

Virtual Care in Alcohol and Other Drugs

Treatment Practice Guide

For services providing alcohol and other drug
(AOD) care



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The Drug and Alcohol Allied Health Leads

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The Nursing & Midwifery Community of Practice AOD

Assumptions and Definitions

Where this Practice Guide sits within the broader picture

The Virtual Care in Alcohol and Other Drugs Treatment Practice Guide (Guide) is delivered within the broader [NSW Virtual Care Strategy 2021-2026](#), which separately looks at improving access to internet data, improving videoconferencing capability, and other considerations that enhance access to care.

This Guide complements the [Clinical Care Standards for Alcohol and Other Drug Treatment](#) including the 6 standards of care for AOD treatment, the Agency for Clinical Innovation [Virtual Care in Practice](#) Guide and the [Alcohol and Other Drugs Psychosocial Interventions Practice Guide](#).

As the system lead for Virtual Care, and as part of the implementation of the NSW Virtual Care Strategy, the Ministry of Health has established the [Virtual Care Connect](#) sharepoint page as a central repository for NSW Health personnel.

Virtual care is applicable to a range of AOD services and is a complementary service delivery mode for enabling virtual sessions within AOD treatment services, for example addiction medicine consultations, SMART Recovery sessions, AOD aftercare programs, outreach services working in rural settings, flexibility for clients with other commitments, enabling privacy for clients, check-ins between appointments, reducing cost of travel etc.

Who is this Guide for?

This Guide is for the use of clinicians and treatment services looking to enhance access to treatment through virtual care, where it is safe to do so and where there may be limited resources to provide in-person treatment, particularly in rural and regional areas of NSW.

This Guide can be applied to a range of AOD treatment models to help embed virtual care delivery as part of business-as-usual.¹

Assumptions

This Guide assumes that clinicians and other care providers delivering virtual care are employed and appropriately qualified to deliver alcohol and other drug treatment in Australia and are practising within their required legal and regulatory frameworks and scope of practice.

Key Definitions

Term	Definition
Carer	'Carer' is used to cover carers, friends, family members, chosen family, network of support or any person supporting the client.
Client	Client refers to any person accessing treatment.
Clinician	Clinician refers to any care provider e.g., GPs, Allied Health, Peer Workers, Case Managers, AOD workers, AOD counsellors, Nurses, Staff Specialists, Aboriginal Health Workers.
Virtual Care	Virtual care is any service delivery by videoconferencing, telephone, remote monitoring, and data sharing and storage.

¹ The evidence base for the efficacy of virtual care for alcohol and other drug treatment is still forming. This Guide will be updated as new evidence arises.

Virtual Care Summary

NSW Health has defined virtual care as ‘any interaction between a person and clinician, or between clinicians, occurring remotely with the use of information technologies’.

Telehealth services are increasingly being referred to as virtual care, as it can be delivered by telephone, videoconferencing, remote monitoring, and asynchronous data (store and forward e.g., email). Any mode of delivery should be considered in the context of a person’s choice, access, individual situation, and benefits, considering clinical requirements.

“I believe that remote access to healthcare is essential. I have been the beneficiary of healthcare to address issues to do with drug use, that have been over the phone or through a video call that have been top class best practice healthcare.” –
AOD client experience

How virtual care supports AOD services

Virtual care is an important facilitator to care and at times may be the only access point to care, for example to those who live in rural and regional locations. No matter the mode of service delivery, the service priority is unchanged: to provide care when, where, and how people need.

Virtual care core objectives include:

- Safe, appropriate, and equitable access to care
- Positive person, carer, and family experience
- Positive clinician experience

Who can provide virtual care?

If you are a clinician who is qualified to deliver AOD treatment in-person, you are also able to deliver the same care virtually.

When to use virtual care

Clinicians and clients should discuss whether virtual care is a suitable option and consider:

- clinical appropriateness
- access to suitable devices and reliable internet

- access to an appropriate and private location
- confidence and knowledge using online technology
- client safety e.g., domestic violence risk
- client preference.

A client’s treatment journey is not linear and therefore virtual care might not always remain the safest or preferred treatment delivery mode for your client. Virtual care needs to be continuously assessed throughout treatment and at times a routine in-person treatment mode may be required.

Virtual care delivery tools

There are a range of virtual delivery tools that are available. Discuss the preferred tools for your service with your [district virtual care manager](#) or service manager/supervisor prior to commencement of virtual care.

Consider priority populations

You can ensure equitable access for priority populations, by assessing individual needs and identifying access facilitators and addressing barriers, for example:

- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse (CALD) communities
- People with disabilities (physical/cognitive)
- People experiencing homelessness
- People with low literacy

This is a non-exhaustive list. See suggestions on ways to [support priority populations](#).

A positive virtual care experience is influenced by several factors e.g., access to safe spaces, adequate internet data, access to a suitable device, and these may change. As a care provider you should routinely assess your client’s individual needs.

Services should ensure equitable access to virtual care, through ongoing work with priority populations on service models and solutions that address access barriers.

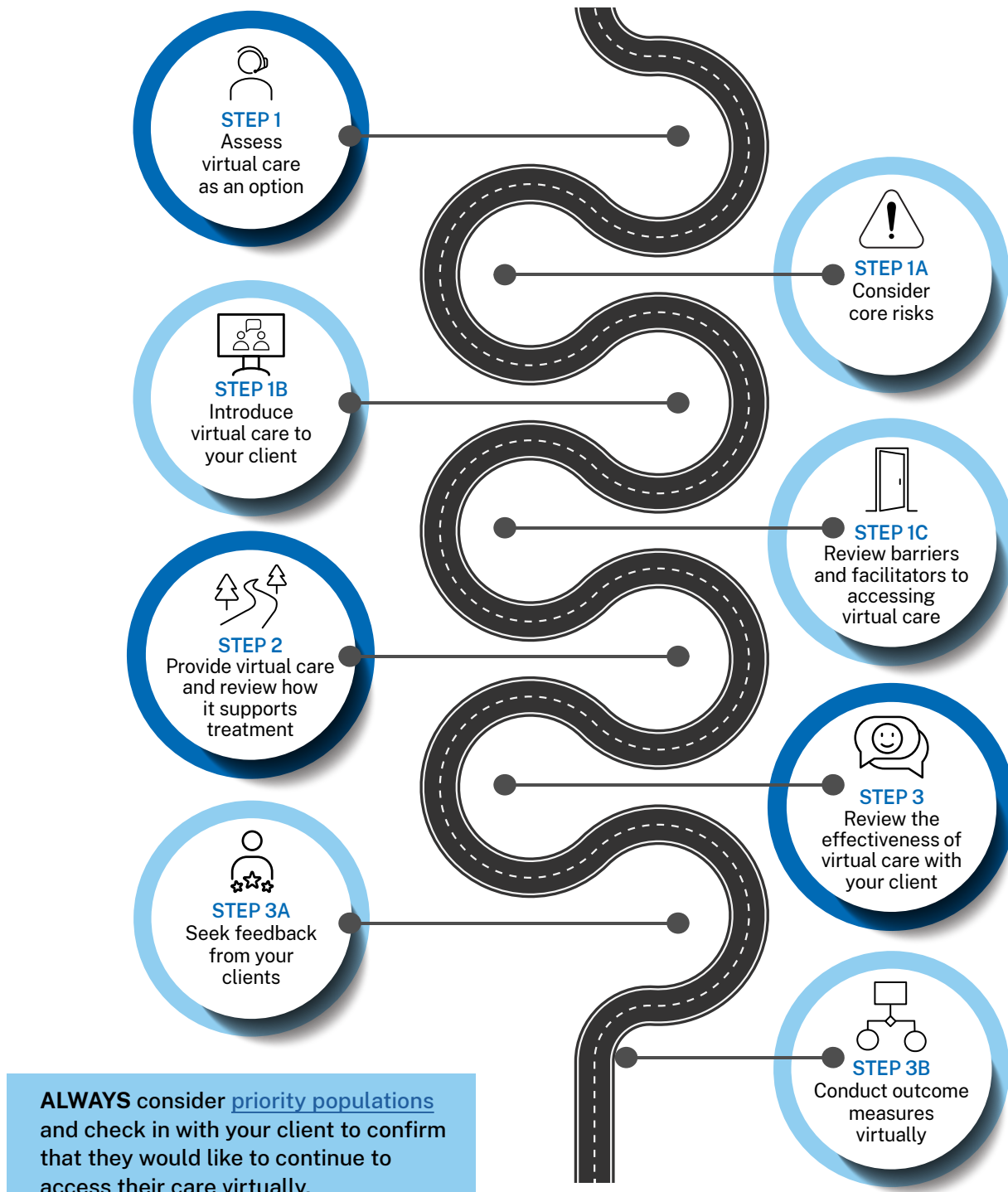
Consider partnerships and creative solutions to increase virtual care access

Practical ideas to addressing barriers could be developing working agreements with community and health centres, other services, libraries, and private business who could provide private spaces and access to computers for appointments. Some telecommunication providers also have schemes available to supply laptops, data etc.

Governance within virtual care

The use of virtual care to deliver AOD treatment should align with the principles of the [Clinical Care Standards for Alcohol and Other Drug Treatment](#) and the [Alcohol and Other Drugs Psychosocial Interventions Practice Guide](#). Clinical care standards, policies, guidelines, and directives that apply to in-person appointments for AOD treatment also apply to virtual care, regardless of the modality and location of care. Any mode of delivery offered, including virtual modalities, need to meet the safety, privacy, and security standards.

The collaborative virtual care decision-making journey



Principles of Virtual Care Delivery in AOD Services

Principles of care applicable to all services

“All clients should have the opportunity to make informed decisions about their care. Following assessment, all appropriate options for treatment should be discussed, and agreement with the client is made on the proposed care plan. This requires a discussion and examination of the range of available treatment options, their relative advantages, and disadvantages, including known evidence regarding safety and effectiveness. This is fundamental to informed decision-making in health care”.²

The [principles of virtual care](#) have been developed to complement existing clinical principles and models of care. These principles will support those developing or redesigning a model of care to provide high-quality, person-centred care that is digitally enabled.

Types of virtual care

AOD care will mostly use telephone and video-conferencing when delivering care virtually. You as the care provider and your client together will determine which mode is appropriate to meet individual and treatment goals.

Further information on [telephone](#) and [videoconferencing](#) is available on [Virtual Care in practice](#).

The Agency for Clinical Innovation (ACI) have developed ‘[Spotlight on Virtual Care](#)’ sharing examples of good practice clinical care and learnings on providing virtual care in NSW.

EXAMPLE The ACI in partnership with St Vincent’s Hospital Network (SVHN) and Murrumbidgee LHD have developed the ‘[Spotlight on virtual care: Alcohol and Drug Telehealth Service](#)’ Report.

The collaborative virtual care decision making journey

Virtual care options can form part of the treatment journey and facilitate tailored treatment delivery that meets individual, and lifestyle needs. Virtual care can also provide access to treatment and support that would otherwise not be accessible.

Care delivery modes can be changed at any time, based on the client’s needs, preferences, and clinical appropriateness. Hybrid care may be an option, using a combination of virtual (audio and video) and in-person appointments, to ensure safe and appropriate care while reducing barriers in accessing care.

This section outlines the pathway you, as the clinician can take when assessing, offering, and providing virtual care to clients.

Note – This section is a guide only and you will need to ensure all individual, clinical, and service considerations are factored into the decision-making journey.



STEP 1: Assessing virtual care as an option

Before offering virtual care to your client, assess potential benefits and risks for your client. If you identify risk factors that might impact on the client’s capacity to engage in virtual care safely, consult with your service/team. Determine if virtual care is safe to provide, and how virtual care could be facilitated – consider protective factors and collaborative opportunities with other services.

“Virtual care has been so easy to use, and I have been pleasantly surprised by how well my patients have taken to it” – Addiction Medicine Specialist

Note – Assess each client individually.

² NSW Health Clinical Care Standards, Alcohol and Other Drug Treatment, May 2020.



STEP 1A: Consider core risks

Core risks should be continuously assessed for all clients receiving drug and alcohol treatment, as per the Clinical Care Standards, [Standard 4](#). Core risks include domestic violence, child wellbeing, overdose, complicated withdrawal history, recent release from hospital or correctional facility, risk of harm to self or others and risk of homelessness or eviction.

Increased vulnerability and risk to experiences of violence, abuse, and neglect,³ including domestic and family violence has been identified within drug and alcohol treatment services.

If core risks are identified, clinical judgement is required to identify if virtual care is appropriate. Have a protocol in place for when it is identified that the client is at risk of self-harm, suicide, overdose, medical emergency, child protection concerns or witnessing violence, where access to clinical supervision, critical incident debriefing and line management direction, would be required.

NSW Health's Domestic Violence Routine Screening (DVRS) Program and virtual care

NSW Health alcohol and other drug services are mandated to undertake domestic violence routine screening with women aged 16 years and over accessing their services. Virtual care should not be used to conduct a domestic violence routine screening due to risk of the perpetrator being present or potential monitoring of devices. For NSW Health services the [Domestic Violence Routine Screening \(DVRS\) policy directive](#) [PD2023_009] expressly requires DVRS is conducted in-person only.

Clinicians should consider:

- If an in-person appointment can be arranged to conduct the domestic violence (DV) routine screen prior to commencing virtual care.
- When an initial in-person appointment cannot be facilitated with the AOD clinician:
 - Consider collaboration with other services working with the client who may be able to conduct the in-person screening and with the client's consent share the results with the AOD clinician. This may include a GP, pharmacotherapy clinic, needle and syringe program or legal service.

- Consider if safe virtual care can still be provided without conducting a DV routine screen. Noting that you should specify within the Drug and Alcohol Assessment Form that the routine screening was not able to be completed. Where there is a disclosure of domestic violence via virtual care, clinicians should acknowledge the disclosure and check with the client whether it is safe to talk further about their experiences.

Information on providing virtual care when domestic violence risk has been identified, is available within the [Appendix](#).

Note – At the earliest safe opportunity, a clinician should conduct an in-person domestic violence routine screen.

Resource – Further guidance on how to respond to disclosures is available through the [Violence, Abuse and Neglect and Telehealth](#) page.



STEP 1B: Introducing virtual care to your client

If virtual care is assessed as safe to provide for your client, introduce the option of virtual care to your client early in their treatment journey.

Some ways that you might choose to introduce virtual care to your client may include:

- Asking if your client has heard of virtual care and if they are familiar with how to access it. Explain different options for virtual care as appropriate.
- Outline some of the benefits virtual care could provide to your client and answer any questions they might have about its impacts on their treatment journey.
- Explore any concerns the client may have regarding virtual care and their preference for treatment modality.

It may be helpful to communicate these key messages to your client:

- Virtual care is just one option for your treatment, we can decide together when and how often we use it, if at all and can stop using it at any time.
- Virtual care will only be used when it is safe to do so.
- Before a virtual care appointment, you will be given information about how to connect, what to expect and how to get help.

³ Violence abuse and neglect is an umbrella term for child abuse and neglect, domestic and family violence, and sexual assault.

- Some virtual care appointments will use a portion of your internet data. For example, a 30-minute video call will use approximately 160MB of your data, which is comparable to a Facebook Messenger video call or a Facetime video call.

Resource – NSW Health resource for patients, carers, families and the community: [‘Virtual Care in NSW – for patients, carers, families and the community’](#)



STEP 1C: Review barriers and facilitators to accessing virtual care

The following considerations should be assessed for any potential barriers and facilitators to support access to virtual care:⁴

Potential barriers	Possible facilitators
Physical assessment is required.	Arrange for a local clinician to perform an in-person physical assessment during a virtual care consult. If client is geographically restricted from accessing a clinician, a home assessment may be facilitated with support person conducting assessment under clinician instruction.
Client inability to participate in virtual care such as physical, mental, social, and cognitive barriers.	Invite a support person to attend appointments with the client.
Inability of client to access a safe and private location at home to receive care virtually.	Suggest or help arrange for the client to access appointment from a local clinic or facility or a friend/family's place. Ensuring that client confidentiality, privacy and emotional safety are not compromised.
Appointments not attended by client.	Identify primary reasons for client non-attendance and implement facilitators e.g., scheduling appointments when school-aged children are at school.
Lack of clinician knowledge and capability in virtual technology.	Access necessary training and resources prior to commencing virtual care delivery, noting differences in training needs when delivering care via telephone vs. videoconferencing.
Ability of client to access appropriate device, software, and internet.	Provision of data and device packs, use of local facilities such as a library, GP clinics or Aboriginal Medical Service.



STEP 2: Provide virtual care and review how it supports treatment

Explore your client's preferences and individual needs. The following should be considered with your client:

- Virtual care can support AOD programs where in-person care is not available, such as, state-wide aftercare programs may require delivery solely via virtual care modalities.
- Preference to participate in a virtual care appointment.
- Availability and access to a suitable device e.g., videoconferencing units/systems or a personal device capable of videoconferencing.
- Availability and access to reliable internet connection, including internet or mobile data quota/allowance.
- Escalation protocols during a virtual appointment e.g., emergency escalation requiring 000 to be called if medical/mental health concerns arise. The client should be aware of and have consented to these protocols, prior to accessing virtual care.

Virtual care supports integrated care and can function as a connector between different services along a person's treatment journey. It can support transfer of care through 'warm referrals' by enabling the next service to participate on a virtual care appointment to assist care transfer.

The client's experience of participating in virtual care can increase their ability and confidence to access other types of virtual supports. Examples such as self-help groups like SMART Recovery and/or family drug support groups.

⁴ Virtual care in practice, March 2021 Agency for Clinical Innovation https://aci.health.nsw.gov.au/_data/assets/pdf_file/0004/651208/virtual-care-in-practice.pdf

“Practically all my contact with my prescriber is over the phone... I don’t lose work hours. The quality of appointment has been better as the doctor asks questions and listens to what I’m saying.”
– AOD client experience accessing virtual care.

Care facilitation for rural and regional NSW based clients

In rural and regional NSW, availability of specialist AOD staff often does not meet the demand for treatment. Traditionally, fly-in-fly-out models have been used to support filling these treatment gaps, however this is costly. Virtual care is an option to provide access to specialist care in a sustainable model for rural and regional clients.

Virtual care can increase the reach of AOD treatment and provides an effective mode of service delivery. Opportunities to increase access to virtual care can include exploring linkages with services who may be able to provide access to devices or data plans for virtual care.



STEP 3: Review the effectiveness of virtual care with your client

It is important when delivering care, virtually or in-person, that you can develop a positive therapeutic connection with your client.

Regularly checking in with your client to review the effectiveness and ongoing appropriateness of the delivery mode can assist.

There are several indicators that you can consider when reviewing effectiveness:

Clients’ attendance to virtual care appointments:

- If your client is frequently unable to attend appointments, discuss reasons for this and whether any changes to arrangements are required.

Clients’ engagement with their virtual appointment:

- If a client is not actively participating in the virtual care appointment this may be an indicator that the use of virtual care requires review.

Practice considerations:

- Review if the camera is regularly on or off during video appointments, and if this is affecting ability to review and support the client.
- If children or other household members are often entering the room with the client unexpectedly. Consider the impact on appointment disruption, or children/other household members becoming privy to the therapeutic conversation and any safety risks associated with this.
- Local clinicians becoming inadvertently privy to conversations between the client and the virtual care clinician.

Clinician providing virtual care from home:

- A clinician looking to provide virtual care from home, will need to ensure that the effectiveness of the virtual appointment is not negatively impacted by the clinician working from home, ensuring:
 - Prior discussion and approval from the Service Manager of the arrangement and intention to provide virtual care from home.
 - That clinical notes are not handwritten, using a secure and private room, and using a headset to ensure client privacy. Ensure access to a private space without disruption, to support effective virtual care.

Additionally, there are several indicators that may show that virtual care might be a more effective service modality for your client’s treatment, e.g., clients’ frequent non-attendance to in-person appointments.

Resources – Available on Virtual Care Central – [Guide to successful consultation](#) and [having difficult conversations virtually](#)

‘I find very little difference now between over-the-screen and face-to-face in achieving satisfying consultations and none of my patients have requested an appointment with a face-to-face doctor after our virtual care consultation!’ –
Addiction Medicine Specialist



STEP 3A: Seek feedback from your clients

Client experience of service is an important measure of success within virtual care and a key component of delivering value-based healthcare. Surveys are effective at enabling de-identified feedback and can be embedded into virtual technology to be provided to clients automatically following each appointment.

However, services should consider:

- client anonymity
- available feedback mechanisms
- risk of survey fatigue

Regularly ask your client how they are finding virtual care and if there were any aspects they would change. Peer workers can play a key role in the feedback mechanism and may draw out more direct and honest perspectives from clients.

Some example questions include:

- Now that you have accessed virtual care several times, how would you rate out of 5, how easy the technology is to use? (0 being very difficult and 5 being very easy)
- How comfortable are you finding being openly able to talk with me via virtual technology out of 5? (0 being very uncomfortable and 5 being very comfortable)
- Do you experience any difficulties around hearing me/sound quality via virtual care?
- Is there anything else you might want to add or say?

An example [virtual care client survey](#) is available in the appendix and can be adapted as per your service needs.

Following feedback from clients it is important to review and evaluate any opportunities for service improvement. This can be done either individually with your client or at the service level to use feedback to improve service delivery.



STEP 3B: Conducting outcome measures virtually

During treatment it is important to routinely conduct outcome measures, to monitor a client's progress.

There are a range of AOD outcome measures available for use and several which have been validated for use virtually, including the Australian Treatment Outcomes Profile (ATOP). Contact your local service to confirm which outcome measure is preferred and if it is validated for use virtually.

When conducting an outcome measure assessment which contains client reported outcomes, it may be beneficial to share a virtual copy of the assessment with the client, who can then view the questions e.g., via email or the videoconferencing platform

Arrange an in-person assessment if the client requires a physical assessment as part of an outcome measures assessment. If this is not available, consider collaboration with other services that the client is attending in-person to conduct these assessments e.g., their GP.

Note: Documentation requirements for virtual care are the same as in-person care.

Supporting priority populations

Priority populations may require additional consideration when delivering virtual care to ensure that care is appropriate and safe. The following groups have been identified as priority populations within AOD services:

- Aboriginal and Torres Strait Islander people
- Rural and regionally located people
- People experiencing homelessness
- LGBTQI+ people
- Young people
- Pregnant women
- People with mental health concerns
- People who identify as culturally and linguistically diverse (CALD)
- People who have had contact with the criminal justice system
- Older people
- People with disabilities

Supporting priority populations to access and benefit from virtual care

Consider individual needs of priority populations to ensure safe and appropriate care. Some suggestions are to:

Involve support people where needed:

- Providing opportunity for a family member or significant other to attend virtual appointments with the client if the client requests it.
- Connecting the client with local Peer Workers and / or Aboriginal Health Workers to receive support during virtual appointments.
- Ensuring care is [integrated and trauma informed](#).

Support secure access (e.g. internet and facilities) for:

- Supporting clients to access a private environment and appropriate devices, with consideration to being aware of cyber security risks, e.g., when accessing a public device. This may include the local hospital or community health centre, educational facility, community facilities such as a library, local Aboriginal Medical Service or other Aboriginal or non-government organisations.
- Providing support with virtual technologies to build skills and confidence. Providing simple guides on accessing virtual care, with easy-to-read formats with rights and responsibilities.
- Supporting access to virtual care through assistive technologies and NDIS.

Link in with other relevant services:

- Linkages to other services such as the Substance Use in Pregnancy and Parenting Services, mental health services, youth services etc.
- Understanding history of incarceration may impact on the client's comfortability and level of trust in speaking openly.
- Exploring linkages with the client's local GP clinic, Aboriginal Medical Service or other Aboriginal organisations providing services, to support the client.

Consider diverse individual needs:

- Be mindful of capacity for people who are neurodiverse to read and understand body language during virtual care appointments.
- Ensuring cultural safety through awareness of role and influence of family and community in level of disclosure regarding the use of substances. Review the [Aboriginal Cultural Activities Policy](#) and [Communicating Positively: A guide to appropriate Aboriginal Terminology](#) for more information.
- Access virtual [translator/interpreter services](#) for culturally and linguistically diverse (CALD) communities

What to consider when providing virtual care

Clinician responsibilities

When providing care virtually, clinicians are to follow all relevant frameworks, processes, and service regulations within their local service. There are several key considerations that clinicians must consider when deciding to use virtual care, to ensure safe, person centred, and effective care.⁵

Resource – Further information is available through the Agency for Clinical Innovation [Virtual Care in Practice Guide](#).

Administrative considerations

- Ensure you are using the relevant service type for the care being provided, in the Activity Reporting section of the Drug and Alcohol clinical note (please see the [appendix](#) for definitions):
 - Audio – clinician end
 - Audio-visual – patient end with clinician
 - Audio-visual – clinician end
- Inform your client if another clinician is joining as part of continuity of care e.g., clinician joining from another device.
- Ensure consent forms and documentation refers to virtual care modalities.
- Documentation requirements are the same as in-person care, with all required documentation captured securely in the client record system used by your service, noting the client provided consent to virtual care modality.

Clinical considerations

- Follow local service procedures and guidelines for missed appointments, concerns around the client's presentation or changes in their demeanor. This includes assessing the level of risk and responding appropriately to ensure client safety.

- Assess appropriateness for treatment via virtual care and communicate with your respective team to use virtual care modality and consider safety mechanisms, as needed.
- Ensure continuity of care by providing ongoing treatment, this may include assessing effectiveness and feasibility of virtual care if risks/concerns/issues arise and communicate these concerns with your client.
- If the client is receiving opioid dependence treatment, ensure that any requirements for a physical in person assessment may be facilitated, e.g., by a local clinician
- Ensure clients' cases are presented regularly at local AOD service case review meetings and escalate risks or concerns in a timely manner with relevant personnel.
- Have a safety protocol in place for when a virtual care appointment ceases unexpectedly e.g., technology failure, or assessment of changing client needs during appointment.
- Client experience of AOD treatment, including apprehension, personal beliefs about data security, skills and knowledge level of using internet platforms, convenience, and comfort.
- Consider using virtual care modes for transfer of care appointments, involving the client, current clinician and the new service provider being referred onto.
- Follow your local service procedures and guidelines around setting clinical expectations with your client. This may include requiring your client to agree to a Virtual Care Shared Rights and Responsibilities.

⁵ Virtual care in practice, March 2024, Agency for Clinical Innovation
<https://aci.health.nsw.gov.au/virtual-care-in-practice>

Some virtual specific requirements you may place into a Virtual Care Shared Rights and Responsibilities may include:

- I will access virtual appointments from a safe space or discuss alternative options with the clinician at the earliest available time, including rescheduling appointments until a safe space can be organised.
- I am aware that I am unable to record my virtual appointments without consent from all participants.
- I understand that at times I may be required to attend an in-person appointment for any physical assessments that cannot be completed virtually.
- I understand that if I don't attend a virtual appointment without advising the clinic, that the clinic will attempt to contact me in the first instance, followed by contacting my emergency contact (*note - it is important to explain why this would occur and to document any exceptions*).
- I agree to have my camera on during video appointments.
- I am aware that if I feel unsafe at any time during my virtual appointment that I am to communicate this as soon as possible to my clinician, without compromising my safety.
- I agree not to include other participants in a virtual appointment without informing my clinician.
- I am aware that the appointment will be included in my medical record, as per usual process.
- I agree to not consume substances during virtual appointments.

Your service will most likely have a Treatment Agreement available, which you can discuss with your service to modify to consider virtual aspects of treatment.

Environmental considerations for clinicians

- Select a quiet and private environment with minimal background noise. The use of headsets can assist. Virtual appointments should not be conducted in shared office spaces.
- Maintain a professional appearance and note that patterned clothing and poor lighting can affect image quality during video consultation.
- Ensure the camera captures all participants in the room and use speaker tracking if available during videoconferencing.

Example Eye contact is an important social factor when connecting with your client; this can be difficult when delivering care virtually. There are several ways to improve your eye contact demonstrated in this [video](#).

Note – *Direct eye contact is not considered appropriate in some cultures, if unsure you should ask the client what communication practices are appropriate and safe and what are not.*

- Ensure confidential client information is not visible in the background when videoconferencing, such as caseload boards.

Note – The use of a virtual background is to be considered a last resort, as they can hamper rapport building, use additional data, and can lead to missing important information about the client.

- Advise the client to attend virtual care appointments from a safe place. A virtual appointment should not proceed until a safe place is established for the client.

Example A client attending a virtual care appointment whilst on a public train may not be an acceptable safe place. Headspace have developed client focused information on [setting up a safe space at home to talk with your counsellor](#).

Equipment considerations

- Ensure that the virtual care appointment is scheduled using an approved [NSW Health platform](#) that meets the clinical needs of your local service.
- Ensure equipment meets clinical requirements and meets the technical requirements for videoconferencing including internet connectivity, hardware, and a software solution.
- Ensure virtual care equipment is secure, such as phones, laptops, and data storage devices. This includes ensuring devices, firewalls, and virtual private networks (VPNs) are updated with the latest security patches.

How and when to move between service modes of delivery

The importance of communication

Communication is imperative throughout the clinician–client relationship to ensure care is person centred. Decisions around changing modalities of service delivery at any stage of the treatment journey, must be made in consultation with your client. If virtual care is identified as no longer appropriate, you should discuss alternative service delivery modes with your client.

You should inform clients that at any time they can change their mind about how they access care, providing the mode they choose is appropriate.

Ceasing use of virtual care – during an active virtual care appointment

There may be times when an active virtual appointment needs to stop. For example, client needing in-person care such as a medical emergency or technology failures. In these situations, follow your local service procedure. During these events clearly communicate to your client the need to change their service delivery mode and what they can expect next.

Setting up a protocol with your client at the start of the virtual care journey for these situations is important. This may include collecting your client's emergency contact details and seeking their consent on the protocol to be followed.

Example Informing the client, “if I can't get in contact with you after 3 attempts in 5 minutes, we will contact your emergency contact”.

Ceasing use of virtual care – during the treatment journey

Throughout the use of virtual care, you may determine that the use of virtual care is no longer appropriate or clinically safe and will seek to cease its use. Protocols need to be in place to ensure cessation does not compromise your client's treatment.

Your client may also decide that virtual care no longer fits their needs and preferences. When this occurs, you should discuss with your client if a modification is required to the use of virtual care or if they would prefer to access care in-person.

Escalation and Risk Management

Prior to conducting a virtual care appointment

Prior to conducting a virtual care appointment ensure you have familiarity with your local services risk management processes. Situations resulting in deterioration of the appointment will require similar management approaches to in-person appointments.

In addition to your local management approaches, there are several virtual specific management processes available to support the appointment. These may include, ensuring local clinicians are available for clients at high risk of an adverse outcome or using videoconferencing over phone-based appointments to monitor body language.

During an active virtual care appointment

In the event of a high-risk situation occurring during the virtual care consult follow local service escalation procedures and protocols, including notification to your line manager. Escalation processes are to be followed in the event of deterioration, including processes available to clients and any carers also attending an appointment.

Whilst there are several risk management approaches available, it is important that the individual needs of each client are understood and supported as best as possible to reduce risk of an adverse outcome.

Ensuring safety and clinical governance in virtual care⁶

When implementing virtual care within an AOD service it is essential that governance processes are considered and in place prior to commencement of service delivery. Staff involved in providing virtual care should understand these arrangements and the roles and responsibilities that they have.

Governance

Core principles – governance and leadership

- Clinical governance of virtual care should support the delivery of safe and high-quality care to clients, just as with in-person appointments. Regular systems of clinical governance remain in place and may need to be adapted to be inclusive of virtual modes of service delivery, e.g., reporting of clinical incidents (via ims+ within NSW Health) and risk management processes.
- Clinicians should have access to any required medical and technical devices to provide high quality care. This can include utilisation of iDose devices and systems, which support accurate dosing of methadone and records within the electronic medication administration record.
- Clinicians must work in accordance with their services code of conduct and must protect information (including client information) from unauthorised access and misuse:
 - Appointments should always take place in a suitable and private environment. This applies at all points of connection.
 - Staff ensure that appropriate anti-viral and antimalware software is installed.
 - Ensure only approved hardware and software are used.

- [Clinical care standards](#), policies, guidelines and directives that apply to in-person appointments also apply to virtual care, regardless of the modality and location of care. Local policies need to be reviewed and adapted to integrate virtual care modalities.
- NSW Health clinicians delivering services to clients virtually should be supported by clinical guidance and systems that support the identification, management, and monitoring of risks to clients' safety, privacy, and confidentiality and to service integrity. This includes providing support to clinicians to recognise, assess and respond to the increased risk and vulnerability of people experiencing, or at risk of domestic and family violence, child abuse and neglect and sexual assault through the use of some virtual care modalities, e.g., virtual care in the home.
- Clinicians and support staff must be trained in using virtual care platforms and equipment. This includes development of appropriate virtual etiquette and support to adapt clinical practice and workflows.
- If sending client clinical information to a client email, ensure secure transfer platforms are used. For example, NSW Health is making changes to how unit record health data (for secondary purposes) is shared. Unit record data can only be shared via secure platforms, such as [Kiteworks](#).

Resource – The Agency for Clinical Innovation have developed an [Implementation Checklist](#) to support the adoption of virtual care alongside the comprehensive [Virtual Care Practice Guide](#) which can provide further detailed information on the use of virtual care.

⁶ Virtual care – Embedding safety in practice. Agency for Clinical Innovation
https://aci.health.nsw.gov.au/_data/assets/pdf_file/0020/651206/virtual-care-embedding-safety-in-practice.pdf

Recording and transcribing of virtual appointments – privacy policy

In general, virtual care appointments must follow the same privacy rules as in person appointments. Virtual appointments should not be recorded or transcribed unless exceptional clinical circumstances require it.

Agreement to participate in a virtual appointment does not qualify for consent to record or transcribe the appointment. Information provided to clients, such as a statement of Virtual Care Shared Rights and Responsibilities, should remind clients that virtual appointments are generally not to be recorded or transcribed by either the client or clinician. If recording or transcribing is required by the AOD service or client due to an exceptional clinical circumstance, the consent of the client and clinician must be obtained. Client and clinician consent may be written or verbal and must be documented in the client's health record.

There are currently no NSW Health endorsed or recommended artificial intelligence (AI) transcription services available for use. Consult with eHealth NSW prior to use of any AI technology, to identify any security risks.

Contact your services local privacy officer prior to any recording or transcribing of virtual appointments. A list of [LHD and SHN local Privacy Officers](#) is available. Any recordings and transcriptions should be managed in accordance with:

- the [Health Records and Privacy Information Act](#) (applicable to all)
- the [Surveillance Devices Act 2007](#) (applicable to clients and clinicians)
- the [State Records Act 1998](#) (applicable to NSW Health AOD services)
- the [NSW Health Privacy Manual for Health Information](#) (applicable to NSW Health organisations)

Any recording or transcription of a virtual appointment without documented consent may be in breach of the above legislation.

Storage of any recordings which capture personal or health information of clients must comply with the [State Records Act 1998](#) and the [Health Records and Information Privacy Act 2002](#). For further information on data storage requirements, see section 9 of the [Privacy Manual for Health Information](#).

Virtual modalities support staff confidence and collaborative care

Access to professional development and networks

Virtual modalities can support AOD clinician and worker education through the provision of peer learning, clinical supervision, and clinical support sessions. Clinical education is not always possible in-person due to time and availability.

Providing virtual education can facilitate cross-collaboration across the state and support clinicians access to specialist education sessions.

Access to other clinical staff during appointments

The use of virtual care can also enable clinicians to bring in other relevant clinicians, with the client's consent, during appointments. This can support collaborative care, through a multidisciplinary approach for the client, with clinicians located outside of the AOD clinicians' service.

Example – Virtual case conferencing with multiple service providers, enabling care planning for client and clear allocation of tasks for each clinician in attendance e.g., pregnancy family conferencing.

Resources

For clinicians

Agency for Clinical Innovation (ACI):

- [About Virtual Care](#)
- [Principles of virtual care](#)
- [Virtual Care in Practice](#)
- [Virtual care: Implementation checklist](#)
- [Virtual Care Central](#) note: login required.
- [Resources for clinicians and their patients](#)
- [Virtual Care videoconferencing platforms](#)

NSW Health

- [Virtual Care Connect](#) note: login required.
- [Establishing and Implementing Virtual Care Services Guide](#) note: login required.

Network of Alcohol and Other Drugs Agencies (NADA)

- [Remote supervision – Practice Tips](#)

Health Education Training Institute (HETI) (*NSW Health employees only*)

- [Introducing virtual care in consumer conversations](#). Course Code 487521515
- [Establish a confident telepresence in a virtual care environment](#). Course Code 487522974
- [Determining the suitability and appropriateness of virtual care with consumers](#). Course Code 533841511
- [Collaborating to conduct patient assessment with virtual support](#). Course Code 535007136

Mental Health Professionals Network

- [Telehealth: How to make it work](#)

Medical Board (Ahpra)

- [Telehealth consultations with patients](#) (Codes, Guidelines and Policies)

For clients

NSW Health

- [YourRoom](#)
- [Virtual care in NSW for patients, carers, families and the community](#)
- [How do I use virtual care?](#)

Agency for Clinical Innovation

- [Preparing for a virtual appointment](#)

Using technology safely

- [How to reduce the risk of technology-facilitated abuse](#) – eSafety Commissioner
- [Women's Technology Safety & Privacy Toolkit](#) – WESNET

Appendix

Providing care when domestic violence risk is identified

When assessing virtual care safety for your client, it is essential to plan for and continuously assess risk of domestic and family violence and other forms of violence, abuse, and neglect (VAN).

Where a woman discloses experiencing domestic (or family) violence either through the screening or other interactions, clinicians are to respond in line with the [Domestic Violence Routine Screening Policy Directive PD2023_009](#) or if outside the NSW Health system, respond in line with your organisations clinical practice guidelines.

Many services policies and procedures recommend in-person service provision over virtual care for clients currently experiencing VAN or if a clinician has concerns related to these issues. Rather than having a blanket exclusion, assess each individual situation to make a clinical determination.

Consider existing protective factors:

- Client is not currently living with the perpetrator (*not to be considered a sole protective factor*)
- Already receiving support from domestic and family violence or other VAN services and collaborating with these services where possible and beneficial.

- Have strategies/plans in place to access support safely, including access to a safe device, processes in place to erase internet history and having a code word to use if the client becomes unsafe during a virtual care session.
- Ensuring client experience of care is positive. Peer workers can support this by maintaining contact and safety and supporting confidence and skill development with virtual technology.
- Strategies to communicate safely whilst at home or in another safe place.

Further information is available on the [Violence, Abuse and Neglect and Telehealth](#) page and information of safety tips is available on [WesNet](#).

Clinicians may not know of the presence of violence, abuse and neglect when assessing for suitability for virtual care and therefore should familiarise themselves with the 'Responding to disclosures of people experiencing violence, abuse and neglect during telehealth consultations' section of the [Violence, Abuse and Neglect and Telehealth](#) page.

Definitions of service types for virtual care for Activity Reporting in Clinical Notes

Service Type	Definition and When to Use
Audio – clinician end	<ul style="list-style-type: none">• Method used by the individual service provider(s) to communicate with the client is telephone, or equivalent voice only technology. The two parties involved in the service are not located in the same physical area.• This category is to be reported by the service unit that is NOT based at same location as the client / patient (i.e. the remote consultant).
Audio-visual – patient end with clinician	<ul style="list-style-type: none">• The method used by the individual service provider(s) to communicate with the client is videoconference, videotelephony technology, or another video-based technology, where no less than two separate locations are using the technology.• This category is to be reported by the clinician / service unit that is based at same location as the client and that booked the videoconference facilities/room that the client used. Any clinician / service unit not based at the same location as the client/patient should use the appropriate 'clinician end' category.
Audio-visual – clinician end	<ul style="list-style-type: none">• The method used by the individual service provider(s) to communicate with the client is videoconference, videotelephony technology, or another video-based technology. The two parties involved in the service are not located in the same physical area.• This category is to be reported by the service unit that is NOT based at same location as the client (i.e. the remote consultant).

Alcohol and Other Drugs Virtual Care – Client Survey Example

Please complete this survey to let us know how your experience of virtual care for alcohol and other drug treatment was.

Your response will be anonymous with feedback used to improve the experience of virtual care for clients and to ensure that virtual care is meeting client needs.

This survey is optional.

Question 1

Please indicate how satisfied you are with your experience of virtual care/telehealth.



Question 2

Did you achieve the result you were hoping for from your most recent virtual care session?

- ☐ I achieved the result I wanted. (Go to Question 3)
- ☐ I somewhat achieved the result I wanted. (Go to Question 3)
- ☐ I did not achieve the result I wanted. (Go to Question 2.1)

Question 2.1

Please provide further information on why you feel you did not achieve the result you wanted today.

Question 3

Were you comfortable receiving treatment from the clinician via virtual care/telehealth as compared to in-person care?

- ☐ I felt more comfortable receiving treatment virtually from the clinician compared to in-person care.
- ☐ I felt as comfortable receiving treatment virtually from the clinician compared to in-person care.
- ☐ I did not feel comfortable receiving treatment virtually from the clinician and would prefer in-person care.
- ☐ I have not received in-person care.

Question 4

How effective do you feel virtual care will be for your treatment journey compared to in-person care alone?

- ☐ My experience of virtual care is more effective than in-person care
- ☐ My experience of virtual care is the same as in-person care
- ☐ My experience of virtual care is less effective than in-person care
- ☐ I have not received in-person care

Thank you for your feedback.