Evaluation Report of the National Drugs Rehabilitation Framework Pilot

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Acknowledgments

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Glossary of terms:

Active site:

An active site refers to a site that was actively implementing the framework at the time of data collection.

Advanced stage implementer site

The term advanced stage implementer site was used to denote a site that had implemented the framework in its entirety.

Care plan*[1]

A care plan is a documented agreement of a plan of action between the service user and service provider based on SMART (Specific, Measurable, Attainable, Realistic and Time-bound) objectives. Care plans should document and enable review of service user needs, goals and progress across four key domains:

- Drug and alcohol misuse
- Health (physical and psychological)
- Offending
- Social functioning (including housing, employment and relationships).

A care plan should be brief and readily understood by all parties involved and should be a shared exercise between the service user and the service provider. The care plan should explicitly identify the roles of specific individuals (including the service user) and services in the delivery of the care plan. Care plans should be reviewed both routinely and when a change in a service user's circumstances makes it necessary.

Care planning*

Care planning is a process for setting goals, based on the needs identified through an assessment, and planning interventions to meet those goals with the service user. Care planning is a core requirement of structured drug treatment. An integrated care plan involves two or more agencies. (See also shared care planning at the end of this section).

* All terms were taken directly from the National Drug Rehabilitation Framework Document.

Case management*

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

Case manager*

The case manager is the identified person who has a formal role in the management of inter-agency communication and the provision of co-ordinated care for the service user in question.

Comprehensive Assessment*

Comprehensive assessment is targeted at drug misusers with more complex needs and those who will require structured drug treatment interventions. The assessment aims to determine the exact nature of the individual's drug and alcohol problems, and coexisting problems in the other domains of health (mental and physical), social functioning and offending. Comprehensive assessment can be seen as an ongoing process rather than a single event. It provides information that will contribute to the development of a care plan for a service user.

Core service user

A service user attending the main programme of a service or availing of the general services offered rather than a service user that is attending some ancillary part of a programme or service.

Early stage implementer site

The term early stage implementer site was used to denote a site that had implemented some but not all framework protocols.

Four Tier Model

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

The Four Tier Model

The four tier model of care (taken directly from the NDRF 2010 P9) will act as the overarching framework for the provision of rehabilitation pathways. Briefly, these tiered *interventions* are described as follows.

Tier 1 interventions include the provision of drug-related information and advice, screening and referral to specialised drug treatment services. They are delivered in general healthcare settings (emergency departments, liver units, antenatal clinics, pharmacies, or in social care, education or criminal justice settings [probation, courts, prison).

Tier 2 interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community or hospital based. The interventions include information and advice, triage, referral to structured drug treatment, brief interventions and harm reduction e.g. needle exchange programmes.

Tier 3 interventions are mainly delivered in specialised structured community addiction services, but can also be sited in primary care settings such as Level 1 or Level 2 GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community based specialised drug assessment and co- ordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

Tier 4 interventions are provided by specialised and dedicated inpatient or residential units or wards, which provide inpatient detoxification (IPD) or assisted withdrawal and/or stabilisation. Some service users will require inpatient treatment in general psychiatric wards. Acute hospital provision with specialist “addiction” support will be needed for those with complex needs e.g. pregnancy, liver and HIV-related problems. Others will need IPD linked to residential rehabilitation units to ensure seamless care.

Initial Assessment *

An initial assessment usually takes place when a drug misuser first contacts specialist drug treatment services. The aim of an initial assessment is to determine the seriousness and urgency of a service user’s problems and the most appropriate type of treatment for the service user. It involves a fuller assessment of the individual’s drug and alcohol problems than is conducted at screening, as well as assessment of a service user’s motivation to engage in treatment, current risk factors and the urgency of need to access treatment. As a

result of this assessment, an individual might be offered services within the assessing agency or onward referral to another service. A further outcome of an initial assessment is that, where appropriate, work is undertaken to further engage and prepare the individual for treatment.

Key informants

A key informant was an individual that was nominated by a pilot site co-ordinator for interview. These individuals were not key workers, case managers or managers, but were nevertheless seen as instrumental to the implementation of the NDRF. The majority of key informants were members of Drug Taskforce Treatment and Rehabilitation Committees or equivalent, a small number represented 'the missing voice of the family' and the remainder were in senior management, removed from frontline delivery but managing senior individuals involved in the implementation.

Key worker*

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

Key working*

Key working is a process undertaken by the key worker to ensure the delivery and ongoing review of the care plan. This usually involves regular meetings between the key worker and the service user where progress against the care plan is discussed and goals revised as appropriate. The key worker is usually a member of the multidisciplinary team responsible for delivering most of the service user's care.

National Drug Rehabilitation Implementation Committee (NDRIC)

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

National Senior Rehabilitation Co-ordinator*

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

Pre-implementation site

A site that had not actively implemented the framework at the time of data collection i.e. a site that remained in the pre-implementation planning phase and had not managed to integrate the framework into practice.

Rehabilitation*

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

Rehabilitation Co-ordinator*

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

Service Level Agreement (SLA)*

A service level agreement is a negotiated agreement between two parties where one is the funding organisation and the other is the service provider. It usually includes a clear and

detailed specification and formalised agreements in relation to the service to be delivered and the measurable outputs and outcomes expected.

Shared Care Plan*

Where there are multiple agencies involved in setting objectives with the service user, these should be combined to form a shared care plan, which the case manager oversees.

Executive Summary

This is the first external examination of the pilot of the National Drug Rehabilitation Framework (NDRF). A selection of service providers, service users and key informants were interviewed across ten volunteer pilot sites. Of the ten pilot sites six had begun implementing the framework and four had not. There were qualitative and quantitative components to the evaluation.

The quantitative findings come from questionnaires filled out by 81 individuals, all from pilot sites implementing the framework. There were 14 service users, 48 key workers/case managers and 19 service managers. All service users had completed an assessment and all had a key worker. Two thirds had a case manager. Overall, service users were satisfied with the service they were receiving. Three quarters of key workers/case managers always engaged in care planning, and the remainder sometimes, with similar ratios for engaging in interagency meetings. Service managers were more likely to experience difficulty implementing comprehensive assessments than initial assessments.

All bar one manager said care planning was being implemented but of those doing so all except three reported difficulties. Implementation of confidentiality protocols was in some way difficult for over three quarters of service managers. Service managers reported varying levels of access to support services such as addiction, education and employment, housing, justice and law reform services. All service managers were engaged in interagency working but all reported at least some difficulty implementing service level agreements. Both service managers and frontline staff reported an improvement in communication, sharing of information and referrals following implementation of the framework.

The qualitative findings come from interviews with 74 individuals. Interviews took place with 14 service users from the pilot sites that were implementing the framework. In addition, there were interviews with 12 key workers, 8 case managers and 12 service managers from the pilot sites. Ten coordinators from the pilot sites were interviewed. In addition 18 key informants were also interviewed. Fourteen of these were from pilot sites that were not

implementing the framework. There was near universal enthusiasm for the framework and optimism that its aims could be achieved if commitments to the framework were re-iterated by all agencies. Better inter-agency working was seen as key. One of the fears expressed by many was that the momentum gained could be lost if all agencies who have an input decided to pull back from the implementation. There is already some evidence of 'missing partners'. When asked about their experience with their key workers and case managers, service users were generally very positive and felt supported in the process. Service users spoke about the benefits of connecting with a service and the direct effect that this had on their lives.

In terms of the benefits that were more directly attributable to the framework, care planning was the most recognisable practice for service users; the majority of service users had a clear idea of their goals and aspired to build on the current success.

Four sites were not implementing the framework when this evaluation fieldwork was being carried out. While parallel work to the framework was most likely taking place in these sites there were no service users who could be interviewed as possible beneficiaries of the framework. The two most commonly cited reasons for non-implementation were politics and lengthy pre-implementation planning. Some interviewees saw this as a lost opportunity and there was a sense that if people had their time back they would have begun implementing sooner.

Notwithstanding the findings and some of the challenges uncovered in the roll-out of the framework there was near universal support and enthusiasm for the framework, even where it was not being implemented yet. The purpose of the evaluation was to provide learning on what was, and was not, working. All findings, both positive and negative, provide a stimulus for increased learning and can be used to advance the implementation of the framework nationally.

CHAPTER ONE: INTRODUCTION AND LITERATURE

Introduction:

As part of the mid-term review of Ireland's Drug Strategy in the first decade of this century, *Building on Experience, 2001-2008, the Report of the Working Group on Drug Rehabilitation* was published in 2007. Arising from the report of the Working Group the National Drug Rehabilitation Implementation Committee (NDRIC) was established. In order to put the recommendations of the Working Group into effect NDRIC developed the National Rehabilitation Framework, which was published in April 2010.

Elements of the framework included an integrated model of rehabilitation, care planning and case management, standardised assessment procedures and a range of accompanying protocols, agreements and quality standards. The framework was widely disseminated and service providers were encouraged to implement it. Pilot sites expressed an interest in participating, co-ordinated through Drugs Task Force Treatment and Rehabilitation Sub-groups.

This present report is the result of the evaluation of the pilot of the framework across 10 pilot sites.

Literature

The National Drug Rehabilitation Framework (NDRF) was developed to improve the quality and quantity of interagency referrals between drugs services (community, voluntary and statutory) and the range of services that a person may need to access in their recovery. However, challenges exist regarding how to make the NDRF a reality, particularly at an organisational level and as a routine, sustained aspect of standard practice. Prior to reviewing findings, it is of interest to look first at the literature regarding service provision within the substance use services, as well as factors that influence any systems change.

Problematic alcohol and substance use is associated with a wide range of serious health, social and economic complications (Hesse and Tutenges 2011). Consequently substance users' needs are often quite complex. Substance users are less likely to be in employment, and more likely to be in need of support with housing, relational and legal issues (Drake, McHugo et al. 1998). Primary tasks of treatment for alcohol and substance use are to (1) identify the specific needs that alcohol and substances are being used to meet and (2) develop and reinforce skills that provide alternative ways of meeting those needs (Stephens, Babor et al. 2002).

The National Institute for Clinical Excellence (NICE) Guidelines suggest treatment for problematic substance misuse should always involve a psychosocial component. These guidelines recommend *psychosocial interventions in the treatment of people who misuse opioids, stimulants and cannabis in the healthcare and criminal justice systems* (Pilling, Strang et al. 2007). Psychosocial interventions encompass a wide range of components, including *self-management skills training, family intervention, self-help groups and other consumer-oriented services, supported employment and housing, and case management* (Frese, Stanley et al. 2001).

The type of intervention should be selected on the basis of the treatment need of the individual patient, guided by the available evidence base of effectiveness, and not by the interests of the service provider (Killaspy, Kingett et al. 2009). Motivational interventions, contingency management and behavioural couples therapy are the key evidence-based psychosocial interventions for the management of problematic substance use. Moreover, the authors categorise these interventions as either low- or high-intensity:

- Motivational interventions (low-intensity)
- Contingency management (low-intensity)
- Behavioural couples therapy (high-intensity)

Psychosocial interventions can be delivered by a range of frontline staff (Medical Doctors, Nurses, Pharmacists, Counsellors, Psychologists, and Key workers) with the relevant competencies. The competencies of the clinician or key worker when delivering an intervention are imperative to service user outcomes. In a systematic review Pilling, Strang et al. (2007) emphasize some of the key competencies required as follows:

- *the ability to engage a service user appropriately while demonstrating satisfactory levels of warmth, in order to build rapport and trust, which fosters an ability to adopt an 'individual approach that is consistent with and compliments the service users.*

- *The ability to adjust the nature of the intervention according to the needs of the patient*

- *The ability to deal with complex emotions, as well as understanding and working with the service user's emotional context including service user motivation.*

However, Killaspy, Kingett et al. (2009)emphasize that the mere publication of competencies or the implementation of appropriate training programmes are not sufficient to achieve effective service delivery. Rather Killaspy, Kingett et al. (2009) suggest that adequate supervision is required in order to consolidate training and maximise the benefit of the investment in time and resources. Moreover, in addition to training and supervision, quality assurance and clear protocols for the delivery of the interventions need to be in place if effective service delivery is to be achieved.

Evidence based standardised models of care

There is a growing momentum to move towards implementing evidence based standardised models of care across the health service. Although there is a considerable literature on organisational factors associated with implementation of standardised care, little research has examined such systems change in the addiction service settings. Research focusing specifically on the implementation of such changed practice can inform policymakers, administrators and providers about factors that facilitate or hinder the implementation process (Aarons and Sawitzky 2006). An improved understanding of such factors can lead to the development of optimal implementation strategies tailored to specific organisational and service contexts (Aarons and Sawitzky 2006). One model of evidenced-based standardised care that has gained popularity in the addiction services in recent years is case management. Case management is an evidenced based standardised model of care that has been used in the field of addiction since the 1980s (Vanderplasschen, Rapp et al. 2004).

Case management is a service user centred strategy involving assessment, planning and brokering between applicable services to provide the relevant resources and advocacy to meet the service users' needs (Vanderplasschen, Rapp et al. 2004). The purpose is to improve the co- ordination and continuity of service delivery. Several models of case management exist. Hesse, Vanderplasschen et al. (2007) offer a concise summary and definition of case management. The 'Brokerage' case management model sets out to help service users to identify their needs and broker services to meet these needs.

Gillespie and Murty (1994) provide a useful analysis of networked service delivery systems with particularly helpful insights into the function and impact of various types of community linkages. According to Gillespie and Murty agencies can be characterized by the links they develop and maintain with other community-based services. The Center for Substance Abuse Treatment (1998a) applies Gillespie and Murty's model classification scheme to substance abuse case management, yielding what they refer to as three 'inter-organisational models of case management; (i) the single agency (ii) the informal partnership (iii) the formal consortium (Gillespie and Murty 1994).

- In the single agency management model the individual establishes a series of unconnected relationships on a needs basis with colleagues in other agencies. The has complete autonomy and control of the case and is accountable only to 'the parent agency' (The Center for Substance Abuse Treatment, 1998a).

- In the informal partnership model, several employees from a number of agencies work collaboratively, but informally, as a transitory team to meet the needs of the service user. This is done on an individual case basis and may involve multiple agencies exchanging numerous resources. The responsibility for the service user is shared, even though accountability for services provided remains with the individual agencies.

- The formal consortium model brings case managers and service providers together through more formal means, such as service level agreements. Service providers work together for multiple service users on an on-going basis and are accountable to the consortium. To ensure coordination among consortium members, a single agency typically

takes the lead in coordinating activities and maintains final control over selected resources and interagency processes.

All three models offer clear descriptions of existing arrangements of interagency case management services, and methods for administering them. However, the most appropriate model for a particular agency or programme hinges on its own history and mission, the needs of its service users, and the environment in which it operates. In developing a model, it is of note to remember that neither organisations nor environments are static, and interagency models may evolve in complexity from the single agency to the informal partnership to the formal consortium. Although each model has advantages and disadvantages, a model's fit with its service users, the agency culture, and organisational climate determine its effectiveness for a particular programme (McNabb and Sepic 1995). Nonetheless, the philosophical orientation of a programme can affect the efficacy of any interagency arrangements. It is vital that a mutual understanding of a programme's history and philosophy is reached. Compatibility in both programme philosophy and organisational structure is fundamental if interagency cooperation is to occur; otherwise the service may experience a 'clash' with partner agencies (The Center for Substance Abuse Treatment, 1998a).

The literature examining the efficacy of case management is relatively recent. Studies conducted thus far have suffered from significant methodological problems that include small sample sizes, poorly defined or implemented case management interventions, problems in evaluation design and measurement and lack of distinction between case management and comparison interventions (The Center for Substance Abuse Treatment, 1998b; Hesse, Vanderplasschen et al. (2007). Nevertheless, despite these shortcomings, some valuable insights have been gained from work in the mental health and substance abuse fields. The ease of access to community services may help or hinder the effects of case management. In areas where services cannot easily be accessed, linkage was improved, whereas in areas where services may easily be accessed more modest improvements were seen around service user outcomes, which may indicate the level of work that must occur between services before any change in service user outcomes are observed.

In a recent Cochrane review Hesse, Vanderplasschen et al. (2007) carried out a meta-analysis of the effectiveness of case management In order to assess successful linkage with other services, illicit drug use outcomes, and a range of related outcome. The study examined 1230 studies that applied case management to substance using populations. Due to the strict Cochrane conditions (regarding clinical trials and randomisation) the authors only included data from 15 of the 1230 studies. These 15 studies included 2391 patients and compared a model of case management with interventions referred to as 'treatment as usual' or 'standard community services'. Outcome on illicit drug use was reported from seven studies with 2391 patients; however, the effect size for illicit drug use was not significant. In addition, the effect size for service linkage was moderate. Moreover, of the 15 studies the authors only found a single, large trial comparing case management with psycho education and drug counselling that found case management was superior to psycho education and drug counselling in reducing drug use. The authors concluded: *there is current evidence supporting that case management can enhance linkage with other services*, however, *evidence that case management reduces drug use or produces other beneficial outcomes is not conclusive (p.7).*

Vanderplasschen, Rapp et al. (2004) concluded that for problematic substance users requiring a variety of services (e.g. concerning employment, substance abuse, health and child care), the implementation of one specific model of case management is likely to be effective. The strengths-based case management appeared to be the most effective model; however, only two clinical trials by a single research group existed at the time. Other factors that are likely to influence models of case management are availability of training and supervision, and the degree of integration of case management in the network of services. Moderator analyses suggested that the use of a manual to guide the case management intervention may also be effective.

Nevertheless, the authors suggest that given the rather modest effects found in their meta-analysis it is unlikely that case management directly affects primary outcome measures such as substance use, employment, housing, and criminal activities. Case management was most effective at linking the substance user with appropriate services. Furthermore,

Vanderplasschen, Rapp et al. (2004) assert if case management is expected to improve primary outcomes it should be clear that this intervention is best seen as an adjunct to existing (evidence-based) services in the substance abuse treatment services.

The proposed move towards the standardised approach of the National Drug Rehabilitation Framework (NDRF) is largely based on, but not limited to, case management. This is recognised within the context of the National Drugs Strategy, as the Rehabilitation Framework is placed within the context of the treatment rehabilitation actions in the National Drugs Strategy which, among others, seek to expand the availability and access of services and implement a quality and standards framework in the addiction services. This is quite new in Ireland and has not been previously researched at a national level. Thus knowledge of factors that assist or hinder this process are extremely critical in understanding if this systems change is to continue nationally.

Factors influencing the implementation of changed practice

There is a growing literature suggesting several factors may influence adoption and sustainability of new practices and systems change. Of particular interest is the context in which the change will be implemented i.e. organisational culture and climate, leadership and readiness to change.

Context:

The context into which any new practice is implemented is often complex. Studies have identified a number of contextual constructs thought to be necessary for effective implementation of change in organisations (Glisson 2002). The most commonly cited are organisations' culture and climate. Definitions of organisational culture and climate vary considerably. Beidas, Aarons et al. (2013) offers a concise definition of each. Organisational culture is defined as shared beliefs and expectations of a work environment, whereas organisational climate is defined as shared perceptions about the work environment's impact on its own employees.

Leadership

Leadership may also drive implementation of changed practice, although few studies have examined its effects (Beidas, Aarons et al. 2013). According to Beidas, Aarons et al. (2013) preliminary investigations focusing on the relationship between leadership and organisational variables suggest that high quality leadership is vital in times of system change and may mitigate poor organisational climate and high levels of staff turnover. Moreover, high quality leadership is also associated with positive staff attitudes towards adopting new practices (Beidas, Aarons et al. 2013). It is therefore essential to examine if high-quality leadership and characteristics of leaders (e.g., attitudes) predict more successful implementation.

Readiness to change:

The literature focusing on organisational change asserts that organisational 'readiness to change' is critical to successful implementation of new practices (Armenakis, Harris et al. 1993, Sweeney and Whitaker 1994, Amatayakul 2005, O Connor and Fiol 2006). Weiner, Amick et al. (2008) contend that organizational readiness for change is a critical precursor to successful change implementation. Moreover the authors further suggest that health care settings only achieve partial success when they initiate organisational change (Weiner, Amick et al. 2008). The authors conducted a systematic review in health services research regarding organisational readiness to change and concluded this topic was still in its infancy. There is a paucity of research focusing on readiness to change within addiction health research(Hagedorn and Heideman 2010).

Hagedorn and Heideman (2010) reviewed the conceptualisation and measurement of organisational readiness to change, across a range of health services and related fields such as education and human services. The authors concluded that there was insignificant consistency in the conceptual terminology regarding organisational readiness to change. Very few tools exist to measure organisational readiness to change. Furthermore the available tools for measuring such concepts are of limited value given their poor reliability and validity.

CHAPTER TWO: METHODS

The starting point for this evaluation was the 'terms of reference for pilot projects to inform the implementation of the National Rehabilitation Framework' (2010)'. The pilots were to:

- Support the implementation of the National Rehabilitation Framework and the integrated care pathways model in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation
- Build awareness and knowledge of the National Rehabilitation Framework amongst key stakeholders
- Identify progress in implementation
- Identify gaps in services and drivers/obstacles in respect of implementation
- Assess the initial impact of the Framework
- Help to clarify roles and inform implementation of the Framework (A detailed background to this is given in Appendix 1).

A national Senior Rehabilitation Co-ordinator was appointed and NDRIC was established in an overseeing and monitoring role. Each pilot site was to identify a specific number of clients across Tiers 1 to 4. The pilots were to assess the impact of the framework on service users and their families, key organisations involved in the implementation and relevant agencies and Government Departments. Selection criteria were set for pilot projects and it was acknowledged that , together with the HSE, key roles existed for the Rehabilitation Co-ordinators in conjunction with the Treatment and Rehabilitation subgroups of the local and regional drugs task forces. The key outputs of a structured monitoring and evaluation mechanism for the pilots were described and the final evaluation report was to include the following:

- Description of the evaluation process
- Consultation with relevant stakeholders
- Assessment of the extent to which the Framework is meeting the need for which it was intended; this will be further informed through an assessment of the level of engagement and compliance with the Framework among services

- Review of international and national research on the potential benefits of the National Rehabilitation Framework
- Assessment of both Structural and Process Indicators for participation/implementation of the framework across a range of projects/sites
- Outcome Indicators to inform assessment of the quality and effect of the Framework
- Conclusions and recommendations

The authors submitted a protocol, based on the published terms of reference for the pilot projects, in June 2010 to carry out this evaluation. The details of the research protocol agreed with NDRIC are set out in the ethical approval obtained(Appendix 2).

Design

A mixed methods approach was employed in the present study. Both quantitative (questionnaires) and qualitative (focus groups and interviews) methods were used, in addition to the documentation of three case studies.

Pilot sites

Ten pilot sites participated in the study. Six sites were based in Dublin. All sites were self-selected. i.e. they responded to a call from NDRIC to participate in the piloting of the NDRF. All participating sites returned a written proposal. While there were some similarities in these proposals, for the most part they were quite different (in terms of size, partner agencies, time in existence). Some pilot sites planned only to include addiction services, others named ancillary partners such as An Garda Siochana and the Irish Prison Service. All pilot sites that returned a proposal within the timeframe stated were accepted by NDRIC into the study. It became apparent immediately before data collection that not all pilot sites had begun the implementation of the framework locally. Some sites were still at the planning or pre-implementation stage and had not in fact managed to integrate the framework into practice. Thus it was no longer appropriate to meet with service users, key workers, case managers or managers in pre-implementation sites about their experience of implementing the framework, since anything reported by them would relate to treatment as usual and not the NDRF. We contacted all local co-ordinators and asked each of them to categorise their sites according to whether or not they were actively implementing the

framework at that time, i.e. if service users were being worked with according to NDRF. Co-ordinators promptly replied and the new categorisation was applied.

Table 1 below gives the full characteristics of each pilot site. The table illustrates the implementation stage each site was at (pre-implementation, early implementer or advanced implementer) as well as a profile of participating sites (number of partner agencies, level of establishment, geographical location, assignment of co-ordinator, i.e. voluntary or paid position and part or full-time).

Table: Characteristics of 10 pilot sites

Level of implementation at time of data collection	Advanced stage implementer site	Early stage implementer site	Pre-implementation site
	1	5	4
Range of partner agencies across all site	2	3-16	3-16
Geographical location	Rural[2]	City[3] and Rural	City and Rural
Characteristics of service users	Predominately alcohol with some poly-drug use	Predominately poly-drug use	Predominately poly-drug use
Establishment of addiction specific services within pilot site	Recent <5 years	Recent <2 years	Established > 15 years
Range of tier services provided by partner agencies	2-4	1-4	1-4
Coverage of addiction specific service provision available in geographical area (not necessarily included in pilot)	Low	Low-High	Low-High
Specific services provided by partner agencies across pilot sites	Counselling, Outreach, Aftercare programme, Family Support, Gender Specific support, Key working, Case management and Community Medical Detoxification	Probation, Counselling, Outreach, Aftercare, Key working, Case management, Methadone maintenance, Community Detox, Education and Training. Family Support, NDRIC Specific: Key working, Case management, Education and Training	Probation, Counselling, Outreach, Aftercare, Key working, Case management, Methadone maintenance, Community Detox, Education and Training. Family Support, non-Specific: Key working, Case management, Education and Training
Status of Co-ordinators (10 co-ordnators, 10 sites)	The co-ordinator of this advanced implementation site was part-time and also held another senior level managerial addiction specific full-time position.	Two of the coordinators of the early stage implementation sites were designated co-ordinators with no other role/responsibilities; one was part-time and covered one site the other was full-time and covered one site spread over two counties. 3 The remaining three co-ordinators of the early stage implementation sites were	The four coordinators of the pre-implementation sites were part-time and also held other addiction training/education, managerial positions.

		part-time co-ordinators and also held other addiction training/education, managerial, full-time positions.	
Status of partner agencies	Non-statutory	Statutory and Non-statutory	Statutory and Non-statutory
Implementation phase*	All 9 protocols actively implemented between all of the partner agencies	The implementation of the NDRF was in its infancy. Not all protocols implemented. Not all partner agencies actively involved in the process	Pre-implementation sites had not managed to implement the NDRF. One of the partner agencies had managed to implement NDRF assessment and care planning practices on an intra-agency level. However, beyond the scope of intra-agency work, no other protocols were being implemented. In addition, one partner agency had withdrawn from the process due to a change in management and lack of available resources.

A detailed description of each of the 10 pilot sites is given in Appendix 3

Participants:

Interviews with services users, key workers and case managers were conducted in the advanced stage and early stage implementer sites. Interviews with the Coordinators were conducted in all 10 sites. The majority of key informants were from the pre-implementation sites

Service users:

Fourteen service users (6 male and 8 female) were interviewed, representing six implementation sites. The service users were quite a homogenous group, all being white and Irish. Two participants were attending residential facilities at the time of interview. Eleven others were attending community methadone programmes and one was drug free in the community.

Key workers

Twelve key workers (six male and six female) were interviewed, representing six implementation sites. The key workers were a diverse group with a variety of skills and training across a range of health, social care and related fields. A number of key workers

came from unrelated fields such as business and hospitality. Some were relatively new to the field whereas others had spent many years working within the addiction services. The majority of key workers involved in the pilot were employed by non-statutory agencies.

Case managers

Eight case managers were interviewed (seven were female), representing six implementation sites. The case managers were quite a homogenous group who mostly came from therapeutic disciplines with several years experience in the field of addiction. The majority of case managers involved in the pilot were employed by non-statutory agencies.

Managers

Twelve managers were interviewed (five males and seven females) representing six implementation sites. The managers were quite a diverse group with a varied educational background, predominantly within the social sciences. The majority of managers interviewed were trained or educated to postgraduate or equivalent level, with several years' experience in the field of addiction. The majority of managers involved in the pilot were employed by non-statutory agencies.

Co-ordinators

Ten co-ordinators were interviewed (four male and six female) representing ten sites. One co-ordinator who represented a regional site made up of a number of counties was interviewed twice[4]. The pilot site co-ordinators were a diverse group with a variety of skills and training across a range of health, social care and related fields. Some co-ordinators were relatively new to the field whereas others had spent many years working within the addiction services. The majority of co-ordinators were employed by a non-statutory agency; however, almost half had strong links with the HSE. Either they were employed with monies that came from the HSE or they had established relationships with their colleagues in HSE addiction services. The greater part of the group worked in this role on a part-time basis, often assuming the role of co-ordinator in addition to a full-time post with the addiction services.

Key informants

A total of eighteen key informants were interviewed. The majority of key informants were interviewed to gain insight into their experience of the NDRF in pre-implementation sites (N=14). The majority of key informants (n=14) were members of the Drugs Task Force Treatment and Rehabilitation Sub Committee or equivalent[5]. In the majority of pre-implementation sites the chair of the local Treatment and Rehabilitation Sub Committee was interviewed. It is important to note that one pre-implementation site only provided two members of their Treatment and Rehabilitation Sub Committee neither of whom was the Chair. Two other key informants were interviewed in relation to the exclusion of family in the NDRF. The remainder (N=2) were nominated by co-ordinators as individuals who were instrumental in the implementation process but were not a key worker, or a manager. Key informants were quite a diverse group representing several disciplines (medicine, counselling, nursing, policy makers, administration) working within the Addiction Services with various years of service.

Data sources:

1. Quantitative Questionnaires

Questionnaires were sent to respondents when considered to have been finalised and 'signed off' by NDRIC. Copies of the various questionnaires are given in Appendix 4.

Key worker/and manager questionnaires

A list of names and postal addresses of all key workers /case managers and managers participating in the pilot were sought from local co-ordinators. Based on this mailing list all were contacted and asked to complete the questionnaire based on their experience as a participant in the pilot site.

Service user questionnaires

The original research methodology agreed by NDRIC proposed to collect service users ´questionnaires, matched to the key worker/working with them. At the time of the proposed methodology, based on feedback from pilot co-ordinators, it was estimated that between 250 and 400 service users would participate in the evaluation. As there were 10 sites participating in the study this averaged 25-40 service users per site. The questionnaire

was made up of mainly demographics and included the Treatment Outcome Questionnaire (TOP) and two questions from the Addiction Severity Index (ASI) ('how troubled or bothered have you been in the last year by alcohol problems' and 'how important to you is treatment right now').

The original proposal sought to administer the questionnaire pre and post implementing the NDRF for each servicer user. The service user was to be new to the service and to his/her key worker/case manager. One of the research authors (JI) negotiated with three local co-ordinators to meet with a group of key workers and case managers who would administer the questionnaire. Three two-hour sessions with a total of 18 participants were spent discussing the practicalities of administering the questionnaire to service-users. In addition JI had sought permission for and acquired a training suite from the National Treatment Agency to train key workers and case managers in administering the TOP. During these three sessions it transpired that all key worker and case managers felt that this was a reasonable undertaking.

The NDRIC committee voiced concerns about the pre- and post- administration of TOP and two questions from the ASI to approximately 300 service users as part of an outcome assessment of the pilot of the framework. The concerns related to the possible over-interpretation of the outcome data. A discussion took place over several weeks in relation to the benefits of collecting outcome data as advocated by the researchers and the concerns of NDRIC in relation to possible over-interpretation. In the end, the decision of NDRIC was to omit the collection of any objective outcome data and the service user data collection was confined to questionnaire administration/interview of 14 service users.

Following the feedback from NDRIC and Co-ordinators the key worker/case managers' and managers' questionnaires were posted out in late July 2012. Questionnaire data were collected between July and December 2012 (with the exception of the service user questionnaires which were administered by the researcher (JI) at time of qualitative interview). Co-ordinators were kept updated on the number of service users or managers who had completed the questionnaire and were asked to contact and remind the participants who had not completed questionnaires to do so.

2. Focus Groups

The primary purpose of the focus groups was to allow stakeholders to input into the content of the topic guides for the qualitative interviews before finalisation. Two focus groups were conducted by the field researcher (JI) in July 2012 with relevant stakeholders from the service providers' participant group representing key workers, case managers, managers, key informants and co-ordinators. Each pilot co-ordinator was asked to attend one of the focus groups and nominate at least two colleagues who would represent one of the four other groups (i.e. key worker, case manager, manager, or key informant). In addition three other participants were invited to take part, one service user advocate and two family support advocates. The service providers attended one of two groups. However, the three advocates attended both focus groups. Group one had twelve participants, while group two had fourteen. The focus groups were held in a central location in Dublin. Ten sites were represented. All co-ordinators were furnished with the relevant topic guides for discussion in advance and asked to disseminate them amongst their colleagues, particularly those planning to be in attendance. If a colleague had a comment and could not attend co-ordinators were asked to collate issues and feed them back to the research team. Each focus group lasted approximately one hour. Participants were broken into groups, representing service user, manager and key worker/case manager topic guides. Participants were given the first 15 minutes to review the topic guides once again; the remainder of the time was given over to the discussion of each. Despite being allocated a group all participants were given the opportunity to feed into each of the topic guides. As the service users were not present particular emphasis was given to service user questionnaires.

The focus groups were digitally recorded. A full explanation of the purpose of the focus group was given to the participants at the beginning of the sessions and confidentiality was assured. The topic guides for all interviews are given in appendix 5. This interview schedule provided a framework that allowed for focused, conversational, two-way communication between the facilitator of the focus groups and the participants. However, there was flexibility within the discussions to probe further for details or discuss issues as they arose (Darker, Ivers et al. 2013).

Interviews commenced shortly after they were finalised by focus group participants.

3. Qualitative interviews

Qualitative interviews with service users, key workers, case managers, managers, local co-ordinators and key informants were conducted. A key informant was a professional that did not identify with any of these groups but was instrumental in implementing the framework locally or had a key stake in the framework, e.g. the chair of a local treatment and rehabilitation subcommittee or a missing voice e.g. family support agencies.

All sites, including pre-implementation ones, had a Treatment and Rehabilitation subcommittee or equivalent. Because of the importance of capturing the experience of pre-implementation pilot sites it was decided to interview the chair of the Treatment and Rehabilitation subcommittee of each pre-implementation site and 2 or 3 randomly selected members, depending on the size of the committee. Furthermore, the implementation of the NDRF was a key agenda item for this group.

All interviews were conducted by the field researcher (JI). Where possible, a central service in each site provided a room for the interviews. However, in certain sites it was not possible for a participant to travel to a central location and in this instance the researcher travelled to the participants. All interviews were digitally recorded. The interviews were conducted between September 2012 and February 2013.

Case studies

A mixed method explanatory case study was conducted with a core qualitative component and an additional quantitative component was developed to study context regarding the presence or absence of multiple, inter-related contextual elements and associated strategic approaches required for implementation(Stetler, Ritchie et al. 2009). A case is a pilot site (i.e. a geographical area with at least two partner agencies which had agreed to implement the NDRF). Particular focus is given to exploring the role and development of 'context' in the routine use of the NDRF in practice within targeted pilot sites ('case'). Specifically, this theoretically-based approach sought to identify key contextual elements and related patterns and relationships in pilot sites where the NDRF was being piloted.

The ***purpose*** of this case study approach is to understand both key contextual factors and related strategic processes in pilot sites implementing the NDRF in order to:

Identify key contextual elements and processes related to successful implementation of NDRF across pilot sites;

And

Identify key contextual elements that distinguish successful implementation and sustainability across similar pilot sites.

Data analysis

1. *Quantitative analysis*

Questionnaires were inputted and analysed using SPSS 18.0. SPSS was then employed to produce frequency distributions.

2. Qualitative analysis

The recordings of all interviews and focus groups were transcribed verbatim. Interviews lasted an average 45 minutes. To enhance validity, a summary of the main points was given at the end of each focus group and participants were asked if it was an accurate portrayal of what had been discussed. An idiographic approach to analysis was adopted, and each transcript was examined in detail. Rigorous line-by-line coding was applied, with a focus on experiential claims and concerns (Larkin, Watts et al. 2006). Patterns in the data were then clustered into a thematic structure. Content thematic analysis was utilised to identify and categorise major themes and sub-themes (Ivers and Downes 2012, Darker, Ivers et al. 2013). The themes were then reviewed and refined to ensure they formed a coherent pattern and to recode where necessary. The texts and emerging themes were reviewed by three researchers all of whom had varying levels of immersion in the project. One author (JI) carried out the interviews and focus groups. Both JI and the second author (JB) conducted the detailed coding and theme-development. A third researcher (a non-author, CD) who had not been involved in either the study design or data collection but is familiar with qualitative methodologies and addiction service research reviewed the coding frame and original text independently. Any differences in interpretation by the researchers were resolved through discussion. In reporting the results, the identities of the participants have been anonymised. All participants have been given pseudonyms in order to protect their identity.

Ethical approval:

Ethical approval was granted for the study by the Ethics Committee at The Drug Treatment Centre Board.

CHAPTER THREE: QUANTITATIVE DATA

The following chapter presents the descriptive findings from the 14 service users (collected at time of interview), 48 key workers/case managers and 19 managers that completed the postal questionnaire.

The service user findings are presented below. An emphasis was placed on service user satisfaction. However, the setting has to be noted i.e. service users were nominated by the service provider and more often than not the questionnaire was conducted within that service. A large body of research exists on the problems associated with taking service user satisfaction measures in such a context (Larsen, Attkisson et al. 1979, Williams 1994, Ford, Bach et al. 1997, Sitzia 1999).

Service user quantitative findings

Of the fourteen service users interviewed, the majority (N=11) were attending community based methadone maintenance programmes. The others were in residential treatment for opiate dependence (N=2) while drug-free in the community (N=1).

Assessment

All participants (N=14) said that they had completed an assessment. When asked how satisfied they were with this process, (n=11/79%) were either very satisfied or satisfied and (n=3/21%) were dissatisfied. When asked if they had a key worker all participants said yes (N=14). When asked if they had a almost two-thirds said yes (n=9/64%). Of the group that had a (n=9/64%) when asked if they felt part of the care-planning process all participants said that they did; when asked how satisfied they were, participants said they were satisfied (N=6/67%) or very satisfied (N=3/33%).

In addition, participants that said that they had a (N=9/64%) were asked whether they were referred to any other services. All of these participants said that they were (N=9). When asked how satisfied they were with this process, participants responded, satisfied (N=5/63%) or very satisfied (N=4/44%).

Consent and Confidentiality

When asked whether written consent was obtained from the service user before referral to another service and sharing of this information with this service, the majority of participants said that it was obtained (N=9/64%). In addition when asked how satisfied they were with this process participants said they were either satisfied (N=5/56%) or very satisfied (N=4/44%)

When asked if they were informed about the confidentiality protocol between services that are referring service users and in turn exchanging information the majority said that they had been (N=8/89%).

When asked if any interagency meetings were held to support their care-plan all participants said that there had been (N=9/64%). While the majority of participants said that they attended (N=8/89%), one had not. Of the participants that had attended we asked how satisfied they were with the process. They said they were either satisfied (N=5/63%) or very satisfied (N=3/38%).

There was a good distribution of time attending treatment between the service users ranging from 6 months to 24 months. The table below illustrates this distribution.

0-6 months	N=3	21%
6-12 months	N=4	29%
12-18 months	N=5	36%
18-24 months	N=2	14%

However, perhaps more interesting, when asked how much longer they expected to attend services the majority (N=11/79%) suggested that they would still be attending in 12-18 months time. It is noteworthy that of the participants that suggested they would be 0-6 months (N=3/21%) in contact, two were in a drug free residential facility and the one other participant was attending college and drug-free at least 12 months.

Key workers' and case managers' quantitative findings:

A total of 48 key workers/case managers completed the questionnaires. The majority of key workers/case managers were female. Most participants identified their service as a tier 2

service. The majority of key workers/case managers held an addiction specific qualification (N=26/54%) while the remainder suggested that they held a related qualification (N=22/46%). When asked about the level of qualification participants reported a range. The table below illustrates the level of key worker/case manager qualifications.

Certificate Level	N=3	6%
Diploma Level	N=24	50%
Undergraduate Degree Level	N=14	29%
Postgraduate Degree Level	N=7	15%

Assessment

The majority of key workers /case managers reported that the service completed initial assessments (always n=26/54%; sometimes n=22/46%). Two thirds (n=32/67%) of key workers /case managers reported using a brief intervention tool. When asked if they then refer to the most appropriate service just above half said that they did (n=26/54%) more than a quarter (N=14/30%) said that they did not refer on to most appropriate service while the remainder of participants (N=8/15%) did not respond.

The majority of key workers /case managers reported using a brief screening tool (n=31/65%). There are several brief screening tools being utilised by key worker/case managers. However, the most commonly used were the MAP and the AUDIT.

Moreover, of the participants that reported using a brief screening tool (n=31/65%) the majority suggested that this was either extremely effective (n=19/61%) or effective (n=10/32%). Half of the key workers/case managers reported that their service completed comprehensive assessments. Almost three quarters (n=35/73%) of key workers/case managers reported between 25 and 75% of core services users completed a comprehensive assessment. The majority of key workers/case managers reported feeling either confident (n=19/40%) or totally confident (n=12/24%) or somewhat confident (n=15/32%) in this role.

Care planning

All participants reported engaging in care planning either always (n=35/73%) or at least sometimes (n=13/27%). In addition, when asked if core service users had a care plan the majority (n=41/85%) of participants suggested that they had.

Two thirds (n=32) of key workers/case managers said that care plans are written. Moreover, of these, when asked how involved the service user was in this process participants said almost half (n=15/47%) of the time service users are totally involved, more than a quarter (n=9/28%) are somewhat involved while just under a quarter (24%) of service users are involved a noticeable amount in the care plan process.

Case management

Just over half (n=25/52%) of key workers reported being a case manager. Almost two thirds of these case managers (n=16/65%) felt sometimes competent in this role, while almost a quarter (n=6/23%) said they rarely felt competent.

Interagency working

The majority of key workers /case managers (n=43/89%) said that they either always (n=29/60%) or sometimes (n=14/29%) work with agencies in their NDRIC network. Moreover, respondents reported engaging in interagency meetings either always (n=34/71%) or sometimes (n=14/29%). When asked if these interagency meeting are arranged as per NDRF protocal respondents answered as follow; always (n=25/52%) sometimes (n=18/38%) or not at all (n=5/10%).

Information sharing

All key workers/case managers said that they engaged in information sharing. When asked if it was practice to inform the service users of how and when information is shared participants reported always (n=34/71%) or sometimes (n=14/29%). When asked if written consent is obtain from the service user when sharing information when making a referral more than half (n=27/56%) of participants responded always, more than a quarter (n=13/27%) said sometimes while less than a fifth (n=8/17%) said they rarely obtained written consent.

All key workers /case managers reported adhering to a protocol when sharing service user information. Three quarters of key workers /case managers (n=36/75%) reported feeling confident when applying the confidentiality protocol while the remaining quarter (n=12/25%) reported not feeling confident applying this protocol. Key workers /case managers suggested that the confidentiality protocol was either somewhat effective (n=24/50%) or effective (n=24/50%).

Post Implementation of NDRF

The majority of key workers/case managers (n=39/81%) reported some improvement either somewhat (n=19/49%), totally (n=8/20%) or a noticeable amount (n=12/31%) in knowledge of services and relationships with colleagues within their network following implementation of the framework. Almost two thirds (n=30/63%) of key workers/case managers reported strengthened relations in their NDRIC network post implementation.

Quality assurance

Two-thirds (n=32/67%) of key workers/case managers reported using a quality assurance framework. Moreover, of this group (n=32) the majority (n=23/72%) reported having implemented a quality assurance framework in the last 12 months. When asked how effective was the quality assurance framework two thirds (n=21/66%) suggested it was effective, just above a quarter (n=9/28%) said it was somewhat effective, the remaining participants (n=2/6%) did not respond.

Managers' quantitative findings

Nineteen managers completed the questionnaire. Over half (n=10/53%) of the managers reported their service as a Tier 3. All managers reported that their services reported using a brief screening tool. Four screening tools were mentioned. There was a good spread of type of screening tool used across services.

Assessment

The majority of managers (n=16/84%) reported that the service completed initial assessments. In addition managers believed that the staff were either competent (n=10/52%) or very competent (n=9/48%) in this role. Moreover, the majority (n=15/79%) of managers reported referring service users to the most appropriate service as suggested by

the framework. The majority of managers reported the initial assessment to be somewhat effective (n=6/32%) or effective (n=11/58%) or extremely effective (n=2/10%).
Only one fifth of managers reported that their service was not completing comprehensive assessments. Of the managers that did report completing comprehensive assessments no one manager reported all core clients to have completed an NDRF comprehensive assessment. The majority of managers (n=18/94%) reported their service to have implemented care planning. However, over one quarter (n=5/26%) of managers said that they had not implemented the NDRF confidentiality and information sharing protocols. Less than one fifth (n=3/16%) of managers reported not having implemented a client discharge strategy.

Intra-agency implementation

Managers were asked about the level of difficulty experienced when trying to implement initial and comprehensive assessments within the agencies that they managed. Not surprisingly managers were more likely to report experiencing more difficulty when implementing comprehensive assessment than initial assessment. Similarly, managers were more likely to report experiencing more difficulty when implementing case management rather than key working.

Over three quarter of managers (n=15/79%)reported finding it either somewhat difficult or difficult trying to implement care planning in their agency. Over three quarters of managers (n=15/79%) reported finding it either somewhat difficult (n=3/17%) or difficult (n=11/56%) trying to implement the confidentiality protocol. The majority of managers reported finding it somewhat difficult (n=12/63%) or difficult (n=3/16%) to implement a client exit strategy.

Care Planning Practices:

Over two thirds of managers (n=14/74%) reported their core service users having care plans; of these, the great majority (n=12/89%) involved the service user in the development of their care plan most of the time. However, just over a fifth (n=3/21%) suggested that service users were totally involved in the care planning process. Of the managers three quarters (n=14/74%) reported having implemented care planning. In addition, almost three quarters (n=14/74%) of managers reported their service was developing integrated care plans (i.e. involving other agencies). However, more than one quarter (n=5/26%) were not.

Moreover, in over half (N=10/52%) these cases managers reported that integrated care plans did not always include the service user.

The majority (n=18/95%) of managers reported that care plans included details of the service user and all other agencies involved in the care plan. In addition, the majority (n=18/95%) of managers reported that care plans included realistic holistic goals for the service user. Similarly, the majority (n=18/95%) of managers reported that care plans included referrals made and interagency meetings.
The majority (n=18/95%) of managers reported that care plans included details of the service user and all other agencies involved in the care plan. In addition, almost three quarters (n=14/74%) of managers reported that care plans include agreed interventions and time lines. However, over one quarter (n=5/26%) did not involve such basic information.

The majority of managers were more likely to report having access to addiction (n=16/84%) and other health services (n=18/94%) only sometimes when attempting to implement a care plan. The majority of managers reported either sometimes (n=12/63%) or always (n=5/26%) having access to education and employment when attempting to implement a care plan. Managers reported either sometimes (n=16/84%) or rarely (n=3/16%) having access to housing resources when attempting to implement a care plan. In addition, managers reported either always (n=2/10%) or sometimes (n=15/79%) or rarely (n=2/10%) having access to justice and law reform resources when attempting to implement a care plan. Managers reported having access either sometimes (n=14/74%) or always (n=5/26%) to family support when attempting to implement care planning.

Interestingly almost half of managers (n=9/48%) suggested that the lead agency is determined by the capacity of the service provider rather than client preference. Almost a third (n=6/31%) of managers reported only sometimes obtaining written consent from a service user when sharing information and making a referral. Managers reported either always (n=16/84%) or sometimes (n=3/16%) forwarding a copy of the initial and comprehensive assessments when a referral is made. Managers reported either always (n=14/74%) or sometimes (n=5/26%) information sharing in their network to be effective. All managers (n=19) reported where involuntary discharge occurs it is both policy and practice

to arrange alternative support for the service user. The majority of managers (n=18/94%) reported that it was both policy and practice to ensure that service users are aware of their rights around alternative support and re-engagement following involuntary discharge.

Interagency work

All managers (n=19) reported engaging in inter-agency work within their NDRIC network either always or sometimes. Moreover the majority of managers (N=14/74%) reported interagency meetings were arranged as per NDRF protocols and the majority of these managers (n=14) found this protocol to be either somewhat effective (n=9/64%) or effective (n=5/36%) with one non-response.

Inter-agency implementation

Almost half of managers found it difficult (n=8/42%) or somewhat (n=9/48%) difficult to implement service level agreements with interagency colleagues for key working and case management. Similarly the majority of managers found it difficult (n=10/52%) or somewhat difficult (n=7/37%) to implement service level agreements with interagency colleagues around comprehensive assessment and care planning. All managers reported finding it either difficult (n=11/58%) or somewhat difficult (n=8/42%) to implement service level agreements with interagency colleagues around client exit strategies. In addition, the majority of managers reported finding it difficult (n=11/58%) or somewhat difficult (n=6/32%) to implement service level agreements with interagency colleagues around confidentiality and information sharing.

Post implementation of NDRF

Managers reported either somewhat (n=10/52%), a noticeable amount (n=7/37%) or total (n=2/10%) improvement in knowledge of services and relationships with colleagues within their network following implementation of the framework.

Managers reported either somewhat (n=10/52%), a noticeable amount (n=7/38%) or total (n=2/10%) improvement in communication and sharing of information within their network following implementation of the framework. Managers reported either somewhat (n=9/48%), a noticeable amount (n=8/42%) or total (n=2/10%) improvement when accessing services within their network as well as an increase in referrals following implementation of the framework.

All managers reported an increase in referrals either somewhat (n=13/68%), a noticeable amount (n=3/16%) or total (n=3/16%) following implementation of the framework. Moreover, the majority of managers (n=16/84%) reported that their service used a quality assurance framework. Moreover, all managers that reported using a quality assurance framework suggested that the framework was either somewhat effective (n=7/37%), effective (n=6/32%) or extremely effective (n=6/32%).

Summary and discussion of quantitative findings

All service users had completed an assessment. When asked if they had a key worker all participants said they had. When asked if they had a almost two-thirds said they had. Of the group that had a case manager, when asked if they were part of the care-planning process all participants said they had been. Overall, service users suggested that they were satisfied with the service they were receiving at the time of interview.

Key workers and case managers reported engaging in care planning either always (n=34/71%) or at least sometimes (n=14/29%). Two thirds (n=32/66%) of key workers/case managers said that care plans are written. Moreover when asked how involved the service user was in this process keyworkers/case managers said almost half (n=22/46%) of the time service users are totally involved, more than a quarter (n=14/29%) are somewhat involved while just under a quarter (n=12/25%) of service users are involved a noticeable amount in the care plan process.

Just over half of key workers (n=25/52%) reported being a case manager. The majority of key workers /case managers said that they always (n=29/60%) or sometimes (n=14/28%) work with agencies in their NDRIC network. Moreover, the majority of respondents reported engaging in interagency meetings either always (n=34/71%) or sometimes (n=14/29%).

When asked if these interagency meetings are arranged as per NDRF protocol, key workers/case managers said that they were either always (n=25/52%) or sometimes (n=18/38%).

Managers were asked about the level of difficulty experienced when trying to implement initial and comprehensive assessments within the agencies that they managed. Not

surprisingly managers were more likely to report experiencing more difficulty when implementing comprehensive assessment than initial assessment. The majority (n=14/79%) of managers reported referring service users to the most appropriate service as suggested by the framework.

Only one fifth of managers reported that their service was not completing comprehensive assessments. Of the managers that did report completing comprehensive assessments no one manager reported all core clients to have completed an NDRF comprehensive assessment. The majority of managers (n=17/89%) reported their service to have implemented care planning. However, over one quarter (n=5/26%) of managers said that they had not implemented the NDRF confidentiality and information sharing protocol. Less than one fifth (n=3/17%) of managers reported not having implemented a client discharge strategy.

Both managers and frontline staff reported an improvement in communication and sharing of information within their network following implementation of the framework. Interestingly, all participants reported an increase in referrals following implementation of the framework. Moreover, the majority of participants reported that their service used a quality assurance framework.

CHAPTER FOUR: FINDINGS FROM QUALITATIVE INTERVIEWS

The findings presented here are based on content thematic analysis of interviews with 14 service users, 12 key workers, 8 case managers and 12 managers in 6 of the 10 sites. Content thematic analysis is gaining popularity in the health service literature as an analytic tool to describe the process of implementing change within clinical settings from the participants' point of view (Biddle, Markland et al. 2001). Data are presented in thematic form, thus are representative of a group rather than any one individual. It is not the aim of any qualitative study to achieve a representative sample in terms of either population or probability. Statistical representativeness is not a primary requisite when the purpose is to understand a process (Mays and Pope 1995).

Several themes emerged from the analyses. A topic emerged as a theme if at least four participants cited it. Each key theme is listed below with relevant sub-themes, followed by a discussion of these findings. (Please note quotes are reproduced verbatim).

Service User Findings:

Service user perception/experience of the NDRIC System

Participants were asked about their experience with their key workers and case managers. They were generally very positive and felt supported in the process.

> *"[key worker name removed] - she - how she put it to me was very understandable for me and at first I was saying 'Jesus Christ'! Not all these forms!" but when she explained to me, you know, the whole - what it was all about I thought it was really good. So we done all the necessary forms, now …Yeah, it was probably a bit daunting at first but we got there, you know, we did - we got through them and it was kind of - I found it a bit difficult, some of the questions, you know, thinking back but [key worker name removed], she was great, you know, helped me around it, you know, kind of saying things that'd refresh my memory. But yeah it went very well, it did now and I'm going to link in with her now in another two week (*Aisling service user 4).

"Brilliant, absolutely fantastic. She was always there for me, you know, all I had to do was pick up the phone and I'd regular appointments the whole time and, you know, it was now, it was really good only for I wouldn't have had me confidence back, you know …"(Paula service user 6).

"If I have anything that's bothering me or anything, like, you know I'll talk about it, just get it off my chest kind of thing, you know. He'll just give you advice, you know, kind of - just tell you what way to deal with it or what have you, you know. Not to get too stressed over it and not let things bother you too much, you know?" (Colin service user 7).

Benefits of connecting with services:

Participants spoke about the benefits of connecting with a service and the direct effect that this had on their lives.

"...- I was doing a lot of binge drinking and stuff like that due to depression and due to my living environment and stuff like that - when I was doing that programme with the [name removed], the drinking programme, the detox programme I found it very good because you had to be breathalysed and stuff like that there so you knew that you were up against - you knew that you had a challenge, you know, and how to work around it and so I found by them breathalysing a person would even keep them, you know, kind of, keep you to not drinking and stuff. I - then after finishing the programme I got, - I kind of got a clearer picture and they were telling me things, stuff that could happen me with taking blackouts with alcohol and stuff like that so I felt I gained a lot from it, [name removed], has been very supportable to me self and to the programmes that they're running" (John service user 2).

"That's a big thing for me. First, I got stable on drugs - you know, stabilised away from drugs. Then, I got substance-free, you know, I'm not on any medication now. And education" (Aisling service user 4).

"Yeah, with [key worker name removed] breaking it down and, like, spreading out days for me, like, it was - that's how I actually kicked it [crack]" (Mary service user 9).

Benefits of NDRF

Other participants spoke about the benefits that were more directly attributable to the framework. Care planning was the most recognisable practice for service users.

> *"....you know, like, from where I start, you know, to where I am now, you know, it's only when you look, you know, like say when I did it with her I've progressed since then. I'm in college, I'm doing me diploma, so it's kind of - it's showing me as well where I'm at and how I'm progressing and I think it's a great thing, I really do"* (Aisling service user 4)

> "*Care plan, yeah, I think I did a care plan with counselling and drinking and all that kind of stuff and I finished me counselling here and - well I kind of didn't finish but I kind of cut the [? 02.52] because I got good - I did the whole programme of the detox, that included counselling and assessed and stuff like that there but …it was great really great*!" (Karl service user 1)

> *"Because it'd be pretty hurtful and it can pull a person down, like you know, to be repeating yourself over because - I thought it was good, you know, [service name removed]knew the whole lot and they just relayed it back to that nurse and stuff so you didn't have to repeat yourself again"* (Aisling Service User 4).

Goals and aspirations

The majority of participants had a clear idea of their goals and aspired to build on the current success.

> *"My short-term would be to do my recovery and get myself better, you know, and focus on doing the right things, like, and knowing how to - so I won't end up relapsing and stuff like that and then long-term to continue on having my sobriety I suppose and eventually getting my kids back into my life and stuff like that and hopefully have a job as well, like, you know, get things back to normal basically, like you know"* (Service User 4).

"I was a hairdresser so I'd love to finish that, like. I did it for five years so I'd love to do that and go on maybe to college in September and study it. Yeah, it's on my To Do list, yeah" (Service User 11).

"At the moment we're in FÁS now and there's new teachers after coming in and they'll be doing, like, music with us and woodwork and, you know, kind of back like schoolwork with us, like maths and English, you know, stuff that would interest us which I think is very good" (Service User 10).

Service Provider Qualitative Findings

Benefits of the National Drug Rehabilitation Framework

When asked about the benefits of implementing the NDRF, participants were generally very positive. Benefits were seen as having direct positive effects on service delivery. The uniform approach of a national framework offered a consistency to service provision. The notion that a service user could relocate and have their care plan travel with them was met with great enthusiasm. Participants mentioned working within a quality framework throughout the process.

The benefits of piloting the NDRF were seen as direct and immediate. The idea that services were joining together in a consistent, standardised framework to form a common approach to service delivery and reduce duplication was evident amongst all participant groups, across the majority of pilot sites.

Interagency working

The most commonly cited benefit of implementing the NDRF amongst managers was interagency working. By engaging with their colleagues they believed they could improve services for clients, access better resources and work more efficiently.

"The interagency protocols ...will enhance the work of whatever agencies happen to be involved in that and bottom line make things an awful lot easier for service users,

people accessing services and to deal with their issues in relation to addiction" (Anne manager).

"Being able to pool community resources together to have one massive multi-disciplinary team" (Jane manager).

"Really at the level of inter-agency work, coordination of care, we saw the benefits for both organisations because we could see how people were, like, falling through the cracks. I talked about us being a counselling service and I suppose we have our ethical boundaries around disclosure and the protocols themselves then allowed us the whole process of being able to share information that was extremely important for the on-going care for both organisations working with users, so it gave us I suppose a medium through which we could communicate appropriately and ethically with an organisation, another organisation outside of ours around the care and wellbeing of mutual service users (Mary manager).

The biggest piece, I think for us here, is really getting real inter-agency work **(**Ben Co-ordinator).

Accountability

The notion of accountability was mentioned quite often throughout the course of the interviews. Participants spoke of accountability as a welcome consequence of the framework. This perceived level of accountability allowed for more meaningful work to take place, offering a more client-centred approach.

It brings services into a level of accountability as well for me and that, you know, it also creates that space where multiple agencies can come together and know how they can begin to talk about service users in a real way. (Niamh Co-ordinator)

You know, it brings up people's competence issues, they're - if they're unclear it puts them in a place and again I said that the NDRIC tells you that you really start to have a very meaningful conversation with your service users which stops them [services] *from,*

as I said previously, prescribing to a Service user, "Well this is what I'm going to do", it really brings them into the whole - so that, that's what I'm finding is that really the standardised assessment tools and even the care plan, the care plan in itself is at times become like a bat to beat, to beat this process with (Aine co-ordinator).

In addition, Co-ordinators questioned how accountability would be managed beyond the pilot.

Nobody would - who'd haul in the inter-agency piece [beyond the pilot]? Who will hold somebody to account in that inter-agency piece (Donna co-ordinator).

Shared understanding

The perception that an entire pilot site would work in a uniform way with shared language and paperwork was met with great enthusiasm. The participants perceived the framework to bring with it a set of quality standards, framed in evidence-based practice

….the framework is asking or looking or suggesting that we work, you know, in a more collaborate and inter-agency way of working, that there is a quality standard framework as well being used by the services that are taking part in the pilot but they're suggesting a general that you have the standard quality. **(**Susan co-ordinator).

NDRIC provides a first time from a national perspective where substance misuse services have a framework to work within and that hopefully gives it, you know, the quality piece, standards! (Niamh co-ordinator).

Participants welcomed this as an opportunity to professionalise the addiction services. The standards issue also raised the issue of perceived professionalism.

It's a standard, a way to work consistently with clients.....we should be looking at more authority for key workers to do their work, often they're not respected by other statutory agencies, so if they want to call a meeting or they recommend a certain course of action or maybe they write a letter supporting something, not all professionals will

respect them as an equal (Aine co-ordinator).

"We're speaking the same language …it's so simple, but beneficial" (Maura case manager).

… whether they're 100 per cent compliant to the NDRIC protocols doesn't matter at this point to me. It's a shared understanding and working towards being 100 per cent compliant if you like. But, when I mention my care plan and they mention theirs and the clients' goals and needs, it's shared. It takes out not knowing somebody, where referrals often used to rely on an interpersonal relationship with the other agency it doesn't anymore (Evelyn case manager).

Communication

Communication had improved and was seen as a direct benefit of the framework:

Just the kind of open communication that was never there before, like I said I didn't know some of the staff that worked for some of the services and now nearly kind of seeking them out, seeing if they're going on training to have a laugh [laughs] but it's - no, it is, it's been really beneficial, like, it's just opened up so much more communication between services that, like, there was one particular service I didn't know I could directly refer to. I thought it had to be a drugs service ……there's a barrier already broken down in that she's able to progress straight into another service
(Laura key worker).

I suppose in general what I'd see it be about is ease of sharing information, I see it specifically as a benefit for the client first but with that I see it also as a benefit for ourselves....which would make the job of the project worker or the drug worker easier... (John key worker).

Client centered

Client centred practice was mentioned significantly throughout the course of interviews with key workers. Placing the client at the centre of their sessions was perceived as a benefit.

> *I see it as a benefit for the client in relation to seamless transfer through projects, seamless referrals to different projects, as in that a client isn't going to have to go and kind of repeat the story over and over again, that if somebody has an assessment done and a care plan done, that care plan and assessment can then be shared (*John key worker).

> *Where we put a structure in place we look at all of the nine domains, the things that bring about what is supposed to be, like, holistic living, that wraparound approach and we gear the client towards what their needs are but I just think that the client's needs and their wants are two very different things, like, we have a client who's living homeless and he has his own little apartment and he doesn't want, you know, he doesn't want anything else, that's fine. That's where he's at and that's fine and sometimes, you know, we are so caught up in "Oh my God but they're homeless. Oh my God, they're this" but we don't really see what the client, the client is sometimes happy where they're at.*

Efficient work practices

Other participants noted more efficient work practices as beneficial.

> *We work smarter now* (Marion key worker).

> *I think it was - definitely NDRIC would have had a part in that, yeah, if I hadn't have been a part of this I don't think I'd be working as efficiently. I would be quite, you know, regimented in how I work* (Sarah key worker).

> *"We can track them and they're coming back and if there are issues we can help them*

to deal with the issue, that's fabulous" (Paula Case managers).

"*I'd say probably the biggest benefit would be somebody - not a lot of people but some people kind of fall through the net and I would see that people would be supportive from start to finish so that people don't go missing out of the system, that's probably the most significant thing and that the* (Evelyn case manager).

"the benefits of that was that they didn't have to keep repeating the information, there was less trauma for them, less invasion into their, I suppose, privacy but then the positive side was that say if I left or if somebody - or they disengaged and then re-engaged, they were able to pick up and say, well okay, everything is listed, everything is detailed so we know where we were with them"(Tara case manager).

Disadvantages of Working with the National Drug Rehabilitation Framework

Paperwork and time constraints were the two most frequently cited disadvantages of working with the framework. Moreover, both were often interlinked. The time that the paperwork and administration took was perceived negatively by participants.

Paper work

The additional paperwork was the most noted disadvantage for participants since commencing work with the framework. While services varied in the approaches to paperwork across sites, nevertheless, all sites experienced an increase in paperwork. Sites and the agencies involved in each site were required to nuance and contextualise the framework, developing the appropriate forms and measures necessary to implement a protocol across all sites.

"....there would have been changes in the way they did paperwork …there's lots more of it! (Aine co-ordinator).

"Most agencies would say they have been doing this along, it just the paperwork

that's the biggest ask" (Susan co-ordinator).

Time consuming

Co-ordinators noted the time needed in order to implement the framework locally. Several complex occurrences, such as philosophical shifts and adopting a more shared approach needed to take place before the framework could be operationalized.

> *there's actually a lot of time used in getting people to change their kind of work philosophies around "I don't just to go my work and do my thing and link in with other agencies" but rather we have to approach this as some sort of team of different groups and as a team we've got to kind of get all on the one page and come to some more kind of common understandings about how we can work together and then actually get on and start doing the work with clients which needs a lot more consultation and it means a lot more meeting times and all of that. So the drawback is going to be in time lost at the - you know, certainly for the next couple of years should NDRIC continue to go - until it becomes a more naturalised way of working* (Ryan co-ordinator).

The majority of key workers also cited time constraints as the most common disadvantage of working with the National Drug Rehabilitation Framework.

> *… the drawback would be the extra work ...the time constraints, it does take a lot of time ...In terms of paperwork and in terms of time I always finding I have to chase my tail* (Sarah key worker).

> *Just that I suppose it's the size of the documentation can be a bit kind of [exhales]*(Laura key worker).

Paperwork and time constraints were also the two most frequently cited disadvantages of

working with the framework from the case managers' perspective. Moreover, both were often interlinked. The time that the paperwork and administration took was perceived negatively by participants.

> … "*That's the biggest issue that I would see. Trying to make hours to, you know, fit in meetings or the extra paperwork or maybe the extra hours that are needed now to meet will - the lady that I'm Case managing because my day is fairly full already, so trying to - extra hours, that will be the drawback for me"* (Evelyn case manager).

> *"I suppose and this is probably - this is more probably in terms of work and workload I think there's probably not enough hours in the day* … (Maura case manager).

> "*Well yeah, there's always going to be drawbacks to the likes of, it's a little bit more time consuming, you know, there's more of a pressure on resources for the small projects, cos there so much more to do"* …(Paula case manager).

Adhering to the framework

Another commonly cited disadvantage from the manager perspective was the resources required to implement the framework locally and the constrictions of adhering to a framework.

> *"The biggest drawback, time, people.... we don't have the capacity"* (Siobhan manager).

> "*All this had to happen on our money, we were expected to implement a framework with less money and less staff*?" (John manager).

> *"You know, once you're actually doing the case management and the shared care plan for people, identifying service users, getting them on board, it's so time consuming, you know?* (Jane manager)."

Others perceived the notion of a care-plan or assessment travelling with the service user to a new place or residence as a disadvantage, as it may prohibit the service user having a 'fresh start'.

> "*What about a client that wants a fresh start, and the assessment and file is there, they may want to leave all that behind*"(Maura case manager).

> "*We get a lot of lads from the prison and some that are going to prison, what happens, say 'Johnny' puts it all behind him and starts fresh we have all his information but maybe he wants to tell his story again....his changed one? .... Where does that leave us?"*(Nora case manager).

Some managers spoke of the restrictions of a framework, not necessarily NDRF

> *"While I liked the shared approach I sometimes felt stuck at other peoples pace, especially at the beginning" (Mary manager).*

> *"Yeah, people find it a bit constrictive, you know, people can find it all – 'Well hold on I don't want to do it that way'…*" (Jim manager).

Changed Practice

Since signing up to the pilot the majority of co-ordinators spoke of experiencing change. The level of change was quite different across pilot sites, representing a significant overhaul of practices.

> *Well, what's new is the - since we started rolling out this there, God I'm trying to think what date it was, the 17th or something of last month but since we've started rolling it out it brought into place a standardised form in the six agencies in terms of initial needs and a comprehensive needs identification form and a shared care planning*

policies and all that kind of stuff, you know, care planning forms and all things like that, so all that's new, 100 per cent new. You know, as I said in terms of I suppose the culture of key working , care planning, and case management wasn't happening really (Susan co-ordinator).

A standardised form in the six agencies in terms of initial needs and a comprehensive needs identification form and a shared care planning policies and all that kind of stuff, you know, care planning forms and all things like that, so all that's new, 100 per cent new …(Aine co-ordinator).

Case managers and managers did not perceive the work practices of their agency to vary in any great depth since participating in the pilot. Most felt that they were already carrying out the work set out in the NDRF but perhaps labelling it as something else. The biggest perceived changes related to policy changes or more specifically realigning their agencies' policies to fit with partner agencies in order to work more collaboratively. The level of change required to bring existing policies in line with local partners was quite vast across pilot sites.

"Well we had already worked together with the Simon Community for quite some time in a loosely kind of collaborative way and we had felt that it'd benefit both organisations if dealt with it in a more structured way, so I suppose with the protocols, we had already been working on for about 18 months when we really became aware of the whole NDRC framework" (Theresa manager).

*"I mean when you say is it new: I would have always worked this way myself but maybe not as cohesively…" (*Nora case manager).

"So, I mean obviously around care planning and confidentiality and all of that, we had to update that sort of stuff and we are actually still in that process, you know, and I think it was mainly about updating cos we do that stuff anyway"(Jim manager).

… the biggest change was probably around looking at how we did work with interagency stuff (John Manager).

The majority of key workers had experienced change in their practices. Some key workers noted this as quite tangible, such as paperwork

Changed paperwork

Paperwork was also cited as a common source of change, being able to identify change in practice.

"We've changed all of our paperwork to match what goes on with NDRIC, we've changed, you know, our care plan, everything has changed around how we work, how we record as well has changed and hopefully we'll have a database next year and everything will be done around, again, how NDRIC is as well... (Marion key worker).

"We say "right, what is NDRIC doing?" in terms of paperwork and we'll try and marry that and we're in a huge process of change at the moment as well in terms of paperwork, in terms of getting it, bringing it into kind of - having it ready for next year you know what I mean? So we've kind of been working that way (Sarah key worker).

"Not a lot of change, just a lot more paperwork (Brendan key worker).

Approach to client work

Others noted less tangible changes, focusing on process or changes to the approach they took with service users.

"That would have been something we had kind of half done before … it was just sometimes, you know, the way of working was as chaotic as the clients themselves …" (Edward key worker).

"There's no part of the client's life that we work with that we're not involved with in some way so it's a more wraparound approach. It's more professional as well, today. It's no longer "oh yeah I went to Probation today", tick, the whole conversation's recorded now" (Sarah key worker).

"I found in terms of the goals and stuff like that we have worked from NDRIC kind of paperwork because we're always changing our paperwork, we don't have a database so everything is still on paper so we would say "Right, what is NDRIC doing?" and we'll try and marry that and we're in a huge process of change at the moment as well in terms of paperwork, in terms of getting it, bringing it into kind of - having it ready for next year you know what I mean? So we've kind of been working that way" (Lisa key worker).

"Huge structure and because of that we're seeing higher numbers now and people come through the door "Oh I heard you were able to do such-and-such for such-and-such, can you do that for me?" (Sarah key worker).

What worked?

When asked what worked some case managers believed that the framework was and had to remain client centred.

…*"But the important difference I suppose between before and the way they were doing it now was the client was encouraged to really take control and take power of his own or her own recovery and be involved in the decision-making process as to what it was that they needed as opposed to us telling them 'We have all these services and I think you should do that one' …* (Lisa case manager).

*"People are different, so it's working with the individual rather than 'oh they're just an addict' I think that really works" (*Paula case manager).

"*Its, 100% about the client"* (Evelyn case manager).

Others experienced change, in terms of the introduction of a more systematic approach to the same type of work.

I hear this all the time… "We do Key working, we do case management"… but the reality of it is it's not a uniform system so all services in their own right to some degree have a level of Key working and probably do, do a level of case management as they have their case meetings or their clinical meetings and they attempt to do that, however it's quite silo'd for one and it's not clear so when you start to look at people's definitions of those things it's not a standardised thing and they have elements of the tasks within that but it doesn't move, it's static, it doesn't move anywhere. So the NDRIC for me in terms of being new is it gives you a clear set of pathways, you know …(Niamh co-ordinator).

….it's seeing how that's working and filling in the gaps and blocks and identifying them and the biggest piece, I think for us here, is really getting real inter-agency work. (Donna co-ordinator).

Some participants spoke of a more nuanced experience of change such as realignment of services.

…the tier system …… that was new, it was wider - we didn't use it a lot though because it didn't make a lot of sense to people which is something I've heard repeated in different areas …(Aine co-ordinator).

What didn't work?

When asked about aspects of the framework that didn't work, the tiered system was most commonly named. Participants did not see this system as the most logical fit.

*"..the one thing that didn't work in the framework for ages is the tiers***…** (Donna co-ordinator).

"the tier system …… that was new, it was wider - we didn't use it a lot though because it didn't make a lot of sense to people which is something I've heard repeated in

different areas ...(Aine co-ordinator).

The tier system- it didn't really fit?… (Ian co-ordinator).

Others perceived the framework to be client-led and this was not always viewed as beneficial by some case managers, particularly at early stages of treatment.

"… the clients are very ill when they come to us at the start of their treatment so we need to be allowed to have a significant say in what we would think, you know, their care plan should be, you know, teaching them in terms of kind of relapse and preventative stuff. Sometimes people don't see stuff and, like, when they come to us they have their28 days or their 35 days and they come to us for their extra 12 weeks, sometimes it's not until they come for their extra 12 weeks that they begin to kind of wake up from the, I suppose, unconsciousness of addiction"(Maura case manager).

"There's a lot of onus put on the client or she - the client has a lot of say in "I don't like her as my social worker, I don't like her as my case manager, I don't like her as my key worker", whatever, and can - we have to respect that and maybe look to find somebody else. In this work, in addiction work… you know, all of our clients, when we're working with them in treatment centres, hate us at a particular time because the difference between addiction and regular counselling stuff is you've a mirror and you've to keep holding it up, that's our job!" (Susan case manager).

"There's a lot of decisions put on the client in beginning – the is assigned but they may know someone for years... maybe it's too much for them?" (Paula case manager).

Barriers to Implementation

Several barriers emerged that hindered the implementation process.

Training

The national training [6]was one of the main perceived barriers to implementation. For the most part the training was a source of frustration. Moreover, It appeared to be a quite commonly cited reason for delayed or late implementation.

Okay, so the training definitely one of the huge delays to everything, the case management training was massive delay, it kind of stalled and stalled and stalled and people were getting agitated and a bit disinterested because it was taking so long and then when it finally came it wasn't, I suppose, that well received so I think that that put a bit of a skew on everything and there was nearly a year I think getting it off the ground and then when it got off the ground people weren't that happy with it. So it did leave a bad taste on the pilot as a whole and I suppose that is one thing that I was conscious about with the pilot, that if one section of it, whether it be quality standards or the case management or whatever goes bad it can have a domino effect on the whole pilot and I suppose my reputation and NDRIC's reputation (Eoin co-ordinator).

We were waiting for this national training, they came and it was - it didn't. It [the training] didn't happen for us … No, it didn't deliver what I was looking for, it didn't deliver - what turned out to be, you know, the people on the ground were saying - they were back to the stuff of the theory and actually for us as people sitting in the room we get this kind of thing, you as the trainer, this still doesn't tell us what. "There's six days of this training" and it's like "Oh my God" and, you know… (Niamh co-ordinator).

"Well, I suppose four days of it was a total waste and then I suppose, well I know I felt it and a lot of others were saying the same, it's just - we went there with an open mind and it was going to be new and it was something exciting and something different and then it's like we were back to - very much back to basics and we all felt it was a waste of time" (Paula case manager).

The bloody training that nearly took the whole thing out (Paul key worker).

I think in the early days it was difficult. Particularly when the training was mentioned,

don't talk about the war! (Laura key worker).

*… but the delivery of it [the training]and the explanation of it from trainers I'm more confused today than I was when I read the framework!…I wasn't allow to ask any question?(*Brendan key worker).

Culture

Culture was referred to as a barrier to successful implementation throughout the interviews and site visits. Some participants spoke of culture when discussing the absence of formal procedures.

*"… So and that's kind of the culture as well around [local name removed], you know, a lot of chasing people up, and it shouldn't be the case … you know, in terms of I suppose the culture of Key working, care planning, case management isn't happening really (*Susan co-ordinator*).*

*"You know, in terms of I suppose the culture of Key working, care planning case management wasn't happening really" (*Aine co-ordinator*).*

Others used 'culture' to denote local politics and the need for change - a shift in the way of working.

*There are issues that are happening there that are not to do with the NDRIC, you know what I mean? So that just pulls up the politics of the HSE and, you know, and it pulls up the politics, you know, in terms of everyone's signing up for funding and it's this whole changed culture sort of thing and that, you know, managers have to have the ability, you know, to be clear and to understand this and to take some responsibility. I can't do this by myself (*Niamh co-ordinator*).*

Yeah a change of culture, a change of mind-set in the way we're going to go about things I think, realising your service's positives and by the same token services realising okay sometimes they're venturing into tiers that maybe and responses that they shouldn't be or that they're not skilled in doing so. I think there was yeah … So I think that's been a

*huge hold up (*Eoin co-ordinator*).*

"I would say that there's a culture - within the HSE there's a culture within medicine that is reluctant to talk and hear different ideas which is very different from the culture I came from, you know what I mean… where, you know, basically nurses or social care workers would have a lot of respect and input into Some medical treatment team, you know, so I think that culture has to be broken down, you know, for it to be really… otherwise it's tokenism …" (Jim manager).

Ownership of service users

Participants spoke of the sense of negative ownership that agencies assumed around service users and their pre-existing protocols.

Within some of the agencies I suppose, a kind of sense of ownership of some service users (Donna co-ordinator).

You had some people that I suppose were obviously very precious regarding the bits, you know, in their protocols and then you had another group who was actually quite precious about the bits that were in their protocols so it was a lot of, like, negotiation and working through what is best, trying to see actually where the differences were in the two documents (Orlaith co-ordinator).

"*I suppose I can understand why people would be - why people would be nervous I suppose about moving clients on [because of the National Drug Rehabilitation Framework] and ownership and I think that's a terrible word and I don't mean it but that word has come up, but that's what it is and its hard....* "(John key worker).

'Missing partners'

There was a perceived sense of 'partnership' amongst agencies that made up a pilot site. The theme of *'missing key partners'* emerged throughout the pilot phase as a major barrier

to successful implementation and furthermore threatened the continued existence of the framework. Participants spoke of a perceived lack of engagement with certain key local and national 'partners' beyond the pilot. At local level participants noted the obvious lack of engagement with their Health Service Executive (HSE), Addiction Services colleagues:

I think [pause] from my own perspective the HSE aren't massively involved in the pilot sites. Ours would be a little bit unusual ..... because we have so many people from the HSE addiction service trained, you know? [pause] And essentially they're supposed to be the ones ensuring that case management is happening but I'm not sure how much -- with the exception of ours [pilot site] of course, but across the board, how much they're in it?...

…..One of the difficulties I think is that the HSE can be very hierarchical …… and I think that there can be a little bit of a sense, you know, that maybe the people aren't of a certain standing and things and I think that they, you know, there's a certain amount that you need to try and balance, like, it's definitely harder to have, like, the HSE involved, I have to say in this area it's absolutely brilliant, like, I mean just everyone has been so committed and so involved (Orlaith co-ordinator).

***"...** Yeah, yeah, I had relationships with people, I can have side conversations in the corridor, you know, HSE-based and in fairness they do have HSE involvement in them, the other ones, you know, [pause] it's a big structure and if you're not in it I'm not too sure if you'd know how to negotiate it"* (Orna co-ordinator).

"I've been trying to work in [pilot site name removed] for the last year in trying to get this implemented and some of the struggles, again, have been with the HSE teams. I think that that's where the biggest drawback comes, is with the HSE services" (Niamh co-ordinator).

"*Getting the HSE on board, I mean I would hold my breath, we just had to get going otherwise we still wouldn't have started* (Mary manager)

"*Our biggest barrier is we don't have a direct referral process into the HSE. Or clinical*

support from psychiatry that's a big concern" (Siobhan manager).

Given the remit of the it was not surprising that lack of engagement of colleagues would be seen as a barrier to implementing the framework.

> *"That's interesting, I suppose - I suppose personnel, like, a lot of it is based on how active the personnel involved in it can be I suppose it's keeping the momentum a little bit isn't it, you know, and just keeping it - and I suppose people's everyday work, engaging colleagues meetings* …"(Lisa case manager).

> "*I would say the biggest barrier is probably the way that services engage, interact and plan on behalf of clients is the biggest barrier*" …(Nora case manager).

Support

Support emerged strongly as a theme throughout the co-ordinators' interviews. It was spoken of in two respects, support received and support required, at local, intermediate and national levels. For the most part participants felt supported.

Current Support

Participants felt generally supported locally by their line managers, implementation committees [T&R group] and Drugs Task Forces.

> *it's a constant sort of cultivation of what you need and I suppose for me …… I feel very, very well supported and backed in that, you know, she gets it[line manager], she - it's the way to go, she's quite there in terms of how that's, you know, where that's going and being rolled out in her expectation of people, you know, taking that on board so I have that* (Niamh co-ordinator).
>
> *I mean regionally the, say for here the support of the taskforce is vital, I mean it's part and parcel of sort of - like, that conceptual framework of service provision in the area so it has to fit into that so you have to have that support and you have to have that*

link-in even if it's just kind of from the point of view of it being supported without actually - I mean we get on and do the work but the role of the HSE is vital and particularly from a point of view of funding because they're not going to work if they're not - if there's not some sort of resource allocation into it. I mean from our point of view we don't necessarily need somebody to - the HSE to fund a rehab coordinator but we do need them to fund the counsellor and the GP and the nurse, you know, that side of it, so the service provision side (Ian co-ordinator).

Co-ordinators mentioned the support and rapid turn around from NDRIC

Well I think, you know, in terms of the support you do get from NDRIC and the quickness of responses and, you know, things like that is brilliant …(Susan co-ordinator).

For the most part key workers felt supported locally by their line managers and local committee members.

Her door[manager] is always open, there's no structured - there is obviously structured, you know, supervision once a month or whatever but I would have conversations with her every day, as soon as I come in from outreach, straight in "How was it?", "Yeah, grand" whatever. There is never a topic that cannot be discussed, she's brilliant like that and [local co-ordinator] is very supportive as well in terms of, you know, what do we do, where do we go, how are we going to do this? (Sarah key worker).

...my manager would be on the managers' meeting for T&R but if they're - you know, we have come up against one or two blocks that just, you know what I mean, key working level hasn't been enough, it's had to go that other step further and I know my manager has supported us very well in being able to inform the wider management around what blocks we're coming up on as a service or vice versa, if it's coming from us or something like that and I think as well [local co-ordinator] has been, you know, quite integral in all that. She's a huge part of that, being able to

keep that ticking over, getting it done (Laura key worker).

I certainly enjoyed the aspect of organisations within this drug taskforce area coming together on a once a month basis … (John key worker).

Ongoing Support

There was a genuine belief amongst participants that the framework could be implemented and would be beneficial. However, merely producing the framework is not enough. Several additional supports would also need to be provided, namely additional funding and protected time to case manage. Participants acknowledge the need for ongoing support, beyond the pilot, with several levels of support and resources such as training as well as supported review.

"I really believe - I honestly and truthfully believe that but I think if we don't have the manpower and if it's not supported all it'll be is kind of a ghost framework. We need, we need to be supported in rolling it out, we need the support system behind us, we need extra hours, you know, we'd need the funding for that if extra hours need to be given which the girls - we need that because that happens from - "I don't have enough time, I don't have enough time". I believe it can work, I really do" (Maura case manager).

"And it's all fabulous down on paper but if you do not have the support systems in place to support, to give the practitioners what they need to do to implement …… waste of - and it's creating more paperwork for people. So, I - it's new so I'm not kind of settled with it yet, I'm standing back and saying it'll be fabulous and after that I'm saying yeah, if it's carried through, if we're given the support we need, it will be fabulous... " (Lisa case manager).

"There needs to be some sort of support for us, maybe an on-going training and yeah, it's some link between all of the workers too, you know, like, the case management is linked - some link maybe between all the Case managers too that we can have a

meeting, that we can, you know, do a bit of brainstorming, that kind of stuff" (Evelyn case manager)**.**

Yeah, for it to become kind of - it needs kind of a lot of on-going support and very active support from management and it needs to be tied in, that people need to be trained to work this way because, you know, people that were still knocking out in training courses, whether that's counsellor training courses, social work training courses, whatever, you know, Probation officer training courses, all of that way of training people to work needs to be changed because otherwise what you're doing is you're training people to work one way, they come to an agency which has a different way of working, you know, most people are trained to work kind of as individuals connected to an agency to reach that agency's goal and how they go about doing that tends to be about "We'll work out kind of our plan along the lines of what our agency does here" but agencies will be working in kind of a different way now and people need to know of that as they're coming through their own training. So, that'd be one of the things that'd cause a lot of difficulty of it. The other thing is operational policies and sometimes maybe even philosophies within agencies need to be changed and then management has to really support and drive workers, push on this whole kind of an agenda for workers to start to work differently and then continue to work differently. So there's kind of organisational changes that has to happen to make this a standardised or a naturalised way or working
(Ryan co-ordinator).

Moreover, co-ordinators mentioned the forum of peer co-ordinators as a great source of support. The peer support and exchange of knowledge and resources was perceived to be of great value and therefore should be continued beyond the pilot.

I think that's definitely after helping me big time and especially the sharing of information and sharing of forms and everything like that, you know, I would have kind of been lost without that group, you know, when this was starting. I was just flung in and they were so helpful at bringing me up to scratch and, you know,

knowing that we were obviously only getting to the stage of starting so people were handing me comprehensive forms, you know, and it was great so I think that's definitely very important, all that support (Susan co-ordinator).

I mean if the national coordinator doesn't have an communication with the local coordinators I think they're completely disconnected from what's happening on the ground, I mean they have to know what are the issues that… are coming up, I mean otherwise you've a complete disconnect which is often said about the addiction area between policy and what happens ... (Orlaith co-ordinator).

Coming together

Bringing local agencies and co-workers together was the most commonly cited success of the framework to date.

"Bringing agencies together was seen as a great success"
(Marion key worker).

I think the - bringing the Key worker together – that was a real success! (Laura key worker).

...One thing that really worked was I've brought people together in here from different organisations around the who literally maybe would have only heard of each other in the past, do you know what I mean? That was great (John key worker).

Definitely all the service providers in our team suddenly know what the other person does, for example, in the case management it would have maybe been only one person maybe would have been dealing with, say for example, homeless teams or whereas now everybody is involved and it could be anybody that makes the contact or the referral so it's much more of a team, it has brought much more of a teamwork to the system than previously (Claire key worker).

"The training, well not the training but bringing all staff in one local together that really was a success" (Siobhan manager).

"I think the success in the current phase is the almost that there was a bond created in the mayhem"(Peter manager).

"In [pilot site removed] our Key worker and managers met regularly and they were a great support to each other. That was hugely successful" (Jim manager).

"Regular meeting with our colleagues with a clear goal to improve services that has been our best piece of work" (Anne manager).

Systematic approach

Other successes were more framework specific such as the systematic approach to client work.

I think the case management, the systemic approach of working I think that's been the most successful (Sarah key worker).

A systematic approach to our work (Edward key worker).

*Also I think just having clear guidelines has been really successful (*Claire key worker).

Challenges

Several challenges emerged for key workers through the pilot process; some were context dependent such as funding and loss of resources, whereas other challenges were more specific to the implementation of the framework, such as buy-in from local partners and frustrations regarding agencies that 'volunteered' to be part of the process but later withdrew or hindered the process.

Local challenges

Participants acknowledged local issues that may prove challenging, nevertheless they also acknowledged the need to further the process by taking action and implementing the framework.

> *...and if it doesn't fit and that's fine and I don't necessarily have too much of a problem with that but I would have a massive problem with it if this doesn't work because of people's fear, because of people's lack of transparency and because of people's lack of trust in the system and I think there is a lack of trust* (John key worker).

> *I mean we've had meetings here now where, I mean some of us have been kind of banging our heads off the wall for the want of a better expression because of maybe what I would refer to as intransigence on the part of some organisations with regard to first of all, sharing of information, second of all who has - I mean one of the major blocks that we came up against within our own area: can a project worker be a case manager?*(Brian key worker).

> *I suppose I can understand why people would be - why people would be nervous I suppose about moving clients on [because of the National Drug Rehabilitation Framework] and ownership and I think that's a terrible word and I don't mean it but that word has come up, but that's what it is and its hard....* (John key worker).

The most frequently cited challenge for managers was negotiating the interagency piece, sharing of service users, their information, entering into new relationships.

> *"I suppose, yeah, so the biggest challenge really was to tease it out with other services: confidentiality, sharing, you know, would clients be let go from their services to move forward?"* (Peter manager).

> *The biggest challenge for us was the defining the and lead agency, like everyone thought it should be them"* (Mary manager).

"So the big challenge really I think for the NDRIC stuff, the framework, was around the interagency piece and about the process of agency referrals, about cross-agency case meetings, about - and the massive piece I think is about the relationships with HSE" (John manager).

In addition, the uncertainty of whether the framework would continue to exist beyond the pilot appeared to be a challenge for key workers

I'm baffled now with NDRIC.... I thought it was going to be the holy-grail (Brendan key worker).

Is this it, will this be how we work from now on or will it all fall apart after the pilot? (Marion key worker).

If this is how we are going to work, let's just do it and get [profanity removed] *on with it* (Edward key worker).

IT System

Another major challenge that emerged during the interviews with key workers was the lack of shared IT systems.

The database, for me the database because I could - there's days when I couldn't get on it… (Marion Key worker).

I'm a little bit kind of frustrated because the - I mean we done so much work here, so many meetings getting paperwork together, as in referral on forms, initial interview

forms, care plan forms, gaps and blocks, all of those different documents, I mean spent so much time doing them, yet there's no real correlation to those forms ... [profanity removed]and the database.

Participant Recommendations

Participants put a number of recommendations forward to aid in future roll-out . The most commonly articulated include: continued momentum, outcome driven funding and governance.

Momentum

Participants frequently mentioned how crucial it was to keep the momentum of the process and ensure continuity.

".... I think for making sure clients are looked after through a standard is one thing, making sure they've got rights is the second thing, making sure we're getting value for money is the third thing and then the fourth thing for me, the big one, is about how we commission services, well you don't really have commissioning here yet, you know what I mean, but to me it's about how you - how do you stop service duplication...."(Theresa manager).

"Keep the process going, its been good, I think it's good for clients to move through different approaches because it's like anything, you know, we go to junior school, we go to high school, we go to university, we're always kind of moving through. We go to a job, we move through, we get a promotion and that's the same to me about treatment, you know, it should be like you're going through services…" (Jane manager).

"*Keep it going. Keep it going, it is needed, keep it going and fund it. That's - probably the recommendation and worry and that, it's a great idea …" (*Susan case manager).

"*Roll it out and keep it going, but support and review it"* (Nora case manager).

*"Check in on the process – make sure were all on the same page" (*Mary manager).

"*Keeping constant dialogue I suppose that would be the big one really. Meet regularly make sure locally everyone knows what's happening next"* (John manager).

"I want to see a triage, it's almost like Casualty, you triage cases and then I think the high complex needs cases certainly need that kind of level of case management. I think there'll be some clients that come through here, they might be coming out of detox or out of rehab, they've kind of done a lot of head work, you know, they're fairly stable, you know, is there a need to case manage? Probably not, probably good active Key working to resolve social issues and whatever would suffice, you know? So I think there has to be some sort of screening process for case management, some sort of triage" (Jim manager).

Outcome driven funding

The notion of outcome driven funding emerged as a theme throughout the co-ordinator interviews. There was a suggestion amongst some participants that funding should be directly linked to service user outcomes.

As a condition of their funding, that they demonstrate inter-agency work, they demonstrate …Well in their - both in their application and in their report back to funders, that they would demonstrate, you know, how many clients - and, see, we don't have that accountability here, you know, how many clients do they work with under the framework, do they have care plans, case managers, is there service-level agreements, the assessments, and the piece that's central to the framework is clients being progressed on, how do we - because that's what we've every month to come back and report and one of the questions is how many - what progressions have your clients had because that's being lost … (Donna co-ordinator).

Furthermore it was suggested that this could offer a transparent solution to a shortage in

funding.

> *I suppose it's a lot of things, I think that part of it, I suppose it's missing at the moment, is around auditing, I think that, you know, there needs to be - I suppose it's not just enough that it's happening, you know, with managers I think there needs to be something, some kind of checks around standards and that as well …*
> *….. I think definitely something I was saying to earlier around the HSE bit, I mean, like, I think either that there's something built-in that the HSE would conduct audits or - I think that auditing is really important, like, going forward, I think that you just have to, maybe through SLA's or something, you could build-in some kind of audit process, I mean I know there's the care plan review going on at the moment in the HSE so maybe that could be extended to HSE-funded projects? Do you know what I mean to see are they - if they're signed up to the NDRIC process, are they - how - to what degree they are following it. Definitely, or if funding is coming down every six months maybe it's every six I don't know, maybe that's a bit overkill maybe. Annually definitely though* (Orlaith co-ordinator).

Governance

The role of governance was perceived as the next logical step. There was a need for governance at several levels; some participants spoke of the role of NDRIC moving toward auditing and evaluating the process.

> *At the moment…. it's [the framework] more about protocols and how you work, I think it's more - it needs to be something in the governance piece, so I suppose, like, you know, NDRIC has a role for monitoring the implementation of the protocols so how are they actually going to put that into practice? Like, is it all just going to be on feedback from the pilot coordinators or are they going to have any direct monitoring? Are they ever going to do any kind of, like, spot checks or could you be open to some kind of an inspection to see, like you know, to what degree, you know, your care plans are meeting bits, do you meet all the minimum domains for an assessment, like you know, all that kind of information …*(Orlaith co-ordinator).

They'll continue it but if nobody is to coordinate that it won't continue, they'll go back into their own doors, close them and do the work as they did (Donna co-ordinator).

Others suggested that a Ministerial directive would be required.

What would support the role completely is if the minister explicitly said, you know, as the way you work and a part of your and its prerequisite of your funding (Donna co-ordinator).

Participants were asked for their opinion on whether the framework would continue to exist beyond the pilot phase i.e. in 3 or 5 years time. The majority of co-ordinators believed it would, however, the longevity of the framework was contingent on a number of influencing factors.

I think it'll continue to exist because there's been too much time and energy and effort put in to just binning it. Will it flourish, will it thrive, and will it do what it's supposed to do? Mmm, I don't know. A directorate would help ... (Ryan co-ordinator).

I know it would've came up, it's really important, is how can we professionalise Key working …… you know, and especially for some of our Key workers who feel they're less, you know, or are maybe perceived to be less and I think the training is great where it's standardised but the other side of it is supporting Key workers in their role as well is a very difficult job and just that lack of [thinks] - there's no set supervision for Key workers, there's nowhere that it says. You should only work with X number of clients, your caseload should be this.... And within that then is there's standardised supervision, what is supervision because - like, within therapy it's very clear you're supervised with a clinician and it's, I think you need almost the same in Key working" (Donna co-ordinator).

I'd like to see some kind of, like, national piece looking at pathways, so, like, I think it's good I suppose that things happen at a local level but I think maybe some guidance around how addiction services should be working with, like, child protection or how addiction services should be working with housing and maybe trying to tease out some of

the pathways between those kind of services, that needs to be next (Donna co-ordinator).

Pre-Implementation

From the pre-implementation sites 14 key informants were interviewed about their experience of not implementing the framework. Several themes emerged. Participants saw the direct benefits and these were not dissimilar to implementers; however, for the purpose of analysis we focus on their experience of not having implemented the NDRF.

Reasons for non-implementation

Participants were asked for reasons for sites not having implemented the framework locally. The two most commonly cited reasons for non-implementation were politics and pre-implementation planning.

> *"I would say local politic*s" (John key informant 1).

> *"It's politics, local politics and power and the fact that there's so many duplicate services in this very small area that I think if it is implemented and implemented properly the real gaps and the real blocks will be revealed and I think collectively projects are scared they might be closed down, they may be found out for what they do or don't do"* (Jennifer key informant 3).

> *It seemed to me that we went through a very fastidious process where we were trying to cover all angles to be - to plan in advance, what if and this outcome and that outcome and this one and that one which in some way I suppose is good …… but as I see it, we missed the boat. We are not implementing yet the programme so you are doing your evaluation and it's only an evaluation on the policy, not on the evaluation. Personally I'm somebody who would prefer to be less precise in the paperwork to start with and then as we do the experimentation to adapt and to adjust and to improve on the paperwork* (Jean key informant 2).

Challenges for implementing

Interestingly as a group key informants were the most likely to doubt the feasibility of implementing the NDRF.

> *"I've been involved at three different stages of what is now NDRIC, in its early conception as .... and the theory is brilliant, I've always supported the theory but it comes back to being delivered on the ground level consistently, coherently for the staff and the client and above all then, its being followed up on. I suppose for me every three years this fad of inter-agency protocols comes about because there's no follow-through*" (Graham key informant 10).

> *"it's about sometimes you can have all the singing and dancing, the Gold Standard stuff but it's not practical in reality so, like, if you're going to take an hour and a half to do a care plan entirely, that's not going to be done…"*(Jean key informant 2).

> *"it's very hard to - it's very hard to impose a kind of a sort of an order on it and I think that's why there's a kind of a kickback against things like NDRIC and, you know, all of those sort of information systems and things like that, they're seems to be that - because it's very hard to categorise people in a sense…"* (Ciara key informant 10).

> *..."macro level as well. So, I think it's very hard then to impose a model on such a diverse range of agencies and workers who are then providing services to such a diverse range of service users"* (Vera key informant 5).

> *"I don't know, my big concern is the - how implementable it is for large groups of people and busy services …"*(John key informant 1).

Perception of lead in time

When asked if the time spent planning rather than implementing divided the group, some participants saw this as fundamental to the process, whereas others perceived this as a lost opportunity.

> "*It's been very beneficial for me I suppose, I'm not necessarily sure how it's going to feedback down the line, I think the training bit has been good but I think some of the training was probably from a HSE perspective and from a medical aspect, not - from the point of view of the time that was committed to the training versus the outcome of it, I think okay, the benefits were - or the liaison inter-agency communication, meeting people] but certainly from the doctor who attended, she found it very anti-medical"* (Jean key informant 2).

> *… but as I see it, we missed the boat. We are not implementing yet the programme so you are doing your evaluation and it's only an evaluation on the policy, not on the evaluation. Personally I'm somebody who would prefer to be less precise in the paperwork to start with and then as we do the experimentation to adapt and to adjust and to improve on the paperwork* (Jean key informant 2).

> *I don't know if it's an exact conspiracy but there's definitely a reluctance to implement it and I suppose there was even somebody employed to come in and try to help us out but sure that year of funding came and went …… with little impact. I suppose a lot of projects are very much caught up in how they've always done things and that whole old culture of "We'll look after our 100, you* look *after your 100 and the ones that really want to leave, we'll get them into rehab somewhere"* (John key informant 1).

What would you do differently?

Interestingly when asked what they would do differently participants suggested that they would have begun implementation**.**

"As I say I would maybe be less precise on the protocol... and try to implement it and then to adjust and improve after we have implemented it. That would be my only change" (John key informant 1).

"I would make it part of funding - I don't see why it wouldn't be included in a service level agreement that you must do it" (Dan key informant 7).

".....collaboration between the HSE and the statutory - community agencies, ultimately that is it" (Les key informant 9).

Others appeared to be more direct:

"Told people that this is what has been agreed nationally and implemented it and not leave it probably does sound a little bit dictatorial but that's what needs to happen sometimes to kill this culture of whatever's going on in this closed shop, to say "This is how it is and these are requirements and unless these requirements are met in a certain - whatever time frame it is, it will obviously be reflected in how you're funded" *"* (Maura key informant 11).

..."service agreement amongst one, two, three, four, five, six, ten, 12 agencies" (John key informant 1).

Missing Voice of Family

Prior to data collection it was apparent that the framework had a gap. There was no clear protocol for dealing with and including the family in the treatment of the service user. Thus, the research team sought to include their voice in data collection. We consulted with the Family Support Network, a national family support and advocacy group to identify potential participants. Three members were included in each of the focus groups and two additional members were included in the qualitative interviews. We interviewed both male and female

members who were based within and outside of Dublin, some of whom were also parents of individuals attending the treatment services.

The two main concerns of the family advocates were: the lack of consultation with families and agencies representing this group during the development of the framework and the later failure to include the family in the framework. Three main themes emerged from family support advocates, 'the need to include the family', 'the benefits of including the family' and 'the type of inclusion required'.

The need to include the family

The need to include the family was strongly advocated for by participants, for example including the family for encouragement and support should an individual be required to present to another health service.

> *"Well I suppose the only way I can describe it is I mean you, if you're a mother and your child is sick but anyone, regardless of it being an addiction, it if was cancer, if it was diabetes you'd want to be there and you would be encouraged to be there whole way through, you know, supporting him and encouraging him. And I think what happens - I think that doesn't happen in the addiction services and I think because of the whole, you know, I suppose, you know, with addiction comes a lot of manipulation, a lot of lies, a lot of secrecy and I think - I honestly think a lot of the treatment services buy-in to that because they divide the family. They take the drug user and they work with the drug user in isolation and the rest of the family is left and I think by doing that but nearly encourage, you know, all of that …*(Catherine family advocate interviewee 2).

> *… secrecy and manipulation and I think it nearly, it goes against nature and I think especially in Ireland, like, families are very close and I think it divides, you know, it drags a divide between the family and - and I think unfortunately what happens then is that the family member, the families - I mean say for example your child is a heroin user, we'll stick to heroin because it's what I know best, and we'll say your son's a heroin user and he goes on to a clinic and you might be provided with methadone but might be living at home. So you might not know as a parent how toxic methadone can be and sometimes - and I know the history of methadone and the way it used to*

come into the homes is that it'd probably come in a Coke bottle or something like that. So you may not know the dangers of that and yet your son is living at home, you may have younger siblings living at home" (Jimmy family advocate interviewee 1).

"It's not - and it thinks this is where - this is where the confusion is: family members don't need to know how much methadone or how much medication that their children are on but they do need to know that they're on some kind of medication and that this medication might be dangerous to other people. So that's kind of what I think they need to know. I think what it would look like is it would look like the whole family is supporting the drug user …treated me with civility and that's not the way it happened" (Paul focus group respondent 1).

But that is very typical of what happens, the doctors don't want to deal with family members for some reason and I think - I think it's something that the HSE needs to look at because I think if they're looking at good practice or best practice then they need to examine what they're doing. But I think what we're trying to do - I think would be to change that, we're trying to change the mind-set of people rather than change policy (Jerry focus group respondent 1).

Benefits of involving the family

The family support advocates were not necessarily advocating for the family to be informed about every detail of the service user's treatment, but rather the service user be given the choice of including the family and also taken through the benefits of having family involved.

"Well, it's where the individual feels their family would help. I mean when people are coming out of detox families get called to be putting people up, to house them. You know, families are pulled in when they're needed so the individual should know that - whether their family can be helpful or not to them. But the family members, in my experience, are very able people" (Jimmy family support interviewee 1).

I think it needs to be explained, like, "If your family is involved this is what could happen and this is the support you could have versus not being involved" and I think

it's, you know it's how it's asked but I think the big thing for families is as well is the families need basic information. I know for me, again, and I know I keep going back because it's the only way I can explain it … is that I know when my son eventually went into treatment I thought "Okay, he's cured. It's over, it's done". But nobody told me that there was relapse and that was actually worse than finding out about the drug use initially and I think that for families is so devastating and can knock families back and I think just the basic information on the process of addiction needs to be told to families initially (Catherine family advocate interviewee 2).

It would be still the same as it was 18 years ago. And even though, I mean there was three parents on that monitoring committee for [Clinic name removed], I think I sat on it for maybe five or six years, we have never, even though we knew the work we do and that we worked with parents, I have never personally got a referral from City clinic. I know that hundreds - I mean I know they were full to capacity in those years in the mid to late 90s and that was 130 people I think they had and I think there's 600 now and we have never got a referral (Catherine family advocate interviewee 2).

"I mean again the family support group that I was involved with in the mid-90s, I mean I remember we got - in '99 we got groups together to see how many groups there were and it was Dublin again at the time and I think there was eight groups and now it's 83" (Jimmy family advocate interviewee 1).

Type of required Inclusion

The family advocates suggested that the service users should simply be asked what kind of inclusion they would like the family to have and that various levels of inclusion are offered based on their responses.

"When the Family Support Network originally talked we were wishing that one question on an assessment form would be okay, you know, in the assessment form, like even "Who's your next of kin?", you know, "Would you like your next of kin to be involved?", it's a simple matter - the same – I think the alcohol services in Ireland

have been helpful in that regard, they've always involved families. And the international research shows that individuals will do better with family involvement and the alcohol services in Ireland have always involved the families (Jimmy family advocate interviewee 1).

"In relation to the care planning "Were the needs of your family considered and support offered to them?" in terms of your care plan?" (Jerry focus group respondent 1).

"And then the last one from ourselves is around information sharing. Was it discussed with the service user, the level of information sharing that could go on with your family, what kind of level they wanted that to be. Yeah, I'm just very conscious that, you know, there's a whole load of protocols on information sharing with the agencies but there doesn't seem to be any addressing information sharing with the family" (Jerry focus group respondent 1).

"We can talk about a cancer patient coming home, their family has to be involved because that family's going to care for that person because the resources aren't there to send somebody in the mornings, afternoon and evenings, that's not happening now and it's the same thing with somebody that has an addiction. In most - a lot of cases a family member is taking care of them, you know, they may be sort of helping them with food, with clothing, the basic needs that a person needs and yet they're not involved" (Jimmy family advocate interviewee 1).

Discussion of qualitative findings

The majority of participants interviewed articulated the use of framework documents such as 'Assessment and Care-planning' in much the same way as is present in the framework document, with most participants asserting that both were established practices commonly used by their agencies prior to engaging in the NDRF pilot process. However, 'Case Management' yielded more of a mixed response; either participants were unfamiliar with

this practice or they had undertaken it in more of a contained fashion more akin to a Hesse et al (2011) Brokerage model 'Case Conference' or Single Agency Model (The Center for Substance Abuse Treatment, 1998a). These meetings were often confined to a single sitting and would not include the service user. In many instances the service user would be informed that a meeting was scheduled. However, he/she would rarely be informed of what occurred at the meeting unless they needed to take particular action. The NDRF model of 'case management' was seen as a complex undertaking that required a fair amount of organisation and generated quite a lot of administration. Nevertheless, the majority of 'case managers' interviewed suggested that this was a very worthwhile exercise from the perspective of the service user.

Accountability was high on the agenda of participants across all groups, who cited this as a benefit of the framework. The NDRF offered participants a comprehensive set of standards that were clear and concrete; moreover, the framework allowed and even anticipated local issues and the Gaps and Blocks protocol offered a transparent mechanism for resolution. The backup and transparency of the gaps and blocks protocol was new across pilot sites and was valued greatly amongst the co-ordinators.

Interestingly the issue of client-centred services was mentioned both as something that worked and something that did not work. The issue of power between service users and case managers was not always perceived to be best placed with the service user. That is, some case managers that worked in residential rehabilitation programmes believed that there is a point early in treatment when the service user is quite vulnerable and may make choices based on negative behaviours such as manipulation. Some case managers cited this as beneficial, whereas others believed it could lead to relapse if not managed correctly. However, given the context, both groups case managed service users at very different stages on their continuum of care. The case managers that viewed the framework as empowering were based in the community and seeing service users at various stages of treatment, whereas the case managers that cited the need for caution were suggesting a phased approach where the professional would take the expert lead and as the service user progressed through treatment this 'power relation' could be renegotiated. The community

based case managers, however, perceived the service providers to be far too prescriptive in the individual's treatment and rehabilitation.

When asked about disadvantages and challenges participants cited the same two responses, time and paperwork. The introduction of this more systematic approach was perceived to require more work, the consequence of which would be more intensive work with fewer service users. This was not necessarily a negative comment as the case managers interviewed appeared for the most part to believe that the NDRF was a better way to work.

In general, service provider participants felt supported through the pilot process, by their managers and the local co-ordinators. However, they were ambivalent about the future of the framework beyond the pilot; how would they engage key missing partners such as HSE Mental Health Services or more auxiliary partners such as Probation services. They were uncertain whether the HSE would fully engage with the framework or how NDRIC would ensure that the framework existed beyond the pilot. Who will coordinate the roll-out of the framework? The single most cited success of the framework for key workers was the simple act of bringing people together. As a whole the key workers believed that the framework could be rolled-out nationally and would continue to exist. However, further consultation, continued support both top-down and bottom up and clear communication would have to occur to ensure its continued existence.

It is notable that during the pilot phase only six sites managed to engage their HSE Addiction Service colleagues. Of these six, four were 'pre-implementation sites' where the framework was not being implemented. However, where the HSE Addiction Services were involved this was often on an individual basis, forged through personal arrangements with local pilot co-ordinators. No formal service level arrangements were in place. The need to formalise working relationships was evident throughout the interviews.

Participants supported the notion of outcome driven funding and viewed this as an inevitable move in the current economic climate. Substance abuse treatment programmes, including those that receive public assistance, are increasingly operating in a standardised care environment. Policymaking and clinical decision making in a standardised care

environment depend on outcome data that have traditionally described the impact of substance abuse treatment interventions in terms of 'value for money' i.e. services used and money spent (The Center for Substance Abuse Treatment, 1998b). Traditionally, publicly funded services did not receive funding to collect such data and were discouraged from using funds designated for service delivery to conduct evaluations. In the US and more recently in the UK, however, many service providers fund and evaluate their own programmes. This development reflects the agencies' desire to improve service provision. Moreover, the role of Local and Regional Drugs Task Forces should be acknowledged. Drugs Task Forces are tasked with evaluating projects. The Department has specifically notified Drugs Task Forces to take this into account when considering project funding for 2014.

The issue of fidelity to the framework was dealt with quite differently across pilot sites. Some sites relied solely on the co-ordinators to ensure fidelity with no real checks; other pilot sites built in quarterly or bi-annual reviews. Nevertheless, at the time of data collection there were no concrete mechanisms to ensure fidelity to the framework. One pilot site built in observation sessions for Key working and case managing practices, whereby the co-ordinator would attend the first couple of sessions in the capacity of observer and later feedback to the frontline worker how he or she had applied the framework. When asked about the existence of the framework beyond the pilot phase two themes emerged; the need for fidelity checks and the required support structures, without which continued existence would be threatened.

When asked about fidelity to the framework, beyond a pilot phase, three themes emerged; (i) the need for governance (ii) the relevant supports and (iii) the need for a national directorate. The allocation of relevant resources, the supported guidance of a national office coupled with the opportunity for continued review and evaluation were all seen as fundamental to any proposal to roll-out the NDRF nationally. The need for a national directive from the Minister's Office was voiced several times throughout data collection. The adherence to a national policy based on best practice, with Ministerial backing, gave the NDRF great credence amongst pilot sites. Moreover, it was suggested that without Ministerial direction and on going support and governance the NDRF would be just another *'Fad',* one of several attempts at 'just introducing another way of working'.

There was a general belief amongst participants across all groups that the framework could be implemented and would be beneficial. However, if the framework continued to exist it would have to be supported and given adequate resources. Participants suggested that training, regular peer meetings and forums, as well as protected time to case manage, would be crucial. Encouragingly, the most frequently occurring recommendation from the case managers was to keep the momentum of the framework going and not to allow the work that had gone on during the pilot phase to be lost. Moreover, of the key informant participants interviewed as part of the pre-implementation sites, the majority suggested that the prolonged lead-in time was a lost opportunity to implement the framework.

The inclusion of a protocol outlining the various points of inclusion for family members and the limitations of confidentiality and information sharing (as recommended by the National Family Support Network) should be seriously considered by NDRIC. Including the family and agencies representing them appears to be a logical step for NDRIC when attempting to implement a holistic evidence based best practice with the addiction rehabilitation services.

CHAPTER FIVE: CASE STUDIES

The National Drug Rehabilitation Framework (NDRF) was developed to improve the quality and quantity of interagency referrals between drugs services (community, voluntary and statutory) and the range of services that a person may need to access in their recovery. However, challenges exist regarding how to make the NDRF a reality, particularly at an organisational level and as a routine, sustained aspect of practice. The following is a multi-method explanatory case study with a core qualitative component and additional quantitative component. A case is a pilot site (i.e. a geographical area with at least two partner agencies which had agreed to implement the NDRF). Particular focus is given to exploring the role and development of 'context' in the routine use of the NDRF in practice within targeted pilot sites ('case'). Specifically, this theoretically-based approach sought to identify key contextual elements and related patterns and relationships in pilot sites where the NDRF was being piloted.

Case Study Methodology

While we had methodologically approached sites as either active or non-active during site visits and further analysis of data, it became apparent that implementation was happening at various levels i.e. pre-implementation (not actively implementing) or (actively implementing) early or advanced in implementation. The selections of cases were chosen to include *those characterised by a continuum of care across a range of service providers. They could include a mix of cases where the National Rehabilitation Framework is working well, where implementation is relatively advanced and cases where relatively little progress has been made,* as per terms reference (Appendix 1, p114). Thus, for the purposes of case study data we will present two 'active' cases (i) an advanced stage implementer case (case 1) i.e. implemented the framework in its entirety and (ii) an early stage implementer case i.e. had implemented some but not all protocols (case 2) in order to illustrate the extent of implementation at the time of data collection. The third case (case 3) illustrates the typical explanation for non-implementation i.e. still in the pre-implementation planning stage at the time of data collection.

The purpose of this case study approach is to understand both key contextual factors and related strategic processes in pilot sites implementing the NDRF in order to:

- Identify key contextual elements and processes related to successful implementation of NDRF across pilot sites;

And

- Identify key contextual elements that distinguish successful implementation and sustainability across similar pilot sites.

Theoretical framework

The Content, Context, and Process model of the strategic management of change was the case study's theoretical framework (Stetler et al 2009). Stetler et al (2009) employed this theoretical framework to study context; in terms of *'the presence or absence of contextual factors and associated strategic approaches required for routine use of Evidence Based Practice' or systems change in the US* (p.2). The *Content, Context, and Process* model offers a clear and concise approach to case study evaluation. The following components makeup the model: 'the WHY/motivation for change, the HOW/process of change, and the WHAT/content of change'. In addition, the model also highlights similarity and dissimilarity between a 'receptive and a non-receptive context'. A receptive context has characteristics which appear to be positively associated with progress; and a non-receptive context has 'a configuration of features which may be associated with blocks on change' (p.3).

Table 2: Characteristics of each case study

Characteristics	Advanced stage implementer site	Early stage implementer site	Pre-implementation site
No. of partner agencies in site	2	7	6
Geographical location	Rural[7]	City[8]	Inner-city
Characteristics of service users	Predominately alcohol with some poly-drug use	Predominately poly-drug use	Predominately poly-drug use
Establishment of addiction specific services within pilot site	Recent <5 years	Recent <2 years	Established > 15 years
Range of tier services provided by partner agencies	2-4	1-4	1-3
Coverage of addiction specific service provision available in geographical area (not necessarily included in pilot)	Low	Low	High
Specific services provided by partner agencies	Counselling, Outreach, Aftercare programme, Family Support, Gender Specific	Probation, Counselling, Outreach, Aftercare, Key working, Case management,	Counselling, Outreach, Aftercare, Family Support, Key working, Case management and Education and Training

	support, Key working, Case management and Community Medical Detoxification	Methadone maintenance, Community Detox, Education and Training.	
Status of Co-ordinator	Peer nominated voluntary basis. Working as a co-ordinator in addition to a full-time post within the addiction service	Appointed. In paid position with no other role/responsibilities	Peer nominated voluntary basis. Working as a co-ordinator in addition to a full-time post within the addiction service
Status of partner agencies	Non-statutory	Statutory and Non-statutory	Non-statutory
Implementation phase*	All 9 protocols actively implemented between all of the partner agencies	The implementation of the NDRF was in its infancy. Not all protocols implemented. Not all partner agencies actively involved in the process	Site 3 had not managed to implement the NDRF. One of the partner agencies had managed to implement NDRF assessment and care planning practices on an intra-agency level; however, beyond the scope of intra-agency work, no other protocols were being implemented. In addition, one partner agency had withdrawn from the process due to a change in management and lack of available resources.

*At time of data collection.

The following is a general cross comparison between cases using *Content, Context, and Process model* (Stetler et al 2009).

The WHY/motivation:

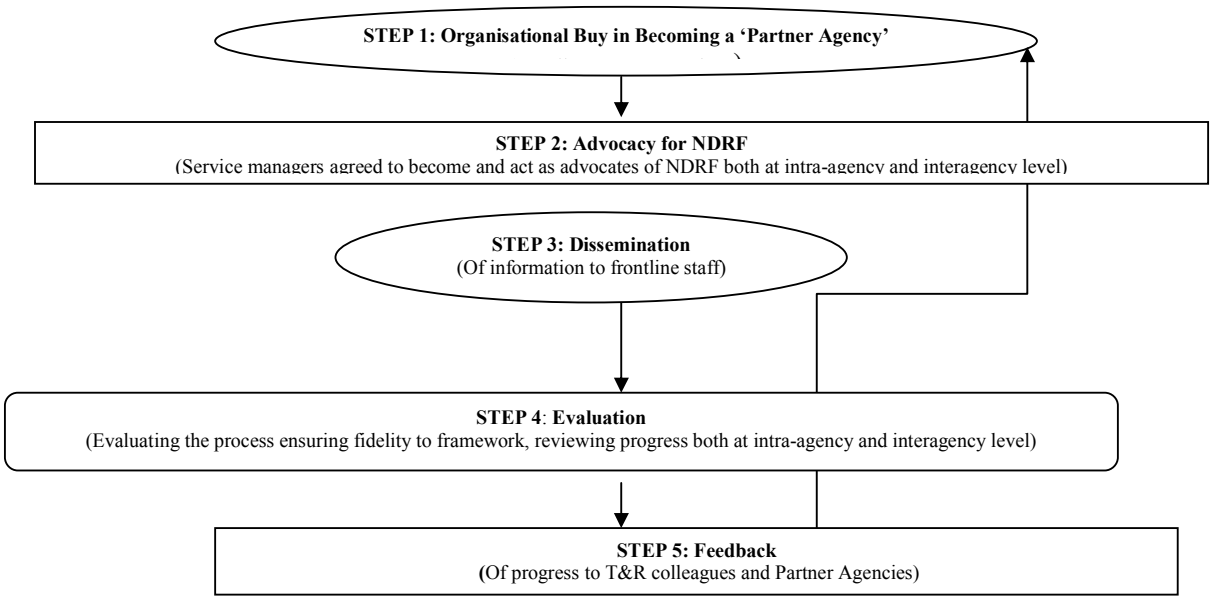
The motivation for participating in the piloting of NDRF became apparent quite early in the interview process. When asked about the benefits of implementing a national framework, participants were generally very positive. Benefits were seen as directly affecting service delivery and impacting service users for the better. The uniform approach of a national framework offered consistency for both staff and service users. The notion that a service user could move to another location and have their care plan travel with them was met with great enthusiasm. Working within a quality framework was mentioned throughout the process. Participants knew that this brought accountability but it also brought structure and organisation. There was an overarching belief amongst all three cases that the NDRF could genuinely improve upon current treatment provision. When asked about their motivation for implementing the NDRF, the most frequent response was related to improved service provision.

The HOW/process of change:

The three sites were all quite different in terms of 'buy in' from relevant partner agencies. The advanced stage implementer site adopted a phased approach. They identified a partner agency that would allow them comprehensively to provide all relevant (tier 2-4) services necessary for a service user to complete detoxification and reintegrate into the community. Once they identified these goals they committed to pilot, review and reassess practices until

they had implemented the NDRF in its entirety. The early stage implementer site, however, was quite different. They, like most other 'active' sites in the evaluation, had identified all agencies within the geographical area that provided a service to individuals with addiction issues and attempted to pilot the NDRF with all identified services. They proposed to pilot the NDRF with seven large umbrella agencies, three of which were national agencies. It is noteworthy that no one pilot site with multi-agency partners had managed to implement the NDRF with all partner agencies at the time of data collection. The pre-implementation site at the time of data collection had not managed to either engage or remain in negotiations with all proposed pilot partners.

As with each site, the tender proposals were all quite different. While the pre-implementation sites did not explicitly mention this as a factor for non-implementation, two observations are worth noting. The advanced site kept the partner agencies small; moreover, when asked about the process of advancing the implementation process, the advanced site participants believed that keeping the partnership small and 'tight' allowed for gaps and blocks to be identified early on in the process. In addition, the advanced site were quite explicit about engaging partners in the proposal process, securing service level agreements, whereas this was only implied by the pre-implementation site. It may explain the lack of engagement of named proposal partners later in the implementation process. In addition, where early stage implementation sites had secured service level agreements, gaps and blocks were identified much more readily.



The figure illustrates the steps required to implement the NDRF for participating pilot sites (1) T&R Buy in 'Becoming a partner agency',(2)'Advocacy', (3) 'Dissemination', (4) Evaluation and (5)'Feedback'. Case 1 had managed successfully to navigate the process. When asked about difficult stages they identified step 3 and 4 (between dissemination and evaluation) as the most intricate. However, participants suggested that the process was not always linear. Following the initial piloting of NDRF it became apparent that staff were still unsure about issues relating to case management, in particular which agency would become the lead agency. As with any shared process the loss of autonomy caused some unease. Several regroupings occurred before the ambiguity subsided. When asked about factors that assisted staff through this turbulent stage, it was suggested that the fact that this was 'National Policy' and seen as 'Best Practice' kept the process moving. Cases 2 and 3, however, appeared to experience most difficulty between steps 1 through 3, (from *'buy in' to 'dissemination'*), in particular step 2 'advocacy' caused most uncertainty. Both cases 2 and 3 reported ambivalence from key workers' and case managers' around assuming the lead agency, i.e. who would be the lead agent.

The co-ordination and inclusion of multiple agencies meant that key partner agencies 'buy in' occurred to varying degrees; with some agencies piloting the NDRF, without service level agreement from other key partner agencies, allowing implementation to occur at best at an intra-agency level. This haphazard implementation across pilot sites caused confusion amongst frontline staff resulting in an uncertainty about the sustainability of the NDRF. Moreover, this lack of direction caused ambiguity, which was met with great resistance. It is notable that the majority of pre-implementation sites experienced most difficulty with pre-implementation steps 1 through 3, i.e. between ensuring 'buy in' and disseminating information; whereas the majority of early stage implementer sites were stuck between steps 2 and 4, between becoming an advocate and evaluating the process. It is of note that both advocacy and evaluation are most reliant on a leader who can influence agency policy and change practice.

In addition, all three cases had varied levels of establishment in response to addiction. For example, the advanced stage implementer case (case 1) was based in a rural area that had very few services and, of the available services, the focus was predominantly on alcohol.

Similarly the early stage implementer case is based in a small city with a wide rural hinterland, with no addiction specific services prior to 2009, with current service provision focusing on opiate based treatment services. The pre-implementation case is based in a well-established area with several decades of addiction specific service provision. The establishment of pilot sites is an important consideration. It would appear from the case studies that the longer establishment of service brought issues of 'culture' or specific ways of working, which led to issues of non-receptivity to a national NDRF.

Culture was referred to as a barrier to successful implementation throughout the interviews and site visits. This notion of culture was referred to in two ways- the lack of engagement from statutory partners, due to a non-statutory perception that their colleagues had a perceived superiority and on the part of the statutory employees that their non-statutory colleagues are '*poorly trained*' and '*lack in expertise'* and secondly, the presence of '*personality politics'* (if we get on – it gets done) resulting in a lack of formal service level agreements.

The advanced stage implementer site had confined the pilot to two partner agencies. Both believed that this was a necessary step for a continuum of care for their service users. The advanced stage implementer site had a more discernible NDRF receptive context and the early stage implementer site had a lower NDRF receptive context. However, in contrast, the pre-implementation case had a discernibly higher level of non-receptivity. In the early stage implementer site, despite the positive intent and initial structural efforts, the elements of NDRF-related receptivity were not yet operationalized to a sufficient degree to have implemented the NDRF, with the site displaying a mixed context in relation to strategic change (i.e. some welcomed it and got behind it, others felt compelled to go along with the process, while others actively resisted it). The pre-implementation site displayed quite an erratic context relative to strategic change; i.e. they did not manage to engage all relevant partners named in the proposal and lost some key partners during the planning (advocacy and dissemination) phase.

The WHAT/content of change:

The use of 'framework language' was employed to varying degrees across each of the pilot sites. None of the service users across all pilot sites interviewed recognised the language of the framework i.e. assessment, care-plan, case management. However, once these concepts were discussed in terms of *goal setting and review and meeting with all relevant agencies*

involved in treatment, service users immediately recognised these concepts as part of their current treatment service. When service users were asked how their current treatment episode compared to earlier episodes, service users noted a more structured, focused and inclusive service.

There were few differences between active and pre-implementation sites. However, a distinct difference was their perception of the pilot phase. Active pilot sites had seen the pilot phase as an experiment, a genuine opportunity to see how the framework translated into practice and learn through the process, whereas the pre-implementation pilot site got held up in preparing and planning for the pilot of the framework. When questioned about this, the co-ordinator suggested that they did not want to introduce new practices only to come back to colleagues in 6-12 months and make changes. Rather they wanted to have everything in place before they began implementation. Given that sites were vastly different and often involved a number of agencies the need to have a lead-in phase where agencies learn to contextualise the framework is paramount and should not be avoided.

Case 2, the early stage implementer case, took a novel approach to piloting case management locally. Following localised training the pilot co-ordinator was present at all initial case management sessions. The role of co-ordinator at these sessions was twofold to support and provide feedback to the and to ensure fidelity to the case management protocol. Three participants who were interviewed during the case 2 site visit had been observed in the role of by their co-ordinator. The participants said while they initially found this daunting, the feedback was quite helpful, offering some validation of the process.

Discussion of Case Study Findings:

The main finding from the case studies is that organisational culture and climate were associated with addiction service providers' attitudes toward adoption of the NDRF. Culture was used to denote a number of things; openness to change, willingness to work collaboratively across agencies and the value of a client-centered approach. Climate was used to denote work done prior to the NDRF, groundwork in order to prepare for the implementation of the NDRF and general use of evidence based best practices. The organisational cultures and climates within which the NDRF was being implemented varied with attitudes toward adoption of the NDRF in what could be described as predictable ways.

That is, in general, more positive organisational culture and climate was associated with more positive attitudes toward the NDRF. As suggested by the findings, having a positively perceived local leader who can influence organisational culture and who can introduce and guide change in practice may facilitate receptivity to change in provider behaviour *(*Stetler et al 2009).

Consequently, when faced with organisational change, it is crucial for the agency and programme leaders to attend to frontline providers' attitudes and beliefs about adopting new approaches to treatment and outcome assessment (Stetler et al 2009). and to create an infrastructure to allow frontline providers the opportunities to reflect upon and where necessary re-evaluate attitudes and beliefs in relation to these changes.

The case study has particular implications for the future roll-out of the NDRF in addiction service settings, such as those in the pilot. Staff attitudes, work demands, productivity requirements, and service users may affect general attitudes toward implementation. To the extent that organisational cultures and climates are positive, attitudes toward change in practice or implementation of the NDRF may also be more positive. Needs assessment or pre-implementation evaluation of frontline provider attitudes toward adopting the NDRF and of organisational context may help in the development of optimal implementation strategies. Bringing partner agencies together to plan and develop localised strategies for implementation is crucial.

Where culture and climate are less than optimal, organisational improvement interventions can target aspects of the work environment likely to impact on attitudes toward change. For example, capitalising on local organisational leaders (Rogers, 1995) and developing skills of frontline providers may support future implementation. Future roll-out should exploit, but not limit, organisational improvements based on empirical knowledge and evidence of effectiveness demonstrated in the pilot.

Service providers' attitudes toward implementing the NDRF represent just one aspect of the complex context of addiction service delivery (Stetler et al 2009). The case studies further support the notion that organisational context, including culture and climate, are necessary

considerations in the implementation of the NDRF. The case studies also provide specific evidence that the service context is critical in understanding attitudes toward implementation of new policies and practices (Stetler et al 2009). Fostering working cultures and contexts that promote adoption of the NDRF may help to improve the ease and success of future implementation of the NDRF into other community settings.

CHAPTER SIX: DISCUSSION AND RECOMMENDATIONS

This evaluation has three data sources;interviews,case histories and questionnaires. There is an overlap in relation to many of the findings and the data from each source is supported from the others. The findings are also supported by the literature. In this chapter the results from all sources are synthesised. Finally, recommendations are made based on the learning from the data.

At the outset it needs to be said that co-operation from all particpants was excellent. People gave freely of their time through all phases of the evaluation. There is also much goodwill towards the framework and a real desire for it to be implemented and supported in full , in order to have the maximum beneficial impact on service users.

Sustainability

One of the themes that recurred in all settings was sustainability. Fears were expressed that the momentum from the publication of the framework which carried through to the pilot phase could be lost post evaluation. All initiatives need a combination of top down and bottom up support. A re-emphasising of support for the principles of the framework from the co-ordinating Government Department, with concomitant support from each contributing Department, was seen as essential. Workers did feel supported at local management level but wanted to see that support being articulated at higher level. 'Missing partners' were identified. While all accept that funding is a challenge the need for a local 'champion', the co-ordinator, was made clear by all. The framework was written in different economic times and both the pilot and future roll-out of the framework had been envisaged to take place under the leadership of a local full-time rehabilition co-ordinator. These posts have not been maintained, casting the future of the framework in doubt. The value of the national senior rehabilitation co-ordinator post is apparent but this needs to be supplemented at local level. If each Local and Regional Drugs Task Force is to take on the responsibility for the future roll-out of the framework as originally envisaged then each needs to be supported with a full-time rehabilitation co-ordinator, accountable to the

national senior rehabilitation coordinator for matters related to the implementation of the framework. As the HSE is the nominated lead agency for the framework it is important that accountability mechanisms have a seamless track through the HSE. This needs to be renewed initially at the level of the drugs task force.

New way of working

This issue covers a multitude, but is central to the roll-out of the framework. While some elements of the assessment process preceded the pilot phase, in many locations the introduction of case management was more problematic and not always smooth. There was a range of reported uptakes of the use of case management and there is scope for improvement. Linked to this is the issue of inter-agency working. Moving from the principle of inter-agency working to its implementation has to be actively worked on. It brings up issues of trust, financial insecurity and cultural clashes . All agencies represented in this evaluation signed up implicitly to inter-agency working but this was not always the practice. This is remediable but requires leadership. It will also require direction and this request is coming from many frontline workers in this evaluation. The literature suggests three possible models for inter-agency substance use case management; single agency model with a series of unconnected relationships, informal partnerships and formal consortia. While informal arrangements often can achieve more than formal arrangements the learning from this evaluation is that a more formal approach to interagency working is required, and desired. This will entail service level agreements or other such constructs, with active monitoring by NRDIC. In this way the unusual finding of 'pre-implementers' in this evaluation should not arise in the future.

Culture

Culture can often be a code for other things but it was raised on numerous occasions. Its influence is hard to measure but it is there. New ways of working , particularly inter-agency working, challenge existing cultures and pre-implementation training on this issue would help. Politics with a small 'p', territoriality, inappropriate 'ownership' of clients and unwillingness to change are all obstacles that can slow down implementation. This is a critical issue in implementation and many of the failures of implementation globally can be put down to these sensitive issues not being confronted. These matters can all be addressed through training, once acknowledged. The training input to date was perceived negatively by

some interviewees. Even with a national framework one size may not fit all and it would be worthwhle in future training exercises if the local climate, culture and landscape were more fully explored prior to delivery of training. Again, this will be important for the existing pilot sites and any new sites which take on the roll-out of the framework nationally.

Non-implementation

The finding that some sites were not implementing the framework was surprising. The difference between pre-implementer sites and sites that were implementing may not be great. It could be that what occurred to differentiate the sites that had begun implementing from those that had not was a differing threshold for getting started on new initiatives. While process is important paperwork and protocols are means to an end, not an end in themselves. There are learnings from this in terms of future roll outs and the language of implementation will have to be more direct and less open to mis-interpretation in the future.

Client centredness

Most agree with this in principle but respondents in statutory services had differing views to those in non-Governmental organisations, with the former having a greater degree of scepticism. This is partly because of genuinely differently held views between service providers on whether all service users participating in the pilot sites were best placed to decide on their therapy. This is an age-old difference that has to be worked through, involving greater dialogue between service providers and service users. Service users feel more involved since the pilot sites began implementing the framework but whether this can be attributed to the framework cannot be proven.Without greater involvement of service users the roll-out will fail. It did not prove possible to carry out any outcome measurements in this evaluation and hence there is no data to inform a needs assessment. Before commencing a roll-out of the framework nationally a needs assessment exercise incorporating data from service users should be carried out.

Framework instruments and information technology

There is a natural tension between having a standardised approach and having person-centred services. Most see the framework as a way to improve standards. The framework

processes and documentation were well received, particularly the gaps and blocks instrument. There is also a tension between rigorous documentation and excessive paperwork. The majority feel that the framework errs on the side of the latter. Notwithstanding this, all agree that the framework documentation, instruments and tools are worthwhile and should be utilised.This needs to be addressed, as documenation is important. How the documentation will be completed needs to be refined , otherwise credibility with practitioners will suffer. The sense is that the various framework documents should be mandatory, not an optional extra. Information technology was not seen as being well used during the evaluation. Being able to track service users' progress through the various steps in the implementation of the framework is generally not possible. This will require decisions and actions at Department of Health level to allow more extensive use of information technology and record linkage. The spirit of the framework is that this should be routine but it will not happen just by wishing it.

Structures

The evaluation touched more on process than structure and function is nearly always more important than structure. However, structure has a place. If structures are too loose you will end up with pilot sites unsure whether they are in or not, as happened with this evaluation. There is room for a much more crisp central direction for the subsequent roll-out of the framework, without stifling local initiative. Apart from the need for a more directive approach from the Department of Health other Government Departments need to clarify and re-iterate their commitment to the framework. In addition to the previously stated coordinator issues there is scope for NDRIC to review its process of monitoring of the framework and to re-examine what is the best make up of NDRIC to make it fit for purpose to enable it to deliver on the spirit of the framework. This evaluation entailed interviews with 60 service providers, across five designations;key worker, case manager, manager, local co-ordinator and key informant.

Limitations of the evaluation

Most of the data is from service providers rather than service users. Service providers may have an unduly rosy picture of issues although this did not come across in the interviews. The relative paucity of service user input is a weakness as true change should be driven as much as possible by service users.

The evaluation is very much one of structures and processes rather than outcomes. Any future evaluations should have outcomes measurement.

There was no longitudinal element to the evaluation. Even for the service provider process data it would be beneficial to follow up this exercise post evaluation. The findings of the evaluation need to be digested at pilot site level and internalised as much as possible. Roll-out cannot take place without, or be imposed on, service providers and their employing agencies.

The terms of reference of the pilot project included that the evaluation should assess the extent to which the framework is meeting the needs for which it was intended. It has not been possible to assess this.

Conclusions

The National Drug Rehabilitation Framework is in its infancy and its planned roll-out is a very important development. This evaluation is the first external examination of the roll-out, conducted across sites that have put themselves forward for examination. It is an examination of procedures and process rather than outcomes, with input from mostly providers but also a perspective from a selection of users of the service. The spirit in which the evaluation has been carried out is to identify what are the enablers and challenges that have been identified so that the more systematic roll-out can be informed by the learning from this exercise. Because provider issues are critical to any service delivery the recommendations will focus mostly in that area.

At the outset there was almost universal enthusiasm about the framework and what it is attempting to do and quite a degree of optimism, in spite of the challenging economic circumstances in which the country finds itself, that the considerable shift in focus that is required will take place. Interviewees did not hold back on what they thought the deficiencies were and there was consensus across the different stakeholder views on what the principal challenges would be.

Recommendations

There is a sense that momentum has been built around the framework but a fear that it may be lost post this pilot phase. All stakeholders would welcome direction from Ministerial level

and from NDRIC. Accordingly, **a reiteration from the Minister for the Drug Strategy and the Department of Health of the importance and value of a national roll-out of the framework would maintain the momentum that has been gained.**

Gaps in service provision and problems of access to essential services were highlighted. Mention was frequently made of 'missing partners' in the process. **All agencies, particularly statutory, need to re-examine their commitment to the framework and formally re-commit.**

Nearly all participants feel supported, both by their own line manager, the area co-ordinators and NDRIC. In terms of capacity the local co-ordinators are very committed to the process but most are part time in the role. **Co-ordinators should be assigned full time to the role.** The dedicated role of Rehab Coordinator needs to be filled by the HSE in partnership with the Drugs Task Force (and relevant community & voluntary services) taking into account the availability of resources and the number of clients and services that will be engaged in the NRF.

It is important that NDRIC takes a central role in monitoring the roll-out of the framework. In that regard all key elements need to be appropriately represented on NDRIC, including service users.

In addition, the roles of all players in the roll-out and implementation of the framework need to be made explicit.

Inter-agency working is perceived as a pre-requisite for successful implementation of the framework and also a great challenge. **Organisational culture within certain categories of services will need to change and the benefits of the framework will have to be explicitly identified.** The framework has policies and recommendations for good practice in relation to inter-agency working and the findings suggest that **these will need to be monitored and implemented, in areas such as confidentiality, information sharing and handing over of responsibilities for and to service users where appropriate**. In addition, **more formal arrangements by way of service level agreements will need to be drawn up in future if agencies volunteer to participate in the implementation of the NDRF.** Training proved a

problem for some respondents in this evaluation and **a fit for purpose training plan should be drawn up for the future and delivered so that these issues of culture can be addressed pre-implementation and throughout implementation.** Because of the finding of non-implementation in several sites, as well as addressing the process of change through training **it would be important to consult with future sites to assess their readiness to change and to identify local gaps and blocks to implementation.**

Paperwork is important but is seen as very time consuming so **more efficient ways of documenting activity should be explored. Once the core NDRF documentation , tools and information requirements are agreed by all stakeholders they should be made mandatory, not discretionary. The possibility of record linkage should be pursued with the Department of Health as legislation will be required to bring this into effect.** This issue has been raised for over a decade and if introduced, with appropriate privacy protection legislation, it will enhance the capacity to measure outcomes almost as a matter of routine.

This evaluation had limited service user involvement. Such service user feedback as was reported was positive. From the limited sample there was a sense that service users in the main were being involved in their care planning. **Each service user who is registered as participating in the framework should have a written copy of their care plan and this should be reviewed at agreed intervals.**

It is important that **a more extensive examination of the roll-out involving greater service user input should be carried out in the near future**.

One of the major challenges, even with the best will in the world, will be capacity for agencies to deliver on the framework. To address this, **a needs assessment of service users across all services and agencies should be carried out to determine the potential demand and need for the framework.**
As a follow on to this evaluation **more detailed feedback from the 10 sites should be obtained and any recommendations coming from that exercise should be considered by NDRIC.**

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APPENDICES

Appendix 1:Terms of Reference
for Pilot Projects to inform the implementation of the National Rehabilitation Framework

To be read in conjunction with the National Framework Document

OVERVIEW
The pilots will:

- support the implementation of the National Rehabilitation Framework and the integrated care pathways model in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation
- build awareness and knowledge of the National Rehabilitation Framework amongst key stakeholders
- identify progress in implementation
- identify gaps in services and drivers/obstacles in respect of implementation
- assess the initial impact of the Framework
- help to clarify roles and inform implementation of the Framework

The pilots will inform the future development of the National Rehabilitation Framework including key areas such as:

- shared care planning
- case management and key working
- inter-agency working
- intra-agency working as appropriate
- shared understandings of client confidentiality
- development and implementation of protocols to facilitate the above
- development and implementation of service level agreements to facilitate the above

In line with the recommendations outlined in The Report of the Working Group on Drug Rehabilitation, 2007, the HSE appointed the National Senior Rehabilitation Co-ordinator and established the NDRIC to oversee and monitor the implementation of the recommendations of this Report.
The NDRIC has recently produced a National Rehabilitation Framework document to provide:

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

The NDRIC regard the National Rehabilitation Framework as the first step in the implementation of a co-ordinated inter-agency approach to the delivery of integrated rehabilitation services as set out in the Report of the Working Group on Drug Rehabilitation. The National Rehabilitation Framework makes clear that all the needs of clients accessing substance misuse services should be addressed and that services need to work together to make sure those needs are met. The NDRIC sees the adoption of the integrated care pathway approach as an essential element of good practice and a major factor in working with service providers to improve treatment outcomes. Following the approval of the

National Rehabilitation Framework the development of pilots in selected locations represents the next step to inform the process further and to gain practical experience of implementing the Framework.
At a national level the NDRIC will continue the development of national protocols and service level agreements needed to promote the integration of service provision through the buy-in and participation of all the relevant sectors, departments and agencies.
The Report of the Working Group on Drugs Rehabilitation identifies the central importance of and Regional Drugs Task Forces, through their Treatment and Rehabilitation Sub-Groups, in supporting the management of a coordinated approach to rehabilitation at and regional level which compliments the lead role the HSE has in this area. The NDRIC shares this view and regards the Drugs Task Force Treatment and Rehabilitation Sub-Groups as a significant driving force together with nominated Rehabilitation Co-ordinators to progress the development of effective client rehabilitation care pathways at and regional level.
There have been many developments towards improving integrated care for substance users across the country and through HSE mainstreamed services. The main aim of the pilot projects will be to implement the recommendations of the Report of the Working Group on Drugs Rehabilitation using the National Rehabilitation Framework to build on current practice. It is intended that the NDRIC and key stakeholders will consider the outcomes of the pilots and decide on actions to be taken to progress the implementation at a National level.

2. Scope of Pilots

The scope of the pilots concerns the initial implementation and operation of the National Rehabilitation Framework.
Each pilot site will identify a specific number of clients across Tiers 1-4 and involve a variety of substance addictions.
Progress of clients should be tracked and evaluated on an ongoing basis including care pathway and transition across services/agencies for the duration of the pilots.
The pilots will address:

1. Initial impact of the National Rehabilitation Framework on
    a) service users and their families
    b) The key organisations involved in implementation in terms of policies and practice. Areas to be considered include screening, assessment, referral, shared care planning, key working and case management. This will involve seeking feedback from persons engaged in these areas of activity.
    c) relevant agencies and Departments

2. Identification of factors that affect implementation (drivers and obstacles) in stakeholder bodies.

3. Recommendations for actions to be taken by the stakeholders to support implementation

4. Future thinking on specific roles

The above will be documented on a periodic basis during the course of the pilots and will be used to inform wider and on going implementation of the National Rehabilitation Framework Document.

A detailed evaluation tool will be developed that will assess the implementation of the National Rehabilitation Framework; structures, process and outcome indicators in relation to service users and providers (more details in section 6).

3. **Organisation of the Pilots**

The HSE, as lead agency for treatment and rehabilitation, will lead out on the pilots. The nominated Rehabilitation Co-ordinator, in conjunction with the Local/Regional Drug Task Force Treatment & Rehabilitation Sub-Groups, will work to make decisions on how best to facilitate the pilots consistent with the National Rehabilitation Framework. They will be responsible for the development and growth of /regional co-ordination, collaboration and joint action amongst agencies as set out in the National Rehabilitation Framework. This will be done under the guidance of the NDRIC through the National Senior Rehabilitation Coordinator.

Three strands are proposed:

a. Implementation and operation of the Framework

b. Development and implementation of protocols around assessment, referral, information sharing, shared care planning, and dispute settlement in line with the national protocols, and service level agreements (including schedules therein)

c. Impact of the National Rehabilitation Framework and strategies for progression

The values and considerations that underpinned the development of the National Rehabilitation Framework by the NDRIC inform the approach to the pilot

Selection Criteria for Pilots

The HSE as lead will, in conjunction with the Senior Rehabilitation Co-ordinator and other agencies decide on the most appropriate locations for the pilot sites.The following are essential to facilitate the running of a pilot:

d. Drugs Task Force areas should have fully functioning Treatment & Rehabilitation Sub-Groups with the membership in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation & reflecting NDRIC membership (i.e. representatives of those involved in the shared care plan should be around the table – see Figure 1 in Framework, page 5)

e. Have identified an agreed nominated Rehabilitation Co-ordinator in the area who will be a member of the Treatment & Rehabilitation Sub-Group and who will lead the Sub-Group in regard to the implementation of the National Rehabilitation Framework.

The following are desired to facilitate the running of a pilot:

f. That the catchment area has services and clients across four tiers (see page 8 of Framework)

g. Coverage of a range of substances of abuse (including alcohol)

h. Clients requiring multidisciplinary/interagency working (to include where possible clients involved with the criminal justice system)

4. **Roles and Responsibilities**

Central to pilot participation is a commitment by all stakeholders to work as a partnership. This partnership approach (between Government Departments, state agencies and the community and voluntary sectors) provides a solid foundation from which all of those involved in the rehabilitation should work. The lead role of the HSE implies a commitment to actively partake, fund, resource and provide/develop standardised training (through the HSE's national addiction training programme) for the pilots in this process. This will help to inform the continued roll-out of the National Rehabilitation Framework and the implementation of the recommendations of the Report of the Working Group on Drugs Rehabilitation. Future thinking on specific roles will be informed by learning from the pilots.

It is acknowledged that together with the HSE, key roles exist for the newly appointed Rehabilitation Co-ordinators in conjunction with the Drugs Task Force Treatment & Rehabilitation Sub-Groups. The following is an overview of the key responsibilities attached to these roles in the implementation of the National Rehabilitation Framework during the pilots.

a. Drugs Task Forces & Treatment and Rehabilitation Sub-Groups

The Drugs Task Forces and Treatment and Rehabilitation Sub-Groups commit to:

- **i.** Identify all services within their boundaries and align their interventions to the 4 Tier Model (mapping of TF funded projects is being facilitated by the NDRIC)
- **ii.** Explore collaborations with Primary Care Teams, Social Care Networks, HSE Addiction Services through HSE Representatives, GPs, Community Education Programmes etc.
- **iii.** Together with the nominated Rehabilitation Coordinator, contribute to the design, establishment and operation of inter-agency partnership arrangements
- **iv.** Together with the nominated Rehabilitation Coordinator, monitor the implementation of service level agreements

b. Rehabilitation Co-ordinators

The nominated Rehabilitation Co-ordinator for the /regional area commits to:

- **i.** Take the lead role on the Drug Task Force Treatment & Rehabilitation Sub-Group for the implementation of the National Rehabilitation Framework through the development of an implementation plan.
- **ii.** Ensure, alongside the Treatment & Rehabilitation Sub-Group, that protocols and service level agreements, in line with the national protocols, are developed, in place and effectively implemented.
- **iii.** Bring together key partners and lead the development of interagency arrangements, and establish effective links with relevant agencies
- **iv.** Report on progress periodically to NDRIC/ National Senior Rehabilitation Co-ordinator

5. Key Outputs

The HSE will commit to fund, as appropriate, a structured monitoring and evaluation mechanism for the pilots, which in turn will further inform their development.An evaluation tool will be developed to assess the implementation of the National Drug Rehabilitation Framework. The objective of this evaluation is to assess the quality and effects of the National Drug Rehabilitation Framework, as set out in April 2010 document, in order to:

- Guide future work of the National Drug Rehabilitation Implementation Committee
- Offer independent examination of the implementation of the National Rehabilitation Framework

The final report will include the following:

- Description of the evaluation process
- Consultation with relevant stakeholders
- Assessment of the extent to which the Framework is meeting the need for which it was intended; this will be further informed through an assessment of the level of engagement and compliance with the Framework among services
- Review of international and national research on the potential benefits of the National Rehabilitation Framework
- Assessment of both Structural and Process Indicators for participation/implementation of the framework across a range of projects/sites
- Outcome Indicators to inform assessment of the quality and effect of the Framework
- Conclusions and recommendations

The following are *desired* key outputs:

a. Each pilot sites Rehabilitation Co-ordinator will produce a report to the NDRIC which includes the following:

i. Update and monitoring on the state of implementation of the National Rehabilitation Framework in pilot sites

ii. Assessment of impact. This will also include surveys of awareness of the National Rehabilitation Framework amongst staff and service users

iii. Case studies of implementation/impact. These will drill further down into levels of awareness, and how the Framework is working and being implemented in particular fields or sectors. Possible case studies include those characterised by a continuum of care across a range of service providers. They could include a mix of cases where the National Rehabilitation Framework is working well, where implementation is relatively advanced and cases where relatively little progress has been made. The focus of case studies will be decided in consultation with the main stakeholders.

iv. Completion of activity reports for the NDRIC (e.g. level of referral, care plans etc.). Template for such reports to be developed by the NDRIC

v. Identification of gaps in knowledge/skills/competencies to inform training needs and development

vi. Identification of gaps/shortfalls in services provision and waiting times

vii. Feedback from service users; experiences, benefits and evidence of progression

b. Task Force Treatment & Rehabilitation Sub-Groups together with the Rehabilitation Co-ordinators will facilitate the development of protocols and schedules within SLAs, and assist agencies with their implementation. This will be done under the guidance of the National Senior Rehabilitation Co-

ordinator and informed by national protocols and SLAs as developed by the NDRIC.

c. Synthesis report and recommendations by NDRIC

i. Agreed national protocols detailing:
1. Agreed referral pathways for key services including FAS CE etc.
2. Agreed dispute settlement procedure
3. Agreed information sharing procedure
4. Agreed recognised assessment tools

ii. Identifying the major barriers to the implementation of the National Rehabilitation Framework

iii. Examples of good practice

iv. Practical recommendations for how Drugs Task Forces and service providers can, within existing financial support levels, improve the delivery of integrated care, particularly in relation to sharing of information.

6. Timeframes

Following the HSE's consultations it is hoped to establish the pilots by the end of the summer 2010 feeding back to NDRIC on a quarterly basis with an expected detailed assessment report due after 12 – 18months.

Appendix 2: Ethics Protocol

DRUG TREATMENT CENTRE BOARD RESEARCH ETHICS PROTOCOL

A. Details of Applicant & Title of Project.

Title of Project: Evaluation of the National Drug Rehabilitation Framework

Principal Investigator **Prof Joe Barry** **Signature:**

Name of Researcher: Jo-Hanna Ivers **Signature:**

Position: Researcher

Centre: Department of Public Health & Primary Care

Address for correspondence:

Department of Public Health & Primary Care,
Trinity College Centre for Health Sciences,
Adelaide & Meath Hospital Dublin, Incorporating the National Children's Hospital,
Tallaght,
Dublin 24.

Telephone number: 01-8963737

Name of Sponsor: Dr Brion Sweeney **Signature:**

Position: Consultant Psychiatrist in Substance Misuse

Centre: The Drug Treatment Centre Board

Name(s) and Position(s) of Collaborator(s):

Professor Joe Barry Principal Investigator
Ms Jo-Hanna Ivers Co-investigator

Date of Application: 30th June 2011

Proposed starting date: February 2012

December 2011

B. General:

1. Abstract:

(In less than 250 words and as far as possible in lay language, state objectives of study. (Methodology and relevance of study both academically and to the Drug Treatment Centre Board's services).

The current study will evaluate the implementation of the National Rehabilitation Framework from the perspective of both service users, service providers and other key informants. The study will utilise quantitative and qualitative research methods to gather data. Data collection will take place over a six month time period in both community and rehabilitation drug services nationally across the range of tiered services.

Aims and objectives:

The aim of this evaluation is to assess the quality and effects of the National Drugs Rehabilitation Framework, July 2010, in order to:

- Guide future work of the National Drugs Rehabilitation Implementation Committee
- Offer independent examination of the implementation of a National Drugs Rehabilitation Framework for substance abuse.

The Objectives of this evaluation are:

- To review international and national research on the potential impact of the National Drugs Rehabilitation Framework.

- To assess structural, process and outcome indicators for participation in implementation of the framework across a range of services.
- To assess the applicability of the framework as well as any outcomes

- To make recommendations based on these findings.

2. Background to the study:

Understanding the differing experiences of service users regarding the implementation of the National Drug Rehabilitation Framework offers the best prospects for improving our understanding of their health needs and the opportunities before us to better meet these needs. The proposed research initiative aims to achieve this by conducting an evaluation of the Implementation of the National Drug Rehabilitation Framework. Evaluation is a systematic method for reviewing the experiences of a population, leading to agreed priorities and recommendations regarding resource reallocation that will improve health services.
The proposed study has two components:

(a) Process measurement: (i) documentary analysis and (ii) interviews with key informants (service users, service providers and committee members.

(b) Outcome measurement: (i) administration of base line and follow up instruments (ii) interviews with service users.

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3. Hypotheses:
N/A
4. Subjects:
Data collection will take place with a sample of service providers and service users attending a range of drug and alcohol services, (non-substance specific services, open access drug and alcohol treatment services, structured community-based drug and alcohol services and residential drug and alcohol services) nationwide.
4. a Sites:
There are eight research sites in total. Research sites were self-selected. Sites responded to a call from the National Drug Rehabilitation Co-ordinator to participate in the evaluation.

5. Instruments to be used in evaluating subjects:

Please refer to Appendix B for copy of all instruments to be employed.

6. Method:

Data collection

Data collection will comprise two key components:

1. Quantitative questionnaires/instruments.
2. Qualitative Interviewing.

Quantitative Data

The suite of questionnaires/instruments will be administered to between 25-50 drug users at each of the eight sites at baseline and 6 month follow up. The specific questionnaire/instrument to be administered to a given service user will be a matter for the service providing care and will be dependent on where on the 'wheel of change' the service user is.

Qualitative Interviews:

It is envisaged that between 20-30 service users will be interviewed to document their experience of the process. The rationale for using a qualitative approach is that it facilitates understanding people from their own frame of reference. Interviews provide an unstructured forum for current service users to raise and explore the issues around their health needs which they see as important.
Where possible the research will aim to reflect national experience i.e. Dublin as well as other cities, and rural areas. A major strength of qualitative data is the rich thematic texture that can arise from this type of analytic undertaking. The major goal within this segment of evaluation is the elaboration of a conceptually rich and contextually grounded understanding of the need for and benefit of a national drugs rehabilitation framework for substance users, a goal which is not possible to capture in a methodological format, such as a questionnaire, that is more conducive to larger sample sizes.
The topics that will be covered in the focus groups will include:

- Service users' awareness of care planning and level of participation in the process.
- Service users' perception of the impact of care planning.
- Service users' awareness of the various stages of treatment and rehabilitation.
- The range of facilities and treatment services that is available in a given area as well as the structure of the services available.
- Interagency care plan collaboration.
- The specific role of these services in the care planning
- How treatment services could be improved.

7. Treatment of data:

(Outline how the data will be recorded, stored and analysed)

The project will be overseen by Prof. Joe Barry. The project researcher (Jo-Hanna Ivers) will be responsible for all data entry. The data will be anonymised and assigned a code once agreement has been received from service users for this to occur. The anonymised copies of data will be kept in a locked filing cabinet by the researcher in the Dept. of Public Health & Primary Care, Trinity College Centre for Health Sciences, Adelaide & Meath Hospital Dublin 24. Only direct members of the research team (Prof. Joe Barry and Ms. Jo-Hanna Ivers) will have access to the data. The data will be stored for a period of 10 years (as per Trinity College Dublin guidelines) after which time it will be destroyed. The data will be analyzed using appropriate qualitative and quantitative methods.

8. **What inclusion and exclusion criteria for recruitment and selection of participants?**

Inclusion criteria

Any service users between the ages of 18-64 years attending a service within the research site will be eligible to participate.

Exclusion criteria

Terminal illness.
Acute, severe psychosis.

9. How will participants be recruited?

Service users will be recruited ly through both community and rehabilitation drug services in each of the eight research sites. It is intended that 25-50 service users will be recruited from each treatment site.

10. How will the health of the participants be monitored during and after the study?

Participants will be monitored by their usual key worker/throughout the course of the study.

11. What medical examination will persons selected for inclusion in the study undergo before participating in the study?

No medical examination will be performed for study purposes.

12. What inducements or rewards will be offered to participants?

No inducements or rewards will be offered to participants for study purposes.

13. What payments, monetary or otherwise, will be offered to the investigators for undertaking this study?

The work is funded under a service level agreement between the Health Service Executive and Trinity College Dublin. Funding is being used to pay the salary of the project researcher.

14. What payments will be made for facilities used in conducting the study?

There will be no payments to facilities used in this study.

15. What action will be taken to ensure that the identity of each participant remains confidential?

Signed consent forms will be kept separately from all subsequent data collected. Each participant will be assigned a code for the purposes of data entry and analyses. No individual participant will be referred to in any report by name.

16. Was the participant's family doctor notified of the proposed study?

Yes □ No √□

17. Will data relating to subjects or controls resulting from the research be stored on computer? Yes_____.

If so, the requirements of the Data Protection Act. 1988 must be complied with.

18. Please state that you will observe the code of practice on the use of Audio Visual Materials.

Yes √□ No □ Not Applicable □

Please attach a copy where applicable to your application.

19. What arrangements exist to provide compensation to each participant who may suffer injury of loss as a result of this research project?

All service users will be screened by their key worker/within the agency responsible for their care plan. Each service users will be given any extra support, counselling etc. within the context of this research by these agencies.

20. Give details of any risks to subjects or to controls from investigative or therapeutic procedures or from withholding of therapy?

NOTE: for the protection of both the investigator and the subject the list must be comprehensive and must also appear in full in the patient information leaflet.

We do not perceive any major ethical concerns or risks associated with this study. The instruments will be administered ly by a key worker that has an established relationship with the client as part of his/her care-plan. The researcher that will conduct the interviews is a Psychologist with several years' experience in the Addiction Services and extensive experience employing qualitative methods. All Key workers participating in the study are employed as Key workers/project. Their qualifications range from Diploma to Postgraduate education. In addition all staff will receive a uniformed training

in Key working, Care planning and Case Management overseen by the ***Substance* Misuse Strategy Office, Social Inclusion Unit, Health Service Executive.**

21. Any other information of interest to the committee in regard to this study.
No.

22. A signed Consent form should be attached to this form:

Signature of Principal Investigator: _____

Appendix A:
Evaluation of the National Drug Rehabilitation Framework
Patient Consent Form

Consent Form

The research study has been fully explained to me. I have had opportunities to ask questions concerning the project and procedures involved. I am aware that participation is voluntary and that I am free to withdraw my consent at any time. I am aware that my decision not to participate or to withdraw from the study will not restrict my access to health services normally available to me. I understand that my treatment records may be accessed by researchers. I am happy for the information gathered about my experience of the addiction services, without my name or an identifying information to be passed on to the research team. I consent to be followed up and am aware that I made be asked to take part in an interview at a later stage. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner.

I, the undersigned, hereby consent to participate in the described study as outlined in the information sheet.

_____ (Please sign here)

_____ (Please print your name here)

Date: _____ Time:_____

Statement of interviewer's responsibility: I believe that the participant understands my explanation and has freely given permission for their information to be anonymised and passed onto the research team.

Interviewer's Name:

Interviewer's signature:

Date:

Appendix B

Evaluation of the National Drug Rehabilitation Framework

Participant Information Sheet

What is the purpose of this research? We are asking patients to participate in this study in order to gain a better understanding of their experience within services that are implementing the National Drug Rehabilitation Framework.

What procedures will be performed for research purposes?

If you agree to be a part of the study you will complete a questionnaire with your key worker, which will be repeated in six months' time. Your information will be anonymised, this means that your information will not have your name on it. Your anonymised information will be given to the research team from Trinity College Dublin. In addition some patients will be asked to participate in a follow up interview in order to gain a better understanding of your experience of working in this new way. The interview will be done by a Researcher and anything you say will be strictly confidential.

What are the potential risks of taking part in this study?

There are no risks attached to your participation in this study.

What are the potential benefits of taking part in this study?

The main benefit is to help improve services for patients accessing Addiction Services.

Do I have to take part? No. It is up to you whether you take part or not. If you decide not to take part, we will entirely respect your decision. If you do decide to take part you will need to sign a consent form. You are still free to withdraw from this research at any time.

What treatments or procedures are available if I decide not to take part in the study?

You will still receive your usual treatment if you do not take part in this study.

What will happen to the study results?

The study results will help doctors and researchers to improve treatment for patients accessing the Addiction Services. The results of the study may be made available for publication. Your data will not be traceable back to you in any way.

Further information: You can get more information or answers to your questions about the study or your participation in the study from Jo-Hanna Ivers, at the Dept. Of Public Health & Primary Care, Trinity College Dublin, who can be telephoned at 01-8961087.

Thank you for considering contributing to our study.

Appendix 3: Description of 10 pilot sites

The 10 evaluation pilot sites:

Ten pilot sites participated in the evaluation of the pilot of National Drug Rehabilitation Framework. Six were based in Dublin and four were based outside Dublin. Of the six Dublin sites, two were inner city (site A and B) the other four represented suburban districts, two in west Dublin sites (C&D), one in South County Dublin (site E) and the other in North County Dublin (site F). Of the four sites outside of Dublin, one was a small rural town in the North-east of the Country (site G), one was in the South East of the Country (site H), another was in the mid West of the Country (site I) and the final site was in the South of the country (site J).

Site A was a North Inner city Dublin site representing a large (15-20) consortium of services ranging from primary addiction services to secondary training, education and family support services. The services in this site were long established providing addictions services in excess of 20 years. Pilot site A could be best described as an early stage implementer site. The coordinator of site A was part-time and also held another addiction training/education full-time position. Site A had a functioning T & R group.

Site B was a South Inner city Dublin site representing a medium (5-10) consortium of services ranging from primary addiction services to secondary training, education and family support services. The services in this site were long established providing addictions services in excess of 20 years. Pilot site B could be best described as a pre-implementation site. The coordinator of site B was part-time and also held another full-time addiction specific position as a frontline service provider. The T&R group in site B was quite fragmented and often convened with three members.

Site C was a Dublin west suburban site representing a large (15-20) consortium of services ranging from primary addiction services to secondary training, education and family support services. The services in this site were long established providing addictions services in excess of 15 years. Pilot site C could be best described as a pre-implementation stage site. The coordinator of site C was part-time and also held another addiction training/education full-time position. Site C had a functioning T & R group equivalent.

Site D was a Dublin west suburban site representing a large (15-20) consortium of services ranging from primary addiction services to secondary training, education and family support services. The services in this site were long established providing addictions services in excess of 20 years. Pilot site D could be best described as an early stage-implementation stage site. The coordinator of site D was a part-time designated paid coordinator that held with no other post. Site D had a functioning T & R group.

Site E was a South Couth Dublin suburban site representing a medium (10-15) consortium of services ranging from primary addiction services to secondary training, education and family support services. The services in this site were long established providing addictions services in excess of 15 years. Pilot site E could be best described as a pre-implementation stage site. The coordinator of site E was part-time and also held another addiction training/education full-time position. Site E had a functioning T & R group.

Site F was a North county Dublin suburban site representing a medium (10-15) consortium of services ranging from primary addiction services to secondary training, education and family support. The services in this site were long established providing addictions services in excess of 15 years. Pilot site F could be best described as an early stage implementation site. The coordinator of site F was part-time and also held another addiction training/education full-time position. Site F had a functioning T & R group.

Site G was in a small rural town in the North-east of the country. Site G represented the smallest (two agency) site in the pilot providing primary addiction services and secondary training, education and family support services between both agencies. The services in this site were recently established providing addictions services less than 5 years. Pilot site G could be best described as an advanced stage implementation site. The coordinator of site G was part-time and also held another addiction specific CEO full-time position. Site G had a functioning implementation committee made up of both services, but no T&R group.

Site H was in the South East of the country. Site H represented a large (15-20) consortium of services ranging from primary addiction services to secondary training, education and family support services. The addiction specific services in this site were established less than 2 years. The secondary services were long established some in excess of 20 years. Pilot site H could be described as an early stage implementation site. The coordinator of site H was a full-time designated paid coordinator that held with no other post. Site H had a functioning T&R group.

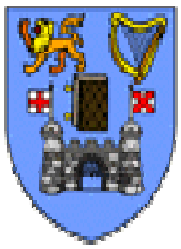
Site I was in the mid West of the country and was made up of a medium (10-15) consortium of services countywide ranging from primary addiction services to secondary training, education and family support services. Services had quite a geographical spread. The services in this site were quite established providing addictions services in excess of 10 years. Pilot site I could be best described as a pre-implementation stage site. The coordinator of site I was part-time and also held another addiction training/education full-time position. Site I had a functioning T&R group.

Site J was in the South of the country representing a medium (10-15) consortium of services countywide ranging from primary addiction services to secondary training, education and family support services. Services had quite a geographical spread. The services in this site were long established providing addictions services in excess of 15 years. Pilot site J could be best described as an early stage implementation site. The coordinator of site J was designated part-time but also held another rehabilitation position. Site J had a functioning T & R group.

National Drug Rehabilitation Framework

EVALUATION
Service User Questionnaire
Administered by Researcher

Department Public Health & Primary Care
Trinity College Dublin



DEMOGRAPHICS & BACKGROUND
Gender
Male ☐
Female ☐
How old are you? ……
Were you born in Ireland?
Yes ☐

No ☐ what country were you born in? ……
How long have you lived in Ireland? ……..
Which of the following (CSO defined) do you identify with?
White ☐
Black
Asian ☐
Oriental ☐
Other
Specify ……..……. ☐
Which of the following (CSO defined) traditional/cultural communities do you identify with, if relevant?
Settled ☐
Roma (Gypsy) ☐
Traveller ☐
Mixed Details …… ☐
Other ☐ Details …… ☐
Not relevant ☐
At what age did you finish school? ……..
What is the highest level of education you have completed?
No formal education ☐
Primary education ☐
Lower secondary (preparation for Junior Cert. or equivalent) ☐
Upper secondary (preparation for Leaving Cert. or equivalent) ☐
Third level ☐
Do you have an educational qualification?
No ☐
Yes ☐ Select your highest educational qualification from the following:
Junior/Intermediate/Group Cert. ☐
O Levels/GCSE's/NCVA Foundation Cert. ☐
Basic Skills Training Cert. or equivalent ☐
Leaving Certificate/ A Levels (incl. Applied and Vocational) ☐
NCVA Level 1 Certificate or equivalent ☐
National Certificate/Diploma/NCEA ☐
Primary degree (third level bachelor degree) ☐
Professional qualification (of degree status or higher) ☐
Both a degree and a professional qualification ☐
Postgraduate certificate or diploma ☐
Postgraduate degree or masters ☐
Doctorate (PhD) ☐
Are you currently on a training/education programme (including CE schemes)?
No ☐
Yes ☐ Details ……..
Are you currently employed?
No ☐
Yes ☐
What is your job? ……
Full-time ☐ **Part-time** ☐
Which of these best describes your usual occupation over the last *6 months*?

Status	Description	Tick
In Paid Job	Self-employed	
	Working full-time (30+ hours per week)	
	Working part-time	
Not in Paid Job	Seeking work for the first time	
	Unemployed (having lost/given up job)	
	Home (domestic) duties	
	Unable to work due to permanent illness/disability	
	Not working (seeking work)	
	Not working (not seeking work)	
	Government training/education scheme	
	Government employment scheme (CE, job options, etc.)	
	Retired	
	Student	
	In Prison	
	Other, specify	

TREATMENT INFORMATION

What type of treatment/service are you currently receiving?

Methadone maintenance programme Yes □ No □

If yes Community Clinic □ GP □

Structural detoxification Yes □ No □

If yes In-patient□ Out-patient□

Residential rehabilitation Yes □ No □

Needle Exchange Yes □ No □

Non-clinical intervention Counselling □

Special CE Schemes □

Re-integration/rehabilitation □

Programme

Other.....

What are the most important reasons you have for coming to this treatment/service at this time?

1 ……..

2 ……..

3 ……..

Who would you say has been most important in getting you to come to this treatment/service at this time (this can include anyone who encouraged you to come here or referrer)?

1 ……..

2 ……..

3 ……..

What change(s) in your drug use do you hope to achieve by coming here?

……..

……..

Do you think that coming here will help you to achieve any of the following?

	Yes	**No**
Less crime	□	□

Staying out of jail/legal trouble	□	□
Better family relationships	□	□
More contact with your children	□	□
Job, employment skills or education	□	□
Better physical health	□	□
Improved mental/emotional health	□	□
A better daily routine/stability	□	□
Improved housing circumstances	□	□
Better financial circumstances	□	□
Other	□	□

Specify ……..……..

(If relevant) what is the duration of this treatment programme? ……..……

How long have you been coming here? ……..……..

How long do you expect to be in contact with this service? ……..……..

How important do you feel that it is for you to have help with your drug use at this time?

(0) Not important at all □
(1) A little important □
(2) Moderately important □
(3) Quite important □
(4) Extremely important □

How important to you now is treatment/intervention for alcohol/drug problems?

Not at all □
Slightly □
Moderately □
Considerably □
Extremely □

Have you had to wait on a waiting list in order to be seen by somebody from here?

No □
Yes □

How long did you have to wait? ……..……..

Treatment Outcomes Profile

Client ID | D.O.B. (dd/mm/yyyy) | Name of keyworker

TOP interview date (dd/mm/yyyy) | Gender: M ☐ F ☐ | Treatment stage: Start ☐ Review ☐ Exit ☐ Post-treatment exit ☐ | Total for NDTMS return

Section 1: Substance use (Use NA only if information is not disclosed or not answered)

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	units/day	0–7	0–7	0–7	0–7	0–28
b Opiates/opioids (illicit)*	g/day	0–7	0–7	0–7	0–7	0–28
c Crack	g/day	0–7	0–7	0–7	0–7	0–28
d Cocaine	g/day	0–7	0–7	0–7	0–7	0–28
e Amphetamines	g/day	0–7	0–7	0–7	0–7	0–28
f Cannabis	spliff/day	0–7	0–7	0–7	0–7	0–28
g Other problem substance? (name.....)	g/day	0–7	0–7	0–7	0–7	0–28

*includes street heroin and any non-prescribed opioid, such as methadone and buprenorphine

Section 2: Injecting risk behaviour (Use NA only if information is not disclosed or not answered)

Record number of days client injected non-prescribed drugs in past four weeks
(If no, enter zero and 'N', and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	0–7	0–7	0–7	0–7	0–28
b Inject with needle or syringe used by someone else?	Yes ☐ No ☐				Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes ☐ No ☐				

Section 3: Crime (Use NA only if information is not disclosed or not answered)

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	0–7	0–7	0–7	0–7	0–28
b Drug selling	0–7	0–7	0–7	0–7	0–28
c Theft from or of a vehicle	Yes ☐ No ☐				Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes ☐ No ☐				
e Fraud, forgery and handling stolen goods	Yes ☐ No ☐				
f Committing assault or violence	Yes ☐ No ☐				Enter 'Y' or 'N'

Section 4: Health & social functioning (Use NA only if information is not disclosed or not answered)

a Client's rating of psychological health (anxiety, depression, problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good — 0–20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	0–7	0–7	0–7	0–7	0–28
c Days attended college or school	0–7	0–7	0–7	0–7	0–28

d Client's rating of physical health (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good — 0–20

Record accommodation status for the past four weeks

e Acute housing problem	Yes ☐ No ☐	Enter 'Y' or 'N'
f At risk of eviction	Yes ☐ No ☐	Enter 'Y' or 'N'

g Client's rating of overall quality of life (able to enjoy life, gets on with family and partner, etc)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good — 0–20

RELATIONSHIPS & LIVING SITUATION

If respondent is in a residential agency (including detoxification unit) record details for the place of residence prior to this.

Where have you been living for the past *3 months*?

		Tick Yes			Tick Yes
a	Own house/flat		h	House/home of relatives	
b	Rent house/flat		I	Hospital	
c	Bedsit/hotel/ boarding house		j	Residential rehab	
d	Hostel/shelter		k	Detoxification unit	
e	Squat		l	Halfway house	
f	Sleeping rough		m	Prison	
g	House/home of friends		n	Other, specify	

In which one of these places are you living at the moment?

……

Do you currently have any of the following housing problems?

Homelessness □
Eviction notice □
Arrears □
Other □
Specify ……..

With whom do you live?

Partner & children □
Partner □
Child(ren) □
Parent(s) □
Parent(s) & Child(ren) □
Sibling(s) □
Other family □
Friend(s) □
Alone □
Other □ Specify ……..

Is anyone you are now living with using illegal drugs or using prescription drugs to get high or for other non-medical effects?

No □
Live alone □
Yes □ Relation (parent, sibling etc)? …….

Is anyone you are now living with receiving alcohol or drug treatment (including A.A. or N.A.)?

No □
Live alone □
Yes □ Relation (parent, sibling etc)…….

Does the area where you currently stay have any of the following?

Anti-social neighbour's □

Vandalism ☐
Burglary/theft ☐
Drug dealing ☐
Assaults/muggings ☐
Gang violence ☐
Intimidation ☐
Other ☐
Specify ……..

In the past *3 months*:

		No. of days *contact* (saw or spoke to on telephone) in past 3 months	**No. of days *conflict* (major argument) in past 3 months**
a	Partner (if any)		
b	Mother		
c	Father		
d	Sibling(s)		
e	Friend(s)		

Do you have any children younger than 18 years (parent/guardian)?

No ☐
If Yes ☐ **Details** ……..

	Gender		**Age (years & months)**	**Live with you? (Y/N)**
Child 1	M ☐	F ☐		
Child 2	M ☐	F ☐		
Child 3	M ☐	F ☐		
Child 4	M ☐	F ☐		
Child 5	M ☐	F ☐		
Child 6	M ☐	F ☐		

Do any of your children have a problem with drugs or alcohol?

No ☐
Yes, with drugs ☐
Yes, with alcohol ☐
Yes, with drugs & alcohol ☐

In the past *3 months*, on how many days have you seen or spoken with each of your children? [If in residential setting, record for period prior to admission]

Child 1 ……
Child 2 ……
Child 3 ……
Child 4 ……
Child 5 ……
Child 6 ……

WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last four weeks.**

		Very poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	1	2	3	4	5
2	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5	How much do you enjoy life?	1	2	3	4	5
6	To what extent do you feel your life to be meaningful?	1	2	3	4	5
7	How well are you able to concentrate?	1	2	3	4	5
8	How safe do you feel in your daily life?	1	2	3	4	5
9	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
10	Do you have enough energy for everyday life?	1	2	3	4	5
11	Are you able to accept your bodily appearance?	1	2	3	4	5
12	Have you enough money to meet your needs?	1	2	3	4	5
13	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5

14	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16	How satisfied are you with your sleep?	1	2	3	4	5
17	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18	How satisfied are you with your capacity for work?	1	2	3	4	5
19	How satisfied are you with yourself?	1	2	3	4	5
20	How satisfied are you with your personal relationships?	1	2	3	4	5
21	How satisfied are you with your sex life?	1	2	3	4	5
22	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24	How satisfied are you with your access to health services?	1	2	3	4	5
25	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Do you have any comments about the assessment?

Consent Form

The research study has been fully explained to me. I have had opportunities to ask questions concerning the project and procedures involved. I am aware that participation is voluntary and that I am free to withdraw my consent at any time. I am aware that my decision not to participate or to withdraw from the study will not restrict my access to health services normally available to me. I understand that my treatment records may be accessed by researchers. I am happy for the information gathered about my experience of the addiction services, without my name or an identifying information to be passed on to the research team. I consent to be followed up and am aware that I made be asked to take part in an interview at a later stage. Confidentiality of records concerning my involvement in this project will be maintained in an appropriate manner.

I, the undersigned, hereby consent to participate in the described study as outlined in the information sheet.

_____ (Please sign here)

_____ (Please print your name here)

Date: _____ Time:_____

Statement of interviewer's responsibility: I believe that the participant understands my explanation and has freely given permission for their information to be anonymised and passed onto the research team.

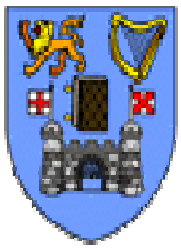
Interviewer's Name:

Interviewer's signature:

National Drug Rehabilitation Framework

EVALUATION
Key workers Questionnaire
Self –administered

DEPARTMENT PUBLIC HEALTH & PRIMARY CARE
TRINITY COLLEGE DUBLIN



Date of completion _____ Pilot site Id_____
Name _____

(Please complete the following questionnaire with your core client/patient group in mind)
AGENCY DEMOGRAPHICS & BACKGROUND
Agency name ……
Service(s) provided ……
Tier (if you are unsure please see diagram attached on p.20)……..

Initial Screening
Is your service tier 1?
Yes ☐
No ☐
Does your service use of a brief intervention screening tool?
Yes ☐
No ☐
If yes, details.....

If yes, do you then and refer to most appropriate service?
Yes ☐
No ☐
On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how would you rate this tool **1 2 3 4 5 6 7 8 9 10**

Are you a key worker i.e. the named person who is assigned to work closely with the Clients involved in the NDRIC evaluation?
Yes ☐
No ☐
If yes, which of the follow key tasks do you undertake with clients when Key working:

Key Tasks	**Tick (where appropriate)**
Engaging with the service user	
Ensuring written consent	
Completing assessment and developing a care plan	
Advocating on behalf of service user	
Working to fulfill care plan actions relating to their direct service provision	
Engaging and sharing information with other agencies as required	
Keeping relevant case notes/records	

Initial Assessment:
Do you complete the initial assessment? Yes ☐
No ☐
Do you feel competent (*properly or sufficiently qualified and or personally capable)* in this role? Yes ☐
No ☐
If no (explain).....

……
……
……

Do you feel you have a clear understanding of the range of problematic drug use?

If yes, does this understanding allow you to: (Please tick most appropriate)	**Always**	**Sometimes**	**Rarely**	**Never**
Determine the seriousness and urgency of the drug/alcohol problem				
Assess the nature and extent of problem use				
Assess service user's motivation to engage				
Assess Risk factors				
Make Appropriate referrals made				

Care Planning

Do you implement care planning? (Please circle most appropriate)

Always Sometimes Rarely Never

Do core service users have a care-plan? (Please circle most appropriate)

Always Sometimes Rarely Never

What percentage of core clients have a care plan?

(Please explain)……

Are your care plans generally?

Verbal □

Written□

Does Care plan include a section/domain on following (Please tick as appropriate)	Tick	Education & Training, Personal Development	Tick
Drug Specific Interventions		Justice, Law and Criminal Issues Support	
General Health Services, Health Promotion, Mental, Physical and Intellectual Disability etc		Family Support & Childcare	
Employment (including community employment), Work Placements		Transition Programmes (e.g. structured pre-induction	
Community Integration, Social & recreational Activities		Budgeting & Money Management	
Housing & Tenancy Support & independent Living		Aftercare	

In your experience, what are the advantages / benefits of developing a care plan?

……
……
……
……
……
……

In your experience, what are the disadvantages / barriers of developing a care plan?

……
……

……
……
……
……

How involved are clients in the development and implementation of their care plans

Not at all Somewhat A noticeable amount Totally

Do you have access to the following adequate resources to fully implement care plans? (Please tick most appropriate)	Always	Sometimes	Rarely	Never
Specialists Addiction Services				
General Health Services (including mental, physical, and intellectual disability)				
Education/training/personal development				
Employment (including community employment schemes and work placements)				
Housing (including supported housing)				
Justice, Law and Reform				
Family Support Services				
Budgeting & Money Management Services				
Social Recreational Activities				

How often are integrated care plans been developed? (Please circle most appropriate)

Always Sometimes Rarely Never

Does this integrated care plan include:	Tick
Consent from the service user to share information with other	
The service user and all other agencies involved	
Realistic goals, that address the physical, psychological, social and legal needs identified	
Appropriate referrals	
Interagency meetings	
Agreed interventions	
Agreed timelines	

How is the lead agency determined?

Intensity and regularity of contact with service user□

Capacity of service provider □

Client preference □

None of the above□

All of the above □

Case Management:

Are you the case manager, i.e. the identified person who has a formal role to manage interagency communication and the provision of co-ordinated care for the service user in question? Yes □

No □

If yes, which of the follow key tasks do you undertake with this client when case managing:	Tick as appropriate
*Ensuring a care plan is in place and SMART objectives set	
Arranging regular reviews to monitor and assess the progression of the care plan	
Review the care plan at regular intervals with the service user, all agencies involved, and where appropriate with the service users family	
Follow up on referrals and general goals	
Responding to blocks that may arise	
Follow up on referrals and general goals	
Responding to blocks that may arise	
Oversee/co-ordinate a shared care plan made up of individual care plans	

* Service user service objectives should be expressed as SMART (specific, measurable, achievable, relevant and time bound) objectives and interventions, and to this end regularly reviewed for progress.

How often do you have access to adequate identifiable services/resources to act as case manager? (Please circle most appropriate)

Always Sometimes Rarely Never

Comprehensive Assessment

Do you complete the comprehensive assessments? (Please circle most appropriate)

Always Sometimes Rarely Never

What percentage of core clients have a care plan?

(Please explain)……..……..

Do you feel competent (*properly or sufficiently qualified and or personally capable)* in this role? (Please circle most appropriate)

(a)Always (b)Sometimes (c)Rarely (d)Never

If c or d please elaborate.....

……..……..

……..……..

……..……..

……..……..

……..……..

Which of the following qualifications do you hold (please circle most appropriate)?

Addiction Specific Qualification | Related Social Science Qualification | Unrelated Qualification | No Qualification

If you circled one of the above, what is highest level (please circle most appropriate)

Certificate (or equivalent) | Diploma (or equivalent) | Bachelors Degree (or equivalent) | Masters Degree/PhD (or equivalent)

Do you feel confident *(feeling secure in your ability to undertake necessary tasks)* in this role? (Please circle most appropriate)

(a)Always (b)Sometimes (c)Rarely (d)Never

If c or d please elaborate.....

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.....

Do you feel competent (*properly or sufficiently qualified and or personally capable)* in identifying possible mental health issues? (Please circle most appropriate)

(a)Always (b)Sometimes (c)Rarely (d)Never

If c or d please elaborate.....

.....

.....

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.....

Once you have identified the need for a more specialist services, (beyond your competencies) is required to meet the need of a particular client.

How ready are you to refer them? (Please circle most appropriate)

Unwilling Reluctant Somewhat Willing Willing

If unwilling or reluctant (please explain)

.....

.....

.....

.....

How confident *(feeling secure in your ability to undertake necessary task)* do you feel in relation to:	Not at all	Somewhat	Confident	Fully Confident
Completing an initial/ comprehensive assessment				
Undertaking tasks of a key worker				
Undertaking tasks of a case manager				
Referring to other agencies				
Applying the Confidentiality and information sharing protocol				
Interagency working				

Confidentiality and Information Sharing

Do you feel confident *(feeling secure in your ability)* when applying confidentiality protocol?

Yes □

No □

(If No) Details

……
……
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……
……

Do you share information about clients with other agencies in your NDRIC Network? (Please circle most appropriate)

Always Sometimes Rarely Never

Is this generally? Verbal □
Written□
Both □

Do you follow a protocol when doing so? (Please circle most appropriate)

Always Sometimes Rarely Never

On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how effective is the information sharing protocol?

1 2 3 4 5 6 7 8 9 10

Is it policy to ensure that the service user is aware of their rights and informed of the purposes of the assessment? (Please circle most appropriate)

Yes □
No □

Is it practice to ensure that the service user is aware of their rights and informed of the purposes of the assessment? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it policy to Inform the service user of how, where and when and with whom their information should be shared with? (Please circle most appropriate)

Yes □
No □

Is it practice to Inform the service user of how, where and when and with whom their information should be shared with? (Please circle most appropriate)

Always Sometimes Rarely Never

Does your service refer to other services in your area? (Please circle most appropriate)

Always Sometimes Rarely Never

If yes, do you have a SLA for interagency referrals?

Yes □
No □

How involved were you in the negotiation process?

Not at all Somewhat A noticeable amount Totally

Is written consent obtained from the service user for sharing information and making the referral? (Please circle most appropriate)

Always Sometimes Rarely Never

Do you forward details of the initial assessment with referring letter to the new agency to which the referral is being made? (Please circle most appropriate)
Always Sometimes Rarely Never

Do you forward details of the comprehensive assessment with referring letter to the new agency to which the referral is being made? (Please circle most appropriate)
Always Sometimes Rarely Never
Overall how effective is the sharing of information in your NDRIC Network?
Not at all□ Somewhat effective □ Effective□ Extremely effective□
In your experience, what are the advantages / benefits of having a Confidentiality and Information Sharing protocol?
……
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……
……
……
……

In your experience, what are the disadvantages/ barriers to having a Confidentiality and Information sharing protocol?
……
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……
……
……
……

Involuntary Discharge
Where involuntary discharge occurs is it policy to arrange an alternative support service appropriate to their needs of client? (Please circle most appropriate)
Yes □
No □
Where involuntary discharge occurs is it practice to arrange an alternative support service appropriate to their needs of client? (Please circle most appropriate)
Always Sometimes Rarely Never

Is it policy to ensure that the service user is aware of their rights around arrange an alternative support? (Please circle most appropriate)
Yes □
No □
Is it practice to ensure that the service user is aware of their rights around arrange an alternative support? (Please circle most appropriate)
Always Sometimes Rarely Never

Exit meetings
Are exit meetings part of your agencies policy? (Please circle most appropriate)

Always Sometimes Rarely Never

Are exit meetings part of your agencies practice? (Please circle most appropriate)

Always Sometimes Rarely Never

Who organizes the exit meeting……
……
……
……

Who attends the exit meeting……
……
……
……

Should relapse occur, how quickly can a service user re-engage?
(Please circle as appropriate)

Immediately 1-Week 1-Month More (specify)…….

What criteria does the service user have to satisfy before they re-engage?

……
……
……
……
……

Is it policy to ensure that the service user is aware of their rights around re-engagement?
(Please circle most appropriate) Yes □
No □

Is it practice to ensure that the service user is aware of their rights around re-engagement?
(Please circle most appropriate)

Always Sometimes Rarely Never

Interagency Working

Do you work with other agencies in the NDRIC network? (Please circle most appropriate)

Always Sometimes Rarely Never

Do you follow a protocol when doing so? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it policy for your agency to engage in interagency meetings? (Please circle most appropriate) Yes □
No □

Is it practice for your agency to engage in interagency meetings? (Please circle most appropriate)

Always Sometimes Rarely Never

(If yes) Have interagency meetings been arranged as per protocols (Please circle most appropriate)

Always Sometimes Rarely Never

On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how effective is this protocol? **1 2 3 4 5 6 7 8 9 10**

In your experience what are the 3 advantages / benefits of having an interagency working?

……

……

……

In your experience what are the 3 disadvantages /barriers of interagency working?

……

……

……

Can you answer the following questions with the implementation of the NDRIC framework in mind?

As a result of implementation of the National Drugs Rehabilitation framework, has the following occurred:	Not at all	Somewhat	A noticeable amount	Totally
Improved knowledge of services in the NDRIC network				
Improved communication between services				
Improved sharing of relevant information between services				
Improved relationships between agencies and services				
Easier access to services				
Increased referrals between agencies				
Increased number of meetings between agencies				
Better understanding of the work of other agencies				

Overall how effective is the interagency working in your NDRIC Network?

Not at all□ Somewhat effective □ Effective□ Extremely effective□

In your experience has the implementation of the NDRIC framework disimproved interagency working? (Please circle most appropriate)

(a)Always (b)Sometimes (c)Rarely (d)Never

If c or d please elaborate.....

……

……

……

……

……

In your experience has trust/rapport between agencies diminished since the implementation of the NDRIC framework? (Please circle most appropriate)

(a)Always (b)Sometimes (c)Rarely (d)Never

If c or d please elaborate.....

.....

.....

.....

.....

.....

Do you have access to a pilot co-ordinator?

Yes □

No □

Have you ever used the gaps and blocks form?

Yes □

No □

(If yes) Details

.....

.....

.....

.....

.....

Was the issue resolved? Yes □

No □

Details .....

.....

.....

.....

At what level was matter resolved:	**Tick**
Case Manager	
Rehabilitation Co-ordinator	
Drugs Task-force Treatment and Rehabilitation Sub-group Meeting	
Senior Rehabilitation Co-ordinator.	
NDRIC committee	

How did you find this process?

Details .....

.....

.....

.....

.....

Quality Assurance

Does your service use a quality assurance framework (QUADs/HAQU or equivalent?)

Yes □

No □

(If yes) Details .....

(If yes) how long has your agency employed a quality assurance framework?

On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how effective is this protocol? **1 2 3 4 5 6 7 8 9 10**

Overall how effective is the quality assurance framework you employ? (Please circle most appropriate)

Not at all Somewhat effective Effective Extremely effective

Education & Training

Do you provide education and training to service users?

Yes

No

Do service users receive a formal qualification (FETAC/FAS or Equivalent)?

Yes

No

(If yes) Details (include level)……

Are any of your courses FETAC accredited?

Yes

No

Implementation of framework

How has the implementation of the National Drugs Rehabilitation framework changed your practice? (Please circle most appropriate)

Not at all Somewhat changed Changed Transformed

If change has occurred was this for the better

Yes

No

How has the implementation of the National Drugs Rehabilitation framework changed the policies of your agency ? (Please circle most appropriate)

Not at all Somewhat changed Changed Transformed

If change has occurred was this for the better

Yes

No

In your experience has the framework strengthened relations in your NDRIC Network? (Please circle most appropriate)

Always Sometimes Rarely Never

As a result of implementation of the National Drugs Rehabilitation framework, has the following occurred:	Not at all	Somewhat	A noticeable amount	Totally
Improved work client work				
Improved knowledge of services in the NDRIC network				
Improved communication between services				
Improved sharing of relevant information between services				
Improved relationships between agencies and services				

Easier access to services				
Increased referrals between agencies				

Has the implementation of the National Drugs rehabilitation framework lead to an improvement in care being provided by services? (Please circle most appropriate)
Always Sometimes Rarely Never

In your experience, what are the three most important successes that have occurred as a result of implementing the framework?

……
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……

In your experience, what are the three most important challenges you faced when implementing the framework?

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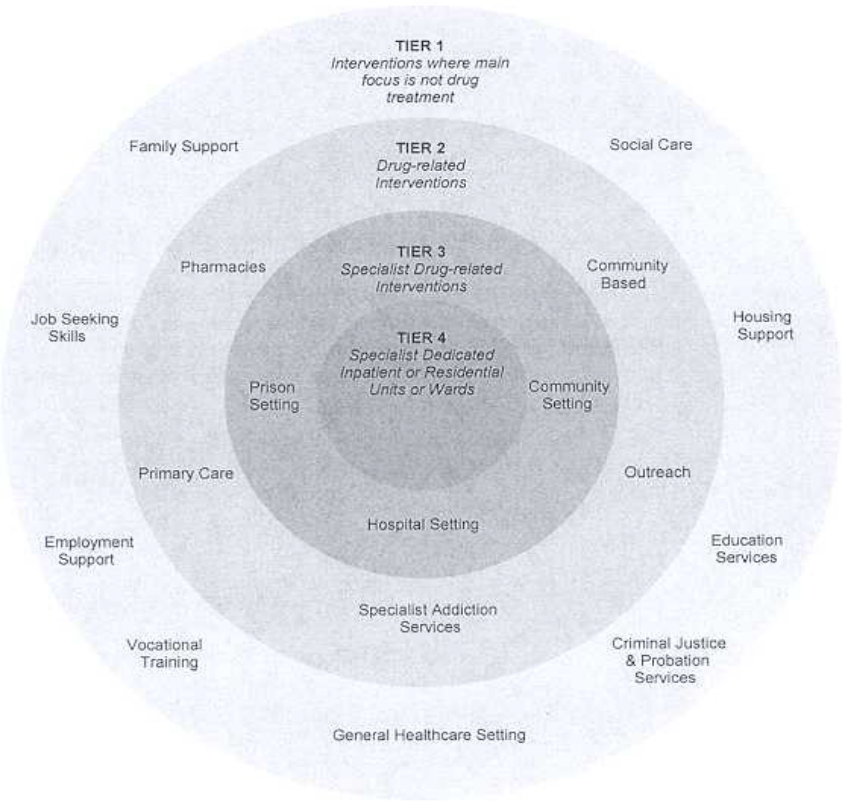
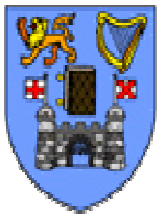

TIER 1
Interventions where main focus is not drug treatment
Family Support
Social Care
TIER 2
Drug-related Interventions
Pharmacies
Community Based
TIER 3
Specialist Drug-related Interventions
Job Seeking Skills
Housing Support
TIER 4
Specialist Dedicated Inpatient or Residential Units or Wards
Prison Setting
Community Setting
Primary Care
Outreach
Hospital Setting
Employment Support
Education Services
Specialist Addiction Services
Vocational Training
Criminal Justice & Probation Services
General Healthcare Setting

National Drug Rehabilitation Framework

EVALUATION
Manager Questionnaire
Self-administered

DEPARTMENT PUBLIC HEALTH & PRIMARY CARE
TRINITY COLLEGE DUBLIN



Name _____ Pilot site Id_____
Date of completion _____

AGENCY DEMOGRAPHICS & BACKGROUND
Agency name ……
Service(s) provided ……
Tier (if you are unsure please see diagram attached on p.21)……
Is your agency a budget holding service?

Yes □
No □
Is your service tier 1? Yes □
No □
Does your service use of a brief intervention screening tool?
Yes □
No □
If yes, details.....

If yes, do you then and refer to most appropriate service?
Yes □
No □
On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how would you rate this tool **1 2 3 4 5 6 7 8 9 10**

Which of the following qualifications do you hold (please circle most appropriate)?

Addiction Specific Qualification	Related Social Science Qualification	Unrelated Qualification	No Qualification

Details (including level)……
……
……
What percentages of your agency's staff hold the following qualifications:

Addiction Specific Qualification	Related Social Science Qualification	Unrelated Qualification	No Qualification
.....	.....	.....	.....

Initial Assessment:
Does your service complete the initial assessment?
Yes □
No □
If no why.....
……
……
……
How effective is the initial assessment?
Not at all□ Somewhat effective □ Effective□ Extremely effective□
Is your staff competent (*properly or sufficiently qualified; capable)* to complete an initial assessment?
(a)Very competent (b)Competent (c)Requires more training (d)Incompetent
If c or d please elaborate.....
……
……
……
In your experience, what are the advantages / benefits of completing an initial assessment with the service user?
……
……
……
……

……
……
In your experience, what are the disadvantages / barriers of completing an initial assessment with the service user?
……
……
……
……
……
……

Comprehensive Assessment:

Does your service complete the comprehensive assessment?

Yes ☐

No ☐

If no why.....
……
……
……

Is your staff competent (*properly or sufficiently qualified; capable)* to complete a comprehensive assessment?

(a)Very competent (b)Competent (c)Requires more training (d)Incompetent

If c or d please elaborate.....
……
……
……

Has your service implemented the following policies: (tick only were appropriate)	Yes	No
Initial screening/assessment		
Key working		
Case managing		
Comprehensive assessment		
Care planning		
Confidentiality and information sharing		
Client discharge strategy		
Exit strategy		

Having answered yes to some or all of the above

As a manager how difficult was it to implement the following protocols within your service: (tick only were appropriate)	Not at all	Somewhat difficult	Difficult	Extremely difficult
Initial screening/assessment				
Key working				
Case managing				
Comprehensive assessment				
Care planning				
Confidentiality and information sharing				
Client discharge strategy				
Exit strategy				

Having answered yes to some or all of the above

At management level how difficult was it to negotiate/agree upon the following SLA/protocols with your interagency colleagues: (tick only were appropriate)	Not at all	Somewhat difficult	Difficult	Extremely difficult
Initial screening/assessment				
Key working				
Case managing				
Comprehensive assessment				
Care planning				
Confidentiality and information sharing				
Client discharge strategy				
Exit strategy				

In your experience, what are the advantages / benefits of completing a comprehensive assessment with the service user?

……
……
……
……
……
……

In your experience, what are the disadvantages /barriers of completing a comprehensive assessment with the service user?

……
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……
……
……
……

Care Planning

Has your service implemented care planning? (Please circle most appropriate)

Yes □

No □

Do core service users have a care-plan? (Please circle most appropriate)

Always Sometimes Rarely Never

In your experience, what are the advantages / benefits of developing a care plan?

……
……
……
……
……
……

In your experience, what are the disadvantages / barriers of developing a care plan?

……

……
……
……
……
……

How involved are clients in the development and implementation of their care plans

Not at all Somewhat A noticeable amount Totally

Do you have access to the following adequate resources to fully implement care plans? (Please tick most appropriate)	Always	Sometimes	Rarely	Never
Specialists Addiction Services				
General Health Services (including mental, physical, and intellectual disability)				
Education/training/personal development				
Employment (including community employment schemes and work placements)				
Housing (including supported housing)				
Justice, Law and Reform				
Family Support Services				
Budgeting & Money Management Services				
Social Recreational Activities				

How often are integrated care plans been developed? (Please circle most appropriate)

Always Sometimes Rarely Never

Does this integrated care plan include:	Tick
Consent from the service user to share information with other	
The service user and all other agencies involved	
Realistic goals, that address the physical, psychological, social and legal needs identified	
Appropriate referrals	
Interagency meetings	
Agreed interventions	
Agreed timelines	

How often do you act as the lead agency? (Please circle most appropriate)

Always Sometimes Rarely Never

How is the lead agency determined?

Intensity and regularity of contact with service user□

Capacity of service provider □

Client preference □

None of the above□

All of the above □

In your experience, what are the advantages / benefits of having a key worker assigned?

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In your experience, what are the disadvantages/ barriers of having a key worker assigned?
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……

Referral between agencies:

Does your service refer service users to other services? (Please circle most appropriate)

Always Sometimes Rarely Never

Have your staff, information on the criteria for access to other services, current waiting times and referral processes for other agencies/services in your area?

Yes □

No □

Confidentiality and Information Sharing

Are your staff competent (*properly or sufficiently qualified; capable)* when sharing information?

(a)Very competent (b)Competent (c)Requires more training (d)Incompetent

If c or d please elaborate.....
……
……
……

Do you share information about clients with other agencies in your NDRIC Pilot-site? (Please circle most appropriate)

Always Sometimes Rarely Never

Is this generally? Verbal □
Written□
Both □

Is it policy to ensure that the service user is aware of their rights and informed of the purposes of the assessment? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it practice to ensure that the service user is aware of their rights and informed of the purposes of the assessment? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it policy to Inform the service user of how, where and when and with whom their information should be shared with? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it practice to Inform the service user of how, where and when and with whom their information should be shared with? (Please circle most appropriate)

Always Sometimes Rarely Never

Do you refer service users to other services? (Please circle most appropriate)
Always Sometimes Rarely Never

Are you aware of the criteria for access to other services, current waiting times and referral processes for other agencies/services in your area?
Yes □
No □
Is written consent obtained from the service user for sharing information and making the referral? (Please circle most appropriate)
Always Sometimes Rarely Never

Do you forward details of the initial assessment with referring letter to the new agency to which the referral is being made? (Please circle most appropriate)
Always Sometimes Rarely Never

Do you forward details of the comprehensive assessment with referring letter to the new agency to which the referral is being made? (Please circle most appropriate)
Always Sometimes Rarely Never
Overall how effective is the sharing of information in your NDRIC Pilot-site?
Not at all□ Somewhat effective □ Effective□ Extremely effective□
In your experience, what are the advantages / benefits of having a Confidentiality and Information Sharing protocol?
……
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In your experience, what are the disadvantages/ barriers to having a Confidentiality and Information sharing protocol?
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Involuntary Discharge
Where involuntary discharge occurs is it policy to arrange an alternative support service appropriate to their needs of client? (Please circle most appropriate)
Always Sometimes Rarely Never
Where involuntary discharge occurs is it practice to arrange an alternative support service appropriate to their needs of client? (Please circle most appropriate)
Always Sometimes Rarely Never

Is it policy to ensure that the service user is aware of their rights around arrange an alternative support? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it practice to ensure that the service user is aware of their rights around arrange an alternative support? (Please circle most appropriate)
Always Sometimes Rarely Never

Exit meetings
Are exit meetings part of your agencies policy? (Please circle most appropriate)
Always Sometimes Rarely Never
Are exit meetings part of your agencies practice? (Please circle most appropriate)
Always Sometimes Rarely Never

Who organises the exit meeting……
……
……
……

Who attends the exit meeting……
……
……
……

Should relapse occur, how quickly can a service user re-engage?
(Please circle as appropriate)

Immediately 1-Week 1-Month More (specify)…….
What criteria does the service user have to satisfy before they re-engage?
……
……
……
……
……
Is it policy to ensure that the service user is aware of their rights around re-engagement? (Please circle most appropriate)
Always Sometimes Rarely Never
Is it practice to ensure that the service user is aware of their rights around re-engagement? (Please circle most appropriate)
Always Sometimes Rarely Never

Interagency Working
Do you work with other agencies in the NDRIC Pilot-site? (Please circle most appropriate)

Always Sometimes Rarely Never

Is it policy for your agency to engage in interagency meetings? (Please circle most appropriate)
Always Sometimes Rarely Never

Is it practice for your agency to engage in interagency meetings? (Please circle most appropriate)

Always Sometimes Rarely Never

(If yes) Have interagency meetings been arranged as per protocols (Please circle most appropriate)

Always Sometimes Rarely Never

On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how effective is this protocol? **1 2 3 4 5 6 7 8 9 10**

In your experience what are the 3 advantages / benefits of having an interagency working?

……

……

……

In your experience what are the 3 disadvantages /barriers of interagency working?

……

……

……

Can you answer the following questions with the implementation of the NDRIC framework in mind?

As a result of implementation of the National Drugs Rehabilitation framework, has the following occurred:	Not at all	Somewhat	A noticeable amount	Totally
Improved knowledge of services in the NDRIC Pilot-site				
Improved communication between services				
Improved sharing of relevant information between services				
Improved relationships between agencies and services				
Easier access to services				
Increased referrals between agencies				
Increased number of meetings between agencies				
Better understanding of the work of other agencies				

Overall how effective is the interagency working in your NDRIC Pilot-site? (Please circle most appropriate).

(a)Not at all (b)Somewhat effective (c)Effective (d)Extremely effective

If c or d please elaborate.....

……

……

……

……

……
In your experience has the implementation of the NDRIC framework disimproved interagency working? (Please circle most appropriate)
(a)Always (b)Sometimes (c)Rarely (d)Never

If c or d please elaborate.....
……
……
……
……
……

In your experience has trust/rapport between agencies diminished since the implementation of the NDRIC framework? (Please circle most appropriate)
(a)Always (b)Sometimes (c)Rarely (d)Never
If c or d please elaborate.....
……
……
……
……
……

Do you have access to a pilot co-ordinator?
Yes □
No □
In your experience how has the role of the pilot co-ordinator worked?
(a)Not at all (b)Somewhat effective (c)Effective (d)Extremely effective
If c or d please elaborate.....
……
……
……
……
……
Was funding provided in by your agency or a partner agency to fund the role of pilot co-ordinator?
Yes □
No □
Please elaborate.....
……
……
……
……
……
Can the interagency collaboration be sustained beyond the pilot phase, without a pilot co-ordinator?
Yes □
No □
Please elaborate.....

……
……
……
……
……
Have you ever used the gaps and blocks form?
Yes ☐
No ☐
(If yes) Details
……
……
……
……
……

Was the issue resolved? Yes ☐
No ☐
(If yes) Details
……
……
……
……

At what level was matter resolved:	**Tick**
Case Manager	
Rehabilitation Co-ordinator	
Drugs Task-force Treatment and Rehabilitation Sub-group Meeting	
Senior Rehabilitation Co-ordinator.	
NDRIC committee	

How did you find this process?
(If yes) Details
……
……
……
……

Quality Assurance

Does your service use a quality assurance framework (QUADs or equivalent?)
Yes ☐
No ☐
(If yes) Details ……
(If yes) how long has your agency employed a quality assurance framework?
Details ……
On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how effective is this protocol? **1 2 3 4 5 6 7 8 9 10**
Overall how effective is the quality assurance framework you employ? (Please circle most appropriate)

Not at all Somewhat effective Effective Extremely effective

Education & Training

Do you provide education and training to service users?

Yes ☐

No ☐

Do service users receive a formal qualification (FETAC/FAS or Equivalent)?

Yes ☐

No ☐

(If yes) Details (include level).....

Are any of your courses FETAC accredited?

Yes ☐

No ☐

Implementation of framework

How has the implementation of the National Drugs Rehabilitation framework changed your practice? (Please circle most appropriate)

Not at all Somewhat changed Changed Transformed

If change has occurred was this for the better

Yes ☐

No ☐

How has the implementation of the National Drugs Rehabilitation framework changed the policies of your agency? (Please circle most appropriate)

Not at all Somewhat changed Changed Transformed

If change has occurred was this for the better

Yes ☐

No ☐

Prior to the implementation of the NDRIC framework how would you rate your agencies work in the following areas :	Non-existent	Not at all effective	Somewhat effective	Effective	Extremely effective
Initial screening/assessment					
Key working					
Case managing					
Comprehensive assessment					
Care planning					
Confidentiality and information sharing					
Client discharge strategy					
Exit strategy					
Interagency working					
Quality assurance					

At managerial level how involved were you in the negotiation process(s) with your interagency colleagues regarding the implementation of the NDRIC framework?

Not at all Somewhat A noticeable amount Totally

What was required of you (i.e. meetings, committees, development and or revision of documents, etc)?

_____
_____
_____
_____
_____
_____

On a scale of 1-10 *(1 being not at all and 10 being extremely effective)* how would you rate this process

1 2 3 4 5 6 7 8 9 10

What mechanisims are in place to ensure that the implementation of the framework is happening with your managerial colleagues (i.e. regular meetings, audits committees, etc)?

_____
_____
_____
_____
_____
_____

As a manager of a named service within a pilot-site, charged with ensuring that the framework is implemented how effective was this process, in terms of?	Not at all	Somewhat	A noticeable amount	Totally
Representing all relevant agencies				
Giving voice to all relevant agencies				
Keeping all relevant agencies informed of decisions required to implement the framework				
Ensuring all milestones were met				
Offering support/guidance around the practicalities of implementing the framework (i.e. staff negotiation).				

Overall how difficult was it to get staff involved in the implementation of the NDRIC framework? (Please circle most appropriate)

Not at all Somewhat difficult Difficult Extremely difficult

As a result of implementation of the National Drugs Rehabilitation framework, has the following occurred:	Not at all	Somewhat	A noticeable amount	Totally
Improved knowledge of services in the NDRIC Pilot-site				
Improved communication between services				
Improved sharing of relevant information				

between services				
Improved relationships between agencies and services				
Easier access to services				
Increased referrals between agencies				

What mechanisms are in place to ensure that the implementation of the framework is happening within your service (i.e. regular meetings, audits, individual and or group supervision , etc)?

_____
_____
_____
_____
_____
_____

In your experience has the framework strengthened relations within your NDRIC Pilot-site? (Please circle most appropriate)

Always Often Rarely Never

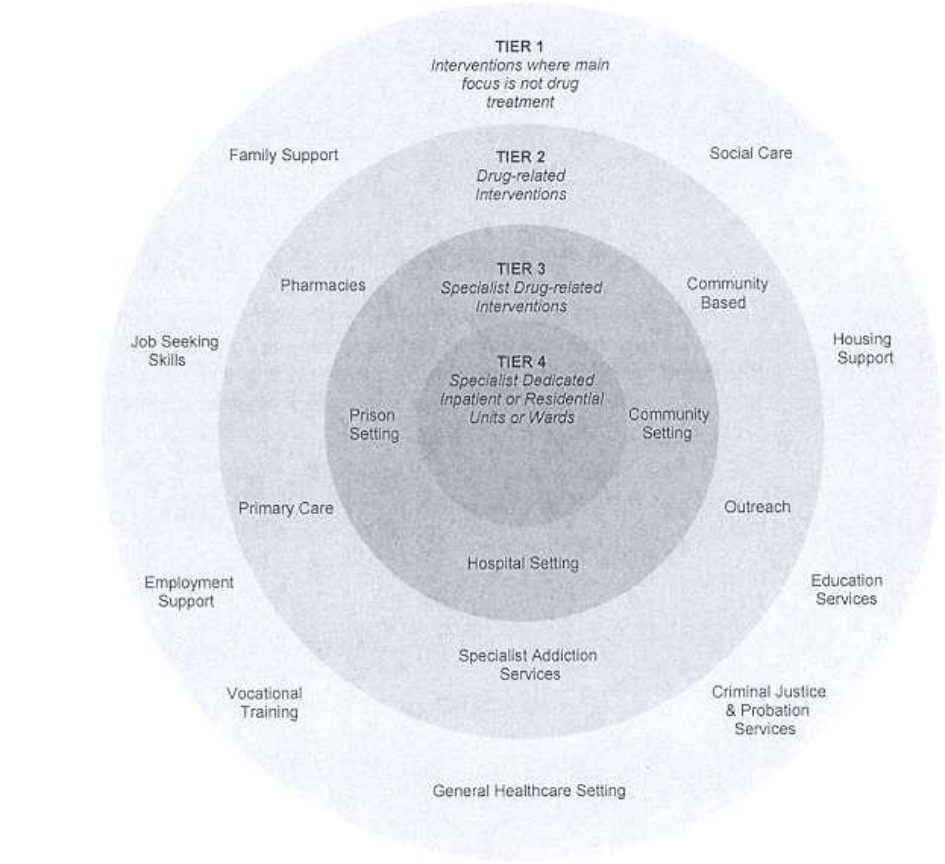
Has the implementation of the National Drugs rehabilitation framework lead to an improvement in care being provided by services? (Please circle most appropriate)

What are the three most important changes that have occurred as a result of implementing the framework?

……
……
……

Overall how effective is interagency working in your NDRIC Pilot-site?

Not at all Somewhat effective Effective Extremely effective


TIER 1
Interventions where main focus is not drug treatment
Family Support
Social Care
TIER 2
Drug-related Interventions
Pharmacies
Community Based
TIER 3
Specialist Drug-related Interventions
Job Seeking Skills
Housing Support
TIER 4
Specialist Dedicated Inpatient or Residential Units or Wards
Prison Setting
Community Setting
Primary Care
Outreach
Hospital Setting
Employment Support
Education Services
Specialist Addiction Services
Vocational Training
Criminal Justice & Probation Services
General Healthcare Setting

Appendix 5: Topic Guides

Service User

Care planning/case management

- Do you know who your key worker /is?
- How long have you been with the agency?
- What phase of treatment are you at?
    - What are current goals for treatment
    - Are goals and objectives being achieved or not?
- Do you have a care plan?
    - If yes, how long have you had a care plan?
    - Benefits of having a care plan?
    - Disadvantages of having a care plan?
- Level of interaction (time spent in a week/month etc)
    - How often do you link with your keyworker?
    - How often is your care plan reviewed?
    - Will the goals you set be achieved within the time you agreed?
        - (If not, then why?)
    - Are you happy with the pace?
- Are the goals and objectives realistic?
- Should priorities be changed to put more focus on achieving the goals?
- Have you been in this or a similar to this service before?
    - If yes, do you notice any changes to the service you are receiving now?

Interagency Work

- What other agencies are involved in your care plan?
    - What is their involvement?
    - How often do you meet with them?
    - Do all the agencies involved in your treatment attend these meetings?
        - If yes how often has this happened?
    - Are there advantages to having other agencies involved in your treatment plan?
    - Are there disadvantages to having other agencies involved in your treatment plan?

Information Sharing

- Is your information shared across agencies involved in your treatment plan?
    - If yes, how do you imagine this happens?
- What would you see as the benefits of agencies involved in your treatment plan sharing information?
- What would you see as the disadvantages of agencies involved in your treatment plan sharing information?
- Recommendations (what would you like to see happening that is not happening at present).

TOPIC GUIDE

Managers

Implementation of policies and practices

- Level of organisation required to implement framework
- Changes to policies and practices (what level of change was required to bring existing policies/practices in line with framework, level of support provided to do this, resources given, required, etc)
- Benefits of having a national framework
- Disadvantages of having a national framework
- Barriers to implementation
- Current Implementation phase (Are goals and objectives for implementing the framework being achieved or not?)
    - (Will the goals be achieved according to the timelines specified by participating pilots in their plan? If not, then why?)
    - (Trends regarding the progress (or lack thereof) toward goals, including which goals and objectives.)
- If the framework is not being implemented
    - Are the goals and objectives still realistic?
    - Should priorities be changed to put more focus on achieving the goals?
    - Do you apply the framework to all clients you key work (if not why not).
- Do personnel have adequate resources (money, equipment, facilities, training, etc.) to fully implement the framework?
- Recommendations

Fidelity to the framework and its implementation

- Is fidelity ensured (are there support structures in place to ensure fidelity to framework (supervision, case management review meetings?)

    a. If yes do these occur at individual, team, agency or interagency level?
- Any actions needed by management/co-ordinator/NDRIC to ensure fidelity long-term?

Care planning

- What is your understanding of care planning?
- Benefits of care planning
- Disadvantages of care planning
- Barriers to implementing care planning?
- Recommendations

Interagency working

- What is your understanding of interagency working?
- In general how do you find interagency working in your area?
- Benefits of interagency working?
- Disadvantages of interagency working?
- Barriers to implementing interagency working?
- Recommendations

Information Sharing

- Do you have a protocol for information sharing?
- Was this developed?
- What is your understanding of the rationale for information sharing?

- Benefits of information sharing?
- Disadvantages of information sharing?
- Barriers to information sharing?
- Recommendations

Learning

- What works
- What doesn't
- Why
- What could have been done differently

Recommendations

- Any recommendations
- What would you like to see happening that is not happening at present).

TOPIC GUIDE

Co-ordinators(active)

Implementation of policies and practices

- Level of organisation required implementing framework?
- What does the role of co-ordinator require?
- How many hours per week do you give to this role?
- How do you find this role?
- How long are you in post?
- How long do you expect to be in post?
- Did you volunteer? If not how did you assume role?
- What if any, support did you receive as a co-ordinator?
- What were the advantages of being a co-ordinator?
- What were the disadvantages of being a co-ordinator?
- What, if anything could have been done differently to ensure that your job as a co-ordinator was manageable?
- Changes to policies and practices (what level of change was required to bring existing policies/practices in line with framework, level of support provided to do this, resources given, required, etc)
- Benefits of having a national framework
- Disadvantages of having a national framework
- Barriers to implementation
- Current Implementation phase (Are goals and objectives for implementing the framework being achieved or not?)
    - (Will the goals be achieved according to the timelines specified by participating pilots in their plan? If not, then why?)
    - (Trends regarding the progress (or lack thereof) toward goals, including which goals and objectives.)
- If the framework is not being implemented
    - Are the goals and objectives still realistic?
    - Should priorities be changed to put more focus on achieving the goals?
    - Do you apply the framework to all clients you key work (if not why not).
- Do you have adequate resources (money, equipment, facilities, training, etc.) to fully implement the framework?
- Recommendations

Fidelity to the framework and its implementation

- Is fidelity ensured (are there support structures in place to ensure fidelity to framework (supervision, case management review meetings?)

    a. If yes do these occur at individual, team, agency or interagency level?
- Any actions needed by management/co-ordinator/NDRIC to ensure fidelity long-term?

Learning

- What works
- What doesn't
- Why
- What could have been done differently

Recommendations

- What would you like to see happening that is not happening at present).

TOPIC GUIDE

Co-ordinators (inactive)

Implementation of policies and practices

- What does the role of co-ordinator require?
- How many hours per week do you give to this role?
- How do you find this role?
- How long are you in post?
- How long do you expect to be in post?
- Did you volunteer? If not how did you assume role?
- What if any, support did you receive as a co-ordinator?
- What were the advantages of being a co-ordinator?
- What were the disadvantages of being a co-ordinator?
- What, if anything could have been done differently to ensure that your job as a co-ordinator was manageable?
- Changes to policies and practices (what level of change was required to bring existing policies/practices in line with framework, level of support provided to do this, resources given, required, etc)
- Benefits of having a national framework
- Disadvantages of having a national framework
- Barriers to implementation
- Current Implementation phase (why are goals and objectives for implementing the framework not being achieved)
    - (Trends regarding the progress (or lack thereof) toward goals, including which goals and objectives.)
- If the framework is not being implemented
    - Are the goals and objectives realistic?
    - Should priorities be changed to put more focus on achieving the goals?
    - Do you apply the framework to all clients you key work (if not why not).
- Do you have adequate resources (money, equipment, facilities, training, etc.) to fully implement the framework?
- Recommendations

Fidelity to the framework and its implementation

- How will fidelity be ensured (are there support structures in place to ensure fidelity to framework (supervision, case management review meetings?)

    a. If yes do these occur at individual, team, agency or interagency level?
- Any actions needed by management/co-ordinator/NDRIC to ensure fidelity long-term?
- **Learning**

- What works
- What doesn't
- Why
- What could have been done differently

Recommendations

What would you like to see happening that is not happening at present).

TOPIC GUIDE

Key informants

*Dear reviewer a note for your reading reference: Key informants are individuals that were instrumental to the implementation of the national framework (LDTF members, committee members etc) . Key informants are **not** key workers or managers. They are individuals that would not otherwise be captured. This gives all pilot sites an opportunity to involve key individuals.*

Implementation of policies and practices

- What was your role in implementing the framework?
- Level of organisation required (role and responsibilities (time commitment, committee membership, negotiation/agency buy in etc).
- What is your day-to-day role in your pilot site?
- At what point in the process did you get involved
- How did you get involved in the implementation?
- Why did you get involved in the implementation?
- What level of commitment was needed?
- How did this fit with your day-to-day role in your pilot area?
- How did you find the process?
- What were the successes?
- Barriers to implementation
- What were the challenges?
- What would you do differently?
- What are the gaps in the current phase of the implementation?
- What are the challenges going forward?
- Current level of involvement
    - (Are goals and objectives being achieved or not?)
    - (Will the goals be achieved according to the timelines specified by participating pilots in their plan? If not, then why?)
    - (Trends regarding the progress (or lack thereof) toward goals, including which goals and objectives.)
- Are the goals and objectives still realistic?
- Should priorities be changed to put more focus on achieving the goals?
- How has being involved in the framework changed your role in your pilot site?

Fidelity to the framework and its implementation

- Is fidelity ensured (are there support structures in place to ensure fidelity to framework

- What is your role in ensuring fidelity
- How will your pilot site ensure fidelity long-term?

Learning

- What are the major leanings
- What worked
- What did not work
- Why
- What could have been done differently

Recommendations

TOPIC GUIDE

Key workers

Implementation of policies and practices

- Changes to policies and practices (what level of change was required to bring existing policies practices in line with framework, level of support provided to do this, resources given, required, etc)
- Benefits of having a national framework
- Disadvantages of having a national framework
- Barriers to implementation
- Do you have adequate resources (money, equipment, facilities, training, etc.) to fully implement the framework?
- Current Implementation phase (Are goals and objectives for implementing the framework being achieved or not?)
    - (Will the goals be achieved according to the timelines specified by participating pilots in their plan? If not, then why?)
    - (Trends regarding the progress (or lack thereof) toward goals, including which goals and objectives.)

- What has been the biggest success of implementing the framework?
- What has been the biggest challenge of implementing the framework?
- If the framework is not being implemented
    - Are the goals and objectives still realistic?
    - Should priorities be changed to put more focus on achieving the goals?
    - Do you apply the framework to all clients you key work (if not why not).
- How has client work changed post implementation of framework
- How has interagency work changed post implementation of framework

Care planning

- What is your understanding of care planning?
- Benefits of care planning
- Disadvantages of care planning
- Barriers to implementing care planning?

Interagency working

- What is your understanding of interagency working?
- What is your understanding of the role(s) of the lead professional, and key worker?

- Benefits of interagency working?
- Disadvantages of interagency working?
- Barriers to implementing interagency working?

Information Sharing

- Do you have a protocol for information sharing?
- Was this developed?
- What is your understanding of the rationale for information sharing?
- Benefits of information sharing?
- Disadvantages of information sharing?
- Barriers to information sharing?

Fidelity to the framework and its implementation

- Is fidelity ensured (are there support structures in place to ensure fidelity to framework (supervision, case management review meetings?)

a. If yes do these occur at individual, team, agency or interagency level?

- Any actions needed by management/co-ordinator/NDRIC to ensure fidelity long-term?

Learning

- What works
- What doesn't
- Why
- What could have been done differently

Recommendations

- Any recommendations
- What would you like to see happening that is not happening at present).