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Section 1:

Screening & Assessment

Screening and Assessment Protocol

Protocol Outcomes

1. People with problematic drug use identified
2. Overview of main issues for service user outlined
3. Services currently and previously engaged with service user are identified
4. Necessity for comprehensive assessment or case management is identified
5. Service user referred or stays in current service
6. Keyworker assigned
7. Overview of wider needs for service user identified through comprehensive assessment

When to use particular assessment/screening forms

Type of Assessment	Screening	Initial (NDTRS)*	Comprehensive
Type of Services	Generic services that are not drug specific e.g. A&E, hospitals, Social workers, probation. Service users can be screened using the evidence based W.H.O. approved screening tools -AUDIT ¹ & DUDIT ² . If they require further support with drug and alcohol issues they will be referred onto a drug or alcohol service. AUDIT & DUDIT are also the screening tools used as part of the Irish national SAOR model of Screening and Brief Intervention.	All staff involved in case management training can carry out initial assessment which contains the minimum domains outlined by NDRIC. Generally first point of contact in addiction services. <i>*The NDTRS form should be sent to the HRB on a monthly basis as per the NDTRS Training Protocol Part II (2012: 4). The NDTRS provides the basis of an initial assessment as per NDRIC guidelines</i>	All staff involved in case management training can carry out a comprehensive assessment which contains the minimum domains as outlined by NDRIC.
Purpose/When to Use	To ascertain level of drug & alcohol use.	To determine the seriousness and urgency of the drug/alcohol problem. The nature and extent of the use including motivation to engage with treatment & rehabilitation services and any immediate risk factors should be identified. Also identifies if a comprehensive assessment is necessary-depending on complexity.	To identify the service users needs and framework that will be required for a care plan. It will also identify services that will and should be involved in an interagency care plan.

¹ AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care, Second Edition, World Health Organization, Department of Mental Health and Substance Dependence.

² Appendix 3 in Berman, Bergman, Palmstierna & Schlyter (2003) DUDIT (Drug Use Disorders Identification Test) Manual Stockholm: Karolinska Institutet

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<http://www.emcdda.europa.eu/html.cfm/index10451EN.html>



A.U.D.I.T SCREENING TOOL³

*Alcohol Use Disorder Identification Test***

****Forms part of Initial Assessment**

³ AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care, *Second Edition*, **World Health Organization**, Department of Mental Health and Substance Dependence.

AUDIT SCREENING TOOL⁴



Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard drinks do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 5 or more S.D.'s if female, or 7 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

⁴ AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care, Second Edition, World Health Organization
Department of Mental Health and Substance Dependence

How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Total score

Once an individual's risk has been identified, the next course of action is decided:

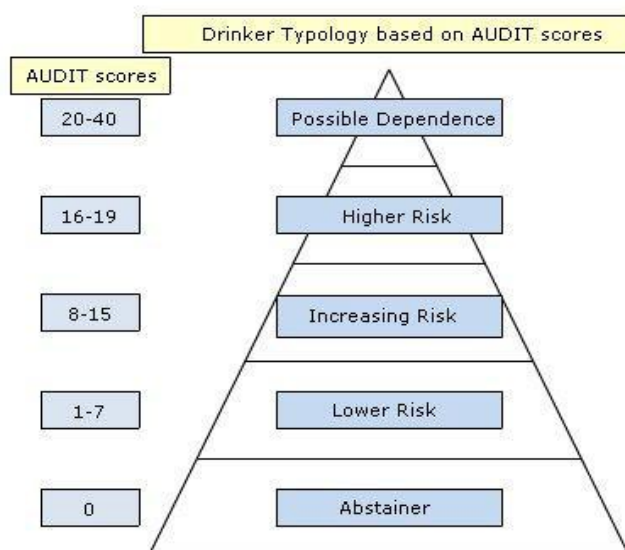
AUDIT score 0: Abstainer - no action is required for this group unless the individual is abstinent because this was the only solution to an existing alcohol problem. In this case, the practitioner might consider congratulating the patient on successful maintenance of abstinence.

AUDIT score 1-7: Lower risk – Service users in this group should be given positive reinforcement where appropriate and advised that they are unlikely to experience alcohol-related problems as a result. This reinforcement might be helped by giving information on standard drinks's and the drinking guidelines.

AUDIT score 8-15: Increasing risk - Service users in this group should be offered Brief Advice. Individuals who have previously had Brief Advice and are still scoring in the increasing risk range could be given Extended Intervention by a competent practitioner or referred on.

AUDIT score 16-19: Higher risk - Service users scoring in this group should be offered Brief Advice. Individuals in this range who have previously had Brief Advice and who are still scoring in the higher risk range could be given Extended Intervention by a competent practitioner or referred on.

AUDIT score 20-40: Possible dependence - scoring 20+ on the AUDIT should be considered for referral to an appropriate service for treatment for alcohol dependence unless adequate resources exists in the primary care setting to offer this treatment.





D.U.D.I.T SCREENING TOOL⁵

*Drug Use Disorder Identification Test***

****Forms part of Initial Assessment**

⁵ Appendix 3 in Berman, Bergman, Palmstierna & Schlyter (2003)
DUDIT (Drug Use Disorders Identification Test) Manual
Stockholm: Karolinska Institutet
Correspondence: Anne H. Berman, anne.h.berman@chess.su.se
<http://www.emcdda.europa.eu/html.cfm/index10451EN.html>

D.U.D.I.T SCREENING TOOL⁶

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you

Male () Female () Age ()	0	1	2	3	4	Score
1. How often do you use drugs other than alcohol?	Never	Once a month or less often	2-4 times a month	2-3 times A week	4 times a week or more	
2. Do you use more than one type of drug on the same occasion?	Never	Once a month or less often	2-4 times a month	2-3 times A week	4 times a week or more often	
3. How many times do you take drugs on a typical day when you use drugs?	0	1-2	3-4	5-6	7 or more	
4. How often are you heavily influenced by drugs	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
6. Has it happened, over the past year that you have not been able to stop taking drugs once you started?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
7. How often over the past year have you taken drugs and then not done something you should have done?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never	Less often than once a month	Every month	Every week	Daily or almost daily	
10. Have you or anyone else been mentally/physically hurt because you used drugs?	No		Yes, but not over the last year		Yes, over the last year	
11. Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?****	No		Yes, but not over the last year		Yes, over the last year	

Total _____

****Pills count as drugs when you take:

- more of them or take them more often than the doctor has prescribed for you
- pills because you want to have fun, feel good, get "high", or wonder what sort of effect they have on you
- pills that you have received from a relative or a friend
- pills that you have bought on the "black market" or stolen
- pills do NOT count as drugs if they have been prescribed by a doctor and you take them in the prescribed dosage.

⁶ Appendix 3 in Berman, Bergman, Palmstierna & Schlyter (2003) DUDIT (Drug Use Disorders Identification Test) Manual. Stockholm: Karolinska Institutet
Correspondence: Anne H. Berman, anne.h.berman@chess.su.se

Quick scoring guide for the DUDIT⁷

- For items 1-9 the responses are coded 0, 1, 2, 3 or 4. Items 10 and 11 are coded 0, 2 or 4. Sum up all the points for the 11 items. The maximum score is 44.
- A male client with 6 points or more probably has drug-related problems, i.e., risky or harmful drug habits that might be diagnosed as substance abuse/harmful use or dependence.
- A female client with 2 points or more probably has drug-related problems. (These numbers are preliminary but can be used as guidelines until more data are available.)
- A client with 25 points or more is probably heavily dependent on drugs

Focus for each DUDIT item:

Nr	Item	Focus
1	How often do you use drugs other than alcohol?	Frequency per week/month
2	Do you use more than one type of drug on the same occasion?	Polydrug use
3	How many times do you take drugs on a typical day when you use drugs?	Frequency per day
4	How often are you influenced heavily by drugs?	Heavy use
5	Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Craving
6	Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Loss of control
7	How often over the past year have you taken drugs and then neglected to do something you should have done?	Priorization of drug use
8	How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	"Eye-opener"
9	How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Guilt feelings
10	Have you or anyone else been hurt (mentally or physically) because you used drugs?	Harmful use
11	Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?	Concern from others

7. Appendix 3 in Berman, Bergman, Palmstierna & Schlyter (2003)
DUDIT (Drug Use Disorders Identification Test) Manual
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Correspondence: Anne H. Berman, anne.h.berman@chess.su.se

Initial Assessment Protocol

Key Steps:

Step 1: Alcohol and drug services will undertake an initial assessment with all new referrals and self referrals that do not already have a care plan/ case manager in place. This will be done within the first two weeks of the service user making contact with the service. The purpose of the initial assessment is to ensure the individual is referred to the correct service, inform a care plan and to ascertain whether they need a comprehensive assessment and a case manager.

The *Service User Information & Consent form* should be explained and signed at this initial assessment stage.

Step 2: If the initial assessment highlights the need for two or more services to support the individual then the service user will be offered case management and a comprehensive assessment will be undertaken.

Rationale for the format of the 2015 Assessment document:

Assessment summary sheet

The purpose of the Assessment Summary Sheet is to give a working snapshot, a clinical concept of the case, summarizing the case in this fashion can primarily help with timely presentation at case conference.

Consent(s)

There are several levels of consent. The purpose of which is:

1. Without primary consent (page 12) there can be no client, and as such there can be no case and can be no intervention, primary consent must be sought by the primary initial assessor.
2. PASS/Homeless consent (page 13) this is only sought by the homeless services case manager/key worker. As such it is specific to the homeless service if the client is engaging with the homeless services and is about to have their data inputted in the homeless services data systems.
3. Additional consents. (page 13) This covers most other possibilities. The need for additional consent(s) may or may not be known at initial assessment, the need for additional consents may develop as the care plan progresses

HRB References (Specific to Drug & Alcohol Services)

Given that most of the questions in the initial assessment form are mirrors of the of questions' on the HRB form, the HRB references numbers which accompanies' the questions throughout the initial assessment form are designed to aid the initial assessor in filling out the HRB forms, without having to have the client present, and thus prevent duplication of process for the client and the assessor.

Assessors Actions

The section Assessors' action acts' only as a memory prompt.

The list of possible actions, on page 21 and again on page 33 are by no means exhaustive nor is it by any means meant to be limiting and or restrictive. The list is a mere signpost. It is however, important to note that the assessor's action need not be part of the initial care plan, they can be and often are distinctly separate actions.

Care Plan^[or] Interagency^[or] Session note

This is a non-restrictive universal note capturing tool. It is designed to capture the topics' of, and, or attendees' to meetings' and, or phone-calls' relevant to the care plan.



Assessment Summary Sheet

Client Name	DOB	AGE	File No	Episode		
				New Client	New Episode	
				Former Client	New Episode	
				Former Client	Continuing Episode	

Referral source Supporting documents Reason for referral	<ul style="list-style-type: none"> • Referrers document: Yes No Not Applicable
Primary substance Secondary substance Other(s)	<ul style="list-style-type: none"> • 1 • 2 • Tertiary • Current Rx / Med. Script
Treatment History	<ul style="list-style-type: none"> • Tx Hx • • • Current Tx /Rx
Primary Goal	<ul style="list-style-type: none"> • •
Needs	<ul style="list-style-type: none"> • Client is seeking • Client was offered •
Noted Concerns	<ul style="list-style-type: none"> • Childcare • Medical / Pyshiatric • Legal • Other
Presented at Case Conference	<ul style="list-style-type: none"> • Supporting Documents Yes No • SASSI DUDIT AUDIT • CAGE PDSQ • Other(s) _____ • Urine analysis Yes No Not Applicable

Initial care plan:

Signed _____

Dated _____



Service User Information & Consent Form

This consent & confidentiality form is designed to give you an understanding of:
What happens to the information you give
Who has access to the information you give

_____ Male ☐ / Female ☐
[Service User Name: Block Capitals]

Date of Birth _____

1. I understand that by signing / marking this form below, I give consent to the recording of my personal information which is ordinarily confidential to the Service. Consent does allow that information to be discussed as a team.
2. I understand that I have the right to withdraw consent for the sharing of information at any time, ***except*** where there is a professional obligation for confidentiality to be extended (*e.g. Child Protection, risk to self, risk to others, Court order*).
3. I understand that the information I provide is ordinarily not disclosed to people outside the Service without further written consent from myself or from my legal guardian, if I am under 18 years of age.
4. I understand that my information / records are retained in electronic [computer] and, or paper form, and are the property of the service provider.
5. I understand that I have the right to access any information held in that record.
6. I understand that consent applies to the duration of this current assessment and, the service provided following on from this assessment.
7. I understand that attending this service requires appropriate behaviour.
8. I also understand that selected information from my records' is also retained by the Health Research Board without the use of my name (Drug & Alcohol Services only)
9. All requests for a report for an external agency regarding my attendance at or my treatment with this service ***must be requested in writing with 10 working days advance notice***. Such reports may require some additional consent.

Please note: In the event of the team becoming aware of information that would indicate that you, or someone in your care, or any other person, may be at risk, then staff of this Service have a professional responsibility to report that concern to a relevant authority.

I CONFIRM THAT THE ABOVE CONDITIONS HAVE BEEN EXPLAINED TO ME AND THAT I FULLY UNDERSTAND AND AGREE TO THEM.

Signature of Service User: _____

Date: ____/____/____
DD/MM/YYYY

Signature of Staff: _____

Date: ____/____/____
DD/MM/YYYY



CONSENT SPECIFIC TO HOMELESS SERVICES PASS DATABASE SYSTEM

Signed _____ Date _____
(Service User)

Signed _____ Date _____
(Assessor)

Name of organisation: _____

Project Worker: _____

Contact telephone number: _____

ADDITIONAL CONSENT(S) GIVEN

Additional Consent(s)
For sharing my information with persons named below

- I give consent to communicate with the below named people / service provider

Signed: _____ Date: _____
[Service User]

Witnessed: _____ Date: _____

ADDITIONAL CONSENT(S) WITHDRAWN

Withdrawal of Additional Consent(s)
For sharing my information with the persons named below

- I withdraw consent to communicate with the below named people / service provider

Signed: _____ Date: _____
[Client]

Witnessed: _____ Date: _____

National Waiting List for Opiate Addiction Treatment Information Sheet for Client

The National Waiting List (NWL) provides information about waiting times for clients who present for treatment for Opiate Dependency. The NWL has been designed to assist with service planning and development within the HSE Addiction Services.

All information on the NWL is treated in the strictest confidence in compliance with Data Protection legislation

I have been advised and I understand that my details will be placed on the HSE National Waiting List for treatment when the following validation processes are complete:

- (a) to establish that my name is not already on a waiting list
- (b) to establish that I am not currently in receipt of treatment

I have been advised and I understand that my details will be dealt with in a confidential manner and will be kept safe and secure and that I can request my details to be removed from the NWL at any time.

I have been advised and I understand that my details will be removed from the National Waiting List, when:

- I commence treatment
- Or, I no longer require treatment, when offered treatment
- Or, I cannot be located by the addiction service

I have been advised and I understand that I should keep in regular contact with the Addiction Service with regard to my status on the NWL.

Signature of Client: _____

Date: ____/____/____
DD/MM/YYYY

Signature of Staff: _____

Date: ____/____/____
DD/MM/YYYY



Source of Referral: **[HRB15a]**

Referral Date: **[HRB13]** ____/____/____

Assess Date: **[HRB16]** ____/____/____

Ref Number: **[HRB3]**

PASS ID: _____

INITIAL ASSESSMENT FORM

Name of Client:		Male [HRB4]	Female [HRB4]
Date of Birth [HRB6]		Age [HRB5]	

What is the reason for your referral/access to this service? **[HRB14]**

Alcohol Use ☐ Illicit Drug Use ☐ Licit Drug Use ☐ Other ☐ Homelessness ☐

TICK ALL APPROPRIATE BOXES

If 'Other ☐' selected above give details _____

**** It is of the utmost importance to the care plan that
where relevant the appropriate appendices are fully completed ****

Current / Last / Most Recent Address: _____

Phone Number _____ **Mobile Number** _____

Agree to contact at above address Yes No On mobile Yes No

Living With **[HRB7a]**

Alone ☐ Parents/ Family ☐ Friends ☐ Partner(alone) ☐

Partner & Children ☐ Alone & Children ☐ Foster Care ☐

Other ☐ Not Known ☐

Living Where **[HRB7b]**

Stable accommodation ☐

Institution (prison, clinic) ☐

Homeless ☐

Other unstable accommodation ☐

Not known ☐

Accommodation type: _____

Nationality **[HRB10]** _____

Ethnicity: **[HRB10a]** White Irish ☐ White Irish traveller ☐ Any other white background ☐ Black African Background ☐ Any other Black Background ☐ Chinese Background ☐ Any other Asian Background ☐ Other ☐ Do not wish to answer this question ☐

Age left Primary or Secondary School **[HRB12a]** _____
Highest Primary or Secondary Education level reached **[HRB12b]** _____

Employment Status **[HRB11]** _____ Occupation _____
Source of Income _____ Amount of Income _____
What days do you work _____
What hours do you work _____

G.P Name _____ G.P aware of Drug Use: Yes ☐ No ☐
GP Address: _____

Medical Card Yes ☐ No ☐ Applying for ☐
(Homeless Service Only) Medical Card Number _____ Valid until _____

Substance use in family Yes ☐ No ☐ _____
Details _____

No. of children _____ Age Range: _____
(Homeless Service Only) No. Of current dependent Children _____

Child Care/Welfare/Protection Concerns _____

Living with Substance Users/Gamblers/other addictions Yes ☐ No ☐
Details _____

Current links with Agencies/External Professionals Involved Yes ☐ No ☐
Other services involved in care plan to date _____

NEXT OF KIN

Name of next of kin / emergency contact: _____
Relationship of next of kin / emergency contact _____
Next of Kin/Family aware of substance use: Yes ☐ No ☐
Enter contact details of Next of Kin _____

SUBSTANCE USE, GAMBLING, EATING DX, HISTORIES [HRB14, 24A, 24B-28E]

<u>DRUGS USED</u>	<u>ROUTE OF TRANSMISSION</u>	<u>FREQUENCY</u>	<u>QUANTITY</u>	<u>DURATION OF USE</u>	<u>AGE 1ST USED</u>	<u>DATE LAST USED</u>
<u>ALCOHOL</u>						
<u>CANNABIS</u>						
<u>HALLUCINOGENS</u>						
<u>BENZODIAZEPINES,</u> <u>HYPNOTICS &</u> <u>SEDATIVES</u> <ul style="list-style-type: none"> • <u>PRESCRIBED</u> • <u>STREET</u> 						
<u>HEROIN</u>						
<u>METHADONE</u>						
<u>OTHER OPIATES</u>						
<u>COCAINE</u>						
<u>AMPHETAMINE</u>						
<u>ECSTASY</u>						
<u>OVER THE COUNTER</u> <u>DRUGS</u> <u>ANY OTHER DRUGS:</u> [i.e: Solvents / Gas]						

Head-shop / Steroids? Others.....]						
<u>DRUG OF CHOICE:</u> <ul style="list-style-type: none"> • <u>PAST</u> • <u>PRESENT</u> • <u>FIRST DRUG</u> <u>TAKEN</u> 						
<u>GAMBLING</u>	FORMS OF	FREQUENCY	AMOUNT	DURATION	AGE 1ST	LAST GAMBLED
<u>EATING DISORDERS</u>						

RISK MANAGEMENT

Ever injected [HRB29b]	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Age first injected [HRB29c]	_____	
Ever shared [HRB30]	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Injected in last month [HRB29a]	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shared in last month	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If using I.V. needles how are they obtained		
If using IV needles how are they disposed		
HIV test	Yes <input type="checkbox"/>	No <input type="checkbox"/> Date Estimated _____
HBV test	Yes <input type="checkbox"/>	No <input type="checkbox"/> Date Estimated _____
HCV test	Yes <input type="checkbox"/>	No <input type="checkbox"/> Date Estimated _____
Last vaccination date: (Location) _____ Date Estimated _____		
Type of vaccination		
Place of vaccination		
Any History of STI's	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Unprotected Risk:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

JUSTICE / LEGAL

Supports habit with: _____

Most serious charge: _____

Current charge Yes ☐ No ☐ _____

History of Assault Yes ☐ No ☐ _____

Details of convictions/Probation?

HARM REDUCTION ADVISE GIVEN

Needle Exchange time and places Yes ☐ No ☐

Safer sex Yes ☐ No ☐

Drug Interactions' Yes ☐ No ☐

Other (give details) _____

PREVIOUS TREATMENT

Ever Treated for Substance Use/Gambling [HRB22] Yes ☐ No ☐

Number of previous treatments Treatment Type(s) _____

Longest time Drug/Gambling Free: _____

Date Free From: _____ Date Free To _____

Previous Treatment(s) _____

Agency _____

Reason for leaving _____

Current methadone treatment? [HRB 21a, 21b] Yes ☐ No ☐

Other Current Treatments/Medications Yes ☐ No ☐

Details: _____

Previous methadone maintenance Yes ☐ No ☐

Any services currently involved in care provision Yes ☐ No ☐

OTHER RELEVANT HISTORY

Any known Allergies [Medical or Any Other]

Past / Recent relevant medical history:

Currently Prescribed Medications

Any history of seizures? Yes ☐ No ☐

If 'Yes' give details _____

Ever seen by a Psychiatrist/Psychologist/Counsellor/Occupational Therapist: Yes ☐ No ☐

If 'Yes' give details

Any Occupational Therapy or Other diagnosis _____

History of Overdoses Yes ☐ No ☐

Accidental Overdose _____

Deliberate Overdose _____

History of Self Harm Yes ☐ No ☐

History of Domestic Violence Yes ☐ No ☐

History of suicidal thought Yes ☐ No ☐

Details

Treatment requested by Service User Yes ☐ No ☐

Specify:

Assessors Actions required following initial assessment ***not*** requiring comprehensive assessment

- *Children First / Child protection / Social work referral*
- *Direct provision treatment* [HRB 18a-1]
- *Progress to opiate substitution protocols* [HRB 18a-2]
- *Refer on to other treatment provider* [HRB 18a-3]
- *Psychiatric assessment or review* [HRB 18a-4]
- *Medical assessment* [HRB 18a-6]
- *Nursing viral screening or review* [HRB 18a-6]
- *Harm reduction psycho-educational group* [HRB 18a-6]
- *other / Involving placement on a list* [HRB 18a-6]
- *Referral to HAT / Homeless Action Teams*
- *Key working toward another services provider* _____
- *other* _____

Assessors' comments & ***Initial Care Plan***

Initial assessment completed by:

Signature _____

Date ____/____/____

Comprehensive assessment needed:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Comprehensive assessment arranged	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Common assessment needed:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Common assessment arranged	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Annex 'A'

Specific Housing information relevant to primary homeless services'

Can you outline the main reasons for you becoming homeless on this occasion?	
Have you been homeless before?	
If yes, please give brief details	
Have you ever slept rough?	
If so when and for how long?	
Are you registered with a Local Authority	
If so please specify which Local Authority	
Do you have any outstanding rent arrears with a Local Authority	
Have you ever received a deposit from C.W.O towards private rented accommodation	
Address of property/properties deposit was given for	
*Date of receipt of deposit- approx	
*Are you currently entitled to receive a deposit from Social welfare office	
Have you ever lived independently	
Have you ever been in state care under age of 18 years? If so please specify type e.g. residential or foster care.	
What are the main reasons for you becoming homeless? e.g. relationship, drug, alcohol issues, discharge from prison/hospital or other.	
If you were evicted from accommodation could you outline the reason for the eviction	
What difficulties would you say you have experienced in attempting to maintain accommodation in the past	

Comprehensive Assessment Protocol

Step 1: Prior to the comprehensive assessment being undertaken the service user will be informed of the consent already agreed upon. The worker will then contact services currently working with individual, to see if a case manager/care plan is already in place. Services can add or withdraw agencies named on the *additional consent form* as case progresses with service users consent.

Step 2: If there is a case manager already assigned then two workers and the service user will meet or it will agreed over the phone how the agencies work to support the care plan.

Step 3: If no case manager exists then the service undertaking the comprehensive assessment will take the role of case manager/lead agency

- Note that for some services where case management is integral to the service e.g residential or day programmes, the initial and comprehensive assessments may be done in one sitting at referral or entry to the service, In lower threshold services the assessments may be done over a period of visits or meetings.



COMPREHENSIVE ASSESSMENT SECTION

Physical Health

Have there been any changes to your physical health since you completed your initial assessment
If so, what changes have occurred?

Any documented general health diagnosis or conditions

Are there needs in relation to physical health & well-being

Detail needs and any relevant case history:

Interest in pursuing medical appointments

Services currently or most recently involved in physical health

Name & Org:

Phone/email:

Interventions/supports:

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

Mental Health & Well-being

*{Metal health and Well-being should include
Spiritual, Emotional, and Psychiatric Aspects}*

Have there been any changes to your mental health since you completed your initial assessment
If so, what changes have occurred?

Any documented mental-health diagnosis or condition:

Are there needs in relation to mental-health & wellbeing

Any history of self harm, attempts at suicide, or suicidal though

Detail needs and any relevant case history:

Any periods of general emotional wellness

Would you be open to attending mental health appointments

Services currently or most recently involved in mental health & well-being

Name & Org:

Phone/email:

Interventions/supports:

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

RELATIONSHIPS

Family & Others

Family, Partner, Spouse, Children, [Names, where they are living, frequency of contacts]

Are there any relationships which pose a risk to Children, or Others, or your care plan

Any Behaviours which pose a risk to Children, or Others, or your care plan

Any need or concerns with regards to your significant relationship

(e.g. Domestic violence, Substance use, criminal activity, any other?)

Are you open to attending social work or other supports

Services currently involved or most recently involved:

Name & Org:

Phone/email

Interventions/supports:

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan

SOCIAL SUPPORTS & OTHER SOCIAL OUTLETS

Any former or current hobbies:

Any desire to develop a new hobby or outlet

Any attendance at ANY fellowship [AA, NA, GA, OA, Faith/Church etc etc] or link with any sponsor

Would there be a benefit in more or, different social supports or social outlets

What non-substance using outlets are there

Services currently involved or most recently involved

Name & Org:

Phone/email:

Interventions / Supports

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

EDUCATION/TRAINING

Age left primary or secondary school

What was your reason for leaving at that time

Highest level completed

Literacy or learning difficulties

Any additional education or training that have been completed

Are there any aspirations with regards to Education / Training / Vocation

Are there needs/interests in relation to further education, training, vocation

Services involved or most recently involved

Name & Org

Phone / Email

Interventions / Supports

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

ACCOMMODATION

How would you describe your current accommodation [Stable or Unstable]

Any needs or concerns in relation to current accommodation

Is the current accommodation situation suitable for children, or spouse, partner, care plan

Is there any history of involvement with any homeless services?

Any history of evictions:

Any history of sleeping rough

If homeless, are you registered on the housing list or with the local assessment and placement service:

[Ensure Appendix 'A' is completed if required] Plus ** Possible referral for Homeless Action Teams**

Services currently involved or most recently involved:

Name & Org:

Phone/Email:

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

LEGAL ISSUES

Current (or suspected) outstanding charges

Current (or suspected) arrest warrants

Upcoming court dates:

Most serious charge to date

Any history of violence, aggression, threatening or bullying, toward self or others

Any history of Sexual assault, Arson, firearms or other weapons, charges

Services currently involved or most recently involved

Name & Org:

Phone/email:

Interventions / Supports

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

FINANICAL ISSUES

Do you have any current financial needs, or financial concerns or financial stressors

Do you have any current debts

Are you currently linked in with any agency (e.g. MABS, CWO, VDP, etc etc)

Services currently involved or most recently involved

Name & Org:

Phone/email:

Interventions / Supports

Proposed means of meeting identified needs

[Is additional consent required to advance this aspect of a care plan]

ASSESSMENT OF PRIORITIES

What are your care plan priorities over the next three months

Any other relevant info to the case:

Assessors actions required, **following** comprehensive assessment

- *Children First / Child protection / Social work referral*
- *Direct provision treatment* [HRB 18a-1]
- *Progress to opiate substitution protocols* [HRB 18a-2]
- *Refer on to other treatment provider* [HRB 18a-3]
- *Psychiatric assessment or review* [HRB 18a-4]
- *Medical assessment* [HRB 18a-6]
- *Nursing viral screening or review* [HRB 18a-6]
- *Harm Reduction psycho-educational group* [HRB 18a-6]
- *other / Involving placement on a list* [HRB 18a-6]
- *Referral to HAT / Homeless Action Teams*
- *Key working toward another services provider*

- | | | |
|---|------------------------------|-----------------------------|
| ○ <i>Medical / Physical Need identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Mental Health Need Identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Relationship Need Identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Social Support Need Identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Education / Vocation Need identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Accommodation Need Identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Legal Need Identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| ○ <i>Financial Need Identified</i> | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Assessors comments

Comprehensive assessment completed by:

Signature _____

Date; ____/____/____

Shared Care:

Case Management Needed Yes ☐ No ☐

Case management case conference required Yes ☐ No ☐

Case Manager assigned [HRB 33a[25-26]] [Name] _____

Case Managed Case Conference [Date] _____

Case manager contacted Key workers / Key Agencies _____

Annex ‘B’: Adult Minnesota Treatment Programme: Page 1 of 4

COMPREHENSIVE DRUG / ALCOHOL / GAMBLING HISTORY

Gather the narrative from the age first used drugs / alcohol / gambling to the current day
and the consequences of same over time

[illegible]

Annex 'B': Adult Minnesota Treatment Programme : Page 2 of 4

Drug / Alcohol Narrative History: Continued

[illegible]

Annex 'B': Adult Minnesota Treatment Programme: Page 3 of 4

COLLATERAL HISTORY

NAME _____

RELATIONSHIP TO CLIENT _____

CONSENT FORM SIGNED Yes ☐ No ☐

Name:

Address:

Contact details:

Concerned person service offered: Yes ☐ No ☐

Give details:

Other interventions offered (strengthening families) Yes ☐ No ☐

Give details:

Annex 'B': Adult Minnesota Treatment Programme:Page 4 of 4

MEDICAL CONSULTATION

Date: _____

Completed by: _____

Screening Tools:

Completed D.S.M I.V Yes ☐ No ☐ If D.S.M.I.V completed. attach same

Completed M.A.S.T Yes ☐ No ☐ If M.A.S.T completed attach same

Other assessment tool used Yes ☐ No ☐ If other tool(s) used attach same and give details:

Referral to acupuncture service: Yes ☐ No ☐

Date of referral:

Section 2:

Referral Protocol

Referral Protocol

When to use: This protocol should be used when making referrals to agencies to access services for a service user.

Protocol Outcomes

1. Service user accesses appropriate services in line with agreed interagency care plan goals/needs
2. Agreement and clarity among service providers and service user regarding referral to another service, including steps and timeframe involved
3. The service user is supported throughout the process as required and appropriate follow-up takes place
4. Service user will be tracked and supported to minimise disengagement from services.

Key Steps

Step 1: A referral to a different agency should be made when a service user's need is identified following an assessment and some form of service outside of the assessing agency is required.

Step 2: In this context, all services should ensure the availability of clear information and staff knowledge concerning criteria for access, current waiting times and referral process.

Step 3: The service user should be supported in the referral by the referring service with regards to needs identified in the assessment and/or care plan. Written consent should be obtained prior to any contact with other services. If a service user does not consent to their information being shared, then this should be respected.

Step 4: The Case Manager should provide a new agency with the Cork/Kerry referral form⁸ together with a cover letter (see appendix 2) outlining their role and the signed additional consent form

Step 5: Following referral, the person making the referral should follow up with the service user and the service to ensure that the service user has engaged with the new service, and share the assessment form and care plan as appropriate.

Step 6: If there is likely to be a significant wait in a service or programme, then a plan should be put in place by the Case Manager for the interim period, which may focus on preparatory activities or maintaining motivation. If there are problems in engaging other services, then the Case Manager should refer to the Gaps and Blocks Protocol (see pg 61).

Step 7: If disengagement occurs following referral, then the referring agent and Case Manager should be notified by the agency to which the service user was referred.

⁸ If the service you are referring to require their own agency specific referral form to be completed then proceed as requested.

Referral Form

Steps for Referral	
1	Obtain service user's agreement (Interagency Consent for Release of Information form completed and signed and sent with referral form)
2	Make telephone call to receiving agency to agree appointment details
3	Fill out and send form directly to the individual who took the appointment
4	For services with walk-in facilities where an appointment is not required, give the service user the contact details of the service i.e. the contact telephone number, the address and the opening times of the service and forward as above.

Checklist	
<input type="checkbox"/>	Interagency Consent for Release of Information Form signed and attached
<input type="checkbox"/>	Assessment Completed

Referral Form (ctd)

Service User Details

Service User
Name:

D.O.B.

 / /

Address:

Can the service user be contacted by post at this address?

Yes

☐

No

☐

Service User's phone
numbers:

Home:

Mobile:

Can the service user be contacted at these numbers?

Home

Y

☐

N

☐

Mobile

Y

☐

N

☐

Agency:

Referral from:

Referral Date:

 / /

Referral To:

Reasons For
Referral:

The initial appointment is for (please tick):

Interagency meeting

☐

One-to-one with service
user

☐

Other (please state):

Confirmed:

Date

/

/

Time

Location

Signature of referring agency staff:

Section 3:

Interagency Care Plan Protocol

Interagency Care Plan Protocol

When to use: An Interagency Care Plan should be developed when two or more agencies are working with a service user. This will ensure that only one overarching care plan is developed and provide more focus for the service user ensuring that goals are set progressively and care plans build upon each other while potentially conflicting goals are avoided.

Protocol Outcomes

1. Interagency Care Plan is developed with areas of need identified
2. Actions and interventions on care plan are agreed between service user and all service providers involved
3. Case Manager and Lead Agency identified
4. Keyworker/point of contact in each service responsible for an action is identified
5. A timeline is agreed for each action
6. A regular review date of at least every 3 months is set for the care plan
7. The Interagency Care Plan is updated reflecting the service user's current needs and detailing the supports being provided
8. Enhanced service user involvement
9. Enhanced inter-agency working

Key Steps

Outline of the Interagency Care Plan

Step 1: The care plan is a collaborative process between the service user and the services involved in their care. The agencies currently involved will be identified with the service user during the assessment process. When developing the Interagency Care Plan it is essential, at this stage, that other relevant services (required to meet agreed goals) are identified.

Step 2: The Interagency Care Plan will outline the interventions agreed, referrals required and timeframe outlined to review the intervention/issue/action identified. A care plan should be developed with realistic goals and address the physical, psychological, social and legal needs of the person. The Case Manager should provide a copy of the Interagency Care Plan to the service user and agencies involved when agreed. All actions and timescales should be clearly outlined on the plan.

Step 3: Any referral or interagency meeting at this stage should be carried out in line with the Referral Protocol or steps outlined for an Interagency Care Plan Meeting.

Interagency care plan meeting/Case management meeting.

- An Interagency Care Plan Meeting is any meeting which takes place between two or more agencies involving the service user in relation to the development, progression or review of the Interagency Care Plan of a service user.
- The general purpose of an Interagency Care Plan Meeting is to support service user involvement, review progress and ensure clarity in relation to the Interagency Care Plan and to foster a co-ordinated approach among agencies, ensuring sufficient supports and reducing duplication. The specific purpose(s) of an Interagency Care Plan Meeting should be outlined such as:
 - a. Referral,
 - b. Change of Case Manager,
 - c. Care Plan Review etc.
- While not all interactions between services may require an Interagency Care Plan Meeting or the involvement of the service user, there are some circumstances in which it is essential:
 - a. there is a transfer of case management roles between services⁹
 - b. the service user has requested it
 - c. a Lead Agency/Case Manager cannot be agreed*
 - d. there is a divergence of views on progressing the Interagency Care Plan or appropriate interventions cannot be accessed*

⁹ This should be formally recorded in the care plan and documentation will be transferred accordingly- see C.M Transfer form pg 52.

* It is recommended that services try and address contentious issues (such as where services have divergent views on progressing care plan or determining the Lead Agency) without involving the service user at first.



Interagency Care Plan - Cover Sheet

Service User Details:

Service User
Name:

--

D.O.B.

/	/
---	---

Address:

Telephone:

--

Case Manager:

--

Agency:

--

Date of first
contact:

/	/
---	---

Agreed Review
date:

/	/
---	---

Checklist:

- ☐ Assessment Complete
- ☐ Release of Consent for Information Form Signed
- ☐ Referral Form.

Interagency Care Plan - Action Sheet (ctd.)

Service User Details

Service User Name:

D.O.B.

 / /

Drug and Alcohol Use:

	State actions to be undertaken	By whom?	When?
1			
2			
3			
4			

Outcome to Date:

Physical and Psychological Problems:

	State actions to be undertaken	By whom?	When?
1			
2			
3			
4			

Outcome to Date:

Social Supports:

	State actions to be undertaken	By whom?	When?
1			
2			
3			
4			

Outcome to Date:

Legal Problems:

	State actions to be undertaken	By whom?	When?
1			
2			
3			
4			

Outcome to Date:

--

Accommodation Supports

	State actions to be undertaken	By whom?	When?
1			
2			
3			
4			

Outcome to Date:

--

Risk Assessment:

	State actions to be undertaken	By whom?	When?
1			
2			
3			
4			

Outcome to Date:

--

Date: _____ / _____ / _____

Signed (Service user):

--

Signed(Case Manager):

--



Interagency Care Plan -Review Sheet

Service User Details:

Service User Name:

D.O.B.

 / /

Present:

1		2	
3		4	
5		6	
7		8	

Location:

Item	Outcome
1	
2	
3	
4	
5	

Date:

 / /

Signed (Service user):

Signed (Case Manager):



Interagency Care Plan - Case Manager Transfer Form

Previous Case Manager:

Agency:

Newly Agreed Case Manager:

Agency:

I am satisfied with the manner in which this review has been conducted and with the agreements that have been reached with my involvement and/or on my behalf.

Service User Signature (if present):

Previous Case Manager

New Case Manager:

Date:

/ /

Section 4:

Keyworking/Care Planning/Case Management

Keyworking , Care Planning and Case Management Local Protocols Cork/Kerry.

Introduction

These protocols are based on the National Rehabilitation Framework and a facilitated session with local services organised by Joe Kirby, Rehabilitation Co-ordinator. The basic content has also been developed in reference to QUADs documents.

Contents

1. Glossary
2. Principles
3. Case Management
 - Identifying the lead agency/case manager
 - Involving Other Services in the Interagency Care Plan
 - Transfer of Case / Onward Referral
 - Case Closure
4. Key Working
 - Working with a case manager in another service
 - Attending case meetings
 - Exiting Key Working / Case Closure

1. Glossary

Key worker: a named person who is assigned to work closely with the service user to:

- Ensure consent for all service delivery and information sharing.
- Develop a care plan in relation to what their particular service can provide (this may involve communicating with a case manager and other key workers as required).
- Advocate on behalf of the service user where required.
- Keep relevant case notes/records.

Case manager: the case manager has same roles as a key worker with the additional duties of:

- Ensuring that the service users needs are matched by appropriate service delivery through engaging other services in the interagency care plan as required and appropriate.
- Monitoring the agreed interagency care plan and ensuring objectives are SMART¹⁰
- Undertaking formal care plan reviews every 3 months.
- Communicating with other agencies and responding to interagency issues relating to the interagency care plan as they arise.

Lead Agency: the agency which houses the case manager.

The lead agency should commit to providing case management services for a minimum period of six months and ensure continuity of service provision should the individual case manager leave their post. Management in the lead agency should provide support to the case manager should there be any impediments to progression of the service users care plan.

¹⁰ Specific, Measurable, Attainable, Realistic, Time lined

2. Principles

- Service users can be self referred into services or referred by another agency
- A service user should only ever have one case manager.
- Any drug service whose staff have completed the N.D.R.I.C training can undertake assessments and work in the case management role.
- Interagency work is essential to good case management; in all instances the service will strive to ensure that other agencies are involved appropriately and effectively in an interagency care plan.
- Continuity of care should be prioritised. Where a service user is no longer appropriate to be case managed by one particular organisation, this organisation will endeavour to find another service to provide case management or key working. If an appropriate service can not be found then the service of first contact will provide what supports are possible and will attempt to resolve the issues through Gaps and Blocks systems.

3. Case Management

Identifying Lead Agency/Case manager.

- Prior to the comprehensive assessment being undertaken the service user will be informed of the individual service's confidentiality policy and asked to sign a consent to share information form. The worker will then contact services currently working with individual, to see if a case manager/care plan is already in place.
- If there is a case manager already assigned then two workers and the service user will meet or it will agreed over the phone how the agencies work to support the care plan.
- If no case manager exists then the service undertaking the comprehensive assessment will take the role of case manager

In the instance that two services view themselves as best placed to take the role of lead agency/ case manager the following should be done:

- Services should attempt to resolve the issue firstly between staff and secondly between service managers. Note that the service user's views should be taken into consideration in this decision.
- If this still cannot be resolved, a case meeting should be held with the service user. It may also be appropriate to involve representatives from other agencies. The lead agency should be agreed co-operatively through a chaired discussion, taking the service users views into consideration.

In general the lead agency should meet the following criteria:

- The lead agency will have the most contact with the service user.
- They will provide a dedicated case manager with sufficient time to manage the interagency care plan.
- They will commit to managing the case for a period of no less than six months.

The only circumstance where there are likely to be two case managers is when there is social work involvement: where the social worker is case manager for the child or for the case and where one or both of the adults have case managers. In this instance roles should be clearly agreed and all workers should strive to work together.

If it is determined that the service user is not appropriate for the service, an assessment should be undertaken by the agency to determine who is best able to meet the service user's needs and is able to provide case management. The organisation will play an active part in supporting the referral of the service user to the appropriate service.

Involving Other Services in the Interagency Care Plan

Following the signing of the consent to share information form, the engagement of other services in the care plan can be done through mail and phone contact or through an interagency case meeting (as described in the Interagency Case Meeting Protocol).

Note that when emailing the HSE, service user information can only be sent in encrypted systems within the HSE email system, or should include initials only and not relate to any personal information. The appropriate course of action will be decided by the case manager, in consultation with the line manager if necessary.

When involving other services (non drug & alcohol specific) such as probation, social work, doctors, mental health professionals etc, the role of the case manager should be explained and sufficient information and actions should be obtained to complete all areas of the shared care plan. Services should be provided with a copy of the information in relation to their involvement in the shared care plan (with service user's consent).

HSE methadone provision services, if any are involved should receive a full copy of the shared care plan (with service user's consent if not already specified on release of information form).

If there are problems in engaging other services then these should be brought to the case manager. If they cannot be resolved at the service level then they will be brought to the rehabilitation co-ordinator through the Gaps and Blocks form.

Care Plan Reviews

These will be undertaken quarterly and will involve a review of: all care plan action - what has worked well, what challenges have presented, any gaps and blocks, new issues arising, as well as next steps care plan actions.

Transfer of Case / Onward Referral

The role of case manager will be needed to be transferred to another agency when:

- The service user progresses along the continuum of care.
- The service is no longer best placed to meet the service user's needs.
- The service user relapses and so is no longer appropriate for the programme / the service user leaves the service.
- The service user requests to be case managed by another service.

A meeting should be held to transfer the case. The handover meeting should involve a copy of care plan and assessment being transferred to a new case management agency. A care plan review should be undertaken in order to establish the most important supports to be put in place at the current time.

Case Closure

Case closure can be divided into two categories, each with their own procedures:

Positive Case Closure:

This occurs when the service user has achieved all their goals and both the worker and service user are in agreement that intensive case management is no longer required. If a service user completes a programme although still has unmet care plan goals and needs, the case should be transferred to another provider. In the case of a positive case closure:

A case closure / exit meeting will be arranged. The purpose of this is to identify progress made, an aftercare plan and the appropriate support services in the event of a relapse. The case closure meeting will involve the case manager and service user.

Other Case Closure:

This describes the following: the service user stops attending the service for a significant period of time. The service user decides they do not wish to be case managed or key worked. In this case attempts should be made to contact the service user (mail, phone, through messages in other services), to ask whether they would like to be case managed/ key worked by another service, or key worked within our service (if they have decided not to be case managed). It is important that the option of having a case manager is kept open to individuals at all times. If they are interested in another service the worker should arrange a case transfer if possible.

4. Key Working

Working with a case manager in another service

If the case manager is located within another service, the key worker should, provided there is service user consent, contact this person and seek to ensure that there is an agreed care plan and there is no replication in service delivery.

At any point in the key working process any changes to service delivery from what was agreed in care plan from the perspective of the organisation should be communicated to the case manager.

Attending Case Meetings

- Key workers should seek permission to attend case meeting from their supervisor / manager as soon as possible. The service will make all attempts to ensure workers can attend meetings.
- If a worker cannot attend the case meeting, they should ensure a written report outlining their contribution to the care plan and any other issues is sent to the case manager. This report should be followed up with a phone call to ensure that any questions and issues can be discussed by phone prior to the case meeting.
- The service may decide to substitute in the instance that the individual's key worker is not available, all efforts should be made to handover case information to the worker attending.

Service User Exiting Key Working / Case Closure

If an individual is leaving the key working relationship a meeting should be held which identifies goals achieved and how supports will be provided in the future. The service user should be informed that if circumstances require, they may re-engage with the service at any time.

Section 5:

Confidentiality Protocol

Confidentiality and Information Sharing Protocol

When to use: It is recognised that maintaining confidentiality is crucial to the building of a trusting and respectful working relationship with the service user. It is equally important that all parties recognise that confidentiality is never absolute and service users should be given a clear understanding of the limitations to confidentiality at the outset. All agencies should have appropriate policies and procedures in place to legally allow them to share information.

Protocol Outcomes

1. The service user understands issues relating to confidentiality, including their right to privacy, as well as the limits to confidentiality. The service provider must discuss these issues with the service user to ensure this understanding¹¹
2. The service user is clear about the processes by which they can consent to agreed personal information being shared amongst different parties to the Interagency Care Plan, as well as how to review and withdraw consent.
3. Services agree a definition of what information is considered appropriate and necessary based on the role and responsibility of staff attending and engaged in the interagency care planning process and the role and function of their agencies.

1. Rationale

Confidentiality is key to working well with service users.

2. Purpose

- To ensure that the confidentiality of service users involved in the Cork/Kerry projects are protected in a consistent and appropriate manner.
- To provide staff and service users with information on the Cork/Kerry regions agreement on confidentiality, guidelines regarding handling of information, the extension of confidentiality and responsibilities for the management of confidentiality.

3. Scope

This agreement covers all employees and service users participating in case management across Cork/Kerry. .

4. Glossary of Terms and Definitions

- Confidentiality - All information that is obtained through the course of organisational business and service provision is confidential. In general, an employee shall not at any time, during or following working with a service user disclose such information in any form to any person without the written consent of the service user.
- Extension of confidentiality - In certain circumstances information can be passed on to a third party without the consent of the individual whose information it is.

¹¹ Legislation can be accessed at www.irishstatutebook.ie; Children First: National Guidelines can be accessed at www.dohc.ie; and Information Governance Guidelines can be accessed at www.hiqa.ie

- Wrongful disclosure – When confidential information is passed on to a third party without permission either by accident, negligence or design.

5. General

- Confidentiality is not absolute and therefore can not be guaranteed. The designated lead agency which employs the appointed case manager is responsible for collecting consent and storing/coordinating information. Individual agencies are responsible for the data collected by them, as each agency would be considered a separate data controller under the Data Protection Acts¹². All service users are to be made aware of the Cork/Kerry regions confidentiality agreement.
- All service users have the right to have a copy of the relevant information held by services involved in case management in line with the consent provided. Requests for a copy of this information should be made in writing by the service user to the agency from which they wish to obtain their information.
- Information about a service user will not be passed on to any third party except in the following cases:

(a) Where written consent has been obtained from the service user.

(b) Where there is a legal obligation to extend confidentiality such as a court order to release information.

(c) Where the release of the information is in the vital interests of the individual or another individual.

- All service users have the right to withdraw consent for the sharing of information at any time, except where there is a legal obligation for confidentiality to be extended as outlined above.
- All service user files are to be kept in a secure place within the organisation. Workers are expected to exercise care to keeping safe all documents or other material containing confidential information.
- All service users files should be kept in a locked filing cabinet, with the key held only by staff members involved in relevant service provision.
- Agencies utilising electronic storage of information operate as per their existing confidentiality guidelines.

6. Roles and Responsibilities

Responsibility of Rehabilitation Co-ordinator Cork/Kerry:

Ensuring that all core project members are briefed on their responsibilities when dealing with confidential information.

Liaising with individual Project Managers around confidentiality issues.

Liaising with core project team members around confidentiality issues.

¹² Data protection act found at www.dataprotection.ie

Project Managers Responsibility:

Ensuring that a copy of this agreement is available to all his/her staff who are working/involved with a case management approach in Cork/Kerry region.

Ensuring that a copy of this agreement is available to users of the service.

Ensure that all staff confirm they have understood this confidentiality agreement and how it may differ from their projects normal confidentiality policy.

Supporting and supervising their staff in the execution of this agreement.

Ensuring that staff receive any training that may be necessary – Training needs specific to the region should be raised with the Rehab Co-ordinator.

Individual's Workers Responsibility:

To act in accordance with this agreement.

To keep service users informed of their rights regarding confidentiality.

7. Informing Service Users

All service users should be made aware of the following:

- Individual agencies are responsible for the information collected by them. Certain and relevant information will be shared between agencies in line with the consent provided.
- Service Users have the right to a copy of all personal data that is held by each agency in relation to them where requested.
- Circumstances in which confidentiality may be extended. (see point 9)
- Their consent to share information can be withdrawn at any time.
- This information should be given to service users by their keyworker.

8. Obtaining Consent to Share Information

Information held by the case manager and all other agencies which is not independently available to a third party, cannot be disclosed without the individual's written consent.

Consent must be sought in writing using a standardised consent form and amendments should be recorded. The service user should be informed each time information regarding them will be shared with a third party.

The consent form should stipulate:

The third party with whom the information is to be shared.

The timeframe that the consent form applies to.

The organisations covered by the consent form.

The date and signature

The service user should also be verbally informed of:

The third party with whom the information is to be shared.

Whether the third party has a confidentiality policy.

The reason for sharing the information.

(The 3rd party may not be signed up to the interagency protocols. It should be explained that the case manager/agency doesn't have as much control over the data once given to a third party. However the 3rd party should be bound by the data protection act)

9. Limits to Confidentiality

Confidentiality is not absolute and cannot be guaranteed. Limits to confidentiality exist to protect workers from withholding information that may require immediate action in the interest of public or individual safety.

Application of extensions of confidentiality will in all cases be decided by the project manager. In their absence this decision will be delegated to the most senior staff person. The rehabilitation Co-ordinator should be informed of any extensions to confidentiality.

Confidentiality may be extended when a service user discloses that:

- There is a risk of serious harm to self or others. In this circumstance information may need to be shared with Social Work, An Garda Síochána or a mental health practitioner as appropriate.
- Where there is a suspicion/risk of harm to children. The agency should follow the national guidelines (Children First) in relation to reporting the suspected child abuse to social work or an Garda Síochána as appropriate.
- Confidentiality may also be extended as required by certain legal obligations (e.g. court order).

In the event of a disclosure of any of the above, the worker should inform the service user that they may need to report the issue to their project manager. If it is necessary to pass on the information the service user's consent should be obtained if possible. If this is not possible, the service user should still be informed of the decision to share information.

10. Sharing Information with agencies (non drug & alcohol specific) e.g Social work, probation etc

- In all cases, requests for information from organisations must be accompanied by a signed consent from the service user to share information. The project manager should be made aware of all requests for information from outside agencies.
- If a service is requested to write a report on a service user – this report would only be written further to a court order or where the service user consents.
- Care must be taken with phone calls in relation to queries around service user to ensure that information is not unintentionally passed on to a third party. Service user attendance or presence in the service should not be confirmed without the service user consent.
- If a staff member becomes aware of pertinent information relating to service user from sources outside of their project, their manager should be informed before the information is passed onto colleagues.
- Staff members called to give evidence in court should contact the Project Manager, who will provide support in this area.

11. Data Protection Breach

Data protection breaches will be dealt within projects through their internal structures. The rehabilitation co-ordinator should be informed of any data protection breach

12. Data Protection Responsibilities

In addition to the duty of care regarding confidentiality outlined above, the Data Protection Acts imposes legal obligations on the Cork/Kerry project and on the constituent services. The following eight Data Protection principles apply to the Cork/Kerry project regarding information.

1. Obtain and process information fairly.
2. Keep it only for one or more specified, explicit and lawful purposes.
3. Use and disclose information only in ways compatible with these purposes.
4. Keep it safe and secure.
5. Keep it accurate, complete and up-to-date.
6. Ensure it is adequate, relevant and not excessive.
7. Retain for no longer than is necessary.
8. Allow individual's access to their personal data, on request.

13. Email, Fax, Social Media and Phone Usage in Relation to Confidentiality

Phone usage

Care should be taken not to unintentionally disclose information when communicating by phone. Confirmation that an individual is attending the service to a person who has not been covered through consent to share information, could be considered a breach of confidentiality.

Fax usage

Faxed messages containing sensitive case information should only be sent to specified individuals at confirmed numbers. All faxes should contain cover sheets stating the person whom the fax is intended for. Receipt of fax should be confirmed by phone. Using pre-programmed numbers on the fax machine is preferable to dialling the number every time.

Email usage

Any information from which a service user could possibly be identified should not be sent via email.

Social media

Staff and service users should not form relationships through social media (e.g. accepting friend requests on Facebook) as this can lead to inappropriate information sharing.

14. Service user Request for Information

If a service user wishes to have access to their file, they need to complete a written request. Requests for a copy of this information should be made in writing by the service user to the agency from which they wish to obtain their information. Staff can assist with this.

The request will be processed by the Project Manager with that agency who will respond to the request within ten working days. In such cases care will be taken to ensure that any information relating to other individuals that is held within the service user's file (i.e. in letter from an external agency that relates also to other family members) is blanked out.

Section 6:

Gaps & Blocks Protocol

Gaps and Blocks Protocol

If the worker encounters a barrier or block to progression in a service users care plan that relates to the provision of service they should undertake the following steps:

- In the first instance raise it with colleagues for informal advice, as appropriate.
- Request advice from the supervisor / manager.

If the issue can not be resolved within the service then the issue should be recorded on a Gaps and Blocks form and will be sent to the rehabilitation co-ordinator.

At this point the rehabilitation co-ordinator will work with members of the treatment and rehabilitation group, the advisory group and the national co-ordinator to resolve the issue.

If it cannot be resolved at this level, the Gaps and Blocks form will be delivered to the National Rehabilitation Co-ordinator: HSE.

Gaps & Blocks Reporting Form

NDRIC reporting level only

This form is for recording when there are issues with the working processes or systems within drugs and/or alcohol services. Please DO NOT identify the service user. Please ensure you have discussed possible solutions with relevant team members before completing form. Before sending this form to the NDRIC, ensure that a local gaps & blocks process has been enacted through the drug task force treatment & rehabilitation committee.

An initial response will be received within ten days of NDRIC receiving this form.

1. Pilot project name:

Date:

2. Pilot Coordinator Name and Contact Details:

3. Please provide a brief overview of the process issues only which NDRIC need to be aware of, and the reasons why a local solution is not obtainable at this stage.

4. Please list the actions and communications taken thus far to resolve the issue (identify who, what, and outcome for each step).

Which protocol does this form relate to?

Action – what was done to resolve the gap or block	Outcome – what was the result of the local initiative	Reasons – why does the gap or block persist

5. Can you make practical recommendations for how this situation could be resolved?

6. Any other relevant information you need NDRIC need to be aware of:

Before sending this form, please ensure that the case manager has discussed this issue with the staff team and / or a peer case manager, and flagged the process issues at the treatment & rehabilitation committee of the appropriate Drug Task Force.

NDRIC will assume all local avenues have been explored and will then work to address the gap or block at a national level on receipt of form.

Once the issue has been flagged at the NDRIC level, any suggested solutions will be fed back to both the NDRIC pilot coordinator and the relevant drug task force.

Signed _____

Date _____

DTF

Gaps & Blocks Reporting Form
Local DTF Treatment & Rehabilitation Committee Level

This form is for recording when there are issues with the working processes or systems within the NDRIC pilot or partner drugs and/or alcohol services.

Please DO NOT identify the service user. A local identifier or reference code may be required. If more detailed information is required the service user will need to give consent.

Please discuss possible solutions with relevant team members before completing form and referring the matter to the DTF treatment & rehabilitation committee. Initial feedback will be received within ten days of sending the form to the appropriate DTF coordinator.

1. Project name:

Date:

2. Case Manager Name and Contact Details:

3. Please provide a brief overview of the process issues only which the DTF need to be aware of and the reasons why a local solution is not obtainable at this stage.

4. Please list the actions and communications taken thus far to resolve the issue (identify who, what, and outcome for each step).

Which protocol does this form relate to?

Action – what was done to resolve the gap or block	Outcome – what was the result of the local initiative	Reasons – why does the gap or block persist

5. Can you make practical recommendations for how this situation could be resolved?

6. Any other relevant information you need NDRIC need to be aware of:

Before sending this form, ensure that the case manager has discussed this issue with the staff team and / or a peer case manager and feels that this issue warrants attention through the local gaps and blocks protocols.

If the issue persists and a local solution is not possible then the process issues should be notified to the National Drug Rehabilitation Implementation Committee using NDRIC level form, where they will work to address the gap or block at a national level.

Signed _____ Date _____

Appendices

Appendix 1: Service user information sheet on case management.

What is case management?

Case management is having one worker take the lead in organising the services you need and helping you to reach your personal goals. The case manager will work with you to develop a plan and ensure that the right services are supporting you.

A case manager's role is to coordinate all of the services you are involved with and make sure you are receiving the best service possible. To do this, they will need your permission to discuss your needs with the services that are working with you.

The other important aspect of having a case manager is that you should only have to complete one initial assessment form and one comprehensive form. If you change your case manager in the future, then this assessment will travel with you so you will not have to complete one again.

What does it mean for you?

You and your case manager will do an assessment; this could take a few sessions and will ask questions about your needs in different aspects of your life. The aim of the assessments is to find out exactly what supports you require and how these can be met.

You and your case manager will look at what you want to happen and what your needs and goals are. Together, you will make a plan that sets out the steps to achieving your goals and the services that should assist you in this.

Your goals may be immediate and might include issues such as stabilising drug use, or long-term goals such as training/acquiring job skills.

Your case manager will work with you to ensure that all the services you need are supportive of the plan (your goals). If there are any problems, the case manager will work to sort these out.

The case manager will meet with you regularly to support you, and every few months you will meet together to review the plan to make sure there are no problems.

What about confidentiality?

As part of the process, you will be asked to give permission for your information to be shared with other agencies involved in your plan. You have full control of your information. Only relevant information that helps progress your support plan will be shared. The case manager will check with you before they contact other services on your behalf. If you decide not to be involved at any point then that is ok; just let your case manager know.

Do you have to be case managed?

Absolutely not. If you are not interested, then that is ok, you do not have to have a case manager. If you decide not to be involved, you will receive the same level of service you have always received. However, it may be more difficult to achieve your aims if a case manager is not agreed, and assigned the role of working with other services to achieve your goals.

Appendix 2: Introduction letter to external service explaining Case Management role.

Dear *(name)*

I am writing to inform you that I am currently acting as a case manager for *(enter service user name)* and to ensure that the support plan accurately records your involvement in this case. My contact details are set out below should you wish to discuss the support plan or any issues in relation to service provision.

My work as a case manager is informed by the Interagency Protocols that have been produced by the National Drugs Rehabilitation Implementation Committee. (N.D.R.I.C). These procedures can be provided to you on request.

I am operating in this role with the services user's consent. Attached is a copy of the standard release of information form, which confirms permission for sharing of information in relation to this case.

or

I am operating in this role with the services user's consent. A copy of the consent can be provided to your service should there be further communication in relation to the case.

The role of case manager involves completing a comprehensive assessment and then, in discussion with the service user, developing a comprehensive support plan that addresses service user needs in the following categories: Physical health, mental health, family & relationships, education & training, employment, accommodation, income, alcohol use, drug use, social supports.

This support plan will be monitored and reviewed periodically to ensure that barriers to progression are being addressed and that interagency communication is supporting service user efforts and achievement of support plan goals.

In relation to *(name service)* involvement in the support plan I understand that *(include as relevant: information on what service is being provided, the timeframe, the anticipated outcome, and contingency plans)*. A copy of the full support plan summary can be provided to you on request.

If you have any questions in relation to any aspect of the support plan, service delivery or my role as case manager, please do not hesitate to contact me.

Sincerely,

(name) (role/position) (service/project) (contact details: phone, email and address)

Appendix 3: Individual Care Plan Template

Appendix 4: Interagency Case Meetings Step by Step.

This summary may be useful.

After taking necessary steps to arrange and prepare for the meeting...

1. Clarify Lead Agency / Case Manager where needed
2. Case Manager: chairing and recording care plan actions.
3. Initiate a round of introductions (chair)
4. Summarise the meeting aims/purpose (chair)
5. Agree agenda (all)
6. Suggested Agenda:
 - a) Individual service reports and recommendations: solution/recommendation focused (all)
 - b) Service user issues/suggestions and feedback on recommendations (service user)
 - c) Agree on interagency plan / next steps (lead by chair)
 - d) Issues that cannot be met by the services around the table: identify services and who will contact them. In general contacting other services is the role of the case manager.
7. All correct email address and phone number for future correspondence sought (chair)

Initiate appropriate follow-on communication.....

Appendix 5: Chairing Skills – Dealing with Difficult Group Dynamics.

Issue	Solution
The meeting may involve professionals who have nothing to contribute or work against a problem solving approach.	Careful consideration should be made as to which services can contribute to the care plan in a productive way. Having too many people present who can not actively contribute can work to undermine the usefulness of the meeting. Initial conversations on the phone may indicate whether attendance from an agency is required. Case meetings should be held only when necessary and require careful planning.
Professionals are not focused on solution finding.	<p>Keep the session tightly structured:</p> <ol style="list-style-type: none"> 1) Introduce and provide context – what are you aiming for from the meeting. You may wish to create a group contract focusing on communications and aims. 2) Get service reports / updates from each representative (overview and recommendations for the future) – keep to a tightly managed round. If the conversation moves into discussion or disagreement before everyone has talked about what they can offer or what their concerns are, it may make solution finding difficult. 3) If people are not able to focus on finding positive solutions then it may be useful to bring them back to the initial aims of the meeting.
There is an overly negative focus on aspects of the case	<p>If a participant is focusing on negative aspects of the case, it may be necessary highlight the service user's strengths or awareness of the situation.</p> <p><i>'I think its important that we acknowledge that Sam has identified that she has not been attending as much as needed and will prioritise this from now on, what could we do to support this.....</i></p>
Workers are concerned about taking on more work.	<ul style="list-style-type: none"> - Discuss the fact that this is a holistic process for service users and if effective should be more time efficient. - Refer to involvement as 'smarter work', not necessarily 'more work'.
Inappropriate venue and environment.	<ul style="list-style-type: none"> - Discuss where the service user would feel comfortable. - If the chosen venue is not the service user's first choice then ensure that reasons are explained to the service user, i.e. on occasion the meeting will need to suit certain professionals who are not able to travel, i.e. doctors etc.
Difficulties in synchronising people when calling a meeting.	<ul style="list-style-type: none"> - Email and follow up by phone call. - If necessary organise meeting around 'key-players'. - It may be wise to check the availability of the most significant agency before informing other people of prospective dates.
Bad note keeping or record keeping.	<ul style="list-style-type: none"> - Ensure agenda is relevant to the case, specific to the issues that need to be addressed and is checked off item by item before the meeting is complete. - Ensure minutes are concise records of decisions and next step

Case manager is not chairing the meeting

Information is disclosed which is in breach of confidentiality guidelines, i.e. 'I was told this in confidence....'

The service user does not turn up at the case meeting.

actions on agenda items– not a record of all discussions.

- Use a care plan structure for minutes, i.e. action, person responsible, date and review.
- Clarify decisions at end of meeting, by reading out the notes, all to agree on wording.
- If people leave before the end of the meeting then seek agreement that they will read minutes and email any feedback.
- Minutes should be written and sent ASAP
- All participants should be emailed, with a read receipt function on the email (go to options and tick the read receipt box).
- It can be helpful for someone other than the chair to take minutes.

- Where the Case Manager is not chairing the meeting i.e. someone more experienced is happy to do it, then the CM should take minutes and ensure these are sent out.
- If the chair does not allow sufficient time for clarification of decisions the minute taker should ask to read out the list of decisions and ensure all agree to wording.

- Remind all of the guidelines for confidentiality.
- In a respectful fashion, remind participants that information should be ignored if it is in breach of confidentiality. Care should be taken where possible to ensure that points are made respectfully, possibly by talking in the abstract i.e.

'perhaps we should not discuss the point raised about issue B, as it was disclosed in confidence, although considering the facts we have, can we come up with a plan....'

- Remind all that only information relevant to the issue needs to be discussed. One technique is to draw people back to the agenda:

'to ensure that we address all of the points we need to look at today, could I just draw us back into the agenda, the issues we are looking at now are.....'

- If the confidentiality is breached by a non-professional (i.e. family member), inform them of 'meeting rules' and why these are in place. It may also be useful at some point to call a break and then discuss this in private so that the reasons are understood and the person leaves feeling like an equal contributor to the meeting.

- Generally the meeting can go ahead as the service user has given permission for the meeting to occur. In this case the outcomes will need to be agreed with the service user before these are considered to be finalised.

- It is especially important in this circumstance that the case manager uses a very consultative approach to ensure that the service user is not pressured into agreeing to the professional recommendations.

One agency considers there to be no need for a meeting to take place.

Service providers disagree on significant points

The service user is not being included in discussions.

The information being discussed is not based on fact. There is an overly negative tone to the meeting or professionals are not being solution focused.

- Case meetings should be held only when necessary and require careful planning.
- This need for and reasons for the meeting should be sent around by email to all required participants and followed up by phone call.
- If cooperation is not forthcoming and there is a clear need for involvement then it may be necessary to send in a Blocks and Gaps form to the local coordinator.
- If a facilitated discussion does not arrive at a useful compromise or understanding then the workers may need to arrange a time outside of the meeting to discuss these differences.
- The chair may need to point out professional boundaries if it is felt that this is needed.
- To encourage service user focus, the chair may need to re-frame the issue or question from the service user's point of view.
- Make sure silent participants have an opportunity to contribute; their views may break a stalemate.
- Ask directly for the service user's input and feedback. If the service user is having trouble explaining their views, then break it down into a number of open questions;
- *'what do you think of the plan,' 'is that summary what you recall happening', 'do you feel happy that the what has been agreed is....'*
- If discussions are particularly tense or dense it may be useful to request a short break so you can check with the service user and ensure that they are happy with how it is going, as they may not be able to raise their own issues within the context of the meeting.
- Acknowledge the attendance and contributions of the service user. Their participation in the meeting itself is a significant commitment and strength that can be worked with.
- Clarify the position: *'just to clarify, was it that particular action witnessed by a staff member etc'*
- Ask for the service user's view.
- It may be useful to interrupt overly long or negative explanations of someone's ones 'past failures' by summarising the service position;
- *'so if I could summarise the agency position on what has happened so far, you have not been able to make any progress due to missed meetings and the main issue now is the need to get commitment that the next meeting will take place....'*

Appendix 6: Key working/Care planning/Case management Training Participants.

2012 - Pilot Phase training (6 days)

2013 – Cork Training Joe Kirby & Gordon Kinsley (3 days)

2013 - Managers Trainings (Five 1 day trainings)

2014 – Cork Training Joe Kirby & Gordon Kinsley (3 days)

2014 – Kerry Training Joe Kirby & Gordon Kinsley (3 days)

A series of five case management training days were rolled out across the region in 2013 specifically aimed at managers and their individual services/sector

Manager groups who attended

- HSE Seniors
- Homeless sector
- Local Drugs Task Force
- Regional Drugs Task Force
- Com/Vol Tier 3 & 4 drug & alcohol services

Key working/Care planning/Case management training Participants 2012 / 2013 / 2014

RDATF Projects	HSE Drug & Alcohol Cork	CLDATF Projects	“Cara Lodge” –
Participants:	Participants:	Participants:	Matt Talbot
Pilot	Pilot	Pilot	Ahiohill,
<i>Des Bailey</i>	<i>David Wyse</i>	<i>Trish Barret</i>	Enniskeane,
<i>(KDYS Killarney)</i>	<i>FrancisLehane</i>	<i>(Blackpool)</i>	Co.Cork
<i>Gerard Lowe</i>	2013	<i>Ann Jordan (TVG)</i>	
<i>(KDYS Listowel)</i>	<i>Claire Foy</i>	2013	Participants:
<i>Nicola Whelan</i>	<i>Daniel O Connell</i>	<i>Ailish McDonald</i>	Pilot
<i>(Mallow)</i>	<i>Ian Cremin</i>	<i>(Farranree)</i>	<i>Olive Riordan</i>
2013	<i>Liam O Mahony</i>	<i>Andrew Fiddow</i>	
<i>Mary Mackasey</i>	<i>Pat O’ Riordan</i>	<i>(Douglas)</i>	2013
<i>(Mitchelstown)</i>	<i>Patricia Moynihan</i>	<i>Ciaran O Connell</i>	<i>Sharon O’Donavan</i>
<i>Siobhan Mackey</i>	<i>Peter Graham</i>	<i>(Togher)</i>	
<i>(Fermoy)</i>	<i>Richard Dore</i>	<i>Kerry Dineen</i>	
<i>Gemma Turner</i>	<i>Barry Corker</i>	<i>(Togher)</i>	
<i>(Cobh)</i>	<i>Joanne Rolfe</i>	<i>Theresa Clifford</i>	
<i>Gemma Hillario</i>	<i>Larry O’ Reilly</i>	<i>(Mahon)</i>	
<i>(Tralee)</i>	<i>Marianne Wall</i>	2014	
<i>Eddie McBride</i>	<i>Marie Harding</i>	<i>Sinead Mgrath</i>	
<i>(Youghal)</i>	<i>Robert Field</i>	<i>(Greenmount)</i>	
	<i>Robert O’ Driscoll</i>	<i>Yvonne O’ Toole</i>	
2014	<i>Laura Desmond</i>	<i>(Dublin Hill)</i>	
<i>Catherine Buckley</i>	2014	<i>Therese Spillane</i>	
<i>(Macroom)</i>	<i>Peter Mackey</i>	<i>(Gurranabraher)</i>	
<i>Deidre Nagle</i>	<i>Aine o Sullivan</i>	<i>Lisa sheehan</i>	
<i>(Killarney)</i>	<i>Vourneen O Mahony</i>	<i>(Glen)</i>	
<i>Julie Cummins</i>	<i>Cara Bourke –O’</i>	<i>Celine Hurley</i>	
<i>(Bandon)</i>	<i>Shaughnessy</i>	<i>(Knocknaheeny)</i>	
	<i>Jeremy Cooper</i>	<i>Sinead Magrath</i>	
	<i>Trish Yarrow</i>	<i>(Greenmount)</i>	
	<i>Brid Mooney</i>	<i>Claire Mccarthy</i>	
	<i>Tim Stuart</i>	<i>(Ballincollig)</i>	
	<i>Aoife Ni Labhradgh</i>	<i>Orla O’ Shea</i>	
		<i>(Togher)</i>	
		<i>Stephen Connolly</i>	
		<i>Jackie Daly</i>	

Key working/Care planning/Case management training Participants 2012 / 2013 / 2014

Link worker HSE Cork <i>Dermot o' Regan (Pilot)</i>	Cork Prison, Participants: <i>Francis Russell (Pilot)</i> 2013 <i>Brid Wallace</i>
Link worker HSE Kerry <i>Pat O' Connor (Pilot)</i>	2014 <i>Vicky Seaman</i> <i>(Cork Alliance)</i>

HSE Kerry Counselling & Advisory Service

Brandon House,
Upper Rock Street,
Tralee,
Co. Kerry

Participants:

Pilot

Doloras Tiernan
Pat O' Connor

2013

David Twomey
Mary Conroy

2014

Pat Hannafin
Tommy Kerwick
Aine Carton
Geraldine O'Rourke
Jimmy Carton

Cork Simon Community,
Participants:

Access Housing Unit

Pilot

Mark Jordan
Claire O'Donnell

2013

Ewa Pilewska
Mags Dunne
Marie O' Sullivan
Brian Quinn

2013

Aoife O' Leary

Key working/Care planning/Case management training Participants 2012 / 2013 / 2014

Matt Talbot services,
“Rockview”,
Trabeg Lawn,
Douglas,
Cork.

Participants:
Pilot
Sharon Lambert
2013
Edel Foley
Pat Riordan
Patrick Cooney

Novas Tralee,
Arlington House,
5 Church Road,
Tralee,
Co Kerry.

Participants:
Pilot
Tom Wall
2013
Liam Horan
Marilyn O Mahony
Novas West Cork
2013
Julie Brosnan

Renewal House,
Shanakiel,
Blarney road,
Cork city.

Participants:
Pilot
Eileen Crosbie
Bernice O’ Sullivan
Helen

Tabor Lodge Treatment center,
Ballindeasig,
Belgooly,
Co.Cork

Participants:
Pilot
Dan Cottrell
Mary Carroll
2013
Alice Meaney
Ber Tobin
2014
Deidre Creedon

Talbot Grove
Castleisland,
Co Kerry.

Participants:
Pilot
Donal O’Connor
2014
Sean Fleming
Eileen Murphy
Evelyn Curtain
Peggy keane
Tony O’ Leary
Mary O Sullivan
Kit McCarthy
Mary Reidy
Donal O’ Connor

Anchor Treatment center,
Mallow

Pilot

John O’ Connor
Paddy Allen
Miriam O’ Connell

Fellowship House,

Pilot
Finbarr Cassidy
Audrey Cull

Appendix 7: Referral and Assessment for Residential Treatment (Tier 4)

This document seeks to name the criteria that can guide referrals to residential tier 4 facilities (Part A).

It provides guidance on additional assessment requirements at tier 4 (Part B).

Introduction

Types of Tier 4 Services

- Specialised Statutory Units:

Inpatient units for medical stabilisation and detoxification programmes.

- Independent/Voluntary sector residential facilities for detoxification programmes.

- Psychiatric Inpatient Treatment:

Some service users will require inpatient treatment in general psychiatric wards i.e. if there is an acute psychiatric disorder i.e. psychosis, suicidal ideation/intent etc.

The results indicate poorer outcomes in treatment in psychiatric units compared to specialist addiction services. The SCAN Consensus report (2006) and the Report of the Working Group on Residential Treatment and Rehabilitation (Substance Abuse) (2007) recommend that inpatient detoxification programmes should be provided in dedicated specialist units (ref. 1, 2).

“The use of general hospital or psychiatric beds for detoxification should be the exception since the evidence base indicates better outcomes from specialist units.” (Corrigan 2007)

However the MTC Review of Tier 4 HSE Funded Residential Rehabilitation Services (ref.3) accepts that this practice will continue in Ireland due to the absence in some areas of the country of inpatient/residential units for treating substance misuse disorders.

- Medical ward in a General Hospital:

It is recommended that acute hospital provision with specialist “addiction” support will be needed for those with complex needs: pregnancy, liver disease and HIV (NHS Health Advisory Service: 4 Tier Model of Care), or if there is an acute medical problem.

- Residential Rehabilitation Units:

Residential Rehabilitation units providing specialised addiction counselling, addressing the persons psychological, emotional, behavioural and personal/family issues. “Step –down” or half way house may be required as a follow on from residential treatment. These facilities address the ongoing rehabilitation needs of the client and provide extended care while ongoing training, education, accommodation, welfare needs are addressed.

Services provided at Tier 4

- Detoxification, stabilisation programmes, assessment, residential rehabilitation.

- Other: Appropriate interventions provided on site or referrals made to other agencies to support identified needs arising from a comprehensive assessment and care-plan: medical/dental, psychiatric/psychological, social/accommodation, employment/training, family and childcare, legal issues etc.)

- Counselling interventions: Addressing the persons psychological, emotional, behavioural and personal/family issues. Insight about addiction and its consequences, identification of areas of life/personality that need to change, introduction to new coping skills, exploration of areas of sensitivity and vulnerability in a safe environment, gradual introduction to and practice of recovery lifestyle.

Relevant Supporting Literature

1. The Report of the Working Group on Residential Treatment and Rehabilitation (Substance Abuse)(ref. 2):

“In both the UK and USA, there is agreement that treatment should be tailored to the individual, guided by an *individualised treatment plan* and based on a *choice of treatment levels* where the preferred level of care is the *least intensive* one *which meets the treatment objectives* while ensuring the safety and security of the patient.(Mee-Lee at. al. 2003)”, thus supporting the 4 Tier Model of Service Delivery.

2. The SCAN Consensus Report (ref. 1) found that good treatment planning combines “modality matching”, (where a service user’s needs are matched to a specific treatment approach regardless of the setting and this is done for all pertinent problems identified in the assessment) with “placement matching” (where a service user is referred to a particular setting, inpatient / outpatient) whereby the least intensive level of care can effectively provide the resources that will meet the service user’s needs.

3. The American Society of Addiction Medicine has developed its own tier model of service provision. A full description of the levels described in relation to tier 4 services is outlined in these guidelines (ref.4).

A. Criteria/Suitability for Tier 4 Services

The SCAN Consensus Report, The Report of the Working Group on Residential Treatment and Rehabilitation (Substance Abuse), and the MTC Review of Tier 4 HSE funded Residential Rehabilitation Services have outlined criteria for entry/referral to Tier 4 Services and include the following as well as others included by the Subgroup of NDRIC (Tier 4 Services):

Alcohol:

This is an overview detailing who would be suitable for Tier 4 services as well as specific groups of service users/those who are at risk, where a Tier 4 service is the recommended intervention.

- Identified need and preferred choice of the individual.
- Severe alcohol dependence.
- Risk of having severe alcohol withdrawals as based on previous symptoms or a recent history of high alcohol intake.
- At risk of *Delirium Tremens* or seizures.
- Those who do not live in an environment that supports an outpatient detoxification programme (homeless or living in hostels, or B&Bs, or homes where there are other alcohol and drug users).
- Concurrent medical disorders/acute physical illness that may complicate their management i.e.
 - epilepsy,
 - confused or hallucinatory state,
 - acute physical illness
 - Wernicke’s encephalopathy
 - confusion, staggering gait,
 - uncontrolled eye movement,
 - coma, low BP, Hypothermia,
 - unexplained neurological signs,
 - if injectable thiamine is required.

- Concurrent Psychiatric disorders/ Acute Psychiatric Illness that may complicate their management, i.e.
- risk of suicide
- Previous unsuccessful outpatient/home alcohol detoxification programmes.
- Where continuity of care is essential for preserving gains achieved in residential treatments i.e. “that transition from detoxification to residential rehabilitation and then to step-down accommodation be seamless” (Report of the HSE Working Group on Residential Treatment and Rehabilitation).
- To provide intensive psychological interventions to begin to equip alcohol users with the skills of managing their daily life and managing staying drug free (SCAN Consensus Report).
- “Greater social deterioration, less social stability and higher risk for relapse, benefit more from residential treatment. (Models of Care for treating alcohol Misusers)

Opioids and Other Drugs:

Higher completion rates for inpatient detoxification programmes compared to outpatient detoxification programmes are seen for this group (50% and 77% completion rate vs. 20% completion rate; 81% vs 17% completed withdrawal programme compared to outpatient treatment in the Maudsley Hospital Study, Gossop et. al. 1986).

This is an overview detailing who would be suitable for Tier 4 services as well as specific groups of service users/those who are at risk, where a Tier 4 service is the recommended intervention:

- Identified need and preferred choice of the individual.
- Individuals who do not live in an environment that supports an outpatient detoxification programme (i.e. homeless, or living in hostels, or B&Bs, or homes where there are other alcohol and drug users, isolation or lack of family support)
- Individuals who have failed an outpatient withdrawal programme or outpatient rehabilitation programme.
- Those who have complex needs, i.e. co-morbid psychological/psychiatric ill health; dual diagnosis, and requiring assessment and treatment of co-morbid disorders.
- Severity of dependence and dependence on more than one drug or alcohol, chaotic drug use requiring stabilisation of drug use, detoxification programmes, a break from drug use, in depth assessment and treatment of physical or psychiatric health needs.
- History of complications during previous withdrawal programmes.
- Where treatment is required for medical and social reasons (Day: Opiate detoxification in an inpatient setting, 2005)
 - Medical reasons: physical complications, i.e. cardiac conditions associated with cocaine.
- Pregnant women: stabilisation programmes, titration up of substitution treatment, detoxification programmes when appropriate.
- Stable patients: need to consider inpatient treatment as there is a higher completion rate of a detoxification programme in an inpatient setting compared to an outpatient setting (Day: Opiate detoxification in an inpatient setting, 2005).
- Those with less severe dependence and particular early in their drug/alcohol using careers (SCAN Consensus report).
- Where continuity of care is essential for preserving gains achieved in residential treatments i.e. “that transition from detoxification to residential rehabilitation and then to step-down accommodation be seamless” (Report of the HSE Working Group on residential Treatment and Rehabilitation).

- To provide intensive psychological interventions to begin to equip drug users with the skills of managing their daily life and managing staying drug free (SCAN Consensus Report).
- “Greater social deterioration, less social stability and higher risk for relapse. Benefit more from residential treatment. (Models of Care for treating alcohol Misusers) (report of the Working group on Residential treatment +rehabilitation).

Additional Criteria specific to Residential Rehabilitation Treatment

Additional criteria include the following for placement in tier 4 residential rehabilitation services where an inpatient / outpatient detoxification programme is completed or not required:

- No capacity to remain clean and sober in a tier 3 setting
- No environment to sustain stability
- Lack of awareness of the consequences of addiction to self and others
- History of relapse
- A vulnerability which emerges when exploring psychological/life/historical issues
- Geographical reasons.

As well as identifying service users who are suitable for residential treatment and rehabilitation, it is also important to keep in mind that not all service users require or are suitable for residential treatment and rehabilitation.

B. Comprehensive Assessment for Residential Treatment

Assessment 1

This is based on the domains outlined in the “Comprehensive Assessment – Minimum Standard Guidance”, The assessment may be completed by a number of disciplines (multidisciplinary) all supporting the assessment and application for residential treatment. i.e. medical assessment, psychiatric assessment, counselling assessment, assessment by Rehabilitation Integration Officers/ Service, assessment by key worker/case manager, etc. Assessment will also need to consider:

- “Criteria” for Residential Treatment as outlined above.
- Level/type of residential treatment required as per ASAM Guidelines (level III/IV).
- Assessment of severity of problems and level of function.

Assessment 2

This is made by the staff in the Residential Unit. Assessments follow the domains as outlined in the “Comprehensive Assessment” but assessment also ensures that criteria are fulfilled as outlined by the specific residential unit. Assessments in the Residential Units will further ensure: (SCAN Consensus Report)

- Assessment of substance use through self report and through use of other subjective and objective measurements / laboratory investigations.
 - Assessment of physical health: past history, current medications, current health assessment, physical health examinations, investigations and treatment required/care plan.
 - Physical health assessments may be repeated during a person’s stay in residential treatment.
- More specialist health assessments will need to be arranged for specific groups i.e. elderly, pregnant women, individuals with liver disease and blood borne virus infections. Regular

liaison with primary care teams and acute medical services will be required and appointments made for assessment and follow-up care arranged.

- Assessment of mental health.
 - Assessment and treatment of co-morbid psychological and psychiatric need throughout residential treatment.
- Assessment of level of function and severity/ complexity of difficulties.
- Assessment of neuropsychological needs and cognitive functions.
- Assessment of level of daily living skills and coping skills.
- Assessment of type of psychological interventions required to meet individual needs and skills required to be developed.
- Family tree assessment and assessment of family needs and involvement.
- Assessment of ongoing educational/training needs.
- Assessment of ongoing accommodation needs.
- Assessment of aftercare plan and supports/agencies required.

References for Appendix 7

1. The SCAN Consensus Report. Inpatient treatment of Drug and Alcohol misusers in the National Health Services.
2. The Report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Abuse), HSE, 2007
3. Growing Potential Monalee, Training and Consultancy. MTC Review of Tier 4 HSE Funded Residential Rehabilitation Services
4. Mee-Lee D., Shulman GD., Fishman M., Gastfriend DR., Griffith JH (2001) ASAM Patient Placement Criteria for the treatment of Substance Related Disorders. Second Edition Revised (ASAM PPC-2R) Chevy Chase MD: American Society of Addiction Medicine. Inc.

Appendix 8: Needle Exchange Services

Appendix 9: Monitoring

Locally:

Southern Regional Drug & Alcohol Task Force – NDRIC data attached to DATF reporting form (quarterly)

Cork Local Drug & Alcohol Task Force – NDRIC data attached to DATF reporting form (quarterly)

HSE – Senior management report to Area Operations Manager with NDRIC data (monthly)

Nationally:

Rehabilitation Co-ordinator feeds data to National Rehabilitation Co-ordinator & NDRIC