TORBAY RECOVERY CO-ORDINATION PROTOCOL FOR DRUG AND ALCOHOL SERVICES
## Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Application: All Tier 3 and Tier 4 Drug and Alcohol Services in Torbay</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Introduction and Background</td>
</tr>
<tr>
<td>3</td>
<td>1. Key Components of Recovery Co-ordination</td>
</tr>
<tr>
<td>4</td>
<td>2. Who the Recovery Co-ordination applies to</td>
</tr>
<tr>
<td>5</td>
<td>3. Criteria for Recovery Co-ordination</td>
</tr>
<tr>
<td>5</td>
<td>4. Assessment Domains</td>
</tr>
<tr>
<td>5</td>
<td>5. Recovery Co-ordination Documentation</td>
</tr>
<tr>
<td>7</td>
<td>6. Risk assessment and management</td>
</tr>
<tr>
<td>11</td>
<td>7. Recovery Co-ordination Standards</td>
</tr>
<tr>
<td>11</td>
<td>8. Additional notes on the Recovery Co-ordination Process</td>
</tr>
<tr>
<td>12</td>
<td>9. Service User Rights</td>
</tr>
<tr>
<td>12</td>
<td>10. Loss of contact/refusal to maintain involvement with service</td>
</tr>
<tr>
<td>13</td>
<td>11. Accessing Tier 4 Rehabilitation – Funding &amp; Services</td>
</tr>
<tr>
<td>13</td>
<td>12. Involvement of carers in recovery coordination</td>
</tr>
<tr>
<td>14</td>
<td>13. Recovery Co-ordination coordination in Prison</td>
</tr>
<tr>
<td>15</td>
<td>14. Team manager responsibilities in relation to Recovery Co-ordination</td>
</tr>
<tr>
<td>15</td>
<td>15. Recovery Co-ordination role &amp; responsibilities</td>
</tr>
<tr>
<td>16</td>
<td>16. Audit</td>
</tr>
<tr>
<td>16</td>
<td>17. Training Requirements</td>
</tr>
<tr>
<td>18</td>
<td>18. Confidentiality and its limitations</td>
</tr>
<tr>
<td>21</td>
<td>Appendix 1 - Standards for Recovery Co-ordination</td>
</tr>
<tr>
<td></td>
<td>General standards</td>
</tr>
<tr>
<td></td>
<td>Referral</td>
</tr>
<tr>
<td></td>
<td>Assessment</td>
</tr>
<tr>
<td></td>
<td>Individualised Recovery Plans</td>
</tr>
<tr>
<td></td>
<td>Reviews</td>
</tr>
<tr>
<td></td>
<td>Transfer of care</td>
</tr>
<tr>
<td></td>
<td>Record keeping</td>
</tr>
<tr>
<td></td>
<td>Holding and sharing of information</td>
</tr>
<tr>
<td></td>
<td>Discharge from Recovery Co-ordination</td>
</tr>
<tr>
<td></td>
<td>Re-referrals</td>
</tr>
<tr>
<td>29</td>
<td>Appendix 2 – Risk Assessment Guidance</td>
</tr>
<tr>
<td>35</td>
<td>Appendix 3 – In-Patient Drug / Alcohol Detoxification</td>
</tr>
<tr>
<td>41</td>
<td>Appendix 4 - Rehab Flowchart</td>
</tr>
<tr>
<td>42</td>
<td>References</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total no of pages</th>
<th>42</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of development</th>
<th>December 2015</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ratified by DPT/TSDFT</th>
<th>TSDFT – Care &amp; Clinical Policies sub-group. Ratification date: 16 December 2015 DPT -</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Review date</th>
<th>December 2018</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Linked to Policies</th>
<th>TSDFT – Attendance Management guidelines for substance misuse services DPT – non-attendance policy (CA03)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lead</th>
<th>Graham Shiels – Torbay and South Devon NHS Foundation Trust; Andy Wray – Devon Partnership Trust</th>
</tr>
</thead>
</table>
INTRODUCTION AND BACKGROUND

This protocol was developed to provide guidance to all staff that work with people with substance misuse problems in Devon Partnership Trust and Torbay and Torbay and South Devon NHS Foundation Trust Drug & Alcohol Services. The protocol sets out a systematic process and procedure for applying Recovery Co-ordination within the context of the existing and recent national policy changes and best practice guidance.

The major policies underpinning this document are as follows:-

- National Treatment Agency’s treatment effectiveness strategy (2005-08)
- Medications in recovery: Re-orientating drug dependency treatment”, NTA (July 2012)

This aim of this protocol is to support treatment effectiveness at practice level and is intended to:

- Provide guidance to improve the effectiveness of Recovery co-ordination
- Provide a framework for services which provide structured drug/alcohol treatment, to plan and review the recovery focused interventions they provide to service users
- Assist practitioners in tailoring recovery planning to specific phases in the service user’s treatment journey, focused on engagement, delivery, maintenance or reintegration, and successful exit from treatment
- Set out the necessary elements of Recovery Co-ordination while retaining flexibility to allow for individual service user needs or variations in local services

1 KEY COMPONENTS OF RECOVERY CO-ORDINATION

1.1 The four main elements of Recovery coordination are:

1) Systematic arrangements for assessing the health and social needs of people referred into drug and alcohol services
2) The formulation of a recovery plan in collaboration with the service user which identifies the needs and goals of the service user and seeks to address this via health and social care interventions from a variety of providers
3) The allocation of a recovery coordinator to keep in close touch with the service user and to monitor and co-ordinate care
4) Regular review and, where necessary, agreed changes to the recovery plan

1.2 Principles

- Support people to exercise increasing responsibility for their drug and alcohol use
- Support people in the context of their family and social roles.
- Respect the choice of people who look to services for support and value the experience they bring to the recovery relationship.
- Promote personal recovery outcomes, support self-management and facilitate social inclusion

2. WHO RECOVERY COORDINATION APPLIES TO

2.1 Recovery coordination applies for the purposes of this protocol to all adults from 18 years accepted and being treated by Devon Partnership Trust and Torbay and South Devon NHS Foundation Trust drug and alcohol services residing within the Torbay Local Authority boundary.

2.2 It applies to people in the community services and also to those in in-patient care (detox/stabilisation), day services and other residential care.

2.3 For service users with dual diagnosis (psychiatric co-morbidity); meaning a combination of severe/enduring mental illness and substance misuse, their care is subject to the national guidelines for Enhanced CPA (Care Programme Approach). In most cases, this will be under the care of a Community Mental Health Team (CMHT) often caring jointly with a substance misuse service. For substance misusers on Enhanced CPA, Recovery coordination and care coordination programmes should be in accordance with the prevailing mental health guidance and legislation and be the responsibility of a statutory mental health team.” (11) The Devon and Torbay Dual Diagnosis strategy provides clear guidance on the responsibility of services as well as which agency should take the lead role with the individual.

3. CRITERIA FOR RECOVERY CO-ORDINATION
3.1 The criteria for Recovery coordination are identical to the criteria for comprehensive assessment, namely drug and alcohol misusers who present with one or more of the following:

- significant drug and alcohol misuse problems in two or more problem domains (see below ‘Assessment Domains’)
- a need for structured and/or intensive intervention
- significant psychiatric and/or physical co-morbidity
- significant risk of harm to self or others
- contact with multiple service providers
- pregnancy
- children ‘at risk of significant harm’ due to parental drug/alcohol misuse
- a history of disengagement from drug and alcohol treatment services

### 4. ASSESSMENT DOMAINS

4.1 The assessment tools outlined in ‘Recovery coordination Documentation’ (see below) incorporate assessment of the following domains:

- drug use (including type of drugs, quantity/frequency of use, pattern of use, route of administration source of drug)
- alcohol use (including quantity/frequency of use, pattern of use, whether above ‘safe’ level, alcohol dependence symptoms)
- psychological problems (including self-harm, history of abuse/trauma, depression, severe psychiatric co-morbidity, contact with mental health services)
- Physical problems/issues (including complications of drug/alcohol use, pregnancy, blood-borne virus transmission/risk behaviours, liver disease, abscess, overdose, enduring or severe physical disability.
- social issues (including childcare issues, partners, domestic violence, family, housing, employment, benefits, financial problems)
- legal problems (including arrests, fines outstanding charges/warrants, probation contact, imprisonment, violent offences criminal activity)

### 5. RECOVERY COORDINATION DOCUMENTATION

5.1 Referrals

5.1.1 A record will be completed on all new referrals to the service. This information will be registered on HALO as part of Recovery coordination and for the purposes of NDTMS data recording.

5.2 Assessment
5.2.1 An **Initial Assessment** will be completed on all people referred into the services. For those being referred into a tier 3 or 4 drug service a Client Evaluation of Self at Intake (**CESI**), **Treatment Outcome Profile (TOP)** and **General Health Care assessment** will be completed.

**CESI Graphs** will be transferred from Tier 2 to Tier 3 electronically by means of HALO;

5.2.2 Following completion of an initial assessment and team allocation thereof, if the service user is referred into a specific Tier 3 or Tier 4 modality, the **Comprehensive Assessment** will be completed.

5.2.3 Information from Initial Assessment and Comprehensive Assessments will also be registered on HALO electronic case management system.

5.4 **Individual Recovery (Care) Plan**

5.4.1 An **individualised Recovery/Care Plan** (hereafter referred to as an Individual **Recovery Plan** (IRP)) will be developed jointly alongside the service user, identifying strengths as well as looking at areas to support recovery. This could include mutual aid, volunteering, recovery capital, community rehab, SMART, NA.

5.4.2 The service user will be asked to sign the plan and retain a copy. In some circumstances, it may not be possible to obtain a signature the reasons for this should be clearly noted on the IRP e.g. “service user refused”. This recovery plan should be a live document and as such subject to regular review.

5.5 **Review**

5.5.1 The Individual Recovery Plan will be completed on all on-going service users no longer than three months after initial assessment. The **Treatment Outcome Profile (TOP)** and **Client Evaluation of Self in Treatment (CEST)** will be undertaken within the first 13 weeks of treatment and then every 26 weeks after this for drug users (more frequently if agreed therapeutically helpful between keyworker and service user).

5.5.2 A supplementary review will be completed after a further three months or sooner where appropriate.

5.5.3 Reviews thereafter will be completed at intervals of three months or sooner in response to significant changes in the individual’s presentation.

5.5.4 Where appropriate, recovery plan reviews will include the service user’s carer, and as part of this process, their views and needs will be taken into account. This is subject to the service user’s consent. The Carers support worker may become involved in this process as appropriate, and with the proper consent in place.
6. RISK ASSESSMENTS AND MANAGEMENT

It is recognised that very few situations are risk free and risk cannot be eliminated, only reduced. Positive risk taking is an important part of recovery and will be more likely to happen if a range of choices are available to the service user. A written record of all decisions taken and the rational is essential. The service user and any involved carers (with service user consent) should be fully part of the process unless there are justifiable reasons for their exclusion.

6.1 Risk Assessments

6.1.1 All people referred to DPT and TSDFT drug and alcohol services will have an initial risk screening assessment (RF1) - to identify immediate presenting risks and to enable action/response to minimise this risk i.e. safer injecting advice/needle exchange provision/child protection issues. Where a significant level of risk may be present this will require a Comprehensive Risk Assessment (RF2) together with an individual action plan RF3.

6.1.2 If the risk screening reveals areas of concern, the practitioner/worker will discuss this with their line manager or in their absence their deputy. Any immediate presenting risks will need to be proactively managed.

6.1.3 A comprehensive risk assessment (RF2) will be completed to determine the extent, level and circumstances surrounding risk and to inform the Risk Management Plan (RF3). This assessment may well need to be repeated if circumstances change considerably and should be routinely discussed at individual action plan review.

6.2 Risk management

6.2.1 If the concern is significant, the assessor will complete a Risk Management Plan (RF3) to plan action to manage the risk(s) identified, including timescales and person(s) responsible. The recovery co-ordinator will discuss the plan with their Team Leader/Service Manager, who will then sign it off if they are satisfied with the action therein.

6.3 Contingency Management

6.3.1 As part of Recovery co-ordination, a contingency plan will be developed and mutually agreed between the recovery coordinator and service user. This should include discussion of risk and, where possible, the risk plan should be mutually agreed and managed on a clinical level. Important information on the identified risk(s) will be recorded in the service user’s case record, including the Individual Recovery Plan, and may be shared on a ‘need to know’ basis with others.
6.2.3 This may not always be possible in situations where information about risk to self or others may need to be conveyed in spite of objections by the service user.

6.2.4 Information sharing with other agencies/professionals will conform to the existing and agreed protocol on sharing of information. (13)

6.2.5 For more immediate or serious risk, the practitioner/worker will notify and discuss with the Team Leader/Service Manager, who will then decide what action will be taken. This does not preclude any essential action that may need to be taken by the individual practitioner/worker if the immediate circumstances warrant it.

6.2.6 All significant information should be gathered and verified before acting on that risk. If possible, a consensus view should be reached among all those involved, reviewing both clinical and management considerations.

6.2.7 Options available to the recovery co-ordinator and Team Leader/Service Manager include:

- Continuance of routine risk monitoring
- An urgent risk management meeting
- Convene a risk enablement panel
- Additional specialist assessments, e.g. consultant psychiatrist
- Sharing of information with other agencies
- Informing local safeguarding children team
- Alerting local adult safeguarding team (SPOC)
- Alerting local security management teams
- Informing out of hours team in specific circumstances e.g. if there are concerns about a service user’s whereabouts and their mental health condition
- Where mental capacity or vulnerability is identified then to consider safeguarding adult process (For definitions see Torbay safeguarding adults protocol 2012, version 2.

6.2.8 The Team Leader/Service Manager will be made aware of all service users currently presenting with significant risks. All practitioners/workers have a responsibility to inform their Team Leader/Service Manager of service users on their caseloads with identified significant risk problems.

6.2.9 Clinical team meetings will be the usual forum for the sharing of information about and discussion of service users presenting with enhanced levels of risk.

6.2.10 Robust links should be established through Service Managers/ nominated deputies with all risk management forums e.g. Multi-Agency Public Protection Meetings (MAPP), Child Protection strategy meetings and conferences,
Probation Service risk management meetings, and MARAC meetings. Take out list or you have to describe all and include adult safeguarding

6.2.11 All clinical staff are required to attend mandatory risk assessment and management training

6.2.12 In the event of a significant serious untoward incident occurring staff will be required to incident report this on their services risk management systems. Managers will be required to undertake a review of the SUI to identify any service learning that should be shared across teams. Any recommendations arising from SUI should be incorporated into clinical practice and policies and processes may need to be reviewed accordingly

6.2.13 The risk assessment and management principles are set out in the following flowchart.

Fig 1: Risk assessment and management flowchart

Referral

Assessment
Stage 1

Initial Risk Assessment (RF1)

YES

Significant risk identified

NO

Stage 2

Complete comprehensive risk assessment (RF2)

Review with recovery plan

Stage 3

Discuss with service user

Inform team manager

Discuss with supervisor

Complete risk management plan (RF3) if required

Risk remains unmanaged

Inform relevant others e.g.
- Statutory organisations/procedures
- Carer of service user
- Consultant Psychiatrist/mental health service

Risk now managed

Stage 4

Call urgent case/risk meeting

Complete risk management plan

Review risk plan (RF3)

Risk not reduced or increases

Review care plan

Risk diminishes

Planned Discharge
7 RECOVERY COORDINATION STANDARDS

A full set of Recovery coordination standards is presented in Appendix 1 and covers the following topics relating to the process of recovery coordination:

1. General Standards
2. Referral
3. Assessment
4. Individualised Recovery Plan (IRP)
5. Review
6. Inpatient detoxification/stabilisation admission and discharge
7. Transfer of care
8. Record keeping
9. Holding and sharing of information

8. ADDITIONAL NOTES RELATING TO THE STANDARDS

8.1 Where possible, decisions regarding the allocation of referrals received should consider service user choice, appropriate matching of need with available skills and the previous treatment history of the service user.

8.2 Allocation should be a managed process making the most effective use of team resources.

8.3 All service users referred to Drug and Alcohol services in Torbay will have a recovery coordinator. Their role will be to work alongside the service user to identify the individual’s recovery needs and to coordinate a package of interventions to address any identified needs.

8.4 The recovery co-ordinator may commission additional assessments such as a prescribing assessment, assessment for the community rehabilitation programme or for consideration of a residential detoxification.

8.5 Where there is more than one team involved, there will be an explicit documented agreement about who will be responsible as recovery co-ordinator. In line with Models of Care and the Torbay Dual diagnosis strategy, Recovery coordination rests with the highest Tier of service involved in treatment.

8.6 The service user must be informed of any change of recovery co-ordinator, as must other involved professionals, carers or significant others as appropriate. Again, the service user’s views should be taken into consideration regarding the choice of recovery co-ordinator and the decision will be made through a face-to-face meeting between the existing recovery coordinator and the service user.
9. SERVICE USERS RIGHTS

9.1 Recovery coordination will ensure the individual service user is at the centre of all actions.

9.2 Service users will be given clear, relevant and appropriate information to enable informed choices and decisions.

9.3 Service users will have full involvement in care as specified in “Models of Care”, including regular consultation regarding satisfaction of treatment.

9.4 The service user will be the focus of their own “individual recovery plan” (IRP) which will be measurable, transparent and fully negotiated, conceived and agreed with the individual.

9.5 Use of ITEP as a delivery tool will contribute towards achieving points 9.1 to 9.4 above, and enable treatment to be responsive to subtle changes in the individual’s circumstances and needs.

9.6 Good practice guidelines to be followed.

“To feel valued and listened to throughout the treatment journey, this being the most fundamental area of Service User Involvement”.

10. LOSS OF CONTACT/REFUSAL TO MAINTAIN ENGAGEMENT WITH THE SERVICE

10.1 If a service user fails to attend appointments, every action should be taken to re-establish contact e.g. writing to the service user (by letter and/or e-mail), text, telephone contact,

10.2 home visit or attempts to engage in known areas in which the service user may be present should be considered but only after all other attempts to engage have been unsuccessful. Home visits should be risk assessed and agreed in advance by the clinician’s line manager.

10.3 Any service user has a right to refuse contact with the drug & alcohol service. However, as in the case of co-morbidity/dual diagnosis and where there is serious concern about a service user’s mental health presentation, this will be communicated to other relevant professionals i.e. CMHT Consultant Psychiatrist or other appropriate mental health clinician or GP. Similarly where the individual is identified as a vulnerable adult or where children may be at increased risk due to disengagement of the service user, this information must be communicated in a timely fashion to appropriate involved agencies.
10.4 The recovery co-ordinator will document all action taken in trying to re-establish contact with the service user, and the outcome of this, as well as any follow-up actions on HALO.

10.5 Staff should ensure that they follow their respective organisations policies in respect of non-engagement or non-attendance at appointments

**11. ACCESSING TIER 4 COMMUNITY REHABILITATION AND RESIDENTIAL DETOXIFICATION**

11.1 Devon Partnership Trust and Torbay and Torbay and South Devon NHS Foundation Trust fully comply with the ‘Protocol for use of Fair Access to Care Services (FACS) by Staff in Partner Agencies’ (14)

11.2 Devon Partnership Trust and Torbay and Torbay and South Devon NHS Foundation Trust are working in partnership with Jatis to provide a community rehabilitation programme. Information about this provision and the process to follow in referring an individual to the community rehabilitation programme can be found in appendix 3

11.3 A Residential detoxification programme can be accessed via Broadreach House. Staff should follow the relevant care pathway to access this intervention for service users they are working with. Please see appendix 4

**12. INVOLVEMENT OF CARERS IN RECOVERY COORDINATION**

12.1 Evidence suggests that involving carers at every stage in the recovery journey helps the service user achieve their goals (18). As such, recovery coordinators should capitalise on this, and ensure that there is a consistent offer of the involvement of the service users’ family and friends, and that this approach is encouraged and embedded in the service delivery, and offered universally.

12.2 It must be borne in mind that carers of drug and alcohol misusers will doubtless have needs themselves, and a referral to the carers service should be offered. Following the introduction of the Care Act (2014), the carer should be involved in the assessment of the client (with consent).

12.3 Additionally the carer themselves are entitled to an assessment of their own needs, and provision of a plan to support them put in place.

12.4 Within adult substance misuse services within Torbay, there is a dedicated carers support worker, who is there to provide advice, support and assistance to carers of those with drug and alcohol problems. A support group runs weekly to deliver some of this support, and is peer-led.
12.5 Recovery coordinators will record the carer status of the service user on HALO (whether providing or receiving that care), and also on the Individual Recovery Plan (IRP) will note if there are carer(s) involved, and if so whether the service user would like them to be involved in their recovery planning.

13. RECOVERY COORDINATION IN RELATION TO PRISON

13.1 The Integrated Drug Treatment System (IDTS) was rolled out across all prisons in England and Wales in 2006. The objective of IDTS is to expand the quantity and quality of drug treatment within HM Prisons.

13.2 Where a service user, currently in treatment, receives a short-term custodial sentence or short-term remand, the recovery coordinator should liaise with the services within the prison with a view to continuing treatment of that individual in the prison setting and upon their eventual release from custody.

13.3 If the service user is to remain in HMP for 29 days or more, the episode with the team should be closed. If 28 days or less the episode remains open to the service.

13.4 In cases where there is clear evidence that the prescribing intervention is not beneficial, or the risks outweigh the prescribing intervention, the recovery worker must discuss with clinical lead prior to requesting detoxification within HMP. In all cases the rational must be documented.

13.5 Designated staff from within the drug treatment system are responsible for the coordination of treatment between prison and the community. They are required to gather information related to any individuals currently in prison who on their release intend residing in Torbay. Information related to treatment whilst in prison, medication prescribed on release and any plans in respect of this together with information related to clinical risks. This information should be shared with their clinical lead and a review of the information and request carried out. In some circumstances where the individual being released has been well known to the treatment system and present with multiple risks a decision should be made as to whether the community service will agree to the request for the continuation of any prescribing intervention. The decision and the rationale for this should be clearly documented in the clinical records of the service user and a letter / email sent to the prison to inform them of this decision and to request the individual is detoxed prior to release.

13.6 All individuals released from prison are able to access the full range of services provided within the drug and alcohol treatment system

13.7 The Prison service are required to provide clear information to the drug and alcohol service in relation to the prescribing interventions provided to the
individual in prison and any details in respect of the prescription they have been
issues with in the prison including dispensing pharmacy, dose and date that any
prescriptions run to. If being discharged on a Friday without a prescription then
the Prison should indicate what medication was dispensed to the individual in
prison on the day of their release

13.8 The designated staff from the drug service responsible for the coordination
and transfer of treatment from the prison to the community will arrange to assess
the individual on the day of their release from prison, provide harm reduction
information and to arrange for the individual to see a prescriber. As part of this
assessment the suitability and appropriateness of the individual being dispensed
medication on their day of release given the potential risks associated with the
individual having used substances following their release from prison and prior to
their appointment with the drug service

14. TEAM MANAGER RESPONSIBILITIES IN RELATION TO
RECOVERY CO-ORDINATION

14.1 To ensure that all team members are familiar with, and conform to, service
Recovery coordination standards.

14.2 To oversee that a systematic and comprehensive assessment of health and
social care needs is completed on all service users, recording both factual and
person-centred information.

14.3 To monitor the working of Recovery coordination through regular caseload
management supervision including TOP and ITEP (essentially CESI, CEST and
node link mapping tools in use in drug services), risk assessment and
management, inter-agency working and psychosocial intervention delivery as
described within the IRP for the service user.

14.4 To ensure the team has effective communication systems with related
teams for the transfer of information routinely and in crisis situations.

14.5 To be aware of those service users presenting the most risk e.g. through
supervision at any one time and make decisions with the recovery coordinator
about any necessary action to reduce risk.

14.6 To audit all aspects of the working of Recovery coordination on a regular
basis.

14.7 To inform the appropriate senior manager of any serious shortcomings in
the operation or design of the recovery co-ordination.
Roles and responsibilities

The clinical team leader will:

- Ensure that all team members are familiar with and adhere to all appropriate Trust standards as well as professional standards of practice.
- Oversee a systematic and comprehensive assessment of health and social care needs for all people seeking support from the service, recording factual and person-centred information.
- Ensure the team has effective communication systems with related teams and network partners for the transfer of information routinely and in crisis situations.
- Register people who present the most risk at any one time and make decisions with the Recovery coordinator, the person and their supporters/carers about any necessary action to reduce risk.
- Monitor the implementation of Recovery coordination and report serious shortcomings or concerns.

15. RESPONSIBILITIES OF RECOVERY CO-ORDINATORS

15.1 To co-ordinate all assessments and develop an Individual Recovery Plan, which should be a joint statement/plan agreed with the service user and significant others (where appropriate) outlining what should happen and when using the appropriate information from assessments, ITEP mapping tools, and informed by CESI/CEST results (drug services only).

15.2 To ensure that other key people involved or affected have an opportunity to share their views and opinions.

15.3 To consider whether a full carer’s assessment is requested by the carer in accordance with the Care Act (2014). This is also subject to service user consent.

15.4 To act as a reference point for other professionals, relatives, carers and advocates.

15.4 To encourage the service user to register with a GP in the Torbay locality and ensure that the GP is involved and informed as necessary. Note that without a verified GP registration, a number of treatment options may be unavailable, particularly Substitute prescribing.
15.5 To maintain regular contact with the service user and monitor their progress wherever they may be within the drug and alcohol treatment system. If a service user who remains vulnerable refuses to take part in the Recovery coordination process, all steps should be made to continue engagement.

15.6 To organise reviews at appropriate intervals and ensure that all those involved in the recovery plan are consulted and involved directly in the review where appropriate.

15.7 To explain the Recovery coordination process to service users and others involved, making them aware of rights, roles, confidentiality including the limits of confidentiality.

15.8 Consider the need for advocacy for the service user, or carer if appropriate, and make them aware of local options.

15.9 Remain in contact with individuals who enter hospital inpatient wards/units or the prison system and, if appropriate, prepare an appropriate plan following discharge/release.

15.10 Identify unmet needs and communicate these to the Team Leader/Service Manager who in turn may refer these unmet needs to senior managers within the organisation and the commissioners of the service.

15.11 Arrange for someone to deputise when absent and to pass on the recovery Co-ordinator role to someone else if no longer able to fulfil it via the line manager.

15.12 To regularly update the team manager about their caseload and in particular, individuals presenting with high risk behaviours.

15.13 To receive and actively engage in regular management and clinical supervision appropriate to the work being undertaken.

16. AUDIT

16.1 Audit on all aspects of the Recovery coordination should be carried out:-

- By Team Leaders/Service managers as part of an organisational Governance programme addressing specific issues.
- Routinely through caseload management supervision.
- By the relevant LA Clinical/Governance Lead in partnership with Senior Practitioners of respective services (which must include addressing NTA and local priorities).
17. TRAINING

17.1 All staff involved in Recovery coordination will receive appropriate training linked to implementation of this operational protocol and mapped to DANOS competencies.

17.2 Induction of all new staff will involve Recovery coordination training, which is also mapped to DANOS.

18. CONFIDENTIALITY AND ITS LIMITATIONS

18.1 All staff have an obligation to safeguard the confidentiality of personal information. This is governed by law, contracts of employment and by professional codes of conduct. All staff should be made aware that breach of confidentiality could be a matter for disciplinary action and provides grounds for complaints to be made against them.

18.2 Only minimum identifiable information necessary to satisfy a specific purpose should be shared on a strict ‘need to know’ basis.

18.3 If a service user wishes information about them to be withheld from someone or a particular agency, their wishes should be respected unless there are exceptional circumstances where a breach of confidentiality can be justified. The decision to release information in these circumstances should be made by a senior professional/manager within the agency, in accordance with authority designated by the Caldicott Guardian, in line with the local information sharing protocol, using their professional judgement and accountability; it may be necessary to take legal or other specialist advice. The Data Protection Act and Freedom of Information Act must be taken into account.

18.4 Circumstances in which disclosure of information without the service user’s permission may be professionally appropriate:

- Where a child is believed to be at risk of significant harm (Children Act 1989) or vulnerable adult legislation (Mental Capacity Act 2005)

Contact details are as follows (correct as at 8 September 2015):-

**Torbay Children’s Safeguarding Hub**

Tel: 01803 208100
18.5 Breaching client confidentiality

Confidentiality can be breached in the following circumstances, but should be clearly documented and the intention to do so discussed with the service user, except where to do so would place others at risk of significant and immediate harm.

- Where there is evidence of risk of serious harm to the public
- Where there is evidence of risk of serious harm to self
- For the prevention, detection or prosecution of serious crime
- Where the service or individual is instructed to do so by a Court (NB. This can involve all clinical notes being subpoenaed)
- If the service user gives information about a serious crime which has been committed, such as a murder, manslaughter, rape, treason or kidnapping (Police and Criminal Evidence Act 1984)
- If a service user gives information about suspected terrorism (Prevention of Terrorism Act 1998)
- Under the Mental Health Act 1983 where a service user objects to their ‘nearest relative’ being consulted re:-
• An application for Treatment Order (Section 3) is being considered

• An application for assessment and/or treatment in relation to the service user has been made

• Under the Mental Health (Patients in the Community) Act 1995 where the service user is known to have the propensity to violent or dangerous behaviour.

18.6 All staff involved in Recovery coordination will be familiar of the Information Sharing Protocol agreed by treatment providers. (13)

Appendix 1

STANDARDS FOR RECOVERY COORDINATION

1. Introduction
The National Treatment Agency’s (NTA) treatment effectiveness strategy focuses on improving the quality of treatment provision, to match the improvements in access and capacity, which have already been achieved (1). This has been further underpinned by the publication of “medications in recovery: Re-orientating drug dependency treatment”, the findings of the NTA expert group chaired by Professor John Strang (July 2012) (2).

The NTA treatment effectiveness strategy identifies some of the critical success factors to improving drug treatment and bases a delivery plan upon them. It identifies the need to refocus activity by prioritising the development of the quality and effectiveness of treatment to match the improvements in access since 2001.

Since the treatment effective strategy there has been the development of the Treatment Outcome Profile (TOP) (NTA October 2007) (4). This is an outcome measuring tool that is undertaken with service users at intake and then again within the first 13 weeks of treatment, and is subsequently completed every 26 weeks thereafter, and finally on discharge from treatment. In alcohol services, the locally developed treatment monitoring tool should be used in place of the TOP form.

There is now a wealth of empirical evidence to suggest that good care planning, embedded in policies, procedures, monitoring and evaluation, improves service user outcomes. Evidence from US methadone programmes suggest those services, which responded to service users’ needs, provided the help they required and actively involved them in care planning, were much better in enabling service users to stay in treatment longer and achieve abstinence from illicit drugs (5).

2. General Standards for Recovery Co-ordination

Service users and carers should:

• Be treated with dignity and respect.

• Be treated as equal partners in planning the interventions best suited to their needs.

• Be given appropriate information about:
   The ‘drug & alcohol treatment system’ and what can be expected to happen;
   Confidentiality and its limitations;
   Medication including risks and side effects;
   Complaints procedures;
   Current knowledge about the evidence base for the treatment of drug & alcohol problems;
   Accessing social care provision;
➢ Carers right to a separate assessment of their own needs and their responsibilities to the person they are caring for.

• Know who their recovery coordinator is, how to contact them and who to contact if their recovery coordinator is not available.

• Be listened to and given time and space to recount their experiences, anxieties and hopes.

• Be offered choices about the services they receive and the people they work with.

• Be fully informed about the reasons for restriction of choice if this becomes necessary.

• Have their concerns respected and acted upon appropriately as soon as possible.

• Expect that files kept on them will contain all relevant information in an orderly and accessible format, should they wish to see them.

• Have any specific cultural, racial, religious, disability and gender needs taken into account.

3. **Standards for Referral**

• Pre-referral discussion should take place wherever possible to ensure that only appropriate referrals are made.

• If referrals are targeted to an individual team member, they should go through the same single point of entry to ensure consistency of approach, and follow the agreed allocation process within the service.

• The agreed Integrated Care Pathway “Matching client need with drug/alcohol service provision in Torbay” should be applied at all times.

• If referrals are not accepted, the referrer will receive an explanation of the decision with suggestions for a more appropriate referral route.

4. **Standards for Assessment**

• Everyone who is referred to the DPT and TSDFT Drug and Alcohol Services and meets the eligibility criteria, is entitled to receive an initial assessment and where appropriate a comprehensive health and social care assessment. The referral will be comprehensively assessed and the individual will enter structured treatment within 21 days of the referral.
• Assessment is made jointly with the service user, in which the purpose of the assessment is explained to them, the scope and limitations of confidentiality are outlined and conclusions are shared and negotiated.

• The assessment should be holistic, and across the range of physical, psychological, social, employment, education, leisure, financial, spiritual and criminal domains.

• The assessment will include both mapping tools and ‘factual’ assessments.

• Other people such as carers, families and significant others should be consulted with the permission/suggestion of the service user. This should be encouraged by recovery coordinators as integral to the service user’s recovery capital.

• Needs should be assessed and recorded even if no services / resources are available to meet those needs.

• Each assessment will include a screening risk assessment indicating whether further risk assessment is required or not.

• The assessment should include a formulation or summary.

5. Standards for Individualised Care Plans – QuADS Standard 26

• All service users accepted into Tier 3/Tier 4 services will have an individual care plan.

• Everyone involved in the individualised recovery plan should be in broad agreement about the aims of the plan and any disagreements recorded.

• The plan should be written in clear, respectful and jargon-free language.

• Where appropriate, individualised recovery plans should contain a contingency / crisis plan which has been discussed and, where possible, agreed with the service user and relevant others.

• All information relating to assessed risk should be recorded.

• The individualised recovery plan should be communicated to all appropriate parties on a ‘need to know’ basis and with the full understanding and consent of the service user wherever possible.

• The service user should sign the individualised recovery plan if appropriate. If he/she does not wish to, this should be recorded on the plan.

• The service user will be offered a copy of the individualised recovery plan.
• The care coordinator will sign the individualised recovery plan.

• Individualised care plans should be recorded on the appropriate form.

• Planned objectives should be stated with; responsibility for action, time scales and anticipated outcomes.


• The format and timing and setting of the review will be appropriate to the needs of the individual.

• The purpose of the review should be recorded i.e. whether it is a regular review or whether it is due to exceptional/unforeseen circumstances.

• In the case of a review meeting, people involved in the individualised plan should be invited to contribute. If they are unable to attend, this should be recorded and relevant comments written on the review form. Consideration should be given to requesting a report from those unable to attend.

• In the case of a less formal review, the opinions of other involved people should be sought and recorded

• Transfer and discharge information will be recorded.

• The outcome of the review will be recorded and a copy of the review form will be sent to all relevant parties.

• The service user will be asked to sign the review form.

• The recovery coordinator will sign the review form.
Standards for transfer of care

- **All transfers within Torbay between drug and alcohol treatment agencies should follow the internal transfers protocol (drugs or alcohol)**

- Where possible, a transfer should be part of a planned process allowing time for a new recovery co-ordinator to be appointed and a handover completed.

- Transfer of service users to another service should involve telephone, electronic and written communication for handover.

- Ideally disengagement should not occur before the new team has established a relationship but it is recognised that this may not always be possible.

- Where appropriate the recovery coordinator should try to ensure that the service user registers with a GP in the new area.

- Prescribers should liaise with their counterpart in the new area prior to transfer of care and begin handover to the new prescriber within four weeks.

- Transfers should follow a full review of the IRP.

- Any on-going social care services should be discussed with the new recovery co-ordinator.

- Where the service user is moving LA areas, and is in receipt of supervised consumption this should be continued unless discontinuation is deemed clinically safe by the prescriber. The issue of payment should be discussed and agreed between the prescribing service and the pharmacy in advance of any arrangement.

- The above standards apply except when a service user moves out of a team area on a temporary arrangement, for example to an adjacent LA area, when the original team will retain responsibility.

- If the change is more permanent, the recovery co-coordinator and the consultant (if involved) will liaise with the new service, ideally at a review meeting, but by other means if this is not possible.

7. **Standards for record keeping**
• Staff should be familiar with the record keeping protocol or their respective organisation.

• Records should be kept of all contacts with the service user and with significant others in relation to the interventions that the patient receives.

• There should be a single, integrated, sequential, written record for each service user

• All records will conform to NDTMS, Information Governance, professional and any additional HALO requirements.

• Any written documentation should be signed, dated and timed. Black ink must be used and writing must be legible. This is in keeping with DPT and TSDFT record keeping policy.

• Service users in DPT and TSDFT have the right to access files through existing Access to Records Procedures.

8. **Standards relating to holding and sharing of information**

• “Staff should only have access to personal information on a need to know basis, in order to perform their duties …relevant clinical and professional details should be available to all those, but only those, involved in the care of the individual.” (Manual for Caldicott Guardians; Governing the Receipt and Disclosure of Patient/Service user Information, para. 21)

• Each agency will ensure that they have mechanisms in place to enable them to address the issues of physical security, security awareness and training, including safe haven requirements and security management

• “Each agency will take all reasonable care and safeguards to protect the physical security of information technology and the data contained within it”. (Manual for Caldicott Guardians)

• “All personal files and confidential information must be kept in secure, environmentally controlled locations when unattended, e.g. in locked storage cabinets, secure protected computer systems etc. Keys to lockable storage cabinets should be held only by staff that require regular access to the information they contain. Keys must be held in a secure place.” (Manual for Caldicott Guardians)

• Sharing of information for the purposes defined above should be done by a telephone call back system, secure e-mail or secure “safe haven” fax method or other locally agreed process with the relevant IG department.
• Further guidance can be obtained from the DPT or TSDFT information governance departments as applicable.
Discharge from recovery co-ordination

• Discharge from Recovery coordination may only happen at a review or through workload management with the line manager or clinical supervisor or following discussion/decision made at clinical meetings.

9. Re-referrals

• All re-referrals will follow the usual process of referral as per local arrangement.

Appendix 2: Risk Assessment Guidance (last updated November 2015)
1 SUMMARY

1.1 These clinical risk assessment and management procedures have been designed for use by the Torbay Drug and Alcohol Services commissioned by Torbay Public Health Commissioning team. Services should continue to utilise their own policies regarding non-clinical risk assessment, hazard and incident reporting etc.

Currently these services include:

- Devon Partnership Trust Addictions Services
- Torbay and South Devon NHS Foundation Trust Drug and Alcohol Service

Collectively known as “Torbay Drug and Alcohol Services (TDAS).

1.2 Designed to complement the assessment processes which are outlined in Models of Care (NTA 2003), the Torbay and Devon Drug and Alcohol Services Risk Assessment and Management Procedures comprise of four stages:

Stage 1 Initial risk screen (RF1) - to determine whether a significant level of risk may be present which requires Comprehensive Risk Assessment and gain an overview of the service user’s circumstances.

Stage 2 Comprehensive risk assessment (RF2) - to determine the extent, level and circumstances surrounding risk and inform Risk Management Plan.

Stage 3 Risk management plan (RF3) – to plan action to manage the risk(s) identified, including timescales and person(s) responsible.

Stage 4 Risk review – a continuous process of re-visiting the risk assessment and risk management plan and identify whether the current risk management plan is effective, still required or needing to be updated.

1.3 Both the Initial Risk Screen and the Comprehensive Risk Assessment consider the following areas of risk:
- Substance specific risks
- Risk to self
- Risk to others
- Risk from others
- Risk to children
Additionally, the *Comprehensive Risk Assessment* explores protective factors (such as the service user's personal resources/coping skills, support networks, environmental factors etc.).

**Guidance notes**

2.1 Risk has been identified as “the possibility that a given course of action will achieve an undesired outcome or some undesired outcome will develop” [Alaszewski et al. 1994].

Assessment of risk should take into account:
- The probability of a risk occurring
- The likely impact of such an event
- The individual's resilience to manage risks factors

Risk assessment should also consider present factors as well as historical events. It is an on-going process which considers risks to the individual and to others.

2.2 Risk assessment should be carried out according to a locally agreed protocol by means of standardised documentation across drug and alcohol services.

2.3 Drug and alcohol users may also encounter substance specific risks, which may be short or long term. Substance specific risks may be physical (involving morbidity and mortality), psychological/psychiatric, social and criminal.

It should be noted that on occasions, drug or alcohol use may conversely be a protective factor which may assist the individual's capacity to manage or avoid certain risk factors (e.g.: self medicating against symptoms of mental ill health).

2.4 Whilst problematic drug and alcohol use is not in itself indicative of children being at risk, it is well documented that parental problem drug use causes serious harm to children at every age from conception to adulthood. (Hidden harm 2003) (15). Also bottling it up: The next generation (Turning point 2011) (16) estimated that there are a total of 2.6 million children living in the UK with parents who are drinking hazardously. The “Hidden Harm” report highlights the possible factors impacting upon the child as a result of parental substance misuse thus:-

“Poverty; physical and emotional abuse or neglect; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialisation;
3. INITIAL RISK SCREEN (RF1)

3.1 An Initial Risk Screen should be undertaken routinely by the worker completing the initial assessment using the Drug and Alcohol Services Initial Risk Screen (RF1)*.

3.2 Risk screening assists in identifying the need for an immediate Risk Management Plan to address any imminent presenting risks. It should determine the current level of risk and the need for a Comprehensive Risk Assessment (RF2)*.

3.3 In the event of a risk screen identifying any immediate risks, an immediate risk management plan must be implemented to manage and minimise imminent risks. This must be discussed and agreed with a line manager, supervisor or senior team member who should countersign the immediate risk management plan.

3.4 The details of any immediate action taken must be shared with the service/agency responsible co-ordinating the service user’s care and any other relevant agencies involved in the service user’s care. This should be done with the service users consent unless the risks are such that they present an immediate and significant risk of harm to the individual or others. The service user should be informed of exactly which information will be shared and with whom. This includes sharing any relevant information indicating a risk to community pharmacy staff who may dispense medication to the service user.

3.5 If a risk management plan is not required because the actions required have been incorporated into the service user’s initial action plan (IAP), this must be noted on the initial risk screen (RF1). This is only permissible if the Initial Risk Screen indicates that a comprehensive risk assessment (RF2) is not warranted.

4. COMPREHENSIVE RISK ASSESSMENT (RF2)

4.1 The Drug and Alcohol Services Comprehensive Risk Assessment form (RF2) should be completed when evidence of significant, serious or complex risks have been identified by the Drug and Alcohol Services Initial Risk Screen (RF1).

4.2 In cases where the worker is responsible for completing both the initial and comprehensive assessments, the RF2 may also be used without a RF1 being completed if an immediate Comprehensive Risk Assessment is clearly warranted and appropriate.
4.3 The RF2 must be undertaken by the service/agency responsible for developing and coordinating the service user’s recovery plan and should ideally be completed by the service user’s recovery co-ordinator (key worker), and should be completed as soon as possible after the RF1 has highlighted the outstanding risk.

4.4 All available sources of verbal and written information must be consulted as part of the Comprehensive Risk Assessment process, i.e.:

- Correspondence
- Multi agency reports/correspondence
- Current and past treatment records
- Full history
- Previous presentation(s)
- Service user
- Carers

Other relevant informants and agencies should also be consulted as a part of this process (e.g. housing/Social Services/Probation etc).

4.5 Any case conference minutes (adult or child focussed) should be added to the service user’s file and relevant information clearly referred to on the RF2.

4.6 If a risk management plan (RF3)* is not required because the identified actions have been addressed in the service user’s individual recovery plan, this must be noted in the comprehensive risk assessment (RF2). This is only permissible when:

1. all the actions identified by the comprehensive risk assessment would form a routine component of the service user’s recovery co-ordination, and;
2. no current or significant risks to the service user or others have been identified within by the comprehensive risk assessment; and;
3. the actions required do not require sharing with a third party or outside agency.

In addition, workers should discuss all decisions to this effect with a supervisor/line manager/senior team member.

For example:

Scenario 1: A comprehensive risk assessment indicates that the service user is engaging in high risk substance use, however this behaviour is being addressed in key work sessions and by a prescribing intervention and forms a central part of the service user’s IRP. Therefore a separate risk management plan is not required, though this should be reviewed at a minimum of every 3 months.

Scenario 2: A comprehensive risk assessment indicates that a service user may be a high risk to pharmacy staff. This must be shared with any pharmacy where
the service user attends to collect their medication (whether under supervision or not). Therefore a separate risk management plan is required and must be shared with all relevant professionals involved in the service user’s care.

Scenario 3: A comprehensive risk assessment indicates that the service user’s children are at risk of neglect due to the service user’s ability to parent being significantly affected by their drug use. This must be shared with Children’s Services. Therefore a separate risk management plan is required.

4.7 Alcohol/drugs and driving: If the service user holds or is applying for any kind of driving licence, the guidance notes for workers on drug and alcohol use and driving must be followed and a Drugs, alcohol and driving information leaflet offered to the service user.

5 RISK MANAGEMENT PLAN (RF3)

5.1 A Risk Management Plan will be agreed, documented and shared with all involved parties, which wherever possible, this must include the service user. The Risk Management Plan must include:

- The risk(s) identified
- Risk management plan (action to be taken), including a contingency plan (what the plan is if things go wrong)
- Who is responsible for individual action(s)
- Anticipated outcome of risk management plan
- Time scale(s) for action(s) to be carried out
- Who/how the plan has been discussed (e.g. clinical team meeting, supervision)

The worker responsible for co-ordination of the Risk Management Plan must complete this on HALO. The plan should also state the review date and will be numbered for reference purposes (i.e. plan no 1, 2, 3 etc).

5.2 The Risk Management Plan must be approved by the worker’s manager/supervisor. It is the responsibility of the recovery coordinator to inform their line manager whenever an RF2 / RF 3 is completed for a service user. The line manager is then responsible for recording their agreement (or further actions to be taken before it can be agreed) on the HALO record for the service user.

6 RISK REVIEW

6.1 All Initial Risk Screens, Comprehensive Risk Assessments and Risk Management Plans must be reviewed at an interval of no more than 3 months, (or sooner if indicated by significant changes). Wherever
possible, this should be tied into recovery planning and recovery planning review cycles.

6.2 If the immediate risks previously identified have passed and a Risk Management Plan is no longer required, this must be documented clearly in the service user's record on HALO and the individual recovery plan review form, quoting the plan reference number. The date the Risk Management Plan has ended must also be stated on the RF3. This should be agreed by a team leader/manager/supervisor as per section 5.2.

6.3 If the Risk Management Plan is still valid, this must be noted on the recovery plan review with new timescales for action stated. The original RF3 documentation must never be amended.

6.4 If the risk review indicates that there is need for a new risk management plan, a new RF3 must be completed and given a new reference number. The original RF3 documentation must never be amended.

Appendix 3

IN-PATIENT DRUG / ALCOHOL DETOXIFICATION

DEVON PARTNERSHIP NHS TRUST
DRUG & ALCOHOL SERVICES

IN-PATIENT DRUG / ALCOHOL DETOXIFICATION

Description of Modality

This ICP applies only to inpatient episodes which are care planned by tier 3 services. It does not include unplanned admissions; admissions co-ordinated by any other health or social care team; or where withdrawals are managed whilst the patient is an inpatient for treatment of another condition.

Detoxification can be from one or more CNS depressants (opiates, benzodiazepines, alcohol) or CNS stimulants (amphetamines, cocaine).

The following forms of inpatient treatment are most commonly provided:

- Withdrawal from prescribed or street opiates either via reducing prescribing regimens of opiates (eg buprenorphine) or by using ameliorative medication (eg lofexidine)
- Withdrawal from alcohol using reducing prescribing regimens of benzodiazepines
- Withdrawal from benzodiazepines using reducing prescribing regimens
- Symptomatic treatment for stimulant withdrawal.
- Stabilisation on or titration to an effective dose of medication.

Initiation of prescribing of drugs used in relapse prevention may be undertaken following detoxification as part of a care planned intervention.

Other health care interventions may occur during the inpatient stay as part of addressing the holistic needs of the client (e.g. offer appropriate tests for hepatitis B and C and HIV with informed consent, provide hepatitis B prophylaxis where indicated.)

These interventions will take place within Broadreach House

Broadreach House provides an inpatient setting that offers 24 hour medical and nursing care, to meet the needs of individuals who require this level of intervention.

Eligibility Criteria

Alcohol

Inpatient alcohol detoxification will be considered for service users if they meet any of the following criteria:

- Drink over 30 units of alcohol per day
- Have a score of more than 30 on the SADQ
- Have a history of epilepsy, or experience of withdrawal-related seizures or delirium tremors during previous assisted withdrawal programmes
  - Need concurrent withdrawal from alcohol and benzodiazepines
  - Regularly drink between 15 and 20 units of alcohol per day and have:
    - Significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease*) or
• A significant learning disability or cognitive impairment.
• Have identified risk management issues which indicate a need for inpatient treatment

**Drug**

Inpatient drug detoxification will be considered for service users if they meet any of the following criteria:

• They have not benefited from previous formal community-based detoxification
• The service user is experiencing significant comorbid physical or mental health problems
• If there is concurrent use of opiates, benzodiazepines or alcohol
• They are experiencing significant social problems that will limit the benefit of a community-based detoxification.

Residential detoxification may also be considered for people who have less severe levels of opioid dependence, for example those early in their drug-using career.

**Exclusion Criteria**

Broadreach will not admit:

• Perpetrators of Sexual Abuse
• Individuals with unstable epilepsy
• Those with Liver failure
• Individuals who are presenting with jaundice
• Referrals will be considered on a case by case basis
• The decision to admit an individual who is significantly physically unwell will rest with the Broadreach service. Clinical staff should consider liaising with the individuals GP where the person they are working with has significant health problems

**Admission Times and duration of treatment**

• Clients will be admitted to Broadreach House on either a Monday Tuesday or Wednesday. They will be informed of the confirmed date and time in advance of the admission
• The length of admission will vary depending upon the assessed needs of the service user. It is anticipated that this will be between 7-14 days

**Cost to Individual using this service**

• This intervention is free to residents of Torbay. However individuals may be required to make their own arrangements to travel to and from Broadreach. This is dependent upon what benefits if any the individuals receives. If in paid employment then the individual will be required to pay the costs of their transport to Broadreach.

**Overview of Process**
This is a recovery coordinated and planned intervention. Consideration of the appropriateness of an in-patient detoxification should occur at any point during the individual’s presentation to the drug and alcohol services treatment and recovery system in Torbay.

The individual may decide that they wish to be considered for detoxification or alternatively this may initially be discussed with the service user during 1:1 recovery planning sessions.

The service users Recovery coordinator should initially discuss the suitability of the individual for an in-patient admission at the services clinical team meeting, Alternative options should be considered to include a community based intervention provided in individuals own home or in supportive accommodation where available (Jatis)

If the clinical team are in support of the planned intervention and the individual meets eligibility criteria then the service user will be asked to complete an application form with the support of their recovery worker.

The recovery worker will make the identified clinical lead within the Shrublands Service aware of these plans and proposed application

The recovery worker will be required to email the application including information obtained from GP, copies of risk assessment and any mental health or pain management assessments to the Shrublands clinical lead to review. (Please see attached assessment documents required)

Referrals will only be considered if preparation work with the service user can clearly be evidenced and that a clear post detox plan is identified and in place to support the individuals longer term abstinence from drugs / alcohol.

If all the paperwork is in place and evidence of preparation and post detox planning is provided then the application will be forwarded to Broadreach for consideration.

Broadreach will review the assessment documentation and will contact the individual’s recovery worker to book an assessment within one week of have received the completed assessment documentation.

The assessment with Broadreach will be facilitated by the individual service user’s recovery coordinator. The assessment will either be via Skype or via telephone

Following this assessment the recovery coordinator will be informed by Broadreach house within 48 hours of the outcome of the assessment. If admission is agreed then a date for the admission will be booked.

If the admission is declined information will be sought by the recovery coordinator on the reasons for this decision and this will then need to be discussed with clinical lead /NMP / consultant so that an alternative plan can be developed.

If date of admission is agreed then recovery coordinator will need to develop a travel plan with the service user.
The service user will be required to complete worksheets provided by Broadreach and to take these with them on their admission date.

A Travel warrant and taxi can be booked for individuals who are receiving benefits via the Shrublands Administrator on 01803 291129. If the individual is in paid employment then they will need to make and pay for their own travel arrangements with the support of their recovery worker.

On admission the recovery coordinator will need to update the electronic case management system (HALO) regarding the inpatient modality which is a tier 4 intervention.

The recovery worker / coordinator will be responsible for cancelling any community prescribing interventions following the normal notification process

The Recovery Coordinator will also be responsible for liaising with staff at Broadreach during the admission in relation to progress and discharge arrangements for the service user.

Due to the risks of relapse and reduced opiate tolerance following detoxification service users should be provided with information about these risks both verbally and in writing.

In the event of the service user failing to attend the planned admission, further work will need to be undertaken with them prior to any further consideration or offer of a new admission date.

**Recovery Planning**

The recovery plan and work undertaken prior to admission with the service user should include:

- Practical Pre-admission Preparation: (e.g. childcare, booking time off work)
- Psychological Pre-admission Preparation: (e.g. anticipating cognitive & emotional reactions to withdrawal in the case of detoxification)
- Aftercare / Post-detox Preparation: Tie in with any residential placement or subsequent prescribing intervention.
- Relapse Awareness plan that identifies triggers (internal, external, situational), coping with cravings.
- A Timetable of actions after discharge.
- Ensuring that a contingency plan is in place in respect of any self - discharge or disciplinary discharge. This should focus on reducing the risks associated with any potential return to drug or alcohol use following a period of abstinence, and arranging a formal review / re-assessment.

**Admission to Broadreach**

- The service user will be expected to arrive on time for their planned admission. On arrival a member of the Broadreach staff will orientate them to the ward environment/routine and a service user agreement will be completed.
- The service user will be prescribed medication to mitigate and manage any withdrawal process from drugs / alcohol.
• Monitoring of objective withdrawal symptoms will be undertaken by Broadreach staff.
• The service user will be required to attend 1:1 counselling sessions as well as a group work programme during their admission to Broadreach

Planned Discharge Process

• The service user will be discharged at the end of the intervention by the Broadreach service. Broadreach staff will be required to communicate the individuals travel plans to the community recovery worker.
• Broadreach will provide the recovery worker with a Counselling and Medical Report.
• The recovery worker will arrange to see the service user at the earliest possible opportunity post discharge from Broadreach to arrange and implement / action the post discharge relapse prevention plan.

Unplanned Discharge Process

• In some instances the service user will be discharged prior to their planned discharge date. An example would be where the service user breaches their service user agreement due to illicit drug or alcohol use or verbal or physical aggression directed at Broadreach staff or other service users. Where criminal acts have taken place a decision will need to be made by Broadreach staff as to whether or not the police should be involved in investigating the incident.
• Broadreach will be required to notify the recovery coordinator or in their absence the clinical lead for the service of this planned discharge.
• The individual’s recovery worker / coordinator will be required to make contact with the service user at the earliest opportunity to review their on-going treatment requirements and to provide harm reduction information.
• Clinical discussion at the community teams clinical team meeting should take place to review the reasons for the individuals discharge and any learning from this as well as actions to be undertaken with the individual.
• On rare occasions, clients may need to be transferred to the care of a Consultant Psychiatrist/Mental Health Team if there are concerns about their mental health. Close liaison with mental health services will then be required to formulate ongoing care plans.
• On rare occasions the service user’s physical health may deteriorate whilst undertaking detoxification and prompt admission to a general medical hospital.
• A service user may also make a decision to take their own discharge from the unit prior to the end of the intervention and against medical advice. The responsibility for arranging travel back to Torbay and paying for this will in this instance rest with the service user. Broadreach will be required to notify the community recovery coordinator of this decision and they will be responsible for arranging a timely appointment to review the service users on-going recovery needs. Harm reduction information should be provided to individual service users in these circumstances
• Should a service user not complete this modality a multi-disciplinary team discussion must take place prior to any further treatment intervention being provided

Completion of Modality
• The service user will be recovery co-ordinated and provided with regular appointment and support to implement the services users post detox plans.

Other services which Modality interfaces

• Recovery coordinated interventions
• Community prescribing
• Community rehabilitation programme
• Wider recovery community support and engagement

Appendix 4: REHAB FLOWCHART
Request made for Residential Community Recovery Rehabilitation (Drug and/or Alcohol)

At Open Access
Community Rehabilitation Coordinator allocated as keyworker

At recovery coordinator session

Referral to Prep for Community Recovery Model group programme
Community Rehabilitation Coordinator / Group Facilitator to deliver Prep group work programme (4 Week Programme with 2 sessions per week)

2 Weeks prior to completion of Prep Group
Community Rehab Coordinator reviews progress and service user intention for engaging in the community recovery programme.

If service user wants to pursue residential community programme allocate to community rehabilitation coordinator

If service user chooses not to pursue this programme continue in structured community treatment

Upon completion of prep group work programme community rehabilitation coordinator supports service user to move into Jatis

Service user engages in the 15 week residential community recovery programme supported by the community rehabilitation coordinator and Jatis

After care plan to be developed jointly with service user, the community rehabilitation coordinator and resettlement worker (2 weeks prior to completion of main programme)

Service user moves into move on accommodation and is supported by resettlement worker.

Final review completed by community rehabilitation coordinator (4 weeks after completion of main programme.

Discharge

Next scheduled review date of this protocol: December 2018
References


16 Drugscope (2011). Bottling it up: The next generation The effects of parental alcohol misuse on children and families
