National Protocols & Common Assessment Guidelines

to Accompany the National Drugs Rehabilitation Framework

National Drugs Rehabilitation Implementation Committee
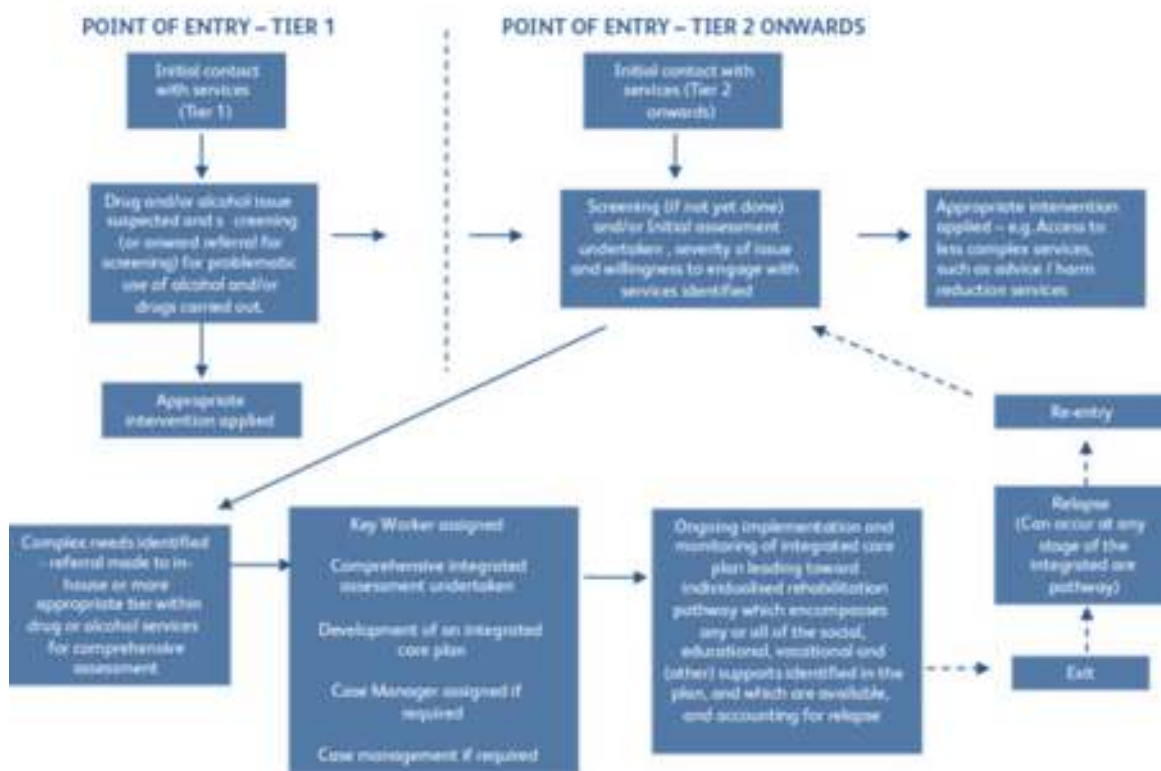
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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Introduction

This document aims to align the National Drugs Rehabilitation Framework Document's model of integrated care pathways (see diagram below) with common assessment guidelines and national protocols to enable the implementation of this model.

National Drugs Rehabilitation Framework (HSE, 2010).

COMMON ASSESSMENT GUIDELINES

The guidelines detail criteria which should be included in any assessment a service provider undertakes with a service user, across the four tier model of service interventions.

1. Screening

a. NDRIC Framework

Screening is Step 1 in the Integrated Care Pathway. The Framework states that when contact is made with a service provider offering tier 1 only intervention and drug or alcohol misuse is apparent, they should undertake an in-house short and user friendly screening, utilising a brief intervention tool, and including speedy onward referral, where appropriate. This initial screening should be carried out by the agency with which first contact was made wherever possible. The development of an agreed screening tool is in line with action 36 of the National Drug Strategy 2009 – 2016.

"Continue to develop and implement across health services the screening/assessment of people presenting with early indicators of drug and alcohol issues, utilising a uniform brief intervention tool, and including referral where appropriate."

b. Guidelines

The HSE and the Office of the Nursing Services Directorate have developed the document, *A Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use for Nurses and Midwives in Acute, Primary and Community Care Settings.* This will support nurses in all acute clinical care settings such as mental health, primary care and the accident and emergency services to deliver screening and brief interventions to patients. This framework can be utilised by all allied health and social care professionals.

The framework applies to:
- nurses and midwives employed in both the adult and children's setting in the HSE who wish to undertake screening and brief intervention skills;
- allied health and social care professionals who offer screening and brief intervention to service users presenting with problem alcohol use to all healthcare settings; and
- staff in integrated services areas and primary care teams.

2. Initial Assessment

a. *NDRIC Framework*

Step 2 in the Integrated Care Pathway is an initial assessment. The Framework states that this should be carried out by trained and competent people with a clear understanding of the impact of problematic drug use. The aim of this initial assessment is to determine the seriousness and urgency of the drug/alcohol problem. It will involve an assessment of both the nature and extent of the problem use as well as the service user's motivation to engage with treatment and rehabilitation services and any immediate risk factors. It will also determine the linkages required to other health and, depending on the complexity of the case, whether a comprehensive assessment is necessary.

This step aims to match the person to the service that best meet their needs.

b. *Guidelines*

It is the view of the NDRIC that the initial assessment (step 2) of choice should incorporate the National Drug Treatment Reporting System (NDTRS) Form requirements. The completion of the NDTRS form is a mandatory requirement for drug treatment service providers and the NDRIC have worked with the Health Research Board to modify the NDTRS accordingly, to meet the requirements of an initial assessment. The form is presented in appendix 1.

3. Comprehensive Assessment

a. *NDRIC Framework*

The comprehensive assessment is Step 3 of the Integrated Care Pathway. The Framework states that the comprehensive assessment is appropriate for service users with more complex needs. It should identify the services that will be involved in the shared care plan so as to meet these needs. The assessment should be part of an on-going process and review so as to accommodate these needs as they change over the course of the shared care plan.

Comprehensive assessments need to be carried out by trained and competent people with a clear understanding of the impact of problematic drug use (tier 2 upwards). Standardised assessment forms should ease collaboration between services and ensure services work to similar standards for assessment, particularly where components from the initial assessment form are easily integrated into the comprehensive assessment. There should be

a readiness to refer to more specialist services to assess an area of need which has been identified but is beyond the competence of a particular professional – multidisciplinary working is at the centre of the integrated care pathways model.

b. *Guidelines*

The comprehensive assessments undertaken from Tier 2 upwards should, at minimum, include all the domains outlined in appendix 2. Service providers may wish to add additional domains to the criteria for their service's comprehensive assessment but should not take away from the items detailed here.

Service providers should aim to use acceptable evidence-based comprehensive assessments that include all the items detailed in appendix 2.

4. Referral and Assessment for Residential Treatment (Tier 4)

Addressing the issue of drug/alcohol dependence is a complex matter. There can be a number of phases of need, or stages in the Continuum of Care, that must be addressed. Stabilisation, detoxification, counselling support/psychosocial interventions and rehabilitation needs should be assessed throughout the whole continuum.

Clients' needs vary and not all clients will need to avail of all aspects of a 4 tier system. Some clients can have all their needs met through accessing services at tiers 1, 2 and 3. However it is important to assess when a client needs to access a tier 4 service.

Appendix 3 seeks to name the criteria that can guide referrals to residential tier 4 facilities.

Appendix 3 also provides guidance on additional assessment requirements at tier 4.

Criteria for placing adolescents in tier 4 services should also be considered. This is outside the scope of this document.

NATIONAL PROTOCOLS

The National Drug Rehabilitation Implementation Committee (NDRIC), established to progress the recommendations of the Rehabilitation Report, has developed a National Drugs Rehabilitation Framework Document which sets out an integrated model of rehabilitation provision based on shared care planning. Under the framework NDRIC is to develop broad national protocols to form the basis for the development of local protocols to be agreed by relevant organisations at local level.

In this context a protocol is an agreement among service providers setting out the basis on which they will work together towards the provision of integrated rehabilitation services. This document presents the first of the national interagency protocols to support collaborative working between services to help, in the first instance, the work of the pilot projects with the implementation of the National Rehabilitation Framework.

These national protocols are a work in progress which may be amended by NDRIC to reflect the learning which emerges from the pilots. A further protocol covering Confidentiality and Sharing of Information will be completed and added at a later date.

It is the responsibility of NDRIC to oversee the implementation of these national protocols across all agencies and the development and implementation of agreed local protocols is therefore seen as an essential element in the local implementation of the rehabilitation framework.

Overarching principles:

1. The service user is always involved and at the centre of the care planning process.

2. There should, in all cases be only one case manager or one lead agency for the service user, at any point in time which should be agreed in consultation with the service user and all agencies involved in their care.

3. Care planning involves thinking beyond the immediate service being provided to address the comprehensive needs of the service user. A comprehensive assessment underpins the development of a service user's care plan.

4. For interagency care planning to work effectively there must be a willingness among service providers to appropriately share information relevant to their work.

5. Service providers must ensure that the service user understands all the processes, as they occur, including matters relating to confidentiality.

6. Service providers operate within a wider framework of quality standards across disciplines. NDRIC recommends that QuADs or equivalent standards such as HAQU are implemented in all organisations engaged with drug rehabilitation.

7. If the service user refuses to participate in any inter-agency care planning or withdraws previous consent provided, the service user's needs should continue to be met insofar as is possible and the issue revisited at an appropriate time in the future.

8. Where a staff member leaves their case manager or key working role, the organisation will continue to ensure this service is provided.

9. Where significant delays occur in accessing services, every effort should be made by services to keep the service user engaged in the interim period.

10. If the service user relapses or disengages from a service, the case manager should liaise with relevant services/supports to reengage the client with the most appropriate service.

11. Services take responsibility for ensuring that staff implement the agreed protocols and adhere to them.

12. The process of assessment (both initial and comprehensive), needs analysis and care planning form part of a developmental process as the client engages with services over time. Goal setting, multi-agency meetings and the ongoing review of care plans will also take place over extended periods of time.

Protocol 1

Initial assessment & matching the service user to the most appropriate service

Outcomes

A. Identification of main presenting issues and any services, key workers or case manager already engaging with the service user.
B. Indication, upon initial assessment completion, of whether comprehensive assessment/case management is necessary at this point in time.

C. The service user is referred to the most appropriate service or continues to work with the service they initially presented to - in either case a key worker will be assigned to the service user.

Key Processes

1. An initial assessment should be undertaken when a service user presents or is referred to a service expressing a desire for help with their problem drug use.
2. The initial assessment should be carried out by a trained and competent person. Training levels and competencies to be determined by NDRIC.

3. Before starting, the person undertaking the assessment should ensure the service user has an understanding of the assessment process and matters relating to confidentiality.

4. The initial assessment should be completed in line with the common assessment guidelines, and it should determine the most appropriate service or support to meet the service user's presenting needs.

5. The person undertaking the assessment should explain and seek written consent to share information that the service user has provided in the initial assessment for purposes of referral or making contact with other services.

6. The person undertaking the assessment should explore what services, if any, the client is already linked to, along with whether the client is ready for referral to other services at this stage following which a care plan should be developed.

7. Any referral or interagency meeting at this stage should be carried out in line with the Referral Protocol or the Interagency Care Plan Meeting Protocol.

Protocol 2

Comprehensive assessment & developing an Interagency Care Plan

Outcomes

A. Completion of a comprehensive assessment addressing the wider needs of the service user.

B. Development of an interagency care plan with all areas of identified need addressed and actions/interventions agreed between the service user and all service providers.

C. The Case Manager in the lead agency is identified along with the key worker/point of contact in each service responsible for progressing each action and an agreed time-line.

D. The interagency care plan is regularly reviewed and updated reflecting the current needs of the service user.

Key Processes

1. As the service user continues to engage with services following initial assessment, a comprehensive assessment should be undertaken as part of the process to developing an interagency care plan. An interagency care plan involves the service user and all existing and future services involved in their care, contributing to its development.

2. The interagency care plan will outline the interventions agreed, referrals required and timeframe outlined to review the intervention/issue/action identified.

3. If a comprehensive assessment has already been completed by another service, there may be some value in obtaining a copy which may be updated with the service user.

4. The key worker should obtain the service user's written agreement to share relevant information that the service user has provided in the comprehensive assessment for purposes of referral or making contact with other services for additional supports.

5. The comprehensive assessment should be carried out by a trained and competent person. Training levels and competencies to be determined by NDRIC.

6. The comprehensive assessment should be completed in line with the common assessment guidelines and a care plan developed with realistic goals and addressing the physical, psychological, social and legal needs identified.

7. An essential part of developing the interagency care plan is the involvement of services already working with the service user and with any new services identified to agree actions and timescales.

8. Any referral or interagency meeting at this stage should be carried out in line with the Referral Protocol or the Interagency Care Plan Meeting Protocol.

9. Criteria for determining the most appropriate lead agency, should include :

    a. Intensity and regularity of contact with service user

    b. Capacity of service provider

    c. Client preference

10. The case manager is generally appointed from within the lead agency, but both positions may change over time, by agreement at the interagency care plan meetings, as progress of the interagency care plan goals is achieved.

11. The case manager assigned to the service user will manage and co-ordinate the implementation of the interagency care plan agreed among the services identified in the interagency care plan.

12. The case manager is responsible for monitoring and following up on referrals and general goals and responding to issues or blocks as these arise.

13. The case manager is responsible for ensuring the interagency care plan is reviewed with the service user at agreed intervals and updated as required.

Protocol 3

Referral between agencies

Outcomes

A. Service user accesses appropriate services in line with agreed interagency care plan.

B. Agreement and clarity among service providers and service user regarding referral to another service, including steps and timeframe involved.

C. The service user is supported throughout the process as required and appropriate follow up takes place.

Key Processes

1. A referral to a different agency should be made when a service user's need is identified following an initial and/or comprehensive assessment which requires some form of service outside of the assessing agency.

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

3. The service user should be supported in the referral by the referring service having regard to the service user's own wishes, their needs and the nature of the service involved.

4. Written agreement to share information must be obtained from the service user, if not obtained already, for this purpose.

5. The case manager should send the new agency any referral documents together with a cover letter outlining their role, highlighting the importance of the agreed interagency care plan.

6. Following referral, the person making the referral should follow up with the service user and the service to ensure that the client has engaged with the new service.

Protocol 4

Interagency Care Plan Meetings

Outcome

A. The interagency care plan is updated reflecting the service user's current needs and detailing the supports being provided.

B. Enhanced service user involvement.

C. Enhanced inter-agency working.

Key Processes

1. An interagency care plan meeting is any meeting which takes place between two or more agencies involving the service user in relation to the development or progression of the interagency care plan of a service user.

2. The general purpose of a case meeting is to support service user involvement, review progress and ensure clarity in relation to the interagency care plan and to foster a co-ordinated approach among agencies, ensuring sufficient supports and reducing duplication.

3. While not all interactions between services may require an interagency care plan meeting or the involvement of the service user, there are some circumstances in which it is essential although it is recommended that services try and address contentious issues (such as where services have divergent views on progressing care plan or determining the lead agency) without involving the service user at first:

    a. a lead agency/case manager cannot be agreed

    b. there is a transfer of case management roles between services

    c. there is a divergence of views on progressing the interagency care plan or appropriate interventions cannot be accessed

    d. the service user has requested it for a specific purpose

4. The case manager should prepare the service user for the meeting and outline the purpose and aims of the meeting to all the services involved.

5. Persistent lack of engagement by any service with the interagency care plan process including at meetings should be managed through the Gaps and Blocks process.

6. The case manager takes responsibility for both chairing and recording care plan actions.

7. As soon as possible after the meeting the case manager should circulate the outcome of the meeting and any actions arising and enter decisions and actions on the care plan.

8. Any change of lead agency/case manager should be managed by a three-way handover meeting to support the service user and to discuss actions on the interagency care plan with written follow up setting out any revisions to the interagency care plan.

Protocol 5

Gaps and Blocks

Outcome

A. Addressing barriers to service provision necessary for service user progression set out in agreed care plan

Key Processes

1. As set out in the Rehabilitation Framework any barrier to service user progression identified in the implementation of a service users care plan, including difficulties in inter-agency co-ordination, should be followed up by the case manager with the relevant service(s).

2. If such a barrier remains unresolved following all attempts to resolve it between services, including an interagency case meeting, then the case manager should progress the matter to the rehabilitation co-ordinator* for resolution via a Gaps and Blocks Form (appendix 4).

3. There may be occasions when the matter is progressed by someone other than the Case Manager following efforts to resolve it via an interagency care plan meeting.

4. All relevant parties, including the service user, should be notified by the rehabilitation coordinator* that the matter has been raised.

5. Where, despite the further efforts of the rehabilitation coordinator* and case manager, the issue persists, the rehabilitation coordinator* can raise the matter at the next Drug Task Force Treatment and Rehabilitation Sub-Group meeting, in line with the Rehabilitation Report.

6. Where, despite the combined efforts of all involved, the Treatment and Rehabilitation Sub-Group is unable to resolve an issue, the gaps and blocks form should be referred by the rehabilitation co-ordinator to the National Rehabilitation Co-ordinator for resolution at the National Drug Rehabilitation Implementation Committee.

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* The role of the proposed rehabilitation co-ordiators will be carried out by nominated pilot rehabilitation coordinators for the duration of the pilot projects, established to inform the implementation of the National Rehabilitation Framework.

7. Actions arising from the NDRIC discussions on reported gaps and blocks in services should be reported back through rehabilitation co-ordinators* to the Treatment and Rehabilitation Sub-Groups within a reasonable timeframe.

Protocol 6

Confidentiality and Information Sharing

Core Principle

It is recognised that maintaining confidentiality is crucial to the building of a trusting and respectful working relationship with the service user. It is equally important that all parties recognise that confidentiality is never absolute and service users should be given a clear understanding of the limitations to confidentiality at the outset. In this context it is important that all services have clear policy guidelines in relation to client confidentiality which comply with national legislation and guidelines. Service providers are responsible for ensuring that their staff understand and comply with their responsibilities under relevant legislation when report writing, explaining confidentiality and working with service users, storing/securing data, and sharing information with other agencies individuals (Data Protection Act 1988 & 2003; Freedom of Information Act 1997 & 2003; Child Care Act 1991; Children First: National Guidelines for the Protection and Welfare of Children 2011; Information Governance: a Guide for health and social care staff, HIQA 2011).[†]

Within the context of interagency care planning, service providers are responsible for ensuring that clients are encouraged to actively engage in this process and that they are given a clear understanding of the purpose and benefits of sharing agreed personal information. As part of the shared care planning process, information is shared for the purposes of service planning, and helping the service user meet the goals set out in the interagency care plan.

Outcomes

A. The service user understands issues relating to confidentiality, including their right to privacy, as well as the limits to confidentiality. The service provider must discuss these issues with the service user to ensure this understanding.

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

B. The service user is clear about the processes by which they can consent to agreed personal information being shared amongst different parties to the interagency care plan, as well as how to review and withdraw consent.

C. Service providers develop their own or shared policies and procedures regarding confidentiality and sharing information which are compliant with relevant national legislation and guidelines. Service providers are responsible for ensuring that their staff are compliant with these. Policies are not limited to, but must include:

    a. limits of confidentiality;
    b. acquiring consent/release of information and review/ withdrawal of same;
    c. report writing;
    d. recording of case notes;
    e. secure storage of personal data both hardcopy and electronic;
    f. sharing information within each agency;
    g. sharing information with other agencies;
    h. dealing with family members & informal enquiries;
    i. dealing with under 18's;
    j. modes of communicating personal information; and
    k. dealing with accidental, planned, or deliberate disclosure without permission.

D. Partner services demonstrate a willingness to work collaboratively by developing a local Confidentiality and Information Sharing Protocol, based on the National model.

E. Services agree a definition of what information is considered appropriate and necessary; this is based on the role and responsibility of staff attending and engaged in the interagency care planning process and the role and function of their agencies.

F. Services agree a process whereby disagreements and other issues pertaining to the sharing of client information can be addressed.

G. Service providers or the nominated pilot rehabilitation co-ordinator submits the local shared Confidentiality and Information Sharing Protocol (along with associated policies), to the Data Commissioners Office to ensure compliance with the Data Protection Act.

Key Processes

1. In the development of a local Confidentiality and Information Sharing Protocol, partner services should share all their policies and procedures relating to confidentiality and the sharing of client information. Policies and procedures should fall within a recognised good practice or quality standards framework and must comply with national legislation and guidelines (as outlined in this national protocol). A standard release of information form

should be agreed between the partner agencies setting out agreement to share necessary and appropriate information in the context of the interagency care plan and this should precede the commencement of any interagency process.

2. All staff participating in the interagency care planning process must be aware of the shared Confidentiality and Information Sharing Protocol, and relevant legislation/ guidelines, as well as their own agencies policies and procedures. Service providers are responsible for ensuring that their staff receive training in all aspects and areas relevant to their role in interagency care planning.

3. The key worker should explain the process of interagency care planning to the service user (see Protocol 2) and obtain written consent via a release of information form for the sharing of agreed information; this should occur before any interagency communication takes place. This form should specify the agencies involved in the interagency process and the information to be shared and the purpose of this.

4. The release of information form should be reviewed with the service user at regular intervals of not more than six months by the case manager (see Protocol 2), and if any additional agencies are invited to join the interagency care plan process then the consent of the service user must be obtained beforehand.

5. Service users must also be made aware of the limitations to confidentiality and the circumstances when this will apply.

6. Services must ensure that they follow the wishes of the service users in what information they share with other agencies; agencies must only request information which is relevant to their own role or that of the agency (see overarching principal 4).

7. Services must train their staff in how to manage potential disclosures at all stages in the working relationship including during interviews to ensure that the client is fully aware of the limitations to confidentiality before disclosure is made.

8. Where a dispute arises concerning the sharing of information, services should meet to review what information has been requested and why. The requesting agencies should be able to justify their need for the information and its context in relation to their own role with a service user. The case manager and interagency group should verify the request, discuss the issue with the service user, and agree a collective response. Any actions arising out of the sharing of the information need to be documented.

9. Services should have a clear policy on dealing with both formal and informal enquiries relating to service users, and this must be understood by staff, volunteers and service users alike. If it is clear that there has been a breach of confidentiality, whether accidental or not,

a follow up process must ensure that the service user is informed and steps taken to ensure the incident is not repeated.

10. The service provider must comply with the requirement to notify the office of the Data Commissioner of particular breaches of confidentiality as specified by the Data Commissioner.

APPENDICES

Appendix 1: Initial Assessment– Minimum Standard Guidance

Note that any information relating to the NDTRS is in italics, although NDTRS requirements are subject to change.

These items/domains are considered <u>minimum</u> requirements; any other items/domains can be added subject to the requirements of the initial assessing programme.

(Starts on next page)

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General Information

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- *Name* (also include nick names):
- *Address*:
- **County:**
- **Phone number:**
- *Date of birth* (dd/mm/yy):   *& Age*
- *PPS no.* (7 numbers followed by 1 or 2 letters):
- *Source of referral* (please circle):
  Self   Family   Friends   Other drug treatment centre   GP
  Acute Hospital Service (excluding A&E)   Social / Community Services
  Court/Probation/Police   Outreach Worker   Harm Reduction programme   School
  Prison   Employer   Mental Health Liaison Nurse at A&E   Accident &
  Emergency other   Mental health service (including psychiatrist)   Not known
- *Date of referral* (dd/mm/yy)**:**

- **Next of Kin 1**
  Name
  Address
  Phone
  Is this person aware of drug use / contact with this service?   Y   N

- *Living with* (circle one):
  *alone   parents /family   friends   partner   partner & children   alone with children   foster
   care   other.. Not known*

- *Living where* (circle one):
   stable accommodation   institution   homeless   other unstable accommodation

- *Ethnic Origin   (circle as many as appropriate)*
  *white Irish   white Irish Traveller   other white background   black African
   other black background   Chinese background   other Asian background   Do not wish to
   answer, other, please list*

- *Nationality / Country on passport:*

- **Services / workers you are in contact with over the last year (we will only contact them after consenting with you).**

 Organisation   Workers Name (contacts if known)

 (The worker may wish to prompt the following: probation officer, addiction treatment centre, counsellor, social worker, housing service, other key working service, children's support services).

Alcohol Use

- Measurement tool to be agreed as per national guidelines (e.g. AUDIT)
- Brief relevant case history
- Services currently involved or which have been involved in the care plan to date.
- What supports / progress are required in this area (shorter term)?
- Any future goals (longer term)?

- *Specify main type of alcohol consumed*:
  Beer   spirits   wine   fortified wine   cider   alcopops
  Other..

- *How many drinks were consumed over a typical drinking session over the past month*................ *If none, put o*

- *Number of days alcohol was consumed over the past month*... *If none, put o*

- **Please categorise the extent of the drinking problem (as per tool)**
  hazardous drinker   harmful drinker   dependent drinker

- *Ever previously treated for problem* <u>*alcohol*</u> *use*? *Circle one*
  Never treated   Previously treated   Not known   Not applicable

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Drug Use

- Measurement tool to be agreed as per national guidelines (e.g. MAP)

- *Type of contact with this programme* circle one
  First treatment   One or more treatment periods   Not known

- <u>Number of times started treatment in this programme this year</u> **(Jan to Dec)** *.................*

- *Ever previously treated for problem* <u>*drug*</u> *use*? *Circle one*
  Never treated   Previously treated   Not known   Not applicable

- **If previously treated, state which drug** *.........................*

- **If previously received opioid replacement treatment,** *please specify age first received opioid substitution treatment ....   Not known*

- *Specify first drug used (excluding alcohol) ....age at first ....*

Drug type Please rate order of preference / regularity in the brackets e.g. 1, 2, 3 ect..	Age at first use	How often 1. daily or almost daily 2. several times a week 3. at least once a week 4. less than once a week 5. not known	Amount used	Route of transmission. 1. inject 2. smoke 3. eat/drink 4. sniff/snort 5. sublingual 6. rectal 7. topical	Harm reduction awareness (Y / N) Discuss harm reduction issues, (see guidebook for info)
Heroin (___)					
Cocaine (___)					
Benzodiazepine (___)					
Amphetamines (Crystal Meth) (___)					
Ecstasy (___)					
Cannabis (___)					
Alcohol (___)					
Methadone (___)					
Tobacco (___)					
Codeine (___)					
Other (___)					

Risk behaviours

- **Brief relevant history of possible risk behaviours**
- **History of injecting** *circle one   never injected   has injected   not known*
- ***Age in years first injected*** *..........................   not known*
- **Frequency of injecting** *circle one   injected in the <u>last 30</u> days   injected in the <u>last year</u>, but not in the last 30 days   ever injected, but not in the <u>last 12 months</u>*
- ***History of sharing needles or syringes*** *circle one   never shared needle or syringe Has shared   Not known*
- **Frequency of sharing** *circle one   shared needle or syringe in <u>last 30</u> days shared needle or syringe in <u>last 12 months</u> but more than 30 days ago shared needle or syringe more <u>than 12 months</u> ago   not known/don't want to answer*

Ongoing Care

- **Services currently involved or which have been involved in the care plan to date.**
- **What supports / progress are required in this area (shorter term)?**
- **Any future goals (longer term)?**

ASSESSMENT DETAILS – for office use only

- ***Date of initial assessment*** *(dd/mm/yy)***:**
- ***Assessment outcome*****:** *circle one   Suitable   Unsuitable*
- ***Centre assessment criteria fulfilled*** *circle one if applicable YES   NO   Pending*
- ***Date assessment criteria fulfilled*** *if applicable (dd/mm/yy):*
- **Referral for Comprehensive Assessment** *circle one   YES   NO*

END

Appendix 2: Comprehensive Assessment – Minimum Standard Guidance

Date of Assessment

Core Demographic and Client Details
- Name, Address, Contact number, DOB, Identification No., Ethnicity, Gender

Name, Address, Contact Number of GP
- Medical Card/ Other

Name, Address, Contact Number of next of Kin

Name, Address, Contact Number of referrer / referring agency

Name, Address, Contact numbers of other agencies attending

Reasons for referral

Presenting problems/ Complaints/
- **History of presenting problems/Complaints**

Current Drug and Alcohol use
- Amount, frequency, mode of use, duration of use, age of 1st use
- Evidence of harmful use/ dependence
- Evidence of withdrawal symptoms/ intoxication
- Financial costs of use and means of financing use.
- Consequences of Alcohol/ drug use: Health, social, economic, legal

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Current Physical Health and symptoms/ Ill health/ disabilities

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Current Mental Health / Psychological symptoms

Current assessment of risk behaviours

Current Medications Prescribed

Past History of Drug and Alcohol use:
- Age of 1st use, Progression of use
- Age of 1st injecting
- History of Overdoses

Past treatments for Drug and Alcohol Use
- Places of Treatment/ Type of Treatment

Past Medical History
    • Past viral testing and results
    • Vaccination History
    • Past Operations/illnesses/diseases

Past Psychiatric History /Past Mental Health Issues
    • Diagnosis, Treatment, Consultant and Service attended
    • Any episodes of Deliberate Self Harm

Family History/ Family Structure/ Supports   • Any Family History of Addiction or mental health problems

Personal History:
    • School, Education, Problems in school
    • Highest educational level achieved
    • Courses / training schemes
    • Employment history / Current employment status

Social History / Social Functioning.
    • Accommodation
    • Living arrangements
    • Children
    • Relationships with partner / spouse/ family/ friends
    • Hobbies/ Activities/ Social outlets / Supports
    • Spiritual and Religious matters
    • Cultural and Ethnic factors.
    • Financial Situation and benefits received/ Medical Card

Criminal History /Legal Issues
    • Past charges, conviction, prison sentences
    • Current charges, court cases, convictions
    • Probation Officer/ Solicitor

Assessment of Motivation and Readiness to change
Assessment of Goals: • Service user's goals and their own assessment of need.
Formulation/ Diagnosis/ Assessment of Needs

Care Plan/ Management Plan
- Biological Markers: Urinalysis, bloods, physical examination if appropriate
- Referrals to others / other agencies to support identified needs
- Interventions required: Biological, Psychological, Social, Rehabilitation
- Residential treatment / treatment in the community
- Identification of unmet need / service deficit.

END

Appendix 3: Referral and Assessment for Residential Treatment (Tier 4)

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

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

Introduction

Types of Tier 4 Services

- Specialised Statutory Units:
  Inpatient units for medical stabilisation and detoxification programmes.

- Independent/Voluntary sector residential facilities for detoxification programmes.

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

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

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

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

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

- Residential Rehabilitation Units:
  - Residential Rehabilitation units providing specialised addiction counselling, addressing the persons psychological, emotional, behavioural and personal/family issues.
  - "Step –down" or half way house may be required as a follow on from residential treatment. These facilities address the ongoing rehabilitation needs of the

client and provide extended care while ongoing training, education, accommodation, welfare needs are addressed.

Services provided at Tier 4

- Detoxification, stabilisation programmes, assessment, residential rehabilitation.

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

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

Relevant Supporting Literature

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

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

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

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

A. Criteria/Suitability for Tier 4 Services

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

<u>Alcohol:</u>

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

- Identified need and preferred choice of the individual.
- Severe alcohol dependence.
- Risk of having severe alcohol withdrawals as based on previous symptoms or a recent history of high alcohol intake.
- At risk of *Delirium Tremens* or seizures.
- Those who do not live in an environment that supports an outpatient detoxification programme (homeless or living in hostels, or B&Bs, or homes where there are other alcohol and drug users).
- Concurrent medical disorders/acute physical Illness that may complicate their management i.e.
    - epilepsy,
    - confused or hallucinatory state,
    - acute physical illness
    - Wernicke's encephalopathy
    - confusion, staggering gait,
    - uncontrolled eye movement,
    - coma, low BP, Hypothermia,
    - unexplained neurological signs,
    - if injectable thiamine is required.
- Concurrent Psychiatric disorders/ Acute Psychiatric Illness that may complicate their management, i.e.
    - risk of suicide
    - Wernicke's encephalopathy
- Previous unsuccessful outpatient/home alcohol detoxification programmes.
- Where continuity of care is essential for preserving gains achieved in residential treatments i.e. "that transition from detoxification to residential rehabilitation and then to step-down accommodation be seamless" (Report of the HSE Working Group on Residential Treatment and Rehabilitation).
- To provide intensive psychological interventions to begin to equip alcohol users with the skills of managing their daily life and managing staying drug free (SCAN Consensus Report).
- "Greater social deterioration, less social stability and higher risk for relapse benefit more from residential treatment. (Models of Care for treating alcohol Misusers)

Opioids and Other Drugs:

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

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

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

Additional Criteria specific to Residential Rehabilitation Treatment

Additional criteria include the following for placement in tier 4 residential rehabilitation services where an inpatient / outpatient detoxification programme is completed or not required:
- No capacity to remain clean and sober in a tier 3 setting
- No environment to sustain stability
- Lack of awareness of the consequences of addiction to self and others
- History of relapse
- A vulnerability which emerges when exploring psychological/life/historical issues
- Geographical reasons.

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

B. Comprehensive Assessment for Residential Treatment

Assessment 1

This is based on the domains outlined in the "Comprehensive Assessment – Minimum Standard Guidance", as developed by the NDRIC (appendix 2). The assessment may be completed by a number of disciplines (multidisciplinary) all supporting the assessment and application for residential treatment. i.e. medical assessment, psychiatric assessment, counselling assessment, assessment by Rehabilitation Integration Officers/ Service, assessment by key worker/case manager, etc.

Assessment will also need to consider:
- "Criteria" for Residential Treatment as outlined above.
- Level/type of residential treatment required as per ASAM Guidelines (level III/IV).
- Assessment of severity of problems and level of function.

Assessment 2

This is made by the staff in the Residential Unit. Assessments follow the domains as outlined in the "Comprehensive Assessment" but assessment also ensures that criteria are fulfilled as outlined by the specific residential unit.

Assessments in the Residential Units will further ensure: (SCAN Consensus Report)

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

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disease and blood borne virus infections. Regular liaison with primary care teams and acute medical services will be required and appointments made for assessment and follow-up care arranged.

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

END

References for Appendix 3

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

Appendix 4: Gaps & Blocks Reporting Form

This form is for recording when there are issues with the working processes or systems within drugs and/or alcohol services. Please DO NOT identify the service user at this stage. If more detailed information is required the service user will need to give consent. Please discuss possible solutions with relevant team members before completing form. Feedback will be received within ten days of sending the form to; (please email is possible)

1. **Project name:**   **Date:**

2. **Case Manager Name and Contact Details:**

3. Please provide a three line overview of the problem.

4. Please list the actions and communications thus far (identify who, what, and outcome for each step).
    1.
    2.
    3.
    4.
    5.

5. What is the outcome or the current situation.

3. **Can you make practical recommendations for how this situation could be improved for your service user or others?**

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