COMBAT STRESS

Presenting Situation Case Study

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Veterans' Substance Misuse Case Management Service

Ross is a 52 year old male who served 14 years with the British Army. On leaving the Army in 1982 he worked for a transport company until 2011, having been medically retired due to a fused spine and neck complaints.

Whilst serving he witnessed several traumatic events, but reports three specific events and one near miss as prevalent in his mind and causing ongoing distress.

He has lived within council accommodation at the same address for the past 30 years, bringing up two children and living with his wife until her passing in 2014. Both children have left home and are self-sufficient with their own families.

Both Ross and his wife were heavy consumers of alcohol over a number of years and known to substance misuse services since (approx.) 2010, but the passing of his wife in early 2014 led to a significant increase in alcohol consumption, increased and unmanaged distress, risky behaviour changes such as verbal aggression, disengagement with substance misuse services and self-neglect. There was also increased hospital admissions and associated health conditions (subject to a number of falls at home) as a result of what he described as 'overwhelming trauma and loss'.

Self-reported PTSD symptomology including increased distress, dreams leading to poor sleep and hyper arousal.

Key points to note:

Home address main trigger as unchanged since wife passing
Drinking up to 80 units per day
60+ ambulance call outs and/or admissions to hospital in past 12 weeks prior to CSVCMS engagement
SADQ result 51
Contact with mental health services
Suicidal ideation, plan and two attempts by means of overdose

Referral from Combat Stress and local service
Minimal support available from close family
Motivated to engage but self-reports 'poor ability to cope'

Management and Care Planning Case Study

Intensive management initially: Met on several occasions with a view to establishing care pathway and building a therapeutic relationship/building trust. Following initial contact (hospital detox following A&E admission) agreed to meet in community. Relapsed on return home. Attempted to engage again but at clinical site, Ross arrived to meeting intoxicated.

Later informed that he had been taken into hospital again following consumption of vodka and an accident at home.

Case taken to CSVCMS led multidisciplinary balint group with nursing team. A rough draft of case management explored. Explored differences in care pathways and approaches to promote responsibility and engagement.

Developed a care pathway that would allow regular engagement, taking into account the lack of stability and routine Ross had been used to for much of his life. Consideration was given to influences such as survival guilt, co-dependency and the loneliness in grief. Also included the idea of a more assertive outreach approach to promote initial engagement, with a view to building structure and promoting independence and responsibility for recovery.

The care plan was developed to ensure Ross (plus any other stakeholder or healthcare professional) was able to access a single point of contact. This point of contact would have an understanding of all aspects of Ross's current needs (incl. mental and physical health, finance, social support, housing etc.). It was key to ensure that Ross was taking responsibility for as much as possible, but with fast, flexible and appropriate support available as required.

Clear boundaries and expectations were set to ensure service dependence was no more likely than disengagement.

Outcome Case Study

Following the return home from hospital an assertive outreach approach was undertaken to contact and engage. This included undertaking a multi-disciplinary approach to communication and care planning, engaging with all agencies to ensure a clear and consistent approach was undertaken.

Following a request to attend a meeting to explore and agree shared care plan, Ross was supported to attend. A full, comprehensive assessment was undertaken, including TOPS info. The idea of structure and routine were discussed as was the idea of responsibility and engagement.

Structured care plan developed to support biopsychosocial needs. This includes elements of cleaning the home in a structured and time bound way, engaging in psycho educational groups, provision of support to appointments as required and appropriate, engaging in peer support groups and improving his food/fluid intake, and planning ongoing support such as that offered by Combat Stress.

Along with this there will be referrals to a residential rehab. An ongoing invitation to attend the monthly Tedworth House Group in Tidworth (run by Combat Stress) and the opportunity for 1:1 engagement where appropriate.

By maintaining rigid boundaries whilst ensuring a therapeutic relationship based on open communication, recovery focussed and clear accountability, it was possible to allow for a successful transition from community into residential detox (plus secondary rehabilitation placement)

Whilst in the residential setting several visits were made to check in and maintain communication. This allowed for clear discharge planning/Ross to consider and identify discharge needs as a regular feature for discussion at catch up meetings.

Over the course of the rehab placement it was identified that a return to the previous home address to present a significant risk for distress and possible relapse. It was also identified that due to engagement with his GP surgery prior to his admission had resulted in him being discharged from the surgeries list.

It was agreed that a referral would be made to a local veteran's housing project. This referral was made and a supporting document was provided to the project leading to the offer of a large en-suite room being offered in a shared house, access to onsite key worker and support to become involved in community projects.

The large council property is currently in the process of being handed back to the council for reallocation and Ross is able to stay at the veteran's project for two years. It is planned that after the two years, a retirement bungalow by the coast, close to his daughter will be sought.

Now that Ross has had a period of abstinence and has solid support networks in place, a referral will be made to the Combat Stress Regional Welfare Officer, with a view to obtaining an assessment of military trauma and developing a care pathway to support the treatment of his PTSD symptoms.

He will remain subject to 6 weekly reviews whilst under the Combat Stress Substance Misuse Case Management Service.