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SOCIAL WELFARE IN MENTAL HEALTH DEPARTMENT FOR A GOOD CLINICAL PRACTICE

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SUMMARY

The National Plan of Action for Mental Health (PANSM), approved by the Conference of Regions has been from January 24 2013, being implemented by the Department of Mental Health Services. It requires a reorganization of the same, the functional the adoption of a methodology based on the Necessity of Working for projects which are Intervention-specific and differentiated, based on the evaluation of the need and patients and the implementation of care pathways. This implies a systemic approach by of the team, rather than a segmental working mode.

Thus change is necessary in the work culture of the teams, and from the State Regions Conference November 13 2014, has emerged the need to share, among all stakeholders, good practices and the development of Clinical Management Tools so that standards of care can be defined to ensure quality, together with the measurement of Processes and Outcomes

Key words: *quality - standard of care - Good clinical practice - multidisciplinarity*

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Introduction

The Care Pathways are interdisciplinary care plans created to meet the complex health needs of the citizens in order to homogenise the interventions and approaches, optimize the quality of treatments and rationalize the use of resources (PANSM 2013).

Why develop Care Pathways (PCA)?

In the early 90s they were imported into the UK with the aim of supporting organizational change towards evidence based practice implementation.

The routes embed evidence-based practice and guidelines contained within structured documents that guide the care of patients in the presence of identified disease conditions.

As you build care pathways?

First one Identifies key areas, namely the appropriate objectives for the assistance to the pathological condition. Thence one develops an integrated care pathway that specify elements of care in detail in the local protocol, the sequence of events and the patient's expected progress over time. Prepare documentation for the integrated care pathway (Amorosi 2015).

- One then Trains staff in the use of integrated care pathway.
- One tests and then implements the integrated care pathway.
- One regularly analyzes the variations from the integrated care pathway.

The activities of each mental health center pertaining to the UOC Pescara North are comprised as follows:

- *Interdisciplinary intervention* (Civil Hospital, District Basic Health, etc) *Consultancy and extra* – Hospital;
- *Specialist intervention;*
- *Taking charge* (Serious Patients).

INTERVENTION INTERDISCIPLINARY

ADVISORY - hospital

This intervention is part of the relationship between the CSM and the general medical services in particular GPs.

N.B.: It is an activity to increase especially for the timely management of "beginnings".

CONSULTATION HOSPITAL

The activity of union and integration with SPDC to:

- Admissions to TSO and Volunteers planned for the CSM users:
- Visits connection during hospitalization for Therapeutic Project;
- Shared project Dimission.

SPECIALIST TREATMENT and taking in care

Users who need specialized care BUT NOT treatment complex and multi typical of taking charge. Key points:

- -Sharing the goals of care;
- -Information given to both the patient and the family about the nature of the disorder;
- Therapeutic - including the pharmacological and psychological interventions, mainly, but not exclusively, as outpatients.

TAKING CHARGE

Path for users with severe psychiatric disorders and people with complex needs.

The taking charge of serious and multiproblematic patients is the specific mission of the CSM.

The identification of such users is through a multidimensional assessment that considers several areas:

- Diagnosis nosographic elective diagnosis: severe psychotic disorders, major affective disorders, severe personality disorders;
- clinical severity;
- social functioning;
- characteristics of family and social network;
- previous psychiatric and psychological treatments.

The CSM Pescara Nord CSM Penne defines as a "sick patient" the user who has had continuous contact with the service for at least two years and who is rated on the scale of the Global Assessment of Functioning (VGF) lower than 50.

The organizational tool used is the Individualized Therapeutic Rehabilitation Project Territorial (PRITT) developed by analyzing the individual user's needs. It is a program of customized interventions (attention to the person and their needs), which establishes the services which the individual patient will receive (emphasis is on the problems and not on individual services skills).

It provides for the sharing of objectives and co-responsibility in achieving the same through the involvement of all the formal and informal resources.

It monitors the results (health gains) of the interventions.

TAKING CHARGE and PRITT

- Definition of the Project Coordinator (case manager) with monitoring and FUNCTIONS.
- The Project Coordinator ensures integration of various services and operators involved ensuring continuity of care.
- The Project Coordinator ensures agreed goals and Signed by the user and Family Members for the therapeutic Alliance Recovery.
- The Project Coordinator ensures Search and recovery of the relationship with the users who might have been ' lost sight 'of.
- The Project Coordinator ensures attention to families as part of treatment programs.
- The Project Coordinator ensures Development of prevention programs in collaboration with local authorities and with the School.
- The Project Coordinator ensures psychopharmacological and psychological treatment in accordance with the guidelines agreed by the CSM operators.
- The Project Coordinator ensures Psychopathological assessments and periodic psychosocial (BPRS, VADO, VGF) Analysis of the rehabilitative needs (eshousing needs, help in the workplace and with social problems etc.).
- The Project Coordinator ensures Job Placements.
- The Project Coordinator ensures Inclusion in the regional rehabilitation projects entrusted to associations and cooperatives, institutions, indicating the needs of PRITT users.
- The Project Coordinator organises semi-residential rehabilitation treatment (CD) or residential (Psychiatric Rehabilitation Centre, Apartment, Public group or Private Accredited).
- The Project Coordinator ensures that the health care provider sends application for inclusion in relevant District all' UVM.
- The Project Coordinator organises Admission to the Psychiatric Diagnosis and Treatment: he must respect the dignity of the person and of the continuity of care.
- The Project Coordinator ensures Operating Protocol Adoption Coordination SPDC - CSM Pescara Nord.
- The Project Coordinator ensures adherence to procedures for the execution of the Compulsory Health Treatment (T.S.O.).
- The Project Coordinator ensures Taking charge of offender users.
- The Project Coordinator ensures care planning for those already discharged dall' OPG and still in CTR and for those currently still interned in OPG.

The Pescara Nord CSM activates a register of serious cases taken care of and regularly monitors the progress of the therapeutic process through the data of the Regional Information System.

ASSISTANCE TO PSYCHIATRIC PATIENT

There is a Manual of Procedures and an operational protocol for personal health management, nursing, assistance and technical CSM Pescara North and Area Vestina including Integrated social care assessment.

No service system is able to meet alone the needs of the people, because the needs are complex and it is important to have a global view of the nature of the problems.

All of the CSM UOC Operators Pescara and pens are committed, under their personal and professional profile, to ensure that the person with discomfort is considered and appreciated as a bearer of resources and experience, accompanying them in their everyday actions.

All this characterizes our Mental Health Service not only as an organizational model, but also as a model of daily work, which makes use of ideas, projects, concrete achievements, with the aim of reversing a pattern and a way of being and acting imprinted often by prejudice and fear by placing he bearer of discomfort and his family in the centre of the community's attention.

Fight against stigma: against prejudice and mental illness (Amorosi 2014); working step by step, over the years - Strategies to avoid the stigma.

So we want to come from the darkness of the night (deep dark in psychiatry) to the sunrise of a new day through gray days and many difficulties, until we arrive at normality and full integration.

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Appendix 1. Questionnare. Rehabilitation Project Territorial Personal Therapy

Department of Mental Health AUSL of Pescara
Mental Health Center of Pescara Nord - Vestina Area
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Rehabilitation Project Territorial Personal Therapy

Date of issue ..... Service .....
User ..... Born on ..... to .....
Phone numbers .....
Family and / or other role models (Ads, guardian) and telephone number: .....
.....
Diagnosis (ICD-9) ..... Psychiatrist reference .....
Drugs prescribed .....

Pension situation
- □ Working board
- □ Social pension
- □ Invalidity pension (% ..... ; Leg. 68 .....)
- □ Disability with accompanying
- □ Other activity status
- □ Project working ex-harmony

Business bag work project
- □ Project working occupational therapy
- □ Work as employee
- □ Work independently
- □ Housing condition; house owned
- □ House rented

Scale Operation of Personal and Social (FPS module, extracted from the evaluation board VADO)

100-91	Operating more than good in all areas relevant to his age. And 'well-seen by others for its many positive qualities, it seems capable of responding adequately to the problems of life. Interested or engaged in numerous activities.
90-81	Proper operation in all areas, only the presence of problems and difficulties common to many.
80-71	Mild difficulties in one or more of the key areas (eg. Any temporary difficulties in keeping up with the work.)
70-61	Obvious difficulties in one or more main areas, eg. some absence from work not due to physical illness, or occasional acts seem confusing for cohabiting and / or deficiencies of friendships, and / or some light but clear sign of lack of attention to their appearance; no difficulty to play a protected work.
60-51	Marked impairment in one of the areas, eg. absence of friends and difficulty of relationships with family members, but with some social relationship and family problems, or even kept in a protected work; in other areas there may be minor difficulties or obvious.
50-41	Difficulties marked in two or more major areas with no serious or severe dysfunction dysfunction in one main area with no marked dysfunction in other key areas, for example. all the difficulties of the previous level together.
40-31	Severe dysfunction in only one main area with dysfunctions marked in one or more of the three main areas (eg. No socially useful activity, the absence of social acquaintances, but discrete relationship with at least one family.)
30-21	Severe dysfunction in two major areas, or serious dysfunction in disturbing behavior with and without disabilities in three main areas.
20-11	Serious dysfunction in all three main areas, or even very serious dysfunction in disturbing behavior with and without disabilities in other areas. In giving the score, if the pc responds attributed 20-16, if it responds poorly to external stimuli give a score between 15-11
10-1	Lack of autonomy in the basic functions with extreme behaviors (eg. Deliberate defacation) but no life-threatening, or score from 5 ad1, inability to maintain autonomy in the basic functions, such as to threatening the survival (death due to malnutrition, dehydration, infections, inability to recognize the obvious danger.)
0	Insufficient information to give a score to the FPS scale.

N. B. Assign a score taking into account that the assessment covers the following areas:
social, personal relationships, self-care, disturbing behavior.

Appendix 1. Continues

Priority objectives of PRITT: .....

Activities 'under the rehabilitation CSM' that the user needs:

Training for basic skills (self-care , money management , management of the living space ...) ..... □
Psychoeducational interventions to improve insight , compliance and lifestyle ..... □
Training for social skills (communication , socialization ...) ..... □
Cognitive rehabilitation programs (MCT – IPT) ..... □
Art therapy and/or music therapy ..... □
Self-mutual-help groups with a facilitator ..... □
Recovery and protection of the rights of citizenship (leg.104, pension, employment, housing ...) ..... □
Interventions with significant figures (family members, guardians, support administrators ...) ..... □
Training and secure employment ..... □
Activities external contexts to promote social articulation ..... □
Recreation and risocialisation ..... □
Sport and physical activity ..... □
Ssychoeducation groups with family members ..... □

Review of Operating Personnel and Social (for measuring outcomes)

100-91
90-81
80-71
70-61
60-51
50-41
40-31
30-21
20-11
10-1
0

T0 T1 T2 T3 T4 T5 T6

Team of User Reference:

Psychiatrist .....
Psychologist ..... TRP .....
Ass. Soc. ..... Inf. Prof. .....
Case Manager .....
The CSM Director ..... You .....

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