Case Study: Successful transition from hospital to the community

Background

Patient AB has a moderate learning disability which was diagnosed at birth. He suffers from epilepsy and has history of challenging and aggressive behaviour. AB had a disturbed and difficult childhood which saw him placed in several foster homes, as well as a number of community and hospital placements. He has been sectioned under the Mental Health Act over the last 10 years due to physical violence, destruction of property, self-injury and assault on police. While AB was in a hospital placement based in London it was agreed to prepare him for discharge into the community with full understanding of the potential risks.

Support in the Community

To prepare for discharge the Havering Community Learning Disabilities Team set up a community multidisciplinary team (MDT) specifically designed for AB's needs and appointed an experienced care and support provider. Together with the hospital a six-week transition plan was designed and implemented. A purpose built council flat was identified that would allow him to have his own tenancy. Because the flat is specifically for tenants with learning disabilities, AB is able to have 24-hour care by the community care provider in his own home. The MDT and the provider continue to meet regularly to discuss his needs and progress, and have involved the local police in the process.

At the time of writing, AB has been in the community for more than 10 months and has settled into his new home well. There have been several incidents, however these have been managed well by the community MDT, care provider and local police. On one occasion AB was taken to the local mental health hospital for a few hours until the situation had been de-escalated, and then returned to his own home. Additional assessment took place on the run-up to the festive period as this is known to be a time when the patient experiences anxiety and is more liable to present challenging behaviour. It was agreed that the care provider needed some additional funding to give AB 2:1 support when necessary rather than at set times, and this was agreed by both the local authority and CCG.

Since moving back into the community AB has made real progress. He has better personal hygiene, has lost weight and is managing his diabetes due to exercise, his social interaction is improved, and he is now seeking voluntary employment. Most importantly, the experience of living in the community has greatly improved his self-confidence and independence.