Access to Rehab Flowchart

NHS Greater Glasgow and Clyde

West Dunbartonshire Council

West Dunbartonshire Health & Social Care Partnership

Rehab Discussion with Care Manager/ Patient /Client

Work Through "Am I ready for Rehab Workbook"

Complete Checklist in Workbook

In depth discussion about "Readiness" for Rehab

NO

Review at a later date by agreeing goals through Care plan

YES

Further Discussions with Care Manager, Patient, Medic & Psychiatrist (if required)

All in agreement

NO

Yes

Update ASA,Craft & Chronology of any significant events

Identify needs through Care Plan. These should be immediate needs i.e. Physical,Mental,Health,Anger Management, Trauma or other significant needs.

Look at Rehab Options

Discuss Residential Rehab provider options

Evidence of previous/current community supports-stat/non stat services

Evidence of motivation/engagement

Prep Stage - Care manager needs to work in partnership to support patient/client to ensure they are adequately prepared & motivated to engage in this treatment option.

Care Manager to link in with preferred provider & patient/client engagement must also be evident.

It is essential that a clear focus is directed towards this in partnership with the client/patient. Key preparatory work may help and improve treatment engagement, retention, effectiveness and improve outcomes.

SBAR must be completed & aftercare careplan.Both submitted for consideration @panel

Discussions should include but not inclusive of below:

- **Evidence of current/ previous engagement with community services either statutory or non-statutory**
- **Detox (if required) or stabilisation -is Kershaw an option?**
- **Learning from previous experiences of Rehab**
- **What a residential rehab programme entail**
- **Any Outstanding criminal justice issues**
- **Ensuring relevant stat/non-statutory partners are informed that the Patient/Client may be accessing residential rehab**
- **General health and wellbeing**
- **Whole family discussions**
- **Finance and any outstanding debt, what individual contributions are?**
- **Housing needs**
- **Transport**
- **After care**
- **Recovery Capital**

Aftercare

Housing Needs

Wider Recovery Communities

A particular emphasis should be placed on aftercare. It is essential this is embedded within the Care Plan & assists the patient/client in maintaining and sustaining their recovery. If applicable, discussion should take place with commissioned service providers to ensure continuum of care post residential Rehab.

Any Housing needs should be fully identified & discussions taken place with housing providers within the area prior to the planned departure. This will ensure patients/clients can transition into settled accommodation after leaving Rehab.

Linkages with the wider recovery communities should be identified within the area that can help to maintain & sustain recovery. This will ensure links into wider Recovery Orientated Systems of Care(ROSC).

Once all of the above is completed you can put your Patient/Client`s name forward to your NTL/SSW & Joanne Reilly. A date will then be offered by the decision making panel. The Patient/Client will be asked if they wish to attend and be accompanied by an advocate on an appointment basis. The panel consists of - Operational Manager, Lead Clinician, Consultant Psychiatrist, Care Manager, NTL & SSW.

Decision

NO

The decision making panel will provide rationale & recommendations

YES

Care Manager to approach preferred Residential Rehab provider for assessment.