CARE-PLANNING & CARE-COORDINATION

Care Planning and Care Co-ordination are the processes by which people with drug and alcohol related difficulties will be helped in an integrated and systematic way to deal with and overcome these difficulties. Care Planning reaches across the continuum of care and helping provision and will promote systematic working across boundaries between agencies and workers.

The overarching principle of Care Planning and Care Co-ordination is that those who enter into structured drug and alcohol treatment services receive a written care plan which is agreed with the client and is subject to regular review with the Key Worker or Care Co-ordinator. People with drug or alcohol problems who meet the criteria for Care Co-ordination should have access to a named person who acts as their Care Co-ordinator to ensure that the care provided by different services or individuals is co-ordinated by one person to provide a comprehensive and integrated approach.

Care Planning and Care Co-ordination should not be seen as a bureaucratic burden. They represent an essential step towards empowering service users to fully participate in their care and place certain basic information physically in their hands.

Treatment may be provided by a range of professionals and from more than one service at the same time or consecutively.

The aims of Care Planning and Care Co-ordination are to:

a) Develop, manage and review the documented care plan.

b) Ensure that people with drug and alcohol misuse problems have access to a comprehensive range of services across the whole treatment and helping system.

c) Ensure the co-ordination of care across all agencies involved with the service user.

d) Ensure continuity of care and that service users are followed throughout their contact with the treatment system.

e) Ensure that specific risks which are identified in assessment are adequately managed through the Care Plan, and that any new risks are properly evaluated and care plans modified accordingly.

f) Maximise the retention of service users within the treatment system and to minimise the risk of people losing contact with the treatment and care services.

g) Re-engage clients who have dropped out of the treatment system.

h) Avoid duplication of assessment and interventions.

i) Prevent clients falling between services.

CARE-PLANNING

A Care Plan is a structured, often multi-disciplinary and task orientated individual Care Pathway Plan, which details the essential steps in the care of a person with drug or alcohol problems, and describes the main focus of treatment and care. The Care Plan involves the translation of the needs, strengths and risks identified by the assessment into a service response. It is used as a tool to monitor any changes in the service users situation and to keep other relevant professionals aware of these changes. In order to be effective, the service user must be fully engaged throughout the assessment and care planning process and be actively involved in the formulation of the care plan. A Care Plan should:

a) Set the goals of treatment and milestones to be achieved (taking into account the service users views and goals).

b) Indicate the interventions, plans and which agency and professional is responsible for carrying out these interventions (these interventions should always be negotiated with those they name).

c) Make explicit references to Risk Management and identify the risk management plan and contingency plans.

d) Identify information sharing (what information will be given to other professional/agencies and under which circumstances).

e) Where an individual has been difficult to engage in treatment and rehabilitation, the plan should identify a plan for promoting and enhancing their engagement.

f) Identity their review date (the date of the next review meeting should be set and recorded at each meeting).

g) Identify circumstances where other reviews may be necessary.

h) Reflect the cultural and ethnic background of the service user, as well as their gender and sexuality.

A Care Plan should be reviewed and evaluated at regular intervals, and at the request of the service user, their carer or a member of the care team. The date of the next review meeting is set and recorded at each meeting.

REVIEWING CARE PLANS

The following should be assessed when reviewing the Care Plan:

a) The relevance of the plan as it stands.

b) Its effectiveness and outcomes.

c) Any unmet needs.

d) Client satisfaction with care received.

CARE PLANS FOR PEOPLE WITH LESS COMPLEX NEEDS

People with less complex needs may not meet the national criteria for standard Care Co-ordination or enhanced Care Co-ordination. Good practice suggests that all service users receiving Tier 2 services (see DoH Models of Care document) should as a minimum have a written care plan and named Key Worker. Identifying features of people with such lower priority needs are that they:

a) Require support or intervention from only one agency or discipline or require a low level of support.

b) Are relatively stable.

c) Pose little danger to themselves or others.

d) Are likely to maintain appropriate contact with services.

CARE-COORDINATION

Care Co-ordination is the process by which the care plan is brought into being, and supports the service user as they progress along the care pathway. It can have a therapeutic value of its own, enabling and empowering the service user through the direct provision of help and support, monitoring progress and continuing a dialogue with the service user to ensure they achieve the desired most effective outcome. The process will always be one of partnership with the service user.

CO-ORDINATION OF CARE

For Service Users of "Type 1 and 3" Services *(see Section A4,* page 13*).*

Where a service user's needs or risks are not of a complexity to require referral onwards to statutory agencies and comprehensive assessments, they will none the less have packages of care provided according to a Care Plan and co-ordinated by a Key Worker.

CRITERIA FOR CARE CO-ORDINATION

Where an individual passes through the Care Pathway to comprehensive assessment, it is almost certain that they will fall within the qualifying criteria for the Care Programme Approach and therefore be entitled to Care Co-ordination.

ROLE OF THE CARE CO-ORDINATOR

The Care Co-ordinator will be a named professional who will engage with the service user, and support them through the duration of their care plan. Central to the successful fulfilment of this is retaining service users in the service by supporting, motivating and helping solve problems.

The Care Co-ordinator will organise the care and services identified in the Care Plan across social care and other agencies.

The Care Co-ordinator will monitor the progress of the Care Plan by collating information from agencies and individuals who provide particular elements of a Care Plan. This will involve keeping the Care Plan under continuous review, holding regular routine review meetings, and arranging other review meetings where there are significant changes in the client's circumstances or other events.

The Care Co-ordinator should act as a communicator between the service user and those providing elements of the care plan to ensure the appropriate passage of relevant information on progress and developments. They should also draw together relevant information and convene case reviews where developments warrant it, and at regular intervals.