota la vida de la persona – planificació proactiva y eficac per als períodes de transició.

Serveis de DI- Excel.lencia

- Lideratge visionari
- Enfocs basats en els drets humans
- Forca o capacitat professional- formacio local
- MTD Capacitat de reflexionar en equip
- Aceptar quan no ha anat be. Aprende de les errades

PCP

Per a poder tenir una “bona vida”

- *“Life for people with major disabilities supported by good services will often look quite ordinary, but this ordinariness will be the product of a great deal of careful planning and management” (Mansell, 2007)*
- "La vida de gent amb dicapacitat i gran complexitat que esta respatllada per bons serveis, molts cops pareixera que es una vida “ordinara" , pero aquesta"normalitad" será el producte d’una curada planificació i gestió "

- http://www.wales.nhs.uk/sitesplus/documents/863/Forward%20Together%20Strategic%20Framework%20for%20the%20South%20Wales%20Learning%20Disability%20Collaborative.pdf
- https://www.england.nhs.uk/learningdisabilities/care/
- https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf
- http://www.rcpsych.ac.uk/pdf/FR_ID_08.pdf
- http://www.rcpsych.ac.uk/pdf/FRID06.pdf
- http://www.rcpsych.ac.uk/pdf/FRID07.pdf
- http://www.rcpsych.ac.uk/pdf/FR_ID_09_for_website.pdf
- http://hiw.org.uk/docs/hiw/reports/160628merthyren.pdf
- Nice Challenging Behaviour Autism prescribing
- https://www.ldw.org.uk/wp-content/uploads/2019/03/Guidance.pdf
- https://www.gov.wales/sites/default/files/pdf-versions/2023/8/3/1690983553/learning-disability-delivery-and-implementation-plan-2022-2026.pdf

Gracies

Diolch