NHS

National Treatment Agency
for Substance Misuse

Care planning practice guide

National Treatment Agency for Substance Misuse

August 2006

The National Treatment Agency for Substance Misuse

The National Treatment Agency for Substance Misuse (NTA) is a special health authority within the NHS, established by Government in 2001, to improve the availability, capacity and effectiveness of treatment for drug misuse in England.

Treatment can reduce the harm caused by drug misuse to individuals' well-being, to public health and to community safety. The Home Office estimates that there are approximately 250,000–300,000 problematic drug misusers in England who require treatment.

The overall purpose of the NTA is to:

- Double the number of people in effective, well-managed treatment between 1998 and 2008
- Increase the percentage of those successfully completing or appropriately continuing treatment year-on-year.

Reader information

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1 Introduction

1.1 Why produce a practice guide?

The National Treatment Agency's Treatment Effectiveness strategy (2005–08) focuses on improving the quality of drug treatment provision, to match the improvements in access and capacity that have already been achieved. It applies to the treatment of adult drug misusers in England.

This guide forms part of a series of resources designed to improve drug treatment effectiveness at practice level and is intended:

- To provide guidance to improve the effectiveness of care planning
- To provide a framework for services that provide structured drug treatment, to plan and review the care they provide to service users
- To assist practitioners in tailoring care planning to specific phases in the client's treatment journey, focus on engagement, delivery, community integration, and either maintenance in treatment or exit from treatment
- To set out the necessary elements of care planning while retaining flexibility to allow for individual client needs or variations in local services
- To provide guidance on integrating care planning into clinical governance and performance management mechanisms.

1.2 Who is the guide for?

The guide is designed for practitioners and service managers at service level who are providing structured treatment. It will also be useful to local commissioning bodies, including primary care trusts and strategic partnerships when commissioning effective care at practice level.

Many practitioners are already using care planning effectively as a way to improve practice and this guide will be a useful benchmark against which to consider their practice. For others, this guide will be an introduction to the care planning process.

1.3 What is it?

This guide is divided into sections, which are designed to support enhancement of the delivery of effective care planning at practice level. It is not intended to provide a blueprint for practice but to present service providers with guidance to enhance care planning. It provides guidance on integrating care planning into performance management and clinical governance mechanisms.

The practice guide is supported by the e-care planning package (eCP), which is available on the NTA website. The guide, including proforma documents on using nodal link mapping to assist with care planning, can also be downloaded from the NTA website, www.nta.nhs.uk.

2 Drug treatment context

2.1 Care planning policy framework

2.1.1 Background

Care planning is not a new concept and has been a central feature of patient care for many years, particularly in nursing practice. The NHS and Community Care Act 1990 (HMSO, 2000) recommended the routine use of care planning.

2.1.2 Drug treatment reports

Changing Habits (Audit Commission, 2002), the first Audit Commission report on substance misuse treatment identified the underdevelopment of care planning at practice level and the need to develop individual care plans for all service users as well as care co-ordination for those with complex needs.

The second Audit Commission report, Drug Misuse 2004: Reducing the Local Impact (Audit Commission, 2004), identified the improvements made since the publication of Changing Habits. It also identified the further improvements needed to ensure clients' health, social functioning, employability, housing status, and other factors likely to enable clients to achieve stability and contemplate progression out of treatment. The report noted that clients were often unsure about their treatment and were not fully involved as active partners in their care.

2.1.3 Models of Care 2002 and Models of Care: Update 2006

The central role of care planning in drug misuse treatment was identified in Models of Care for Treatment of Adult Drug Misusers (NTA, 2002), which outlined the role of care planning and care co-ordination as key elements of an integrated system of treatment for drug and alcohol misusers. Models of Care 2002 sets out requirements for commissioners and providers to improve systems of care planning in local areas.

Models of Care 2002 identified that service users should have access to appropriate and effective assessment, care planning and care co-ordination. It stated that all those who enter into structured drug and alcohol treatment services should receive a written care plan, agreed with the client and subject to regular review with the keyworker or care co-ordinator. It set out the criteria for care co-ordination for clients with more complex needs, as well as identifying competency frameworks for care co-ordinators and the process for integrating care planning into treatment systems.

Models of Care 2002 has been updated to reflect changes in the drug treatment field, developments in the criminal justice system, recent rises in blood-borne virus infections and the need for Models of Care to link closely to the Government's Treatment Effectiveness strategy.

Models of Care: Update 2006 (NTA, 2006) identifies the need for commissioners and providers to increase their focus on improving the client journey, through a structured care planning approach, by building on the framework of good practice guidelines for assessment, care planning and co-ordination of care provided in Models of Care 2002. Care planning is identified as a cyclical process of assessment, delivery and review, where the changing needs of service users are identified and responded to. Models of Care: Update 2006 identifies that care planning is a key component of structured drug treatment interventions.

Although the principles of care planning and the co-ordination of care set out in Models of Care 2002 are the same, there are some differences articulated in Models of Care: Update 2006. The previous levels of "standard" and "enhanced" care co-ordination are no longer referred to – instead the term "care planning" is used to describe the process for all cases. But there is a clear acknowledgement that clients have a range of needs, from simple to highly complex, and this must be reflected in the nature of the care plan and the degree of co-ordination of care explicitly described in it.

2.1.4 Standards for Better Health

The purpose of the standards is to provide a common set of requirements applying across all healthcare organisations, to ensure that health services are safe and of an acceptable quality and provide a framework for continuous improvement.

Models of Care: Update 2006 specifically supports service development towards development standard D2, which states patients receive effective treatment and care that:

- Conforms to nationally agreed best practice, particularly as defined in the national service frameworks, NICE guidance, national plans and agreed national guidance on service delivery
- Takes into account their individual requirements and meets their physical, cultural, spiritual and psychological needs and preferences
- Is well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations
- Is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

Models of Care: Update 2006 also integrates quality standards identified in the NHS Improvement Plan, Putting People at the Heart of Public Services (DH, 2004) and the Department of Health's Standards for Better Health (DH, 2004), and identifies a new quality requirement (QRP 7) for service providers to

demonstrate “structured treatment delivery: a care planning approach to deliver positive change in clients life”.

2.1.5 NTA and Healthcare Commission Improvement Reviews

The NTA has worked in partnership with the Healthcare Commission to develop detailed criteria for reviewing drug and alcohol treatment services, and carrying out these reviews. These criteria are developed during the process of themed annual improvement reviews of drug treatment systems. Improvement Reviews will review local providers and commissioning functions against these criteria and against Standards for Better Health (DH, 2004).

The reviews for 2005/06 were piloted and developed in consultation with the drugs field. Detailed criteria have been developed for reviewing care planning and co-ordination, and community prescribing, and were published in 2005. They are available on the NTA website at www.nta.nhs.uk. Criteria for future reviews will also be available from the NTA website.

Upcoming themes are:

- 2006/07: Systems management (across the key elements of risk management, patient choice, diversity and effective partnerships) and harm reduction provision
- 2007/08: Tier 4 treatment and diversity (to be confirmed).

There are two parts to an Improvement Review. In the first part, the performance of all organisations taking part in the review is assessed. Using a standard framework, an initial assessment is made of the performance of each DAT and participating healthcare organisation. Wherever possible, this is done using nationally held data to reduce the burden on treatment providers. In the second part, the minority of organisations or treatment systems (approximately ten per cent) that have the weakest assessments are helped in developing an action plan to improve their performance.

The assessments are focused on a small number of key outcomes and quality measures that matter most to patients and the public, and on the key features of services that are necessary to achieve good outcomes and quality for patients and the public.

More detailed information on the review process can be found on the NTA website at www.nta.nhs.uk, and the Healthcare Commission website at www.healthcarecommission.org.uk.

2.1.6 Drug and Alcohol National Occupational Standards (DANOS)

DANOS (Skills for Health, 2003) specifies standards of performance that people in the drugs and alcohol field should be working to. They describe the knowledge and skills workers need in order to perform to the required standard. The DANOS standards describe a wide range of the functions and activities involved in improving the quality of life for individuals and communities by minimising harm associated with substance misuse. There are three key areas in DANOS: service delivery, management of services and commissioning services. More information on DANOS, and the standards, can be found at www.skillsforhealth.org.uk/danos.

The Care Planning Practice Guide refers to DANOS standards that are relevant to particular phases of care planning – engagement, treatment delivery, community integration and treatment completion. See section 5.4 for more details.

2.1.7 Quality in Alcohol and Drugs Services (QuADS)

QuADS (Alcohol Concern and SCODA, 1999) was developed jointly by Alcohol Concern and DrugScope for the Department of Health, and is still widely used by alcohol and drug treatment services throughout England as the set of quality standards for organisations in the sector. QuADS outlines standards for care planning (Section 3: Core care standards, sections 25, 26 and 27). Under the standard statement, “Care planning is based on assessed need and actively involves the service user”, criteria are set out that treatment services should be able to demonstrate, in order to show they meet these expectations.

2.2 Harm reduction in the context of care planning

For some years now, a range, or hierarchy, of goals of drug treatment has been identified in the UK (ACMD 1988, 1989; DH, 1996). These are:

- Reducing health, social and other problems directly related to drug misuse
- Reducing harmful or risky behaviours associated with the misuse of drugs (e.g. sharing injecting equipment)
- Reducing health, social or other problems not directly attributable to drug misuse
- Attaining controlled, non-dependent or non-problematic drug use
- Abstinence from main problem drugs
- Abstinence from all drugs.

In their broadest sense, “…harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs.” (UKHRA, 2005).

Reducing harm from an individual’s drug use will be an important element of care, especially during the engagement phase of treatment. The principle of a hierarchy of goals is a useful one in helping clients look at any of their treatment objectives in a systematic manner.

2.3 Criminal justice

2.3.1 The Drug Interventions Programme

The Drug Interventions Programme (DIP) is a critical part of the Government's strategy for tackling drugs. DIP involves criminal justice and drug treatment providers working together with other services to provide a tailored solution for adults who commit crime to fund their drug misuse. Delivery of DIP at a local level is through drug action team partnerships, using criminal justice integrated teams (CJITs) with a case management approach to offer access to treatment and support. There may be particular considerations for clients in contact with CJITs with regard to care planning and some of these are explored in this document.

For more information on DIP, the Drugs Act and drug treatment in prisons, see Models of Care: Update 2006.

2.4 Treatment Effectiveness strategy – improving client outcomes

The delivery of timely, effective treatment is key to meeting a number of aims of the Updated Drugs Strategy (Home Office, 2002). Effective, well-delivered treatment improves the health and social functioning of individual drug misusers, with evidence that improvements apply to wider social and public health outcomes than just drug-using behaviour (Gossop, 2006).

The NTA Treatment Effectiveness strategy, launched in June 2005, identifies some of the critical success factors to improving drug treatment and bases a delivery plan for 2005–08 upon them. It identifies the need to refocus activity by prioritising the development of the quality and effectiveness of treatment to match the improvements in access since 2001.

One of the critical success factors in delivering improvement in clients' lifestyles and drug-related behaviour, identified in the Treatment Effectiveness strategy, is effective care planning. This should include frequent reviews of care plans, with clients as partners in their drug treatment.

There is now a wealth of empirical evidence to suggest that good care planning – embedded in policies, procedures, monitoring and evaluation – improves client outcomes. Evidence from US methadone programmes suggests services that responded to clients' needs, provided the help they required and actively involved them in care planning, were much better in enabling clients to stay in treatment longer and achieve abstinence from illicit drugs (NTA, 2005).

3 Care planning and drug treatment journeys

The following section describes the stages of the treatment journey and how they are relevant to effective care planning.

3.1 Care planning and structured drug treatment

Care planning is the process of setting goals and interventions based on the needs identified by an assessment and then planning how to meet those goals with the client. Care planning is a core requirement of structured drug treatment. Models of Care: Update 2006 identifies care planning as a key component of Tier 3 and Tier 4 structured, specialist drug treatment interventions. Tier 2 interventions can be included in care plans, in situations where structure is important

Structured drug treatment consists of a range of interventions linked by care planning and keyworking. It may include a client receiving a range of drug treatment interventions concurrently or sequentially, including advice and information, harm reduction interventions, specialist and GP community prescribing, structured day programmes, day care, residential rehabilitation, inpatient drug treatment, structured psychosocial interventions and other structured treatment, including some structured packages of care and some forms of day care.

3.2 Care planning and the client journey

Care planning needs to be delivered within a framework that focuses on the service user's treatment journey. The progression through the drug treatment system was described by the Audit Commission (Audit Commission, 2004) as the client journey and the NTA Treatment Effectiveness strategy divides the treatment journey into four overlapping components

1. Treatment engagement
2. Treatment delivery (including maintenance)
3. Community integration (which underpins both delivery and treatment maintenance or completion)
4. Treatment completion (for all those who choose to be drug-free and who can benefit).

This provides a framework for care planning, which should be specifically targeted and focused on setting goals and objectives, and monitoring outcome in relation to these four stages in the client journey.

Recent research mapping clients' journeys suggests that clients may not fit neatly into sequential stages of engagement, provision and exit from treatment. Therefore, this framework is not intended to be a blueprint for practice but to illustrate that care planning should be a dynamic and evolving process, which needs to be focused on developing interventions at critical points in clients' drug using careers or treatment journeys. A framework for viewing the client journey is provided in Figure 2. The model illustrates how a client enters the treatment system and where the process of care planning happens.

It will be apparent that although it will be useful to see the phases of the treatment journey as conceptually separate, and that these can inform the forms of care plans at different stages, there is room for considerable overlap. They can be particularly helpful in maintaining a focus on the treatment journey.

Key aspects of the process are:

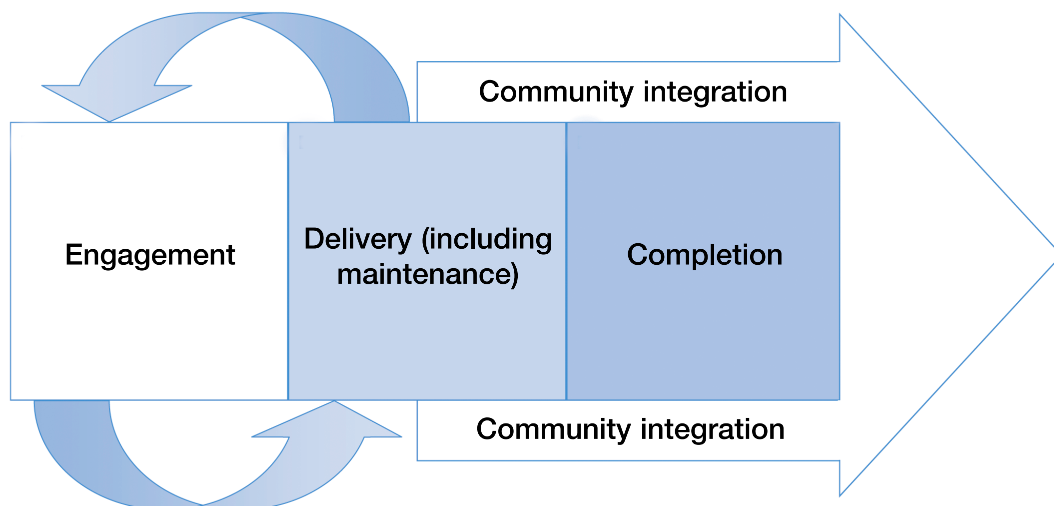

Figure 1: The client's journey

3.2.1 Contact with service providers

Clients may enter the treatment system through a wide range of service providers, including into or from primary care, from CJITs, CARAT (counselling, assessment, referral, advice and throughcare) services and other criminal justice routes (such as probation), and from general medical or psychiatric services. Clients often also present themselves to service providers.

3.2.2 Screening assessment

Screening assessment is a brief process that aims to establish whether an individual has drug and alcohol problems, related or co-existent problems, and whether there is any immediate risk for the client. The assessment should identify those who require referral to drug treatment services and the urgency of the referral. As part of this initial contact, it is likely that the assessor may also provide the client with information about substance use and service providers, and information aimed at reducing harm associated with drug or alcohol use. In some settings and with some clients, other interventions may be delivered at this point to enhance the client's engagement with the treatment system, such as a brief motivational intervention.

3.2.3 Triage assessment

Once drug and alcohol problems have been identified, the client undergoes a triage assessment either with the same assessor or another assessor following referral. In many substance misuse services or enhanced primary care service settings, the screening assessment and the triage assessment processes will take place at the same contact with the client.

The aim of triage assessment is to determine the seriousness and urgency of a client's problems and the most appropriate type of treatment for the client. It involves a fuller assessment of the individual's drug and alcohol problems than is conducted at screening, as well as assessment of a client's motivation to engage in treatment, current risk factors and the urgency of need to access treatment. As a result of a triage assessment, a client might be offered services within the assessing agency or onward referral to another service. A further outcome of triage assessment is that work is undertaken, where appropriate, to further engage and prepare the client for treatment.

Therefore, triage assessment aims to identify the nature and extent of a client's drug or alcohol use, and then focuses specifically on identifying any immediate needs that will impact on the client's likely engagement with the service or treatment process.

3.2.4 Initial care plan

In some situations, a brief initial care plan may be developed or may be required (e.g. due to identified level of risk) after a triage assessment. This will involve identifying needs, setting goals and planning interventions that assist the client to access, then engage in, comprehensive assessment and treatment over the first weeks following triage and may be focused on reducing specific identified risks. Examples of this type of intervention would include delivering a brief motivational intervention and access to rapid prescribing. The initial care plan will be developed with the allocated keyworker for the initial care plan, whose role is to build and maintain a positive relationship with the client, deliver one or more elements of that care plan (depending on the keyworker's qualification, training, skills and experience) and to co-ordinate input from other providers as needed.

The initial care plan is particularly relevant to CJIT and CARAT clients, all of whom will receive an initial care plan after triage-level assessment if taken onto the caseload. The initial care plan is set at the level of Tier 2 interventions. If an initial care plan identifies the need only for Tier 2 interventions, this will need to be reviewed with the client at regular intervals. If the presenting needs increase the client may have to be referred for a comprehensive assessment.

The initial care plan should include details of the keyworker and agency responsible for the initial care plan, a description of the immediate needs, risks and goals identified, and the planned interventions. For more details on the contents of the initial care plan, see section 8.2.

3.2.5 Comprehensive assessment

Clients should have a comprehensive assessment of their needs as soon as possible. In urgent cases, access to comprehensive assessment should be fast-tracked in line with local policies and be consistent with risk management and clinical governance policies. Following the triage assessment phase, a referral for comprehensive assessment may be made within the service providing triage, or referral may be to another service. The assessment may need to include more than one practitioner (e.g. a prescribing assessment can only be done by a doctor or independent prescriber). A comprehensive assessment may take place over a few weeks and involve assembling information from a variety of sources. Responsibility for completion of the comprehensive assessment must be clear, and services often have a named allocated worker leading for each case. There may be instances where delivery of interventions described in an initial care plan has been sufficient to resolve clients' substance misuse problems. In these circumstances a comprehensive substance misuse assessment would not be indicated.

3.2.6 Comprehensive care plan

Following a comprehensive assessment, a comprehensive care plan should be agreed with the client. It should cover client need as identified in one or more of four key domains:

- Drug and alcohol use

- Physical and psychological health
- Criminal involvement and offending
- Social functioning.

All clients require a comprehensive care plan if they are to receive structured treatment interventions. Again, the comprehensive care plan will be developed with an allocated keyworker, whose role may include building on any treatment engagement work commenced in an initial care plan, if one was needed (see Figure 3), delivering one or more elements of the comprehensive care plan (depending on the keyworker's qualification, training, skills and experience), and co-ordination of input from other providers.

It is important to recognise multidisciplinary involvement in care planning and to appreciate that the role of an allocated keyworker is to oversee the process of multi-practitioner and multi-agency planning, co-ordination and delivery of care,

3.2.7 Discharge and aftercare plans

This is where clients and keyworkers (and other involved practitioners) plan interventions that will assist clients in remaining drug-free and consolidating the progress they have made.

3.3 Treatment phases

3.3.1 Treatment engagement

During the engagement phase of treatment, service users will need to be assessed to ensure treatment can be tailored to their needs. At this stage, they may benefit from motivational work focused on maximising engagement. A specific process of induction into treatment may enhance the engagement of service users, during which it is made clear and comprehensible for individuals what are the roles and responsibilities of the service provider and what are the expectations on service users themselves.

This phase lasts until clients are able to start looking at goals specifically directed at their treatment goals, rather than outcomes specifically concerned with keeping them in treatment. It may last weeks or months and may continue, or be reinitiated, at different times throughout treatment. Interventions delivered in the treatment engagement phase may be described in initial care plans and comprehensive care plans.

3.3.2 Treatment delivery

This phase is when the main treatment interventions identified in the comprehensive care plan are delivered. This may last weeks, months or, in some cases, years. An essential element of this phase of the care planning process is the keyworker ensuring the care plan is regularly reviewed with the client and other care providers. The needs of clients will usually determine the frequency of a care plan review, but this should take place every three months or, at a minimum, annually.

Drug treatment practitioners should work to build effective therapeutic alliances with service users, encouraging full participation in delivering their own care plans. Good-quality drug treatment should be associated with improvements across a range of domains, including an individual's substance use, health, social functioning, and in reduced public health and offending risks posed to others. In the delivery of drug treatment, a greater emphasis is required on improving service users' physical and mental health, especially those with hepatitis C infections and those misusing alcohol.

Service users who are stable but wish to be maintained on substitute opioid medication should have opportunities to receive social support, education and employment where appropriate. In such cases, delivery and community integration often run alongside each other for a period of time. For stable individuals who do not need to continue in specialised drug treatment services, there should be clear pathways into maintenance and monitoring in primary care settings. However, it is vital that these service users have explicit accessible pathways back into specialised structured drug treatment services if required (for example, in case of relapse).

In the treatment delivery phase, it is particularly important to ensure clear and, if necessary, incremental goals, and to monitor achievement of these or a review. It is also important that regular review takes place to ensure that community integration interventions and focus on completion can occur in suitable cases, and are not delayed.

3.3.3 Improving community integration

Whether service users are in treatment (e.g. maintained on substitute opiate medication) or leaving treatment, they should have access to a range of social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains they have made during treatment. The care planning process can be developed to ensure these issues are addressed carefully and systematically.

3.3.4 Improving treatment completion

Few service users who enter drug treatment intend to be in specialist drug treatment indefinitely. For those who wish to be drug-free, commissioners and providers need to create better pathways and exits from specialist drug treatment.

These pathways should include drug-related support (e.g. relapse prevention, mutual support groups, advice and harm reduction) and non-drug-related support (e.g. access to housing, supported accommodation, relationship support, education and training, support to gain employment, and parenting and childcare responsibilities).

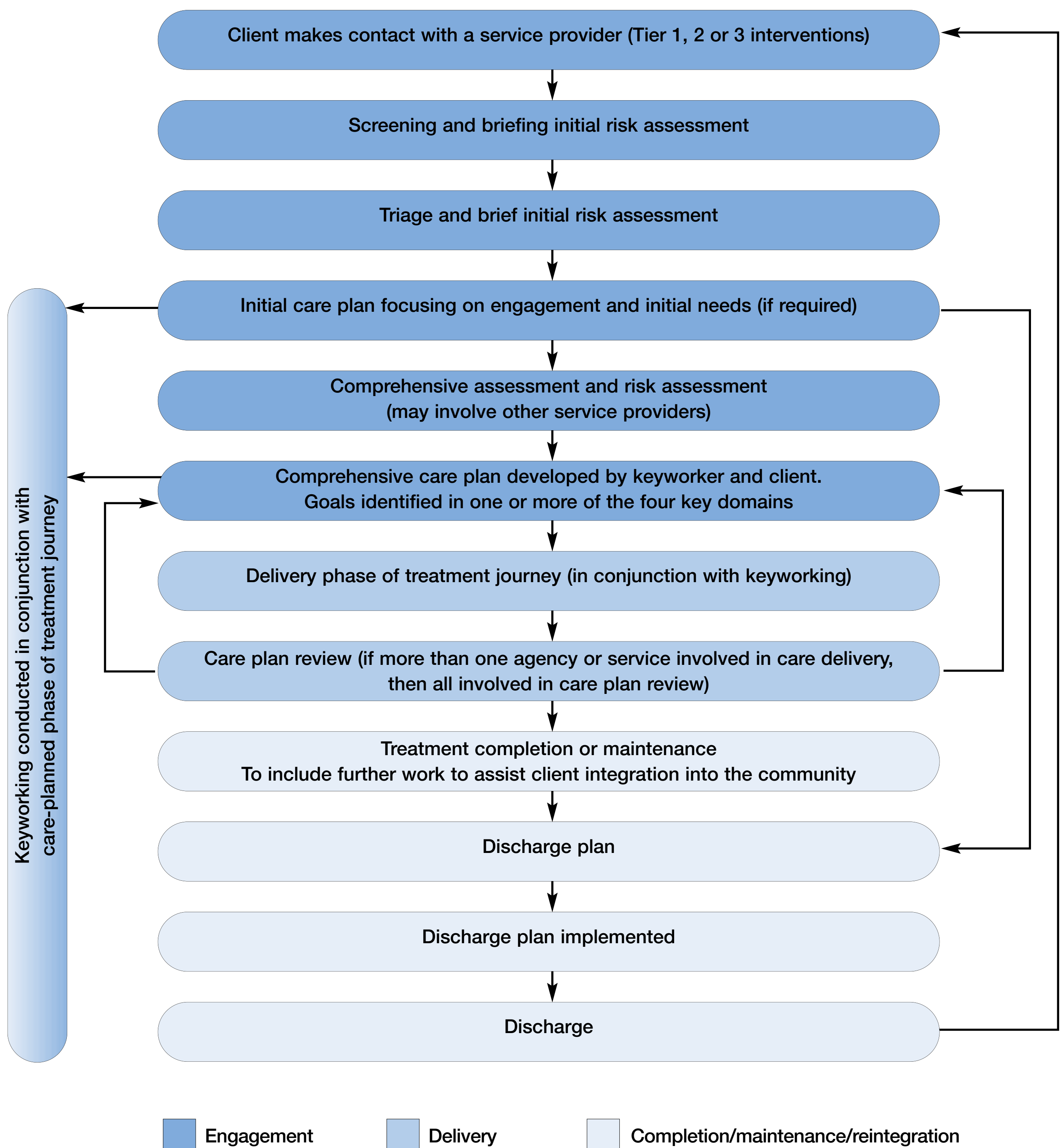

Figure 2: Standard client treatment journey – with initial care plan option included

The care plan can add value at this stage by describing and providing a vehicle for communication in transitional arrangements, and ensuring that aftercare arrangements are developed, or planned for, prior to exit from structured treatment.

3.4 Client treatment journeys

Although it is useful to see the phases of the treatment journey as conceptually separate – and these can inform the forms of care plans at different stages – there is room for considerable overlap.

They can be particularly helpful in maintaining a focus on the treatment journey.

3.5 Care planning and the service user

Care planning should be a partnership enterprise and all care plans should be developed and agreed with the client. Clients should be fully engaged as partners and owners in the delivery of their care. Clients need to agree with, and be involved in developing, all aspects of their care plan. It is particularly important that clients are involved in care plan reviews and in setting new goals. Only by including clients can achievable goals be set, linked specifically to clients' needs.

In 2005, the NTA carried out the first survey of drug service users in England. The survey was designed to provide an opportunity for service users to give their views on the quality of treatment they received. Questionnaires were distributed to 900 drug treatment services identified across England – of these, 6,770 service users from across the country completed and returned their questionnaires. In relation to care planning, the survey found that the majority of service users had a care plan but there were variations in how often this was reviewed. Nineteen per cent of clients did not have a care plan at the time of the survey. Fifty-two per cent had a care plan that had been revised in the last three months – these were the people that were most likely to be satisfied with their treatment. Clients with a care plan that had been reviewed 3–12 months previously had the next highest satisfaction score, followed by those with a care plan that had been reviewed over a year ago. Clients without a care plan were most likely to be dissatisfied with their treatment experience.

Clients who reported high levels of satisfaction also reported drug treatment was having a positive impact on their drug use and criminal behaviour.

Care plans should be developed in a way that empowers clients to take control over their health. In appropriate circumstances and with the client's consent, carers, family and significant others should be included as partners in the care planning process.

Where necessary, client responsibilities and actions should be specified. They should sign and retain copies of their care plans.

A useful framework for encouraging client-led identification of needs and goals is available on the NTA website, www.nta.nhs.uk.

4 The care planning process

4.1 Developing a care plan from an assessment

Substance misuse assessment is a process to establish the nature and extent of drug and alcohol misuse and what level of need an individual may have. Assessments vary in depth and level of detail.

4.1.1 Initial care plan

A triage assessment may identify the need for access to comprehensive assessment but, in instances where clients have urgent needs, the assessor may wish to develop an initial care plan prior to comprehensive assessment. Any such initial care plan should focus on engaging and preparing clients for treatment and addressing a range of immediate needs, such as referral for rapid prescribing and urgent housing concerns. Triage assessment and the initial care plan are means of engaging clients in treatment by focusing on immediate concerns and ensuring fast-track treatment delivery.

If an initial care plan is developed following triage, a keyworker should be appointed to take responsibility for the client's initial care plan. Where an initial care plan has been developed for the client, the identified keyworker should ensure comprehensive assessment is undertaken or that appropriate referral is made to an alternative agency to ensure this happens.

4.1.2 Comprehensive care plan

Comprehensive assessment underlies planning and delivery of structured treatment and other interventions. It may be undertaken solely by the keyworker or in conjunction with other professionals and services, and may be developed using systems of multidisciplinary team working. The result of this process will be the development of a comprehensive care plan, describing the planned agreed actions aimed at addressing the needs and goals identified through the initial and ongoing comprehensive assessment.

Not all clients, particularly those in contact with CJITs, will be required to undergo a comprehensive assessment or require structured treatment. These clients will remain on an initial care plan, which will need to be reviewed with the client at regular intervals. If the presenting drug misuse needs increase, clients may have to be referred for a comprehensive assessment. If clients' needs remain below the threshold for structured drug treatment, they will remain on their initial care plan, which will be reviewed regularly until they are discharged from the CJIT.

One technique that might assist the development of a care plan is node-link mapping (also referred to as mapping). This provides a structure for keyworkers and clients to explore problems (and personal strengths), identify goals, develop plans and undertake specific actions to address goals. This process is described in more detail in a separate document on nodal link mapping, available on the NTA website, www.nta.nhs.uk

4.2 Risk assessment

Assessing risk is an important part of screening, triage assessment and comprehensive assessment, and provides information that will inform the care planning process. Risk assessment should be substance misuse specific as well as reflecting service-wide risk assessment protocols. Substance misuse specific risks that may need to be prioritised in the care planning process could include risks related to overdose, polydrug use or unsafe injecting practices. Wider priorities identified may include risks related to vulnerability, self-harm or harm to others.

The assessment process should result in a written document that can be referred to and used as a basis for discussing care planning, goals and objectives with the client.

4.3 Comprehensive care planning domains

The range of difficulties experienced by drug misusers are sometimes conceptualised as domains. Models of Care: Update 2006 identifies the need to ensure that four key domains are addressed through effective care planning while clients are in treatment, as well as any other needs identified as important in particular cases. Although the priority given to different domains of functioning or need may change throughout the client's journey through treatment, the focus of care planning is to plan interventions which realise benefits and monitor progress in each of these four key domains. Services should be able to show that benefits have been achieved by clients throughout treatment across them.

It is important that the four key domains are presented in a simple way using milestones and interim goals where appropriate. The domains are listed below. Examples of the types of areas covered by a domain are outlined in Appendix 1 and in the e-care planning package (eCP) which is available on the NTA website, www.nta.nhs.uk.

4.3.1 Drug and alcohol use

- Drug use, including types of drugs, quantity and frequency of use, pattern of use, route of administration, source of drug (including preparation) and prescribed medication
- Alcohol use, including quantity and frequency of use, pattern of use, whether in excess of "safe" levels and alcohol dependence symptoms.

4.3.2 Physical and psychological health

- Physical problems, including complications of drugs and alcohol use, blood-borne infections and risk behaviours, liver disease, abscesses, overdose and enduring severe physical disabilities. Pregnancy may also be an issue
- Psychological problems include personality problems or disorders, self-harm, history of abuse or trauma, depression and anxiety and severe psychiatric co-morbidity. Contact with mental health services will need to be recorded.

4.3.3 Criminal involvement and offending

- Legal issues including arrests, fines, outstanding charges and warrants, probation, imprisonment, violent offences and criminal activity. Involvement with workers in the criminal justice system, for example probation workers.

4.3.4 Social functioning

- Social issues, including childcare issues, partners, domestic violence, family, housing, education, employment, benefits and financial problems.

4.4 Goal setting

Once the areas of client need have been identified, during triage or comprehensive assessment, the keyworker and client prioritise those needs. Appropriate goal setting is essential to effective care planning. An important mechanism for enhancing treatment effectiveness can be to identify goals that enable clients to identify small incremental changes in functioning in specific domains. If a client can achieve small incremental changes and gain recognition from keyworkers or other workers providing therapeutic services, this can increase motivation by enhancing self esteem and self efficacy.

4.4.1 SMART goals

Goals in care plans should be SMART (specific, measurable, achievable and realistic, time-limited).

- **Specific** – goals need to be very clear. There should be no ambiguity about a goal. Both keyworker and client should be able to describe in detail and agree what they expect to be achieved. The way a goal is written into a care plan needs to be very specific and unambiguous, so keyworkers and clients still agree about what should have been achieved when it is reviewed.
- **Measurable** – most goals can be measured directly or indirectly. For example, if clients wish to reduce their drug use, then the goal should not simply read "reduce heroin use", but should specify by how much and over what period. It is possible to measure this latter goal if frequency of opioid-negative urine samples is an appropriate measure, but this is not useful if the aim is to reduce daily heroin consumption each day. This might be measured by an expected improvement in injection sites or other indicators of improved stability. It is important to be able to be clear about what has or has not been achieved when the care plan is reviewed.
- **Agreed** – the client must agree with any goals and be fully involved in developing and reviewing them.
- **Realistic** – it is a common problem in care plans for goals to be unrealistic. For example, abstinence from drugs may be a goal shared by the client and keyworker, but a client's previous treatment progress may indicate this would be difficult to achieve in the timescale covered by the care plan (usually three months). Therefore, helping the client to set a more achievable and realistic goal – such as a reduction in illicit use by an agreed amount – would be more productive, as would other markers of less harmful use, such as improved wound care. Goals may need to be hierarchical, with limited ones being set initially, despite an overall goal being desired in time.
- **Time limited** – all goals should have a time limit set, within which the keyworker and client expect the agreed changes to have taken place. Goals without time limits may be postponed to some unspecified future time and never be addressed directly. Setting a time limit helps keyworkers and clients focus attention on actions that need to be taken. Furthermore, care plans need to be reviewed on a regular basis and the agreed frequency of review provides a framework within which the keyworker and client can decide whether a goal has been achieved. Some goals might be achieved quickly and this may trigger an unscheduled care plan review, with new goals set within new time limits.

4.4.2 Other considerations

When developing goals with a client the keyworker must also consider the following:

- Who is responsible for the interventions targeting the goals or actions to be taken? A number of interventions may be identified in the care plan and these may involve a number of different staff members working with a client. For example, a keyworker may work with a client on safer injecting, while a group worker may be working with the client's participation in a structured day programme and a GP may take the lead on managing a prescription. In each case, the people responsible for helping the client achieve the goal, using the intervention, should be specified
- A client may be unwilling or unable to work on a goal at any one time. This should be acknowledged either when goals are being set or at the care plan review

- A care plan is a collaborative venture which will always involve the client but may also require the involvement of other practitioners or services
- Clearly, some clients may not have needs in a particular domain – they may, for example, not have housing or employment problems. Other clients may have problems across all domains. Although clients may have wide-ranging needs, the care plan should not be very complex**.** It needs to be realistic and priority setting must happen to allow the client to focus on SMART goals. Even if longer-term goals are described, it should be clear what goals should be achieved by the next care plan review
- Occasionally, clients may have difficulty identifying goals even though they recognise their needs in a certain domain. In this situation, keyworkers might assist clients to identify goals using techniques such as node-link mapping.

4.5 Care plan contents

A care plan is a record of the care planning process. It should be brief and readily understood by all parties involved. A care plan is a structured, often multidisciplinary, task-oriented individual care pathway plan, detailing the essential steps in the care of clients and describes the expected course of their expected treatment and care. The care plan involves the translation of the needs, strength and risks identified into a written document that is responsive to the phase of the client journey. It is used as a tool to record changes in the situation of the client and can be used with other methods of communication, as appropriate, to keep other relevant professionals aware of these changes to assist in monitoring progress.

The care plan must:

- Set the goals of treatment and milestones to be achieved (taking into account the views and treatment goals of clients and developed with their active participation)
- Set goals in some, or all, of the four key domains, to ensure that the focus is on a range of the client's needs
- Indicate the interventions planned and which agency and professional is responsible for carrying out those interventions
- Make explicit reference to risk management and identify the risk management plan and contingency plans where needed
- Identify the engagement plan to be adopted with clients who are difficult to engage in the treatment system
- Identify the review date.

At a minimum, the care plan should include:

- Client name
- Keyworker name
- Identified goals in relation to specific interventions planned
- Roles and responsibilities of keyworker and client
- Name and roles of other individuals identified in delivering care (including the GP)
- Review date
- Client signature
- Keyworker signature.

A checklist of care plan contents is outlined in section 8.

4.6 Care planning and keyworking

The keyworker is a dedicated and named practitioner responsible for ensuring the client's care plan is delivered and reviewed. This would normally be the practitioner in most regular contact with the client. However, given the range of settings in which structured treatment is provided, the keyworker may be a drug worker, criminal justice worker, nurse or doctor. In primary care the keyworker may be the GP, but more commonly would be a drug worker supporting the GP.

As good practice, keyworking involves the building of a therapeutic relationship with the client, during and following comprehensive assessment, and then developing and ensuring implementation of a comprehensive care plan. In the case of the development of an initial care plan following triage assessment, the keyworking role will occur at an earlier stage but the allocation of keyworker for the comprehensive care plan will be determined by the subsequent comprehensive assessment and local practice.

As a minimum, the following should be delivered during keyworking sessions:

- Developing and agreeing the care plan with the client, monitoring implementation of the care plan and checking progress against milestones in the care plan, and delivering elements of this directly as appropriate
- Providing information and advice on drug and alcohol misuse
- Directly delivering, or ensuring delivery of, harm reduction work and motivational interventions
- Directly delivering other psychosocial and medical interventions, as described within the care plan, and subject to the competency and agreed role of the keyworker.

This would normally involve regular meetings between the keyworker and the client, where progress against the care plan would be discussed and revised as appropriate. Another crucial component of keyworking is liaising and collaborating with other providers to co-ordinate care (and other key agencies involved with the client, such as probation offender managers and housing workers). This may include referral, liaison or joint working towards goals with other service providers and tracking client progress across a range of providers.

For clients in contact with CJITs or CARATs, the keyworking role may be described as case management.

4.7 Confidentiality and information sharing

Part of the assessment process should be establishing with a client how information relating to them may be shared and for what purpose. This may be revisited as part of the care planning process, although it should have begun at the time of assessment. Agencies should have clear policies about how assessment information and care plans are shared. The limits of confidentiality generally must also be explained early, so that relationships with staff and the keyworker are based on an appropriate understanding of these issues.

The care plan record can involve input from a range of practitioners, service users and carers, and from a number of agencies. A care plan record could also be used to share information with others involved in the care plan, in line with service policies on confidentiality and the sharing of information. If care plans are used as information sharing tools, it is important that, as for all personal clinical information, the minimum information required for this purpose is shared, while maintaining its value as a core tool for working with clients. This approach should help to minimise the number of situations in which the care plan cannot be shared without alteration, due to lack of required consent. For example, very sensitive information may not sensibly be presented in this format (and the related goal and intervention in such a case may be described in the care plan to reflect this sensitivity appropriately).

All services should have clear policies on confidentiality, consent and information sharing, which are agreed with partner agencies. These should be made explicit to clients and include circumstances where information may be shared without the client's consent, such as the risk of significant harm to children.

Care plans are normally part of the client's confidential record and current established policies and practice in services will apply. All recipients will be expected to use the information properly and in line with agreed data sharing policies and standards of the service.

Some information sharing may be central to ensuring service users have access to a range of services to meet all their needs and to providing seamless integrated treatment involving other services. Explaining this may help in obtaining consent for such purposes.

Depending on local arrangements, explicit written consent for the sharing of the care plan may not be required and may be considered implicit when the client signs the care plan with full explanation of its use. However, as for any case where there may be doubt, it is important to ensure consent does obtain, and where consent is withdrawn (or expanded) this should be fully respected and the appropriate communication of the care plan should be discussed further with the client.

It is generally likely to be good practice for information sharing consent to be reviewed when the care plan is reviewed, depending on the frequency of review or the particular circumstances.

5 Drug treatment interventions

5.1 Harm reduction

A harm reduction approach recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse, by a range of measures such as reducing the sharing of injecting equipment, support for stopping injecting, provision of substitute opioid drugs for heroin misusers and support for abstinence from illegal drugs.

Most harm reduction interventions specifically aim to prevent diseases due to blood-borne virus (BBV) infections (most particularly HIV and viral hepatitis infections) and other drug-related harm, including overdose and drug-related death. All drug treatment services – residential or community-based – should provide, as part of core treatment, distinct harm reduction interventions aimed at reducing the spread of BBVs and risks of drug-related deaths.

Care planning and specifically goal setting should be within the context of a harm reduction approach. Many clients may have abstinence as a final goal, but a comprehensive care plan may have to concentrate initially on interventions likely to reduce the harm from drug misuse. Any initial care plan developed following triage is likely to have a greater focus on harm reduction than abstinence, but should actively support goals of abstinence in motivated individuals. In practice, harm reduction interventions that target areas of risk identified in assessment – normally small and incremental steps, which explicitly reduce a range of harms – are advisable.

5.2 Planning drug treatment interventions

Once goals have been established, treatment interventions to meet these goals should be identified. There are a range of drug treatment interventions that can be identified to meet client need, which fall into a number of categories including:

- Advice and information
- Harm reduction interventions
- Community prescribing interventions (specialist or GP)
- Structured day programmes
- Residential rehabilitation
- Inpatient drug treatment
- Structured psychosocial interventions
- Other structured drug treatment.

Drug treatment services should routinely address alcohol use and misuse among clients.

Interventions to improve health may require work with primary care or other secondary healthcare providers, to meet a range of physical healthcare needs, for example, treatment for hepatitis C. If a client is not registered with a GP they should be encouraged to do so. Mental health needs may be met by the substance misuse service if, for example, the client has mild-to-moderate depression and anxiety, and the service has appropriately trained and competent staff. Clients with severe and enduring mental health issues would normally be treated for these conditions by local community mental health teams, working in partnership with substance misuse teams.

Interventions to meet needs in the key domains of criminal behaviour and social functioning would normally involve collaboration with local criminal justice teams, housing services, employment services, and access to education, social services and local voluntary sector agencies.

Other interventions or work identified within the care plan may include:

- Facilitating referral to another agency or inter-agency communication
- Specific actions a client agrees to undertake, such as attendance at the benefits office
- Aftercare, which may include interventions commenced while in treatment (subject to a care plan) or those planned to continue after treatment ends (e.g. attendance at mutual support groups).

When planning interventions, care plans should specify who has agreed to be involved in providing interventions and explicitly identify the named individual within any other organisation involved, or specify the name of the keyworker (or other named worker) in order to negotiate such an arrangement.

5.3 Crisis interventions settings

Clients who present to drug treatment services in a crisis are likely to be vulnerable clients who may be, for example, homeless, recently discharged from hospital, physically unwell or pregnant.

These clients are likely to make initial contact with health services (particularly primary care) and their initial needs may be around rapid access to prescribing. If this is to be considered, an initial care plan is likely to aim to address this specific need in order to engage the client and stabilise their drug use. At this point, the keyworker will focus efforts on delivering one or more specific interventions (depending on their level of skills, qualification and experience), liaising with other workers if necessary, and building a positive relationship with the client. If the initial care plan involves prescribing, an assessment focused on prescribing needs to be undertaken. This can be the beginning of a comprehensive assessment (even if the full comprehensive assessment is done later). The prescribing assessment should be done by a doctor or in some cases by an appropriately trained nurse or pharmacist prescriber.

Once initial needs have been met, the keyworker who has conducted the initial assessment and drawn up the initial care plan with the client will need to ensure that a comprehensive assessment is carried out and a comprehensive care plan developed, after which the same or a new keyworker will be identified.

5.4 Planning interventions – the client journey

This section includes specific actions and competences that can enhance care planning at specific stages in the client journey.

5.4.1 Engagement phase

Once a client makes contact with a service provider, a screening assessment is undertaken. From this first contact, the service provider needs to consider how to engage the client in the treatment process and to deliver interventions that will encourage the client to remain in treatment. Such interventions may include:

- Motivational interviewing or enhancement
- Harm reduction interventions
- Providing clients with information relevant to their drug use and treatment
- Engaging with significant others to support clients in treatment.

Triage assessment then follows and the focus on engagement in treatment remains a priority. The assessor may decide to develop an initial care plan. If the above interventions have not been delivered and are appropriate to the individual client, they may be delivered at this point. After triage assessment, however, additional interventions may be provided as part of an initial care plan, such as:

- Access to prescribing
- Structured psychosocial interventions such as node-link mapping or contingency contracting
- Interventions targeting clients' immediate needs (that will impact on their decision to remain in treatment).

Following comprehensive assessment, the keyworker for this stage of care planning should be identified and should develop and agree the comprehensive care plan with the client and other service providers.

Implementing the comprehensive care plan may involve:

- Regular sessions that include motivational interventions to keep the client engaged in treatment, often predominantly provided by the keyworker
- Monitoring by the keyworker to ensure drug misuse-related interventions are being delivered (e.g. stabilising on substitute medication as planned)
- Provision of interventions to improve the health of the client (e.g. reducing risks of drug-related overdose and transfer of blood-borne viruses), often provided by the keyworker and other workers as appropriate
- Co-ordination of care by the keyworker to ensure needs in other domains are being addressed (e.g. housing advice or writing a report for a court appearance).

The engagement phase often continues beyond the comprehensive assessment of a client's needs and the relevant interventions may continue to be delivered for a sustained period if appropriate.

Throughout, it is important that the keyworker builds a therapeutic relationship with the client. For this, the keyworker and other drug workers needs to be non-confrontational**,** listen reflectively and encourage the client to identify and talk through their problems and needs. In primary care, clients may already be engaged with the GP, although they may need encouragement to engage in a particular type of intervention, such as commencing a prescription.

Unit number	Unit title	Element title
AG1	Plan and agree service responses which meet individuals' identified needs and circumstances	AG1.1: Agree the objectives of services to meet individuals' needs and circumstances AG1.2: Explore and agree strategies for meeting individuals' needs and circumstances AG1.3: Determine and secure resources to implement agreed strategies to meet individuals' needs and circumstances
AG2	Contribute to the development, provision and review of care programmes	AG2.1: Obtain information about individuals and their needs of the service AG2.2: Contribute to planning how individuals' needs can best be met AG2.3: Agree services to be provided to meet individuals' needs AG2.4: Contribute to reviewing the effectiveness of care programmes

Table 1: AG Plan and review integrated programmes of care for substance misusers (relevant DANOS competences: AG1, AG2)

Table 1 shows the parts of the Drug and Alcohol National Occupational Standards (DANOS) that are relevant to the engagement phase of care planning.

5.4.2 Delivery phase

Comprehensive assessment will have identified needs in one or more of four key domains: drug and alcohol use, physical and psychological health, social needs, and criminal and legal issues. Appropriate interventions during this phase may include a combination of:

- Psychosocial interventions, e.g. cognitive-behavioural therapy, coping skills and relapse prevention approaches specifically targeted at drug and alcohol use
- Prescribing, e.g. methadone or buprenorphine maintenance
- Interventions to address risks associated with drug use and interventions to address mental health needs, including prescribing of psychoactive medication and psychological therapies to address underlying psychiatric problems such as depression or anxiety, and interventions to address physical health needs
- Interventions targeting social needs, including housing, childcare, relationships, finances, training, education and employment
- Interventions targeting offending behaviour.

Delivering care and maintaining the therapeutic relationship with the client

To maintain the therapeutic relationship with the client, the keyworker will usually continue to see the client on a regular basis (often being the client's main drug worker), will have clear goals and expectations agreed with the client about each person's responsibilities to help clients achieve their goals, and will maintain clear boundaries with the client and clarity about respective roles in care delivery.

Delivery of the treatment will normally involve regular sessions with the keyworker, with a particular focus on monitoring effectiveness of interventions to bring about a change in functioning in one or more of the four key domains. This may include assisting clients to make changes in their drug and alcohol use, addressing additional physical or psychological health issues, addressing accommodation needs, or helping the client to work on relationships. This may either be delivered by the keyworker as the main deliverer of care or delivered by others, in which case the care will be coordinated by the keyworker.

Co-ordinating care

The keyworker will liaise and collaborate with other providers to co-ordinate care. This may include referral, liaison or joint working towards goals with other service providers and tracking client progress across a range of providers.

Maintenance

When clients reach a point where their key care plan goals have been achieved, including those agreeing to long-term maintenance on substitute medication, the keyworker and client should consider whether:

- The client is in the most appropriate drug treatment service or whether they could be best treated in another service location, for example shared care
- Additional goals should be set to enable client reintegration into the community if this has not already been achieved e.g. education, secure housing, gaining employment, expanding social networks.

As a result, the care plan may need to be modified accordingly. This may involve goal setting for issues such as employment or improved housing, planned transfer to another service, less frequent care planning, or therapeutic sessions with the keyworker, for example taken over by a shared care worker or GP in primary care setting. In this case, clients are still "in treatment" and should receive interventions targeted at assisting the them to sustain the changes achieved and providing the them with further support to address any outstanding needs. This support may include the interventions listed in section 5.4.3.

5.4.3 Community integration

Clients' specific social needs should be addressed to enable them to successfully integrate back into the wider community. To assist with this, they should receive a range interventions, which could include:

- Encouraging the client to establish or maintain contact with mutual aid organisations such as NA or non-12-Step equivalents
- Targeting social needs such as housing, relationships and childcare
- Supporting training, education, employment and life opportunities.

Clients should begin to receive these interventions during the delivery phase of drug treatment, and they should continue into the treatment completion phase, of which they will be a major contributor.

5.4.4 Transfer of care

Sometimes it may be appropriate to completely transfer a client from one organisation to another, for treatment and care. This will involve transferring care planning responsibilities and the role of the keyworker to a new worker. In this situation, clients and all relevant agencies involved in their care must be informed in writing and the name of the new keyworker must be explicitly written into the care plan. A pre-transfer care planning meeting may be necessary if clients' needs are highly complex. The client's

entire care plan and other relevant information should be transferred to the new agency.

In the context of the Drug Interventions Programme (DIP), clients on a criminal justice intervention team (CJIT) caseload requiring Tier 3 interventions will be referred to the agency providing the Tier 3 treatment, and the client's care will usually be transferred from the CJIT team. The transition to structured treatment (Tier 3) is achieved when a comprehensive assessment, followed by development of a full care plan, is completed by the treatment provider. The CJIT case manager or keyworker, with the clients' informed consent, can contribute to this process and in negotiation with the treatment provider will have a continued role with the client until they are actively engaged in treatment with the Tier 3 provider.

If a client consents to transfer of care, either to another agency or from secondary to primary care, the care plan can be forwarded to the new service or practitioner to facilitate communication and continuity of care. As for clinical records, appropriate standards on information sharing should apply. In most circumstances a formal referral should be made and this may involve personal or telephone contact, or written referral, in addition to sharing the most recent care plan review record.

5.4.5 Reviewing care plans

When will the care plan be reviewed?
A care plan is first completed after a client has been assessed for treatment. The assessment process will have provided information to guide the selection of needs and goals to be addressed in the care plan. The comprehensive care plan then needs to be subject to regular review. For the majority of clients, an initial care plan needs to be reviewed as part of development of the comprehensive care plan. CJIT and CARAT clients who remain on an initial care plan will need to be reviewed at regular intervals.

Regular review
The client and keyworker should discuss a timetable for the first review at the outset and the precise timing of subsequent reviews will be subject to local policies and client needs. A client can request a review at any time. The review should take the form of the client and keyworker looking at the written care plan, assessing previous goals, interventions and their outcomes and revising them if necessary. Care planning reviews may also include individuals involved in other aspects of client care from different agencies. For clients whose needs change rapidly, a review may need to take place every few weeks. For others, appropriate dates for review according to need should be set. For instance, a client on methadone maintenance in primary care may only need to have a care plan review once a year.

In general, reviews should be considered approximately every three months, or sooner if indicated. However, for clients who are stable in treatment, annual reviews may be appropriate.

Opportunistic review
For many clients, a change in circumstance or a crisis provides an opportunity for a review of the care plan. For instance, a review by a prescribing doctor to have a dose changed may give the keyworker, the client and the doctor an opportunity to look at other areas of the care plan. This may provide a good opportunity to make a referral to another agency (such as a Tier 4 or a specific psychological intervention).

5.4.6 Care planning and primary care

Many clients' initial or main contact with drug treatment is in primary care. Commonly, GPs and other primary care clinicians work across Tiers 1, 2 and 3 with an individual drug user. While some GPs may screen individual drug-using clients and refer them on to other service providers, or complete a triage assessment prior to onward referral, many may wish to take responsibility for providing Tier 3 interventions to drug-using clients in their practices.

Care planning is an essential element of Tier 3 treatment provision, which may be provided under enhanced services. If a client is ready to engage in treatment at the point of contact with primary care services, the GP or designated primary care drugs worker may undertake a comprehensive assessment (or ensure that a comprehensive assessment is undertaken if other service providers are involved in the client's care). They may also develop a comprehensive care plan that addresses client needs in one or more of the key domains (drug and alcohol use, health, social needs and offending behaviour). In some practices the GP will assume the keyworker role, but more commonly the shared care or primary care worker will take on this responsibility in collaboration with the GP. Whoever assumes the keyworking role for an individual client will also need to review the care plan at regular agreed intervals, at least annually.

Where the GP is acting as the keyworker, it is important to ensure that sufficient time is allocated to devising the plan and reviewing it, and that the GP has appropriate skills to devise and implement the plan.

Appendix 3 consists of a consensus statement on care planning in primary care for all GP and shared care schemes providing Tier 3 interventions. The statement contains an agreement on what a care plan is, what the contents should be, confidentiality as part of the care planning process, and what care planning looks like in different primary care settings.

Tables 2–4 show the parts of the Drug and Alcohol National Occupational Standards (DANOS) that are relevant to the delivery phase of care planning.

Unit number	Unit title	Element title
AG1	Plan and agree service responses which meet individuals' identified needs and circumstances	AG1.1: Agree the objectives of services to meet individuals' needs and circumstances AG1.2: Explore and agree strategies for meeting individuals' needs and circumstances AG1.3: Determine and secure resources to implement agreed strategies to meet individuals' needs and circumstances
AG2	Contribute to the development, provision and review of care programmes	AG2.1: Obtain information about individuals and their needs of the service AG2.2: Contribute to planning how individuals' needs can best be met AG2.3: Agree services to be provided to meet individuals' needs AG2.4: Contribute to reviewing the effectiveness of care programmes
AG3	Assist in the transfer of individuals between agencies and services	AG3.1: Support individuals as they prepare for transfer AG3.2: Make agency preparations for individuals' transfer AG3.3: Supervise individuals during transfer

Table 2: AG Plan and review integrated programmes of care for substance misusers (Relevant DANOS competences: AG1, AG2, AG3, AL1, AL2, AJ1, AJ2)

Unit number	Unit title	Element title
AL1	Counsel individuals about their substance use using recognised theoretical models	AL1.1: Establish and manage the counselling relationship AL1.2: Enable individuals to identify and explore concerns AL1.3: Review options and assist individuals to decide on the course of action
AL2	Help individuals address their substance use through an action plan	AL2.1: Develop an action plan with individuals AL2.1: Review the action plan and conclude the counselling process

Table 3: AL Deliver services to help individuals address their substance use

Unit number	Unit title	Element title
AJ1	Help individuals address their offending behaviour	AJ1.1: Help individuals to understand their offending behaviour and associated risks AJ1.2: Help individuals to change their behaviour positively
AJ2	Enable individuals to change their offending behaviour	AJ2.1: Plan interventions to enable individuals to change their offending behaviour AJ2.2: Enable individuals to develop strategies for changing their offending behaviour AJ2.3: Enable individuals to sustain their behaviour change AJ2.4: Evaluate and review interventions to enable individuals to change their offending behaviour

Table 4: AJ Help substance users address their offending behaviour

5.4.7 The completion phase

Clients enter this phase of the treatment journey when they have achieved changes in one or more of the above domains of functioning and after review of their care plans with keyworkers. In this phase, interventions are targeted at assisting clients to sustain the changes achieved in treatment and providing clients with further support to address any outstanding needs. Clients should continue to receive community integration interventions they began to receive in the delivery phase (5.4.3) to address specific social needs that will enable them to successfully integrate back into the wider community.

These interventions comprise:

- Drug-related support (i.e. support to specifically address a person's drug dependency issues), which could include relapse prevention, mutual support groups and advice, and harm reduction support

Unit number	Unit title	Element title
AK1	Assist individuals to explore future employment, training and education opportunities	AK1.1: Assist individuals to clarify their requirements AK1.2: Identify a range of options for achieving the requirements of individuals AK1.3: Enable individuals to select a course of action
AK2	Assist individuals to plan for future employment, training and education	AK2.1 Identify methods to implement a course of action AK2.2 Develop an action plan
AK3	Enable individuals to access housing and accommodation	AK3.1 Enable individuals to access housing and accommodation AK3.2 Enable housing and accommodation services to support individuals
AK4	Enable individuals to administer their financial affairs	AK4.1 Enable individuals to make payments AK4.2 Enable individuals to claim benefits and allowances AK4.3 Enable individuals to collect benefits and allowances

Table 5: AK Support individuals' rehabilitation. Relevant DANOS competences: AK1, AK2, AK3, AK4

- Non-drug-related support (i.e. support that does not directly address drug dependence), which could include access to housing, supported accommodation, relationship support, education and training, support to gain employment, and parenting and childcare responsibilities.

Discharge and aftercare planning

The keyworker and client will discuss the most appropriate route for the client to leave or end drug treatment. The keyworker and the client could consider aftercare needs in the community, to support changes already achieved or to continue to address a range of needs such as stable housing, education and employment. The process of treatment completion should also involve the drawing up of an "aftercare plan", "discharge plan" or "post structured treatment plan" to ensure that all the support for the client already in place continues if necessary, and that any support not in place is in place in time for the client leaving treatment. This plan may include access to adequate support networks, harm reduction, and rapid access back to treatment if the client requires it. It may also include attendance at mutual aid groups such as Narcotics Anonymous.

With clients who have been involved with CJITs at the start of their treatment journeys, it may be relevant to involve the team in aftercare planning. It is good practice to ensure that patients' GPs are informed of the discharge or aftercare plan and the route back into treatment if required.

Table 5 shows the parts of the Drug and Alcohol National Occupational Standards (DANOS) relevant to the completion phase of care planning.

6 Co-ordination of care

Care planning takes place in a range of different settings and services. This section focuses on care co-ordination and also looks at care planning in the Drug Interventions Programme (DIP), other criminal justice settings, in primary care and for crisis intervention.

6.1 Co-ordination of care

Clients' care plans will detail a range of interventions to meet their substance misuse, health, social and criminal justice needs. These interventions may need to be provided by a range of practitioners and services. Most clients will require a degree of co-ordination of their care while in structured drug treatment. This may be particularly necessary if a client has needs spanning a number of domains, for example heroin misuse requiring prescribing and psychosocial interventions, health problems requiring treatment for hepatitis C and homelessness requiring housing solutions.

The previous levels of "standard" and "enhanced" care co-ordination are no longer referred to in Models of Care: Update 2006. It is clear that clients have a range of needs, from simple to highly complex, and this must be reflected in the care plan and the intensity of care co-ordination. It is expected that the keyworker would co-ordinate care in most cases. External care co-ordination may be required where a client has multiple needs, is under statutory obligations via the criminal justice system, or where care is managed through, for example, the Care Programme Approach (CPA). This enables services to reflect on case mix in a more flexible way taking into account the staff competences, client characteristics and client needs, as well as the systems of multidisciplinary working in place

Co-ordination of care involves co-ordinating clients' treatment and care to meet their full range of needs. It ensures the treatment and care provided by different practitioners and services is co-ordinated to provide a comprehensive and integrated approach. The criteria for whether clients need their care co-ordinating are the same as those for comprehensive assessment – for example, people requiring structured intervention, having significant psychiatric or physical co-morbidity, or in contact with multiple service providers – so potentially apply to all receiving Tier 3 or Tier 4 interventions at some time during their care-planned treatment.

6.2 Co-ordination of care in the criminal justice sector

Co-ordination and continuity of care are vital to the treatment and support given to problematic drug-using offenders as they move between different criminal justice and treatment agencies. Improving continuity of care for clients is reliant upon seamless case management through the effective provision and communication of timely, targeted and correct information. There are often a number of individual workers and different agencies involved in managing care in this context. The Drug Interventions Record (DIR) establishes a common tool for use by criminal justice integrated teams (CJITs) in the community, along with counselling, assessment, referral, advice and throughcare services (CARATs) in prisons, containing a minimum set of data for monitoring and information and information for continuity of care purposes, including continuity between prison and community treatment.

Ensuring a drug-misusing offender is supported, throughout their contact with the criminal justice system or treatment, is essential to maximising their chances of remaining engaged in treatment. Various individuals and agencies may be involved in the case management of an offender at different stages and it is essential that the process is as continuous and uninterrupted as possible for the individual concerned. It is important that, at each stage of the care plan, the keyworker considers whether other professionals are also involved with the individual and whether (within the legal framework) they should be liaising and exchanging information with other individuals or agencies.

Clients can access drug treatment at any stage in the criminal justice process e.g. CJITs in police custody suites, and courts, probation, and CARATS / healthcare in prisons. There is an expectation that these clients will be engaged in treatment following assessment to meet their needs.

Triage assessment and initial care planning undertaken by CJIT focuses more specifically on engaging clients in treatment through a range of early and accessible interventions and where appropriate support after treatment has been completed. This may include a range of Tier 2 interventions such as access to prescribing, access to housing support and benefits advice and regular sessions with the keyworker to enhance motivation. At this point, keyworkers will need to focus efforts on developing a therapeutic relationship with clients addressing their immediate needs.

Once the keyworker has addressed these presenting needs in the initial care plan, there may be a need to develop a more comprehensive care plan following a comprehensive assessment, where appropriate and complex needs have been identified. This may involve the keyworker working with a range of partner agencies to develop and co-ordinate a comprehensive care plan or, in some cases, transferring the client to a treatment agency where a different keyworker will develop a comprehensive care plan. It is important that the keyworker is competent to conduct the comprehensive assessment, if one is required. The keyworker will need to involve agencies in assessing the needs and priorities in each of the four domains (drug and alcohol use, health, social and legal). The keyworker's role here includes co-ordinating a

comprehensive assessment and delivering on aspects of the care plan according to skills and experience.

The keyworker in structured drug treatment services may come from a range of agencies. In most areas the keyworking role will be performed by staff from the agency providing the main drug treatment. If the client has been involved with the CJIT, it is anticipated the CJIT will maintain some degree of involvement with the client and be mentioned in the care plan. For stable clients, the involvement of keyworkers may be minimal although they may have an increased role at a later stage, in the planning and provision of aftercare.

In clients who are being considered for a DRR; probation, with information from the CJIT, with the clients' consent, may be used alongside information from the contracted treatment provider, who will carry out a comprehensive assessment so that a pre-sentence report summarising the proposed care plan can be presented to the court.

Care pathways for clients in the criminal justice sector will vary according to local protocols and the nature of their involvement with the criminal justice system, for example DRR or bail restrictions. It is particularly important for all criminal justice clients to receive interventions which engage them in treatment or support via an initial care plan, and if they need structured treatment, have all their care planned and co-ordinated via a comprehensive care plan. The process of treatment completion should also involve the drawing up of an "aftercare plan", "discharge plan" or "post structured treatment plan" to ensure that the support for the client that is already in place continues if necessary, and that any support not in place, is in place in time for the client leaving treatment. This plan may include access to adequate support networks, harm reduction, and rapid access back to treatment if the client requires it. It may also include attendance at mutual aid groups such as Narcotics Anonymous.

In clients who have been involved with CJITs at the start of their treatment journeys, it may be relevant to involve the team in aftercare planning if they are not already. It is good practice to ensure that patients' GPs are informed of the discharge or aftercare plan and the route back into treatment if required.

6.3 Co-ordination of care for client groups with externally co-ordinated care

Some groups of individuals require particular co-ordination of care with other agencies.

Individuals with severe mental health problems, whose care is co-ordinated under the Care Programme Approach (CPA) – particularly those on "enhanced" CPA – will have a named mental health care co-ordinator. The structured treatment providers usually contribute to elements of the mental health CPA plan of care.

Those who are under supervision or treatment orders from the criminal justice system will need careful integration of planning of their structured treatment to optimise outcomes, for example in the case of those on drug rehabilitation requirements. The probation service may have information on particular risk issues and offending behaviour that may need to be incorporated into the care plan.

Clients receiving community care funding with a social services care manager responsible for their treatment – for example, those in residential rehabilitation – may have their care co-ordination and case management provided by a drug-specific social worker. The drug service interventions and care plan will then be provided in the context of that formal process of planning care.

In these, and other similar cases, a decision will still need to be made about the level of planning and monitoring needed by the provider of the structured drug treatment, which will normally include having a written comprehensive care plan record for the drug treatment.

7 Monitoring, clinical governance and performance management

As part of a quality assurance programme, care planning should be subject to audit at a service level. Care plans are useful in terms of service monitoring because they enable clarification of a number of service indicators in relation to performance. Clients' care and outcomes can be subject to formal monitoring as part of the clinical governance process.

7.1 What care plan auditing can contribute to clinical governance and performance management

There are a number of ways in which auditing the care planning process can contribute to effective clinical governance and performance management.

At agency level, an audit of care planning (or some of its elements) can be done by employing standard audit cycle methodology. The process begins with the identification of the particular element of service delivery to be audited, a clear objective, the setting of a standard to audit against, the measurement of performance against that standard and the resetting of standards. The focus of measurement can then be re-audited if desired.

An audit of care planning can:

- Identify a client's needs and goals within a service and provide a profile of these
- Identify the range of interventions that have been planned to meet these needs and goals
- Identify the extent to which services are client focused, involve service users and are responsive to client needs
- Identify which agencies are involved in the client" care
- Lead to a greater understanding of the client's journey, including possible reasons for retention or exit from treatment
- Identify any gaps in communication and inter-agency collaboration in the care planning process
- Provide a baseline to guide further service development
- Inform the development of training for staff
- Check the quality of care planning across different staff in a service.

7.2 Integrating care planning into clinical governance and performance management

Documentation of care plans is important in order to monitor service performance. Commissioners would normally include a requirement for care planning in service level agreements, with services providing structured treatment. Managers can ensure that care planning is integrated into clinical governance and performance management in a number of ways. These include:

- Periodically subjecting the care planning process to the audit cycle by assessing the quality and completeness of the plans, setting targets and subsequently re-auditing against the targets
- Opportunistic or spot checking of individual clients' care plans
- Regular team presentations and discussion of individual clients' care plans
- Integrating users' views on the content of the care plans and how easy they are to understand
- Developing policy frameworks for the planning, development and review of care plans.

In addition, the DANOS framework provides a tool to integrate care planning into workforce development and training. These specify the standards of performance to which people in the drugs and alcohol field should be working and describe the knowledge and skills that workers need. Skills in care planning are integral to knowledge and skills frameworks for service deliverers, service managers and commissioners. Training, support and review of competences in relation to care planning should be integral to workforce development plans.

7.3 Monitoring outcomes

Monitoring client progress against goals in the four key domains will be important in measuring client outcome. This will normally happen in the first instance, in the context of individual care plan review.

Therefore, consideration needs to be given to the appropriate outcomes for individuals in these domains:

- Drug and alcohol use
- Physical and psychological health
- Criminal involvement and offending
- Social functioning.

A service may decide to use one method or one validated tool to measure progress in the four key domains. For instance, the MAP (Maudsley Assessment Profile, Marsden *et al*, 1998) can be used to look at drug misuse outcomes. Alternatively, clients suffering from specific problems such as depression can be monitored with specific validated tools (e.g. using the Beck Depression Inventory (BDI). Other examples are presented in Appendix 2.

Such an approach has a number of advantages. This allows for objective measures of progress on outcomes for individuals, allowing for comparisons of all client outcomes in a service and enabling such comparisons through regular audit of care plans. Alternatively, a service may decide to collate such client outcome scores on a database.

It is good practice for services to collate client outcome data to enable reflective practice, to use for clinical governance purposes and to assist in service improvement. Service managers will have a role in working with practitioners to understand any analysis of such data and to consider any implications for changes in practice, service processes or structures, and so to manage staff and services on such outcomes as appropriate.

There are a number of steps that workers or agencies need to consider when deciding to monitor clinical outcomes using a validated outcome measure. These include:

- Identifying an appropriate outcome measure within that domain. It should be noted that not all domains of functioning will necessarily have appropriate and accessible outcome measures
- Selecting an appropriate validated outcome measure. (Appendix 4 will assist in this process.)
- Clarifying whether administration and scoring of the measure requires any specific training on the part of the worker
- Ensuring that, having given the client the outcome measure, the data it produces is recorded on the care plan or other appropriate client record in an accessible and comprehensible manner
- Informing the client of the reasons for the use of the measure and how the information it generates is to be used and stored
- Repeating administration of the measure again at an agreed point in order to demonstrate and quantify changes in the agreed area of functioning, which may be useful in some cases.

During the lifetime of the Government's Treatment Effectiveness strategy, the NTA will expect commissioners and managers of services to be able to draw on information about client outcomes and other methods for assessing quality of provision, rather than just relying on the proxy of retention to judge the quality and effectiveness of their drug services. Services will be expected to work towards using systematic audit methodology and clinical outcome data, within a framework of effective clinical governance, routinely to reflect on effectiveness of the treatment provided and to be able to demonstrate benefit clients achieve in treatment.

8 Care plan records

8.1 How to record the care plan

Many agencies have standard paper forms to record care plans. They could also be computerised in the context of a computerised patient record. Within an agency, the records allow a simple way to check that care planning has been done and enables others in the agency can easily understand the needs, goals and interventions.

Any standard record should be simple and understandable enough to share with other agencies. A good test is whether the form could be faxed to a GP or to another agency and be readily understood.

A review should involve recording revised needs, goals and interventions onto a new form.

This practice guide gives a checklist of contents for both the comprehensive care plan and the initial care plan. Care plan records should contain the information below as a minimum and agencies may find the inclusion of other information helpful.

8.2 Initial care plan – contents checklist

- Name
- Date of birth
- Date of initial care plan
- Keyworker and agency responsible for initial care plan (and name of GP)
- Immediate needs and risks identified
- Goals
- Intervention
- Review (focus for clients of CJITs/CARATs)
- Signature of client (optional).

8.3 Comprehensive care plan – contents checklist

- Name
- Date of birth
- Date of comprehensive care plan
- Keyworker and agency responsible for comprehensive care plan (and name of GP).
- Indication of the main phase (or phases) of the treatment journey (i.e. one or more of engagement, delivery, community integration, and maintenance or completion)
- Needs and risks identified, with reference to the key domains – drug and alcohol use, physical and psychological health, criminal justice and social issues
- Goals
- Intervention (and who is responsible for it, including the client if appropriate)
- Review date
- Signature of client.

9 Appendix 1: Examples of care plan contents grouped by domain

9.1 Drug and alcohol use

9.1.1 Example 1

Background

A client is using £200 of crack cocaine weekly although stable on a daily methadone prescription of 70mg.

Goal

To reduce crack cocaine use by 50% over the next three months, as evidenced by production of 50% cocaine-free oral fluid tests.

Intervention

Relapse prevention techniques, including drug diaries within weekly keyworking sessions. Focus on psycho-education and skills development to manage cravings and high risk situations for crack use. Weekly oral fluid tests.

Who is responsible?

The keyworker.

Review date

Review in three months by keyworker and client.

9.1.2 Example 2

Background

A client is now stable on 10mg of buprenorphine daily and has been for three months. The client has abstinence as an eventual goal.

Goal

To reduce dose to 4mg daily working towards full abstinence.

Intervention

To reduce the dose to 4mg over the next three months by reducing dose at 2mg per month monitored by the prescribing doctor. Weekly relapse prevention sessions from keyworker and monthly monitoring by doctor.

Who is responsible?

The keyworker and prescribing doctor.

Review date

Review in three months by keyworker, prescribing doctor and client.

9.2 Physical and psychological health

9.2.1 Example 1

Background

A client who is new to treatment identifies a history of sharing injecting paraphernalia. The client is very anxious about hepatitis C and worried about having a test.

Goal

To increase the client's knowledge of blood borne viruses in preparation for taking a HCV antibody test within three months and to stop needle sharing within three months.

Intervention

To attend the HCV education group the service provides and to discuss the issue in keyworking sessions.

Who is responsible?

The keyworker.

Review date

In three months by client and keyworker.

9.2.2 Example 2

Background

A client who is new to treatment presents with a history of self harm. On reading the client's notes, the clinician identifies that the client has been under the care of a community psychiatric nurse (CPN).

Need identified

To co-ordinate mental health interventions with substance misuse interventions.

Goal

To reduce the frequency of self-harming behaviour, to stabilise client mood and reduce drug/alcohol use through a co-ordinated approach by mental health and substance misuse services.

Intervention

Monthly liaison meetings involving the CPN, keyworker and client, to identify risks and co-ordinate clinical management.

Who is responsible?

The keyworker and the CPN.

Review date

In three months with the client, keyworker and CPN.

9.3 Social functioning

9.3.1 Example

Background

A client presents to a drug service with a history of amphetamine use. In a triage assessment she is found to be street homeless. The initial care plan addresses this housing need

Need identified

Stable accommodation

Goal

Client to make contact with housing services and obtain temporary housing

Intervention

Referral to specialist vulnerable housing worker. Completion of assessment of substance misuse.

Who is responsible?

The housing worker.

Review date

In two weeks.

9.4 Criminal involvement and offending

9.4.1 Example

Background

A client is stable on a methadone prescription and not using illicit drugs. He is housed in stable accommodation. He is arrested for a theft offence committed over six months ago when he was still offending. He is remanded on bail with a condition to attend for an assessment. He is allocated to a DIP worker from the local CJIT team.

Goal

To ensure the client meets the requirements of the court and bail conditions while continuing to attend every treatment appointment.

Intervention

Keyworker and client to communicate care plan and treatment progress to the DIP team. DIP worker to liaise with court. Keyworker to focus in keyworking sessions on problem solving approach to the difficulties and obstacles to maintaining attendance in treatment for the client.

Who is responsible?

The keyworker, client and DIP worker.

Review date

In one month by keyworker and client.

10 Appendix 2: Outcome monitoring tools

Multiple domain measures	Description of measure	Self completion or staff completion	Time to complete	Training required to administer	Where to access measure	Key reference
Maudsley Addiction Profile (MAP)	A 60-item structured interview schedule designed for treatment outcome research. It measures problems in 4 domains: substance use, health risk behaviour, physical and psychological health and personal and social functioning	Staff completion	12-15 minutes	None specified	Copy of measure and user manual downloaded from: www.dass.stir.ac.uk/DRUGS/pdf/Map.pdf	Marsden J *et al* (1998) The Maudsley Addiction Profile (MAP), Addiction, 93, 1857-1867
Addiction Severity Index (ASI European adaptation)	Semi-structured interview measuring severity of problems in 6 areas: drug and alcohol use, medical, psychological, legal, family and social, employment and support	Staff completion	45 minutes	Training required to administer	Further information downloaded from: www.stir.ac.uk/Departments/HumanSciences/AppSocSci/DRUGS/notes.htm	McLellan T *et al* (1980) An improved evaluation instrument for substance abuse patients; the Addiction Severity Index. *J Nerv Ment Dis* 168, 26-33 Kokkevi and Hartgers (1995) EuropASI: European adoption of a multi-dimensional assessment instrument for drug and alcohol dependence. *Europ Add Res*, 1, 208-210
Opiate Treatment Index (OTI)	Interview based multi-dimensional measure with 6 scales: drug use, HIV risk-taking behaviour, social functioning, criminality, health and psychological adjustment	Staff completion	30 minutes	None specified	Details of scale and its development in Darke, Hall, Wodak, Heather and Ward (1992) development and validation of a multidimensional instrument for assessing outcome of treatment among opiate users – The Opiate treatment Index. *Brit J Add*, 87, 733-742	
OTI modified for amphetamine users					Barrowcliff *et al* (1999). Use of a modified version of the Opiate Treatment Index with amphetamine users. *J Sub Use*, 4, 98-103	

Multiple domain measures	Description of measure	Self completion or staff completion	Time to complete	Training required to administer	Where to access measure	Key reference
Global Appraisal of Need (GAIN)	Measure with 8 scales: background and treatment arrangements, substance use, physical health, risk behaviours, mental health, environment, legal and vocational.	GAIN can be administered by staff or by proctored self-administration (i.e. with staff present)	20-90 minutes depending on population, mode and level of severity	None specified	Copy of instrument and general terms of the license agreement for use can be found on: www.chestnut.org/li/gain	See Dennis (2000) Overview of the Global Appraisal of Individual Needs (GAIN). Chestnut Health Systems. (See website address.)
Measures of dependence						
Leeds Dependence Questionn-aire (LDQ)	A 10-item questionnaire measuring various aspects of dependence (e.g. preoccupation, planning, compulsion to continue) on a variety of substances	Self completion	5 minutes	NA		Details of scale and its development in Raistrick *et al* (1994). Development of the Leeds Dependence Questionnaire (LDQ), *Addiction*, 89, 563-572
Severity of Dependence Scale (SDS)	Very brief scale to measure degree of dependence experienced by users of different types of drug. It has 5 items all concerned with the psychological components of dependence	Self completion	1 minute	NA		
Measures of specific constructs						
The Craving Questionn-aires	45-item questionnaires available in 2 versions (current craving and craving over the last week). Adaptations available for alcohol, cocaine and heroin.	Self completion	10 minutes	NA		Details of the Cocaine Craving Questionnaire in Tiffany *et al* (1993) The development of a cocaine craving questionnaire. *Drug and Alc Dep*, 34, 19-28. Details of other measures in Tiffany *et al* (2000) Challenges in the manipulation, assessment and interpretation of craving relevant variables. *Addiction*, 95 (Supp2), S177-S187

Multiple domain measures	Description of measure	Self completion or staff completion	Time to complete	Training required to administer	Where to access measure	Key reference
Measures of specific constructs						
Readiness to Change Questionnaire (RTQ) (Treatment Version)	15-item questionnaire measuring readiness to change substance use that assigns client to one of 3 stages of change and therefore useful at the point of entry into treatment	Self completion	2 minutes	NA		Treatment version described in Heather *et al* (1999) Development of a treatment version of the Readiness to Change Questionnaire. *Addiction Research*, 7, 63-68
Injecting Risk Questionnaire	18-item questionnaire to measure different aspects of injecting equipment sharing and number of people with whom this has occurred	Self completion and staff completion versions available	5 minutes	None specified	Printed copies can be obtained from IRQ Questionnaire, Centre for Research on Drugs and Health Behaviour, Imperial College School of Medicine	Details of scale and its development in Stimson *et al* (1998) A short questionnaire (IRQ) to assess injecting risk behaviour, *Addiction*, 93, 337-347
Drug Taking Confidence Questionnaire (DTCQ)	50-item questionnaire with 8 sub-scales: unpleasant emotions, physical discomfort, pleasant emotions, testing personal control, urges and temptations to use, conflicts with others, social pressure to use and pleasant times with others. Clients report how confident they are that they could resist urge to use a particular drug in different situations.	Self completion	15 minutes	NA	Users guide available: Annis *et al* (1997) the Drug-taking Confidence Questionnaire: Users guide. Toronto: Centre for Addiction and Mental Health Further information can be found on www.camh.net/resources/index, html	Details of scale and its development in Sklar *et al* (1997) Development and validation of the Drug-taking Confidence Questionnaire. *Add Behav*, 22, 655-670

Multiple domain measures	Description of measure	Self completion or staff completion	Time to complete	Training required to administer	Where to access measure	Key reference
Inventory of Drug-Taking Situations	A 50-item questionnaire to assess the situations that precede drug use. It has 8 scales measuring a clients substance use in different situations: unpleasant emotions, physical discomfort, pleasant emotions, testing personal control, urges and temptations to use, conflicts with others, social pressure to use and pleasant times with others. Different version are available relating to different time periods	Self completion	15 minutes	NA	Further information and details of the users guide and training can be found on www.camh.net/resources/index.html	Details of the scale and its development can be found in Annis and Martin (1985) Inventory of Drug-taking Situations. Toronto: Centre for Addiction and Mental Health
Mental health specific measures						
Quality of Life Inventory (QOLI)	Brief but comprehensive measure of life satisfaction/dissatisfaction in 16 areas of life, love, work, health, goals and values, play, creativity, helping, friends, relatives, home, money, children, learning, neighbourhood, community and self-esteem. Takes a non-pathological view of positive mental health and is based on premise that "wellness" is more than just being free from pathological symptoms					

Multiple domain measures	Description of measure	Self completion or staff completion	Time to complete	Training required to administer	Where to access measure	Key reference
Mental Health specific measures						
Beck Depression Inventory (BDI)	21-item rating inventory measuring characteristic attitudes and symptoms of depression. There is a 13-item short form and the more recent BDI-11 (Beck, Steer and Brown). Invaluable tool for screening and diagnosis and to monitor therapeutic progress. New items in the BDI-11 bring it into compliance with DSM-IV criteria and the age range has been expanded to 13-80 years of age.	Self completion	5 minutes	Publisher requires verification of professional qualification to use measure	For copies of the inventory contact publishers: Harcourt Assessment Halley Court, Jordan Hill Oxford OX2 8EJ, UK Tel: 01865 888188 Fax: 01865 314348 Email: info@harcourt-uk.com	Beck AT, Ward CH, Mendelson M, Mock J & Erbaugh J (1961) An inventory for measuring depression. *Archives of General Psychiatry* 4, 561-571.
Beck Anxiety Inventory (BAI)	A brief assessment of the severity of client anxiety. Specifically designed to reduce the overlap between depression and anxiety scales, by measuring anxiety symptoms shared minimally with those of depression. Both physiological and cognitive components of anxiety are addressed in the 21-items describing subjective, somatic or panic-related symptoms. The BAI differentiates well between anxious and non-anxious groups in a variety of clinical settings and is appropriate for all adult mental health populations.	Self completion	5 minutes	Publisher requires verification of professional qualification to use measure	For copies of the inventory contact publishers: Harcourt Assessment Halley Court, Jordan Hill Oxford OX2 8EJ, UK Tel: 01865 888188 Fax: 01865 314348 Email: info@harcourt-uk.com	

Multiple domain measures	Description of measure	Self completion or staff completion	Time to complete	Training required to administer	Where to access measure	Key reference
Hospital Anxiety and Depression Scale (HADS)	Simple scale measuring depression and anxiety. Allows one to establish the presence and severity of both while giving a separate score for each. It gives cut off points to indicate whether someone in "within normal range", or in a "mildly", "moderately" or "severely" disordered state.	Self completion	5-10 minutes	Publisher requires verification of professional qualification to use measure	For copies of the scale, contact publishers NFER-Nelson • by ordering online at www.OnestopEducation.co.uk • By calling Customer Support Team on 0845 602 1937. • By Faxing on 0845 601 5358 • By posting order to: nferNelson, FREEPOST LON16517, Swindon SN2 8BR • By email at: information@nfer-nelson.co.uk	Zigmond AS & Snaith RP. The Hospital Anxiety And Depression Scale. *Acta Psychiatr Scand* 1983, 67:361-70
General Health Questionnaire (GHQ-28	A screening test designed to identify short term changes in mental health (depression, anxiety, social dysfunction and somatic symptoms). It is a pure state measure, responding to how much clients feel their present states "over the past few weeks" are unlike their usual states. It does not make clinical diagnoses and should not be used to measure long-standing attributes. The GHQ focuses on the client's ability to carry out "normal" functions and the appearance of any new disturbing phenomena. Designed for use by doctors, psychiatrists and researchers, it is ideal for use in community and non-psychiatric settings and has 4 different versions:	Self completion	5-30 minutes depending on form used	Publisher requires verification of professional qualification to use measure	For copies of the scale, contact publishers NFER-Nelson • by ordering online at www.OnestopEducation.co.uk • By calling Customer Support Team on 0845 602 1937. • By Faxing on 0845 601 5358 • By posting order to: nferNelson, FREEPOST LON16517, Swindon SN2 8BR • By email at: information@nfer-nelson.co.uk	Goldberg D, McDowell I & Newell C (1987). Measuring health: A guide to rating scales and questionnaires. New York: Oxford Univ. Pr

11 Appendix 3: Consensus statement on care planning in primary care

This document was generated during a consensus meeting with a variety of primary care providers. It demonstrates recognition that structured care planning and review is an appropriate and necessary activity in the primary care drug treatment setting.

National Treatment Agency
for Substance Misuse

Care planning in primary care

Consensus statement from the primary care stakeholder day

Thursday 2 December 2004

1. The need for a consensus statement

The concept of care planning is integral to the Models of Care framework. The need for a consensus statement has arisen in response to an increasing emphasis upon "treatment systems" and upon the significant role of primary care drug treatment provision which is currently being addressed in a whole system review of Models of Care. In addition, there is a need for primary care input into the writing of Models of Care for Treatment of Adult Alcohol Misusers. There is a need for care planning models that are flexible to the variety of differing systems providing drug treatment in the primary care setting.

2. What is a care plan?

A care plan is a description of structured, often multidisciplinary, task-oriented, individually tailored set of interventions. It details the essential steps in the care of a drug and alcohol misuser and describes the user's expected treatment and care requirements.

The process of care planning is an important part of primary care based drug treatment. Devising a care plan is the key part of the assessment process. It can aid both quality improvement and performance monitoring. It can identify and manage risk. It empowers the user and mitigates against professional isolation. It provides professional boundaries to enable professionals to work within their competences. It also provides a focus for care. It should be seen as an evolving document that can vary depending upon the complexity of clinical and related social and healthcare needs.

Care planning needs to take place in all the treatment settings. This includes settings where primary care based drug treatment is provided. The devising and delivery of the care plan can be different in differing primary care based treatment settings.

3. The content of a care plan

The care planning document itself needs to physically exist in either written or computer form or as part of a regular review of the user records. This form could vary according to different treatment settings. Information within the document should be shared freely in accordance with the Data Protection Act. It should be easily understood by the user, the key stakeholders and those in other organisations who may be in receipt of the care plan. Ideally there should be local consistency so that local primary care providers can share information contained in the care plan in a readily accessible format. A paper copy of the care plan should be available to the user.

The content of the care plan in primary care can be informed from the assessment process, which will cover the following domains described in Models of Care.

- Drug use
- Alcohol use

- Physical problems
- Psychological problems
- Housing
- Education and employment
- Issues relating social exclusion
- Legal problems

The care plan is an action plan informed by the assessment process. It is an individualised plan of care and will set the goals of treatment and the milestones to be achieved. It will indicate the interventions planned and which agency and professional is responsible for carrying out the interventions. It will make explicit reference to managing risk. It will describe a process for information sharing. It will reflect the cultural and ethnic background of drug and alcohol misusers, including issues of gender and sexuality where appropriate.

The care plan should have a contingency plan should the milestones fail to be realised. It should also be viewed as a flexible and organic document as one can't plan for all eventualities from the outset. It should also have regular review dates which are set at the beginning of the plan. Timescales for review should be agreed with all parties at the initiation of the plan.

Where a drug user has complex needs, there should be a care plan co-co-ordinator who takes a lead in devising the plan on behalf of the whole team who are involved in the care of the user. The care planning co-co-ordinator could be the drugs-worker, drugs-nurse, or GP providing they have the competences necessary to co-ordinate the completion of the actions agreed in the care plan. Usually it is the person who has the most contact with the user; often this will not be the GP. Where indicated in cases of complexity, care planning and co-ordination will need to take place in, and be led by statutory frameworks (for example in accordance with the Mental Health Act or as part of a court order).

4. Ensuring confidentiality in the care planning process

Sharing the information contained in the care plan should be to all named participants in the care plan (including the user).

In exceptional circumstances some or all of the information contained in the care plan can be withheld from the user if divulging the information would compromise safety to the user, the user's children, the professionals or the wider public. For example such a situation could arise if divulging the contents of the care plan led to deterioration in the mental health of the user. Any of the interested stakeholders may request information from the care plan co-ordinator, in such a situation the request should be discussed with the user and a common decision made as to whether information should be disclosed. The level of information provided to a stakeholder should be decided by the multi-disciplinary team. A decision by the user to provide informed consent to disclosure of information should also be subject to regular review. Obtaining informed consent from the user should be obtained by the service disclosing information, not the service seeking information. Disclosure should take place within the professional codes of conduct of the service.

5. Care planning in different primary care settings

5.1 For GPs involved in providing essential services

The consensus view supports care planning within the context of the primary care setting and recognises that this varies in accordance with the level of expertise and interest of the GPs

GPs will be expected to provide emergency access and diagnostic skills as well as specific Tier 1 interventions and signposting to reduce harm and prevent the spread of blood-borne viruses. Such activities should be “care planned” in accordance with the principles of chronic disease management

It is recognised that for those GPs providing essential services to substance misusers care planning will be integrated into the GP and primary health care team's own clinical systems. Therefore, details of assessment, signposting and basic treatment planning will be recorded on this system.

Information regarding any contact such users have with specialist or enhanced services will be through contacts made with the practice and recorded onto the user's own GP held confidential record in accordance with locally agreed information polices.

There was consensus that basic information regarding prescribing received by clients from another primary care enhanced or specialist setting should always be part of the minimum requirement to a user's own GP.

5.2 Care planning within a shared care setting

In this setting case management will be provided by a designated case manager who will work with primary care staff in working within an approved care planning framework. This framework will adhere to the principles of care planning described above but will highlight how the specific roles and responsibilities of GP and shared care worker will be shared in delivering a co-ordinated care plan.

Shared responsibilities will include monitoring of compliance and continuity of care. The GP is likely to lead on prescribing interventions, changes and additions to medication

The shared care worker is likely to lead on monitoring progress against treatment goals and in developing a holistic treatment plan

In all cases efforts will be made to use a common recording system that is integrated within the GPs own clinical systems

5.3 Care planning in primary care led community drug treatment setting

This treatment context includes primary care trust, non-statutory organisation or mental health trust managed community drug treatment settings. It also includes those primary care based services providing drug services to marginalised populations (such as homeless or asylum-seeking drug users). Often such services are provided through PMS contracts. Care planning in such settings will be a formalised process guided by the local implementation of Models of Care. It will share many of the principles of the care planning process in the shared care setting, namely the need for a designated case manager, a clear definition of the respective roles of prescribing GP and drugs keyworker and the use of a common, integrated recording system. Where the recording system is the client's records, there is a need for regular review and summarising of clinical information to update the plan of care.

12 References

Advisory Council for the Misuse of Drugs (1988). *AIDS and Drug Misuse Report: Part 1*. London: HMSO.

Advisory Council for the Misuse of Drugs (1989). *AIDS and Drug Misuse, Part 2*. London: HMSO.

Alcohol Concern and SCODA (1999) *Quality in Alcohol and Drugs Services (QuADS)*. London: SCODA, Alcohol Concern

Audit Commission (2002). Changing Habits: *The Commissioning and Management of Community Drug Treatment Services for Adults*. London: Audit Commission

Audit Commission (2004). *Drug misuse 2004: Reducing the Local Impact.* London: Audit Commission

Department of Health (2004) *NHS Improvement Plan 2004: Putting People at the Heart of Public Services*. London: DH

Department of Health (2004). *Standards for Better Health*. London: DH

Department of Health (1996) *Report of an Independent Review of Drug Treatment Services in England: The Task Force to Review Services for Drug Misusers*. London: DH

Gossop M (2006) *Treating Drug Misuse Problems: Evidence of Effectiveness*. London: National Treatment Agency for Substance Misuse

Home Office (2002) *Updated Drug Strategy 2002*. London: Home Office

Marsden J, Gossop M, Stewart D, Best D, Farrell M, Lehmann P, Edwards C, Strang J (1998). The Maudsley Addiction Profile (MAP), *Addiction*, 93, 1857-1867

National Treatment Agency (2002). *Models of Care for Treatment of Adult Drug Misusers. Part 2 Full Reference Report.* London: National Treatment Agency for Substance Misuse

National Treatment Agency (2006). *Models of Care for Treatment of Adult Drug Misusers: Update 2006.* London: National Treatment Agency for Substance Misuse

National Treatment Agency (2005). *Retaining clients in drug treatment: A Guide for Providers and Commissioners.* London: National Treatment Agency for Substance Misuse

NHS and Community Care Act 1990. London: HMSO

Skills for Health (2003) *Drug and Alcohol National Occupational Standards* (DANOS). London: Skills for Health. (The full range of competences are available at http://www.skillsforhealth.org.uk/danos)

UK Harm Reduction Alliance (2005). http://www.ukhra.org

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Notes

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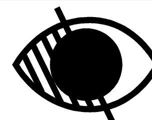

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