Inter-agency Addiction Protocols

Blanchardstown

(I.A.P. Blanch)

Four agencies co-operating and working together

to enhance area-based services for

current and former drug users.

3 Community Drug Teams (C.D.T.`s)

and the

Health Service Executive Addiction Services (H.S.E.).

Endorsed & ratified by the 'IAP Blanch'

Steering Group

December 2009

Part I

INTRODUCTION

The Interagency Addiction Protocols Blanchardstown (hereafter know as I.A.P. Blanch) proposes more formal inter-agency co-operation and quality working relationships between the Community Drug Teams (CDTs) and the Health Service Executive Addiction Services in Blanchardstown, Dublin 15.

This initiative builds on our shared experience of collaboration to create formal protocols similar to those already successfully developed and implemented through the Blanchardstown Interagency Protocols Initiative (formally the EQUAL Inter-Agency initiative 2004).

We particularly acknowledge that the Blanchardstown Inter-agency Protocol Initiative 2004 (BiPi) has largely informed the current report. BiPi has been evaluated as providing a smoother continuum of care to service users (Bookie, S. & Burtenshaw, R., 2006) which serves the goal of this present initiative. It has been endorsed as a model of good practice of inter-agency work by the Reitox National Focal Point to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in the national report for the Republic of Ireland (Johnny Connolly, et al., 2005).

As in the Dept. of Health and Children and HSE's "*Report of the Working Group on Treatment of under 18 year olds presenting for Treatment Services with Serious Drug*

Problems" (September 2005), the adoption of a model similar to the British 4 tier system[1] for mapping addiction interventions contributes to the formulation of these protocols.

Tier 1: interventions include provision of drug-related information, advice, screening and referral to specialised drug treatment.

Tier 2: Include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare

Tier 3: Interventions include provision of community-based specialised drug assessment and co-ordinated 'care-planned' treatment and drug specialist liaison.

Tier 4: Interventions include provision of residential specialised drug treatment, which is 'care-planned' and 'care co-ordinated' to ensure continuity of care and aftercare.

On a continuum of care provision for people who seek assistance with their addictions, this model outlines appropriate interventions for Service Users, from those who have more 'chaotic' drug use through to those trying to sustain a drug free life style.

1 Models of Care for Treatment of Adult Drug Misusers: Update 2006, NHS, National Treatment Agency for Substance Misuse, pp. 20-23.

Aims

IAP Blanch protocols to establish a working structure and tracking process to enable participating agencies to co-operate more effectively in offering Service Users optimum opportunity to address their drug related problems.

By co-ordinating, tracking and quality-assuring care plans we intend to maximise progression for service users across the continuum of care, in a more transparent manner.

These Interagency Addiction Protocols seek to:

1. Establish and document clear inter-agency protocols and working relationships.
2. Ensure that agencies interact with each other and Service Users in a more formal and defined way.
3. Facilitate appropriate targeting of resources in relation to needs with a view to:
   i) Increasing collaboration between services,
   ii) Developing an approach to care plan coordination which benefits Service Users,
   iii) Delivering more coherent and high-quality service provision,
   iv) Avoiding perceived or actual duplication of services and resources,
   v) Maximising effective progression routes for Service Users through the continuum of care,

Agencies Participating in the Initiative

These Protocols cover four service providers in the Blanchardstown area. All have committed to this Interagency Addiction Protocols Project.

The participating service providers are:

- **Hartstown/Huntsown Community Drug Team Ltd.**
- **Health Service Executive, Addiction Services, Local Health Office, Dublin North Central.**
- **Mountview/Blakestown Community Drug Team Ltd.**
- **Mulhuddart/Corduff Community Drug Team Ltd.**

The core work for each of these agencies is with current/former drug users. A detailed list of services offered by each agency participating in this initiative is provided in Appendix 1. (page 90).

Background to the Initiative

This 'IAP Blanch' initiative fits with the agenda for community treatment and rehabilitation identified by the National Drugs Strategy, 2001-2008:

"measures designed to implement the Strategy included (1) better co-ordination between statutory and voluntary agencies in the provision of services." (Department of Community, Rural & Gaeltacht Affairs, 2007, 3.1.2).

The Report of the Working Group on Drug Rehabilitation stated that the aim of their document was to produce:

> *"A framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway".*

The Report proposes a means of ensuring this is through the establishment of interagency protocols as outlined in recommendation 1.1 and 2.1 of their report.

> ***R 1.1*** *Rehabilitation can only be delivered effectively through an inter-agency approach based on a continuum of care that operates within the context of enhanced case management and a quality standards framework. The development of protocols for interagency working, with service level agreements between agencies and coordination by rehabilitation co-ordinators, is required.*

> ***R 2.1.*** *The development of protocols, at national and local level, to facilitate the level of inter-agency co-operation, integration and information sharing needed to implement shared care plans. The protocols will cover the arrangements for the seamless transition of people as they move from the environment of one agency to that of another as well as issues such as a common understanding of confidentiality, common assessment tools, tracking and monitoring, how disputes between organisations should be settled and so on. The protocols will address the sharing of information between the agencies, while respecting client confidentiality and privacy. The broad national*

protocols will be developed through the National Drugs Rehabilitation Implementation Committee and will be approved through the Inter- Departmental Group on Drugs and, at Ministerial level, through the Cabinet Committee on Social Inclusion.

To date in the Blanchardstown Area, informal procedures have been implemented in co-ordinating services, but these procedures and pathways of care have at times been inconsistent. The partner agencies reviewed and agree that this does not best serve client needs.

Therefore, the Statutory and Community Addiction Services in the Blanchardstown area are committed to enhancing structured services to deliver the highest possible quality of client care.

Methodology used to develop Protocols

Preliminary meetings between partner agencies established the I.A.P. Blanch Steering Group to explore issues relevant to protocol development from a managerial point of view. This group sought funding from the Blanchardstown Local Drugs Task Force to engage consultants who would assist in the development of protocols. Following tendering process consultants Mary Mc Mahon, MS.Sc, and Dr. Debra L. Wilson, Phd, MSW, LSW, from M.M.M.A. Consultancy were contracted for a period of time to assist the work of the Steering Group.

Information was then gathered by the consultants from two structured Staff and Management focus groups, one consultation with all three of the Community Drug Teams and another with the HSE clinical team. Dates and times were forwarded and agreed upon by the participating organisations. A copy of a structured interview was forwarded to HSE workers who were unable to attend the information gathering sessions.

The input from respective staff groups together with some guiding principles from the Steering Group relating to inter-agency work began the practical elements for drafting protocols appropriate to our partnership.

We note that formal mechanisms for consulting with Service Users regarding development of Protocols were not implemented by the Consultants on behalf of the Steering Group. This is acknowledged as a deficiency in the process.

The Steering Group wished also to learn from the wisdom of experience elsewhere. The enclosed Literature Review sets our protocols against the background of debate and evidence for implementing such a formal Interagency Protocol and tracking of care provision.

It is proposed that the current protocols be piloted by the respective partners in early 2010 and reviewed in June 2010. We expect that modifications arising from the review will then be incorporated into the protocols.

Literature Review:

Effective Interagency Partnership and its Benefits

A limited literature review was initially furnished by our consultants largely focused on retention in treatment, treatment outcomes and our National Drugs Policy. The Steering Group required more specific reference to inter-agency and inter-professional collaboration which was furnished by Dr Patricia Burke, Registrar in Substance Misuse and Dr Michael Doran, Senior Registrar in Substance Misuse of the National Drugs Treatment Centre Board.

Introduction

Internationally, many countries have difficulties with issues of fragmentation and lack of continuity of care for people with complex needs e.g. dual diagnosis, chronic mental health difficulties.

There are many difficulties involved in bringing together health and social services to provide a structured care plan to people with multiple needs. Key barriers seem to include structural divisions, separate legal and financial frameworks, distinct organisations and differences in terms of governance and accountability.

Despite this, there is growing recognition that interagency and inter-professional collaboration is necessary to deal with the complexity of social problems.

In the UK for example, partnership working between health and social care has been a central feature of policy since the mid – 1990's and there has been a recognition of the need for interagency collaboration to provide seamless services (Glasby et al 2004).

Although there is a substantial and growing literature on partnership working e.g. (Hudson et al 2000, Payne 2000, Bullock et al 2001, Sullivan et al 2002) there are limitations to our existing knowledge (Glasby et al 2003).

1). There is a tendency to focus on the perspectives of policy-makers without exploring the views of service users.

2). Much of the current literature focuses on the perceived virtues of partnership working without clear evidence based research on outcomes.

3). There is a tendency to view health and social care in isolation without seeing them in wider strategic partnerships.

4). Above all, a recent literature review has suggested that the evidence to date focuses on the process of partnership working and not on outcomes of partnerships for service users and carers. (Dowling et al 2004).

Our aim is to review the international and national evidence for the practice of interagency collaboration within drug and rehabilitation services.

In the UK, the National Treatment Agency for Substance Misuse produced a series of reports to assist drug treatment services in developing procedures. One of these reports 'Working in Partnership' outlined good practice for drug treatment services working effectively in partnership with other provider agencies.

The 'Working in Partnership' document advocated the importance of interagency partnership in drug treatment services. It reported that partnership between provider agencies has been one of the five challenges that the Dept of Health advocated in the NHS plan of 2000. This involved the NHS embarking on a new programme with local authorities to examine health care needs of vulnerable adults including those from substance misuse.

A second document 'Quality in alcohol & drug services' produced by Drugscope/Alcohol Concern in 1999, advocated that services should aim to develop & maintain joint working relationships with other provider services.

In order to comply with QuADs standards, services need to

1. Participate in provider meetings with other agencies
2. Have a joint agreed strategy for meeting objectives agreed with other agencies
3. Establish formal protocols for sharing service user information
4. Jointly develop policies on key interagency & service provision issues

Working together with other agencies can also bring considerable benefits to services, their users and the wider community. Some of the benefits to drug services include;

1. Opportunities to broaden drug services through satellite work, Eg. Drug treatment staff working in homeless shelters

2. The potential to develop work that may not be possible for a single agency, Eg. Outreach work that may be unsafe for one person but feasible through partnership

3. Maximising available skills by using staff from different organisations

4. Better, more flexible use of financial resources

5. Breaking down cultural and other barriers to develop a better understanding of other services' skills & priorities

6. Improved communications between services

7. Enabling resources to be maximized when addressing complex issues

Some of the benefits to service users and the community include;

1. More holistic and integrated responses to drug use, as better referral procedures and pathways should be developed between partnership organisations

2. Services that better target the community's needs, through a comprehensive approach to the planning & delivery of services.

3. The ability to promote community involvement in the planning & delivery of services

The 'Working in Partnership' document examined the levels of partnership that can occur either at the Strategic (planning of services) phase or the Implementation (service delivery) phase.

Strategic partnerships:

These are partnerships which are responsible for joint planning & decision- making, which shapes the context within which services operate. This kind of partnership working may also involve a financial or statutory element. Examples include

- ☐ Drug Action Teams
- ☐ Local strategic partnerships

The work of drug services is likely to be directed by these partnerships because of their power and potential for funding.

Implementation level:

There are a range of practical working relationships between services to ensure an integrated package of care for service users. Examples include

1. Drug Interventions Programme, which involves partnership working between police, probation & drug treatment services.

2. Work between primary care organisations & treatment services, particularly around developing joint working practices for needle exchange, methadone prescribing and dispensing services

3. Work between drug misuse services, maternity services and children's health and social care services, through the use of common assessment tools & information services

4. The development of clear protocols between mental health & drug misuse services about treating users with dual diagnosis.

5. Work with a range of other service providers to maximise the opportunities to engage with potential clients and provide them with access to appropriate services (GUM clinics)

The report also advises that Drug Treatment services will need to engage in a wide range of other partnerships in order to reach all members of their communities and provide them access to services.

These partnerships should for example be with:

- Users & user groups
- Carers & carers groups
- Communities & community groups
- Voluntary and community groups for minority groups eg. Ethnic groups, Gay & lesbian groups

Development of Joint working Policies

The report advocates that in order to ensure partnership working is effective; the partners need to agree on a range of joint policies & procedures. The Audit Commission 2004 recommends that services working together should develop a partnership agreement by jointly working through the following questions.

1. **AIMS & OBJECTIVES**

- ☐ What is the purpose of the partnership?
- ☐ What added value will it achieve?
- ☐ How shall success be determined?

2. **STRATEGY & ACTIVITIES**

- ☐ How will the partners realise these goals?

3. **MEMBERSHIP & DECISION MAKING**

- ☐ What should be the basis for membership of the partnership?
- ☐ How will decisions be taken within the partnership?

4. **MANAGEMENT & OPERATION OF THE PARTNERSHIP**

- ☐ What are the main issues to address and how will they be handled
- ☐ What principles should govern the partnership?
- ☐ How will partner responsibility be divided or shared?
- ☐ How and when will performance be reviewed?

5. **RESOURCES**

- ☐ How shall the partnership be resourced?

6. **CONFLICT AVOIDANCE/DISPUTE RESOLUTION**

- ☐ How shall disputes be dealt with?

Good practice for partnership working

The report 'Working in Partnership' then proceeds to examine good practice for partnership working. It examines a number of major studies of joint working initiatives, identifying factors that influence the success of a partnership. It concludes that to ensure successful joint working the partners should:

1. Ensure full strategic & operational commitment to collaboration
2. Be aware of agencies differing aims & values and commit to working towards a common goal.
3. Consult with all relevant stakeholders such as partnership members, staff, trade unions, service users & carers
4. Identify clear roles & responsibilities for individuals & agencies involved in joint working.
5. Develop agreed performance targets
6. Clarify what resources each agency has committed
7. Follow national guidance on joint working for specific issues & client groups
8. Ensure effective information sharing between agencies
9. Set clear guidelines for reviewing partnership arrangements

'Working in Partnership' also outlines the importance of services being aware of different organisational cultures between partner organisations. This will help services to be more open to changes and developing innovative ways of working together.

It advocates a critical factor in developing & maintaining partnerships is performing and identifying strengths or areas for improvement. It supported other groups using the report of 'Working in Partnership' to highlight strengths & weaknesses in their joint working.

The Irish Context

Within the Irish framework, The Working Group on Drugs Rehabilitation produced a strategy document in May 2007 on Drugs Rehabilitation.

Key recommendations from the document in 2007 included that effective delivery of rehabilitation can only occur through an "interagency approach" based on a continuum of care that operates within the context of enhanced case management and a quality standards framework.

The working group also recommended the development of protocols for interagency working, with 'Service Level Agreements' between agencies and coordination by rehabilitation co-ordinators. The rationale given for strengthening of interagency links was that problems involved in inter-agency working were highlighted in the working group as barriers to the progressions of clients through different services.

With regard to implementing the recommendations of the group on rehabilitation it was deemed necessary to afford time to identified personnel to facilitate the development of relationships and networks between people in the various services.

In order to optimise the resources invested in the rehabilitation process it was recommended that internationally accepted best practices and standards subject to an external evaluation process need to be followed and appropriate performance indicators put in place.

In order to facilitate a "more coordinated response to the needs of problem drug users" as well as enabling improved monitoring procedures with respect to the progress of users through the rehabilitation process, the development of a Quality Standards Framework was recommended for service providers with enhanced case management procedures.

The Working Group made a series of recommendations on how an integrated rehabilitation service should be delivered and who should be involved in coordinating the delivery of this integrated service.

It was recommended that protocols be developed at both national and local level to facilitate the level of inter-agency cooperation, integration and information sharing needed to implement shared care plans. It was envisaged that these protocols would allow for the "seamless transition of people" as they move between one agency and another; and that the protocols would cover issues such as a common understanding of confidentiality, common assessment tools, tracking and monitoring, the settlement of disputes between organisations and the sharing of information between agencies in the context of respect for client's confidentiality and privacy.

The Working Group advised the development of national protocols through the National Drugs Rehabilitation Implementation Committee (to be approved through the Inter-departmental Group on Drugs and at Ministerial level, through the Cabinet Committee on Social Inclusion).

Local protocols would be agreed on by the Treatment and Rehabilitation Sub-groups of the local drugs task forces in conjunction with rehabilitation coordinators. (These would be approved by the National Drugs Rehabilitation Implementation Committees).

In order to clarify the roles and responsibilities of each party, it was thought that Service Level Agreements should be developed in line with the protocols at broad national level and at local level. Rehabilitation coordinators in conjunction with the National Drugs Rehabilitation Implementation Committee would take the lead on drawing up the SLA's at national level and approve the SLA's at local level.

The National Level Service Level Agreements would be approved through the Inter-Departmental Group on Drugs. The local service level agreements would be drawn up by the treatment and rehabilitation sub-groups of the local drugs task forces and overseen by the rehabilitation coordinators.

The Working Group further recommended that rehabilitation coordinators (including a service rehabilitation coordinator) should coordinate the overall drugs rehabilitation across the country and should develop protocols governing client referral between services, facilitate the establishment of interagency service level agreements, the monitoring of case management arrangements and the development of a quality standards framework. The establishment of a rehabilitation coordinator's network was recommended.

The Working Group recommended that criteria be developed to ensure that all state funded treatment and rehabilitation programmes accord with quality standards (these quality standards were to be set out by the National Drugs Implementation Committee in conjunction with the HSE).

It was advised that case managers be nominated to liaise with all relevant agencies to ensure that appropriate services were in place for each client.

With regard to training structures it was recommended that these should be developed for case managers and key workers in drugs and rehabilitation services to address issues such as interagency working, accountability and awareness training in relation to the services provided by other organisations.

Learning from "Equal Project"

The Working group noted the model adopted by the Equal Project in Blanchardstown (Blanchardstown Inter-agency Protocol Initiative (BiPi) 2004). The aims of the Equal Interagency Initiative were to bring together agencies working with current/former drug users in the Blanchardstown area so as to establish clear inter-agency protocols and working relationships, to ensure that agencies interact with each other and their clients in a more formal and defined way.

It was envisaged that these changed work practices would result in

- increased collaboration between services
- avoidance of duplication of services
- a lead agency approach
- more coherent and high quality services provision for service users.

The Working Group on Drugs Rehabilitation further noted that the Equal project was subject to two evaluations and that the protocols they developed on confidentiality and lead agency working should prove useful with respect to protocol development.

Interagency working has been linked to related concepts such as service integration. Service integration has been defined by Kahn and Kamerman as a systematic effort to solve problems of service fragmentation and the lack of an exact match between individual or family with problems and needs, and an intervention program or professional speciality with the goal of creating a coherent and responsive human service system.

Interagency protocols may be used to define the roles and relationships between agencies. Protocols are defined in the Webster dictionary as meaning "records that show official agreements arrive at by negotiations" and often include guidelines for case referrals, clarification of each agencies responsibilities for assessing and investigating reports, define the circumstances in which joint investigations should be initiated, establish timelines and provide for information sharing and client confidentiality.

The purpose of an interagency protocol is to clarify the working relationship between the agencies involved, and formalise these understandings in a document which could be used as a guide in maintaining consistency – a tool for negotiating the coordination of planning services, ensuring successful referral of clients to needed services.

Successful protocols may be dependent on agency staff being able to access those services which optimally enable clients to meet their needs. In order for staff to access these services it is necessary to know what services exist, their main target group, referral processes and to form good working relationships with those services.

Beneficial consequences of written protocols could include

1. Gaining a greater understanding and appreciation of the other agency
2. Clarifying roles and boundaries in working with other clients

3. Maintaining consistency of Interagency relationships when there is staff turnover
4. Knowing what both agencies have agreed to
5. Having a basis to negotiate from when exceptional circumstances arise
6. Having an agreed process for resolving differences.

While a written protocol may require commitment and time to organise, it is possible that hours of negotiation in the future may be saved. Written protocols should greatly assist new staff in getting to know agency agreements and procedures for dealing with external parties.

Collaboration

It is theoretically evident that interagency working/policy networking in partnership/collaborative working are not mutually exclusive. McCary (2003) in the Journal of Nursing Management argued that of all the key challenges that workers face in their professional practice, there had been an effective response to the challenges presented in the interagency teamwork setting where collaboration is at the centre of professional activity.

Drug misuse was described by the "Strategic Management Initiative" as being a "cross-cutting" issue, requiring a coordinated response across a range of issues and sectors. Local Drug Task forces (LDTFs) were established according to SMI principles as they brought together people from various sectors with the goal of developing an integrated response.

In a review of LDTF's in 2000 by Ruddle, Prizeman noted that "LDTF's are not only attempting to address an extremely complex issue (drug misuse) but are doing so through a team based approach involving inter-agency and inter-sectoral working. Michael Martin TD in his foreword to the 2001 Health Strategy, Quality and Fairness document, stated that "the Strategy, at all points, envisages cross-disciplinary collaboration to achieve new standards, protocols and methods".

The Working Group on Treatment of Under 18 year olds presenting with Serious Drug Problems (2005) recommended that Treatment Services for child and adolescent problem drug misusers would be based on a tiered model, adapted to an Irish context providing a solid framework for a multi-disciplinary approach to service delivery. This would in their opinion, enable the necessary collaboration and co-ordination required to tailor treatment to the needs of young people presenting with problem drug misuse.

Kichert, Klijn and Koppenjan 1997, identify that various partners should cooperate in a "network", (a structure involving multiple modes-agencies and organisations with multiple linkages) and should have explicit guiding and rules in order to initiate cooperation to activate the parties and to resolve conflicts between parties with differing interests.

Polend (2002) in "Making Service Integration a Reality" noted that integrating services required free flowing communication patterns, which was important for dispersion of decision making throughout the system together with joint establishment of goals and that team members had a personal sense of efficacy. It was also noted that open high performing systems are not without boundaries. Broad but clear boundaries for operation should be established; broad enough to facilitate the increased autonomy needed for dynamic knowledge based work and clear enough to facilitate increased accountability.

CONCLUSION

Partnership or joint working is vital to ensure drug services and other agencies provide integrated and co-ordinated care. Despite the possibility of difficulties occurring with inter-agency work – for example differences in culture or a lack of clarity around funding and accountability – it is important for agencies to collaborate to address these issues.

All agencies involved can help by agreeing both the partnership's strategic goals and the implementation procedures and protocols. These may include developing protocols for information sharing, clear assigning of roles and responsibilities for each agency and the identification of lines of accountability.

A key factor in the success of any partnership is effective communication between all stakeholders and for drug and social care agencies, including service users and carers in the partnership process.

Berg-Weger and Schneider defined interagency working as an "interpersonal process through which members of different disciplines contribute to a common product or goal".

Bruner (1991) uses a definition whereby interagency working is an effective interpersonal process that facilitates the achievements of goals that cannot be realised when individual professionals act on their own. This definition reflects the way interdisciplinary collaboration is written about and increasingly referred to, when compared with other closely related interpersonal processes such as cooperation, communication, coordination and partnerships. (See Page 110 for Bibliography)

Philosophies of Care

It is acknowledged that with the independent development of addiction agencies within the greater Blanchardstown area, respective philosophies of care naturally created different perceptions of emphasis in client care and sometimes even competing systems of care.

We note that competition for limited resources may have constrained perceptions and professional dialogue on shared care pathways for common service users.

We also acknowledge that the diverse needs of substance misusers make it unlikely that any single agency can respond fully to Service User needs.

Evidence from Service User reports to respective staff in partner agencies clearly demonstrates that the target population use several agencies.

Where services are not well coordinated or communicating effectively on clients behalf, service users inevitably encounter difficulties in negotiating what they may perceive as a complex service network, often "falling between the cracks."

Furthermore, complex needs and motivations of service users caught in addictions may effectively split agency or care teams, such that they fail to receive the help they need, and/or be subjected to unnecessary delays, duplication, frustrations, confusion or ineffective service provision.

Sharing and Learning from Experience

Early in this project MMMA Consultancy identified that worker '*buy in'* to interagency procedures would have to be managed. Towards this end, HSE and CDT workers and Management collaborated through focus groups in the process of protocol development by valuing historical and philosophical nuances, exploring common ground and differences, highlighting tensions and proposing ways of resolving difficulties.

MMMA Consultancy's consultation process with staff confirmed that to date interagency work has largely relied on personal relationships between professionals from respective partner agencies. The quality of care provision and professional interaction was therefore arbitrary rather than based on transparent, agreed and objective standards.

The absence of agreed protocols and over-reliance on personalities to effect collaboration clouded perception and positive valuing of partner agencies, posing obstacles to efficient and effective care planning.

From the focus groups and interviews MMMA Consultants reported the following:

- that the Voluntary and Statutory Partners perceived each other with some criticism that the CDT's saw the HSE's emphasis to be on "numbers" as different to their preferred focus on "client-centred care"
- that the HSE team perceived the CDT's on occasion as lacking in professional standards of training.
- that the HSE Staff did not understand that the requirements for employment in the CDT's were similar to their own
- that concern about 'loosing their identity' was expressed by CDT employees in relation to partnership with the HSE.

Strengthening Commitment

These protocols acknowledge that the context for all addiction treatment is within the local community in which Service Users reside. Hence, the implementation of National policy within the local setting of community resources in the greater Blanchardstown area, embraces people living with addictions from assessment and initiation into harm-reduction and treatments, through to recovery aftercare and rehabilitation.

We see substance use disorders as biopsychosocial in nature such that assessment, treatment and rehabilitation/integration require comprehensive and multidimensional service care programmes. This collaborative approach to service provision best determines and delivers the level of care and service needs for each client.

Embarking on the present protocols the participating agencies express willingness, enthusiasm and commitment to work together towards common standards for interagency collaboration. Clarification of roles and responsibilities of both workers and agencies in these protocols helps to provide transparent procedures for interagency interaction, smoothing pathways of care for clients moving through and between services.

Our Inter-agency work seeks to increase Service User participation in their care planning and to improve Service User satisfaction. We also seek to reduce inconvenience for service users and wasteful overlap of resource expenditure through duplication of service delivery.

Our shared philosophy is to effect a seamless continuum of care for Service Users in the Blanchardstown Area. Agreeing common values and protocols for service delivery between partners, we seek to enhance the quality of client care.

Agreed Values and Principles of Joint Working

As part of this Interagency Addiction Protocols Agreement, the three CDTs and the HSE Addiction Service regard the following principles (or values) as underpinning all our collaboration:

1. **Collaboration** We will conduct and communicate our work in an open, accessible, accountable and professional manner, taking account of views from interested stakeholders and providing feedback at regular intervals.
2. **Added Value:** We will strive to maximise the use of resources available for drug treatment, rehabilitation, education and prevention, ensuring that all our services are delivered in a way that is effective, efficient and economic, avoiding duplication and maximising the benefit to service users and the public purse.
3. **Consensual:** We will seek to reach agreement through discussion and decision-making by consensus.
4. **Equality and Dignity**. We will ensure that we work in a non-judgemental way which upholds dignity and respect in the work place.

5. **Leadership:** We will seek to provide leadership in the field of interagency work among drug service providers through the promotion of best practice.
6. **Proactive Responsibility:** We will provide services in a way that consistently and proactively encourages, motivates and supports service users to progress beyond treatment and so achieve drug-free status and full recovery from addiction.
7. **Quality:** We strive to provide excellence of professional service through training and development of our staff and volunteers, affording high quality information and advice to service users, sign posting services available regardless of sector.

Training and Implementation

All H.S.E. and C.D.T. staff in this partnership are trained and qualified to appropriate standards for the grades at which they are employed.

For implementation of these protocols specific training and information will be provided to respective staff members in relation to the protocols.

It is anticipated that strong management structures across all partner agencies will be required to appropriately support staff to implement interagency protocols and maintain agreed standards.

The protocols have been rendered short, precise and uncomplicated in nature for so that they can be easily explained and made accessible to Service Users. Information will be provided to Service Users by respective staff members.