Partners in Recovery Case Study 4

Background (participant and their situation) *Not real name

Mary* has a complex history of severe and persistent mental illness with associated physical and functional impairments. She has a formal diagnosis of Mixed Personality disorder, and Diogenes syndrome. Mary suffers from peripheral neuropathy, vision impairment, malnutrition, IBS /incontinence, osteoporosis, and chronic pain. Mary's condition has resulted in more than 30 hospital admissions over the past 10 years.

She has an extremely complex history of engagement with Queensland Health and Community organisations. Often resulting in the breakdown of service provision, and subsequent de-compensation. Mary maintains a prescribed medication regime of pain medication (opiate) which further adds to her complexity. She currently resides in supported accommodation; however, her tenancy is constantly under threat due to behavioural issues associated with her diagnoses. Mary has the Adult Guardian and Public Trustee in place as she has no connection with natural supports. Mary's capacity to manage her affairs is greatly impacted by the level of dysfunction and complexity surrounding her.

What did you do to engage the person in PiR?

Mary was referred to PIR by Queensland Health Community Mental Health and the Adult Guardian as no other community organisation on the Gold Coast could provide a service to her.

PIR met with Mary and her Queensland Health Case Manager at the supported accommodation residence. We discussed how PIR may be of assistance to her in facilitating services, sustaining her tenancy, and working toward a sustainable care coordination outcome.

PIR Facilitator made contact with stakeholders to announce Mary's participation with PIR and seek communication regarding involvement.

What were the key issues/needs being addressed?

- Stabilisation of her tenancy (risk of homelessness) via PIR advocacy.
- Sourcing community nursing services and personal care assistance for Mary.
- Seeking a Disability Services QLD assessment for Mary.
- Supporting Queensland Health to implement their treatment plan for Mary.
- Linking Mary with Community Mental Health support services.
- Co-ordination with key stakeholders to ensure care coordination objectives for Mary.

What happened to address the issues/needs?

- Provided immediate advocacy on behalf of Mary to accommodation provider. Assured provider that every attempt will be made to assist Mary to sustain her tenancy.
- Attempted to source community nursing via all NGO providers on the Gold Coast. Once Mary's name was given, the providers indicated that they were unable to meet Mary's needs. Brokerage was offered, however, unable to secure service.
- Established care coordination framework for Mary. Contacting stakeholders and discussing the PIR facilitation role.
- In order to make Disability Services referral Mary needed to provide I.D documents. At this stage she had no I.D, nor did any of her stakeholders. Queensland Health only had Medicare identifier.
- Stakeholder meeting held at Mary's residence (with Mary present) to discuss Queensland Health treatment plan and specialist referral process. PIR to support both QHealth and Mary

to maintain specialist appointments and treatment.

- Make referrals to NGO Community Mental Health service providers to assist Mary with transport, social inclusion, and community access.
- Propose referral to the Complex Needs Panel.
- Communicate these processes to stakeholders.

What was the outcome?

Mary was successfully linked with NGO Community Mental Health services, following high level advocacy from PIR, and an assurance that PIR would remain engaged to support the service. She began receiving support through a time limited (funded) program which enabled her to access the community, attend health appointments, and stabilise her tenancy.

Queensland Health and PIR collaborated to present Mary to the Complex Needs Panel. Following this process Mary was granted HASP support going forward. QHealth were then able to work towards discharge planning and stakeholders knew that a sustainable support system was in place.

Mary worked with PIR to guide support services on specific support needs; for example, acquiring I.D documents, preparation for assessments, attending specialist health appointments. Unfortunately, following a period of 6 months the support service that was put in place for Mary withdrew their support. Mary required linking with a new support option going forward. This was particularly difficult due to Mary's history with services. High level advocacy was required in order to introduce a new service. This process required 2 months.

Since Mary engaged with PIR she has not been readmitted to hospital, and is functioning at a more independent level (2.5 years).

What did you or the participant learn?

Individuals in Mary's situation desperately require on-going care coordination services. The nature of her condition results in the constant breakdown of services and relationships. She is highly vulnerable due to identified impairments and fragility.

Time taken at various stages of the participant's journey with PIR:

	Length of time (in weeks)	Total hours (direct+indirect)
Engagement	2 weeks	8
Intake		2
Assessment	2 weeks	8
Action Planning	2 weeks	8
Care Coordination	50 weeks	
Monitoring	20 weeks	
Exit		