CARE COORDINATION PROTOCOLS

The Purpose of Care Co-ordination is to[1]

- Facilitate access to a programme of integrated and co-ordinated health and social care
- Maximise Service User Retention
- Minimise disengagement (Drop out).

Overarching Principles[2]

- Those who enter into structured drug and alcohol treatment services receive a written care plan, which is agreed with and signed by the service user and subject to regular review with the key worker or care co-ordinator.
- Drug and alcohol misusers who meet the criteria for care co-ordination should have access to a named person who acts as the care co-ordinator, to ensure the care provided by different services is co-ordinated by one person.

Aims of Care Co-ordination[3]

- Ensure that drug and alcohol misusers have access to a comprehensive range of services across the four tiers of local drug treatment systems.
- Ensure the co-ordination of care across all agencies involved with the service user.
- Ensure that there is continuity of care and that clients are followed throughout their contact with the treatment system.
- Maximise client retention within the treatment system and minimise the risk of clients losing contact with the treatment and care services.
- Re-engage clients who have dropped out of the treatment system.
- Avoid duplication of assessment and interventions.
- Prevent clients ‘falling between services.

[1] Section 1.4.1 of Models of Care for the Treatment of Drug Misusers 2002 Part 2 page 39
[2] Section 1.4.1 of Models of Care for the Treatment of Drug Misusers 2002 Part 2 page 39
[3] Section 1.4.1 of Models of Care for the Treatment of Drug Misusers 2002 Part 2 page 39

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Criteria for Care Planning and Care Co-ordination

1. The client is receiving a tier 2 and/or 3 intervention.

2. During any period of delay in accessing a tier 3 intervention the referring agency, the agency completing the triage assessment, and the agency from whom they are awaiting a service, all owe a duty of care to the service user.

3. The person completing the triage assessment must act to establish a care plan/care co-ordination process where someone is deemed to be a significant and immediate risk to themselves or others. They should also advise service users of Tier 2 services, which are available whilst they are waiting to access a tier 3 intervention.

Criteria for Care Manager Involvement[4]

- Individuals who demonstrate a willingness to address their substance misuse

and

- have a history of serious or prolonged substance misuse, which is hazardous to themselves, carers/partners or the general public.

and

- have tried community or prison based interventions and who have found that these services did not meet their needs.

Who is Responsible for Care Co-ordination?

- Where a client is receiving 1 treatment intervention the key worker is responsible for planning and managing that client's care and completing the client's treatment plan.

- Where a client is receiving more than 1 treatment intervention the Care Co-ordinator has overall responsibility for completing and co-ordinating the over-arching care plan. Each key worker responsible for delivering an aspect of the client's care within the overarching care plan is responsible for managing and delivering their treatment plan.

[4] KMDAAT Care Management Specification

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- Where a service user meets the agreed criteria for Substance Misuse Care Manager involvement they should be referred and subject to meeting the eligibility criteria, (and once a Substance Misuse Care Manager is allocated) the Care Manager will be responsible for care co-ordination. (Unless alternative arrangements are agreed).

- Where a Substance Misuse Care Manager is delivering a service to a service user they are responsible for care co-ordination following detox. (Unless alternative arrangements have been agreed).

- All service users accessing Tier 3 Services will be allocated a treatment co-ordinator/ key worker. Where service users are accessing only one tier 3 treatment modality this person will be the care co-ordinator.

- Care Co-ordination of service users subject to a Community DRR is the responsibility of the Probation Service. Where a residential DRR has been made the Care Manager will be responsible for care coordination. For other clients involved in criminal justice services and engaged with the Drug Intervention Programme (DIP), the DIP worker will be the Care Co-ordinator pre and post DRR.

- Where service users are referred simultaneously to more than one tier 3 service a decision needs to be taken between the relevant treatment co-ordinators/ key workers as to who will be responsible for care co-ordination. Factors to consider will include expected length and intensity of involvement and previous history of involvement with the service user.

- Under enhanced CPA, service users with severe mental health co-morbidity will be subject to the national guidelines for enhanced CPA. In all cases, the service user will be under the care of a community mental health team. (CMHT) The CMHT is responsible for care co-ordination for service users subject to enhanced CPA.[5]

[5] Adapted from Section 1.4.5.1 Models of Care for the Treatment of Drug Misusers 2002 p 42

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Role and Responsibilities of the Care Co-ordinator [6]

- to develop, manage and review documented care plans based on ongoing assessment (including risk assessment)
- to ensure that the care plan takes account of the service user's presenting needs, and their culture, ethnicity, gender and sexuality
- to ensure ongoing risk assessment and co-ordinate any appropriate risk management plan
- to work towards engaging and retaining the drug (and alcohol) misuser in the treatment and care system
- to co-ordinate care across the range of health and social care agencies
- to act as a facilitator to help the service user to access other appropriate services
- to advise other professionals involved in the care of the service user of changes in the circumstances of the service user which may require a review or change of the care plan
- to ensure essential and appropriate information is shared between agencies
- to develop contingency and crisis management plans for service users with complex needs, where required
- to keep in touch with the service user
- to ensure the completion of the Treatment Outcome Profile (TOPs) at Comprehensive Assessment, 3 monthly review thereafter and at discharge to ensure the early follow-up of discharged service users where possible and appropriate in line with local protocols
- to aim to re-engage service users who have dropped out of the drug (and alcohol) treatment system.

In cases which may be affected by Child Protection issues the care co-ordinator will either attend appropriate forum or ensure another associated profession attends and ensures that any additional risk factors that emerge are addressed in the client risk management plan.

Closures and Transfers

The closure or transfer of care co-ordination must be made in line with local protocols. Evidence of this process must be contained within the client file.

[6] Adapted locally from Section 1.4.6.1 Models of Care for the Treatment of Drug Misusers 2002 p43

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