

National Protocols & Common Assessment Guidelines

to Accompany the National Drugs Rehabilitation Framework

National Drugs Rehabilitation Implementation Committee

November 2011 Update

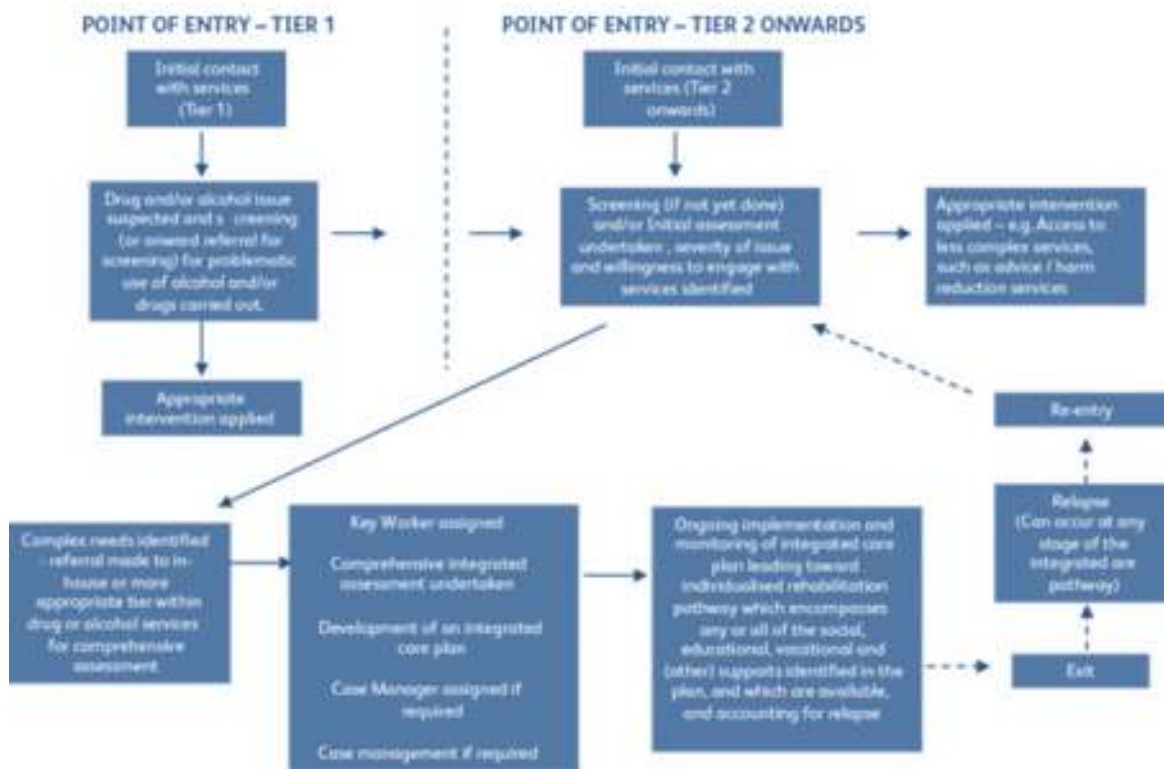


Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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.

Integrated Care Pathway



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, *Guiding Framework for Education and Training in Screening and Brief Intervention for Problem Alcohol Use in the Emergency Department & Acute Care Settings for Nurses and Midwives*. 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.

The HSE National Addiction Training Programme is currently planning a Guideline Framework for staff in all other health and social care settings in the delivery of screening and brief intervention on types all substance misuse.

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.

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 3).
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.

* The role of the proposed rehabilitation co-ordinators 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.higa.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 minimum requirements; any other items/domains can be added subject to the requirements of the initial assessing programme.

(Starts on next page)

General Information

- **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 0*

- **Number of days alcohol was consumed over the past month.....** *If none, put 0*

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

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

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

- **Number of times started treatment in this programme this year (Jan to Dec)**

- **Ever previously treated for problem drug 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 <i>Please rate order of preference / regularity in the brackets e.g. 1, 2, 3 ect..</i>	Age at first use	How often 1. <i>daily or almost daily</i> 2. <i>several times a week</i> 3. <i>at least once a week</i> 4. <i>less than once a week</i> 5. <i>not known</i>	Amount used	Route of transmission. 1. <i>inject</i> 2. <i>smoke</i> 3. <i>eat/drink</i> 4. <i>sniff/snort</i> 5. <i>sublingual</i> 6. <i>rectal</i> 7. <i>topical</i>	Harm reduction awareness (Y/N) <i>Discuss harm reduction issues, (see guidebook for info)</i>
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 last 30 days injected in the last year, but not in the last 30 days ever injected, but not in the last 12 months
- **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 last 30 days
shared needle or syringe in last 12 months but more than 30 days ago
shared needle or syringe more than 12 months 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

<p>Date of Assessment</p> <p>Core Demographic and Client Details</p> <ul style="list-style-type: none"> Name, Address, Contact number, DOB, Identification No., Ethnicity, Gender <p>Name, Address, Contact Number of GP</p> <ul style="list-style-type: none"> Medical Card/ Other <p>Name, Address, Contact Number of next of Kin</p> <p>Name, Address, Contact Number of referrer / referring agency</p> <p>Name, Address, Contact numbers of other agencies attending</p>
<p>Reasons for referral</p> <p>Presenting problems/ Complaints/</p> <ul style="list-style-type: none"> History of presenting problems/Complaints
<p>Current Drug and Alcohol use</p> <ul style="list-style-type: none"> 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
<p>Current Physical Health and symptoms/ Ill health/ disabilities</p>
<p>Current Mental Health / Psychological symptoms</p>
<p>Current assessment of risk behaviours</p>
<p>Current Medications Prescribed</p>
<p>Past History of Drug and Alcohol use:</p> <ul style="list-style-type: none"> Age of 1st use, Progression of use Age of 1st injecting History of Overdoses
<p>Past treatments for Drug and Alcohol Use</p> <ul style="list-style-type: none"> Places of Treatment/ Type of Treatment

<p>Past Medical History</p> <ul style="list-style-type: none"> • Past viral testing and results • Vaccination History • Past Operations/illnesses/diseases
<p>Past Psychiatric History /Past Mental Health Issues</p> <ul style="list-style-type: none"> • Diagnosis, Treatment, Consultant and Service attended • Any episodes of Deliberate Self Harm
<p>Family History/ Family Structure/ Supports</p> <ul style="list-style-type: none"> • Any Family History of Addiction or mental health problems
<p>Personal History:</p> <ul style="list-style-type: none"> • School, Education, Problems in school • Highest educational level achieved • Courses / training schemes • Employment history / Current employment status
<p>Social History / Social Functioning.</p> <ul style="list-style-type: none"> • 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
<p>Criminal History /Legal Issues</p> <ul style="list-style-type: none"> • Past charges, conviction, prison sentences • Current charges, court cases, convictions • Probation Officer/ Solicitor
<p>Assessment of Motivation and Readiness to change</p>
<p>Assessment of Goals:</p> <ul style="list-style-type: none"> • Service user's goals and their own assessment of need.
<p>Formulation/ Diagnosis/ Assessment of Needs</p>

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 – 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.