

Addiction Care Abroad

This document outlines the process to access to Tier 4 residential addiction services, and includes:

1. Introduction
2. The Four Tier Model
3. Pathway for publicly funded access to Tier 4
4. Criteria/Suitability for Tier 4 Services
5. Comprehensive Assessment for Residential Treatment
6. Pathway for publicly funded access to Tier 4 residential addiction services
7. Reimbursement process
8. Reimbursement Rates – Addiction Service Long Stay Detoxification in a Hospital Setting.

Please note this section should be read as a guide and not intended as a definitive description. Service structure and delivery may change from time to time and it is the responsibility of the applicant and his/her referring doctor to ensure compliance with public patient pathways in order to qualify for reimbursement under the terms of the Cross Border Directive.

1. INTRODUCTION

In general addiction services as provided in Ireland are referred to in terms of tier one, tier two, tier three and tier four. The Four-Tier Model of Care implies that clients should be offered the least intensive intervention appropriate to their need when they present for treatment initially. Where lower tier levels of care have not been successful, more intensive interventions should be offered.

A key element of the services user's rehabilitation (including treatment and aftercare) is the assurance that an integrated approach will be taken in the provision of services across HSE and all other statutory and voluntary sectors. To facilitate this all services involved with a service user's rehabilitative care plan and pathway are required to adhere to overarching governance standards with inter-agency feedback and accountability mechanism, as outlined in the National Drugs Rehabilitation Framework (2010).

An integrated model of rehabilitation supports requires a wide range of components. Depending on complexity of need a service user may require support in one, some or all of the following areas (Figure 1). These supports are provided by a range of statutory, voluntary and community service providers.

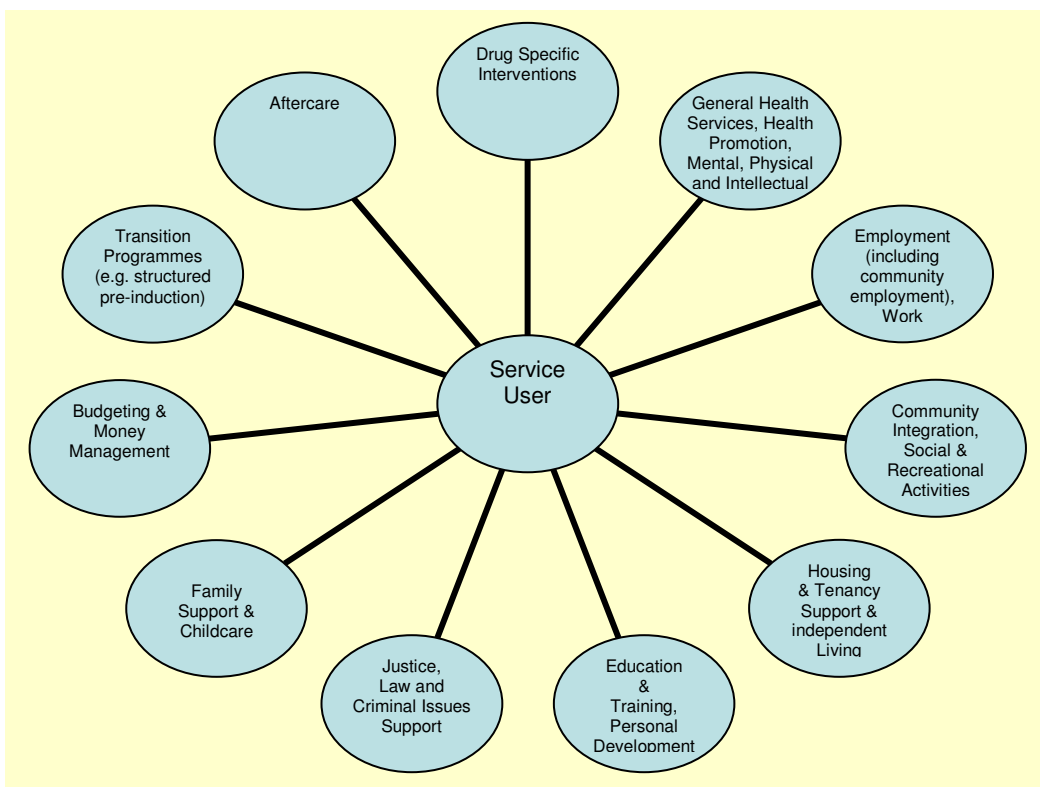
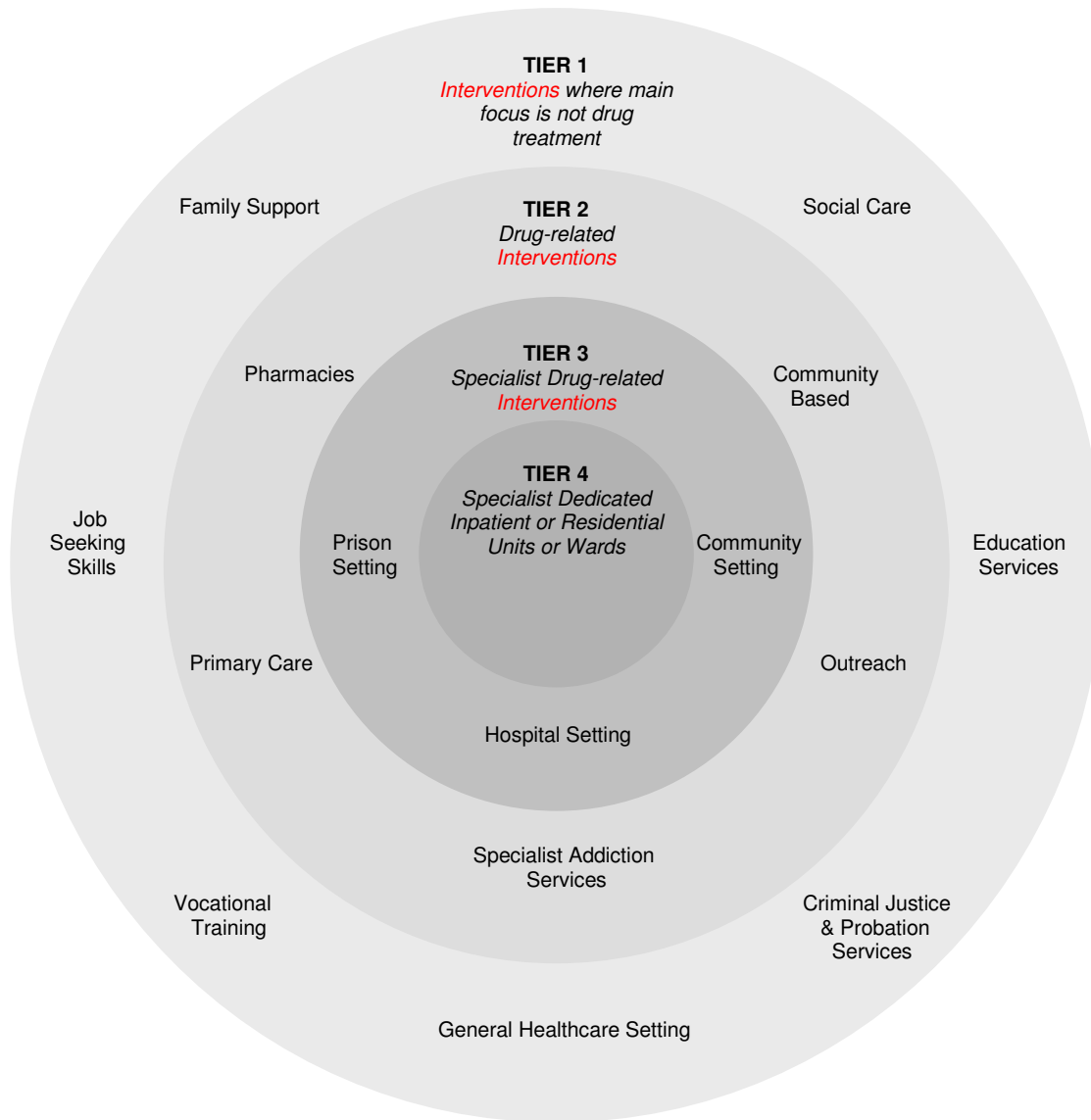


Figure 1: The range of supports required for an effective, integrated model of rehabilitation, National Drugs Rehabilitation Framework (2010).

2. THE FOUR TIER MODEL¹

As noted in the introduction, the four tier model of care acts as the overarching framework for the provision of rehabilitation pathways.² Briefly, these tiered *interventions* are described as follows:³



¹ National Drugs Rehabilitation Framework (2010:12,13)

² The use of the Four Tier Model was recommended in the Report of the HSE Working Group on Residential treatment and Rehabilitation (Substance Abuse) and suggested by the Department of Community, Rural and Gaeltacht Affairs. Report of the Working Group on Drugs Rehabilitation (2007)

³ Taken from *Models of Care for Drug Service Provision* (2004).

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

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

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

Tier 4 interventions are provided by specialised and dedicated inpatient or residential units or wards, which provide inpatient detoxification (IPD) or assisted withdrawal and/or stabilisation. Some service users will require inpatient treatment in general psychiatric wards. Acute hospital provision with specialist “addiction” support will be needed for those with complex needs e.g. pregnancy, liver and HIV-related problems. Others will need IPD linked to residential rehabilitation units to ensure seamless care. “Step-down”⁴ or halfway house accommodation may be required to be made available away from the individual’s area of residence and drug-using networks.

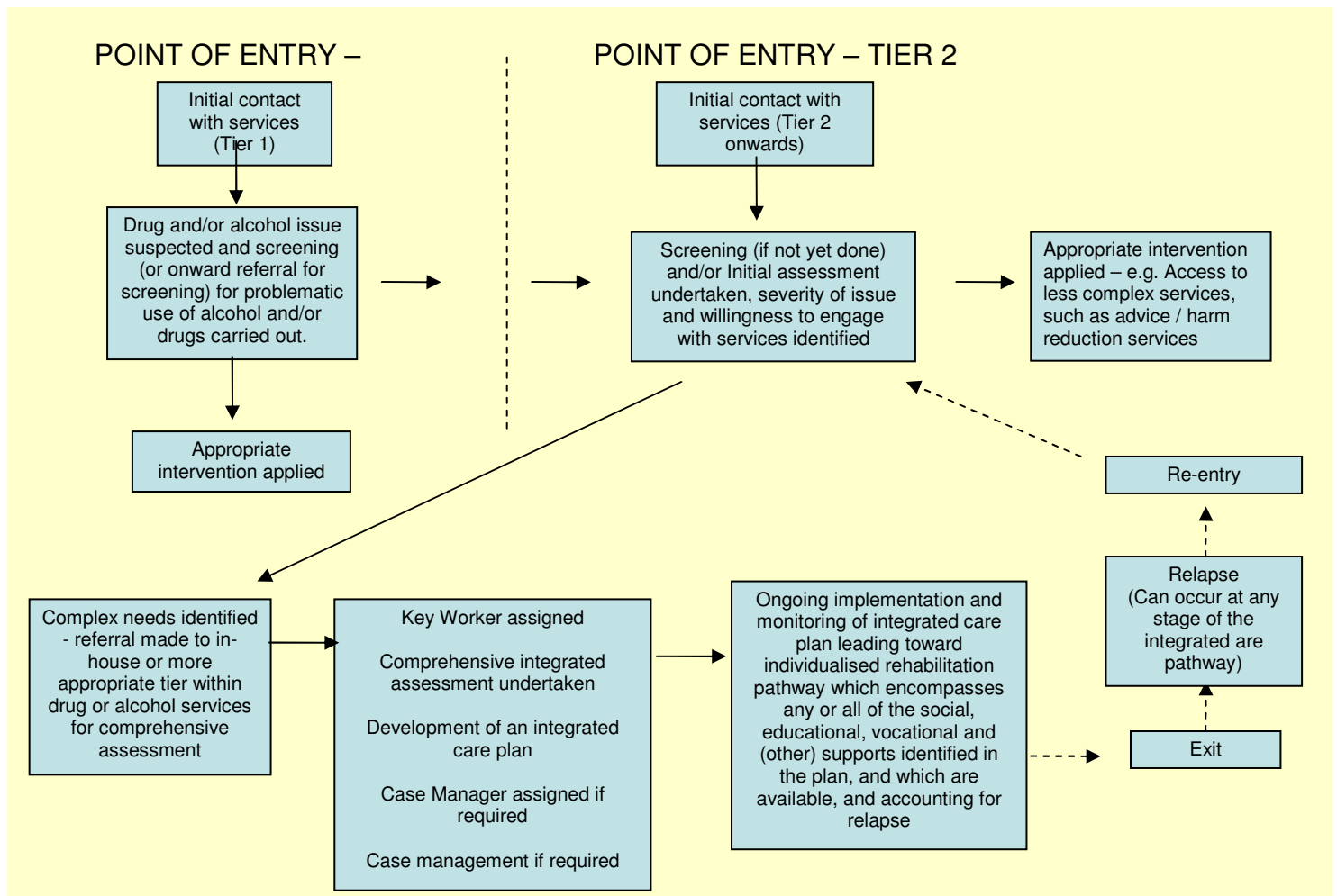
The effective provision of facilities and services requires not only the availability of both existing and additional resources, but also the development of appropriate strategies for the planning, management, financing, implementation and co-ordination of these facilities and services. This will ensure best fit and value for money.

⁴ Included as a Tier 4 intervention when a service user accesses post inpatient detoxification programme/residential rehabilitation programme at Tier 4. It constitutes an aftercare intervention that fulfils the recommendation that accommodation should be accessed after leaving residential rehabilitation if required. It does not relate to stand alone “step down” or halfway houses but is clearly linked to Tier 4 services/residential rehabilitation services.

3. PATHWAY FOR PUBLICLY FUNDED ACCESS TO TIER 4

The following is a synopsis of the pathway process for publicly funded access to Tier 4 residential addiction services in Ireland. This pathway must be complied with to ensure the applicant qualifies for reimbursement under the Cross Border Directive.

The integrated care pathway for rehabilitation as outlined in the National Drugs Rehabilitation Framework (2010) is as follows:



Addressing the issue of drug/alcohol dependence is a complex matter. There can be a number of phases of need, or stages in the Continuum of Care, that must be addressed. Stabilisation, detoxification, counselling support/psychosocial interventions and rehabilitation needs should be assessed throughout the whole continuum.

Clients' needs vary and not all clients will need to avail of all aspects of a 4 tier system. Some clients can have all their needs met through accessing services at tiers 1, 2 and 3. However it is important to assess when a client needs to access a tier 4 service.⁵

⁵ National Protocols & Common Assessment Guidelines to Accompany the National Drugs Rehabilitation Framework, Nov. 2011.

4. CRITERIA/SUITABILITY FOR TIER 4 SERVICES⁶

The SCAN Consensus Report,⁷ The Report of the Working Group on Residential Treatment and Rehabilitation (Substance Abuse),⁸ and the MTC Review of Tier 4 HSE funded Residential Rehabilitation Services⁹ have outlined criteria for entry/referral to Tier 4 Services and include the following as well as others included by the Subgroup of NDRIC (Tier 4 Services):

Alcohol:

This is an overview detailing who would be suitable for Tier 4 services as well as specific groups of service users/those who are at risk, where a Tier 4 service is the recommended intervention.

- Identified need and preferred choice of the individual.
- Severe alcohol dependence.
- Risk of having severe alcohol withdrawals as based on previous symptoms or a recent history of high alcohol intake.
- At risk of *Delirium Tremens* or seizures.
- Those who do not live in an environment that supports an outpatient detoxification programme (homeless or living in hostels, or B&Bs, or homes where there are other alcohol and drug users).
- Concurrent medical disorders/acute physical illness that may complicate their management i.e.
 - Epilepsy
 - Confused or hallucinatory state
 - Acute physical illness
 - Wernicke's encephalopathy
 - Confusion, staggering gait
 - Uncontrolled eye movement
 - Coma, low BP, Hypothermia
 - Unexplained neurological signs
 - If injectable thiamine is required
- Concurrent Psychiatric disorders/ Acute Psychiatric Illness that may complicate their management, i.e.
 - Risk of suicide
 - Wernicke's encephalopathy
- Previous unsuccessful outpatient/home alcohol detoxification programmes.
- Where continuity of care is essential for preserving gains achieved in residential treatments i.e. "that transition from detoxification to residential rehabilitation and then to step-down accommodation be seamless" (Report of the HSE Working Group on Residential Treatment and Rehabilitation).
- To provide intensive psychological interventions to begin to equip alcohol users with the skills of managing their daily life and managing staying drug free (SCAN Consensus Report).
- "Greater social deterioration, less social stability and higher risk for relapse benefit more from residential treatment. (Models of Care for treating alcohol Misusers)

Opioids and Other Drugs:

Higher completion rates for inpatient detoxification programmes compared to outpatient detoxification programmes are seen for this group (50% and 77% completion rate vs. 20% completion rate; 81% vs 17% completed withdrawal programme compared to outpatient treatment in the Maudsley Hospital Study, Gossop et. al. 1986).

This is an overview detailing who would be suitable for Tier 4 services as well as specific groups of service users/those who are at risk, where a Tier 4 service is the recommended intervention:

- Identified need and preferred choice of the individual.
- Individuals who do not live in an environment that supports an outpatient detoxification programme (i.e. homeless, or living in hostels, or B&Bs, or homes where there are other alcohol and drug users, isolation or lack of family support)
- Individuals who have failed an outpatient withdrawal programme or outpatient rehabilitation programme.
- Those who have complex needs, i.e. co-morbid psychological/psychiatric ill health; dual diagnosis, and requiring assessment and treatment of co-morbid disorders.

⁶ See Appendix 2, National Protocols & Common Assessment Guidelines to Accompany the National Drugs Rehabilitation Framework, Nov. 2011

⁷ The SCAN Consensus Report. Inpatient treatment of Drug and Alcohol misusers in the National Health Services (2006).

⁸ The Report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Abuse), HSE, 2007

⁹ Growing Potential Monalee, Training and Consultancy. MTC Review of Tier 4 HSE Funded Residential Rehabilitation Services, HSE internal Report (Unpublished)

- Severity of dependence and dependence on more than one drug or alcohol, chaotic drug use requiring stabilisation of drug use, detoxification programmes, a break from drug use, in depth assessment and treatment of physical or psychiatric health needs.
- History of complications during previous withdrawal programmes.
- Where treatment is required for medical and social reasons (Day: Opiate detoxification in an inpatient setting, 2005)
- Medical reasons: physical complications, i.e. cardiac conditions associated with cocaine.
- Pregnant women: stabilisation programmes, titration up of substitution treatment, detoxification programmes when appropriate.
- Stable patients: need to consider inpatient treatment as there is a higher completion rate of a detoxification programme in an inpatient setting compared to an outpatient setting (Day: Opiate detoxification in an inpatient setting, 2005).
- Those with less severe dependence and particular early in their drug/alcohol using careers (SCAN Consensus report).
- Where continuity of care is essential for preserving gains achieved in residential treatments i.e. “that transition from detoxification to residential rehabilitation and then to step-down accommodation be seamless” (Report of the HSE Working Group on Residential Treatment and Rehabilitation).
- To provide intensive psychological interventions to begin to equip drug users with the skills of managing their daily life and managing staying drug free (SCAN Consensus Report).
- “Greater social deterioration, less social stability and higher risk for relapse benefit more from residential treatment. (Models of Care for treating alcohol Misusers) (report of the Working group on Residential treatment + rehabilitation).

Additional Criteria specific to Residential Rehabilitation Treatment

Additional criteria include the following for placement in tier 4 residential rehabilitation services where an inpatient / outpatient detoxification programme is completed or not required:

- No capacity to remain clean and sober in a tier 3 setting
- No environment to sustain stability
- Lack of awareness of the consequences of addiction to self and others
- History of relapse
- A vulnerability which emerges when exploring psychological/life/historical issues
- Geographical reasons.

As well as identifying service users who are suitable for residential treatment and rehabilitation, it is also important to keep in mind that not all service users require or are suitable for residential treatment and rehabilitation.

5. COMPREHENSIVE ASSESSMENT FOR RESIDENTIAL TREATMENT

Assessment 1

This is based on the domains outlined in the ‘Comprehensive Assessment – Minimum Standard Guidance,’ see appendix 1 & 2. The assessment may be completed by a number of disciplines (multidisciplinary) all supporting the assessment and application for residential treatment. i.e. medical assessment, psychiatric assessment, counselling assessment, assessment by Rehabilitation Integration Officers/ Service, assessment by key worker/case manager, etc.

Assessment will also need to consider:

- “Criteria” for Residential Treatment as outlined above.
- Level/type of residential treatment required as per ASAM Guidelines (level III/IV).¹⁰
- Assessment of severity of problems and level of function.

An example assessment and care plan for use is at appendix 3.

Assessment 2

This is made by the staff in the Residential Unit. Assessments follow the domains as outlined in the “Comprehensive Assessment” but assessment also ensures that criteria are fulfilled as outlined by the specific residential unit.

Assessments in the Residential Units will further ensure:¹¹

- Assessment of substance use through self report and through use of other subjective and objective measurements / laboratory investigations.
- Assessment of physical health: past history, current medications, current health assessment, physical health examinations, investigations and treatment required/care plan.
 - Physical health assessments may be repeated during a person’s stay in residential treatment. More specialist health assessments will need to be arranged for specific groups i.e. elderly, pregnant women, individuals with liver disease and blood borne virus infections. Regular liaison with primary care teams and acute medical services will be required and appointments made for assessment and follow-up care arranged.
- Assessment of mental health.
 - Assessment and treatment of co-morbid psychological and psychiatric needs throughout residential treatment.
- Assessment of level of function and severity/ complexity of difficulties.
- Assessment of neuropsychological needs and cognitive functions.
- Assessment of level of daily living skills and coping skills.
- Assessment of type of psychological interventions required to meet individual needs and skills required to be developed.
- Family tree assessment and assessment of family needs and involvement.
- Assessment of ongoing educational/training needs.
- Assessment of ongoing accommodation needs.
- Assessment of aftercare plan and supports/agencies required.

¹⁰ Mee-Lee D., Shulman GD., Fishman M., Gastfriend DR., Griffith JH (2001) ASAM Patient Placement Criteria for the treatment of Substance Related Disorders. Second Edition Revised (ASAM PPC-2R) Chevy Chase MD: American Society of Addiction Medicine. Inc.

¹¹ SCAN Consensus Report

6. PATHWAY FOR PUBLICLY FUNDED ACCESS TO TIER 4 RESIDENTIAL ADDICTION SERVICES

As outlined in the integrated care pathway for rehabilitation above, the patient will have:

- Undertaken a screening and/or Initial assessment, severity of issue and identified a willingness to engage with services.
- Complex needs will have been identified, and a referral made to in-house or more appropriate tier within drug or alcohol services for comprehensive assessment.

For a GP referral to an addiction services provider:

- A GP may in consultation and agreement with the patient make a referral to an addiction services provider.
- The GP referral for inpatient detoxification services must be based on a comprehensive assessment as detailed above (see appendix 2).
- The comprehensive assessment and care plan is forwarded to a consultant psychiatrist of choice by the GP.
- The patient must attend the consultant psychiatrist in person. The reimbursement rate for this outpatient attendance is a maximum of €130 and is subject to production of proof of travel if same is availed of abroad under the Cross Border Directive.
- The consultant provides a medical report on the assessment to the GP and the patient.
- If the consultant recommends inpatient detoxification for the patient the patient may use that medical report to:
 - Seek inclusion on the inpatient detoxification waiting list (if one exists in the patient's area – some areas do not have waiting lists)
 - Decide to return to the facility abroad for the inpatient detoxification programme.
- If the patient decides to access the inpatient detoxification programme abroad he/she should complete the prior authorisation application form in conjunction with the consultant psychiatrist abroad. The form is available via the following link:
http://www.hse.ie/eng/services/list/1/schemes/cbd/appreimbursement/CBD_Application_Form.pdf and submit same with the medical report and a comprehensive care plan to the National Contact Point, Cross Border Directive Office, St. Canice's Hospital Complex, Dublin Road, Kilkenny.
- The application form will be assessed and a decision given on prior authorisation as soon as possible with a target turnaround time of 20 working days. An application can only be processed when the documentation submitted is complete and any clarifications sought have been provided. The HSE reserves the right to seek comprehensive details of how the service abroad intends to interact with the other relevant services in Ireland e.g. Dept of Social Protection, Housing Authorities, Probation Services, etc and require same to be detailed in the care plan.
- In preparation for discharge, an interagency care plan meeting should be held. The general purpose of which is to support service user involvement, review progress and ensure clarity in relation to the interagency care plan and to foster a coordinated approach among agencies, ensuring sufficient supports and reducing duplication (see protocol 4 National Drugs Rehabilitation Framework, 2011).

7. REIMBURSEMENT PROCESS

- When the patient's episode of inpatient detoxification care is complete and the patient is being discharged the patient should ensure the private facility completes the pro-forma invoice which is available at the following link:
http://www.hse.ie/eng/services/list/1/schemes/cbd/appreimbursement/CBD_PRO_FORMA_INVOICE.pdf
- To claim reimbursement the patient submits:
 - Proof of travel.
 - Completed pro-forma invoice.
 - Original invoice and receipt of full payment from the facility abroad.
 - A copy of the patient's individual rehabilitation plan for the post discharge period.
 - A copy of the discharge record to the referring Irish GP.
- The HSE reserves the right to withhold the reimbursement pending the confirmation of the post discharge rehabilitation plan is being implemented and overseen by the facility abroad.
- Please note when claiming reimbursement the patient is required to complete a HSE vendor form so that the reimbursement can be made directly into the patient's bank account. Under no circumstances will the HSE make a payment to any third party including an advocate for the purposes of a reimbursement under the provisions of the Cross Border Directive.
- Please note that admittance to inpatient detoxification services may impact any Dept of Social Protection payment the patient may be receiving. It is the responsibility of the patient in conjunction with the service provider abroad to interact with the Dept of Social Protection in order to comply with Dept of Social Protection rules.

8. REIMBURSEMENT RATES – ADDICTION SERVICE LONG STAY DETOXIFICATION IN A HOSPITAL SETTING.

Reimbursement Rates – Addiction Service Long Stay Detoxification in a Hospital Setting.

Service Description	Episode of Care	Rate	Comment
Inpatient detoxification in a Category 1 type Hospital (teaching Hospital)	Long stay (to a maximum of 12 weeks inpatient detoxification)	As per HIPE ready recknor available on the CBD website: http://www.hse.ie/eng/services/list/1/schemes/cbd/Ready%20Reckoner.pdf	A patient may only access this type of care once through GP referral. Any further requests for this type of care must be on the basis of assessment and referral by the HSE's addiction team for the patient's area of residence.
Inpatient detoxification (including 12 step programme)	Long stay (to a maximum of 12 weeks inpatient detoxification)	€8,130 (please note this type of inpatient care may have implications for Dept of Social Protection payments)	A patient may only access this type of care once through GP referral. Any further requests for this type of care must be on the basis of assessment and referral by the HSE's addiction team for the patient's area of residence.
Inpatient detoxification and rehabilitation	Long stay total 12 weeks maximum (12 weeks inclusive of initial 3 week detoxification)	€300 per night for 3 weeks = €6,300 plus 9 weeks continued rehabilitation €6,097.50 = a total of €12,397.50. (€8,130 ÷ 12 x 9 = €6,097.50)	A patient may only access this type of care once through GP referral. Any further requests for this type of care must be on the basis of assessment and referral by the HSE's addiction team for the patient's area of residence.
Inpatient rehabilitation	Long stay 8 weeks inpatient	€2,150 per week to a maximum of 8 weeks.	A patient may only access this type of care once through GP referral. Any further requests for this type of care must be on the basis of assessment and referral by the HSE's addiction team for the patient's area of residence.

The HSE does not cover gambling addiction under the terms of the CBD as gambling is not a health issue. However, where gambling is a secondary addiction to a primary addiction of alcohol or drugs it is expected the service provider will treat both addictions in tandem at no additional cost.

Appendix 1: National Drugs Rehabilitation Framework Protocol 2 Comprehensive assessment & developing an Interagency Care Plan¹²

Outcomes

- A. Completion of a comprehensive assessment addressing the wider needs of the service user.
- B. Development of an interagency care plan with all areas of identified need addressed and actions/interventions agreed between the service user and all service providers.
- C. The Case Manager in the lead agency is identified along with the key worker/point of contact in each service responsible for progressing each action and an agreed time-line.
- D. The interagency care plan is regularly reviewed and updated reflecting the current needs of the service user.

Key Processes

1. As the service user continues to engage with services following initial assessment, a comprehensive assessment should be undertaken as part of the process to developing an interagency care plan. An interagency care plan involves the service user and all existing and future services involved in their care, contributing to its development.
2. The interagency care plan will outline the interventions agreed, referrals required and timeframe outlined to review the intervention/issue/action identified.
3. If a comprehensive assessment has already been completed by another service, there may be some value in obtaining a copy which may be updated with the service user.
4. The key worker should obtain the service user's written agreement to share relevant information that the service user has provided in the comprehensive assessment for purposes of referral or making contact with other services for additional supports.
5. The comprehensive assessment should be carried out by a trained and competent person. Training levels and competencies to be determined by NDRIC.
6. The comprehensive assessment should be completed in line with the common assessment guidelines and a care plan developed with realistic goals and addressing the physical, psychological, social and legal needs identified.
7. An essential part of developing the interagency care plan is the involvement of services already working with the service user and with any new services identified to agree actions and timescales.
8. Any referral or interagency meeting at this stage should be carried out in line with the Referral Protocol or the Interagency Care Plan Meeting Protocol.
9. Criteria for determining the most appropriate lead agency, should include :
 - a. Intensity and regularity of contact with service user
 - b. Capacity of service provider
 - c. Client preference
10. The case manager is generally appointed from within the lead agency, but both positions may change over time, by agreement at the interagency care plan meetings, as progress of the interagency care plan goals is achieved.
11. The case manager assigned to the service user will manage and co-ordinate the implementation of the interagency care plan agreed among the services identified in the interagency care plan.
12. The case manager is responsible for monitoring and following up on referrals and general goals and responding to issues or blocks as these arise.
13. The case manager is responsible for ensuring the interagency care plan is reviewed with the service user at agreed intervals and updated as required.

¹² National Protocols & Common Assessment Guidelines to Accompany the National Drugs Rehabilitation Framework (2011: 8,9)

<p>Date of Assessment</p> <p>Core Demographic and Client Details</p> <ul style="list-style-type: none"> Name, Address, Contact number, DOB, Identification No., Ethnicity, Gender <p>Name, Address, Contact Number of GP</p> <ul style="list-style-type: none"> Medical Card/ Other <p>Name, Address, Contact Number of next of Kin</p> <p>Name, Address, Contact Number of referrer / referring agency</p> <p>Name, Address, Contact numbers of other agencies attending</p>
<p>Reasons for referral</p> <p>Presenting problems/ Complaints/</p> <ul style="list-style-type: none"> History of presenting problems/Complaints
<p>Current Drug and Alcohol use</p> <ul style="list-style-type: none"> Amount, frequency, mode of use, duration of use, age of 1st use Evidence of harmful use/ dependence Evidence of withdrawal symptoms/ intoxication Financial costs of use and means of financing use. Consequences of Alcohol/ drug use: Health, social, economic, legal
<p>Current Physical Health and symptoms/ Ill health/ disabilities</p>
<p>Current Mental Health / Psychological symptoms</p>
<p>Current assessment of risk behaviours</p>
<p>Current Medications Prescribed</p>
<p>Past History of Drug and Alcohol use:</p> <ul style="list-style-type: none"> Age of 1st use, Progression of use Age of 1st injecting History of Overdoses
<p>Past treatments for Drug and Alcohol Use</p> <ul style="list-style-type: none"> Places of Treatment/ Type of Treatment

¹³ National Protocols & Common Assessment Guidelines to Accompany the National Drugs Rehabilitation Framework (2011:25-27)

<p>Past Medical History</p> <ul style="list-style-type: none"> • Past viral testing and results • Vaccination History • Past Operations/illnesses/diseases
<p>Past Psychiatric History /Past Mental Health Issues</p> <ul style="list-style-type: none"> • Diagnosis, Treatment, Consultant and Service attended • Any episodes of Deliberate Self Harm
<p>Family History/ Family Structure/ Supports</p> <ul style="list-style-type: none"> • Any Family History of Addiction or mental health problems
<p>Personal History:</p> <ul style="list-style-type: none"> • School, Education, Problems in school • Highest educational level achieved • Courses / training schemes • Employment history / Current employment status
<p>Social History / Social Functioning.</p> <ul style="list-style-type: none"> • Accommodation • Living arrangements • Children • Relationships with partner / spouse/ family/ friends • Hobbies/ Activities/ Social outlets / Supports • Spiritual and Religious matters • Cultural and Ethnic factors. • Financial Situation and benefits received/ Medical Card
<p>Criminal History /Legal Issues</p> <ul style="list-style-type: none"> • Past charges, conviction, prison sentences • Current charges, court cases, convictions • Probation Officer/ Solicitor
<p>Assessment of Motivation and Readiness to change</p>
<p>Assessment of Goals:</p> <ul style="list-style-type: none"> • Service user's goals and their own assessment of need.
<p>Formulation/ Diagnosis/ Assessment of Needs</p>

Care Plan/ Management Plan

- Biological Markers: Urinalysis, bloods, physical examination if appropriate
- Referrals to others / other agencies to support identified needs
- Interventions required: Biological, Psychological, Social, Rehabilitation
- Residential treatment / treatment in the community
- Identification of unmet need / service deficit.