AN EVALUATION OF A FRAMEWORK FOR CASE-MANAGEMENT IN THE CORK/KERRY REGION

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OCTOBER 2017

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GLOSSARY OF TERMS

CARE PLAN±

A care plan is a documented agreement of a plan of action between the service user and service provider based on SMART (Specific, Measurable, Attainable, Realistic and Time-bound) objectives. Care plans should document and enable review of service user needs, goals and progress across four key domains:

- Drug and alcohol misuse
- Health (physical and psychological)
- Housing
- Offending
- Social functioning (including, employment and relationships).

A care plan should be brief and readily understood by all parties involved and should be a shared exercise between the service user and the service provider. The care plan should explicitly identify the roles of specific individuals (including the service user) and services in the delivery of the care plan. Care plans should be reviewed both routinely and when a change in a service user's circumstances makes it necessary.

CARE PLANNING*

Care planning is a process for setting goals, based on the needs identified through an assessment, and planning interventions to meet those goals with the service user. Care planning is a core requirement of structured service provision. An integrated care plan involves two or more agencies. (See also shared care planning at the end of this section).

CASE-MANAGEMENT*

Case-management is the process of coordinating the care of a service user through a shared care plan and resolving any gaps and blocks that arise.

CASE MANAGER*

The case manager is the identified person who has a formal role in the management of inter-agency communication and the provision of co-ordinated care for the service user in question.

COMPREHENSIVE ASSESSMENT±

Comprehensive assessment is targeted at service users with more complex needs. The assessment aims to determine the exact nature of the individual's drug and alcohol use, accommodation requirements and coexisting problems in the other domains of health (mental and physical), social functioning and offending. Comprehensive assessment can be seen as an ongoing process rather than a single event. It provides information that will contribute to the development of a care plan for a service user.

CORE SERVICE USER

A service user attending the main programme of a service or availing of the general services offered rather than a service user who is attending some ancillary part of a programme or service.

* All terms were taken directly from the National Drug Rehabilitation Framework Document.

EARLY STAGE IMPLEMENTER SITE

The term early stage implementer site was used to denote a site that had implemented some but not all framework protocols.

FOUR TIER MODEL

A framework for grouping drug and/or alcohol service interventions into tiers, which correspond to the level of need of clients.

The Four Tier Model

The four tier model of care (taken directly from the NDRF 2010 P9) will act as the overarching framework for the provision of rehabilitation pathways. Briefly, these tiered interventions are described as follows.

Tier 1 interventions include the provision of drug-related information and advice, screening and referral to specialised drug treatment services. They are delivered in general healthcare settings (emergency departments, liver units, antenatal clinics, pharmacies, or in social care, education or criminal justice settings [probation, courts, prison).

Tier 2 interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community or hospital based. The interventions include information and advice, triage, referral to structured drug treatment, brief interventions and harm reduction e.g. needle exchange programmes.

Tier 3 interventions are mainly delivered in specialised structured community addiction services, but can also be sited in primary care settings such as Level 1 or Level 2 GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community based specialised drug assessment and co-ordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

Tier 4 interventions are provided by specialised and dedicated inpatient or residential units or wards, which provide inpatient detoxification (IPD) or assisted withdrawal and/or stabilisation. Some service users will require inpatient treatment in general psychiatric wards. Acute hospital provision with specialist "addiction" support will be needed for those with complex needs e.g. pregnancy, liver and HIV-related problems. Others will need IPD linked to residential rehabilitation units to ensure seamless care.

INITIAL ASSESSMENT±

An Initial assessment usually takes place when a service user presents to services. The aim of an initial assessment is to determine the seriousness and urgency of a service user's problems and the most appropriate type of care for him/her. It involves a fuller assessment of the individual's needs than is conducted at screening, as well as assessment of a service user's motivation to engage with services, current risk factors and the urgency of need . As a result of this assessment, an individual might be offered services within the assessing agency or onward referral to another service.

KEY-WORKER*

The named person assigned to work closely with the service user to provide a range of psychosocial interventions/advocacy for that service user.

± Terms originated in the from the National Drug Rehabilitation Framework Document, however, were later developed to reflect the work conducted in Cork/Kerry

KEY-WORKING*

Key-working is a process undertaken by the key-worker to ensure the delivery and ongoing review of the care plan. This usually involves regular meetings between the key-worker and the service user where progress against the care plan is discussed and goals revised as appropriate. The key-worker is usually a member of the multidisciplinary team responsible for delivering most of the service user's care.

LOCAL DRUG TASKFORCE/ REGIONAL DRUG TASKFORCE

Local and Regional Drug and Alcohol Task Forces (LDATFs and RDATFs) play a key role in assessing the extent and nature of the drug problem in their areas and coordinating action at local level so that there is a targeted response to the drug problem in local communities. They implement the National Drugs Strategy in the context of the needs of their region or local area through action plans which have identified existing and emerging gaps in the following areas: supply reduction, prevention, treatment, rehabilitation and research.

Drug and Alcohol Task Forces comprise representatives from a range of relevant agencies, such as the HSE, the Gardaí, the Probation and Welfare Service, Education and Training Boards, Local Authorities, the Youth Service, as well as elected public representatives and Voluntary and Community sector representatives.

MISSING PARTNERS

Missing partners refers to the lack of engagement with particular key local and national agencies who are viewed as crucial to delivering case-management, which meets the entire needs of the service user. 'Partners' who are instrumental in developing and sustaining effective case-management.

REHABILITATION*

The broad definition of rehabilitation encompasses a structured development process focused on individuals, involving a continuum of care and aimed at maximizing their quality of life and enabling their re-integration into communities.

RESEARCH ADVISORY COMMITTEE

The research advisory committee was a group made up of frontline workers, policy makers, clinicians and service user advocates to oversee the research process. They were convened for the purpose of this research and do not exist as a group beyond this process.

SERVICE LEVEL AGREEMENT (SLA)

A service level agreement is a negotiated agreement between two parties where one is the funding organisation and the other is the service provider. It usually includes a clear and detailed specification and formalised agreements in relation to the service to be delivered and the measurable outputs and outcomes expected.

SHARED CARE PLAN*

Where there are multiple agencies involved in setting objectives with the service user, these should be combined to form a shared care plan, which the Case-manager oversees.

EXECUTIVE SUMMARY

This is the first external examination of the framework for case-managment in the Cork/Kerry region. A consultation day with a range of frontline workers as well as a *research set* consisting of a questionnaire, interviews and service user file was used to gather information about the implementation of the framework. In addition a sample of service users were interviewed across 5 agencies.

All data collection took place between January and June 2017. Overall the participants were enthusiastic for having a shared framework for case-management across the region and high value was placed on the consistency this could offer to service users.

Better inter-agency working was seen as key to providing quality care. However, there were challenges engaging all agencies and the notion of key 'missing partners' was noted throughout the research process. Service user involvement in the evaluation was limited and access to service user files was not permitted in all cases.

Case-management is a system that has evolved over many years and across several disciplines, thus several models exist. The current model of case-management in Cork/Kerry region is a blend of several models.

Most of the respondents suggested that they were either engaging in '*medium-level*' or '*high-level*' *implementation.*

The most commonly cited benefits to participating in the implementation of the framework included: '*consistency*', '*service user involvement*' and '*reduces duplication'.*

The highest proportions of caseloads with complex needs included: *criminal justice, housing/homeless* and *dual diagnos*is.

The benefits of having a shared framework across the Cork/Kerry region included: client centered, reduced duplication, role clarity and professionalism, buy-in from partner agencies, standardisation of both role and paperwork and transparency, service user involvement.

The case-management community supervision, which is supported by the HSE and delivered across both sectors emerged as a key theme with both benefits and drawbacks cited by participants.

The disadvantages of having a shared framework across the Cork/Kerry region included: the hierarchy, the missing partners, loss of professional identity, and the burden of administration.

RESEARCH TEAM

Dr Jo-Hanna Ivers works at the Department of Public Health & Primary Care at the Institute of Population Health, Trinity College Dublin. Jo-Hanna has worked as a researcher in the department of Public Health & Primary Care as part of a wider addiction team since 2009. During this time she has completed some large-scale addiction studies including the evaluation of the National Drug Rehabilitation Framework. Jo-Hanna has specific training and vast experience in a wide range of research methodologies including qualitative, quantitative, neuroimaging process, behavioural intervention and outcome evaluation. Prior to research, Jo-Hanna worked in frontline addiction services.

Professor Joe Barry, Chair of Population Health Medicine at the Department of Public Health & Primary Care at the Institute of Population Health, Trinity College Dublin, has established a drug research group to examine the impact of substance misuse and addiction on population health. His research expertise in this field embraces a wide range of methodologies relevant to the proposal. These include prevalence studies, behavioural and attitude studies, cross-sectional surveys, intervention studies, cohort studies and health outcome studies, including mortality and survival analysis, in addition to policy analysis. He is widely published in international peer-reviewed journals and has extensive experience of the public system and public policy.

ACKNOWLEDGEMENTS

We would like to extend a very sincere thank you to all of the agencies in the addiction, homeless and prison sectors that participated in this research. Participating in research can be demanding and we greatly appreciate the time and effort invested by everyone involved. A heartfelt thank you is extended to all members of the research advisory group for their support and feedback throughout the study.

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CONTEXT OF CASE-MANAGEMENT IN CORK/KERRY REGION

The 2010 National Drug Rehabilitation Framework (NDRF) advocated an integrated and coordinated care approach to drug rehabilitation in Ireland, providing guidelines around standardised protocols (screening, assessments, care-planning, case-management) within the addiction services, then largely absent nationally

In 2011 HSE Drug & Alcohol Services Cork/Kerry employed a Rehabilitation Co-ordinator to support the implementation of the National Drugs Rehabilitation Framework (NDRF) across the Addiction Services in the Cork/Kerry region. The NDRF set the scene for case-management across the Cork/Kerry Addiction Services(inclusive of Cork Prison). It allowed frontline staff from participating agencies in both the statutory and non-statutory organisations to formalize professional relationships and work within a standardized framework that would be recognized nationally. Thus, the NDRF was instrumental in providing a structure for developing and formalizing a case-management approach across the Addiction Services (inclusive of Cork Prison) in Cork/Kerry.

A regional case-management manual to support the process was adapted from the framework. Local training was subsequently developed. Progress within addiction and prison services prompted discussions to engage with the homeless sector to work within this case-management system. In a genuine effort to enter into a partnership, the Cork/Kerry Case-management Framework was developed by bringing all sectors together, adapting the manual and development of a joint assessment which satisfied all sectors involved. It is the development of the work of the Cork/Kerry Case-management Framework across addiction, homeless and prison sector which is the focus of the current evaluation.

RATIONALE FOR CURRENT REPORT

Understanding the differing experiences of service users regarding their treatment offers the best prospects for improving our understanding of their health needs and the opportunities before us better to meet these needs. The proposed research aims to achieve this by conducting an evaluation of the Implementation of a Cross Sectoral (addiction, homeless and prison services) Case-management Framework. Evaluation is a systematic method for reviewing the experiences of a population, leading to agreed priorities and recommendations regarding resource reallocation that will improve health services.

HSE and HSE-funded drug and alcohol services in the Cork/Kerry region have been working within the process of the Case-management Framework since 2013. In 2014, the homeless services joined with the drug and alcohol services in the Cork/Kerry region to undertake the Case-management system and integrate this into their work with persons accessing the homeless services. This now amounts to 70 separate services working within the Case-management Framework across both sectors and including the prison (see appendix 1).

Given the innovative partnership between the homeless services and the drug and alcohol services in the Cork/Kerry region, now is an opportune time to reflect on the progress and impact of Case-management, and to reflect on outcomes for service users. Thus, in January 2017 the HSE Drug and Alcohol services, the Southern Regional Drugs Taskforce, the Cork Local Drug and Alcohol Task Force, HSE National Office of Social Inclusion, and Cork City Council commissioned the Department of Public Health and Primary Care, Trinity College Dublin, to carry out an external evaluation of the Case-management Framework in Cork/Kerry region.

LITERATURE

There is an emerging literature which suggests several crucial factors that influence the adoption and sustainability of new practices and systems of change; for instance the context in which these proposed changes are to be implemented (i.e. organisational culture and climate, leadership and readiness to change).

CONTEXT

The context into which any new practice is implemented is often complex and several models identify organisational factors that may facilitate or hamper the implementation of new practice within health settings [1, 2]. Studies have also identified a number of contextual constructs thought to be necessary for effective implementation of change in organisations[3]. The most commonly cited are an organisation's culture and climate. Definitions of organisational culture and climate vary considerably. However, Beidas et al 2013 offers a succinct definition of each; *organisational culture is defined as shared beliefs and expectations of a work environment, whereas organisational climate is defined as shared perceptions about the work environment's impact on its own employees* [4].

LEADERSHIP

Leadership may also drive implementation of change practice, although few studies have examined its effects[4, 5]. Reichenpfader et al. (2015) suggest while the relevance of leadership in implementation science has been acknowledged, the conceptual base of leadership in this field has received only limited attention[5]. According to Beidas et al. (2013) the relationship between leadership and organisational variables may indicate that high-quality leadership is vital in times of system change and may moderate poor organisational climate and elevated levels of staff turnover. Likewise, high-quality leadership is also correlated with positive staff attitudes concerning the adoption of new practices[4]. Thus, it is crucial to examine leadership and characteristics of leaders (i.e. attitudes) when attempting to examine successful implementation.

READINESS TO CHANGE

The body of work which examines organisational change emphasises organisational '*readiness to change*' as crucial to successful implementation of any new practice [6-9]. Weiner et al (2008) contend that organizational readiness for change is a critical precursor to successful change implementation. Moreover the authors further suggest that health care settings only achieve partial success when they initiate organisational change[8]. Weiner et al. (2008) conducted a systematic review in health services research regarding organisational readiness to change and concluded this topic was still in its infancy[8]. There is a paucity of research focusing on readiness to change within addiction health research.

A recent study by Chilenski et al. (2015) examined how organisational management practices and the emotional context relate to indicators of readiness to implement prevention and evidence-based programmes[10]. The authors found both clear communication and openness of leadership were most important. Organisational-level morale was also a vital predictor of readiness to change[10].

CASE-MANAGEMENT

Case-management is a service user centered strategy involving assessment, planning and brokering between applicable services to provide the relevant resources and advocacy to meet the service users' needs[11, 12]. The purpose is to improve the co-ordination and continuity of service delivery. Several models of case-management exist [13] and offer a concise summary and definition of case-management. The 'Brokerage' case-management model sets out to help service users to identify their needs and broker services to meet these needs.

The literature examining the efficacy of case-management is relatively recent. Studies conducted thus far have suffered from significant methodological problems that include small sample sizes, poorly defined or implemented case-management interventions, problems in evaluation design and measurement and lack of distinction between case-management and comparison interventions[14]. Nevertheless, despite these shortcomings, some valuable insights have been gained from work in the mental health and substance abuse fields. In a Cochrane review Hesse et al. (2007) carried out a meta-analysis of the effectiveness of case-management[13]. The study examined 1230 studies that applied case-management to substance using populations. Due to the strict Cochrane conditions regarding clinical trials and randomisation, the authors only extracted data from 15 studies, which included 2391 patients. These fifteen studies compared a model of case-management with interventions referred to as 'treatment as usual' or 'standard community services'. The authors found that case-management was superior to psycho education and drug counselling in reducing drug use. More recently in Ireland Nic Gabhainn et al (2016) conducted a scoping review of case-management in the treatment of drug and alcohol misuse over a ten-year period from 2003 to 2013. The objective of the review objective of the review was to examine the peer-reviewed non-experimental literature on case-management and substance use[15]. The review identified several characteristics of case-management, which were related to enhance results. The authors found both the duration and intensity of case-management were crucial variables to consider when planning and evaluating case-management.

The authors conclude while there are multiple objectives of case-management, when working with people in recovery (i.e. reducing substance use, reducing hospital visits and admissions and improving psychosocial functioning, nonetheless the current literature is does not adequately address which models of case-management should be used, for particular population and or subpopulations, and under what conditions[15]. Based on the work of Nic Gabhainn et al (2016) Galvin (2017) hypothesized that engagement was a key mechanism to consider when attempting to enhance outcomes of case-management, that is an intensive dose of longer duration, complemented by a good working client-case-manger relationship with devoted care plans is crucial to success[16].

These mechanisms may contribute to greater client engagement and ultimately 'investing in their recovery'. Galvin (2017) concludes further evaluation and blending of case-management with individuals recovering from addiction is needed to investigate the role of these potential features of case-management in delivering improved outcomes for clients.

IMPLEMENTATION OF CASE-MANAGEMENT

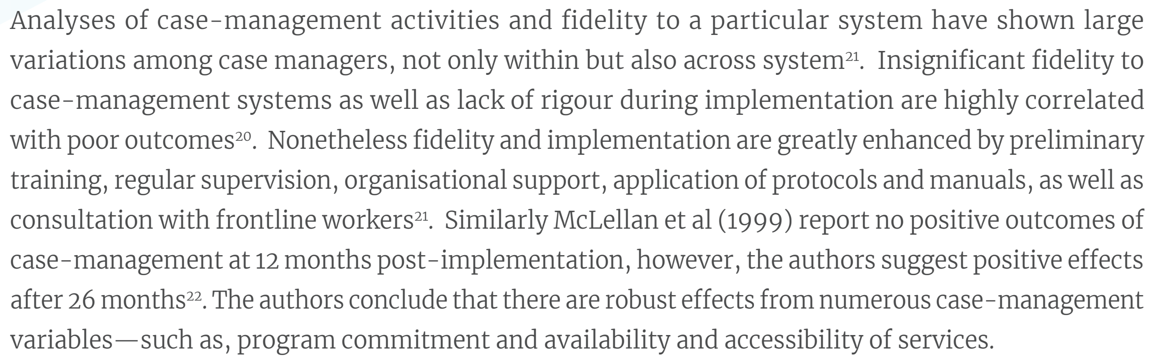
Case-management has been implemented to treat substance users with complex needs in the USA and Canada for at least three decades and more recently also in a number of European countries[17]. However, according to Kolind et al. (2009) case-management is often presented as a set of standardised functions and the application of this intervention is often a subjective task involving numerous problems, which may influence **outcomes** significantly[17].

Rapp et al. (2014) examined the '*deliberate implementation*' of case-management. The authors identified the *deliberate* implementation as a powerful determinant of successful **case-management**[18]. The study focused on experiences across three countries namely; the United States, the Netherlands, and Belgium. The authors suggest that *program fidelity, vigorous implementation, extensive training and supervision, administrative support, a team approach, integration in a comprehensive network of services, and minimal continuity* have all been linked to successful implementation[18].

Moreover, case-management has been implemented across addiction services to improve cost-effectiveness; however, whether this has been achieved remains a contentious issue. Vanderplasschen and colleagues conducted a systematic review, which included (48) peer-reviewed articles published between 1993 and 2003 examining the effects of a number of different models of **case-management** among various **substance**-using populations[19]. The authors found that several studies reported positive effects. However, only some randomised controlled trials demonstrated the overall efficacy of **case-management** when compared with other interventions. In the main, strength-based and generic **case-management** models have proven to be relatively effective for **substance** users in general.

The most positive effects concern reduced use of residential services and increased utilization of community-based services, prolonged treatment retention, improved quality of life, and high client satisfaction [19]. However, the authors conclude that the longitudinal effects of this intervention remain ambiguous. In addition, the authors suggest that while no compelling evidence was found for the effectiveness of **case-management**, specific evidence is available concerning the (differential) effectiveness of intensive **case-management** for complex needs (i.e. substance users experiencing homelessness and or persons with dual diagnosis. Vanderplasschen, et al. (2004) concluded that for individuals requiring a variety of services (e.g. employment, substance abuse, health and child care), the implementation of one specific model of case-management is likely to be effective. The strengths-based case-management appeared to be the most effective model; however, only two clinical trials by a single research group existed at the time of the review[20].

Notwithstanding its extensive application and popularity, case-management remains inconsistently defined, and its application varies significantly regarding field, jurisdiction and professional background of case-managers[20]. Also, contextual factors, diverging objectives, distinct target populations, program and system variables, and other proximate indigenous concerns must be considered[20].



Analyses of case-management activities and fidelity to a particular system have shown large variations among case managers, not only within but also across system[21]. Insignificant fidelity to case-management systems as well as lack of rigour during implementation are highly correlated with poor outcomes[20]. Nonetheless fidelity and implementation are greatly enhanced by preliminary training, regular supervision, organisational support, application of protocols and manuals, as well as consultation with frontline workers[21]. Similarly McLellan et al (1999) report no positive outcomes of case-management at 12 months post-implementation, however, the authors suggest positive effects after 26 months[22]. The authors conclude that there are robust effects from numerous case-management variables—such as, program commitment and availability and accessibility of services.

IMPLEMENTATION OF CASE-MANAGEMENT IN AN IRISH CONTEXT

In 2010 the National Drug Rehabilitation Framework (NDRF) was developed to improve the quality and quantity of interagency referrals between drugs services (community, voluntary and statutory) and the range of services that a person may need to access in their recovery [11]. The document set out to ensure "*the provision of services will be based on the implementation of a comprehensive care plan and an integrated approach to case-management where appropriate*" in Ireland[11].

The proposed move towards the standardised approach of the NDRF is largely based on, but not limited to, case-management. This is relatively new in Ireland. A national evaluation of the NDRF found several factors that both assist and hinder this process[23]. The authors conclude that several challenges exist regarding how to make the NDRF a reality, particularly at an organisational level and as a routine, sustained aspect of standard practice.

METHODOLOGY

AIM AND OBJECTIVES

The overall aim of the current study was to examine the implementation of the Case-management Framework in 70 services across the Addiction and Homeless services and including the Post Prison Release Service in the Cork/Kerry Region.

Study objectives

1. To measure the extent of fidelity to the Case-management Framework across of the 70 services i.e. the extent to which services were undertaking key working, care planning, case-management
2. To measure the impact for service users that can be attributed to being worked within the Case-management Framework (outcome)
3. To measure the impact for service providers that can be attributed to being worked within the Case-management Framework (process)

A combination of quantitative and qualitative research methods was used to gather data from service users and service providers. The purpose of this methodology is twofold (i) to fully consult with all relevant key stakeholders throughout the entire process (qualitative) (ii) to gain insight into their experience of the implementation of the Framework in the Cork/Kerry region (quantitative). The research team employed an 'evolving' methodology, that is, following consultation with frontline staff we adapted research protocol to reflect feedback received.

Instruments used in evaluating subjects

- Qualitative interview schedules (service users, frontline staff and managers - sample schedule attached).
- Questionnaire(s): Two questionnaires were given to frontline workers: 1. Experience of implementing the framework and 2. A sub-sample received a questionnaire on stakeholder involvement.
- Audit matrix: set of key indicators that were applied to the service user file to determine level of implementation and fidelity to the framework.
- Anonyomised electronic submission space (via Survey Monkey) for independent submissions.

Data collection

Data collection took place with a sample of service providers and service users attending a range of drug and alcohol services, (non-substance specific services, open access drug and alcohol treatment services, structured community-based drug and alcohol services and residential drug and alcohol services) as well as homeless services across Cork/Kerry from January 24th to June 21st 2017.

Data collection comprised 5 key components

1. Consultation day –World Café
2. Quantitative questionnaires
3. Qualitative Interviewing
4. Audit of service user file.
5. Individual submissions

Consultation day/World Café

World café is a qualitative methodology to collect information from participants in an informal setting.

The purpose of the world café method was to:

(a) Consult with service providers about current implementation of the framework
(b) Inform the evaluation regarding assessment of important outcomes for Cork/Kerry
(c) Elicit opinion on key outcomes since implementing the framework in Cork/Kerry
(d) Inform the development of the proposed update of the case-management manual (inclusive of initial joint assessment and other common shared practices between drug and alcohol and homeless services).

Quantitative Questionnaires

All frontline staff who had received the case-management training were invited to complete a questionnaire outlining their experience of implementing the framework in the Cork/Kerry region. The purpose of the questionnaire was to capture outcomes on all participants actively implementing the framework. The purpose of the questionnaire is to target the wider population to ascertain a global view of implementation.

Qualitative Interviews

A major strength of qualitative data is the rich thematic texture that can arise from this type of analytic undertaking. The major goal within this segment of evaluation is the elaboration of the understanding of the need for and benefit of a case-management framework for substance users and persons experiencing homelessness, a goal which is not possible to capture in a methodological format such as a questionnaire, that is more appropriate with larger sample sizes.

Audit of service user file

The purpose of the audit was to examine evidence of care planning, case-management and overall fidelity to protocols laid down in the framework. A total of 5 service user files from 5 different agencies were included in the audit. The audit of files took place with both service user and service provider present. With the exception of one file evidence of framework paperwork was being utilised. When asked about the framework protocols and paperwork all frontline workers said that they found that while the consistency of the shared form was beneficial it could be cumbersome at times. Two of the five frontline workers said they did not use the care plan form and found it was unnecessary.

Individual submission

In order to ensure that we gave the entire population an opportunity to participate in the evaluation, as an exit to the research, we built in a mechanism whereby all staff (regardless of whether they were selected for interview) were given the opportunity to make a confidential submission (approximately 500 words) should they wish. The submissions were completely anonymous, the purpose of this being to give participants an opportunity to express a concern/issue that would not otherwise be captured. The link to an anonymous survey monkey space was embedded in an email and sent to all managers and frontline staff.

PARTICIPANTS

A Triangulation of methods using a 'research set' consisting of interviews with frontline implementers, their manager, a service user with whom they are working and the service user's file, was used to examine the implementation of a framework for case-management in Cork/Kerry region.

SAMPLING

A total of 38 addiction services, 8 homeless services and Cork prison were involved in the implementation of a case-management framework in the Cork/Kerry region. All available front line staff (approx. 180) were given a questionnaire to capture their experience of implementation to date.

20 SERVICES (15 ADDICTION SERVICES AND 5 HOMELESS) IN TOTAL WERE SELECTED FOR INTERVIEW

The following criteria were used to select services for interview and audit

- Included all three sectors (Addiction services, Homeless services and the Prison)
- Included all level of implementation (low, medium, high)
- Included all available Tiers (2, 3 4)
- Included both HSE and community/voluntary sectors
- Included urban and rural services
- Included local and regional services
- Included services that operate at a national level

Despite the above criteria four services (HSE clinics, outreach services, services representing minority groups, and services supervising frontline staff) were identified as being crucial to the evaluation and immediately admitted into the study. Each of the above services were contacted and informed that it was selected to participate. Each service manager was asked for a full list of available frontline workers actively implementing the framework. One frontline worker from each of the selected services was randomly selected from the list. All services were given an option to opt out of the evaluation should they wish. One service opted out of the evaluation process due to other work constraints.

Fidelity check

When effective interventions are implemented in real-world conditions, it is important to evaluate whether or not the programmes are practiced as intended. Validity for protocols and accompanying paperwork is a key outcome of the evaluation. Thus, the rigour and scope of adherence are key outcome measures of the evaluation.

Ethical approval

The study received ethical approval from the Health Service Executive.

FINDINGS

Information was gathered from various stakeholders using 5 different methods namely; a 'World Café/consultation day, online quantitative surveys, qualitative interviews, an audit of service user files and an online anonymised submission space. Findings from each of these methods are reported below.

CONSULTATION DAY/WORLD CAFÉ

The World Café was a vital component of the evaluation, the purpose of the consultation was to inform stakeholders of the evaluation and allow them to contribute to the wider methodology. Thus the process, as well as the findings, is crucial.

The 'World Café' took place in Cork County Hall on the 24th of January 2017. The session lasted 3 hours and was facilitated by Dr Jo-Hanna Ivers. A total of 104 participants attended from approximately 70 services operating in the Cork/Kerry region. Participants were organized into 10-12 seated tables and tea and coffee was provided. This was in line with the World Café method to facilitate multiple groups at one time with the provision of tea and coffee to create a relaxed informal setting in which participants felt comfortable talking. Usually participants move tables for each new question so new groups are formed to keep the energy and buzz in the room. However, due to the large number, participants remained at the same table for the entire session.

Three key questions formed the discussion at the World Café: (1) What works about the framework/ case-management approach? (2) What would you like to do differently? And (3) How do we know it's working – what questions should we be asking? The facilitator read out each question. Each table appointed a note taker, a chair and rapporteur to collate feedback and report back to the larger group. Each question was given 20 minutes for discussion. After all questions were answered each table reported back to the larger group. All responses were noted using flipcharts. Charts were taken away and responses were collated based on the consultation.

During the consultation day two key findings emerged; several participants highlighted the necessary inclusion of service users to inform the process of case-management. In addition, it was also suggested that service user files be included when attempting to quantify the level of case-management. Based on the findings of consultation day two distinct changes to the research methodology were made following the consultation, namely; (1) an audit of files (2) interviews with service users.

QUANTITATIVE QUESTIONNAIRES

One hundred and seventy-five respondents across the addiction, homeless and prison service in the Cork/Kerry region were contacted and asked to complete an online survey via Survey Monkey. A total of 48 (27.4%) of frontline workers and managers completed the online survey. The survey sought to capture their experience of implementing the Case-management framework across the Cork/Kerry region. Analyses of their responses are presented below.

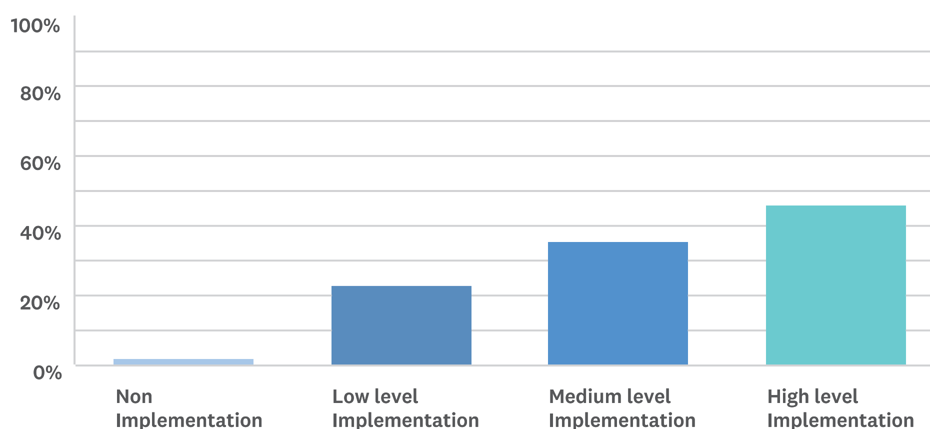
Basic demographics of respondents

Almost two-thirds of respondents (60.4%/n=29) said that they were working in an Addiction Service the highest majority of whom (58.3%/n=28) said they were working in the Community Sector. Almost two-thirds of respondents cited Cork city (60.4%/n=29) as the geographical area, which they covered. The majority of respondents said they represented a '*Tier 2*' (39.5%/n=19) or '*Tier 3*' service (22.9%/n=11). More than half of respondents were female (56.2%/n=27). The most commonly cited categories of roles were '*Community Drugs Workers*' (37.5%/n=18), '*Addiction Counsellors*' (18.5%/n=9) and '*Support Workers*' (18.5%/n=9).

Current level of implementation:

- When asked about the current level of implementation most of the respondents suggested that they were either engaging in 'medium-level' (35.4%/n=17) or 'high-level' (45.8%/n=22) implementation of the framework (figure 1).
- When asked about the percentage of current caseload engaging with the framework the average response was 63.0%. When asked about the percentage of current caseload who had completed an initial assessment the average response was 82.0%. When asked about the percentage of current caseload who had completed a common assessment the average response was 36.0%.
- When asked about the percentage of current caseload who had a key-worker the average response was 66.0%.
- When asked about the percentage of current caseload who had a case-manager, the average response was 44.0%.

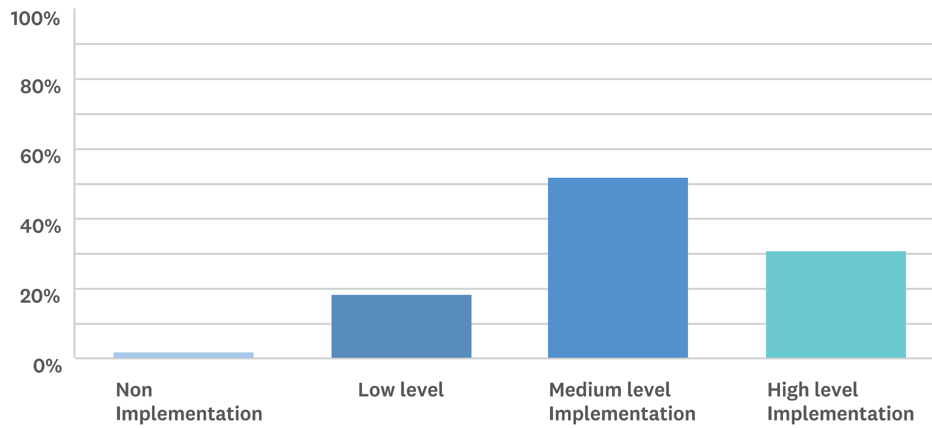
Figure 1 current level of implementation



ANSWER CHOICES	RESPONSES	
Non Implementation	2.08%	1
Low level Implementation (only applies in small number of cases)	22.92%	11
Medium level Implementation (applies to less than half of cases)	35.42%	17
High level Implementation (applies to all my cases)	45.83%	22
Total Respondents: 48		

However, when asked about the current level of implementation their service had reached the majority suggested that service level implementation was medium level (52.0%/n=25).

Figure 2 current level of service implementation

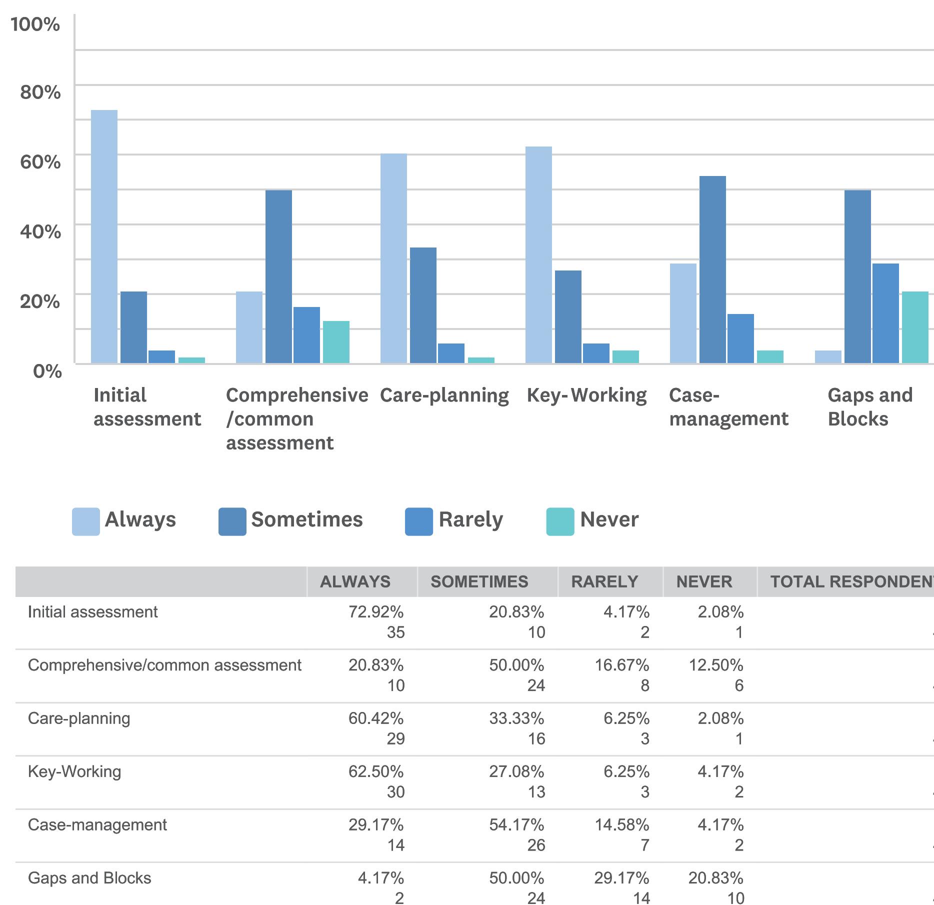


ANSWER CHOICES	RESPONSES	
Non Implementation	2.08%	1
Low level Implementation (only apply in small number of cases)	18.75%	9
Medium level Implementation (apply to less than half of cases)	52.08%	25
High level Implementation (apply to all my cases)	31.25%	15
Total Respondents: 48		

Efficacy of framework

When asked about what how often the specific elements of the framework work well respondents suggested initial assessment, care planning and key-working mostly '*always*' worked well. However, comprehensive assessment, case-management and gaps and blocks worked well only '*sometimes*'.

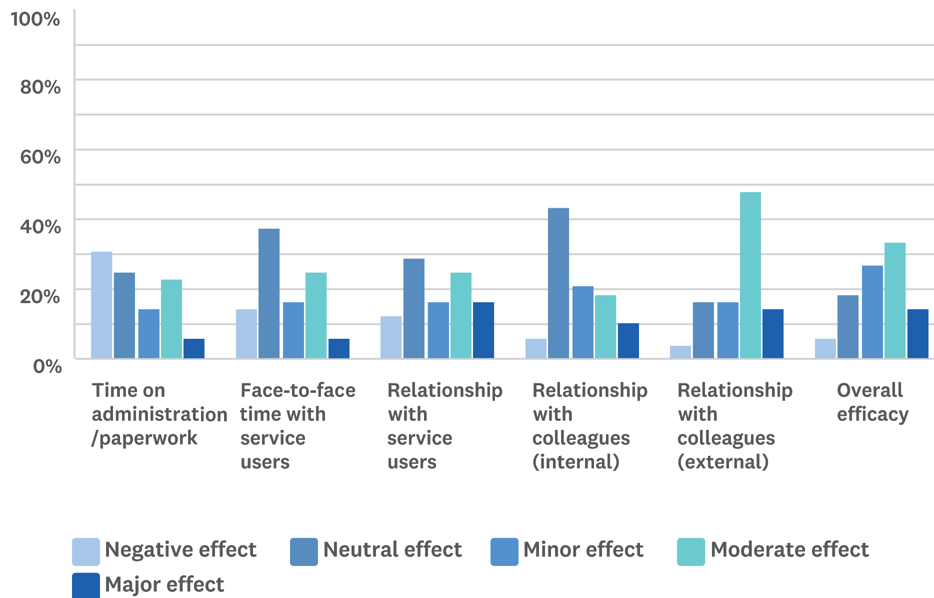
Figure 3 efficacy of the framework



	ALWAYS	SOMETIMES	RARELY	NEVER	TOTAL RESPONDENTS
Initial assessment	72.92% 35	20.83% 10	4.17% 2	2.08% 1	48
Comprehensive/common assessment	20.83% 10	50.00% 24	16.67% 8	12.50% 6	48
Care-planning	60.42% 29	33.33% 16	6.25% 3	2.08% 1	48
Key-Working	62.50% 30	27.08% 13	6.25% 3	4.17% 2	48
Case-management	29.17% 14	54.17% 26	14.58% 7	4.17% 2	48
Gaps and Blocks	4.17% 2	50.00% 24	29.17% 14	20.83% 10	48

Respondents were asked to reflect on specific elements of their work and consider whether there were any improvements since implementing the framework. '*Relationships (with clients, colleagues internal/external)*' were most (41.5%/n=20) improved, whereas '*time on administration*' (31.5%/n=15), '*time face to face with clients*' (14.5%/n=7) and *relationships with clients*' (12.5%/n=6) were most negatively affected.

Figure 4 Improvements following implementation



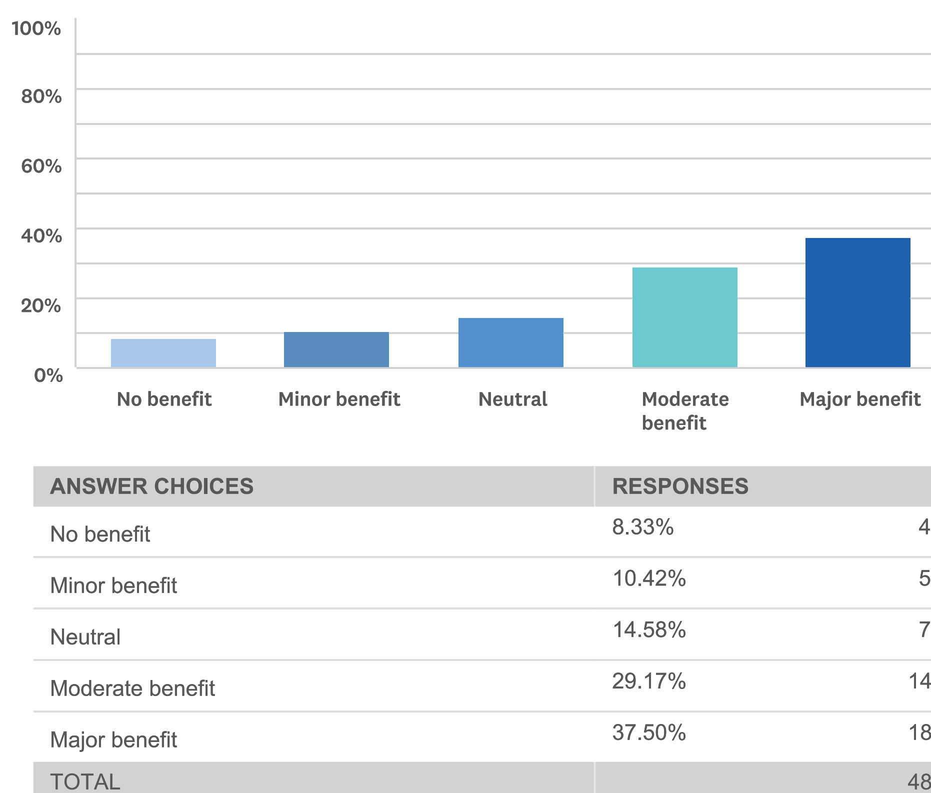
	NEGATIVE EFFECT	NEUTRAL EFFECT	MINOR EFFECT	MODERATE EFFECT	MAJOR EFFECT	TOTAL RESPONDENTS
Time on administration/paperwork	31.25% 15	25.00% 12	14.58% 7	22.92% 11	6.25% 3	48
Face-to-face time with service users	14.58% 7	37.50% 18	16.67% 8	25.00% 12	6.25% 3	48
Relationship with service users	12.50% 6	29.17% 14	16.67% 8	25.00% 12	16.67% 8	48
Relationship with colleagues (internal)	6.25% 3	43.75% 21	20.83% 10	18.75% 9	10.42% 5	48
Relationship with colleagues (external)	4.17% 2	16.67% 8	16.67% 8	47.92% 23	14.58% 7	48
Overall efficacy	6.25% 3	18.75% 9	27.08% 13	33.33% 16	14.58% 7	48

Respondents were asked if there was any element of the Case-management Framework that should be modified or removed; more than half said '*no*' (54.1%/n=26).

Benefits of framework

When asked about the overall benefits to service users for engaging in the framework, the most commonly cited responses related to: '*consistency*' (39.5%/n=19) '*service user involvement*' (16.6%/n=8) and '*reduces duplication*' (16.5%/n=8). When asked about direct benefits for engaging in the framework, the most commonly cited responses related to: '*interagency working*' (41.6%/n=20), '*efficiency*' (35.4%/n=17) and '*continuity of care*' (29.1%/n=14). When asked how has initial assessment benefited usual care, more than one-third respondents suggested it had a '*major*' benefit (37.5%/n=18).

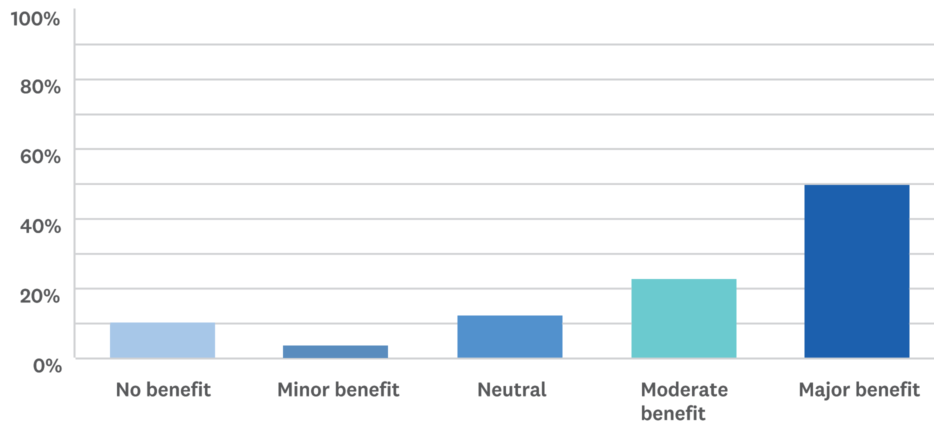
Figure 5 Benefits of the framework



ANSWER CHOICES	RESPONSES	
No benefit	8.33%	4
Minor benefit	10.42%	5
Neutral	14.58%	7
Moderate benefit	29.17%	14
Major benefit	37.50%	18
TOTAL		48

When asked how has care planning benefited usual care half of respondents suggested it had a '*major*' benefit (50.0%/n=24).

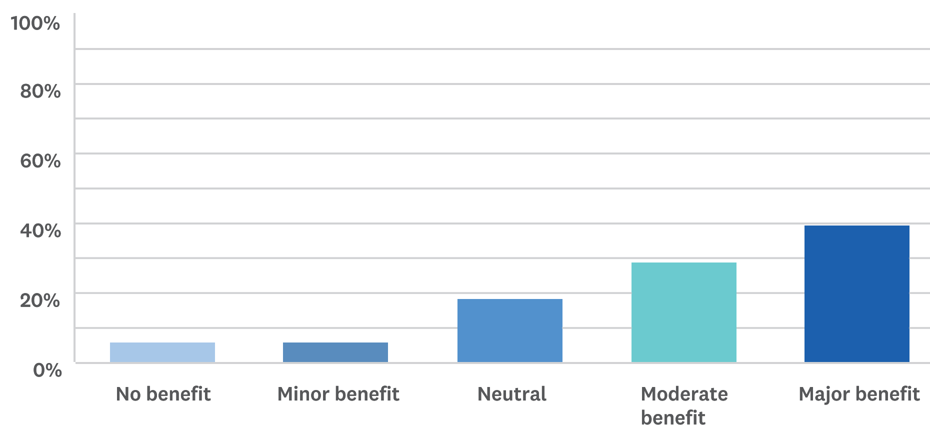
Figure 6 Benefits usual care



ANSWER CHOICES	RESPONSES	
No benefit	10.42%	5
Minor benefit	4.17%	2
Neutral	12.50%	6
Moderate benefit	22.92%	11
Major benefit	50.00%	24
TOTAL		48

When asked how has key-working benefited usual care almost half of respondents suggested it had a '*major*' benefit (39.5%/n=23).

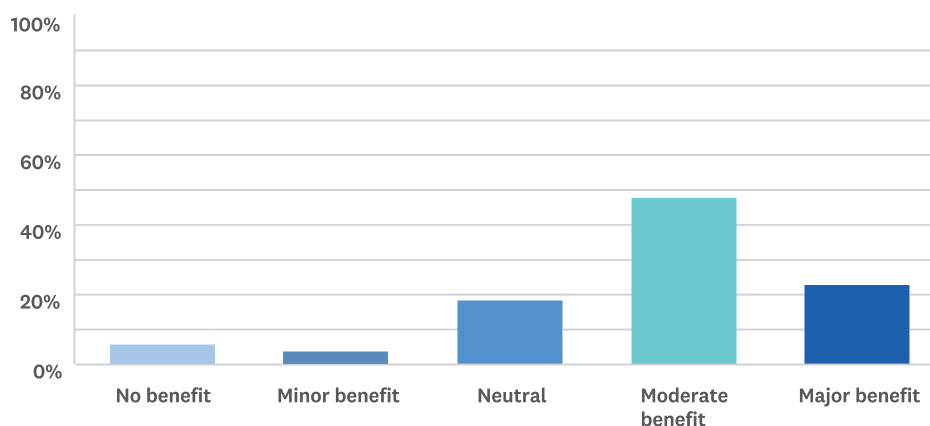
Figure 7 Benefits key-working



ANSWER CHOICES	RESPONSES	
No benefit	6.25%	3
Minor benefit	6.25%	3
Neutral	18.75%	9
Moderate benefit	29.17%	14
Major benefit	39.58%	19
TOTAL		48

When asked how has case-management benefited usual care almost half of respondents suggested it had a '*moderate*' benefit' (47.9%/n=23). The majority of respondents suggested the role of case-manager is not always appropriately assigned (62.5/n=30).

Figure 8 Benefits case-management



ANSWER CHOICES	RESPONSES	
No benefit	6.25%	3
Minor benefit	4.17%	2
Neutral	18.75%	9
Moderate benefit	47.92%	23
Major benefit	22.92%	11
TOTAL		48

In addition, respondents were asked if implementing the framework had resulted in saving time. Half of the respondents said that they had saved time (50.0%/n=24). Furthermore, the respondents were asked to elaborate on how the time saved was used. The most commonly cited responses related to; 'additional appointments' (29.1%/n=7), administration (25%/n=6) and 'building client rapport' (25%/n=6).

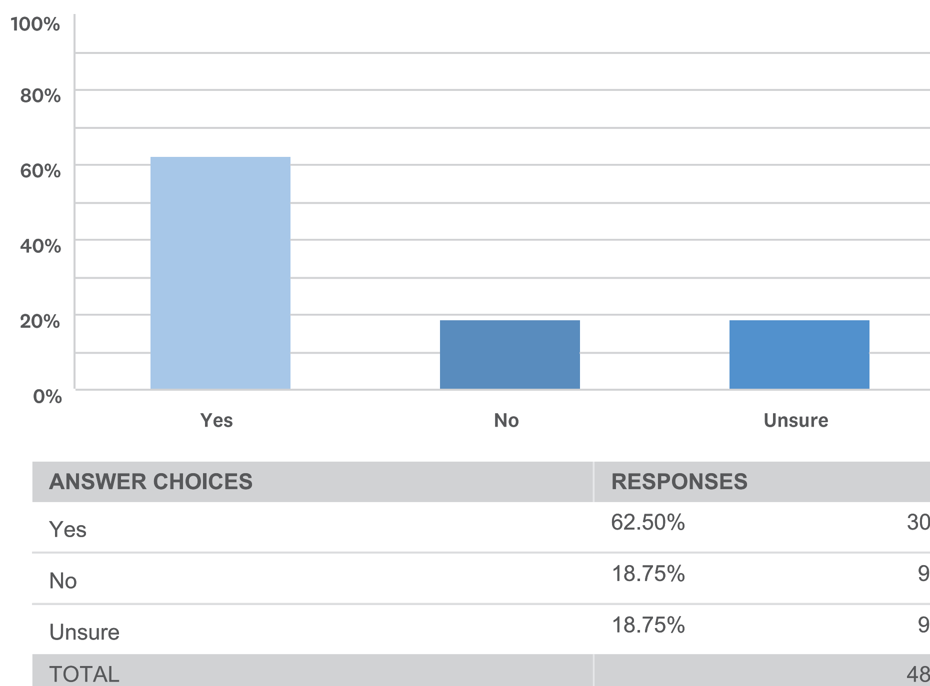
Disadvantages/barriers to implementation of framework

When asked about the main disadvantages to engaging in the framework, the most commonly cited responses related to: '*missing key agencies*' (25%/n=12); '*lack of interagency cooperation*' (22.9%/n=11) and '*poor fit*' (18.7%/n=9). When asked about the biggest barriers to implementing the framework at a service level the most commonly cited responses related to: 'in*adequate support/ time resources*' (31.5%/n=15), lack of '*interagency cooperation/missing partners*' (22.9%/n=11) and '*poor fit*' (16.6%/n=8). Also, respondents were asked about the biggest barriers to implementing the framework at a regional level. The most commonly cited responses related to: '*lack of interagency cooperation*' (41.6%/n=20), '*missing partners*' (25%/n=12) and '*inadequate resources*' (20.8%/n=10).

Level of support implementing the framework

When asked if they felt adequately supported to implement the Case-management Framework the majority said yes (62.5%/n=30).

Figure 9 Level of support



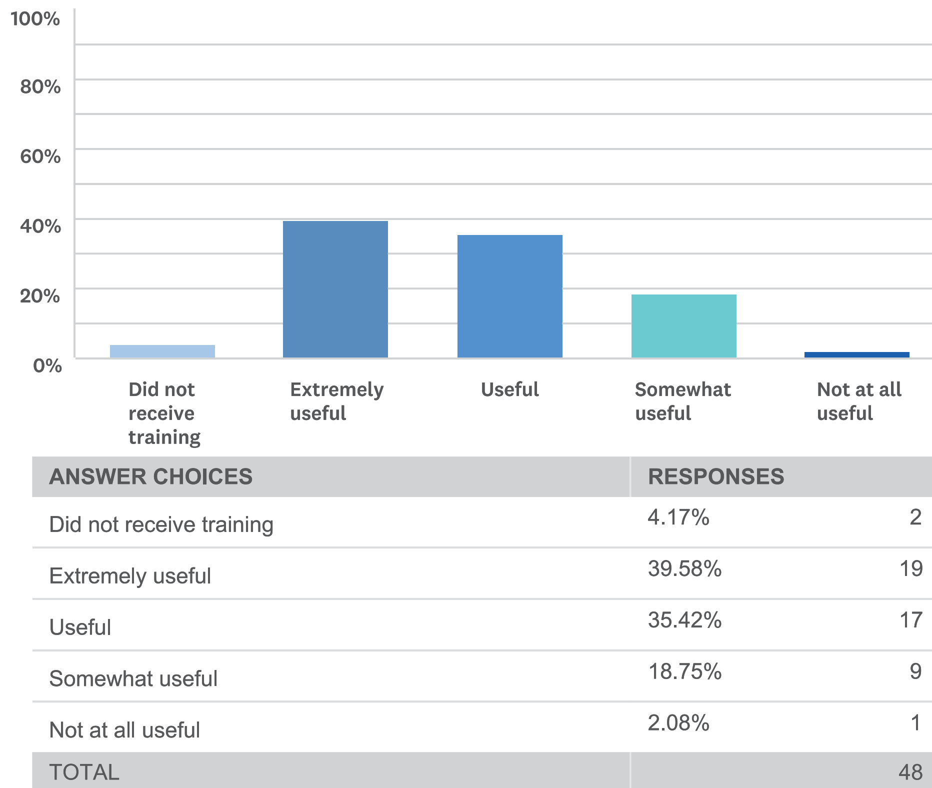
ANSWER CHOICES	RESPONSES	
Yes	62.50%	30
No	18.75%	9
Unsure	18.75%	9
TOTAL		48

When asked if they received direct supervision for case-management the majority of respondents said that they did (77.0%/n=37). Of these almost two-thirds suggested they were part of the community led case-management supervision (64.5%/n=31). Moreover, of these (67.7%/n=21) suggested that this was either '*extremely useful*' or '*useful*'. When asked what was the one thing that would further support them and their colleagues to more effectively apply the Case-management Framework, the most commonly cited responses related to; 'review and evaluation' (33.3%/n=16), engaging missing partners' (27.0%/n=13) and 'additional resources' (14.5%/n=7).

Training

The majority of the respondents had received the pre-implementation training (95.1%/n=46). When asked how helpful they found the training the majority of respondents said it was either '*extremely useful*' (39.5%/n=19) or '*useful*' (35.4%/n=17). Of those who received the training, the majority participated in a community based single day training session (89.3%/n=42). When asked if the training was long enough the majority said '*yes*. However, (56.2%/n=27) said that the training should be repeated *on average* yearly.

Figure 10 Pre-implementation training

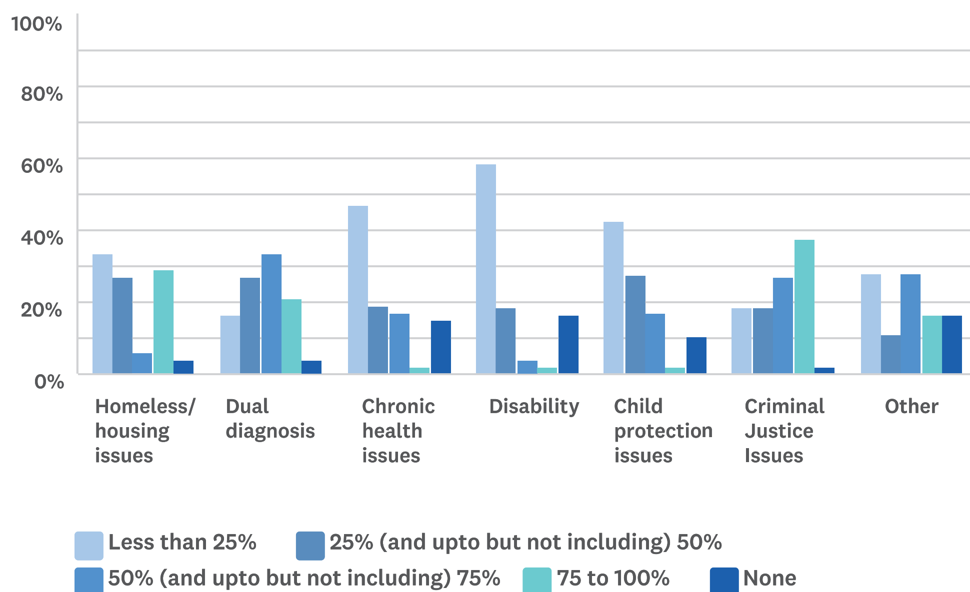


ANSWER CHOICES	RESPONSES	
Did not receive training	4.17%	2
Extremely useful	39.58%	19
Useful	35.42%	17
Somewhat useful	18.75%	9
Not at all useful	2.08%	1
TOTAL		48

Treatment specific elements of framework:

When asked about the percentage of their caseload that have complex needs, respondents cited the highest proportion of caseload with '*criminal justice*' (37.5%/n=18), '*housing/homeless*' (29.1%/n=14) and '*dual diagnos*is' (20.8%/n=10).

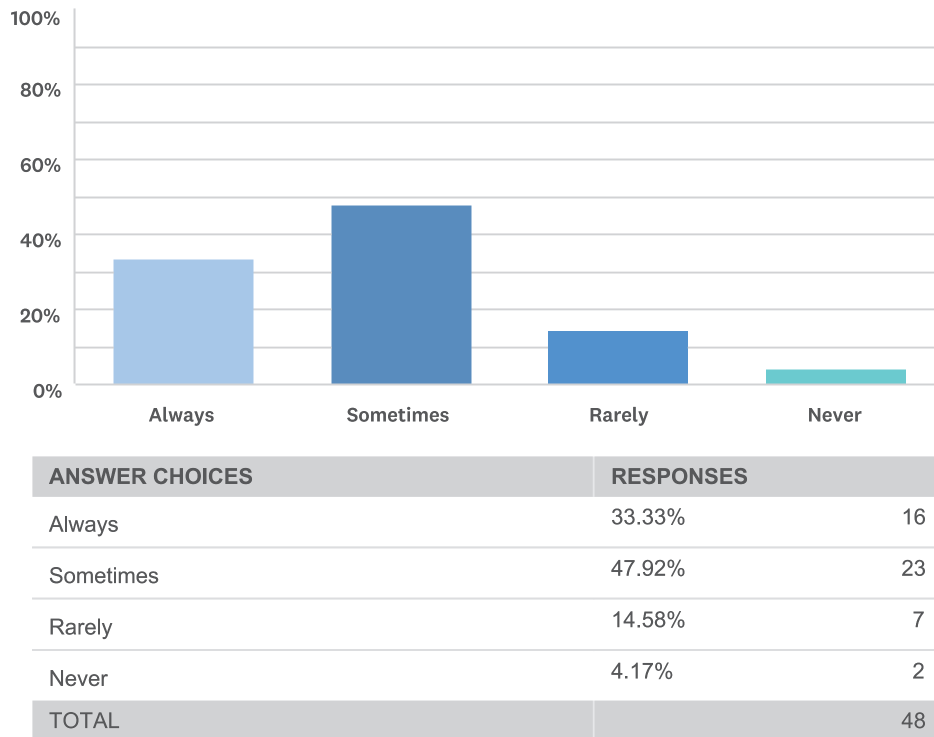
Figure 11 Service users with complex needs



	LESS THAN 25%	25% (AND UPTO BUT NOT INCLUDING) 50%	50% (AND UPTO BUT NOT INCLUDING) 75%	75 TO 100%	NONE	TOTAL RESPONDENTS
Homeless/housing issues	33.33% 16	27.08% 13	6.25% 3	29.17% 14	4.17% 2	48
Dual diagnosis	16.67% 8	27.08% 13	33.33% 16	20.83% 10	4.17% 2	48
Chronic health issues	46.81% 22	19.15% 9	17.02% 8	2.13% 1	14.89% 7	47
Disability	58.33% 28	18.75% 9	4.17% 2	2.08% 1	16.67% 8	48
Child protection issues	42.55% 20	27.66% 13	17.02% 8	2.13% 1	10.64% 5	47
Criminal Justice Issues	18.75% 9	18.75% 9	27.08% 13	37.50% 18	2.08% 1	48
Other	27.78% 5	11.11% 2	27.78% 5	16.67% 3	16.67% 3	18

Respondents said *on average* 39% of their caseload is female, while less than one fifth said they provided female specific services (19.1%/n=9). However, when asked about how important female specific treatment approaches/services are two-thirds (62.5%/n=30) suggested female specific services are either '*extremely important*' or '*important*'. When asked if they included the family in the treatment of service user the majority of respondents said they did 'always' (33.3%/n=16) or 'sometimes' (47.9%/n=23).

Figure 12 Inclusion of family in treatment of service user



ANSWER CHOICES	RESPONSES	
Always	33.33%	16
Sometimes	47.92%	23
Rarely	14.58%	7
Never	4.17%	2
TOTAL		48

Most respondents suggested it was either '*extremely important*' (38.3%/n=18) or '*important*' (27.6%/n=16) to include the family in the treatment of the service user. When asked what were the barriers to including family in the treatment of the service user the most commonly cited responses referred to '*confidentiality*' (26.8%/n=11) or '*lack of understanding*' (29.2%/n=12).

Summary of findings

- Most of the respondents suggested that they were either engaging in 'medium-level' or 'high-level' implementation.
- The most commonly cited benefits to participating in the implementation of the framework included: 'consistency' (39.5%/n=19) 'service user involvement' (16.6%/n=8) and 'reduces duplication'.
- When asked how has care planning benefited usual care half of respondents suggested it had a 'major' benefit (50.0%/n=24).
- The most commonly cited disadvantages to participating in the implementation of the framework included: missing partners and lack of interagency cooperation.
- The majority of the respondents felt adequately supported to implement the Case-management
- The majority of the respondents had received the pre-implementation training (95.1%/n=46). When asked how helpful they found the training the majority of respondents said it was either 'extremely useful' (39.5%/n=19) or 'useful' (35.4%/n=17).
- The majority of the respondents had received the pre-implementation training
- The highest proportions of caseloads with complex needs included: criminal justice, housing/homeless and dual diagnosis.
- On average 39% of respondents' caseload is female
- Most respondents suggested it was either 'extremely important' or 'important' to include the family in the treatment of the service user

QUALITATIVE INTERVIEWS

Thirty eight participants were invited to participate in the qualitative interviews. This consultation included the experiences of service users, frontline workers, managers, and key stakeholders. Both positive and negative experiences of the implementation process and structural barriers that hamper its full utilisation, were identified. The qualitative data yielded crucial information on differences in relation to the needs experienced by frontline workers and their managers as well as other stakeholders. Service users' experience yielded less information on the framework, but focused on the treatment they were receiving. A total of four major themes with several subthemes emerged from the data, namely: current level of implementation, advantages of implementing a shared framework, disadvantages of implementing a shared framework and recommendations for continued implementation of a shared framework (culture, knowledge, and limitations). Data are presented and discussed in terms of their respective themes and subthemes.

Implementation

Naturally implementation emerged as a key theme with current level and knowledge of implementation emerging as subthemes.

Current level of implementation

While several of the participants suggested that they were implementing the framework at a medium to high level more than half of the frontline workers suggested that they did not utilise the framework fully

> *"I would very much stick rigidly to the initial assessment … but I would only use the comprehensive assessment if needed So, what I mean by that – if a client came to me and if they said "I want to go to…" a specific service like a residential treatment centre, and if I agreed with that assessment I'll say "Yeah, that's something that's going to be helpful for you" and if that service required that I pass on a comprehensive assessment, then I would use it in that case. But otherwise I wouldn't use the comprehensive assessment*"(Frontline worker 2).

> *"So, the care plan piece then, I don't use the forms very well for the care plan, the actual care plan forms, but I would – I kind of – yeah I'm not very good at using those care plan forms, I just kind of use my own way of doing the care plan which, you know, you can"* (Frontline worker 6).

> "*Well, what I've actually found that the case manager is actually something in theory, so we've been told we're case managers, so I've had some people go to Tier 4 and I've done all the paperwork and on the paperwork I'm a case manager but when the person has gone to [name treatment centre removed], nobody has ever contacted me and I have never contacted [name treatment centre removed], to see how the client is getting on. I've never called meetings because I suppose traditionally it was 'Well, the client is in Tier 4, they're all counsellors, why do I need to be onboard?' you know? They already have the therapy intervention*" (Frontline worker 11).

Knowledge of the framework
All of the frontline workers interviewed had received the training and were implementing the framework. As such they were all proficient in case-management and its various components. However, the knowledge of the Case-management Framework and the various components of it among service users was quite mixed

> *"Yeah, [name removed] would be my case manager now because she's been connected in every avenue for me for the past couple of years, you know"* (Service user 5)

> *"I don't know, key worker I think"* (Service user 1)

Similarly the advantages of being worked with via a framework were varied

> *"Yeah. Yeah ...my care plan at the moment I suppose is to start my aftercare out in [name of treatment centre removed] and continue on with that for the next two years, go to my meetings and stuff, work through my steps in NA and just continue on with what I'm doing. I'm doing well at the moment"* (Service user 5)

> *To be honest, I don't really like it because, you know, I just – you know, it's like everyone is on my case, like. And I just wish they'd all leave me alone sometimes"* (Service user 1)

Advantages of implementing a shared framework

Several benefits of having a shared framework across the Cork/Kerry region were cited by participants. These included: client centered, reduced duplication, role clarity and professionalism, buy-in from partner agencies, standardisation of both role and paperwork and transparency.

'Client centered'
The notion that the framework was client centred was cited as a clear advantage by the majority of participants.

> *"it gives the client, I suppose, a voice and a clear path and I see when it works it blows my mind, like, when it doesn't work I'm not having the same conversations I was having before"* (Frontline worker 4).

> "*they [the Case-management Protocols] definitely give coherence, give opportunities for the different agencies to work together, definitely a support to service users, completely – I'm completely sold on that*" (Manager 10)

> I suppose there's a – yeah, having the client at the centre of it and then, you know, we're kind of trying to all work off a similar care plan. It makes a lot of sense... (Frontline worker 6).

'Reduced duplication'
Reducing duplication was commonly cited as a key advantage of implementing the framework for case-mangement across the Cork/Kerry region.

> *"...there's no duplication of – of who's doing what, it great ..."*(Manager 6)

Role (clarity and professionalism)

The clear advantages of role clarification was seen as a direct benefit of the framework. Most notable were the opportunity for clarity and professionalism it afforded participants

> *"I think the language, I think the sharing of information, it all – has given permission that we can share information. I think it's great, I think it's – it's clarifying the whole confidentiality piece around it"*(Frontline worker 2).

> *"I feel those of us that were community drug and alcohol workers were doing this work anyway. It was just never recognised,… so, it's as if your assessment hadn't even mattered or counted. Or sometimes I would think if we were dealing with social workers or other agencies, you mightn't – you know, "Oh yeah, sure they're just the community worker" or, you know, so I felt our role in the community…"* (Frontline worker 9).

> *"I think that could be grown to another level by which the community drugs workers, whomever that person is, is seen as a professional. Not necessarily a non-professional, non-clinical person. I think that piece could be grown and the clients would benefit from that"* (Manager 13)

Buy-in partner agencies

The 'buy-in' from external agencies was a leading advantage of the Case-management Framework

> *"…when I link in with other organisations, well I would say to the people I'm working with [the Case-management Framework]– I would say that we're singing off the same hymn sheet. And for me that's great …"* (Frontline worker 8)

> *"I suppose the fact that a number of services are using it means there's an understanding of the system"* (Manager 9)

> *"That you have everything planned out basically, I suppose like. Move everything along, you know, like, if you're feeling down you've got different people and services to branch out to"* (Service user 3)

In addition, buy in from other addiction services, particularly residential, was seen as an issue:

> *"That just baffles me. Especially if it's in service level agreements, if..our funding is dependent on certain things and why .. should* [name of service removed], not *have to buy into it – it baffles me".*

> "…when I ring [name of service removed], depending on what addiction counsellor I talk to now, life is either going to get very hard or very easy. Sure what's the point in having a process then?"

Standardization (roles and paperwork)

Standardization was a major advantage cited by the majority of participants during the course of the evaluation, particularly regarding paperwork and the role of key-workers and case-managers:

> *"it [work prior to framework] never had a structure, it never had a framework and the case management structure actually I think just allowed – put our work practice into a framework anyway. I think for service users it's been invaluable because, you see, before, the old way was if somebody came here and we done an assessment and, say, we referred them to another service, they'd do another assessment…"*(Frontline worker 9)

> *"it provides a recognised methodology for working with young people and concerned people accessing the services. It provides a standard that should be adhered to have consistency across the delivery"* (Manager 9)

> *"So, it kind of gave us an even playing field with treatment centres and outpatient services and we all had a process that we all had to buy into so it didn't really matter where our funding came from, how long we were working there, how many degrees we had, there was no competition. It was all about the client".*

Transparency

> *"I think it has opened up – not sure how I'd best describe it – I think people worked in pockets… so the homeless sector worked with the homeless and the Drug Task Forces worked in the drugs projects worked with those within the community and those in treatment– so, it was isolated, you know, there was – everybody had their own section and their own way of working and there didn't seem to be a connect between all of the – all of the service users, so you could have somebody that was dealing with maybe housing crisis or you could have somebody that was homeless or you had somebody that needed GP services and as they went to each section to get help they had to start all over again. And this has been the greatest benefit to be able to say "This is the situation, this is the care plan, this is the key worker and this is where it's at, this is what's needed next"* (Manager 1)

> "*I think what the [case-management] protocols has done, has done over the time that I've been around and helping to implement it with my team is, we called out some of our problem areas, our gaps and blocks, we tried to deliver a better quality and consistency of service to service users … it's a qualitative, demonstrable care culture, it has a transparent language, it's wholly accountable to clients, to funders, and to practitioners*" (Manager 9)

Complex needs

There was an acknowledgement from the frontline workers who were working with service users who were harder to reach and or had complex needs that the framework was particularly beneficial.

> *"….the case-management piece and through the service user piece as well, it's more focused and I would have had –the documents, the paperwork, you know, it's just a lot more standardised which is great because, you know, when I started back ten years ago it, you know, you were just doing up your own – your own documents and it was different to the next project. You know, like that now sharing, we'll say, the initial assessments and stuff like that now is a lot easier between workers and stuff like that and I think it makes a lot of sense… this can be a difficult piece for the people I work with"*[±]

± Please note however, as with particular subgroups (i.e. members of the travelling community and prisoners only 1 person per group was interviewed, thus no reference is made to respondent identity in order to protect anonymity).

> *"The key benefits are [pause] I'm just thinking of one in particular, it [pause] I suppose for the person themselves that they know that they're being supported still around the – that there is support around the table for them this is key for my guys. That they're – eventually will be honest about what they're using and what they're not using, like, because especially with [reference to population removed], they're very kind of tricky, but this is great"*

Disadvantages:

Several disadvantages of having a shared framework across the Cork/Kerry region were cited by participants. These included: the hierarchy, the missing partners, loss of professional identity, the burden of administration

Hierarchy

Despite having a framework with clear protocols which should mean all referral agents are equal, the majority of participants who identified as a drugs worker perceived there to be a hierarchy.

> *"I think part of it is – I think there's a hierarchy, as in, community drugs workers are not seen as professional, so where – as soon as we do an initial and a comp, if someone, like, if a trained addiction counsellor in a treatment centre did an initial and comp it comes with more weight. Even though the questions and the answers are exactly the same"* (Frontline worker 3)

> *"It depends, like there is one treatment service that wont even talk to you if you are not a counsellor"* (Frontline worker 6)

Missing partners

Not having all the necessary partners to deliver a care-plan was cited as a clear disadvantage to participating in the framework, with Tier 4 services, social work, mental health and GP the most frequently cited.

> *"I think the fact that not all services are involved, you know, like there's a huge amount of clients in this area would have involvement with mental health services and they are not in it"* (Manager 8).

> *"There is, yeah. There'd be – like, people that I would like for to show up, like, that would be sometimes kind of for me personally, like, if I'm talking about myself, like, could be the council, could be the social worker. They wouldn't show up, you know, and I'd feel then, like and, like, "What's going on here? How come this ...?" – and then we'll have another – we'd have another meeting/care plan and then they wouldn't be at that again"* (Service user 3).

> *"So, yeah, I think that the blatantly obvious piece, key piece and then another massive bugbear for me is our GPs in our service are not trained up in case-management. So, our methadone doctors are not trained up, they don't do initial assessments or comp assessment, they don't refer on to other agencies and we can get left picking up those pieces. So, we're only – kind of half our service is trained up and the majority – a lot of the complex clients are the ones on methadone"* (Frontline worker 11).

Clinical jeopardy/compromise

Several participants, particularly those from theraputic disiplines, suggested that the framework interfered with the clinical role and allegiance with the clients:

> *"I'm a counsellor and if, say, I'm attached to the [name accrediting body removed] and one of the guidelines that we need to follow is that we're not allowed to have any dual relationships with clients. So, we're supposed to have a very specific relationship with our client that they come once a week or twice a week for one hour and that we don't have another relationship outside that. But, say, if I get caught into the case-management process and I'm the case manager, then if I'm seeing the client on that therapeutic relationship, then I think there's the possibility of having another relationship... that's a dual relationship"* (Frontline worker 8).

Loss of professional Identity

Moreover, a number of participants with therapeutic backgrounds spoke of the loss of professional identity:

> *"I think for me it – my biggest concern is that we're going to water down the certain professionals and that we all look the same... and we come with different experiences. So – and we need a variety, we need different people, with different trainings and backgrounds and approaches and it would be my concern with using key worker and case manager, that we all look the same ... like even on the forms you don't put your profession on it, but I'm going to look at any psychiatrics and mental health issues versus someone who's not aware of that, so obviously my training is going to impact on the questions versus someone who's coming from housing, they're all obviously going to focus a lot on that piece. You know, so I think it's so important that we actually put your profession at the end of these forms, at the moment it's just 'key worker'* (Frontline worker 11).

Furthermore, some distinctly suggested that they felt 'clinically compromised':

> *"We do have a problem with the comprehensive assessment because we find it's interfering in therapy at times. It's not a therapeutic process, filling up another form, and we find it actually is quite – you're duplicating a lot of the information you already have in the initial assessment form... We've more done it out of obligation than something that we see as beneficial"*(Frontline worker 11).

Administration

The admistration of the necessary paperwork was seen as quite a burden by the majority of participants:

> *"... but it was just, like, the duplication of paperwork that a lot of services are doing and, like, if you – if you're a project worker and you have to fill out Focus Ireland forms, case-management forms and PASS forms, you're not going to do it. It's ridiculous..."* (Manager 2)

> *"I think there's duplication with the initial and the comprehensive. I think it's a little bit, you know, it's a little bit unwieldy and cumbersome I think. It just needs – I think it needs streamlining"* (Frontline worker 6).

Support

For the most part all of the participants suggested that they felt supported through the implementation of the framework.

Support given

Several participants noted having the support of both their organization as well as the Regional and Local Drug Taskforces.

> *I'd have supervision with him kind of every three or four weeks and then my offline supervision is kind of on request really, she does it as a volunteer but she's been my supervisor since I started and that's kind of more personal professional kind of boundary stuff, case-management if there's a client that I'm stuck with.... And then the Drugs Taskforce then do group case-management supervision every six weeks where we – we work in groups, so there's a group of four of us and we meet every six weeks then to talk about just the struggles of being a community drugs worker if we're stressed.*

Required support

The level of required support was seen by the majority of participants as multifaceted. Starting with their peers and direct line manager and including the Regional and Local Drug Taskforces.

> *"I don't know how frontline workers work in a lone project without supervision".*

Moreover, support would have to evolve and change. The situation of the dual role (supervisor and counsellor) was not seen as beneficial and the need for independent supervision was emphasised.

> *"... I just think there's a bit of – a kind of conflict of roles sometimes where, like, you're working with him as a colleague and then he's supervising and then he – it's supposed to be confidential and not fed back to the Drugs Taskforce... if it was just some independent supervisor who just came in and supervised us and had no kind of connection with anyone in the room I suppose I'd just trust the process a bit more."*

Fidelity checks of framework and relevant paper work appeared to be discussed in a haphazard way. When asked about how this is managed at team level no participant spoke of formal space where this occurred.

> *"The initial assessment we all use and we bring that for initial assessment case conference, so that that's very straightforward and staff is very happy with that form and we all see it as very beneficial and very containing and appointments, so that's not a problem..."* (Manager 11).

> *"So, we've had a lot of discussions at team meetings around that. Yeah, that's probably the place that we've had those discussions.. I think?* (Frontline worker 10).

Supervision

The case-management community supervision emerged as a key theme with both benefits and drawbacks cited by participants.

Supervision benefits

> *"Without [Case-management Supervisor], like, I don't know how I'd be practicing but, like, he's just brought such clarity to the whole process of case-management but also to the role, as me – for me as a drugs worker, like, it's been – I cannot emphasise how valuable it's been, his input and his monthly input as a group and monthly in a one-to-one"* (Frontline worker 9).

> "*When you work in the community and especially if you work in a project on your own, like, you don't know if you're doing right from wrong a lot of the time, because you're coming in, you're doing what you think is right but there's nobody to reaffirm, you've nobody to kind of bounce off, you know. So, really like the supervision part, the support piece is massive around that. Even just being able to sit down with other workers and listen to the cases they're dealing with and listen to, you know, who's coming in to them, you know, because it's the same stuff"...* (Frontline worker 1)

> *"I don't think you could do it without it because it gives you a space once a month to go with cases that you might be case managing and, you know, there's – you might have a care plan and you're wondering in your own head, is that right, is that wrong? So, it's somewhere that you can put that, tease it out a bit, [Case-management Supervisor], might come up with another idea that you mightn't be after thinking of. Or it can be a case for you to go and maybe get some reassurance: "No, that's – that's okay, that's as much that can be done with that", do you know? And so I find that very, very supportive".* (Frontline worker 9).

Supervision drawbacks

While the Case-management Supervision was seen as a great support some participants questioned it.

> *"He's [Case-management Supervisor] amazing at what he does, but he's an addiction counsellor in [name service removed] who is funded by the Taskforce and we're funded by the Taskforce, so he's a colleague and a supervisor at the same time and I just don't – I just don't trust it I suppose. I wouldn't be able to go I and say "I'm having a complete meltdown and I feel like I'm having a nervous breakdown and there's no-one listening to me"* (Frontline worker 16).

> *"Being honest, I suppose I wouldn't have chosen to have it, I suppose, because I don't see this as a clinical role"* (Frontline worker 12).

Participant recommendations

Several recommendations were put forth by participants. These included conditional funding, the need for ongoing review and evaluation and the need to engage missing partners.

Conditional funding

The notion of conditional funding was seen by both managers and frontline workers as a viable way to engage the relevant agencies in implementing the framework going forward:

> "*Seriously, at this stage of the implementation I think what's required is strong senior management leadership in agencies across the tiers …… and a big, royal kick up the arse where there's obstacles. I'm – I'm a believer at this point that funding follows protocol"* (Manager 9).
>
> "*…it's in their service delivery agreement that they won't get their funding unless they participate in it"* (Frontline worker 9).
>
> *"The Drugs Taskforce as the direct funders to most of the CBOs or to any of the other organisations that are coming in, as funders, they can say This is what we want to do and this is the way forward"* (Manager 2).

Ongoing review and evaluation

The majority of participants mentioned the need for ongoing review and evaluation of the process as key recommendations.

Reviewing the process

> "*…if evaluation and reviews and forums were held more often where we could ask questions then we'd be a bit more certain about our part in it…"*(Manager 6).
>
> "*… while some of that did happen in early days when the training was done for the case conferencing, that was a long time ago and there probably needs to be some revision and review of how that whole process has gone"* (Manager 5).

Evaluation

> *"It needs to be evaluated and reviewed more often. Because I'm talking here now as if I know it all and I actually am uncertain if I'm doing it right at all"* (Frontline worker 9).
>
> *"I think the treatment providers, ourselves locally, need to put more emphasis on evaluation"* (Manager 10).
>
> *"I think if there was inbuilt reviews and evaluations that aren't going to be seen [pause] as threatening which is part of what's happening here. People would be able to look at it and say "Right, here's what we need to now, here's where we've come from, here's where we are, here's how we got to here, let's catch our breath and then move forward, but move forward together" and that's part of that open dialogue piece…. I think if it was put in one person …. and they were told drive this"* (Manager 13).

Engaging missing partners

> *We've done a huge front – front-loading investment, we've put some of our staff part-time onto mental health teams in a joint training procedure and that has facilitated mental health teams meeting addiction counsellors, getting to know their mettle, getting to trust their competence and their training and qualification and that has allowed them – psychiatrists and some of their colleagues – to see addiction treatment service in a different light.*
>
> *They're also able to see we're competent in working with mental illness as well as addiction which probably before they didn't recognise, they didn't get ... that window. So, we've done it very locally here in Cork to try to marry it. The protocol or inviting mental health to come and look at the protocol, get involved in the protocol, see what's in it for them, I think that – that would be a test case way forward. We're not at – maybe in five or six years' time we're in the position to sort of strategically kick ass manage it. But I understand they're under great pressures too, but it's one – it's the one frontline health service, apart from GPs, where you constantly see addiction interfacing with mental health, clogging up hospital beds, creating great difficulty and challenges to mental health teams. I think the protocol could allow a synergy across the service a lot – a lot more* (Manager)

Summary of findings

- Although several of the participants suggested that they were implementing the framework, more than half of the frontline workers said that they did not utilize the framework fully.
- All of the frontline workers interviewed had received the training.
- The benefits of having a shared framework across the Cork/Kerry region included: client centered, reduced duplication, role clarity and professionalism, buy-in from partner agencies, standardisation of both role and paperwork and transparency.
- The disadvantages of having a shared framework across the Cork/Kerry region included: the hierarchy, the missing partners, loss of professional identity, the burden of administration.
- In the main, participants suggested that they felt supported through the implementation of the framework.
- The case-management community supervision emerged as a key theme with both benefits and drawbacks cited by participants.
- Several recommendations were put forth by participants. These included conditional funding, the need for ongoing review and evaluation and the need to engage missing partners.

AUDIT OF SERVICE USER FILE

The purpose of the audit was to examine evidence of care planning, case-management and overall fidelity to protocols laid down in the framework. A total of 5 service user files from 5 different agencies were included in the audit. The audit of files took place with both service user and service provider present. With the exception of one file, there was evidence of framework paperwork being utilised. When asked about the framework protocols and paper work all frontline workers said that they found, while the consistency of a shared form was beneficial, it could be cumbersome at times. Two of the five frontline workers said they did not use the care plan form and found it was unnecessary.

INDIVIDUAL SUBMISSIONS

The purpose of the individual submissions was to allow participants, (particularly, but not limited to, those who had not been interviewed) an opportunity to voice an important issue that would not have otherwise been captured.

A total of seven individual submissions were made. As submissions were anonymous no specific information is available on participants. Six of the seven submissions were made via Survey Monkey. However, in one case the researcher was directly contacted by a participant who had missed the deadline by a few hours and asked to include their submission. All submissions are included in absolute form below i.e. there is no editing of words. The submissions varied greatly. The following topics emerged: duplication, unco-operative case-management, need for more appropriate level of family involvement, lack of clinical supervision, missing partners and framework as inappropriate fit.

Submission 1:

There are often a number of support plans put up on PASS for a client by different agencies. I think that this is because different services require that they have their own support plan with a client.

Submission 2:

First of all let me start by saying my understanding and use of the Case-management Framework works very well for my Community based project and the people that use the service. Unfortunately one gap that keeps appearing is the lack of referrals from tier 4 & 5 to tier 2 .When I do get an enquiry about a service user coming from tier 4 or 5 I have experienced lack of unappropriate paperwork from tier 4 & 5 under the Case-management Framework. When I first initially take the call/e mail from the tier's and mention this project works under the Case-management Framework , am Informed yes so do we BUT when I ask for the appropriate paperwork and or to be included in the care plan/after care plan of the Service user all communication stop's or I may get a mail with the Service user's Contact information BUT no other paperwork or communication. the project has experienced this from under 18 and over 18 tier 4 and 5 . Unfortunately I no longer send referral forms until I communicate with the upper tier's. Since The Case-management Framework has been mandatory in this project I have had some inquiries but no referrals from tier's 4 or 5 . I cant help thinking were are these service users have they fallen in the gaps or are tier 4 & 5 given them enough support out of the community were they live and work/ go to school.

Submission 3:

"I attended the Case-management Review Day for Cork & Kerry, in Cork on 24 Jan 2017. I am a project worker on a prevention & education project. I don't work directly with drug users (DU), rather with family members (CPs) on a 1- to-1 / group basis. I brought two family members to the Review Day on 24th January to support service user input / feedback. I would like to reiterate a 'gap / block' issue in both the Initial Assessment (IA) and Comprehensive Assessment (CA) process that was raised on the Review Day by myself and the two CPs. The National Drugs Strategy 2009 - 2016 names families as 'service users in their own right' (p. 51). The active involvement of CPs in the rehabilitation process is recommended (ibid point 4.59) The necessity for family involvement in prevention and treatment pillars is also laid out, point 4.16, particularly with under 18s, point 4.40 - 4.42. Children of drug users are identified as particularly at risk and named as a target for prevention measures in point 3.61. We feel that the opportunity to reach out to / refer CPs to supports when their loved one engages in an IA or CA is missed. Both IA and CA forms name child care welfare / protection concerns, but do not name family support (FS) as either a question for the DU (is your partner / parent availing of family support?) or as an opportunity for the worker to provide a referral if their family are not linked with specific services. There is an opportunity to link CPs (through the DU or directly if consent to contact is given) with specific family support interventions, such as FS group or one to one FS, or tailored support specifically for children of DUs or siblings of DUs. These are lost opportunities for both prevention, intervention and rehabilitation to particularly at risk adults and children. The CA Relationships section (p 15), has a similar focus on risk, but lacks specific reference to FS outside of social work involvement. The format doesn't encourage the worker to proactively check if FS is being availed of by CPs connected to the DU. While there is a small font question on possible consent, the CA form doesn't specifically ask for consent / permission of the DU to contact CPs regarding facilitating access to family support. These are all missed opportunities to outreach to vulnerable groups, provide referral to appropriate and empowering FS opportunities, facilitate prevention in children and young people and also to support and enhance the rehabilitation process for the DU".

Submission 4:

"I would like to highlight that not all teams are getting clinical supervision. I think this is imperative for the development and implementation of the case-management approach".

Submission 5:

"There is still some difficulty getting the residential treatment centre to give the initial assessment forms if they are referring a client. They may only give a brief outline that the person completed either successfully or otherwise their treatment. however there are some improvements just not far enough as yet. Sometimes if I have referred a client they don't send them back to me I have to chase where they are at. However I do acknowledge this is happening less in the last two months. Some GP do not engage in the process while I acknowledge there is some progress in this service".

Submission 6:

"We are in serious/urgent need of dual diagnosis clinics or at the very least effective communication between the mental health services and the drug and alcohol sector. The majority of my clients present with an underlying mental health issue that they are managing themselves with a substance, such as cannabis, as the lack of mental health services cannot help them. When they finally get seen by a mental health service, sometimes after being on an 18 month wait list, and they mention substance use of any kind they are immediatley told they are an addict and dumped back into our services until they get "clean" of the very substance that is keeping their mental health issue managable. As a drugs worker I am then put into a very vulnerable position along with my client as I am requiring them to reduce and stop their substance as I watch their mental health issue take flight. It is beyond ridiculous at this stage!!"

Submission 7:

"I believe the framework document produced by NDRIC is excellent in setting out how services should be configured in order to support service users to manage addiction problems. The principles of case-management, care planning, key working, consent, shared care are all sound and need to be adhered to. Progress in implementing the framework is painstakingly slow in the south region but I believe there is a sincere commitment to doing so. As manager of a tier 4 unit there are a number of factors that impede implementation of framework.

1. *We feel that that framework applies only to those clients with complex needs. There are a number of clients attending our service whose needs are not complex in the terms used in the comprehensive assessment document.*

2. *Our assessment tools are different to those of the framework. We feel that to adopt this assessment tool will lead to a loss of valuable data needed to design a care plan for a client undergoing a residential treatment episode.*

3. *We often wonder if National Protocols and Common Assessment Guidelines are being applied rigorously particularly with regard to referral to tier 4 agencies.*

4. *We wonder whether the 4 tier model of treatment still has currency and whether the proper resourcing of this treatment intervention is sufficiently prioritised in national policy".*

DISCUSSION

Reference to the National Drug Rehabilitation Framework (NDRF) [11] was made throughout the data collection phases, particularly by those in the addiction services. However, the knowledge of NDRF varied greatly. Moreover, as the Case-management Framework in the Cork/Kerry region included three sectors, when developing this work both the LDTF and RDTF referred to the framework simply as the Case-management Framework. Thus, for consistency the researcher deferred to the latter.

The majority of participants interviewed suggested that they were implementing the framework at either a medium or high level. Moreover, participants articulated with ease the use of framework documents such as initial assessment, comprehensive assessment and care planning in much the same way as set out in the framework document. However, the execution of case-management elicited more of a mixed response; participants noted several missing partners, in particular mental health services, social work and General Practice. In addition, some participants suggested that assuming the case-management role compromised their clinical relationships with service users.

There was a genuine enthusiasm for the framework and a belief amongst participants across all groups that the framework would continue to be implemented successfully. The benefits were clear and consistent. However, going forward the continued existence of the framework would have to be supported and given adequate resources, (continued supervision and the expansion of supervision to meet the needs of the growing workforce). In addition, participants suggested that training, regular peer meetings and fora would be crucial.

The Case-management Framework was seen as a complex undertaking that required a reasonable amount of organisation and generated a vast amount of administration. Nevertheless, the majority of 'case managers' interviewed suggested that when case-management was properly executed it was a very worthwhile exercise from the perspective of the service user. Transparency was high on the agenda of participants across all groups, who cited this as a benefit of the framework.

The Case-management Framework offered participants a comprehensive set of standards that were clear and concrete; moreover, the framework allowed and even anticipated local issues and the *Gaps and Blocks protocol* offered a transparent mechanism for resolution, which participants appeared to value.

The application of the framework to traditionally hard to reach sub-populations and service users with complex needs within the Cork/Kerry region was extremely important. As such, services specifically targeted at people who are experiencing homelessness, persons with a dual diagnosis, Travellers and prisoners were included in the development and implementation of the Case-management Framework. Findings from the qualitative interviews support the importance of having a framework and attest to the effectiveness of this framework when working with these groups. Likewise, the quantitative survey suggested that relatively high proportions of individuals with complex needs were being worked with within the Case-management Framework.

Participants made several key recommendations. Most notable were those around conditional funding and showcasing the work that has been done to date in an attempt to engage missing partners.

The issue of fidelity to the framework was not explicitly evident and review of the framework and related documentation appeared to occur in a haphazard manner across the region. However, there appears to be a genuine readiness to build a culture of review and evaluation as participants believed this reflective practice would allow them gauge what is helping and what may be hindering their practices.

The inclusion of a protocol outlining the various points of inclusion for family members and the limitations of confidentiality and information sharing should be seriously considered. Including the family and agencies representing them appears to be a logical step for case-management when attempting to implement holistic evidence based best practice with the addiction rehabilitation services.

IMPORTANCE OF THIS RESEARCH

The current study provides much needed outcome data on case-management across the addiction and homeless and prison services in the Cork/Kerry region. Data are presented from services users, frontline workers and managers regarding their experience of the Case-management Framework. Moreover, the study took a holistic approach to data collection, which consulted participants throughout the process that was grounded in both established evidenced-based research and deeply-rooted experiential understanding of the nature of case-management. Both the study topic and the methodology are in line with the National Drug Strategy, which clearly stipulates *People should be helped to meet their goals using a case-management process, and service users should have a distinct say in their own rehabilitation*[24].

LIMITATIONS OF THE RESEARCH

The study is not without its limitations. All data are self-reported and therefore open to bias. Most of the data are from service providers rather than service users. The comparative dearth of service user input is a weakness of the current evaluation as true change should be driven as much as possible by service users[23]. Moreover, the lack of access to service user files limits any inferences we can draw on the actual implementation of the framework.

CONCLUSIONS

There was a genuine enthusiasm for the framework and a belief amongst respondents across all groups that the framework would continue to be successfully implemented. The benefits were clear and consistent. Furthermore, there was a belief amongst respondents that the climate in the Cork/Kerry region offers an eager perspective and supportive environment, which if properly nurtured will continue to aid the development of the Case-management Framework to include all of the necessary partners. Nevertheless, addressing missing partners and ensuring the continued development of the Case-management Framework is a complex task, one which requires addressing multiple factors at an individual, service and broader health, housing and social systems level.

RECOMMENDATIONS

Case-management is a system that has evolved over many years and across several disciplines, thus several models exist. The current model of case-management in Cork/Kerry region is a blend of several models of case-management and lacks a clear working definition. The current framework would benefit greatly from aligning and referring to specific models with clear definitions.

There was a sense of acceptance and permanence of the Case-management Framework as a way of working in the Cork/Kerry Region. However, there was an acknowledgment that more work needs to be done which would require (i) retaining the current partners and (ii) engaging missing partners: both of which require drive and persistence. It is important that the funders from respective sectors take a central role in monitoring the continued implementation of the framework, particularly where a service level agreement exists, offering clear mechanism for review. There need to be dedicated resources that drive the framework. This requires dedicated personnel who will guide and check in on the process at regular intervals, reflecting on how this is going and bringing all the current partners together to discuss. Partners need to have the space to engage with their peers and reflect on how the process is going from a grass roots perspective. The outputs of this process could, in turn, be utilised to showcase work to other potential partners.

With the work of the National Drug Rehabilitation Implementation Committee (NDRIC) and the subsequent pilot of the NDRF, the addiction services have national support for the development and progression of a case-management system. As with the New Drug Strategy[24] a reverberation from the National Office of Social Inclusion of the significance and value of the continued development of the Case-management Framework would maintain the momentum that has been gained and drive the implementation further. Likewise, there is a need to have a national driving force for both the homeless and prison sectors in order to embed this system into practice.

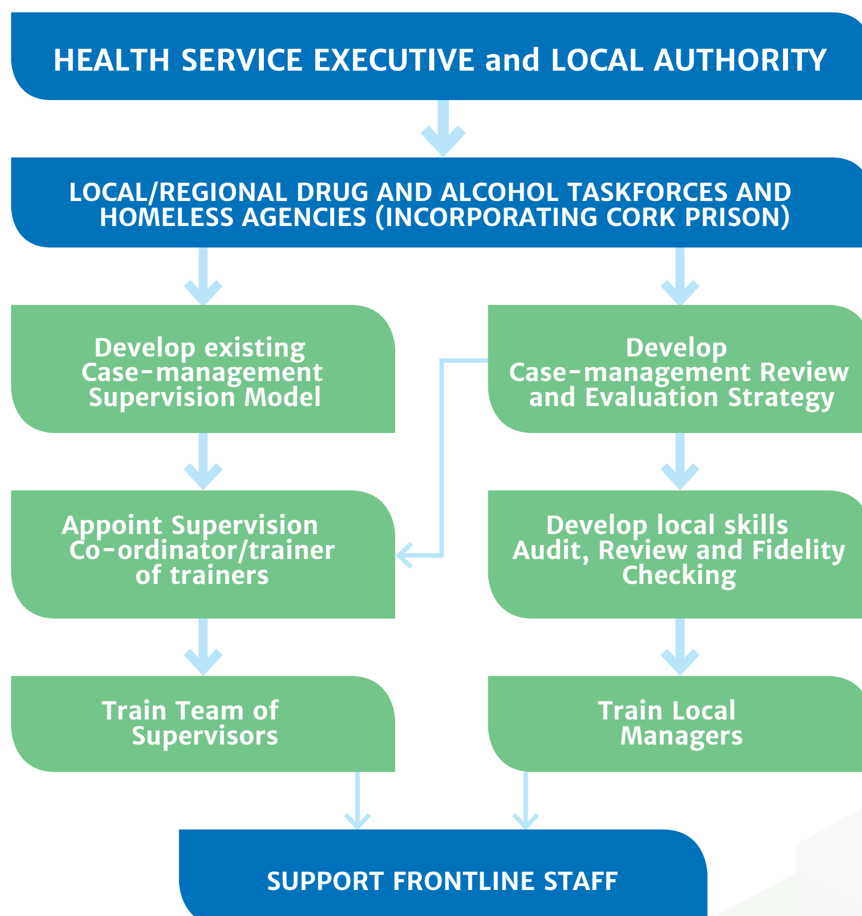
The roles of all key players in the implementation of the Case-management Framework need to be made explicit. Moreover, a focused review of the responsibility of therapeutic disciplines in fulfilling the case-management role needs to be addressed with provisions made to protect the therapeutic alliance with clients.

Inter-agency working is perceived as a pre-requisite for successful implementation of the Case-management Framework. Nonetheless, this also poses a great challenge. A shift in organisational culture within certain categories of services is necessary to adjust to protocols and practices in order to fully engage with case-management. For example, participants spoke of the ad-hoc engagement of tier 4 services with the interagency protocol. The Case-management Framework has policies and recommendations for good practice in relation to inter-agency working. Perhaps the protocol requires an explicit addendum, which sets out more explicit guidelines for engagement upon entry and exit to tier 4 services.

The pre-implementation training proved to be quite successful. However, given the progress of the framework, coupled with the turnover of staff across the region a strategic training plan that includes top-up sessions, as well as review, is warranted.

The enthusiasm for review and evaluation is a key finding of the current report and requires a considered response that would take a grass roots approach and include a number of layers. Such a response would include peer, managerial, Task forces and independent agents to develop a climate and culture to further develop and sustain the Case-management Framework in the Cork/Kerry region. Crucial to this culture and climate is the support and supervision of the frontline staff (see figure 13 below). At present, there are two parallel models of supervision, one aligned with particular disciplines that reflects on the Case-management Framework, while the other focuses on all 'nonclinical' frontline workers, which while noted by the majority of participants as an extremely beneficial model, is nevertheless not without limitations. The existence of two parallel systems perpetuates the divide between frontline workers. There is a need to develop the model to incorporate all necessary disciplines and develop a structure that will ensure frontline workers are fully supported. The development of this model should ensure sustainability and reach across the entire region within the three sectors. Thus, it will be dependent on a team of supervisors rather than any one individual. This model should also include mechanisms to assists in ensuring fidelity to the framework as well as continued review and evaluation.

FIGURE 13: CONTINUED DEVELOPMENT OF IMPLEMENTATION



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APPENDICES

APPENDIX 1

SERVICES WORKING WITHIN THE CASE-MANAGEMENT FRAMEWORK IN CORK/KERRY

Homeless Agencies (8 Homeless Agencies incorporating 30 services)

Focus Ireland

1.Advisory Service

2.Prison In – reach

3.Youth Housing Officer

4.Resettlement Service

Sophia

5.City Park House, Transitional Accommodation

6.Douglas Street, Transitional Accommodation

7.Leitrim Street, Transitional Accommodation, ex offenders

8. Tenancy Sustainment

St Vincent de Paul

9.St Vincents Hostel, Emergency Accommodation, Males only

10. Tenancy Sustainment Officer

11. Deerpark House, Transitional Accommodation, Males only

Threshold

12.Tenancy Protection Service

13. Access Housing Unit

14.Advisory Service

Cork Simon

15.Emergency Shelter, Males & Females

16.Mill House, chronic alcohol issues, Males & Females

17.Riverview, Transitional Accommodation, Males & Females

18.Clanmornin House, Boreenmanna Road –Residential, Males & Females

19.Victoria Road – Residential, Males & Females

20.Tir Na Nóg – Residential, Males & Females

21.Nicholas Street, Move on apartments

22.Charlemont Terrace, Move on apartments

23.Glendalough, Move on apartments

24.Gateway, Tranistional accommodation, Addiction, Males & Females

25.Housing Support

Cork Foyer

26.Transitional Accommodation aged 18-25.

Cork City Council

27. Outreach Worker

GOOD SHEPARD SERVICES

28. Edel House, Emergency Accommodation, Females and Children
29.Aftercare
30. Outreach Worker for Emergency B

DRUG & ALCOHOL SERVICES

1. HSE Arbour House Cork
2. HSE Heron House Cork
3. HSE Brandon House Kerry
4. HSE Edward Court Kerry
5. HSE Community Addiction Counsellor Team
6. HSE Needle Exchange Worker Cork City
7. HSE Link Worker Cork
8. HSE Link Worker Kerry
9. Cork Prison Post Release Service
10. Ballincollig Community Drug & Alcohol Project
11. Hillgrove Blackpool Community Drug & Alcohol Project
12. Hillgrove Farranree Community Drug & Alcohol Project
13. Glen Community Drug & Alcohol Project
14. Traveller Visibility Group
15. The 'Hut' Gurranbraher Community Drug & Alcohol Project
16. Glanmire Community Drug & Alcohol Project
17. Ballyphehane Community Drug & Alcohol Project
18. Douglas Community Drug & Alcohol Project
19. Yew Tree/ Mahon
20. Dublin Hill/Ballyvolane Community Drug & Alcohol Project
21. Greenmount Community Drug & Alcohol Project
22. Carrigaline Community Drug & Alcohol Project
23. Mayfield / 2000 project Community Drug & Alcohol Project
24. Togher Link up
25. Lota/Mayfield
26. Knocknaheeny Community Drug & Alcohol Project
27. Tralee Community Drugs Initiative
28. Listowel Community Drugs Initiative
29. Killarney Community Drugs Initiative
30. Bandon Community Drugs Initiative
31. Cobh Community Drugs Initiative
32. Mallow Community Drugs Initiative
33. Youghal Community Drugs Initiative
34. Fermoy Community Drugs Initiative
35. Macroom Community Drugs Initiative
36. Matt Talbot
37. Talbot Grove Residential
38. Tabor Lodge Residential
39. Renewal House
40. Fellowship House

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