

**INTEGRATED CARE FOR DRUG OR  
ALCOHOL USERS:**

**PRINCIPLES AND PRACTICE UPDATE  
2008**

**Report Produced for the SACDM  
Integrated Care Project Group**

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# **Chapter 1: Integrated Care for Drug or Alcohol Users: Principles and Practice Update 2008**

## **Introduction**

In October 2002 the Effective Interventions Unit (EIU) published, *Integrated Care for Drug Users: Principles and Practice* which set out the definitions and concepts of integrated care for drug misusers. It also set out the key principles underpinning an integrated care approach and provided detailed evidence of effective practice under each of the six key elements of the integrated care process.

Since then a number of developments have taken place within the substance misuse field and health and social care organisations have been re-structured to accommodate better joint working: for example, the development of Community Health (and Social Care) Partnerships in each NHS Board area and Community Justice Authorities.

The specific guidance produced by Scottish Intercollegiate Guidelines Network (SIGN) on the *Management of harmful drinking and alcohol dependence in primary care* (SIGN 74, 2003) and the *Health Technology Assessment (HTA) Report 3: Prevention of Relapse in Alcohol Dependency* (Slattery et al, 2003) suggest that a range of interventions should be employed, not only in specialist alcohol services, but also in primary care, lay services (local councils on alcohol, AA) and in other settings, such as A&E Departments, hospital wards, criminal justice and community care services.

It is important to note that although some of the interventions provided in the treatment of drug misuse differ from those in alcohol misuse the concept of integrated care and the key elements of effective practice contained in this document are common to both.

In addition, substance misuse services (drug and alcohol) and mental health services, in many areas of the country, have been better aligned to allow for the development of closer working relationships.

The introduction of the Single Shared Assessment (SSA) process has created an opportunity for dialogue between care and treatment providers in each area on issues such as levels of assessment, core data sets and information sharing.

## **Purpose of this Document**

From the feedback received from Alcohol and Drug Action Teams (ADATs), service provider organisations and individual service managers and practitioners it is clear that since the publication of *Integrated Care for Drug Users: Principles and Practice*, integrated care has developed at different rates across the substance misuse field in Scotland.

This document has been produced as part of the work of the Scottish Advisory Committee on Drug Misuse (SACDM) Working Group on Integrated Care in order to provide further guidance and information on what integrated care should look like and what it should deliver for service users. It should be read in conjunction with the guidance on *Essential Care: a report on the approach required to maximise opportunity for recovery from problem substance misuse in Scotland* (Scottish Government 2008) in order to identify the way in

which a wide range of health, social care and wider community support structures should work together to meet the identified needs of an individual person who is experiencing problems with alcohol or drugs.

This update builds on the guidance provided in the original document by summarising the evidence, identifying key principles of good practice and setting this in a modern context, taking account of the way in which services are now aligned and delivered.

It draws on the experiences of health and social care organisations in developing partnership working and, wherever possible, draws on examples of good practice from the drug and alcohol field.

It provides further evidence and examples of effective practice in providing integrated care and sets out action points for service commissioners, service managers and practitioners to consider in the planning and delivery of services.

The document should be read alongside the *National Quality Standards for Substance Misuse Services* published in 2006 by the Scottish Executive. The standards have a number of key aims.

- To improve the consistency and quality of substance misuse service provision in Scotland.
- To form the foundation of a framework that is intended to enable service providers to examine and continuously improve their service delivery.
- To increase accountability of service providers and commissioners to the general public and specifically service users and their families.
- To assist service commissioners to make informed funding and contract decisions.

All eleven standards apply to all services involved in supporting people affected by substance misuse – they do not apply solely to ‘treatment services’. The difference occurs in the “evidence” that service providers, commissioners and partnerships use to demonstrate how they are meeting the standards. Thus, examples of written personal plans may well vary in their detail and comprehensiveness depending on the intensity of support available from that service. However, the same principle applies, in that if you use a service, whether as a ‘client’, ‘patient’ or ‘service user’, you should be involved in your care, know what the service is offering to support you and know what part you play in ensuring such support is effective.

Service providers should not operate in isolation of each other. Many individuals and families affected by substance misuse will require the support of more than one service. Sometimes they will require the support of more than one service at the same time. It is therefore critical that the planning, delivery, and evaluation of service provision is both integrated and co-ordinated. It is unlikely that this co-ordination role will be the responsibility of any one service provider, hence the wording of Standard Statements 9, 10 and 11.

When using this manual you may find it helpful to refer to documents written to support the implementation of the *National Quality Standards*.

- Baseline exercise report
- Regional Roadshows report
- User involvement
- Guidance Manual ( to be published)

The full document can be downloaded at

<http://www.scotland.gov.uk/Resource/Doc/149486/0039796.pdf>

### **Structure of the Document**

The subsequent chapters follow the structure of *Integrated Care* (2002) focusing on the key elements of integrated care: accessibility, assessment, planning and delivery of care and information sharing.

Each chapter highlights recent changes in relevant policy, guidance and practice; identifies the key principles against which service delivery should be measured; and draws out the actions required locally to ensure that these issues are being addressed.

These action points are generalised in order to ensure that they are applicable to all areas. Each ADAT and service provider should apply these to their area of responsibility and identify their own areas of strength and weakness. This process should allow the development of a local action plan aimed at addressing identified weaknesses or gaps with clear, locally relevant performance measures.

## Chapter 2: What is Integrated Care?

Integrated care is an approach that aims to **combine** and **co-ordinate** all the services required to meet the assessed needs of the individual.

It requires:

- treatment, care and support to be person-centred, inclusive and holistic to address the wide ranging needs of drug and alcohol users;
- the service response to be needs-led and not limited by organisational or administrative practices; and
- collaborative working between agencies and service providers at each stage in the progress of the individual in treatment, from initial assessment onwards.

### The Rationale: Why is Integrated Care Important?

People who have drug or alcohol misuse problems will, in many cases, have a range of other difficulties in their lives including problems with housing, family relationships, employment, offending behaviour and debt. This means that a wide range of interventions and a range of organisations will need to be involved to assist any individual with substance misuse problems.

Service users (and indeed providers) often feel that there is no communication between the various agencies leading to frustration and disappointment. Service providers may not deliver an effective service because they do not have access to all the relevant information about an individual nor an awareness of the roles of other agencies who could potentially be involved in their care.

Service users also commonly feel that support is weighted towards the beginning of the recovery process, jeopardising this process in the long-term. The EIU *Moving On* report highlighted that clients who have moved on to employment needed on-going support to cope with the transition in their lives.

An integrated care approach founded on co-operation and collaboration between all relevant providers will have a number of benefits for individual service users. It should:

- Promote early assessment and intervention: ensuring that services are accessible and appropriate to the service user's needs.
- Remove barriers to progressing towards recovery: supporting the service user to identify and achieve their own goals whilst acknowledging their own beliefs and culture.
- Provide consistent, co-ordinated and comprehensive care: ensuring that all care providers are working towards a shared aim and minimising unnecessary duplication of activity.



- Ensure a comprehensive and timely response: making sure that all the needs of the service user, physical, psychological and social, are considered and addressed appropriately.

## Goals of Integrated Care

There are a number of different treatment philosophies and approaches in the substance misuse field, reflecting the different needs and priorities of both service users and providers. These approaches have their own intended outcomes. However, it is important to set out the **overarching aim of integrated care** while accounting for these different philosophies.

The **overarching aim** of integrated care is to support drug or alcohol users to overcome their drug or alcohol problem and their associated health and social difficulties by providing effective, co-ordinated and timely treatment and care.

## Which Service Providers are Involved?

Throughout an individual's recovery they may require **different interventions which will usually involve contact with a number of different service providers**. The different interventions and the different service providers should be regarded as being of equal importance within the context of developing a person-centred approach to care. The order with which a person accesses services and interventions should be based on the prioritisation that occurs after the initial comprehensive assessment. This assessment process and resulting prioritisation is ongoing and therefore subject to review and change.

## Which Partner Agencies Need to Work Together?

Planning and delivering an integrated care service for drug or alcohol users will involve ADATs and all associated agencies and organisations potentially involved in the care of drug or alcohol users. It will require communication, co-ordination and co-operation. This involves recognising the role of each agency and developing effective partnership working. No single agency can effectively meet the diverse needs of people affected by substance misuse.

Partnership working is not new. Many organisations have been working in partnership for many years. However, time, careful thought and on-going effort are required to build and maintain effective partnerships. In many ways, ineffective partnerships are easier to characterise. They are often partnerships in which one agency dominates decision making and planning; there is often minimal community and user involvement; aims and objectives are not clarified; and there is little accountability or trust. It is harder to characterise a successful partnership. However, the literature on good partnership working suggests that the **ingredients** of a successful partnership include having:

- clear identity and role for the partnership
- clear identity and role for each partner agency in the planning, design and delivery of services
- shared short and long term aims and objectives

- sufficient time and resource dedicated to partnership building
- adequate training for all members, including community and user representatives
- a supportive atmosphere where discussion and new ideas are welcome
- clear and supportive leadership
- an atmosphere where organisational and cultural barriers can be explored

The National Treatment Agency for Substance Misuse (NTA) *Briefing on Working in Partnership* (2005) looks at the terms used to describe partnership working in the drugs field and the various types of partnership initiatives. It also outlines the benefits of partnership working, factors that influence the success of partnership working and policy development issues.

The NTA guidance identifies a number of common barriers to partnership working:

- Culture clashes, ideological differences and rivalry between organisations
- Difficulty maintaining continuity of care when there are multiple agencies involved
- Difficulties in establishing accountability arrangements when multiple organisations are involved
- Tensions between a health perspective and a criminal justice perspective

The full briefing, including useful web links and references can be downloaded at [http://www.nta.nhs.uk/publications/documents/nta\\_working\\_in\\_partnership\\_2005\\_ddsp8.pdf](http://www.nta.nhs.uk/publications/documents/nta_working_in_partnership_2005_ddsp8.pdf)

To achieve integrated care, partnerships will need to be established at **both strategic and operational level**. The ADAT will have the lead responsibility for co-ordinating the planning and delivery of services in an area. The development of joint resourcing and joint management in local areas through Joint Future provides both an impetus and supporting structures.

At **strategic level**, the ADAT and partners should agree:

- the aims and objectives of an integrated service
- the range of services that could or should be engaged
- the way in which the views and experiences of service users and carers can be represented and addressed when planning, commissioning and reviewing services
- the commissioning and management arrangements, including joint resourcing
- the arrangements for sharing information
- the arrangements for multi-agency training to promote mutual understanding of roles

- monitoring and evaluation arrangements

At **operational level**, service providers should agree:

- common or core assessment procedures and datasets
- arrangements for ensuring that service users and carers are fully engaged as partners in the planning, delivery and review of an individual's care
- systems and protocols for sharing information
- systems and protocols for referral and joint working

Good practice guidance on involving service users in the planning and review of service provision can be viewed at

<http://www.scotland.gov.uk/Resource/Doc/202522/0054004.pdf>

Achieving integrated care will depend upon having effective mechanisms to communicate and exchange ideas between strategic and operational levels. Strategy needs to be developed through dialogue among those who understand how services are currently delivered, and what could undermine any process of change. Success will depend upon service providers having a sense of ownership and understanding of both the principles that underpin integrated care and the changes in practice required to deliver them.

An example of integrated working at strategic and operational levels is the development of Community Justice Authorities (CJAs).

‘Community Justice Authorities will be responsible for distributing funding for criminal justice social work and monitoring and reporting on the effectiveness of joint working between local agencies to tackle re-offending.’

The *Criminal Justice Plan*, published in December 2004, set out proposals for reducing re-offending by improving the management of offenders and ensuring that all organisations that provide offenders' services – local authorities and the Scottish Prison Service (SPS) – work more closely and effectively together.

Once established, CJAs will receive the community component of criminal justice funding and be responsible for ensuring this is used effectively across their area to tackle re-offending and improve offender management. They will also be required to work in partnership with a range of partners including police forces within the CJA, NHS Boards, voluntary organisations in receipt of funding from local authorities or SPS for their work with offenders and/or their families, Scottish Court Service, Crown Office and Procurator Fiscal Service and Victim Support Scotland.’

In December 2007 the Scottish Government published *Better Health, Better Care Action Plan* which makes reference to current cross-cutting working; the new national drugs

strategy to support a framework to deliver drug treatment services; continuity of care during the transition between community and prisons and community; SSA and electronic sharing of information.

The full document can be viewed at

<http://www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf>

## Action Points: What is Integrated Care?

The tables below sets out a number of questions that service planners and commissioners should consider in order to ensure that the principles of integrated care are being met.

<b>Ingredients of a successful partnership</b>
To what extent does the partnership have a clear identity and role?
To what extent is there clarity about the role of each partner agency in the planning, design and delivery of services?
Is there written documentation outlining the shared short- and long-term aims and objectives of the integrated services?
Has there been any consultation with service providers to ascertain whether there has been sufficient time and resource dedicated to partnership building?
How could service planners establish whether all members, including community and user representatives, had received adequate training?
What measures have been taken to provide a supportive atmosphere where discussion and new ideas are welcome?
Have the views of partnership agencies been canvassed regarding their views on the extent to which clear and supportive leadership has been provided?
What measures have been taken to provide an atmosphere where organisational and cultural barriers can be explored?
<b>Strategic Level</b>
What was the process of consultation and agreement in deciding the aims and objectives of an integrated service?
How was the range of services (agencies or organisations) identified?
Have the ADAT and its partners reached agreement on commissioning and management arrangements, including joint resourcing?
Have the arrangements for sharing information been documented and circulated to all agencies?
What are the arrangements for multi-agency training to promote mutual understanding of roles?
Have monitoring and evaluation arrangements been agreed and put in place?
<b>Operational Level</b>
Has agreement been reached locally on the development of common or core assessment procedures and datasets?
Have systems and protocols for sharing information been agreed by all participating agencies?
Are there systems and protocols in place for referral and joint working?

## **Chapter 3: Accessibility**

This Chapter examines and discusses the various factors that influence accessibility to drug or alcohol treatment, care and support services, both in Scotland and elsewhere. These factors will affect (and even determine) the extent to which integrated care can be delivered in any area.

### **What is Accessibility?**

A service is accessible when it is available to all potential users at a time and place suitable to meet their assessed needs and delivered in a user-friendly way. To make services accessible, it is essential to remove the barriers (real or perceived) that individuals experience. These barriers can lead to a lack of engagement and non-attendance. Key issues to be addressed include:

- equity of access for all potential users
- the location and opening hours of services
- the length of time to wait to be seen by a service or to get into treatment
- ensuring an initial (and subsequent) positive experience, as perceived by the user

Above all, a service is accessible when it is designed to meet the needs and aspirations of the individual. In other words, the organisational arrangements should be flexible enough to offer a service that is as person-centred as possible.

### **The Rationale: Why is Accessibility Important?**

Guaranteeing the accessibility of services to users will help ensure that individual users:

- reduce harm to themselves and others
- reduce their drug or alcohol use
- address other health and social problems
- have an opportunity to rebuild their lives

There is a growing evidence base regarding the range and combination of interventions that can work with drug or alcohol users. Research shows that a range of treatment interventions (with a range of philosophies) may work; however, the outcome depends on the individual getting the right treatment at the right time. Ensuring access to a range of interventions and matching interventions to client needs can help promote the effectiveness of treatment. This relies upon systematic and effective assessment procedures.

As outlined in Chapter 2, it is widely recognised that people who have a drug or alcohol problem will have a range of other needs. These must be resolved before the individual can make a full recovery. Interventions which help people to deal with wider problems in their

lives and to move on after stabilisation or recovery also show promise and should also be accessible to all users. This highlights the importance of an integrated approach to the treatment, care and support of users.

The assessment process may identify a need for better and more stable housing; help with addressing difficult family relationships; help with addressing debt problems; and a need to improve employment prospects. Conversely, a referral may be made to a drug or alcohol service because there has been a problem in another area of the individual's life, for example, because a tenancy is under threat and a drug or alcohol problem has been identified.

Overall, the available evidence suggests that (ideally) a broad range of user-friendly interventions that tackle the plethora of health and social needs of drug or alcohol users should be accessible to those who need them at appropriate junctures. This includes being sensitive to the needs of individuals based on their socio-demographic characteristics. However, service users in Scotland and across the UK appear to have difficulties accessing co-ordinated drug or alcohol treatment for a number of reasons including the unbalanced availability of health and social care services and interventions, poor assessment procedures and lengthy waiting lists.

### **Factors that Affect Accessibility**

*Integrated Care* identified a number of service and individual client characteristics that potentially impact on accessibility. These include the needs of specific groups of drug or alcohol users whose circumstances require additional consideration to make services accessible to them:

<b>Service Characteristics</b>	<b>Individual Characteristics</b>
Range of available treatment and care services	Gender
Client awareness and perception of services	Ethnicity
Location of services/distance to travel	Rural and remote residents
Opening times of services	Homelessness
Waiting times	Non-opiate users
Staff attitudes	Parenting status
Assessment procedures	Engagement with other services
Referral arrangements	

### **Recent Updates**

Since the 2002 document there have been a number of publications in a variety of health and social care fields which highlight some of these accessibility issues. The key messages from these publications are outlined in this chapter.

### ***Homelessness and Alcohol Problems***

The *Health Technology Assessment Report 3: Prevention of Relapse in Alcohol Dependence* highlighted the extent of alcohol addiction among the more than 5000 homeless people in Scotland stating that 50% of 'rough sleepers' are alcohol dependent. One of the major problems identified in dealing with this group was their limited access to services and lack of

facilities specifically targeting homeless people. Therefore, there is a need to address this problem and ensure that this marginalised group is offered adequate services.

The HTA report states that, '*in Greater Glasgow, a multi-disciplinary Homelessness Addiction Team with representation from Greater Glasgow Primary Care Trust (PCT), social work and housing (Glasgow Problem Drug Service and the Alcohol and Drug Directorate) has been formed. Particular problems that they have identified in dealing with homeless people include:*

- *a proportion of people who do not wish any help*
- *limited access to services and a lack of facilities specifically for the homeless*
- *ensuring referrals are appropriate*
- *considerable co-morbidity'*

### ***Changing Habits: Multiple Referral Routes, Unco-ordinated Assessment***

*Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults* (Audit Commission, 2002) highlighted that clients make contact and enter treatment through many different routes and several different professionals are involved in making onward referrals to specialist treatment services. People may go to street agencies, community drug services and social services departments or their GP and, in turn, these agencies may either provide or arrange direct treatment interventions or make an onward referral to another service. This system is referred to as the 'multiple entry system' and it is argued that it enables rapid access to services and increased choice regarding the kind of agency approached. However, in order for this system to operate effectively, systematic screening and assessment systems must be used to ensure clients are put in contact with the most suitable provider regardless of their route of entry.

In practice, current means of assessments do not always ensure rapid access or appropriate treatment. One of the main problems is that multiple assessments are often carried out as many areas do not have a common screening and assessment framework or arrangements for sharing information between providers. The other problem is that assessments are often carried out by a single member of staff and are narrowly focused on the client's suitability for one specific intervention. Consequently, options may be limited according to the personal preference or treatment philosophy of the assessor and/or the eligibility criteria for a particular type of service. It is also argued that the current system fails to minimise risk to both individuals and the wider community as those with high level needs often do not receive the more intensive support they require.

In order to avoid inappropriate referrals and ensure that people's needs are dealt with effectively, systems must ensure that there is no disparity between clients' needs and the service provided. Services need validated tools that are able to diagnose the degree and severity of drug dependence, and eligibility criteria that clearly stipulate the type of person they are most likely to help.

In 2004, the Audit Commission published an update report titled *Drug Misuse 2004: Reducing the Local Impact*. The report looks beyond community treatment to determine how



well the national drug strategy is being delivered locally. To improve local performance, some recommendations are aimed at government and national agencies in England and Wales. It provides a number of useful updates and recommendations that are applicable to Scotland. This document can be downloaded at

<http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=BCD29C60-2C98-11d9-A85E-0010B5E78136&SectionID=sect2#>

### ***Young People – A Guide to Assessment***

The *Guide to Assessment* report (EIU, 2004) on young people with, or at risk of developing, problematic substance misuse highlights the need to consider young people as those up to the age of 25 due to the fact that young people mature at different rates. This is important in order not to isolate any particular group and ensure that those providing support are able to engage and relate to the person in question. This document also draws attention to the risk of labelling young people as ‘substance misusers’ when they should be treated as young people above all else. In addition, the authors also stress the need to ensure that young people are at the centre of the assessment process, making them feel fully involved at every stage. They also highlight the importance of not simply focusing on young people’s substance misuse alone but on this problem within the wider context of their lives.

This document also highlights the importance of the employee’s approach when dealing with young people. The authors suggest certain factors that will help to ensure that workers are able to effectively engage with young people and conduct a meaningful assessment. These include:

- An open, welcome and ‘young person friendly’ manner
- Language that young people can easily understand
- An approach that is neither condescending nor patronising
- An upfront and honest style
- An ability to express empathy with the young person’s viewpoint/situation
- An approach that enables young people to identify where they see themselves

The *Step it Up: Charting Young People’s Progress* report (Scottish Executive, 2003) provides further information about the youth work approach to engaging with young people. It is available via the following link:

<http://www.youthlink.co.uk/docs/Training%20docs/stepitupreport.pdf>

It also suggests that projects, which are set up as part of the culture of the community, provide a unique opportunity to engage successfully with young people and be influential within community life.

## ***Needs Assessment: A Practical Guide to Assessing Local Needs for Services for Drug Users***

The EIU's *Needs Assessment Guide* (EIU, 2004) highlights the importance of conducting local needs assessments in order to determine the extent and nature of the drug problem in an area, the socio-demographic profile of users and the most common referral routes. This guide describes needs assessment as a strategic process, the benefits of which include greater capacity within services, better access to services for users and improvements in the quality and range of service provision. In addition, it highlights that needs assessment is an integral part of other strategic initiatives, such as reducing waiting times, which also improve accessibility.

### ***Rural and Remote Areas***

The *Rural and Remote Area: Effective approaches to delivering integrated care for drug users report* (EIU, 2004) highlighted the belief that drug misuse in rural areas in Scotland is on the increase and, therefore, more needs to be done to ensure that people living in these areas have access to care and support services. It identified the use of the internet and other information technology as a means of improving accessibility for service users and communication between service providers. However, it stresses the importance of combining electronic communication with face-to-face contact instead of simply replacing direct contact.

### ***National Treatment Agency for Substance Misuse***

The NTA published a research briefing on *Engaging and retaining clients in drug treatment* in May 2004. This suggests that practitioners and services have a wide range of responses available to minimise poor engagement and retention. The research suggests that low retention figures should appropriately lead to a review of the attitudes and characteristics of the service among other factors. The simple assumption that such problems are only due to poorly motivated drug users is difficult to sustain.

[http://www.nta.nhs.uk/publications/documents/nta\\_engaging\\_and\\_retaining\\_clients\\_2004\\_rip5.pdf](http://www.nta.nhs.uk/publications/documents/nta_engaging_and_retaining_clients_2004_rip5.pdf)

## **Key Principles and Elements of Effective Practice: Accessibility**

*Integrated Care* identified the following key principles and elements of practice to help improve accessibility to integrated drug or alcohol services. These are rarely one-off exercises, but rather they are cyclical or become an integral part of service development and review.

### **1. Establish the need for services in the area**

This is usually achieved by conducting a local needs assessment. The key principles and elements of needs assessment are set out in a separate EIU publication *Needs Assessment: A practical guide to assessing local needs for services for drug users* (2004). This can be downloaded at <http://www.scotland.gov.uk/Resource/Doc/26487/0013530.pdf>

Conducting a local needs assessment will help establish the extent and nature of the drug or alcohol problem in the area; describe the socio-demographic profile of users; and examine common referral routes. This will help build a picture of area population need.

The Audit Commission report *Drug Misuse 2004: Reducing the Local Impact* (2004) suggests that ‘agencies need the combined evidence to plan and build the capacity to respond effectively. The extent to which partnerships have gathered sufficient information varies. Some are collaborating with neighbours to derive the benefit of access to a larger information ‘pool’.’ In Scotland, this may be especially relevant in situations where ADATs are not co-terminus with other planning bodies such as Health Boards or police services. In these situations linking up with neighbouring ADATs may provide a more accurate information pool across the area.

The results of the needs assessment should be written up and distributed to all key stakeholders.

## **2. Review the appropriateness, accessibility and capacity of the existing range of services**

This involves taking a systematic look at the current service profile including both specialist and generic services, and statutory and voluntary agencies. To conduct this review ADATs will need to complete a number of activities including a mapping exercise of current provision (in particular the characteristics and capacity of services) and identifying the relative roles and relationships between service providers.

## **3. Establish whether the existing range of services meets the need identified in the assessment exercise**

It is important to examine whether the capacity of both specialist and generic services is sufficient. Furthermore, it is important to assess whether the interventions and services delivered do indeed meet the needs of the local drug or alcohol using population, and that they are accessible. This is sometimes called a 'gap' analysis.

## **4. Ensure that the range and capacity of services and joint working is adequate**

If gaps in service provision are highlighted, ADATs need to consider how these gaps can be best addressed. This may be achieved by developing more effective multi-agency working, making adjustments to service characteristics and developing new approaches (such as outreach) to meet the needs of the local drug or alcohol using population, including harder to reach groups.

## **5. Establish clear arrangements for joint working between agencies to facilitate an integrated approach to providing health and social care services**

This includes working with other specialist services and generic services, such as mental health, housing services, employment services and youth services. In rural areas, partnerships with generic services may be particularly important. This will be aided by:

- Developing shared screening and assessment tools and procedures across partner agencies.

- Developing referral protocols and procedures for use by all staff.
- Developing joint training for workers across partnership agencies, both at strategic and operational level.
- Using other training approaches, such as work-shadowing and mini-presentations about the services offered.

## **6. Develop more effective assessment processes**

Existing knowledge about the client should be used to avoid duplication of effort by agencies and service providers and frustration for the client. Key tasks are:

- Development of single, core assessment information to be shared by relevant agencies to reduce the number of reassessments.
- Use of a consent statement that allows agencies to share information about the client across their partner agencies.
- Investment in multi-agency training and awareness of the roles of different agencies and their assessment processes.

## **7. Produce clear and concise information about services and make it widely available**

It is important for clients to know about the range of services in their area and how to access them. It is equally important that other service providers also know about the range of services available in order to ensure appropriate referrals.

- Draw together information about services in your area for potential service users, families of drug or alcohol users and other service providers.
- Identify the most appropriate techniques for making information available to both clients and service providers. The material should be designed and adapted for each of its target audiences and clearly state:
  - who the service is most suitable for (and who it is not suitable for)
  - what the service offers (and what it does not offer)
  - what clients can expect on arrival at the service
  - whether clients can bring someone with them
- Service users and service providers should be consulted on the design and content.

## **8. Provide a variety of access points and times**

It should be possible for service providers to take into account the previous progress of clients who have dropped out or relapsed and for clients to enter or re-enter treatment at an

appropriate stage. Going back to the beginning of a care process can be demoralising and counter-productive for both staff and clients.

- Arrangements should be in place to ensure that individuals do not go back to the beginning of the care process.
- Assessment should build on existing information held on the client, rather than start from the beginning again.
- More flexible discharge arrangements should be developed.

## **9. Employ staff with appropriate skills, attitudes, training and qualifications**

It is clear that, in most cases, staff need to have well-developed skills and competencies in their own areas of knowledge and expertise, but also knowledge of the range of provision available and how it can be accessed. Therefore, staff members:

- Should be encouraged to build on existing training and qualifications (e.g. through Scottish Training on Drugs and Alcohol (STRADA) training modules).
- Need to be trained in the assessment processes, referral mechanisms and joint working arrangements that characterise integrated care.

## **10. Clear information sharing protocols**

Clear information sharing protocols should be developed and explained to clients approaching service providers for help. This may be especially important for particular groups, such as female drug or alcohol users with children who may have concerns regarding child protection issues.

## **11. Involve family members**

It is good practice to involve family members and close friends in the care of the user. The research evidence points to the benefits of including significant others in treatment and care. Family members can also be pivotal in securing access to service for drug or alcohol users.

- As part of the assessment process, it is important to assess the level of potential support the individual is likely to receive from family members.
- It is also important to assess the extent to which family members should be involved in delivering treatment, care and support to the individual.
- It is important to be clear about where family members can get help and advice if they require it. There are a growing number of family support groups developing across Scotland.

## **12. Address negative community attitudes**

ADATs and partner agencies should find ways to engage with communities and improve understanding of the nature of drug or alcohol problems and their impact. This may ease the

stigma associated with drug or alcohol use, particularly in rural areas and help the development of services in the area. For further information see the EIU *Guide to Community Engagement* at

<http://www.drug.or.alcoholmisuse.isdscotland.org/goodpractice/EIU-commeng.pdf>.

- ADATs should develop a community engagement strategy for their area. This involves being clear about the definition of 'community', the level of engagement they are aiming for and the techniques they may use to achieve this.
- The strategy should include plans to support user groups and family support groups in the area to help empower these individuals and help reduce community stigma.
- As with all strategies, this should be revisited and reviewed periodically.

### **13. Regularly undertake needs assessments and review the integrated care process and its effect on accessibility**

Needs assessment needs to be a cyclical process linked to action planning and review. Regular reviews of these arrangements and procedures will help to identify if improvements can be made and to build on success. This will include:

- Revisiting and updating the needs assessment exercise described earlier in this section.
- Revisiting the analysis of current need compared to the profile and capacity of service provision.
- Reviewing the effectiveness of joint working arrangements, assessment processes and referral procedures.
- Exploring the attitudes of staff regarding appropriateness of involvement and perceptions of role suitability.
- Reviewing the skill set of staff working in agencies, including identification of training needs.

## Good Practice in Care Planning

An example of good practice cited in the *Good Practice in Care Planning* (National Treatment Agency for Substance Misuse, 2007) is that of Kensington and Chelsea, an inner London borough, which offers a broad range of drug treatment services with close collaboration between them. The services offered are as follows:

- Two large NHS community drug treatment services:

A community assessment service that operates on a relatively short six- to eight-week intervention period with a multi-disciplinary team that provides daily drop-in treatment.

A drug treatment centre that offers medium- to long-term methadone maintenance, detoxification, long-term methadone and buprenorphine maintenance and injectable prescribing.

- A social services substance misuse care management team that performs community care assessments and purchases care packages based on individual need.
- A shared care scheme in which clients are managed by the GP but supported by the keyworker and substance misuse nurses based at the assessment service.
- Several voluntary sector agencies, including a service that specialises in working with crack users, a young people's service and an alcohol service.
- Criminal justice services, including a rapid opiate prescribing service co-located with the community assessment service, a probation-based Drugs Rehabilitation Requirement team and a Drug Interventions Programme team.

Although there is no formal structure for joint working, the services have a history of collaboration with many well-established links between them and good working relationships. This is aided by low staff turnover, which means that many staff members have been working in the different treatment services in this area for a long time. In addition, as a result of the relatively small geographic area covered, many of the service users, in particular the longer term ones, are known across the services. Furthermore, joint working is encouraged by regular borough-wide meetings and forums, and shared staff training events. The DAT partnership holds various events, including conferences to give further opportunity for shared learning and collaboration.

In terms of care pathways and care plans, the services in the borough have a range of care pathways developed to support interagency working and to ensure that no single treatment model is given preference. Although each service does its own care planning, the DAT partnership has an agreed common assessment and care planning framework and tools used by all the treatment services.

As regards information sharing, Kensington and Chelsea has a borough-wide protocol agreed by all treatment services. When a client is transferred, his/her paperwork is provided to the other service so that it can build on the work already done. Furthermore, clients are assigned a keyworker and a GP or specialist doctor and have a care plan showing the different interventions that they are receiving at each service, including their service contracts. Clients often have referral documents containing a summary of their care plans so that all services are aware of the interventions they are receiving and who their keyworkers and doctors are.

## **Actions Points: Accessibility**

<b>Evidence of application of key principles and elements of effective practice</b>
What measures have been taken to establish the need for services in the area? Do these measures provide a reliable and valid account of need?
Has there been a process put in place to review the appropriateness, accessibility and capacity of the existing range of services?
What measures have been taken to establish whether the existing range of services meets the need identified in the assessment exercise?
What processes are in place to ensure that the range and capacity of services and joint working is adequate?
Are there locally agreed standards between commissioners and providers that set out maximum waiting time targets for access to services e.g. between receiving referral and offering 1 <sup>st</sup> appointment?
Are there clearly established arrangements for joint working between agencies to facilitate an integrated approach to providing health and social care services?
Who has been involved in developing more effective assessment processes?
What evidence is there that clear and concise information about services has been produced and made widely available?
What steps have been taken to provide a variety of access points and times?
What steps have been taken to employ staff with appropriate skills, attitudes, training and qualifications?
Have all relevant agencies been involved in the development of clear information sharing protocols?
What steps have been taken to involve family members?
How have negative community attitudes been identified and addressed?
What measures have been taken to periodically undertake needs assessments and review the integrated care process and its effect on accessibility?
Are the processes of needs assessment and quality improvement costed in terms of resources required to meet desired outcomes, and built into strategic planning processes at local level?



## Chapter 4: Assessment

### What is Assessment?

**The purpose of assessment is to identify the needs and aspirations of the individual in order to inform decisions about treatment, care and support** for drug or alcohol users. It usually takes the form of one-to-one discussions between the staff member and the individual. If the assessment process is working effectively, the individual should be a full participant and understand and agree the goals of treatment, care and support.

Effective assessment is an **ongoing process**, not a one-off event. It seeks to identify the range and level of needs of the individual, not only drug or alcohol misuse problems but also health, social and economic circumstances. It explores the individual's attributes and aspirations. The outcome should be informed decisions about treatment, care and support that are regularly reviewed and revised as necessary. Ongoing assessment helps both service users and service providers to measure progress against agreed goals and supports transition to another type of service when appropriate.

As a result of the assessment process, the individual should understand the purpose of assessment and:

- know where he/she is going and why
- receive the 'right' services
- know how and when progress is being made

### The Rationale: Why is Assessment Important?

An effective assessment process is at the **core of effective service delivery and co-ordination**. Assessment is the key to establishing with the individual **as complete a picture as possible of their needs and their state of readiness to change** in order to provide the most appropriate service/s likely to promote a positive outcome. Without this information, the individual may be referred to a service that does not match their needs and aspirations, leading to disillusion and drop-out from services.

### The Wider Context

In the wider health and social care arena, there is an increasing emphasis on broader assessment to encompass the wide range of health and social needs of individuals. For example, the World Health Organisation (WHO) defines it as:

“(Assessment is) a process designed to reach a thorough understanding of a person's problems in the overall context of his or her life with the object of developing a treatment plan that stands the best chance of being helpful.”

## Parental Substance Misuse

Since 2002 and the publication of *Getting Our Priorities Right* (Scottish Executive) there has been an increase in awareness and action regarding drug and alcohol misusing parents. This has required substance misuse services to develop closer working relationships and communication with a range of services, some of which were previously unfamiliar in terms of joint working.

The issue of parental substance misuse must be monitored throughout the client's treatment journey, and continual risk assessment is a multi-agency responsibility. In keeping with the person-centred ethos of *Integrated Care*, all decisions made about how best to support drug-using parents and safeguard the needs of their children should be discussed openly with the client, raising issues of concern and offering support at the earliest opportunity.

A range of guidance documents are now available providing practical guidance and information for practitioners including:

- *Getting Our Priorities Right* (Scottish Executive, 2002)
- *For Scotland's Children: Better Integrated Children's Services* (Scottish Executive, 2001)
- *It's Everyone's Job To Make Sure I'm Alright – Report of the Child Protection and Audit Review* (Scottish Executive, 2002)
- *The Caleb Ness Inquiry Report* (Edinburgh and Lothians Child Protection Committee, 2003)
- *The Charter for Children and Standards Framework* (Scottish Executive, 2004)
- *Hidden Harm: Responding to the Needs of Children of Problem Drug Misusers* (Advisory Council on the Misuse of Drugs, 2003)

## Carers Assessment

The *Carers (Recognition and Services) Act 1995* was introduced to cover the assessment of the ability of carers to provide care. It was the first time that legislation had attempted to specifically address the needs of carers and the first steps towards defining the rights for carers.

Its key purpose was to provide legal recognition of carers and to support carers through the community care assessment process. Carers were able to request an assessment for themselves, within the assessment process for the service user.

The purpose of a carer's assessment is for them to discuss with the social work department what help they need with caring, as well as any help that would maintain their own health and achieve a balance between caring and other aspects of their life, such as work and family commitments.

In addition to examining the support they may need to look after someone, the assessment can be useful to:

- Explore with a professional (someone who is not part of the family or close to them) how the carer feels about caring.
  - Provide them with information on benefits and support, such as carers groups.
  - Explore whether they want to stay in work or return to work and how to make this happen.
  - Look at how caring may affect them in the future and what help they might need.
- (Adapted from *Carers Scotland: Your guide to a carer's assessment* available at <http://www.carerscotland.org/Information/Helpwithcaring/Carersassessmentguide>)

The *Carers (Recognition and Services) Act 1995* can be found at [www.opsi.gov.uk/acts/acts1995a.htm](http://www.opsi.gov.uk/acts/acts1995a.htm)

## The Assessment Process

The development of an effective assessment process at local level for people with drug or alcohol misuse problems will take place within the wider context of Joint Future and specifically, SSA. In this chapter, we set out key areas to be addressed, and principles and elements of effective practice identified from the evidence collected.

## Levels of Assessment

Drug or alcohol users frequently come into contact with a wide range of agencies at different stages in their treatment or recovery. A drug or alcohol user may, for example, present at a Housing Department, Employment Service or Benefits Agency. In those settings, the opportunity to identify the nature and extent of a drug or alcohol problem is probably limited. This can lead to frustration and disappointment when a first contact is followed by an in-depth, lengthy assessment. During the course of treatment, a referral to a specific service may lead to a more detailed assessment. In line with Joint Future guidance, **three levels of assessment** may be appropriate:

- **simple assessment (or screening)**
- **comprehensive assessment**
- **specialist (or in-depth) assessment**

The *Models of Care for Treatment of Adult Drug Misusers: Update 2006* (National Treatment Agency for Substance Misuse, 2006) highlighted that the three levels of assessment (screening, triage and comprehensive assessment), outlined in the original *Models of Care Report* published in 2002, have been found to be 'meaningful and useful'.

The guidance on both drug and alcohol services suggests that it may be appropriate to capitalise on the opportunity of a first contact by conducting a **simple assessment (or screening)** to ensure an appropriate referral is made. This first level assessment could be

described as the ‘gateway’ into a process of care. It should be a helpful, non-threatening experience designed to encourage the individual to engage in a more in-depth exercise and ultimately promote the development of a therapeutic relationship. The data collected at this stage is likely to be relatively basic, probably socio-demographic information, perhaps cursory information about their drug or alcohol use and its likely impact on the individual's ability to access services. Simple assessment could allow access to low level services, e.g. harm reduction advice and information. In addition, it may involve an element of brief opportunistic intervention with the intention of engaging or preparing individuals for treatment.

**Comprehensive assessment** may be used in health and social care settings when the individual has made a direct approach or has been referred by another agency. This assessment could cover more detailed information on drug or alcohol use and other factors such as housing, employment, health and benefits. This assessment should allow some decisions about treatment, care and support to be made, or whether it is appropriate to refer an individual elsewhere.

The *Models of Care Update 2006* report highlights that a comprehensive assessment may be carried out by more than one member of a multi-disciplinary team in order to assess different areas of client need. It also recommends that a full risk assessment be conducted. In addition, it stipulates that comprehensive assessment is an ongoing process and lists the following situations in which it should be undertaken:

- An individual requires structured and/or intensive intervention.
- An individual has considerable psychiatric and/or physical co-morbidity.
- An individual presents a significant level of harm to self or others.
- An individual has contact with multiple service providers.
- An individual has a history of disengagement from treatment services.
- An individual is pregnant or has children ‘at risk’.

**Specialist (in-depth) assessment** may be appropriate when a client has been referred to a specialist agency, or has moved on from entry-level assessment. This assessment would cover in detail the nature and extent of drug or alcohol use, physical and psychological health, personal and social skills, social and economic circumstances, previous treatment episodes and assets and attributes of the individual.

### **What should it cover?**

SSA was designed to be a layered process, building on existing information in a structured way that makes it appropriate to the individual’s need at the time. Certain information should be collected at each stage of this three-tiered assessment process. These are described by Joint Future as core data sets; *Personal Information* core data set and *Assessed Need* core data set. Details of the content of these are set out in Annex 1.

**Simple assessment** should cover:

The 21 items included in the *Personal Information* core data set.

**Comprehensive assessment** should cover:

The 12 sub-headings listed under the *Assessed Need* core data set, including detailed assessment of:

- Presenting problem
- Primary drug profile
- Secondary drug profile
- Injecting behaviour
- Signs and symptoms of oversedation or withdrawal
- Risk to self or others, including dependent children

**Specialist assessment** should cover

Detailed assessment of all data items included under the 12 sub-headings of the *Assessed Need* core data set.

**Who can assess?**

The Joint Future Unit (JFU) has produced a useful breakdown of who could undertake an assessment within the three levels. This could be adapted by ADATs and partner agencies at a local level.

**Simple assessment** – professionally qualified staff in health, housing and social work who are the first contact; vocationally qualified staff; and unqualified staff with training in assessment.

**Comprehensive assessment** – professionally qualified staff in social work or health

**Specialist assessment** – professionally qualified staff in social work, health and housing, who may have recognised expertise; vocationally qualified or trained staff in specialist areas where simple specialist assessment is needed; and professionally qualified or trained staff in specialist independent agencies.

(JFU, 2002)

There are some aspects of the role of assessors within the different levels of assessment to consider:

- what kind of referral they can make
- whether they have any decision-making powers in relation to treatment and care

- whether they have any authority to commit resources

The *Models of Care Update 2006* document also highlights the importance of practitioners only carrying out assessments in accordance with their qualifications and competence, and the need to use the expertise of colleagues when necessary.

## **Recent Updates**

Since the publication of the original *Integrated Care* document and Joint Future guidance, a number of subsequent reports had provided additional evidence and advice on this topic.

### ***Effective Interventions Unit: Young People with, or at Risk of Developing, Problematic Substance Misuse: A Guide to Assessment***

The *Guide to Assessment* report (EIU, 2004) for young people with, or at risk of developing, problematic substance misuse emphasises that one of the most important elements of effective assessment is the sharing of information with young people and with other individuals involved in their assessment. It stipulates that this is a vital area for action in order to ensure that the assessment process is effective for young people, and that it leads to appropriate and relevant treatment, care and support.

Some of the main problems with services identified by young service users in *For Scotland's Children: Better Integrated Children's Services* (Scottish Executive, 2001) included the 'need to repeat the same information to each agency', 'the absence of mutual awareness among service providers' and 'services pulling in different directions'. While the problems identified by service providers were their 'failure to communicate, co-operate or work together'. These findings were supported by the results of consultations with practitioners which formed part of the evidence base for the *Guide to Assessment* (EIU, 2004), which also identified multiple assessment and poor information sharing as a considerable problem for young people and agencies.

### ***Delivering for Mental Health***

The recommendation made in the draft report of *Delivering for Mental Health* (Scottish Executive, 2006) in Section 9: Screening and Identification is as follows:

*'All substance misuse and mental health agencies should have assessment processes which identify co-morbidity systematically to match care appropriate to level of need.'*

This document highlighted several screening and identification tools that should be used in different situations by staff at all levels and in all settings, stipulating that they are reliable

and have been validated in identifying substance misuse and mental health problems. The table below shows the tool to be used according to each situation.

Situation	Tool
Identification of alcohol misuse	AUDIT
Identification of drug misuse	DAST-10
Mental health screening	GHQ-12 or HADS
Alcohol-related brain damage	ARBIAS/SAMH checklist and indicators

Further information about these tools can be found in *Closing the Gaps - Making a Difference: Commitment 13* available at <http://www.scotland.gov.uk/Publications/2007/12/10141643/18>.

The report emphasises that, when properly applied, these tools can identify when further specialist assessment by qualified and trained staff is necessary. It also mentions that, because different agencies have different referral policies, it is important to ensure that clients remain in contact with the original agency until clear transfer arrangements have been made.

In addition, this report highlighted the central role of Primary Health Care teams in identification, care co-ordination and treatment, and emphasises the need to develop this role through engagement and support.

## **Key Principles and Elements of Effective Practice: Assessment**

### **1. Working with the individual**

Service users and their carer should be, and feel that they are, central to the assessment and identification of their needs. Service providers should ensure that they have clear processes for planning and conducting formal assessments at pre-determined intervals and that the service user and their carer are provided with adequate notice and detail of these processes. The principles of these are set out below.

**An effective assessment process** focuses on the individual. It should be:

- needs-led, not service-led, resource-led or unnecessarily time-consuming
- ongoing, not a one-off event
- part of the overall care process

**An effective assessment process** should encompass:

- the gathering of information about the type and level of needs, attributes and aspirations of the individual
- the development of a profile of the individual
- communication of the assessment outcome to appropriate providers

- an action plan, agreed with the individual and other agencies as necessary that identifies appropriate goals and the services likely to meet the assessed needs
- regular review and monitoring with reassessment at agreed intervals

The assessment process should cover the current position and highlight any changes in an individual's circumstances and needs. This commonly includes collecting information on personal, family and social circumstances, physical and psychological health, offending behaviour and injecting-related risk behaviour for drug using clients. It should also cover:

- clients' goals
- clients' expectations
- strengths
- support

The process should have a **clear time frame**. The service user needs to be aware of the proposed length of time involved to complete the assessment process as this appears to have an impact on level of motivation and retention in treatment.

Effective assessment requires the **full involvement and participation** of the individual at every stage, as far as possible, through:

- **The development of a two-way dialogue** to ensure that the individual understands the purpose of the assessment and that the assessor has fully understood the information offered by the individual. From the staff's perspective, it is crucial that they are satisfied that they understand the service user's own perceptions about their needs and problems.
- **Encouraging ownership** by the individual: for example, by the use of tools that support **self-assessment**. The individual should have at least an equal share in the process and the outcome. There should also be an opportunity to record disagreement and agreements.
- **Openness** to ensure that the individual knows: who is involved in the assessment; what issues are being discussed and by whom; what judgement is being made about the type; and level of their needs.

Service users should be able to participate at every stage if they wish. As well as being an active participant in the assessment process, it should also be made clear that they have a role in setting the agenda for consultations and feel that assessment is something that is done *with* them not *to* them.

Staff should be trained in the agreed skills and competencies to be able to build a trusting relationship with the individual and carry out assessment effectively. As far as possible, training should be multi-agency. This training should emphasise the therapeutic value of assessment as an intervention in its own right, increasing self-awareness, self-efficacy and motivation to change. Assessment is much more than a data collection process.



## 2. Assessment practice and procedures

Drug or alcohol users come into contact with a wide range of services at different stages of their treatment, care and support. It may be pragmatic to have **different levels of assessment** to meet the presenting needs of the client; to reduce the risk of over-long initial assessments; and to make the most effective use of time and resources.

**Assessment tools** can help to guide and structure discussion between staff and individuals. Such tools commonly collect information on the individual's drug or alcohol use, risk behaviour and health, social and economic circumstances. There is a need for tools that are **tried and tested and fit for purpose**. Careful consideration should be given to deciding **whether an appropriate tool already exists** and could be used with no or minor modification for the task in hand.

**Self-reporting and collateral reporting** are important and vital sources of information in assessing the impact of substance misuse on an individual.

## 3. Working with other agencies

Agencies should agree the core information that they are willing to transfer to ensure a smooth transition for the drug or alcohol user and reduce duplication. Guidance on **informed client consent** will need to be observed. There should also be agreement about the sharing of **more detailed information** from a third-level or service specific assessment. There may be particular concerns about information sharing in rural areas where communities are smaller and closer.

The ADAT, working with agencies, should draw up **clear, strict protocols** to support information sharing between agencies, as well as guidance on information sharing for clients.

## 4. From assessment to planning and delivery of care

Based on the assessment, an Action Plan should be developed with the individual. This Action Plan should be produced after **discussion and agreement between the individual and staff who have worked with him/her**. Where possible, it should include service providers who are able to provide the appropriate treatment, care and support. It should draw on the outcome of assessment tool(s), self-assessment by the individual, and the judgement of staff.

The Action Plan should recognise the needs, attributes and aspirations of the individual. It should offer a systematic way of supporting the individual to make progress towards agreed goals at a pace suitable for him/her and enable provider(s) to design and deliver the appropriate treatment, care and support 'package'.

### Outline Framework for an Assessment Process for Drug or Alcohol Users

While this framework covers some of the ground already set out in the main body of the chapter, its aim is to **provide more detail on the key principles and components of the assessment process**.

## **Principles of Assessment**

- It must be open.
- It must be fair and accurate.
- It must be focused on the individual and not designed to accommodate the organisational structures or administrative practices of an agency.
- It must respect confidentiality.
- It must encourage full participation and ownership by the individual.
- It must aid progression.

### **It should also:**

- Be continuous but not repetitive.
- Be given adequate time and care.
- Be carried out by competent and well-trained staff.
- Be designed to allow the transfer of accurate, relevant and up-to-date information.

### **The objectives of the assessment process:**

- Identification of the type and level of need and the attributes and aspirations of the individual.
- Agreement jointly with the individual, and other service providers as appropriate, of an action plan for treatment, care and support.
- Agreed goals and arrangements for review and reassessment.
- Communication of the outcome of the assessment process to the appropriate providers and the arrangement of matching provision.

### **The elements of the assessment process:**

- The assessment exercise.
- The profile.
- The action plan.

### **An assessment should be carried out:**

- At initial contact.

- Regularly – but not too often.
- At every transition between services.
- After critical events.

### **What should it cover?**

**Simple assessment** should cover:

The 21 items included in the *Personal Information* core data set.

**Comprehensive assessment** should cover:

The 12 sub-headings listed under the *Assessed Need* core data set, including detailed assessment of:

- Presenting problem.
- Primary drug or alcohol profile.
- Secondary drug or alcohol profile.
- Injecting behaviour.
- Signs and symptoms of oversedation or withdrawal
- Risk to self or others, including dependent children

**Specialist assessment** should cover:

Detailed assessment of all data items included under the 12-sub headings of the *Assessed Need* core data set.

### **Outcome of the Assessment**

#### **(a) The Profile**

From the assessment process, a profile of the individual could be created to cover:

- The type and level of needs, drug or alcohol treatment, social support, life skills.
- Particular circumstances, e.g. family problems, emotional and behavioural problems, debt, which are likely to create barriers to progress.
- The individual's aspirations and attributes, with particular attention to positive experiences in the past.
- Goals – short-term and longer-term.

## **(b) Action Plan**

The Action Plan draws together the outcomes of the various stages of the assessment process. It should be produced after discussion between the individual and staff who have worked with him/her and, where possible, the service providers who are able to provide treatment, care and support. It should draw on the outcome of assessment tool(s); self-assessment by the individual; the judgement of staff; and the profile.

The Action Plan should recognise the needs, attributes and aspirations of the individual. It should offer a systematic way of supporting the individual to make progress towards agreed goals at a pace suitable for him/her and enable service provider(s) to design and deliver the appropriate treatment, care and support 'package'.

The action plan should specify:

- The goals.
- The agreed treatment approach for drug or alcohol use and the service provider.
- The actions to address other problems, e.g. housing, family support, offending behaviour, personal and social skills, education and training needs.
- What the key tasks are for each party and how they will be reviewed and assessed.
- What will constitute progress and how it will be measured?
- Dates for reviewing progress, who will be involved and the format.
- The main contact.

## **(c) Ongoing assessment and review**

This should cover progress made by the individual towards goals including:

- Improvements in health.
- Improvements in family and social functioning.
- Reducing criminal behaviour.
- Reducing drug or alcohol use.
- Improvements in self esteem and motivation.
- Movement towards employability.

The individual should be offered the opportunity for self-assessment where possible as well as taking into account the use of assessment tools and professional judgement.

A planned review should take place at regular intervals to ensure that the care plan is revised to take account of changing needs and circumstances and that service providers are meeting needs appropriately and the agreed quality standards.

**(d) Training**

Staff should have access to regular training in the competencies appropriate to the level of assessment that they are engaged in. There should be opportunities for multi-disciplinary training at national and local level to support the development of joint working and information sharing.

**(e) Supervision and governance**

Services providers should operate systems of governance that ensure that clients continue to receive the right services to meet their needs. This would include regular supervision of staff and case record audit, as well as service-user consultation and satisfaction questionnaires wherever practicable. The NTA published guidance on *Supervision and Appraisal* in July 2004 that sets out general principles of good practice in these areas.

[http://www.nta.nhs.uk/publications/documents/nta\\_supervision\\_and\\_appraisal\\_2004\\_ddsp6.pdf](http://www.nta.nhs.uk/publications/documents/nta_supervision_and_appraisal_2004_ddsp6.pdf)

**Actions Points: Assessment**

<b>Evidence of application of key principles and elements of effective practice</b>
What measures are taken to ensure that the assessment process is led by the needs of the client, rather than those of the service?
Does the assessment documentation record the needs, attributes and aspirations of the client?
In what ways does the assessment process encourage ownership by the individual and what evidence is there of self assessment?
Does the assessment process consist of different levels of assessment (Simple, Comprehensive and Specialist)?
Have assessment tools been tried and tested? Have they been validated for use with this client group? Has there been a process of piloting and service-user consultation for newly developed instruments?
Has there been agreement reached between agencies on the use of common data sets?
Is there documented evidence of the existence and use of information sharing protocols between partner agencies?
Is there documented evidence of an action plan, produced after discussion and agreement between the individual and staff who have worked with him/her, which sets out the support required to help the individual progress towards agreed goals?
What is the process for ensuring that planned reviews are carried out at regular intervals?
How do service managers ensure that staff have access to regular training in the competencies appropriate to the level of assessment that they are engaged in?

## Chapter 5: Planning and Delivery of Care

### What is Planning and Delivery of Care?

The **planning** of care is the process of making decisions about the treatment, care and support that the individual will receive and about who will be involved in providing the appropriate services. It follows from the outcome of the assessment process discussed in Chapter 4 and should produce an integrated care plan.

The **delivery** of care is the process of co-ordinating, managing and providing the care so that the individual receives the right services at the right time and in the right way to match their assessed needs in accordance with the agreed integrated care plan. It is important to clearly identify the level of intervention required according to individual need and to identify how best to manage care effectively.

### The Rationale: Why is Planning and Delivery of Care Important?

Effective planning and delivery of care is important in order to ensure that individuals receive services **in an integrated way**. This will reduce duplication and overlap, maximise the benefits of the efforts of all agencies and service providers, and minimise the number of contacts that individuals have to make with different professionals. Fragmented or disjointed care can lead to disillusion and frustration. An integrated planning and delivery of care process should reduce the complexities for the individual, provide consistency of care and enhance the likelihood of a positive outcome. However, it is worth noting that there are **few robust evaluations** of integrated care planning and delivery.

In 2004 the Audit Commission report on drug misuse in England and Wales (*Drug Misuse 2004 – Reducing the local impact*) stated that, ‘Where local surveys have been undertaken, these often confirm the experience of drug users who report care planning as mainly done ‘to them’ not ‘with them’. Duplication is common, with different professionals asking the same questions. Professional assessment tends to concentrate on drug use and omit other key factors, for example, accommodation, employment and relationships, which affect the journey to recovery. For non-residential treatment provision, the ‘wrap-around’ services to support drug users may also include help with transport, child care and managing personal finance.’

The report suggests that good practice approaches to care planning include:

- A common, clear process shared between client and worker;
- An understanding of confidentiality and consent that aids information sharing; and
- Single assessment and multi-disciplinary review, where possible.

The available evidence suggests that the planning and delivery of care is best provided through the careful co-ordination of the range of service providers that are able to address the individual’s assessed needs. It also suggests that it is useful to include family, partners,

friends and drug or alcohol users themselves in the planning and delivery of care. The key requirements are:

- Communication between agencies and service providers and the individual
- Co-operation and consistency between agencies and service providers
- Co-ordination of services and interventions
- Involvement of drug or alcohol users and their families/partners/friends

### **The Wider Context**

The Joint Future agenda has been a key driver for change in community care generally, which is equally applicable to the drug or alcohol field. The key principles and ways of working that are particularly relevant to the planning and delivery of care are: joint resourcing; joint management; intensive care management; and information sharing.

Ongoing service developments in partnership working between health and social care organisations will result in improved co-ordination, management and delivery of services. This will have a number of benefits for service users, providers and carers. These should include the provision of a more consistent, comprehensive and integrated service and an improvement in treatment and care outcomes. This should also have benefits for service providers who (within an integrated care approach) should be working in a supportive, multi-disciplinary team. The survey of NHS services for opiate users in Scotland showed that respondents were positive about working in multi-disciplinary teams. The main reasons cited were mutual support and working with enthusiastic, trustworthy and like-minded colleagues.

It is important to recognise that the idea of integrated care is not new. It is how integrated care planning and integrated care delivery are defined and described that can vary. Despite these variations, however, there are principles of good practice that cut across a number of fields in health and social care. These are presented throughout this chapter.

One example that has relevance for drug or alcohol users is the Care Programme Approach (CPA) in the field of mental health. It promotes a level of integrated practice because it is a 'whole system approach'. It takes a holistic approach to treatment, care and support. A key element of this 'whole system' approach is effective care co-ordination for individuals with complex needs. As with drug or alcohol users, links need to be made across social work or care services, health, education and employment, housing, criminal justice and voluntary agencies to facilitate access for individuals to the range of services required to meet their needs.

The Care Programme Approach aims to ensure effective collaboration between agencies so that the individual client receives a fully co-ordinated range of services. It entitles clients to:

- A systematic assessment of health and social care needs
- An agreed care plan
- Allocation of a care worker
- Regular review of progress

(Social Work Services Inspectorate, 1999)

A recent and relevant research review – *A Review of Care Management in Scotland* – was commissioned by the Scottish Executive in 2001. The overall aim of the review was to identify how local authorities are using care management to maintain people at home. Although this review did not focus on drug or alcohol users, some of the conclusions are relevant to effective care planning for this group. The research identified gaps in funding systems, in training, and in the reviewing of cases for service users. The report also highlighted a need for clearer differentiation between complex and more straightforward cases in care co-ordination and subsequent levels of intervention.

There are a number of different definitions of care and case management in the health and social care sectors. Overall, a useful distinction can be made between care management and care co-ordination. Care management is often described as an intensive approach for individuals with complex, frequent or rapidly changing needs usually requiring complex packages of active, ongoing support. Care co-ordination is described as relating more to individuals with straightforward needs and may revolve around ‘simple’ or single services.

Every service user should have a care plan. Case records should evidence that the service user has been offered a copy of their care plan to take away. The care plan should be able to clearly demonstrate a clear link to a systematic assessment of the health and social care needs of the service user and should contain evidence that it:

- Involves interagency input to the planning, delivery and review of care
- Is based on the needs of the service user
- Is owned by the service user
- Reflects the service user’s views and the views of their family/carer (where appropriate)
- Has clear links to service user satisfaction



- Identifies and reflects the service user's motivational state
- Includes the planned review date within six months of the date produced

The decision about which individual worker or agency should act as Care Co-ordinator should be taken on the basis of the person most likely to be able to deliver on these requirements. Other considerations relevant to this decision include:

- Service user's preference including giving consent to share information
- Level and nature of assessed risk to the service user and to others
- Relative level and frequency of involvement with service user
- Legal or statutory requirements e.g. Care Programme Approach, Drug Testing and Treatment Orders (DTTOs)
- Funding requirements

The Care Co-ordinator is responsible for assessing and monitoring the service user's needs on an ongoing basis, co-ordinating the provision of care from different agencies, organising care review meetings and inviting relevant parties, ensuring compliance with local protocols and ensuring that the service user and their family are given the opportunity to play an active role in the planning and review of care. Records kept by the Care Co-ordinator should provide evidence of the fulfilment of these functions.

In addition to their normal activities, other agencies are responsible for conducting specialist assessment when required, providing specialist care, monitoring that aspect of care, attending or providing written evidence at care review meetings and providing ongoing feedback to the Care Co-ordinator. Records kept by the worker should provide evidence of the fulfilment of these functions.

## **Delivering for Mental Health**

The *Delivering for Mental Health* draft report (Scottish Executive, 2006) highlights the prevalence of mental health problems in those treated for substance misuse. It states that, between April 2001 and March 2002, more than 40% of those seeking treatment for their drug-related problem in Scotland, for the first time or following a period of 6 months absence, did so as a result of mental health problems.

Therefore, this document draws on three main recommendations for service planning taken from *Mind the Gaps – Meeting the needs of people with co-occurring substance misuse and mental health problems* (Scottish Executive, 2003) and *A Fuller Life – Report of the Expert Group on Alcohol Related Brain Damage* (Scottish Executive, 2004). These recommendations are aimed at planners and commissioners to help them co-ordinate services between several potential agencies. This document also stipulates that responsibilities must be made explicit and monitored. The recommendations are as follows:

- The needs of people who misuse substances and require interventions should be met through a consultative and co-working arrangement between substance misuse and mental health services with agreement reached on the allocation of responsibilities between services which addresses all stages and transitions.
- A shared protocol on the arrangements, including monitoring and review of performance and outcomes, should be agreed and published.
- NHS boards and partner agencies should ensure an effective and accountable commissioning process for this client group.

It further emphasises the central role of Primary Health Care in the identification and provision of care and highlights the benefit of anticipatory care (i.e. adopting a proactive approach and targeting those most at risk) for those with co-occurring mental health problems.

The main recommendation this document makes regarding anticipatory care is the need for screening procedures for co-morbidity with appropriate responses in general practice and across Primary Care. In order to do so, it recommends the matrix taken from the Department of Health *Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide* (2002), which helps identify the problem severity of co-existent psychiatric and substance misuse disorders in order to determine lead agency responsibility. The horizontal axis represents severity of mental illness and the vertical axis the severity of substance misuse. Case examples in each of the quadrants are also provided to aid clarity.

<i>Severity of problematic substance misuse</i>	
<i>Severity of mental illness</i>	High
	e.g. an individual with schizophrenia who misuses cannabis on a daily basis to compensate for social isolation
Low	High
e.g. a recreational misuser of 'dance drugs' who has begun to struggle with low mood after weekend use	e.g. an individual with bi-polar disorder whose occasional binge drinking and experimental misuse of other substances destabilises their mental health
	Low

In addition, it highlights the frequently observed connection between substance misuse and trauma and abuse, eating disorders and self-harm, and therefore the need for substance misuse services to develop their knowledge, skills and capacity in psychological treatments in order to respond effectively. It stresses the need to develop evidence-based psychological therapies in order to extend the range of services available to people with mental health and substance misuse problems.

The full document can be downloaded at  
<http://www.scotland.gov.uk/Resource/Doc/157157/0042281.pdf>

West Dunbartonshire has developed a protocol for joint working between addiction services and mental health services across the area based on this guidance. The implementation of the protocol across all services is being preceded by a process of multi-agency training and awareness raising.

## **Integrated Care Pathways**

The development of Integrated Care Pathways (ICPs) has been identified as an essential way of improving the quality of care for those with co-occurring disorders. The main recommendation made in the *Delivering for Mental Health* draft report is that people with co-occurring substance misuse disorders must not be excluded from the benefits of the ICP approach, and evidence of the consideration of the needs of this group should be an accreditation standard for the ICPs.

Following publication of *Integrated Care* in 2002, the EIU developed a range of short guides on *Developing and Implementing Integrated Care Pathways* designed to act as a practical reference source for anyone involved in the planning, delivery and evaluation of drug services. These are:

- ICP Guide 1, Definitions and Concepts
- ICP Guide 2, Getting Started
- ICP Guide 3, Developing and Implementing ICPs
- ICP Guide 4, Analysis and Review
- ICP Guide 5, Community Detoxification
- ICP Guide 6, Drug Misuse in Acute Psychiatric Settings
- ICP Guide 7, Drug Misuse in General Hospital Settings
- ICP Guide 8, Drug Misuse in Pregnancy
- ICP Guide 9, Single Shared Assessment for Drug Users

*Models of Care 2006* provides further emphasis for the development of ICPs which it believes should be dynamic and able to respond to changing individual needs over time.

It stipulates the need for commissioners to ensure that every drug and alcohol treatment intervention has an ICP that is agreed with and between local providers and built into service specifications and service level agreements. In addition, it states that an ICP should clearly establish which type of client the drug treatment is appropriate for and what the individual can expect treatment services to offer. It should also clearly determine each service's role within the integrated care system and responsibilities towards the individual.

Finally, it draws attention to the need for ICPs for specific treatment types, as an ICP does not necessarily describe all stages of the client's treatment journey but focuses on one treatment intervention in the client's care plan, as well as the need for local ICPs developed for certain client groups, in particular excluded groups who may have difficulties accessing treatment due to their complex needs and vulnerability.

One of the common mistakes in ICP development is to confuse a care pathway with a flow diagram, or algorithm. Where a flow diagram is usually a single page graphic representation of the optimal process of care, an ICP is a series of documentation that records, monitors and evaluates specific part of the client's journey. It should contain the following elements:

- A definition of the treatment interventions provided
- Aims and objectives of the treatment interventions
- A definition of the client group served
- Eligibility criteria (including priority groups)
- Exclusions criteria or contraindications
- A referral pathway
- Screening and assessment processes
- Development of agreed treatment goals
- A description of the treatment process or phases
- Co-ordination of care
- Departure planning, aftercare and support
- Onward referral pathways
- The range of services with which the interventions interface.

*Models of Care 2006* states that, 'These elements are designed to provide clarity as to the type of client the drug treatment intervention caters for, what the client can expect treatment services to provide, and the roles and responsibilities of the service within the integrated care system and towards the individual client.'

### ***Models of Care for Treatment of Adult Drug Misusers: Update 2006***

The 2006 update of *Models of Care for Treatment of Adult Drug Misusers* recognises the need to improve consistency in quality care planning. It stipulates that it should be a routine activity with performance indicators that focus on effective care planning and aftercare outcomes. In addition, it makes note of the fact that care planning was one of the key parts of

the NTA's *Treatment Effectiveness Strategy* (2005), and one of the objectives in its Business Plan 2005/06:

*'..., by 2008, all individuals in treatment will have an identifiable written care plan, which tracks their progress and is regularly reviewed with them.'*

This updated document also identifies what it considers to be the key principles in care planning. It states that the care planning process is an '*essential component of the client treatment journey*' and that keyworking is an essential part of care-planned treatment. It emphasises that care plans and keyworking should focus on the main stages in the aforementioned treatment journey (i.e. engagement, delivery, completion and maintenance), calling for greater client participation in producing and agreeing care plans. It states that care plans should be a shared exercise between the client and the service and should actively cover the client's needs in the following four areas:

- Substance misuse
- Health (physical and psychological)
- Social functioning (employment and education)
- Offending behaviour

In terms of the care plan itself, it stipulates that it should be a brief and easily understandable paper document, which clearly establishes the roles of specific individuals and enables routine and opportunistic reviews of the client's needs. In addition, it should be made readily available to the client and kept on file.

Furthermore, the updated *Models of Care 2006* document highlights the importance of continuity in the treatment and support provided to drug-using offenders as they move between different criminal justice and treatment agencies. It emphasises the need for seamless care management and identifies the Drug Interventions Record (DIR) as a useful common recording tool for use by the Criminal Justice Integrated Team (CJIT) in the community, and Counselling, Assessment, Referral, Advice and Throughcare Services (CARATs) in prisons.

In Scotland, Integrated Case Management is a multi-agency approach focused on reducing re-offending where all agencies working within the Criminal Justice System share relevant information through an electronic case management system. A Community Integration Plan (CIP) is created to support the offender, enabling interventions to be sequenced and co-ordinated according to risk, need and responsiveness. The Enhanced Addiction Casework Services (EACS) provides assessment, treatment interventions and activities tailored to meet the individualised care plan, linking offenders to the national Throughcare Addictions Services (TAS) to ensure continuity of care from prison to the community on release.

## **Good Practice and Care Planning**

A *Good Practice and Care Planning* report has been published by the NTA and is available via the following link:

[http://www.nta.nhs.uk/publications/documents/nta\\_good\\_practice\\_in\\_care\\_planning\\_gpcpl.pdf](http://www.nta.nhs.uk/publications/documents/nta_good_practice_in_care_planning_gpcpl.pdf)

This report identified key factors that influence good performance in care planning based on following three main areas:

### **1. Structures and systems**

- Treatment systems responsive to user needs that encourage users to remain in treatment and make it easy for them to re-enter after dropping out of substitute prescribing or detoxification.
- Good clinical governance and leadership which involves robust structures and key procedures, and practitioners with a firm commitment to high-quality drug treatment.
- Effective local forums and meetings that ensure good ADAT partnerships and joint care planning.
- Criminal justice services that are well-integrated with drug treatment services.
- Good interface between community treatment, and inpatient treatment and residential rehabilitation.
- Access to the full range of drug treatment services which makes care planning comprehensive and client-centred and allows choice.
- Good information sharing protocols to support the easy transfer of information.
- Good systems for recording, sharing and monitoring care plans including computerised systems.
- Regular audits of care planning in order to identify shortcomings and issues for improvement.
- Integrated care pathways linked to care planning in order to help move users through the treatment system, guide individual care planning and promote inter-agency working.

### **2. Partnership working**

- Good relationships between commissioners and service providers involving collaborative partnerships, supportive commissioners and responsive services.
- Good partnership working between drug services with a strong shared vision about how treatment and care planning should work locally.

- Good links with local partners responsible for ‘wrap-around’ services, such as housing, employment and social care services.

### **3. Building good-quality drug treatment**

- Skilled and competent staff.
- Regular, performance-focused staff supervision identified as key to good-quality care planning.
- A strong user involvement ethos.
- Local commitment to care planning, including a commitment to care planning in primary care.
- Keeping the care plan simple in order to help individuals meet their goals and give them a sense of achievement.
- Rapid access to treatment.

### **Changing Habits**

*Changing Habits: The Commissioning and Management of Community Drug Treatment Services for Adults* (Audit Commission, 2002) highlighted the imperative need for good care planning in order to ensure that clients receive an integrated package of care that provides a holistic response to their problems. On examination of 52 case files across six community drug teams in England, the Audit Commission identified the following weaknesses in care planning:

- Clients had not signed a care plan in 39 cases.
- Other agencies had not been involved in the review process in 28 cases.
- There was no clear and precise care plan with short-term goals in 25 cases.
- There was no clear and precise care plan with long-term goals in 24 cases.
- There was no evidence of regular reviews in 7 cases.

### **User Defined Service Evaluation Toolkit (UDSET)**

Recently developed by the Joint Improvement Team (JIT) the focus of the UDSET is on improving outcomes for service users and their carers. It defines outcomes as ‘*the impact or effect of services on people’s lives*’, and highlights the fact that defining user and carer outcomes is increasingly important in order to deliver effective and responsive public services. It states that one of JIT’s main objectives was to combine user and carer involvement with an outcomes approach to delivering, evaluating and improving services. Consequently, work has been carried out to develop toolkits to achieve this objective.

Some of this work focused on developing the UDSET. The purpose of which is to improve practice through the use of user and carer defined outcomes tools, and to support partnerships to integrate evidence on user and carer experience in the development and evaluation of performance measures. It also presents opportunities to ensure that Joint Future objectives, which focus on outcomes, can be achieved. The UDSET evolved in conjunction with the development of the *National Outcomes Framework for Community Care* and *National Minimum Information Standards* (Scottish Government, 2007).

Further information about the development of the UDSET can be found at <http://www.jitscotland.org.uk/action-areas/themes/involvement.html>



## **Key Principles and Elements: Planning and Delivery of Care**

### **1. Use the outcome of the assessment process as the foundation for decisions on treatment, care and support**

This requires an effective assessment process with agreed mechanisms for sharing information between service providers. The production of an Action Plan (from the assessment) should be agreed with the individual. This would set out their needs, attributes and aspirations and would support and enable service providers to design and deliver treatment, care and support in a consistent and integrated way.

### **2. Involve all relevant agencies, service providers and the service user to formulate an Integrated Care Plan**

It is important to agree **how, when and by whom** services will be delivered. An integrated care plan will set out how the agreed goals are to be achieved and how treatment, care and support are to be delivered. To create an integrated care plan, detailed individual service plans should be brought together through case discussions between staff in the various service providers. With the agreement of the service user, copies should be given to all relevant staff. An integrated care plan should cover:

- an individual's needs as identified from assessment
- the goals of treatment and milestones to be achieved
- the interventions and services planned to achieve the goal and the support required
- which service provider and/or professional is responsible for carrying out the interventions
- timing - when, how often, frequency of attendance and expected length of duration
- explicit reference to risk management, risk management plans and contingency plans
- arrangements for information sharing between service providers
- arrangements for monitoring and review with dates

### **3. Include the service user in planning their care, including goal setting**

This requires regular, clear and open communication. There should be openness about constraints to delivering aspects of the services as proposed in the Action Plan and good information about the services available and best suited to meet their needs as part of an integrated care plan. The individual should have the opportunity to participate fully in making decisions about the most appropriate services for them.

#### 4. **Ensure that all involved understand the role of the advocate** (if there is one)

Advocacy should help to ensure that individuals and their families have access to information, understand the options open to them and to make their wishes known. Advocacy should enable the individual's opinions and concerns to be articulated through:

- Informed consent: individuals should be advised of treatment and service protocols, particularly in the sharing of information. An advocacy service could promote individual's awareness of service procedures and information sharing.
- Informed choice: clients should have awareness and an understanding of the range of services available to them and the relative merits of each with regard to the achievement of their individual goals.
- Informed decision making: advocacy can enable clients to have an active influence in the decision making process regarding the planning and evaluation of care.

#### 5. **Introduce a clear system of co-ordination for delivery of care**

This involves being clear about who is doing what, when and how. It is also important to decide whether there should be a **lead care manager (or co-ordinator) or a multi-agency team**. To be effective, co-ordination requires a person and/or persons who are knowledgeable about services and have good links to the range of services required. Effective co-ordination of care delivery requires that:

- the individual knows who they are working with and why
- staff are aware of the parties involved, their role and responsibilities
- communication is open and information shared (with individual's consent)
- service providers offer a consistent approach
- regular formal reviews take place to monitor and evaluate joint progress
- a co-ordinator is identified if required
- a co-ordinating team is identified if required
- contact in emergency situations is clear and agreed by parties

The role of Care Co-ordinator should be formally reviewed as part of the care review process so that the decision on who continues in this role is taken on the basis of current need rather than historical arrangements.

## **Actions Points: Planning and Delivery of Care**

<b>Evidence of application of key principles and elements of effective practice</b>
Is it evident in case records that decisions on treatment, care and support are base on the outcome of the assessment process?
What measures are taken to ensure that the formulation of an Integrated Care Plan involves all relevant agencies, service providers and the service user?
What procedures are in place to include the service user in planning their care, including goal setting?
Have all staff received training on the role of the independent advocate? What is the process for ensuring that advocacy needs are identified and met?
Is there a multi-agency protocol setting out a clear system of co-ordination for delivery of care?

## Chapter 6: Information Sharing

### What is Information Sharing?

The purpose of sharing personal information on individuals between partner agencies is **to ensure access to the appropriate treatment, care and support services** for those individuals. This requires:

- a culture of openness and trust between agencies
- agreement on the core elements of information to be transferred
- agreement on the circumstances when additional, possibly sensitive, information should be shared
- agreed inter-agency protocols governing information sharing
- respect for patient's/client's rights to privacy, confidentiality and consent to the sharing of their personal information.

There are various stages at which information sharing should take place, beginning at referral stage when the sharing of information between staff will assist decision making on the level of assessment required and the speed of response needed to address the individual's circumstances, continuing through assessment, care planning and delivery.

### The Rationale: Why is Information Sharing Important?

A commitment from partner agencies to **the sharing and the safeguarding of client information** is essential to the development and delivery of integrated services for drug or alcohol users. The exchange of information will assist service providers to provide individuals with the best possible service. A common criticism, when things go wrong, is that the right information was not provided to the right people at the right time. For the client, deficiencies in information sharing may result, for example, in delays in getting access to treatment, care and support, or referral on to an inappropriate service. This, in turn, may reduce the chances of a positive outcome and lead to disillusion and non-attendance. A bad experience of attending a service in the past may also reduce the motivation to seek treatment in the future.

Where a service provider has access to an individual's personal information and is referring them on to another provider, they should be mindful of the information needs of the receiving service. At the same time, service providers have a responsibility to clients to share only that information which is necessary to ensure that they benefit fully from the service.

### Improving Information Sharing

Information sharing should take place within an environment of **informed client consent**. In order to achieve informed consent, the client must be advised of the implications of giving or of refusing consent, amongst whom their personal information is being shared and the purposes for which it is being shared. It is important that this process is not undertaken in a

manner divorced from the rest of the dialogue between practitioner and client. For example, it makes good sense to embed the seeking of consent for the sharing of referral information within the dialogue over making the referral itself and the treatment, care and support that it is intended to set in motion.

### **'Protecting the Rights of the Individual – The Regulatory Framework'**

- The Data Protection Act 1998 places a legal duty on data controllers to process data fairly and lawfully, to use no more data than is necessary for the task and to retain it for only as long as it is needed.
- The Human Rights Act 1998 guarantees respect for a person's private and family life. Under the terms of the Act, this right to privacy may be overridden, but only when there is a lawful reason to do so.
- The common law reinforces the need to obtain patient/client consent before sharing information.
- Professional guidelines require clinicians to ensure patients/clients are informed about how information about them is used and that consent requirements are met.
- A substantial organisational framework for protecting the use of patient/client identifying information already exists in Scotland. An example is the Caldicott Framework, set up in March 1999 in response to the Caldicott Committee *Report on the Review of Patient-Identifiable Information*. This requires all NHS Scotland organisations to appoint a senior clinician as Caldicott Guardian.

### **Recent Developments**

There have been a number of new initiatives aimed at assisting service providers to better manage the processes of information sharing and confidentiality. Examples of these are set out below.

#### ***Confidentiality and Security Advisory Group Scotland (CSAGS)***

#### **Data Protection**

In order to provide guidance on the Data Protection Act 1998 staff information leaflets have been made available to NHS Scotland staff. The CSAGS website provides the following link to an example leaflet produced by Lothian Universities NHS Trust:

<http://www.confidentiality.scot.nhs.uk/publications/LUNT-%20DPA%20Leaflet.pdf>

#### **Confidentiality**

The CSAGS sets out the following eight principles to protect patient and service user confidentiality:

##### **1. Involve patients and service users**

- Let patients and service users know what information you wish to record.

- Explain why you need the information and what it may be used for.
2. Inform patients and service users of their rights
    - Make sure patients and service users know their rights to confidentiality and how to exercise them.
    - Respect the right of patients and service users to have access to their health records.
  3. Respect individual choice
    - If patients and service users do not want information about them to be used for a particular purpose, try to respect their wishes.
    - Make sure that patients and service users are aware of the implications of their decision.
    - If you cannot respect a patient's wishes on the use of personal health information, guidance must be sought from the local Caldicott Guardian.
  4. Get it right
    - Make sure health records are accurate, complete and up-to-date.
  5. Keep health records secure
    - Store and send personal health and care information securely at all times to ensure that it cannot fall in to the wrong hands.
    - Ensure requests to see health information are from those with a legitimate right.
  6. Only record what you need
    - Only record the information relevant to caring for the patient or service user.
    - This may include collecting information needed for the administration of care and information required for any research projects in which a patient or service user has agreed to participate.
  7. Share with care
    - Share personal health information required for the treatment and care of patients or service users only on a need-to-know basis.
    - Share personal health information outside the NHS only with your patient's knowledge and express consent.

- You may share information without consent if you are obliged to by law, if required to do so to protect life and limb, or if you must do so in the public interest. You must always however be prepared to defend the basis of such disclosure.

8. Know your obligations to your patients, service users and others

- All staff dealing with personal health and care information should be aware of the issues surrounding confidentiality and be trained to deal with them in an appropriate manner.
- The need for confidentiality should be a contractual obligation for all those employed by NHS Scotland, its contractors and volunteers.

***Department of Health: Social Care Information Governance Toolkit (SCIGT)***

The Department of Health website provides the following link to the Social Care Information Governance Toolkit (SCIGT):

<https://www.igt.connectingforhealth.nhs.uk/Requirements.aspx?tk=653799462&lnv=4&cb=09%3a48%3a57&sViewOrgType=10&sDesc=Social+Care>

***National Treatment Agency for Substance Misuse***

The NTA published two briefings in 2003, *Confidentiality and information sharing* and *Data protection and record retention*. Briefing 1 outlines definitions, good practice and current legislation with regard to confidentiality and information sharing and Briefing 2 outlines the background to the Data Protection Act, providing definitions, procedures and defining the eight key principles in relation to information handling.

Briefing 1:

[http://www.nta.nhs.uk/publications/documents/nta\\_confidentiality\\_and\\_info\\_sharing\\_2003\\_dsp1.pdf](http://www.nta.nhs.uk/publications/documents/nta_confidentiality_and_info_sharing_2003_dsp1.pdf)

Briefing 2:

[http://www.nta.nhs.uk/publications/documents/nta\\_data\\_protection\\_and\\_record\\_sharing\\_2003\\_dsp2.pdf](http://www.nta.nhs.uk/publications/documents/nta_data_protection_and_record_sharing_2003_dsp2.pdf)

## Key Principles of Effective Practice: Information Sharing

These 10 key principles should underpin the sharing of person identifiable information between those '**partner agencies**' who agree to an '**information sharing protocol**'. These are:

1. All staff will respect the service user's rights to privacy and confidentiality.
2. No information will be shared without the prior consent <sup>1</sup> of the service user (or their representative), except in the circumstances referred to in Principle 10 below.
3. Information will only be shared for the purposes agreed to by the service user.
4. The partner agencies will only use shared information for the purposes set out in the information sharing protocol.
5. Service users have a right of access <sup>2</sup>.
6. If service users refuse consent to the sharing of information, the partner agencies will ensure that they are aware of the implications of their decision.
7. Access to person identifiable information will be on a need to know basis.
8. The partner agencies will ensure records are accurate, complete and up-to-date.
9. The partner agencies will make sure that person identifiable information is safe and secure.
10. You may share information without consent if you are obliged to by law, if required to do so to protect an individual's vital interests, or if you must do so in the public interest.

<sup>1</sup> In terms of the practicalities, consent should not have to be sought for each and every incident of data sharing. The information sharing protocol will need to create a framework that defines the scope of consent appropriately, balancing administrative practicality with service user rights.

<sup>2</sup> Access to information regarding their care.



## Glossary of Terms

Term	Meaning
<b>Service providers</b>	Service providers should include: GPs and primary care teams; community-based specialist drug or alcohol services (statutory and voluntary); pharmacies; Scottish Prison Service (SPS); providers of Enhanced Addiction Casework Services (EACS); housing services; employment and training providers; health specialties such as A&E departments, antenatal services and hepatology departments; social inclusion partnership initiatives; social work community care, child care and criminal justice teams; national Throughcare Addiction Service delivered by Criminal Justice Social Work; drug or alcohol courts, arrest referral schemes and DTTOs; providers of residential detoxification or rehabilitation services; employment, education and training providers e.g. further education colleges and enterprise networks; business organisations; and after care services.
<b>Acceptably anonymised data</b>	Data from which in practice the patient/client cannot be identified by the recipient of the information, and where the theoretical probability of the patient's identity being discovered is extremely small.
<b>Anonymised data</b>	Data from which there is no theoretical or practical risk that a patient/client could be identified by the recipient of the information.
<b>Explicit consent</b>	Agreement which is expressed orally or in writing (except where patients cannot write or speak, when other forms of communication may be sufficient).
<b>Implied consent</b>	Assumption that circumstances allow disclosure of information without seeking explicit consent.
<b>Informed patient/client consent</b>	Explicit consent, plus situations where it is acceptable to rely on implied consent because the patient/client has been informed and has not used available mechanisms to refuse consent.
<b>Patient/client identifying information</b>	A data set which may include some or all of the following: a picture of the patient/client, their name, address and full post-code or date of birth.

## **Actions Points: Information Sharing**

<b>Evidence of application of key principles and elements of effective practice</b>
What measures have been taken to ensure that all staff respect the service user's rights to privacy and confidentiality?
Are there safeguards in place to ensure that no information is shared without the prior consent of the service user (or their representative?)
Does the case record document agreement the service user to share information?
How is adherence to the information sharing protocol monitored and evaluated?
Is there a protocol in place that informs the service user of their right of access and sets out procedures for achieving this?
Is there a procedure for documenting when a service user refuses consent to the sharing of information and ensuring that the service user is aware of the implications of their decision?
Does the information sharing protocol clearly describe arrangements where access to person identifiable information is on a need to know basis.
Are there audit processes in place to ensure records are accurate, complete and up-to-date?
What measures have been taken to ensure that person identifiable information is safe and secure?
What processes are in place to ensure that all staff are aware of the requirement to share information without consent if obliged to by law, if required to do so to protect an individual's vital interests, or if in the public interest.

## **Annex 1**

### **1. *Personal Information* core data set**

- ☐ Family name and forename
- ☐ Present address and postcode
- ☐ Unique identifier
- ☐ Previously known
- ☐ Date of birth
- ☐ Gender
- ☐ Ethnicity
- ☐ Referral source
- ☐ G.P Name
- ☐ G.P Address
- ☐ Other professionals/agencies involved
- ☐ Next of kin
- ☐ Dependent children at home
- ☐ Previously known
- ☐ Previous interventions
- ☐ Presenting problem
- ☐ Primary drug profile
- ☐ Secondary drug profile
- ☐ Injecting
- ☐ Signs and symptoms of over sedation and/or withdrawal
- ☐ Consent to assessment
- ☐ Signed permission to share information with other agencies

## **2. *Assessed Need* core data set**

### **Drug use**

- ☐ Other problem drug profile
- ☐ Alcohol use
- ☐ Prescribed drugs/medication
- ☐ Effects on user (positive and negative)
- ☐ Problems/concerns
- ☐ Drug history including alcohol

### **Living arrangements**

- ☐ Household composition
- ☐ Status of residency
- ☐ Accommodation type
- ☐ Carer/cared for
- ☐ Other drug user(s) in household
- ☐ Housing support needs
- ☐ Benefits
- ☐ Heating

### **Physical Health**

- ☐ Past medical history
- ☐ Permanent or long-standing health condition or disability
- ☐ Current care provision
- ☐ Seen by GP in last 18 months
- ☐ Current medical condition
- ☐ Current medication
- ☐ Current treatments
- ☐ Registered disabled

## **Disease prevention**

- ☐ Sleep patterns
- ☐ Diet and food preparation
- ☐ General physical state
- ☐ Body Mass Index
- ☐ Injecting practices/techniques
- ☐ Wound management
- ☐ Oral health
- ☐ Vaccination history
- ☐ History of cervical or breast screening

## **Mental health**

- ☐ Past psychiatric history
- ☐ Current signs and symptoms
- ☐ Risk assessment
- ☐ Current medication
- ☐ Seen by psychiatric services in last 18 months
- ☐ Current diagnosis

## **Social functioning**

- ☐ Relationships
- ☐ Family contacts
- ☐ Social contacts
- ☐ Spiritual and religious matters
- ☐ Cultural and ethnic matters
- ☐ Leisure/hobbies
- ☐ Employment, past and current
- ☐ Learning

## **Legal situation**

- ☐ Current offending behaviour
- ☐ Previous convictions
- ☐ Outcomes
- ☐ Prison
- ☐ Other

**Service user's perspective**

- ☐ Problems and issues perceived and conveyed by the person
- ☐ Person's motivation
- ☐ Advocacy required?

**Collateral information**

- ☐ Carer/significant others' perspective
- ☐ Other service provider

**Biological measures**

- ☐ Biochemistry
- ☐ Virology
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ Pregnancy

**Readiness to change**

- ☐ Stage of change
- ☐ Motivational state
- ☐ Strengths
- ☐ Barriers to change
- ☐ Support system
- ☐ Self-efficacy

**Risk and safety**

- ☐ Needle sharing/exchange/cleaning
- ☐ Sharing of injecting paraphernalia including filters, water and spoons
- ☐ Sexual risk
- ☐ Blood borne virus
- ☐ Sexually transmitted diseases
- ☐ Personal safety – risk from self
- ☐ Personal safety – risk from other
- ☐ Risk to dependent children
- ☐ Public safety

