

# National Drugs Rehabilitation Framework Document



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive

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## Foreword

For many years various policies and reports have clearly indicated the absolute need for an integrated and co-ordinated approach to service delivery.

This document has been produced arising out of recommendations from the Report of the Working Group on Drugs Rehabilitation, May 2007, as a framework to assist services to plan practically and implement a range of different approaches to provide an 'Integrated Care Pathway' for former and current drug users.

Within the field of addiction it is widely accepted that service users have diverse and multiple needs. Hence it follows that it is unlikely that any single agency can provide everything that is needed to address the issues contained within this cycle of addiction. If services are not co-ordinated, service users can have difficulty negotiating the complex service network, 'fall between the cracks,' fail to receive the help they need, and/or be subjected to unnecessary delays, frustration, trauma, and intrusion into their lives. On the other hand, when services are well co-ordinated, it reduces the need for multiple interviews, which, in turn, cuts down on trauma and inconvenience for people and reduces wasteful overlap and duplication.

There are a number of different service agencies in existence in every community. Each of these agencies is guided by its own mandate and each provides a specific service to that community. While recognising the individual integrity and ethos of services it is none the less necessary that they engage in co-operative interagency working. This will gather and retain more people within the care process.

The National Drugs Rehabilitation Implementation Committee (NDRIC) places particular importance on services in all of the four tiers and their role in engaging service users in their treatment and rehabilitation journey. For example, family involvement and family support are crucial in assisting this journey. Likewise, service providers from all tiers, when working with drug users, should be aware of the importance of their role and those of other services within the continuum of care.

It is accepted that there is a need for increased co-operation across the care continuum and that agreed interagency working arrangements would help create a common reference point for agencies to work to common goals for the service user, resolve any disagreements, or issues which in the long run only serve to disrupt the effectiveness of any drug intervention.

Leaders in all positions should identify opportunities to engage, plan and work together.

**Joe Doyle**

National Senior Rehabilitation Co-ordinator

## National Drugs Rehabilitation Implementation Committee Membership

<b>Name</b>	<b>Representing</b>
Joseph Doyle	Chair
Tony Barden	HSE Regional Drugs Co-ordinator/ Area Operations Managers
Chris Black	RDTF Co-ordinators
Denis Breen	Drug Advisory Group / Drugs Task Forces
Joan Byrne	Community Drugs Sector
Eamonn Carey	FAS
Fiona Carolan	Dept. of Education & Science
Frances Nangle Connor	Irish Prisons Service
Paul Conlon	Voluntary Drugs Sector
Michael Conroy	Dept of Community Rural & Gaeltacht Affairs
Paula Cooney	The Probation Services
Majella Darcy	Voluntary Drugs Sector
Mick Devine	Voluntary Drugs Sector
Dr. Hugh Gallagher	HSE GP Co-ordinators
Trish Garland	HSE Counsellors
Keri Goodliffe	Regional Drugs Task Force Co-ordinators
Paul Morrissey	Dept. of Environment, Heritage & Local Government
Dairearca Ní Néill	Dept of Community Rural & Gaeltacht Affairs
Liam O'Brien	National Advisory Committee on Drugs
Dr. Denis O'Driscoll	HSE – Pharmacists
Sgt. Brian Roberts	Garda Drugs Unit
Dr. Siobhán Rooney	HSE – Consultants
Bríd Walsh	Local Drugs Task Force Co-ordinator
Teresa Weafer	Community Drugs Sector
Jelena Ivanovic	Secretary

## Introduction

The role of the National Drugs Rehabilitation Implementation Committee (NDRIC) is set out in the Report of the Working Group on Drugs Rehabilitation, 2007 (The Rehabilitation Report). As outlined in this report, the NDRIC is committed to

- ✓ Overseeing and monitoring the implementation of the recommendations from the Rehabilitation Report;
- ✓ Developing agreed protocols and service level agreements;
- ✓ Developing a quality standard framework which builds upon existing standards;
- ✓ Overseeing case management and care planning processes; and
- ✓ Identifying core competencies and training needs and ensuring that such needs are met.

In line with the recommendations outlined in The Rehabilitation Report, the aim of this document is to provide:

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

The provision of rehabilitation pathways is a shared responsibility of the education, training and employment sectors along side the health, welfare and housing sector, non-governmental organisations, communities, families and the individual themselves.

The NDRIC's proposed rehabilitation pathway is outlined in Section 1. This pathway places the provision of rehabilitative support firmly within the *Four Tier Model* of service delivery.<sup>1</sup> The provision of services will be based on the implementation of a comprehensive care plan and an integrated approach to case management where appropriate.

This framework commits the relevant stakeholders to agree, through pre-set protocols and (through schedules within) service level agreements, the structures which will support and bind that partnership. The protocols will serve to facilitate inter-agency co-operation and information sharing in order to implement shared care plans. The schedules within service level agreements will be developed in line with these protocols. These are outlined in Section 2.

An established quality standard framework will ensure the provision of services in line with evidenced best practice. The quality standards framework chosen by an organisation should build upon the existing standards and the rationale behind its choice is set out in Section 3.

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<sup>1</sup> The tiers refer to the level of the *interventions* provided and do not refer to the provider organisations.

## Section 1: Integrated Care Pathway

The Rehabilitation Report highlights difficulties with inter-agency working as a possible key barrier to the progression of service users through different services. In order to ensure an integrated rehabilitation service in Ireland, the Report highlighted the need for a strengthening of inter-agency links and a focus on person-centeredness.

The key recommendations from The Rehabilitation Report are:

1. Rehabilitation can only be delivered effectively through an inter-agency approach based on a continuum of care that operates within the context of enhanced case management and a quality standards framework. The development of protocols for inter-agency working, with service level agreements between agencies and co-ordination by rehabilitation co-ordinators, is required.
2. An adequate level of treatment provision is central to rehabilitation. An expansion of the range of treatment options, including an increase in the number of residential detoxification beds, for recovering drug users is essential. The HSE led Working Group on Residential Treatment/Rehabilitation should consider the issue of treatment provision and make detailed recommendations in this regard.
3. The impact of Community Employment on rehabilitation should be built upon by complementary support and involvement from the HSE, the Department of Education and Science and relevant agencies to ensure that the health and educational needs of participants are being properly addressed during their period of participation, as well as pre and post such participation.
4. The housing, childcare, educational and health needs and the employment opportunities of recovering drug users should be addressed through specific initiatives.

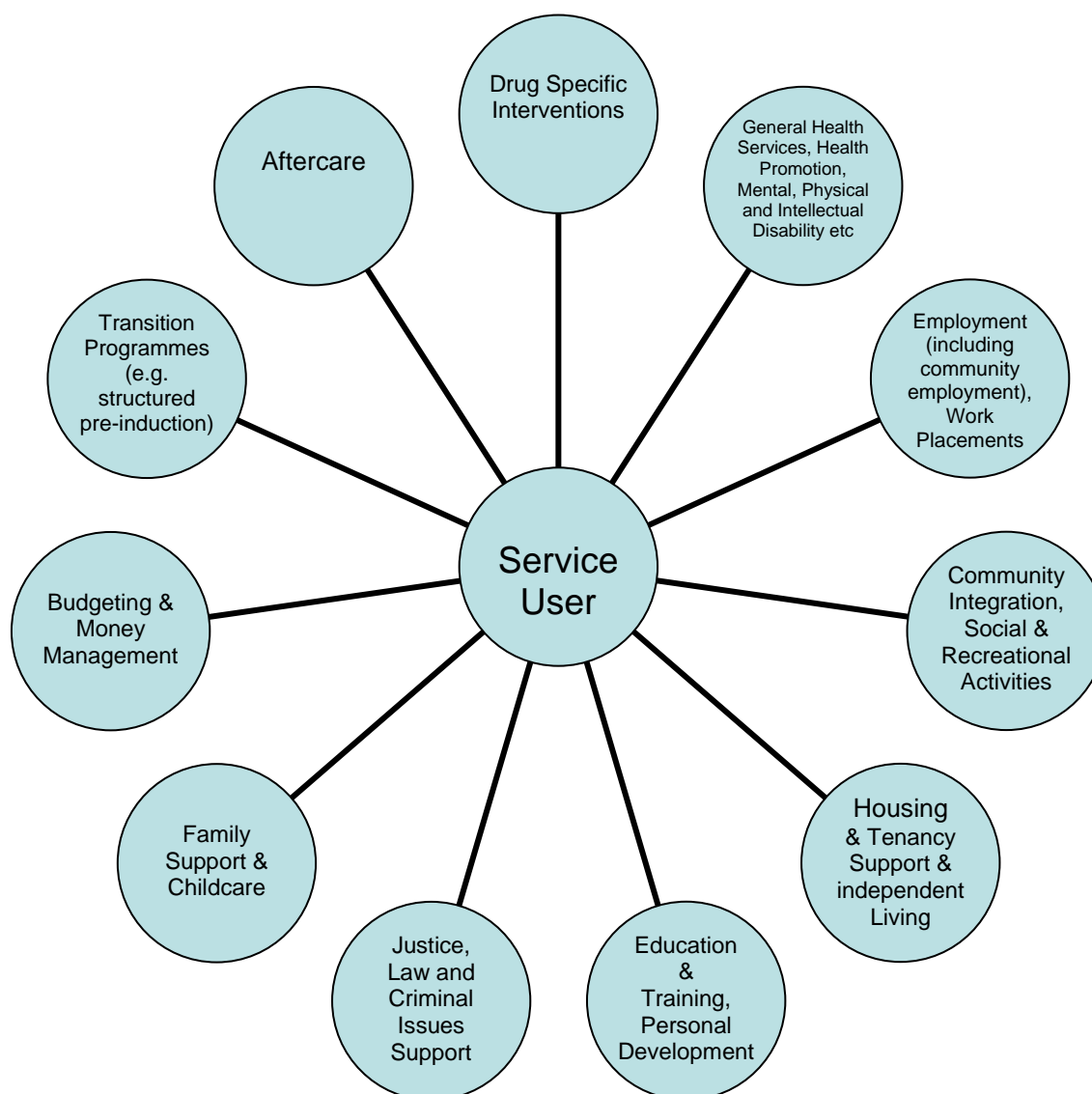
In accordance with Section 4.2 of The Rehabilitation Report, inter-agency links need to be strengthened and services need to be person-centred, matching their identified needs, at any point in time to the appropriate type and level of service along the care continuum.

The following section outlines an integrated model of rehabilitation provision.



## ***Integrated model of rehabilitation provision***

The NDRIC recognise that an integrated model of rehabilitation supports requires a wide range of components. Depending on complexity of need a service user may require support in one, some or all of the following areas (Figure 1). These supports are provided by a range of statutory, voluntary and community service providers.



**Figure 1: The range of supports required for an effective, integrated model of rehabilitation**

Given the diversity of the supports required during rehabilitation, it is recognised that no one agency has the range of competencies, expertise or resources to meet the needs of a service user holistically. The care planning process, with the service user's consent, is intended to co-ordinate the services being received and to identify, through assessments, which supports should be sought for the service user. The service user's needs and input should be central to the development and ongoing implementation of their individual care plan.

Case management will be an essential part of the integrated care planning process; the development of integrated care pathways and the facilitation of services and supports to meet service user needs.

A key element of the services user's rehabilitation (including treatment and aftercare) is the assurance that an integrated approach will be taken in the provision of services across HSE and all other statutory and voluntary sectors. To facilitate this all services involved with a service user's rehabilitative care plan and pathway will be required to adhere to overarching governance standards. Inter-agency feedback and accountability mechanism linked to the funding bodies, as outlined in Sections 2 and 3, will be implemented.

The following key principles underline the integrated care pathway.

1. The Rehabilitation Report identifies that rehabilitation should start at the first point of contact a drug user has with a drug related service (any tier):

*"Accordingly, at an early stage the client's needs should be assessed, ideally in the drug service within which he/she makes first contact with a view to drawing up a care plan.<sup>2</sup>"*

In relation to tier 1, service users may attend non-substance misuse specific services and be exhibiting signs of drug/alcohol misuse. In order to maximise opportunities arising from early interventions, appropriate staff should be trained to look out for signs of misuse in order to provide information and make referral to (the most appropriate tier of) drug service intervention.<sup>3</sup>

2. On making contact with a drug specific service, initial assessment should be undertaken to identify the needs of the service user and the most appropriate service provider(s) to address those needs.
3. The service users journey through the rehabilitation process is based on the four tier model (see appendix 1) of care and should be service user focused and as integrated and seamless as possible.

## **Care Planning and Case Management**

This rehabilitation pathway is based upon shared care planning and the development of an integrated care pathway model. This means that if a service user has a range of needs that cannot be met by one service alone, a number of key workers from different services (collectively known as the care team) will need to work together to provide a more holistic package of support for the service user. The HSE is the

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<sup>2</sup> The Rehabilitation Report, paragraph 4.2, page 32.

<sup>3</sup> The NDRIC identified that there is likely to be considerable variation and capacity across tier 1 services including the likes of emergency departments in hospitals, Garda youth diversion programmes, youth activities, schools and social welfare. The NDRIC are of the view that the most appropriate place for this work to happen is at the Drugs Task Force level under the guidance of the Drug Advisory Group with all the sectors involved and to let the NDRIC focus on the rehabilitation pathway with clients already in treatment.

organisation with the lead role in relation to case management in that they are responsible for ensuring that each person is appropriately supported through the rehabilitation system.<sup>4</sup> The HSE may delegate the provision of case management and the tracking of service users' progression through the continuum of care to other agencies, though it retains responsibility for ensuring that case management is in place.

In order to ensure effective communication and the avoidance of duplication there needs to be one person agreed between all of the services to ensure that all involved are fulfilling their part of the care plan. This person will be the case manager.

### **Key Worker:**

Named person who is assigned to work closely with the service user and provide a range of psycho-social interventions/advocacy.

Tasks include:

- ✓ Engaging with the service user
- ✓ Ensuring consent
- ✓ Completing assessment and developing a care plan with their service
- ✓ Advocating on behalf of service user
- ✓ Working to fulfil care plan actions relating to their direct service provision
- ✓ Engaging and sharing information with other agencies as required
- ✓ Keeping relevant case notes/records
- ✓ Service user service objectives should be expressed as SMART (specific, measurable, achievable, relevant and time bound) objectives and interventions, and to this end regularly reviewed for progress.

Each key worker should develop a care plan with the service user for their particular service (Figure 4a).

### **Case Manager:**

The case manager is the identified person who has a formal role to manage inter-agency communication and the provision of co-ordinated care for the service user in question. They will do this through means of:

- ✓ Ensuring a care plan is in place and SMART objectives set
- ✓ Arranging regular reviews to monitor and assess the progression of the care plan
- ✓ Reviewing the care plan with the service user, all key workers/agencies involved, and where appropriate with the service users family.

The role of case manager may be undertaken by a key worker or another designated person within the agency. The case manager will oversee a shared care plan made up of all individual care plans (Figure 4b).

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<sup>4</sup> This is in line with The Rehabilitation Report, paragraph 3.26, page 24.

The case manager is responsible for co-ordinating the work of key workers in order to avoid duplication of services and to identify any gaps or potential blocks in meeting the individual's needs. The case manager is the main contact person for the care team consisting of key workers from relevant organisations.

It is vital that the case manager is empowered and has access to identifiable services/resources and is capable of brokering problem solving arrangements in a speedy and responsive manner.

The case manager should be supported in relation to overarching governance structures through their management and accountability structures.

### ***The Four Tier Model***

As noted in the introduction, the four tier model of care (appendix 1) will act as the overarching framework for the provision of rehabilitation pathways.<sup>5</sup> Briefly, these tier *interventions* are described as follows.<sup>6</sup>

**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.

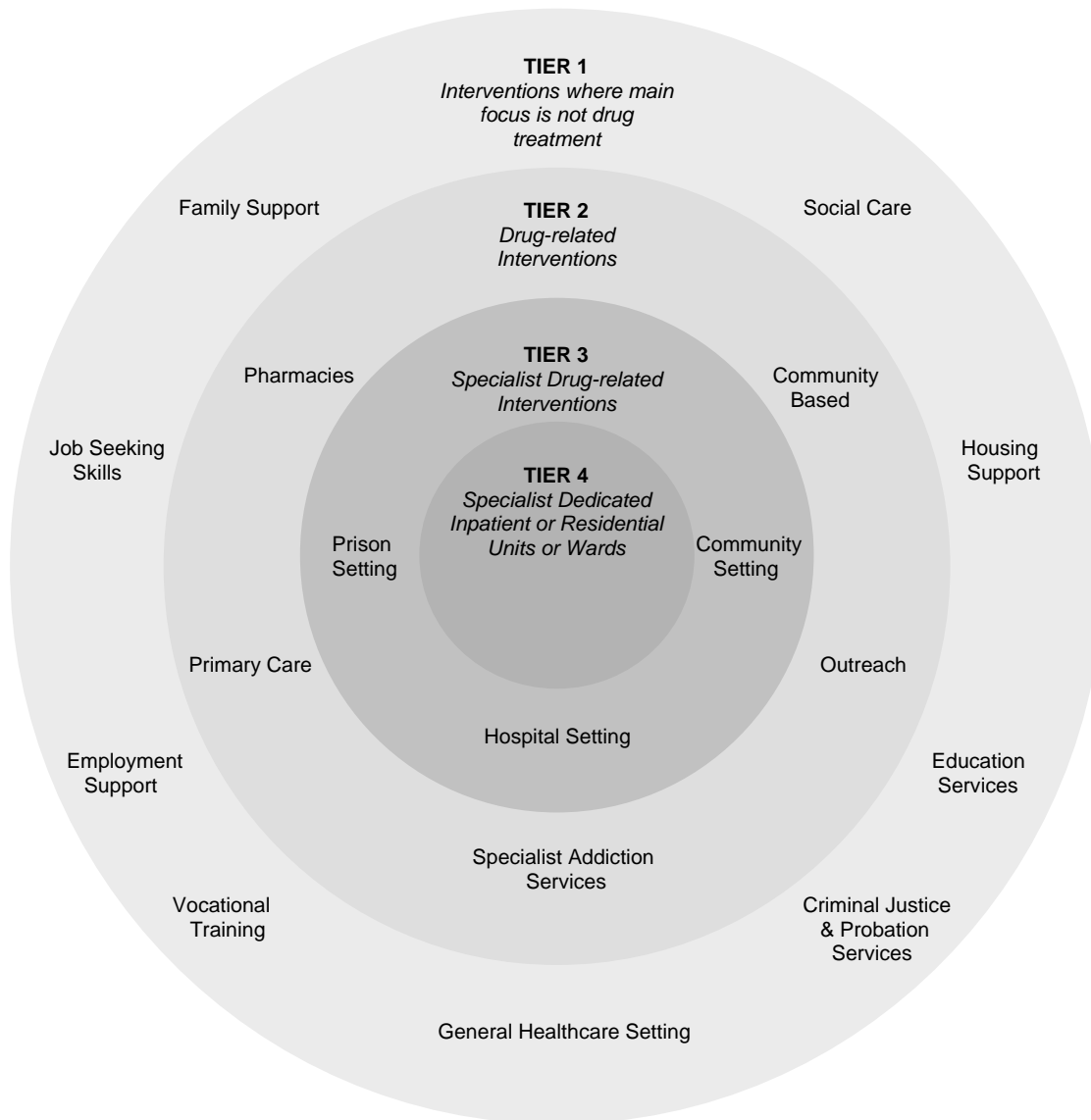
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<sup>5</sup> The use of the Four Tier Model was recommended in the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse) and suggested by the Department of Community, Rural and Gaeltacht Affairs. Report of the Working Group on Drugs Rehabilitation (2007)

<sup>6</sup> Taken from the Report of the HSE Working Group on Residential Treatment & Rehabilitation, 2007

“Step-down” or halfway house accommodation may be required to be made available away from the individual’s area of residence and drug-using networks.<sup>7</sup>

The effective provision of facilities and services requires not only the availability of both existing and additional resources, but also the development of appropriate strategies for the planning, management, financing, implementation and co-ordination of these facilities and services. This will ensure best fit and value for money.



**Figure 2: Rehabilitation Services/Interventions as seen within the Four Tier Model**

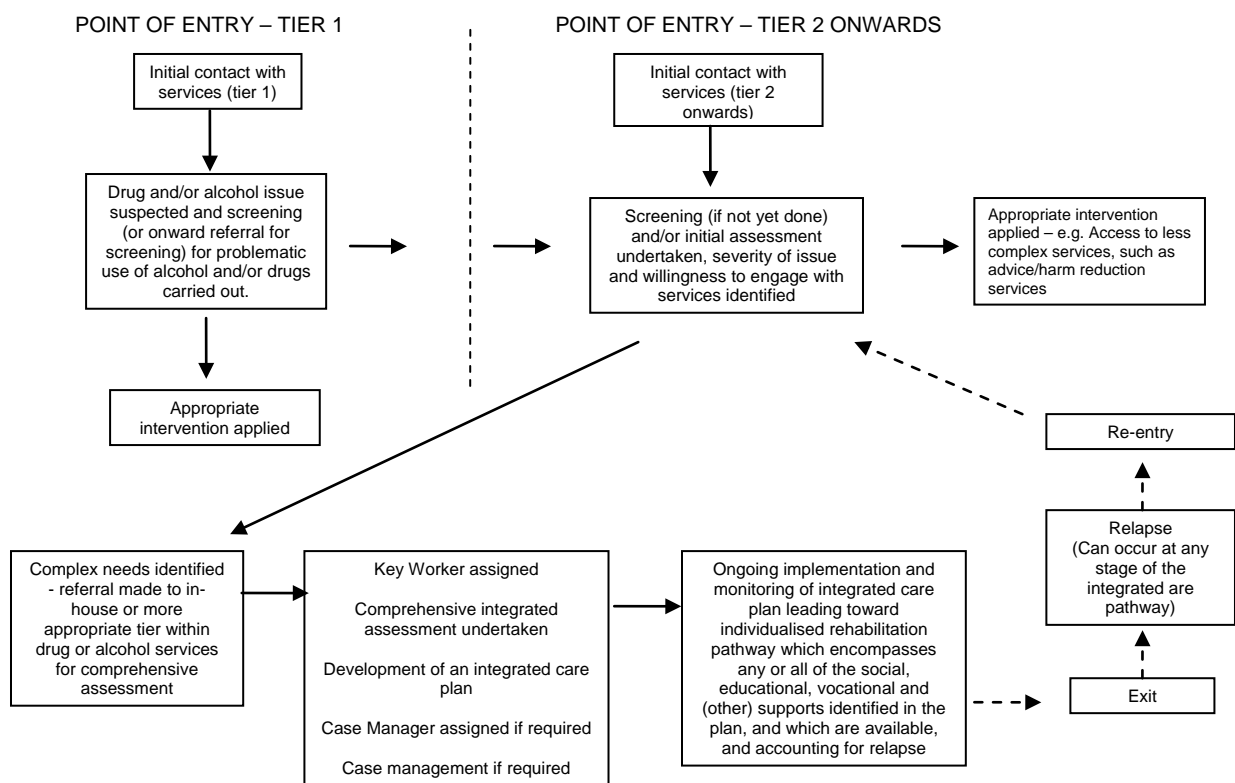
*Note. The above figure reflects the core business of services and these services may operation specific interventions at difference tiers. For example, tier 2 interventions may be delivered separately from Tier 3 but will often also be delivered in the same setting and by the same staff as Tier 3 interventions, as per the National Treatment Agency Models of Care: 2006 Update (see appendix 1 for more details).*

<sup>7</sup> Included as a tier 4 intervention when a service user accesses post inpatient detoxification programme/residential rehabilitation programme at tier 4. It constitutes an aftercare intervention that fulfils the recommendation that accommodation should be accessed after leaving residential rehabilitation if required. It does not relate to stand alone “step down” or halfway houses but is clearly linked to tier 4 services/residential rehabilitation services.

As can be seen from the diagram, there is multiple-agency involvement in drug treatment, and in the provision of other services of relevance to drug users. By planning and delivering services in a co-ordinated manner there will be a decrease in service duplication and elimination of gaps in and between services. It will also assist service user progression by providing a continuum of care. It is envisaged that the four tier model will provide a framework for this to happen and that Primary Care Team's/Social Care Network's as a core element of an integrated HSE service model will improve the co-ordination of service delivery. However, it is recognised that this can only be achieved through cross- and intra-sector collaboration within the HSE, between other statutory sectors in partnership with the community and voluntary sectors.

### **Integrated Care Pathway**

We have expanded the service user journey through a rehabilitation pathway below in more detail.<sup>8</sup>



**Figure 3: Integrated Care Pathway for Rehabilitation**

<sup>8</sup> We have based this journey on the NHS National Treatment Agency for Substance Misuse *Care planning practice guide, the Models of care for treatment of adult drug misusers: Update 2006* and the Scottish Health Executives Effective Interventions Unit *Integrated Care Pathways*.

## **Step 1: Initial Contact – Screening**

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.<sup>9</sup>

*“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.”*

## **Step 2: Initial Assessment & Identification of Appropriate Service (matching person to service)**

An *initial* assessment should be undertaken by a drug and alcohol treatment service provider offering tier 2 upwards interventions. This is a more in-depth assessment than the initial screening outlined at Step 1 but is not a comprehensive assessment of the service user’s drug and alcohol problem.

There are two possible points of entry to this step:

1. An individual is referred for a tier 2 intervention following a screening during a tier 1 intervention where a drug/alcohol problem was identified
2. Alternatively, an individual may go straight to an initial assessment following initial contact with a service provider offering tier 2 onward interventions and skip Step 1.

This initial assessment 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 services and, depending on the complexity of the case, whether a comprehensive assessment is necessary. Individuals with less complex needs may require less complex/structured drug services, such as advice services and low level intervention.<sup>10</sup> Where more complex needs are identified following the initial

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<sup>9</sup> Possible screening tools for suggestion from the NDRIC to those charged with this development include the WHO ASSIST (Alcohol, Smoking and Substance Involvement Screening Test), as it encompasses a brief intervention element in addition to the screening. For screening alone the Severity of Dependence Scales is suggested.

<sup>10</sup> If the assessing agency can meet these needs, the key worker who carried out the assessment can develop a care plan with the service user and be responsible for monitoring their progress. Where needs exceed the capabilities of the assessing service, a referral should be made to a more appropriate agency, a new key worker within the new agency assigned, and a care plan developed as previously described.

assessment, the assessing agency should provide a route for the service user to undergo a comprehensive assessment and enter an integrated care pathway based on needs identified.

Therefore, dependant on the outcome from the initial assessment, a service user may be offered a further service within the assessing agency and/or be referred on to a more appropriate service. The type of intervention/support required may vary from a counselling session to inpatient detoxification or a combination of service interventions. Whatever the needs identified, a care plan should to be developed with the service user and put into action through the key worker assigned.

### **Step 3: Comprehensive Assessment - Key Working & Care Planning (matching services to the person)**

A comprehensive assessment is appropriate for service users with more complex needs. The assessment will identify the services that will be involved in the shared care plan so as to meet these needs. Comprehensive assessments should be part of an ongoing 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 3 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.

Following the comprehensive assessment a case manager should be identified, who will support the individual through their rehabilitation pathway. In some cases, service providers may provide interventions across all four tiers. In such instances they may offer an initial assessment and also arrange the comprehensive assessment, where necessary. If the service user is remaining within the initial assessing service for a comprehensive assessment, a key worker should be assigned who will commence with this and together with the service user develop the care plan. In cases where a service user is referred to a different service, it will need to be decided between both services whether this new agency will act as lead and assign a case manager. All agencies with which the service user engages will assign key workers, who will liaise with each other and with the case manager, and who will work with, and advocate on behalf of, the service user.



The comprehensive assessment should, at minimum, include the following key elements:

1. Identification of all drug and alcohol use and measurement of severity of use.
2. Assessment of other domains, including: psychological problems, physical problems, social issues and legal problems (such as training, family support and housing services – see Figure 1).

There are responsibilities on key workers relating to the undertaking of a comprehensive assessment with a service user. These responsibilities include ensuring that the person being supported is aware of their rights and choices in undertaking the assessment and informed of its purpose in assisting the staff to identify their needs and in supporting them. Key workers should inform the service user when, how, where and with whom their information could be shared, and their rights and choices in this regard. The key worker should emphasise and explain to the service user the significant benefits they will derive from the managed sharing of their information.

When needs have been identified there is a responsibility on the case manager and all key workers (the care team) to advocate for these needs to be met. If barriers exist to meeting the needs of a service user then the care team are required to identify and document these, through a Gaps and Blocks Form (see appendix 2), and seek to ensure that solutions are found to resolve them. This is expanded on further under Step 4.

An individual care plan will be developed for each service user which may require the involvement of a range of service providers and a range of different disciplines through a multi-disciplinary team structure. In cases where a service user has complex and multi-faceted needs they may require a more intensive case management approach.

It is recognised in the National Drugs Strategy 2009 – 2016 that specific attention will be required for people who experience both mental health and substance misuse problems in order to ensure their access to appropriate treatment and support. Therefore, it is essential that the assessing agency is competent in identifying possible mental health issues and is proactive in referring the service users involved for assessment of their mental health needs where this is necessary.

#### **Step 4: Implementation of the Care Plan to Support an Individual Rehabilitation Pathway**

According to the Rehabilitation Report:

*“...rehabilitation care plans should address the needs of the whole person, from measures to address drug use to personal and social development, education and so on. In this way, care plans need to draw upon different settings, e.g. health care might be provided by a GP in a primary care setting and educational training by a community college. Care plans would be dynamic so that they would adapt to take account of progress/setbacks experiences by the client.”*

The following template structures (completed with examples for ease of interpretation) are suggested as the format for the care plans. It is intended that there be one shared care plan for each service user, which will be monitored and reviewed by the case manager. This shared care plan can be split into separate sections, with various key workers taking responsibility for the implementation and review of these:

Date Objective set	Objective and Timescale	How will progress be measured	Work to be done to achieve objective	Referred to	Name of worker & agency	Outcome	Comment: Reasons achieved or not
10/1/10	Stop illicit drug use within 8 weeks	1. Self-report 2. Attend Drug awareness course 3. Urinalysis	1:1 with counsellor concerning motivational interviewing and CBT analysis of triggers Attend next drug awareness course	Counsellor Crumlin	Michael Bloggs Crumlin	Attending 1:1 and successfully engaged with counselling activities Completed drug awareness course 12//6/08 Applied for next treatment course 28//2/2010	Intends to apply for a training course

**Figure 4a: Recommended format for the Care Plan (service user and key worker)**

	Date Objective set	Objective and Timescale	How will progress be measured	Work to be done to achieve objective	Referred to	Name of worker & agency	Outcome	Comment: Reasons achieved or not
<i>Key Worker 1 completes and monitors</i> →	10/1/10	Stop illicit drug use within 8 weeks	1. Self-report 2. Attend Drug awareness course 3. Urinalysis	1:1 with counsellor concerning motivational interviewing and CBT analysis of triggers Attend next drug awareness course	Counsellor Crumlin	Michael Bloggs Crumlin	Attending 1:1 and successfully engaged with counselling activities Completed drug awareness course 12//6/08 Applied for next treatment course 28//2/2010	Intends to apply for a training course
<i>Key Worker 2 completes and monitors</i> →	10/2/10	Improve level of reading and writing over 12 weeks	1. Self-report 2. VEC Teacher-report	Attend all literacy classes in programme	Teacher with help from friend	Joan Smyth Crumlin VEC Centre & Kevin O'Toole	Improvement. Can read newspaper and display competence to a level appropriate to children leaving primary school	Applying for Junior Cert in English
<i>Key Worker 3 completes and monitors</i> →	25/1/10	Address identified health risks associated with illicit drug misuse within 3 weeks.	1. Self-report and 2. Nurse confirmation	Attend 1:1 with nurse. Attend health education course.	Nurse	Denis Murphy Recovery Project	Attended 1:1 sessions. Received leaflets ✓	No health education course as yet. On waiting list • Medical Flag  Contact clinician prior to major decision

**Figure 4b: Recommended format for the Shared Care Plan (Each row is completed and monitored by an individual key worker; the case manager oversees the entire plan)**

Plans should be in place to cover both planned and unplanned departure from a programme of rehabilitation. It is the responsibility of the case manager to follow-up on unplanned departures having been informed immediately by the key worker.

Aftercare should be addressed and planned as an integral part of the care plan. Management of aftercare is a vital part of the rehabilitation process and the prevention of relapse.

### **Involuntary Discharge**

Where a service user is involuntarily discharged (including self-discharges) from a service an alternative support service, appropriate to their needs, should be arranged, where possible, to minimise the chances, or the impact, of relapse. Each service will set out in writing the rights and responsibilities of service users and service providers and what action will be taken in the event of a breach of these. These should be explained verbally when service users first engage with a service. All policies should be applied consistently. All services should have a clear appeals procedure in regard to decisions on barring/exclusion.

### **Service Transfer**

Where a service user is to be transferred to another service, a meeting should be held where all documentation on the case/transfer summary is handed over, with the service users consent and, where relevant, the new case manager is fully briefed. A re-assessment may be undertaken in order to establish the most appropriate supports to be put in place.

### **Gaps and Blocks**

Gaps and blocks 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. In the event that the issue cannot be resolved by the case manager, they should escalate the matter to the rehabilitation co-ordinator for resolution via a Gaps and Blocks Form (see appendix 2). Where, despite the efforts of the case manager and rehabilitation co-ordinator, the issue persists, the rehabilitation co-ordinator can, where appropriate, raise it at the next Drugs Task Force Treatment and Rehabilitation Sub-Group meeting, in line with The Rehabilitation Report.<sup>11</sup> As various partners will be involved in this forum, solutions can and should be sought to overcome these blocks. It is important to note that it is only the issue and/or block which should be discussed rather than the individual case. No names or identifying features should be disclosed during these discussions in order to protect confidentiality. Strict timelines must be put on this process in order to ensure that the service user does not regress in their efforts to attain an improved health status.

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 (pertaining to that issue) should be referred by the Rehabilitation Co-ordinator for that area to the National Senior Rehabilitation Co-ordinator who chairs the National Drugs Rehabilitation Implementation Committee. Issues can then be pursued as appropriate at NDRIC level. Also, collectively, these forms will highlight where there are incomplete services and/or inadequate resources to provide a comprehensive

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<sup>11</sup> The Rehabilitation Report, page 23, paragraph 3.23 states that “the implementation of protocols and SLAs would be monitored on an on-going basis through the Treatment and Rehabilitation Sub-Group of the Task Forces.”

rehabilitation service and inform future planning. 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. Again, strict timelines are required.

### **Step 5: Exit**

When a service user is meeting all objectives from an individual care plan (Figure 4a) and is due to leave a particular agency, the key worker from that agency should hold an exit meeting. When the service user is meeting all treatment and/or rehabilitation objectives from their shared care plan (Figure 4b) and there is no longer a requirement for inter-agency services, the case manager should hold an exit meeting. This is to ensure that the service user, if appropriate, continues to link in to aftercare services and is aware of support services should they relapse in the future. Arrangements for future contact with the service user post-discharge can be agreed at the exit meeting.

Where relapse occurs and the service the individual most recently attended is no longer appropriate to meet their needs, the service must be proactive and facilitate the individual to re-enter a previous stage/level appropriate care to match their needs. In both scenarios, the case manager should take the lead in making the necessary arrangements.

Re-entry into treatment will be based on a new assessment which highlights needs and determines to whom and where the individual is to be referred. An individual's needs and service provisions may be different as a consequence of this new/subsequent assessment. Options will be determined by the nature, context and extent of the relapse and the stage of progress within their original care plan.

## Section 2: Protocols and Agreements

The NDRIC is charged with developing national protocols and service level agreements (SLAs), including schedules therein where applicable, to facilitate the implementation of case management and intra-agency working (integrated care pathways) in drug and alcohol services. It is also the responsibility of the NDRIC to oversee the implementation of these from national to regional/local level.

To assist with the national implementation of this framework document, the NDRIC will propose to pilot the integrated care pathway model described in Section 1 at regional/local level with a view to informing further the protocols and agreements required to implement the model nationally and to gain practical knowledge and experience. Terms of Reference for the pilots will be developed once the framework is approved and will be in line with the integrated care pathway model outlined in Section 1. This model for inter-agency working requires all agencies to commit to a co-ordination of services, implementation of agreed quality standards and ensuring that all employees are trained to meet determined core competencies (more on the latter in Section 3).

During the pilot, local protocols will be agreed by the relevant organisations directly involved in the delivery of rehabilitation at local level. The relevant Drugs Task Force Treatment and Rehabilitation Sub-groups will be responsible for ensuring that such protocols are in place to their satisfaction, though they will not have operational responsibilities. The implementation of protocols and inter-agency working will be monitored on an on-going basis by a nominated rehabilitation co-ordinator, the agencies involved and the Treatment & Rehabilitation Sub-Groups of the Drugs Task Forces, which will normally include representatives of those agencies. These rehabilitation co-ordinators shall advise on matters arising to the National Senior Rehabilitation Co-ordinator (NDRIC Chair), who will subsequently provide quarterly progress reports to the NDRIC (as well as reports to the Oversight Forum on Drugs, as sought) detailing the progress achieved in relation to protocols and SLAs and any difficulties requiring intervention.

### 2.1 Protocols

Protocols will facilitate inter-agency co-operation and information sharing so as to enable the implementation of shared care plans. Protocols that exist at present between agencies on an informal basis will need to be developed formally, and the NDRIC will take the lead on this. Formal protocols will facilitate inter-agency working and the implementation of the integrated care pathway model set out in Section 1. In principle, protocols should cover arrangements for the continuity of care and smooth handover of service users as they move from one agency to another. Specifically they require agencies to formalise the following:

- ✓ Clarity around the referral process
- ✓ Common understanding of service user confidentiality
- ✓ Common assessment tools (where relevant)
- ✓ Understanding around settlement of disputes between organisations

The integrated care pathways and the steps towards shared care planning and case management detailed in Section 1 (supplemented with the attached appendices to this document), set out in detail the procedures which should be followed by agencies in order to achieve these protocols and to successfully implement the new model. More specifically, agencies need to commit to:

- ✓ An understanding of the tier system and a willingness to refer individuals to appropriate tiers following assessment
- ✓ Putting in place case management and key working and facilitating integrated care through shared care plans
- ✓ Identifying and reporting gaps and blocks to service delivery (see appendix 2)
- ✓ Sharing of service user information whilst being mindful of their confidentiality

## **2.2 Service Level Agreements**

The NDRIC will oversee the development of SLAs at national level, in line with the protocols outlined above. These agreements will clarify the roles of each agency and their responsibilities in regard to co-operative inter-agency working. Again this will be done both at a national and a local level. There may be scope to tie levels of funding available for organisations to the levels and quality of inter-agency working that they undertake.

The NDRIC recognises that many statutory sectors organisations already have agreed SLAs with the agencies they fund and, in such cases, rather than create new SLAs, it is recommended that schedules be appended to existing SLAs as appropriate. The SLAs or schedules thereto will commit the agencies to:

- ✓ Implement case management, including by assigning Case Managers and Key Workers
- ✓ Implementing rehabilitation model detailed in Section 1, via the protocols mentioned above – more specifically:
  - Screening – common tool usage
  - Initial Assessment – common tool usage to allow the optimum matching of a potential service user to a service (referral where necessary)
  - Comprehensive Assessment – where necessary should allow the matching of services to the person (referral where necessary)
  - Shared Care Planning – holistic, person-centred, strengths based care planning model, requiring case management
  - Service Transfer, Exit and Aftercare – procedure for continuity of care including exit meeting and follow-on care

It is intended that the pilot will assist in further refining appropriate SLA schedules.

## Section 3: Quality Standards Framework

It is a responsibility on the NDRIC, under the recommendation from the Report of the Working Group on Drugs Rehabilitation, 2007, to ensure that agreed quality standards are consistently applied to the delivery of all rehabilitation services.

Quality standards will:

- ✓ Ensure the provision of a consistently high quality level of service
- ✓ Enhance integrated care pathway/case management procedures
- ✓ Achieve a more co-ordinated response to the needs of problem drug users
- ✓ Facilitate improved monitoring/evaluation procedures with respect to the progress of users through their shared care plan.

The Implementation of quality standards is the responsibility of the service provider. This will be done by individual service providers, in line with a specific quality standards document and implementation will be broadly monitored by the Rehabilitation Co-ordinator for the area. Stemming from this implementation, the core competences required by services staff to deliver rehabilitation programmes must be determined, and any additional training needs should be identified and addressed. Again, the Rehabilitation Co-ordinators can take the lead in following up with the NDRIC on any concerns in relation to this training.

The national standards for drug and alcohol treatment services that have been agreed by the HSE are the Quality in Alcohol and Drug Services (QuADS) organisational standards.

### Clinical Governance Standards

The aim is to have well-informed service users receiving safe and effective care from skilled professionals, in appropriate environments, with assessed outcomes. Among the issues that need to be addressed with respect to clinical and organisational governance are:

- ✓ Risk Management
- ✓ Clinical Effectiveness
- ✓ Clinical Audit
- ✓ Use of Information
- ✓ Reporting Procedures
- ✓ Staffing and Staff Management
- ✓ Education, training and continuous personal and professional development; and service user involvement

### Health

The National Drugs Strategy (2009-2016) requires the development of a clinical and organisational governance framework for all treatment and rehabilitation services to ensure best practice and service user safety.

The Report of the Working Group Examining Quality and Standards in Addiction Services was adopted as national policy by the HSE in January 2009. In line with the findings of this report, the NDRIC recommends that the Quality in Alcohol and Drug Services (QuADs) organisational standards and/or an equivalent standards, for example the Healthcare Accreditation and Quality Unit (HAQU) standards, are implemented in all organisations engaged with drugs rehabilitation, as they are the most suited to the ethos prevalent in addiction services within the Irish health care setting.<sup>12</sup>

The NDRIC recommend that the implementation of quality standards is undertaken on a phased basis in addiction services provided by, or funded through, the HSE and its implementation monitored to ensure a consistent high standard of service provision across all services. Dialogue will be opened up with community and voluntary services funded through the HSE in order to determine timelines for the introduction of QuADs (or equivalent) in services which do not operate under a recognised quality standard framework.

As stated, the NDRIC accepts that QuADs is not the sole benchmarking tool that can be utilised effectively in the Irish idiom. It is acknowledged that agencies in the voluntary sector have over time engaged in the development of standards to varying degrees. It is not the intention of the NDRIC to impede or interfere with this work but rather to complement it. Similarly in the case of the community projects, it is proposed that they will operate QuADS (or equivalent) following an agreed lead-in period. Consideration will also be given in time to the introduction of a quality standard/mark for individual services e.g. clinics, residential services, education and training programmes etc.

It should be noted that the Working Group Examining Quality and Standards in Addiction Services also made recommendations around the introduction, over time, of an agreed accreditation/training process for all staff employed in the addiction services, possibly using the Drugs and Alcohol National Occupational Standards (DANOS).

## **Education & Training**

Within education, all curriculum provision to service users is quality assured under the requirements of the Qualifications (Education and Training) Act, 1999, as set out in the overarching remit of the National Qualifications Authority of Ireland. There are two awards councils – the Further Education and Training Awards Council (FETAC) and Higher Education and Training Awards Council (HETAC), established in 2001 under the Qualifications (Education and Training) Act, 1999.

The National Qualifications Authority published the *National Framework of Qualifications* in 2003. There are 10 levels along the lifelong learning spectrum from the basic level 1 to a doctoral level 10. FETAC is responsible for awards at levels 1 – 6 and HETAC for awards at levels 6 – 10.

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<sup>12</sup> This decision was reached on the basis that it is the leading quality standards tool for addiction services in use by the NHS in the United Kingdom and has been adapted for the Irish Health Service. In addition it has been endorsed by the Rehabilitation Report, 2007 and agreed by the HSE National Working Group on Drugs and Alcohol.



Awards are made to learners on a vast range of programmes and the two Councils have quality assurance responsibilities. Providers have to be quality assured before they are validated to provide programmes leading to awards within the National Framework of Qualifications.

It is intended that the National Qualifications Authority of Ireland (NQAI), HETAC and FETAC, will amalgamate into one statutory organisation in 2010.

### **Labour/Market Force**

FÁS operates to national and international quality standards. From a legislative point of view FÁS is bound by the Qualifications Act and the organisation is subject to the quality requirements of FETAC, HETAC and other national awarding bodies.

These quality requirements have implications for all programmes and services offered by FÁS. Primary among considerations is the labour market focus of FÁS activities allied to the overarching requirement that all learning is recognised and accredited.

In addition to its own programmes and services, the requirements of FETAC/HETAC are built into all contracts issues by FÁS to second providers.

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## Glossary of Terms

### **Aftercare**

Aftercare is both drug-related and non-drug-related support given to a service user as part of their care plan, and if necessary, on-going after the completion of their care plan.

### **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)
- Offending
- Social functioning (including housing, 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 drug treatment.

### **Case Management**

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

### **Case Manager**

The named person who has the formal lead role in the management of inter-agency communication and the provision of co-ordinated care for the service user in question.

### **Competences Required to Conduct Assessment**

The Drug and Alcohol National Occupational Standards (DANOS) outline the basic competences for professionals to undertake different levels of drug and alcohol assessment. Comprehensive assessment is intended to be a multidisciplinary process to ensure a holistic approach to service user need. Where a medical intervention is required, such as substitute prescribing or a psychiatric evaluation, the associated assessment must be undertaken by an appropriately trained doctor.

### **Comprehensive Assessment**

Comprehensive assessment is targeted at drug misusers with more complex needs and those who will require structured drug treatment interventions. The assessment aims to determine the exact nature of the individual's drug and alcohol problems, 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 shared/care plan for a service user.

### **Drugs Task Forces**

Drugs Task Forces are responsible for facilitating an effective, co-ordinated and integrated response to the drug problem in their geographical area. They aim to achieve this through improving co-ordination in service provision and through utilising the knowledge and experience of local communities in designing and delivering those services. The Drugs Task Forces, through their Treatment & Rehabilitation Sub-Groups, are responsible for the sign-off and implementation of local protocols for rehabilitation co-ordination in line with the National Drugs Rehabilitation Framework.

### **Family Support**

There are many interventions targeting families of drug users. All activities targeting families seek to involve relevant family members. Family support can be offered on a one-to-one basis or in a group setting. These can be structured forms of therapy concentrating on improving the relationships between family members, or can be peer led where a number of people with a common problem come together to share their experiences. The purpose of both of these is to come up with a strategy of mutual help and coping with problems related to drug use by a family member.

### **Four Tier Model**

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

### **Initial Assessment**

An Initial assessment usually takes place when a drug misuser first contacts specialist drug treatment 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 treatment for the service user. It involves a fuller assessment of the individual's drug and alcohol problems than is conducted at screening, as well as assessment of a service user's motivation to engage in treatment, current risk factors and the urgency of need to access treatment. As a result of this assessment, an individual might be offered services within the assessing agency or onward referral to another service. A further outcome of an initial assessment is that, where appropriate, work is undertaken to further engage and prepare the individual for treatment.

### **Inter-agency Working**

Inter-agency working requires all agencies involved with a service users care to commit to a co-ordination of services, implementation of agreed quality standards and ensuring that all employees are trained to meet determined core competences.

### **Integrated Care Pathways**

An integrated care pathway (ICP) describes the nature and anticipated course of treatment for a particular service user and a predetermined plan of treatment. A system of care should be dynamic and capable of responding to changes in an individual's needs over time. It should also enable access to a range of services and interventions that meet an individual's needs in a comprehensive way.

### **Inter-Agency Protocols**

Documented agreements which inform the working relationships between two or more agencies.

### **Intra-Agency Protocols**

Documented agreements which inform the working relationships between two or more departments/divisions within one agency (usually a large national agency that would have a number of departments, e.g. HSE)

**Key Worker**

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

**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 would be 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.

**Multidisciplinary Team**

The multidisciplinary team can include psychologists, counsellors, GP's, psychiatrists, nurses, pharmacists, occupational therapists, social workers, education/trainers, and other activity and support staff etc.

**National Drug Rehabilitation Implementation Committee**

The NDRIC is charged with overseeing and monitoring the implementation of the recommendation made in the Report of the Working Group on Drugs Rehabilitation (The Rehabilitation Report).

**National Senior Rehabilitation Co-ordinator**

The National Senior Rehabilitation Co-ordinator is the Chair of the National Drugs Rehabilitation Implementation Committee, which is charged with implementing the National Drugs Rehabilitation Framework. As such the National Senior Rehabilitation Co-ordinator will oversee the implementation of the rehabilitation effort and liaise with the other rehabilitation co-ordinators in regard to operations in their individual areas to ensure consistency and high quality in rehabilitation standards.

**Rehabilitation**

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

**Rehabilitation Co-ordinator**

Rehabilitation Co-ordinators have the lead role in the co-ordination of case management through the Treatment and Rehabilitation Sub Group of the relevant Drugs Task Force at local/regional level, and tracking the progression of service users as they move through the continuum of care. This will be informed through liaison with case managers/key workers as appropriate. Rehabilitation Co-ordinators have a formal role in resolving gaps and blocks in a service users care plan that cannot be resolved by the case manager. They will report to the Health Service Executive National Senior Rehabilitation Co-ordinator on the implementation of the National Drugs Rehabilitation Framework and the overall recommendations of the Report of the Working Group on Drugs Rehabilitation.

**Screening**

Screening is a brief process that aims to establish if an individual has a drug and/or alcohol problem, related or coexistent problems and whether there is any immediate risk for the service user. The screening should identify those who require referral to drug treatment services and the urgency of the referral. Screening may include an element of brief opportunistic intervention aimed at engaging or preparing the service user for treatment. Screening is likely to be carried out in generic settings.

**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.



## Appendices

## Appendix 1:

### Four Tier Model of Service Delivery (Adapted from the NTA Models of Care Update 2006)

Tier	Specialist Skills	Type of Individual accessing services	Type of intervention for addiction difficulties	Intervention delivered by	Examples of interventions at this Tier	Intensity and Duration
1	Competence to screen and identify drug misuse and refer into local specialised drug treatment systems	<b>Considering or commencing experimenting with drugs and alcohol</b>	Drug-related information and advice, screening and referral to specialised drug treatment.	<b>An individual</b>	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]).	<b>Low intensity and ongoing</b>
2	Competent drug and alcohol specialist workers who should have basic competences in line with <i>Drug and Alcohol National Occupational Standards</i>	<b>Abusing drugs or alcohol and encountering some problem with same</b>	Drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare	<b>Multiple services</b>	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.	<b>Low intensity and medium term duration</b>
3	Competent drug and alcohol specialised practitioners who should have competences in line with <i>Drug and Alcohol National Occupational Standards</i>	<b>Substantial problems due to drug or alcohol abuse or dependence</b>	Community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison	<b>A multi-disciplinary team</b>	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.	<b>High intensity and short to medium term duration</b>
4	Medical staff with specialised substance misuse competency for providing assessment, detoxification / assisted withdrawal programmes and stabilisation programmes and interventions for specific groups  Staff in residential rehabilitation units that are registered and meet the standards of occupational practice, and that the unit complies with standards out lined by external Inspections	<b>Drug or alcohol dependence with severe and complex problems</b>	Residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare	<b>A multi-disciplinary team</b>	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. "Step-down" or halfway house accommodation may be required to be made available away from the individual's area of residence and drug-using networks.	<b>Very high intensity and short duration (but can vary to longer duration i.e. 6 months to 1 year)</b>

## **Appendix 2:**

### **SAMPLE**

#### ***GAPS AND 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. As line manager I feel that this issue warrants attention through the gaps and blocks protocols.

## **Appendix 3:**

### **SAMPLE**

#### ***Service User Information on Case Management***

##### **What is case management?**

Case management is about trying out ways of better service provision for people using drug and/or alcohol services. The aim is to support people to achieve their goals by having better communication and co-ordination between services.

Basically if you have some issues you need to work on, or want to make some changes, you may want a case manager. A case manager's job is to co-ordinate all of the services you are involved with and make sure you are receiving the best service possible. To do this they will need your permission to discuss your needs with the services you are involved with.

##### **What does it mean for you?**

- You and your case manager will do an assessment; this could take a few sessions, and will ask about your needs in different aspects of your life. The aim of the assessment is to find out exactly what supports you need and how these can be met.
- You and your case manager will look at what you want to happen and what your needs and goals are. Together you will make a care plan that sets out the steps to achieving your goals and the services that need to assist you in this. Your goals may be immediate such as stabilising drug use, or long term i.e. training in job skills.
- Your case manager will work with you to ensure that all the services you need are supportive of the care plan (your goals).
- The case manager will meet with you regularly to support you and every few months you will meet to review the plan to make sure there are no problems.

##### **What about confidentiality?**

As part of the process you will be asked to give permission for your information to be shared with other agencies involved in your plan. You have full control of your information and can state that certain pieces of information can not be shared with certain agencies. The case manager will check with you before they contact other services on your behalf. If you decide not to be involved at any point then that's fine, just let your worker know.

##### **Do you have to participate?**

Absolutely not, if you are not interested then no problem, you do not have to be involved. If you decide not to be involved you will receive the same level of service you have always received.

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