Ballyfermot Drug Treatment & Rehabilitation Pilot Project

Case Management Protocols and Policies

Date of agreement: 25th March 2011.

1. Case Management Principles

1.1.1. There will only ever be one lead agency and one case manager within the agency.

1.1.2. Assessments will follow the service user, transferring from one lead agency to another.

1.1.3. Service users will provide consent before an exchange of information between service can occur (with the exception of legally required extensions of consent)

1.1.4. Case meetings or multi-agency meetings should always aim to include the service user. The tone and context of these meetings should encourage service user participation.

1.1.5. Differences in the views of professionals around the service users care plan can be considered strength when managed effectively, as each agency can bring a different perspective and information.

2. Case Management Protocols

2.1. Identification of Lead Agency and Case Manager

2.1.1. At first contact with the service user in relation to service provision, the worker should undertake an initial assessment with the aim of finding out:

2.1.1.1. whether they have been assessed or have a case manager, (it should be noted that in many cases the service user may not be aware of whether they have a case manager, it is the role of the worker to ascertain this through calling involved services).

2.1.1.2. whether they would like a key worker or case manager

2.1.1.3. what are the main needs and which service is best placed to meet these

2.1.1.4. what other services are working with the service user

2.1.2. If the service is not appropriate, then a referral will be made to a more appropriate service in line with their referral process. The case management guidebook contains appropriate service information on this.

2.1.3. If the service is best placed to meet the service user's needs and the service user has been informed and agreed to assessment and case management, then the worker will contact the other organisations/ key workers involved in the case to ascertain whether there is already a case manager agreed.

2.1.3.1. If there is a case manager then the worker will work with the service user and the case manager to clarify what their service can contribute to the care plan.

2.1.3.2. If there are two services interested in taking the case management role, An interagency case meeting should be held to agree who is best placed to manage the case. If it is

agreed useful there may be a transfer of the case from one service to another. If two or more services regard themselves to be best place to be the lead agency, the service user's choice should be facilitated as much as possible.

2.1.3.3. If there is no case manager the worker will conduct a comprehensive assessment and establish an initial care plan.

2.1.4. If the service user does not want a case manager or a key worker then low threshold services will be provided (this may require referral) with the aim of building positive relationships and providing appropriate supports. Each service's policy will outline whether a service can be provided in this situation or whether referral is required.

2.2. Assessment and care plan

See Assessment and Care Plan Policy for service specific information.

2.2.1. Before doing the comprehensive assessment the case manager will seek service user consent to share information; ensuring that service has a good understanding of what is involved.

2.2.2. Consent forms are valid for six months and provide a space for the service user to identify information they do not want shared with certain services. Case managers should where possible also obtain verbal consent for communications with new agencies/workers that arise over the course of the six months.

2.2.3. The care plan will be completed after the assessment and will identify: date; objectives and timescale; how will progress be measured; work done to achieve objectives; referral: name of worker and agency (the name of the key workers responsible for the action); outcomes; and comments: (reasons achieved/not achieved).

2.2.4. All entries in the care plan should meet SMART criteria:

2.2.4.1. Specific: be as detailed as possible, i.e. rather than saying reduce drug use, state which drugs are being reduced.

2.2.4.2. Measurable: there will be a clear and (where possible) independent way of measuring whether an objective has been achieved.

2.2.4.3. Agreed: goals should be agreed by service user and worker, ideally the service users will be supported to generate the care plan actions where possible.

2.2.4.4. Realistic: both the service user and the worker should take time to review that the goals are not too ambitious, if goals are very ambitious it may be best to stagger large goals into a number of short term goals

2.2.4.5. Timed: goals should have a stated time frame.

2.3. Engaging other services in the care plan

2.3.1. The first step in co-ordinating interagency involvement in the care plan is for the case manager to contact agencies already involved with the service user in order to clarify their involvement. The outcome of this should be a fully completed section of the care plan, which should be sent to this service.

2.3.2. The next step involves engaging new services to meet the needs identified through the assessment process. Engaging services in the care plan can be done through the following means, (the most appropriate will be determined by the case manager):

- 2.3.2.1. phone and mail contact (template letters are available)
- 2.3.2.2. interagency case meeting between two services
- 2.3.2.3. interagency case meeting with multiple services

2.3.3. The services users doctor in the methadone clinic should receive a copy of the full care plan.

2.3.4. Once the care plan is complete the actions should be progressed and monitored in one-to-one sessions. When a new action is identified this should be added to the care plan with interagency communications and updates undertaken as required.

2.3.5. If the service user has any problems with the plan or any of the services involved in this they should be encouraged to discuss this with their case manager at the earliest opportunity.

2.3.6. Formal care plan reviews should be held every two months.

2.4. Interagency case meetings

Processes for the management of an interagency case meeting are outlined in greater detail in the Interagency Case Meeting Policy. An interagency case meeting should be considered in the following circumstances:

2.4.1. a lead agency / case manager cannot be agreed,

2.4.2. the role of case manager is being transferred,

2.4.3. there are a number of unmet needs. There is no plan on how to address these and appropriate interventions cannot be accessed by reasonable efforts in 1-2-1 communications with service providers,

2.4.4. services have different understandings of the case or there is lack of clarity as to involvement in the care plan,

2.4.5. the case involves several agencies and it is more time efficient and effective to discuss the care plan in a meeting rather than in 1-2-1 contact,

2.4.6. the service user is excluded from the case manager's service, and the role of case manager needs to be transferred.

2.5. The basics of every care plan

There are some basic actions that need to be progressed in the very early stages of the care planning process if needs are identified through the assessment, these are:

2.5.1. Arrange an appointment with the local clinic if the person is seeking drug treatment.

2.5.2. If homeless, then the case manager should ensure the service user is registered with the local authority as 'homeless priority' and registered with the local authority on the social housing waiting list.

2.5.3. If there is no current medical card or GP in place then these should be arranged.

2.5.4. It should be checked that the individual has an appropriate source of income, if not an appointment should be made with a CWO.

2.6. Dealing with difficulties in interagency co-ordination: gaps and blocks process.

2.6.1. If there is an issue in relation to care planning then this should initially be progressed by the case manager with support from their supervisor. This may involve an interagency case meeting. If this is not successful;

2.6.2. The manager of the service should advocate for a resolution with the manager of the service in question. If this is not successful;

2.6.3. The issues should be forwarded through the gaps and blocks process. To do this, a gaps and blocks form should be completed by the case manager. The manger should then email this to the pilot co-ordinator.

2.6.4. On receipt of this the pilot will co-ordinator will:

- 2.6.4.1. email the manager and case manager within two days to confirm receipt and state how the issue will be progressed.
- 2.6.4.2. contact appropriate members of the steering group, T&R network and advisors to progress the issue.
- 2.6.4.3. email any resolutions or next steps tasks to the case manager and manager within ten working days.
- 2.6.4.4. if a resolution can not be found then the issues with a report on actions taken will be sent to the national rehabilitation co-ordinator.

2.7. Service user referral and service commitment to case management

2.7.1. Services providing case management need to agree to undertake this role until an appropriate handover can be made to another case manager. An exception to this is when a positive onward referral has been identified within the six month period and another service takes the role of case

management as part of this progression or the case is closed positively, or the individual disengages (see disengagement protocol).

2.7.2. If a situation occurs where a staff member leaves their case manager role, the organisation will continue to ensure this service is provided, although it should be noted that this is a useful time to reflect if there is another organisation better placed to undertake this role.

2.8. Responding to and disengagement and positive case closure

2.8.1. There are two possibilities for the case management relationship ceasing, the first is a positive case closure meaning that all care plan needs have been met, and that the individual no longer requires this level of support. The second is the service user disengaging. Generally this means that they are not attending or no longer want either case management or sharing of information. In this case, the steps to be taken are (if one step does not have an outcome the next step down the list should be undertaken: the case manager should always consider the most appropriate threshold for the individuals situation):

- 2.8.1.1. the service user should be offered another case manager if possible,
- 2.8.1.2. the service user needs to be offered key working, with a view to moving back into case management at some time in the future,
- 2.8.1.3. if the service user does want a key worker explore whether there is another service that can fulfil this role,
- 2.8.1.4. clarify the minimum engagement required to remain in the service, in order to maintain contact,
- 2.8.1.5. if continued service is not possible, the last option is formally hand over to a 'low-threshold' service, which can informally support the individual and keep the option of case management open.

2.8.2. Once a service user has disengaged then a letter should be sent to agencies involved in the care plan informing them of this.

3. Policy overview

3.1. QuADS states that all services should have service specific policies on: case management, care planning/assessment and confidentiality.

3.2. The following service policies are appendixed. Serviced engaged in the pilot should operate according the procedures outlined, though it is recognise that procedures need to be adapted to accommodate specific practices within the service:

- 3.2.1. Case Management and Key Working Policy
- 3.2.2. Assessment and Care Plan Policy

3.2.3. Case Notes Policy

3.2.4. Interagency Case Meeting Policy

3.2.5. Confidentiality Policy

4. Glossary

4.1. **Case Manager**

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

4.2. **Case Management**

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

4.3. **Care Plan**

A care plan is a documented agreement of a plan of action between the service user and service provider based on SMART (Specific, Measurable, Attainable, Realistic and Time-bound) objectives. 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.

4.4. Key Worker

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

4.5. **Key Working**

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

4.6. Lead Agency

This is the agency that has the most contact with the service user and the ability to case manager, the case manager will always be housed within the lead agency.