Model of Care
Involuntary Drug and Alcohol Treatment Program
NSW Health

Version 5
## Glossary and definition of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accredited Medical Practitioner (AMP)</td>
<td>An appropriately qualified medical professional, delegated by the Director General and NSW Health, and appropriately accredited to issue Dependency Certificates, under the <em>Drug and Alcohol Treatment Act (2007)</em>.</td>
</tr>
<tr>
<td>Involuntary Treatment Liaison Officer (ITLO)</td>
<td>A qualified professional, including qualified doctors or nurses who are trained, have at least five years experience of providing direct drug and alcohol patient care and skilled to assess and screen persons who may be eligible for a Dependency Certificate under the <em>Drug and Alcohol Treatment Act (2007)</em>. An ITLO conducts screening, triage and assessment to a standard of, and in liaison with, the Treatment Centre and AMPs to determine if the person should be recommended for referral for assessment by an AMP for a Dependency Certificate. Note: a medical practitioner must make the referral for assessment for a dependency certificate, if the ITLO is a medical practitioner, s/he may make a referral.</td>
</tr>
<tr>
<td>Referral Network</td>
<td>The Referral Network comprises medical practitioners, ITLOs and AMPs who work together to identify potential involuntary patients, screen and assess patients who may be referred to the IDAT Program.</td>
</tr>
<tr>
<td>Dependency Certificate (DC)</td>
<td>A certificate issued by an AMP following a final assessment of a referred person, which states that the person meets the eligibility criteria for the Involuntary Drug and Alcohol Treatment Program (IDAT Program) and may be detained for treatment under the <em>Drug and Alcohol Treatment Act (2007)</em>.</td>
</tr>
<tr>
<td>Dependent Person (DP)</td>
<td>A person who is assessed by an AMP to be eligible for a Dependency Certificate.</td>
</tr>
<tr>
<td>Drug and Alcohol Treatment Act (the Act)</td>
<td>The NSW Health <em>Drug and Alcohol Treatment Act (2007)</em> (the Act) provides the legislative basis for the Program; includes related Regulations.</td>
</tr>
<tr>
<td>Identified Patient (IP)</td>
<td>A person who is identified as potentially suitable for the Program. The person may be identified by anyone. Once identified, the Treatment Centre, medical practitioner or ITLO may be contacted regarding getting the person assessed for the Program. Note that the Act uses the term “person”, whereas this Model of Care document refers to a “patient”.</td>
</tr>
<tr>
<td>Involuntary Drug and Alcohol Treatment Program</td>
<td>A structured drug and alcohol treatment program, provided for under the Act, that provides medically supervised withdrawal and supportive interventions</td>
</tr>
<tr>
<td>Term</td>
<td>Definitions</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>Alcohol Treatment Program (the Program)</td>
<td>for Identified Patients. The Program comprises an involuntary inpatient residential treatment component and a community based component. The involuntary inpatient residential treatment component comprises two phases. The first phase focuses on the acute medical management of substance withdrawal and referral to other specialist medical care if required. The next phase of inpatient care provides a range of supportive, structured interventions, such as medical, nursing, psychology, social work and occupational and diversional therapy to address the causes and consequences of substance use. The community based component provides a range of medical and psychosocial interventions to encourage continued healthy lifestyle choices and to manage the risks of relapse after the patient has been discharged from the inpatient phase of the Program. This stage responds to the need for long term, comprehensive and holistic supports to achieve sustained behaviour, psychosocial, health and wellbeing outcomes.</td>
</tr>
<tr>
<td>Medical Practitioner</td>
<td>Referrals to AMPs for assessment for a Dependency Certificate may only be received from medical practitioners. AMPs require information on the Identified Person prior to final assessment of the referred patient, thus once a referral is received the AMP will forward a screening request to the medical practitioner. The MP may either complete this or contact their local ITLO requesting assistance with screening and assessment for eligibility for involuntary treatment under the Act.</td>
</tr>
<tr>
<td>IDAT Inpatient Case Manager</td>
<td>Oversees and participates in the management and delivery of treatment and support during the inpatient withdrawal management phase of the program. This role is located at the IDAT Treatment Centre and may be shared across the multi disciplinary team. This role would also work in consultation with the IDAT Transfer of Care Coordinator and the Community Care Coordinator throughout the patient journey from inpatient to community based care.</td>
</tr>
<tr>
<td>IDAT Transfer of Care Coordinator</td>
<td>Oversees the community based care component of the IDAT Program. Facilitates the development and delivery of the Discharge Plan and treatment and support in the community, including follow-up, providing support to those services providing treatment to IDAT patients in the community and facilitate completion of IDAT Outcome Tools. This role is located in the IDAT Treatment Centre. This role would also work in consultation with the IDAT Inpatient Case Manager and the Community Care Coordinator throughout the patient journey.</td>
</tr>
<tr>
<td>Community Care Coordinator</td>
<td>Is a health or social welfare professional identified as the IDAT patient’s main care coordinator/case manager in the community. This person could be based at an NGO, NSW Health, primary care or other social welfare agency. This role is responsible for the coordination and /or delivery of treatment and support in the community. This role is preferably located in the IDAT patient’s LHD of residence and ideally should be identified during the IDAT assessment phase. This role would also work in consultation with the IDAT Inpatient Case Manager</td>
</tr>
<tr>
<td>Term</td>
<td>Definitions</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>and the IDAT Transfer of Care Coordinator throughout the patient journey.</td>
<td></td>
</tr>
<tr>
<td>Model of Care (MoC)</td>
<td>This document, which provides a resource for managers, clinicians and other key stakeholders involved in supporting and delivering the Program. The Model of Care describes the principles, objectives, aims and underpinning approach for the Program and broadly defines the way in which the Program is delivered, to facilitate consistent implementation and assist clinicians and other stakeholders to interpret legislation as it relates to the Program.</td>
</tr>
<tr>
<td>Memorandum of Understanding (MoU)</td>
<td>A Statewide Memorandum of Understanding (MoU), signed by indentified Government Departments, establishes the respective roles and responsibilities of these agencies in delivering and supporting the Program</td>
</tr>
<tr>
<td>Primary carer</td>
<td>A person nominated by the patient to be actively involved in and receive information about the patient’s care and support. The primary carer may be a family member, carer, friend or another professional who is known to the patient. This may include the patient’s Public Guardian, if applicable and appropriate.</td>
</tr>
</tbody>
</table>
# Table of contents

Glossary and definition of terms 2  
Table of contents 5  
Structure of the Model of Care 8  
1. Introduction to the Model of Care 9  
   1.1. Context and legislation 9  
      Drug and Alcohol Treatment Act 2007 9  
   1.2. Involuntary Drug and Alcohol Treatment Program 10  
      Principles of care 10  
      Aims and objectives of the Program 10  
      Overview of the Program 11  
      Multi-disciplinary team 13  
      Care planning, management and coordination 14  
      Whole of government response 15  
   1.3. The Model of Care document 15  
      Supporting documents and references 16  
      Structure of the Model of Care 16  
      Review and update of the Model of Care 17  
2. Delivery of the Involuntary Treatment Program 18  
   2.1. Referral and screening 18  
      Referrals to the Program 18  
      Screening assessment and information gathering 19  
      Screening and information gathering checklist 20  
      Outcome of the screening and information gathering 21  
      Required skills, knowledge and behaviours 21  
   2.2. Assessment (for a Dependency Certificate) 22  
      Who can undertake the assessment 22  
      Assessment 22  
      Location of the assessment 23  
      Issuing a Dependency Certificate 24  
      Waiting lists and prioritisation 24  
      Order for Assessment 25  
      Required skills, knowledge and behaviours 25  
   2.3. Admission and orientation 26  
      Transportation 26  
      Admission and induction to the unit 26  
      Identification of the primary carer 27  
      Initial inpatient assessment 28  
      Assessment of mental health and suicide risk 29
The global care plan 29
Identification of the case managers 30
Review of the Dependency Certificate 31
Required skills, knowledge and experience 31

2.4. Medically supervised withdrawal 32
Development of the withdrawal management plan 32
Supervised withdrawal 32
Required skills, knowledge and experience 34

2.5. Post withdrawal inpatient treatment 34
Continued implementation and review of the care plan 34
Ongoing Intervention 34
Structured interventions 36
Other interventions 37
Extension of the Dependency Certificate 37
Required skills, knowledge and experience 38

2.6. Discharge 38
Discharge planning 38
Assessment for suitability for discharge 40
Transfer for case management responsibility 40
Required skills, knowledge and experience 40

2.7. Community based treatment 41
Implementing community based care 41
On-going assessment and monitoring 42
Interventions and supports 42
Planned step down of support 42
Required skills, knowledge and experience 43

3. Patient management issues and specific patient groups 44

3.1. Patient management issues 44
Managing coerced patients 44
Managing the client group 45
De-escalation 45
Granted leave of absence from the inpatient unit 47
Abscondees 47

3.2. Specific patient groups 47
Patients with co-morbidity 47
Patients with Acquired Brain Injury 49
Patients with dependent children and child protection issues 49
Aboriginal and Torres Strait Islander patients 50
Patients from Culturally and Linguistically Diverse backgrounds 50
Patients experiencing or committing domestic violence 51
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older patients</td>
<td>51</td>
</tr>
<tr>
<td>Patients with criminal justice involvement</td>
<td>52</td>
</tr>
<tr>
<td>Pregnant patients</td>
<td>52</td>
</tr>
<tr>
<td>Homeless or itinerant patients</td>
<td>53</td>
</tr>
<tr>
<td>4. Governance and quality management</td>
<td>54</td>
</tr>
<tr>
<td>4.1. Clinical governance</td>
<td>54</td>
</tr>
<tr>
<td>Critical relationships</td>
<td>54</td>
</tr>
<tr>
<td>Elements of quality clinical care</td>
<td>55</td>
</tr>
<tr>
<td>Clinical risk management</td>
<td>55</td>
</tr>
<tr>
<td>Culture and philosophy</td>
<td>56</td>
</tr>
<tr>
<td>Internal governance and management structures</td>
<td>56</td>
</tr>
<tr>
<td>Complaints and official visitors</td>
<td>57</td>
</tr>
<tr>
<td>4.2. Staffing and workforce development</td>
<td>58</td>
</tr>
<tr>
<td>Accredited Medical Practitionans</td>
<td>58</td>
</tr>
<tr>
<td>Cultural competence</td>
<td>58</td>
</tr>
<tr>
<td>4.3. Quality management and continuous improvement</td>
<td>59</td>
</tr>
<tr>
<td>Performance monitoring and reporting</td>
<td>59</td>
</tr>
<tr>
<td>Robust information technology and data systems</td>
<td>60</td>
</tr>
<tr>
<td>Evaluation and research</td>
<td>60</td>
</tr>
<tr>
<td>5. References</td>
<td>62</td>
</tr>
<tr>
<td>6. Appendices</td>
<td>63</td>
</tr>
<tr>
<td>Appendices 1 Global Care Plan</td>
<td></td>
</tr>
<tr>
<td>Appendices 2 IDAT Brokerage Guidelines</td>
<td></td>
</tr>
<tr>
<td>Appendices 3 IDAT Outcome Tools</td>
<td></td>
</tr>
</tbody>
</table>
## Structure of the Model of Care

This Model of Care document is structured as follows:

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Introduction to the Model of Care</strong></td>
<td>This section provides an overview of the Program, including the underpinning legislation and describes the purpose and structure of the Model of Care for the Program.</td>
</tr>
<tr>
<td><strong>2. Delivery of the Involuntary Treatment Program</strong></td>
<td>This section presents the Program approach for each stage of the patient journey and considers objectives of each stage, activities to be undertaken, time frames for activities, and roles and responsibilities of staff and the identified patient and their primary carer.</td>
</tr>
<tr>
<td><strong>3. Patient management issues and specific patient groups</strong></td>
<td>This section identifies management issues that may arise in the context of delivering the Program and provides approaches to addressing these issues. It also identifies patient groups that may have specific needs and how these should be responded to.</td>
</tr>
<tr>
<td><strong>4. Governance and quality management</strong></td>
<td>This section provides an overview of the governance and quality management approach and processes that underpin the Program, including governance arrangements, staffing and workforce requirements and quality management approaches.</td>
</tr>
<tr>
<td><strong>5. References</strong></td>
<td>This section identifies the range of references that have been considered to inform this Model of Care.</td>
</tr>
</tbody>
</table>
1. Introduction to the Model of Care

1.1. Context and legislation

In New South Wales (NSW) there has been an option for the involuntary treatment of people with severe alcohol and drug problems for almost a century. This had previously been provided under the Inebriates Act 1912. However, a review of that Act, recommended at the 2003 Summit on Alcohol Abuse and subsequently conducted in 2004 by the Parliament of New South Wales Standing Committee on Social Issues, concluded that the Inebriates Act is “fundamentally flawed” and recommended that it be “immediately repealed”.

Responding to recommendations of the Report on the Inebriates Act 1912, the Involuntary Drug and Alcohol Treatment Program (the Program) was developed to provide short term care, with an involuntary supervised withdrawal component, to protect the health and safety of people with severe substance dependence who have experienced, or are at risk of, serious harm and whose decision making capacity is considered to be compromised due to their substance use.

Drug and Alcohol Treatment Act 2007

The NSW Health Drug and Alcohol Treatment Act 2007 (the Act) provides the legislative basis for the Program. The Act “provides for the health and safety of persons with severe substance dependence through involuntary detention, care, treatment and stabilisation; and for other purposes”.

Central to the legislation is the principle of safety of the individual through the least restrictive option of treatment. Involuntary treatment under the Act is essentially a clinical decision, based on an assessment of severity of dependence. The Act incorporates principles to safeguard the rights of those who are detained and treated. The Act emphasises that the rights of the patient are paramount and that this is a last resort treatment option. The Act also sets out the process of involuntary detention and treatment, the role of Accredited Medical Practitioners (AMPs), assessment criteria and the rights of appeal.

The objectives of the Act are to:

- provide for the involuntary treatment of patients with a severe substance dependency with the aim of protecting their health and safety
- facilitate a comprehensive assessment of those patients in relation to their dependency
- facilitate the stabilisation of those patients through medical treatment including, for example, medically assisted withdrawal
- give those patients the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and patient welfare.

In addition, the “Act must be interpreted, and every function conferred or imposed by this Act must be performed or exercised, so that, as far as practicable:

- those persons will receive the best possible treatment in the least restrictive environment that will enable treatment to be effectively given, and
- any interference with the rights, dignity and self respect of those persons will be kept to the minimum necessary.”

---

1 NSW Drug and Alcohol Treatment Act 2007
1.2. Involuntary Drug and Alcohol Treatment Program

The Program is a structured drug and alcohol treatment program that provides medically supervised withdrawal and supportive interventions for Identified Patients (IPs). Potential patients are referred for an assessment by a medical practitioner to an Accredited Medical Practitioner to determine their eligibility for the program. To be eligible, patients must meet all of the following eligibility criteria, set out in the Act:

- the person has a severe substance dependence, and
- care, treatment or control of the person is necessary to protect the person from serious harm, and
- the person is likely to benefit from the treatment for his or her substance dependence but has refused treatment, and
- no other appropriate and less restrictive means for dealing with the person are reasonably available.

The accredited medical practitioner may have regard to any serious harm that may occur to:

- (a) children in the care of the person or
- (b) dependants of the person

Patients who are eligible are issued with a Dependency Certificate for involuntary treatment in an inpatient unit.

Principles of care

Care should be provided consistently with the following principles:

- in conformity with UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, in any decision in relation to involuntary care the person's interests should be paramount
- involuntary treatment should only be used as a last resort
- treatment should, overall, provide benefit to the patient and hence care should be taken not to exacerbate existing or introduce new harms
- there should be appropriate safeguards for the rights of people who are involuntarily detained, including the right to appeal their detention
- a right to treatment and quality of treatment should be ensured.

Aims and objectives of the Program

As stated above, the aim of the Act and the Program is to:

“provide for the health and safety of persons with severe substance dependence through involuntary detention, care, treatment and stabilisation; and for other purposes.”

Using a staged approach, described below, the objectives of the Program are to:

- provide a short term intervention to remove the patient from immediate danger
- allow the patient an opportunity to withdraw from alcohol and other drugs
- allow opportunities for the patient to stabilise and rebuild physical and mental health

3 The Act p.1
enable the patient to address physical, mental and neurological issues that contribute to, are the result of, or occur concurrent to chronic substance use

plan and set up continued voluntary support in the longer term to assist the patient to move towards stabilisation and/or abstinence.

Clinical and social outcomes for the Program include:

- safe completion of the medically supervised withdrawal
- reversal of neuroadaptation with associated reduction in the intensity of craving
- improved general health through the provision of a safe environment, nutrition, rest and physical comfort and through facilitated access to medical care
- improved mental health through enforced abstinence, provision of drug and alcohol services, initiation to appropriate mental health care and the provision of interpersonal support
- restoration of the capacity to make informed decisions about substance use and personal welfare
- reduced risk of relapse through engagement in relapse prevention strategies
- improved social functioning through better management of housing and welfare needs and through enhancing social and support networks.

Overview of the Program

The Program provides a structured drug and alcohol treatment, rehabilitation and care intervention, delivered in both inpatient and community settings. Inpatient units and the hospital grounds on which they are located are gazetted under the Act to deliver the inpatient component of the Program. Inpatient units receive statewide referrals. The community based elements of the Program are managed by a local Community Care Coordinator in liaison with the unit IDAT Transfer of Care Coordinator and are likely to include services provided by local health and social welfare agencies including Alcohol and Other Drugs (AOD) providers.

The inpatient withdrawal component of the program is involuntary. The Act does not provide a legislative basis to compel individuals to engage with post discharge, community based interventions and support. Therefore participation in this component of the Program is voluntary.

Under the Legislation, a patient can be referred for assessment for involuntary treatment by a medical practitioner4 (such as General Practitioners (GPs), Emergency Department (ED) doctors, Addiction Medicine specialists and / or Psychiatrists). Final assessments are undertaken by an AMP.

Anyone can identify a person as potentially suitable for the Program, noting that referral to an AMP must be from a medical practitioner. AMPs require information on the eligibility of the Identified Person prior to final assessment of the referred patient. Thus once a referral is received, the AMP will forward a screening request to the medical practitioner which s/he may either complete or contact their local ITLO requesting assistance to complete the screening and assessment for eligibility for involuntary treatment under the Act.

If the patient refuses to undergo an assessment, a referrer can apply to a Magistrate for permission to conduct a mandatory assessment 4( s.10, or Order for Assessment), which can include a NSW Police escort to the assessment.

If the patient meets all criteria for involuntary treatment, and there is a gazetted inpatient bed available, the patient is issued with a Dependency Certificate stating that they may be detained for inpatient treatment under the Act. Dependency Certificates can be issued for a minimum of seven days and for up to 28 days initially. An AMP can apply to the Magistrate to grant an extension/s of the inpatient care period for up to three months from the day of first admission if:

4 The Act s.9(1)
• The practitioner is satisfied;
  (a) the dependent person is suffering from drug or alcohol related brain injury, and
  (b) additional time is needed to carry out treatment and to plan the person’s discharge, and
• The practitioner presents, with the application, a proposed treatment plan to be followed during
  the additional time granted.

The community based component of the IDAT program provides ongoing health and social support
and intervention to patients for a period of up to six months, once they have been discharged from
inpatient care.

The intent of the Program is that care is coordinated and enables continuity of care between
inpatient and community based settings. This is illustrated in Figure 1.
The involuntary inpatient *residential treatment component* comprises two phases. The first phase focuses on the acute medical management of substance withdrawal and referral to other specialist medical care if required. The next phase of inpatient care provides a range of supportive, structured interventions, such as medical, nursing, psychology, social work and occupational and diversional therapy to address the causes and consequences of substance use.

The *community based component* provides a range of medical and psychosocial interventions to encourage continued healthy lifestyle choices and manage the risks of relapse after the patient has been discharged from the inpatient phase of the Program. This stage responds to the need for long term, comprehensive and holistic supports to achieve sustained behaviour, psychosocial, health and wellbeing outcomes.

The *stepped down* community based component provides support that decreases in intensity and frequency over time, as the individual builds links and relationships with alternative community based treatment and support options. It is acknowledged that some patients may require longer term care without a stepped down approach.

**Multi-disciplinary team**

The inpatient stage of the Program is delivered by a multi-disciplinary care team in the (statewide) inpatient unit. The community care coordinator will be consulted by the care team throughout the inpatient phase. Medical and clinical professionals involved in the care team include:

- Accredited Medical Practitioner
- Addiction Medicine Consultant
- inpatient nursing staff, including clinical nurse consultants, registered nurses and enrolled nurses
- other drug and alcohol workers
- clinical psychologists and neuropsychologists
- counsellors and/or therapists
- social workers
- occupational (and/or diversional) therapists
- other medical and clinical staff as indicated by care plan, such as psychiatrists or other medical specialists.
- IDAT Transfer of Care Coordinator

Care of the patient is handed over to the IDAT transfer of care coordinator and community care coordinator at discharge from the inpatient unit. If possible, the community care coordinator is identified prior to admission to the inpatient unit.

During the community based stage of the Program, the IDAT transfer of care coordinator and community care coordinator will coordinate interventions from a range of professionals, as required to meet the patient's needs as articulated in their care plan.

Other professionals who may also be involved in supporting a patient might include public guardians, Official Visitors, housing workers and Centrelink workers.

Magistrates also play a key role in the Program, reviewing and extending Dependency Certificates and upholding the rights of the patient.
Care planning, management and coordination

Delivery of the Program is underpinned by care planning, management and coordination that reinforces an integrated continuum of care through both inpatient and community based settings. This approach requires practitioners and patients to take a longer–term, holistic view in considering goals and interventions and, by definition, requires multi-disciplinary involvement in care planning and management.

The development of the care plan should ideally commence as early as referral and assessment to assist in identifying the patient’s main treatment and support needs whilst in the IDAT Program. The development of the care plan should be an ongoing process throughout the patient journey and include input from the patient, primary carer (where appropriate), ITLO, IDAT Transfer of Care Coordinator, Community Care Coordinator, Inpatient Case manager and the inpatient IDAT treatment team. The care plan should be continually monitored and reviewed to meet the patient’s changing health and social welfare needs throughout the IDAT Program.

For the IDAT Program the NSW Drug and Alcohol Global Care Plan is to be used (Appendix 1) from the D&A Community Health and Outpatient Care Information System project. The care plan should actively cover the patient’s needs in the domains of substance use, physical health, mental health, socioeconomic, psychosocial, legal and other. It requires the involvement of professionals from a range of disciplines to work together to meet these multiple needs. The plan should also actively cover all stages of the patient journey (including inpatient and community based) and at all times should promote engagement, delivery of care, completion of interventions and maintenance of improved outcomes.

At different stages of the IDAT Program a range of health professionals will be responsible for facilitating the implementation and review of the care plan. At the inpatient unit the IDAT team and the inpatient IDAT case manager will be responsible for the implementation and review of the care plan in consultation with the IDAT Transfer of Care Coordinator and the Community Care Coordinator (where appropriate). During the community based care component of the IDAT Program the IDAT Transfer of Care Coordinator and the Community Care Coordinator will be responsible for the implementation and ongoing review of the care plan.

All parties, including the patient and the primary carer (where appropriate) will be responsible for the planning, management and review of the care plan post discharge from the inpatient unit. It is strongly encouraged that the Community Care Coordinator forms part of the treating team from the point of admission to the inpatient unit (or as soon as is practical afterwards), to work with the patient and inpatient care team to plan for discharge and continued support in the community. This will ensure continuity of care post discharge from the inpatient unit.

To assist with the delivery of the patient’s care plan, particularly during the community care phase, a brokerage model has been developed. This model allows for the allocation of funds to assist with the delivery of the health and social welfare needs identified in the care plan. IDAT Brokerage Guidelines have been developed to articulate the appropriate use of the brokerage model for the IDAT Program (Appendix 2).

Identifying a community care coordinator

This care coordinator will need to be identified on a case by case basis, ideally prior to admission to the Program, taking into account where the referral to the Program originates and where the patient will return to if admitted for inpatient care. In some instances the ITLO may be identified as the community care coordinator.

In some cases, a professional who is already involved in the patient’s care in the community may be identified to take on the care coordinator role. In other cases, if the patient is not actively engaged with services, an appropriate care coordinator will need to be identified in discussion with the referrer, the Program and the patient and / or their family.
Depending on the availability of specialist drug and alcohol services in the local area, it is possible that the care coordinator may not have professional drug and alcohol expertise, although this would be desirable. If this is the case the IDAT transfer of care coordinator should identify appropriate governance and supervision to support the care coordinator to deliver quality care and support. For example, it may be appropriate for an Aboriginal Health Worker to undertake a care coordinator role, with support from a community-based drug and alcohol service.

The community care coordinator and the IDAT transfer of care coordinator will need to engage regularly to provide continuity and quality of care and support for the patient in the community. The IDAT transfer of care coordinator will oversee the delivery of the Discharge Plan and care in the community, including follow-up, providing support to those services providing treatment to IDAT patients and facilitate completion of IDAT Outcome Tools. The community care coordinator is responsible for the coordination and/or delivery of the care plan in the community across the relevant health and social welfare services.

Whole of government response

To support the objectives of the Program and provide opportunities for better outcomes for Program participants, input is required from a range of different government organisations. These include:

- Department of Attorney General and Justice
- Ministry of Health
- Department of Family and Community Services: Ageing, Disability and Home Care
- Department of Family and Community Services: Community Services
- Department of Education and Communities
- TAFE NSW
- Department of Family and Community Services: Housing NSW
- NSW Police Force

A statewide Memorandum of Understanding (MoU), signed by all identified Government Departments, establishes the respective roles and responsibilities of these agencies in delivering and supporting the Program. Local partnerships will be guided by local representatives of all signatories through local steering committees. There may also be a statewide program manager position whose role among other things will be to facilitate these relationships and operational matters.

1.3. The Model of Care document

This Model of Care document provides information about the approach and processes used by the Program that have been developed through the Program Trial and informed by input from NSW Health and identified specialists. Aspects of the Model of Care are likely to be updated as the Program is implemented.

This Model of Care document provides a resource for:

- managers and clinicians involved in supporting and delivering the Program
- other key stakeholders involved in supporting and facilitating the Program, e.g. Magistrates, police, Official Visitors, other MOU signatories
- identified patients and their families and carers.

The purpose of the Model of Care is to:

- describe the principles, objectives, aims and underpinning approach for the Program

---

5 The Program was trialled in 2008-10 in Sydney West Area Health Service.
1. Referral and screening
2. Assessment
3. Admission
4. Withdrawal
5. Post withdrawal treatment
6. Discharge
7. Community based program

Key elements for MoC
- Referral
- Initial information gathering
- Provision of advice or sign post to alternative treatment options
- Additional information gathering
- Assessment by AMP
- Issue of DC
- Referral to alternative treatment option if no DC is given
- Admission to program
- Identification of Primary Carer
- Treatment plan and discharge plan
- Mental Health Tribunal review
- Withdrawal / detox
- Continued assessment and monitoring
- Continued implementation of treatment plan
- Ongoing assessment and monitoring
- Ongoing treatment-clinical and psychosocial
- Review of DC
- Ongoing discharge planning including community based intervention plan
- Assessment of suitability for discharge
- Completion of treatment plan
- Finalisation of discharge plan
- Revise and implement community based intervention plan
- Ongoing assessment and monitoring
- Case management

At each stage of the patient journey, the Model of Care provides an overview of the stage and describes:

However, it should be noted that care should be individualised to the person’s needs and that there is no one-size fits all approach.
the activity (or activities) at that stage and **what** it involves

**who** does the activity and **where** it is undertaken

the underpinning policy or clinical guidelines to support the activity, if applicable

the skills, knowledge and behaviours required to deliver that stage.

The Model of Care also provides information about patient management issues that apply to the Program more broadly, considers effective interventions for specific client groups, and describes the governance and quality management arrangements that underpin the Program management and delivery.

**Review and update of the Model of Care**

It is recommended that the Model of Care be a live document and then reviewed after three years, or as specified by NSW Health.
2. Delivery of the Involuntary Treatment Program

2.1. Referral and screening

**Overview:** This stage involves identifying an individual who may be suitable for the Program, undertaking screening and information gathering to determine whether the patient should be recommended for referral for assessment for a Dependency Certificate, and making the referral for assessment for dependency certificate.

Although the Program involves both inpatient and community-based treatment, access to the Program is determined and managed by the statewide inpatient units. This is because access to inpatient withdrawal is an essential first stage of the Program and capacity of the inpatient units to accept new patients is a key consideration in access to the Program.

**Referrals to the Program**

Patients may be identified as potentially suitable for the Program by anyone, but the IP must be referred by a medical practitioner to an Accredited Medical Practitioner.

Once the AMP at the Treatment Centre has received a referral, a determination will be made as to whether there is sufficient information (a local comprehensive assessment) for the AMP to assess the IP for a Dependency Certificate. If not, further screening and a comprehensive assessment at the local level will be requested of the medical practitioner and local ITLO. Contact details of local ITLOs will be provided to the medical practitioner for liaison regarding further drug and alcohol screening and assessment needs.

Involuntary Treatment Liaison Officer (ITLO) may be:

- at the statewide inpatient unit (for patients residing in areas where the inpatient units are located), or
- part of the ‘Referring Person’s Network’ (for patients residing in other areas in NSW).

Referrals to an AMP for assessment for a dependency certificate can be made by phone, fax or email and can only be received from medical practitioners, for example, General Practitioners (GPs), emergency doctors and psychiatrists.

A screening and referral form is used that captures as many details as possible about:

- the patient, including name, age/date of birth, gender, substance use and history, previous treatment episodes, impact of substance use on functioning and capacity, mental health history, psychosocial functioning, medical and criminal history (if known by the referrer at the time of the referral)
- the referrer
- the community care coordinator and/or ITLO (if identified)
- the patient’s GP, if known (in cases where the GP is not the referrer) and any other health professionals involved with the patient (if known).

The referral is logged by a medical practitioner, recording the time, date and details of the referral, in line with reporting requirements (discussed in section 4.3). A written acknowledgement for the referral must be provided to the referrer within a working day of receiving the referral.

---

Crisis response

---

7 See section 4.2 for details.
The Program is not an appropriate response for patients requiring urgent medical or psychiatric treatment. If a crisis response is required, the referrer should be directed to call '000', or the police, or to transport the patient directly to an ED.

**Screening assessment and information gathering**

An ITLO may come into contact with a potential involuntary patient through their drug and alcohol practice, or receive notification of a person who has been identified as potentially suitable for the program by a third party such as a GP. If the ITLO deems appropriate, an initial screening and information gathering process will be undertaken by the ITLO to the standard required of the AMP to establish whether a patient should be recommended for referral by a medical practitioner for a Dependency Certificate assessment. AMPs will rely on the screening work and comprehensive assessments of ITLOs to assist them gather the information and evidence they need conduct an assessment for a Dependency Certificate.

The initial screening and information gathering process involves considering whether the patient meets or, on further assessment, is likely to meet the high level criteria and threshold for the Program. This involves considering:

- whether the patient has a severe substance dependence (has a tolerance, shows withdrawal symptoms when they stop using, has lost capacity to make decisions)
- that care, treatment or control is necessary to protect the patient (or dependants) from serious harm
- that the patient is likely to benefit from treatment but has previously refused treatment
- that there are no other less restrictive treatment options.

Screening and information gathering also includes a comprehensive and well documented risk assessment to determine risk to self or others, including the risk of suicide, risk to dependent children and of domestic violence.

In order to determine if a person should be recommended to a medical practitioner for referral for a Dependency Certificate assessment by an AMP, additional information to inform a comprehensive assessment will need to be gathered through review of medical records and by requesting information from specialist drug and alcohol services as well as other health and social services (including police) involved with the patient.

It is not necessary for the screening assessment to involve contact with the patient, although this may be appropriate if the patient is already a patient of the ITLO, medical practitioner or the AMP. It may also be appropriate to seek additional information from known family members, carers or guardians, particularly where these individuals have been involved in identifying the person as potentially suitable for referral to the Program. It is important that the expectations of family members, carers or guardians are managed carefully in the case the identified person does not meet the eligibility criteria.

Multidisciplinary input will be required to determine the recommendation for a referral for a Dependency Certificate assessment based on information gathered through the screening assessment. This may require a multi-disciplinary case conference involving professionals already involved in the patient’s care, as well as the AMP and the professional with delegated responsibility (medical practitioner and ITLO) for undertaking screening and information gathering.

At this stage it can also be useful to begin identifying treatment goals in the care plan to assist in identifying the patient’s potential treatment needs for the IDAT Program including inpatient and community based care. Part of this process should include identifying a community care coordinator and key services for the patient in the community, post inpatient IDAT, such as housing, health and social welfare support.

---

8 Section 9:3(a)
Screening should commence as soon as is practicable after a referral. The aim is for screening to be completed within one week of commencement, however it is recognised that this may not be possible in all cases.

**Levels of assessment**

Assessment provides a process to establish the nature and extent of the drug and / or alcohol misuse, the level of need an individual may have and what interventions are required to address these needs. Assessment is often undertaken across a continuum that varies in depth and level of detail, depending on the purpose and anticipated outcome of the assessment process. In the context of the Program, the hierarchy of assessment includes:

- **Screening**: a brief process to identify dependency and immediate risk to the patient. This should be done at the point of referral to the AMP or identification by an ITLO with the purpose of determining whether further information gathering is required.

- **Information gathering (triage)**: a more in-depth assessment to determine the nature of the dependency and risk, the likely treatment needs and to explore previous history of use and treatment in order to determine eligibility for a Dependency Certificate. This type of assessment should be undertaken through additional information gathering at the referral stage or identification by an ITLO and screening stage of the Program with the purpose of determining whether the patient is likely to be suitable for a Dependency Certificate.

- **Comprehensive assessment**: A comprehensive assessment builds on the screening and triage assessments to enable a decision to be made about whether to recommend the identified person be referred to the Program (as completed by the referring medical practitioner or ITLO) and a final assessment to determine whether a Dependency Certificate should be issued to admit the patient to the Program and to consider the nature of the required structured drug treatment interventions (as completed by the AMP). This is described under section 2.2. Comprehensive assessment continues throughout the patient’s involvement in the Program to continue to assess needs, identify interventions required and measure outcomes.

**Screening and information gathering checklist**

The following information should be gathered during this stage in order to make a determination about likely recommendation for referral for a Dependency Certificate assessment and possible treatment options:

- current and previous history of drug and alcohol use and impact on functioning and capacity
- current and previous treatment history, including history of withdrawal and previous complications
- current overview and history of physical and mental health
- psychosocial issues that need to be addressed, e.g. homelessness
- involvement in the criminal justice system and details of bail or community sentencing conditions and pending court dates. This is noting that the patient should be accepted onto the program if charges are pending, except in cases of significant violence or sexual offences (i.e. behaviours that put staff and other patients at risk of harm by the patient)
- risk of harm to self and to others, including children living with the patient
- other risk factors, such as pregnancy

---

9 To the extent this is possible to ascertain, recognising that current substance misuse may mask symptoms and causes of mental and physical health issues.
- willingness of the patient to engage in treatment voluntarily
- availability of less restrictive treatment options that can be accessed
- identification of key significant others, e.g. family, carer, guardian
- identification of community care coordinator (to coordinate care post discharge from the inpatient phase of the Program)
- identification of a GP.
- identification of transportation needs should the patient be issued a dependency certificate and does not reside near the IDAT inpatient unit.

Standardised, validated tools should be used wherever possible, and particularly relating to evaluation\(^\text{10}\).

**Outcome of the screening, information gathering and comprehensive assessment**

On completion of the information gathering, screening and comprehensive assessment process the ITLO makes a recommendation to a medical practitioner as to whether the person should be referred to the AMP for a Dependency Certificate assessment. A medical practitioner must make the referral to the AMP and an ITLO can do this if s/he is a medical practitioner.

Information gathered during this stage and the outcome of the screening and information gathering must be well documented and clearly linked to the decision to refer for a Dependency Certificate assessment.

If a patient is referred for a Dependency Certificate assessment, a face to face (including video-conference) meeting with the AMP is to be arranged, to take place as soon as possible. This is discussed in section 2.2.

If a patient is not considered suitable for a Dependency Certificate assessment the reasons for this decision are explained to the referrer and ITLO, and alternative treatment/ intervention options are suggested. This might include:

- referral or sign posting to an alternative service, and/or
- providing information to the referrer and/or ITLO to enable them to educate family members (from whom the referral request may have originated) to support them to promote rehabilitation, recovery and reduce risk of relapse to crisis and risk of serious harm.

The outcome of the referral and screening assessment must be notified to the referrer/ITLO as soon as possible after receiving the referral.

**Required skills, knowledge and behaviours**

Required clinical competencies at this stage generally relate to assessment and include:

- gathering information
- undertaking screening and triage
- clinical decision making, including identifying and prioritising need.

Knowledge and experience of these competencies in relation to patients with drug and alcohol, mental health and complex and multiple needs is essential.

In addition, activities at this stage need to be supported by administrative competence and experience in inputting, managing, monitoring and reporting data in relation to referrals.

\(^{10}\text{Refer to section 4.3 for further details.}\)
2.2. **Assessment (for a Dependency Certificate)**\(^{11}\)

**Overview:** During this stage, an AMP conducts a final assessment of the patient to determine whether they should be issued a Dependency Certificate for detention and treatment under the Act. An assessment can be carried out under an Order for Assessment (section 10) if the patient does not comply with the assessment. This is discussed in further detail below.

As a result of the final assessment, a patient may be admitted to the inpatient component of the Program, or may be provided with options for alternative, less restrictive treatment.

The AMP assessment process for the Program is guided by the general principles outlined in the *NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines*\(^ {12}\).

Dependency Certificates should only be issued if the patient meets all eligibility criteria and if there is a bed available immediately at the inpatient unit.

**Who can undertake the assessment**

The assessment for a Dependency Certificate must be undertaken as follows:

- Patients residing in areas where the inpatient units are located should be assessed by the AMP at the inpatient unit, who has responsibility for determining whether a Dependency Certificate should be issued.

- Patients living in other areas of NSW should be initially and comprehensively assessed by the referring medical practitioner or an ITLO who is part of the Referring Network, however only a medical practitioner may refer a patient for a DC assessment. An ITLO can determine whether the person may be eligible for a Dependency Certificate and make a recommendation for a medical practitioner to refer to the Program, however, they cannot refer to the Program unless they are a medical practitioner. The Treatment Centre must be consulted to determine whether a bed is immediately available at the inpatient unit. Bed availability may have an impact on the timing of the final assessment by the AMP.

- Patients residing in other areas of NSW may also be assessed by a Medical Practitioner appointed as a temporary AMP for seven working days by the Director of an IDAT unit. This consultation may take place by video-conferencing, with the patient attending.

**Assessment**

After the screening and information gathering process if the ITLO recommends the referral of a patient for a Dependency Certificate assessment, a referral by a medical practitioner is made for a face to face (including video-conferencing) AMP assessment to determine whether a Dependency Certificate for inpatient detention and treatment should be issued. The AMP assessment must take place as soon as practicable after referral from the intake worker.

The AMP undertakes a comprehensive assessment, building on previously gathered information, to consider:

- full drug consumption history including quantity, frequency, duration of use and pattern of use; time and quantity since last use; route of administration; recent pattern up to being presented for assessment;

- full treatment history including treatment refusal and treatment responsiveness.

\(^{11}\) Aspects of the assessment process will be further clarified as the Program becomes operational and the Model of care will be updated accordingly.

\(^{12}\) NSW Health (July 2008) *NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines* Sydney: NSW Health
• risks associated with substance use
• past history of withdrawal and any associated complications
• physical examination including current withdrawal status
• medical and psychiatric history
• mental state examination including a self harm and suicide risk assessment
• cognitive assessment
• determination of capacity to make decisions about substance use and personal welfare
• appropriate laboratory and radiological investigations
• psychosocial considerations to identify motivation to change, expectations, supports, barriers and preferences that may influence withdrawal management
• psychosocial and other risk factors that might impact on engagement with the Program and potential outcomes, such as child protection concerns, domestic violence, pending criminal proceedings, suitability of housing (or whether the patient is homeless) and income.
• Patient treatment needs and health and social welfare support identified in the global care plan for the IDAT Program, including inpatient and community based care.

Standardised, validated tools should be used wherever possible.
The overall assessment should be summarised and should identify\(^\text{13}\):

• potential risks to the patient during withdrawal and subsequent treatment
• problems and barriers that may prevent the patient completing withdrawal and subsequent treatment
• the withdrawal regime and other interventions that have been indicated by the assessment.

This summary assists with continuity and quality of care and in the development of a withdrawal management plan and care plan if the patient is admitted to the inpatient unit.

Note that, with regard to assessment of cognitive impairment, if the patient is issued a Dependency Certificate and admitted to the inpatient phase of the Program, further assessment will be undertaken to consider capacity, neurological, bio-psychosocial and physical functioning to inform a comprehensive care plan. Due to the extensive history of substance misuse of the client group and the likely impact on functioning and capacity it is not appropriate to undertake these types of assessment prior to withdrawal as the validity of the assessment outcomes will be limited.

\textit{Location of the assessment}

AMP assessments can take place in a variety of locations which might include offices of the AMP, local specialist or other services with which the patient may be in contact, office of the patient’s GP, the patient’s home or another familiar place. As a principle, the assessment should be undertaken in a place that is easily accessible to the patient and is safe for professionals. In determining a suitable location consideration must be given to:

• suitability and privacy of the location to undertake the assessment, in particular the physical examination and observations components of the assessment, if required
• the safety of the patient and the AMP and others attending the assessment (e.g. family members).

\(^{13}\) Ibid p15
Issuing a Dependency Certificate

If the comprehensive assessment indicates that a patient is eligible for a Dependency Certificate, the AMP will issue a Dependency Certificate if they are also satisfied that:

- the patient is not willing to undertake voluntary treatment, and
- involuntary care will not introduce new serious harms or exacerbate existing harms to the patient, and
- involuntary care is highly likely to result in reduced, safer substance use or abstinence over an extended period following discharge, or
- involuntary care is highly likely to facilitate engagement with ongoing care following discharge, and
- involuntary care has a good prospect of significantly ameliorating harm to the patient and improving their quality of life, and
- there is a bed available immediately at the inpatient unit.

If, as a result of the assessment and in consideration of these factors, the AMP is satisfied that the patient meets the eligibility criteria specified in the Act, a Dependency Certificate may be issued, stating that the patient may be detained for treatment under the Act for the period stated in the certificate.

Dependency Certificates can initially be issued for a minimum of seven days and a maximum of 28 days.

If a Dependency Certificate is issued, the Act provides for the patient to be immediately detained in order to be transported to the inpatient unit.

Immediately following the issue of a Dependency Certificate, the following steps should be undertaken:

- provision of advice to patient (and family members, carer or guardian, if appropriate) of their right to appeal
- identification in writing of the primary carer(s)
- identification of transport options and arrangement of transport to the Unit. This is discussed in section 2.3.

If the AMP is not satisfied that the patient meets the eligibility criteria, they should suggest suitable alternative treatment options, and / or provide a referral to other specialist services. This must be communicated to the patient and to the referrer.

It should be noted that some patients are not medically safe, e.g. experiencing withdrawal, to be transferred to the Unit immediately after issuing of the Dependency Certificate. These patients are generally treated at the nearest hospital until stable and cleared for transport.

Waiting lists and prioritisation

A patient should not be issued a Dependency Certificate if they cannot be admitted to the program immediately. If no place is available immediately, the reason for this should be given to the referrer and the patient placed on the waiting list until a place becomes available.

---

14 Section 9.3(a)
15 Note that the intent to appeal and the appeal process does not prevent a person from being detained for treatment under the Act. If a person is issued a Dependency Certificate, they will be admitted to an inpatient unit immediately: regardless of the appeal process. A successful appeal will lead to a revocation of a Dependency Certificate and an immediate discharge from the inpatient unit.
The program should maintain a waiting list and patients on the waiting list may be re-assessed for a Dependency Certificate when a place becomes available. It is important that a re-assessment for the Dependency Certificate is undertaken as and when a bed becomes available, to ensure that the assessment considers the most current presentation and takes into account any changes that may have taken place while the patient was on the waiting list.

The Program should prioritise referrals (and patients on the waiting list) in order of severity of need and risk. Decisions about prioritisation should be considered on a case by case basis and include consultation between the AMP(s) and the referring doctor and ITLO.

**Order for Assessment**

Under the Act (section 10), a Magistrate or authorised officer (for example a court registrar) may “by order, authorise the accredited medical practitioner to visit and assess the person to ascertain whether a Dependency Certificate should be issued” if they are satisfied that the person:

- is likely to have a severe substance dependence
- is likely to be in need of protection from serious harm or others are likely to be in need of protection from serious physical harm
- could not be assessed but for the making of the order, and
- is likely to benefit from treatment.

Following a section 10 Order for Assessment, an AMP, with the support of any other authorised officers (such as police officers), should undertake the assessment in a suitable and practicable location. This may include the patient’s home. The Order also provides for the use of reasonable force to enter premises to undertake an assessment.

Following the assessment, the AMP should provide written notice of the assessment taking place to the person who made the Order.

It is expected that section 10 orders will be rare, however due to the requirement of an AMP to physically visit the identified person, on such occasions that the IP is not proximate to a treatment centre or AMP, a suitably qualified medical practitioner with drug and alcohol experience may be identified and under section 7(3) be appointed, temporarily or otherwise, as an AMP with the imposed condition to have the legislated power limited to conducting section 10s and issuing a Dependency Certificate in such circumstances.

**Required skills, knowledge and behaviours**

The following competencies are required at this stage:

- undertaking comprehensive drug and alcohol assessments and risk assessments
- clinical decision making, including identifying and prioritising need
- contribution to the formulation of a treatment or care plan
- interpreting and applying legislation
- upholding patient’s rights and considering the protection and safety of individuals
- appropriate interaction with and management of individuals with complex and multiple needs, including management of aggressive or violent behaviour and heightened states of anxiety and distress
- providing support to carers and significant others where necessary
- brief interventions and support of patients who are distressed
- documentation of assessment outcomes and decisions
It is essential that professionals undertaking activities at this stage have extensive experience and knowledge of working with patients who have a history of substance misuse. Experience and knowledge of working with patients with dual diagnosis and those who demonstrate challenging behaviours is also desirable.

2.3. Admission and orientation

Overview: During this stage, the patient will be admitted to the inpatient unit and oriented onto the unit. This stage also involves an initial assessment, the completion of the care plan and review of the Dependency Certificate, as well as consideration of any transport requirements.

Transportation

If the assessment for a Dependency Certificate does not occur at the inpatient site, a patient should be transported to the unit immediately upon issuing of the Dependency Certificate, or as soon as is practically possible. Brokerage funds can be used to assist in the transportation of patients to the inpatient unit.

Options for transporting the patient to the inpatient unit should be considered as early as screening and assessment and should be determined at the time a Dependency Certificate is issued, in discussion with the patient, the family/careers or public guardian and the local case worker. The IDAT Transport Guidelines, including a transport risk matrix, has been developed to assist in making decisions about the best transport option for the patient (Appendix 3).

The patient can be transported to the unit by:

- family members, carers, friends or guardian
- Local Health District staff
- Health Transport Unit, in limited circumstances
- ambulance, in limited circumstances
- police, in certain circumstances

Transportation arrangements by transport officers are specified under section 20 of the Act. The Act stipulates that transport officers may use reasonable force and restrain the patient in order to transport them to the inpatient unit. The Act also provides a basis for the transport officers to undertake a frisk search and to remove items from their possession that might present a risk of danger to themselves or others, or may assist them to escape during the transportation.

Admission and induction to the unit

The patient will be received at the unit by a member of the clinical team, as per the local unit procedures. All paperwork and administration tasks will be completed and a medical record will be requested, or commenced, for patients who do not have a medical record number in the area in which the Program is located. Information gathered during the referral, screening and assessment for the Dependency Certificate should also be included in the medical file, as should the Dependency Certificate and any documentation pertaining to court orders.

Confirmation of a successful admission should be provided back to the referring party.

In line with local policies and procedures, the admission process may also include a search of the patient’s possessions to check for and remove drugs, alcohol, cigarettes or dangerous items that could present a risk of harm to the patient, other patients or staff.

---

16 The Act stipulates that a member of staff for the NSW Health Service may transport a person to or from the inpatient unit. (s. 19)
17 This is likely to include situations where the patient resists being taken by family or ambulance; threatens to abscond following Dependency Certificate and prior to admission; and/or becomes violent.
18 Such as an order for assessment (section 10 of the Act).
Orientation should take place as soon as the patient is admitted to the unit, unless the patient’s mental or physical state prevents them from engaging in the induction activities. In this case, orientation should take place as soon as is practicable after admission. It is likely that aspects of the induction process, such as providing information about the patient’s rights and about the Program rules, will need to be repeated as the patient progresses through the Program and as their cognitive capacity improves.

The purpose of orientation is to:

- admit and orient the patient to the unit
- provide the patient and their nominated primary carer with information about the unit, including expectations regarding behaviour
- provide information to the patient and their nominated primary carer about their rights in relation to the program, including the process for reviewing and extensions of the Dependency Certificate and their right to appeal.

The orientation will include a ‘tour’ around the unit and the provision of the following specific information:

- The ‘rules’ of the Program and the unit, including roles and responsibilities of patients and staff, behavioural expectations, rules related to smoking on the premises, an overview of the structured day on the unit, visiting hours, the role of and access to Official Visitors and procedures for complaints.
- Overview of the Program including the objectives (why the patient has been admitted), the stages of the Program (inpatient and community based), expected treatment components, the legal status of the patient and the role of the court in reviewing, extending and revoking Dependency Certificates.
- Details of the patient’s legal rights and other entitlements under the Act, including the right to appeal.

Information will be provided in written and verbal form to both the patient and their primary carer and file notes should indicate that information has been provided and discussed.

Identification of the primary carer

The Act stipulates that a patient may nominate a person to be their primary carer under the Act. This is also in line with good practice outlined in the national policy for Consumers and Carers. The primary carer should be informed of the patient’s admission to the program, and, where possible and appropriate, involved in the development of the care plan, particularly the community-based component of this plan. The primary carer may be a family member, carer, friend or another professional who is known to the patient. This may include the patient’s Public Guardian, if applicable and appropriate.

It is likely that a nominated primary carer will have been involved in the referral, screening and assessment stages of the patient journey. If not, the patient will be asked to identify a primary carer upon admission to the inpatient unit. The Act stipulates that the primary carer must be notified within 24 hours after a Dependency Certificate has been issued.

---

19 Where the Involuntary Treatment Program is co-located with a voluntary treatment program, the program will require induction and orientation policies and guidelines that are specific to the involuntary program, although there may be some overlap with the guidelines as they apply to the voluntary program.
20 Set out under sections 16, 18 and 45 of the Act.
21 If the primary carer does not attend the unit with the person either at the time of admission or shortly afterwards, the unit staff will contact the primary carer by telephone and provide written documents by post or email.
22 Section 13(1)
24 Section 17(1)
If the patient is unable to nominate a primary carer on admission, they will be asked again at an appropriate time, but within 24 hours.

A patient may choose not to nominate a primary carer. They may also choose to nominate a person who is to be excluded from being given notice or information about them under the Act. The patient cannot exclude the AMP from being given notice or information about them.

The nomination will be documented and kept in the patient’s medical file. Formal notification will also be provided to the nominated person, by the program.

**Initial inpatient assessment**

An initial assessment following admission to the inpatient unit is required to:

- review the withdrawal and management approach identified in the assessment for the Dependency Certificate, including pharmacotherapy interventions, management of symptoms and providing supportive care. This should be undertaken in consultation with the patient if possible, to promote their right to choose treatment options available to them

- undertake a physical examination and observations to inform the withdrawal management plan. This might include assessing the type and severity of withdrawal symptoms of patients who are withdrawing at the time they are admitted to the inpatient unit

- identify and manage risks associated with the withdrawal, including the risk of mental health issues and the risk of harm to self (including suicide) and others during and after withdrawal

- inform the global care plan including goals for all stages of the patient journey through the IDAT Program (inpatient, inpatient post-withdrawal and community based)

- commence development of a therapeutic relationship with the patient.

The initial assessment in the inpatient unit should include a nursing assessment and plan and review by a doctor. The assessment should be followed up by the admitting consultant within 24 – 48 hours following admission and will build on the assessment undertaken to issue the Dependency Certificate. This initial assessment in the unit is therefore important to reflect duty of care and to provide an opportunity to begin building effective therapeutic relationships with the patient.

Some elements of the initial assessment (such as the physical examination and observations) may not be required upon admission if:

- the supervising consultant for the inpatient unit undertook the assessment for the Dependency Certificate (as the AMP), and

- there is no elapsed time between the assessment for the Dependency Certificate and admission to the unit.

Staff undertaking the initial assessment upon admission should:

- be non-judgemental, empathetic, respectful and objective

- explain the assessment process and encourage the patient to actively participate in treatment decisions, as far as possible

- communicate clearly, allowing time for the patient to understand their withdrawal management and on-going treatment, including assistance that is available to them and the reason behind treatment decisions.

The patient newly admitted to the unit may have a reduced ability to absorb information and to engage fully in the process, until they have commenced or completed their withdrawal. However, it

---

25 Section 13(2)
26 NSW Health (July 2008) op.cit pp 4 - 5
is the responsibility of the program staff to endeavour to engage with the patient through all stages of the care to enable the patient to participate as fully as possible, within their capacity.

Psychometric testing and other assessments required by other members of the multi-disciplinary treatment team should not be undertaken until after withdrawal has been completed to enable valid assessments to be undertaken.

There are a number of outcome tools that are required to be conducted at admission, prior to discharge, 1 month (community care component), 3 months (community care component) and 6 months (community care component). At admission, due to the patient’s withdrawal status, it may not be appropriate to conduct the outcome tools; it is preferable that these tools are completed within 5 days of admission.

The core outcome tools to be completed are (Appendix 3):
- Severity of Dependence Scale (SDS)
- The Australian Treatment Outcomes Profile (ATOP)
- SF-12v2 – quality of life questionnaire
- Montreal Cognitive Assessment (MoCA)
- IDAT Post-Discharge Service Attendance Form

A business rules document has been developed to assist with the use of these outcome tools (Appendix 3).

**Assessment of mental health and suicide risk**

A key element of the initial assessment upon admission to the inpatient unit is the assessment of mental health and suicide risk. Management of risk during the inpatient stage of the Program should be documented in a risk management plan. Assessment of risk and revision of the risk management plan should be on-going throughout the inpatient stay.

**The global care plan**

Following assessment, all domains (substance use, physical health, mental health, socioeconomic, psychosocial, legal and other) of the care plan are to be completed across the IDAT patient journey including:
- withdrawal management (described under section 2.4)
- risk management (described above)
- post-withdrawal (inpatient) (described in section 2.5)
- discharge plan (described in section 2.6)
- community-based treatment (described in section 2.7, and is primarily developed by the IDAT transfer of care coordinator and the community care coordinator).

A care plan (Appendix 1) is a core requirement of structured drug and alcohol treatment. It will:
- identify goals, based on assessed need (see below), relating to substance use, physical and mental health and functioning
- identify the structured interventions that will be provided to enable achievement of the goals and demonstrate how these interventions will achieve goals
- be time-specific and identify clear roles and responsibilities for care team members, other professionals, the patient and their primary carer (if appropriate)
- align to the goals and activities specified in the discharge plan and identify strategies and interventions to support the patient (and care team) to work towards achieving these
be provided to the patient and their primary carer (if appropriate)
be regularly reviewed and updated in response to changing needs and goals of the patient
include the unit’s standard involuntary treatment program such as structured group, exercise and other activities program.

The plan will also identify triggers and risks of relapse (that will be present after discharge) and will outline strategies to address these triggers and risks to prevent relapse or to respond to it appropriately if required. This should include harm minimisation approaches and education. Relapse prevention strategies will be reinforced and practiced through structured interventions at the inpatient unit (described below).

All plans should be placed on patient files and copies should be provided to the patient, primary carer (where appropriate) and community care coordinator (who may not have access to inpatient medical records).

These plans will also be made available to the Magistrate for review and extension of Dependency Certificates.

Care plans should be continuously reviewed and revised to reflect outcomes of interventions and changes in risk and need. Specifically, the plans will require revision based on further assessment after the medically supervised withdrawal has commenced (and is completed) and as the patient’s capacity to engage in further, valid assessments improves. This is discussed further in section 2.5.

Revised care plans should be provided to patients, caregivers (where appropriate) and community care coordinators as needed, or if substantial change/s are made.

It is good practice that a patient (and their primary carer, if appropriate) is actively involved in the development and review of their care plan. This allows the patient to articulate their own goals, fosters ownership of the plan and encourages motivation to achieve goals.

It is likely that patients participating in the Program will not have the capacity or desire to be actively involved in care planning when they are first admitted. The treatment team should continue to motivate the patient to improve active engagement throughout the patient’s inpatient stay. Active involvement in planning is particularly important for discharge and community-based care, to increase the likelihood that the patient will be motivated and continue to engage in the voluntary component of the Program, after discharge.

Identification of the case managers and care coordinators

An inpatient case manager will be identified for the patient upon their admission to the inpatient unit. This role is located at the IDAT Inpatient Unit and may be shared across the multi disciplinary team. The inpatient case manager will have responsibility for the planning and management of care during the inpatient stage of the Program.

If not already appointed during the screening and assessment phase, the inpatient treatment team will be responsible for identifying a community care coordinator located in the community to which the patient will return.27 The treatment team and more specifically the IDAT transfer of care coordinator should work closely with the community care coordinator to plan for discharge and enable continued care and support post discharge. It is important for the community care coordinator to establish a trusting, respectful relationship with the patient (and their family if appropriate), before the patient is discharged into the community.28 This may require the community care coordinator to visit the patient at the inpatient unit.

The inpatient team will convene regular multi-disciplinary case conferences to review the patient’s care and to oversee revision and implementation of the care plan as required. The community care coordinator is part of the care team and should be included in case conferences.

27 It is likely that a community-care coordinator may have already been identified during initial screening and information gathering.
28 If they do not have a pre-existing relationship.
Review of the Dependency Certificate

Dependency Certificates must be reviewed by the Magistrate as soon as is practicable[^29], ideally no more than seven days after they are issued. The purpose of the review is for the Magistrate to ensure that, on the balance of probability, the patient meets the criteria for detention under the Act[^30].

The review may be attended by the patient, their primary carer, the AMP and/or delegated Program staff, and other medical witnesses, as appropriate. The review of the Dependency Certificate will include a review by the Magistrate of the AMP reports and recommendations and the care plan. The Magistrate may also seek the views of the patient and their primary carer and may discuss the Dependency Certificate with medical and clinical staff present.

The possible outcomes of the review are:

- confirmation of the Dependency Certificate and continuation of treatment as planned
- confirmation of the Dependency Certificate, but for a shorter period, in which case the care plan, including the discharge plan, will be revised
- revocation of the Dependency Certificate and discharge from the involuntary inpatient unit, noting the patient should have the option of staying on in the unit as a voluntary patient if it is likely to be beneficial[^31].

Required skills, knowledge and experience

Key competencies required at this stage include:

- ability to relate and interact with patients with complex and multiple needs, and their families
- undertaking assessments to identify and prioritise need
- contributing to development, coordination and review of care plans
- ability to make referrals based on identification of need
- contributing to an integrated, coordinated care and prioritisation approach and working in collaboration with other people from a variety of agencies
- providing brief interventions and using motivational interviewing techniques
- managing and responding to risk and safety issues, including managing abusive and aggressive behaviour
- provision of support and fostering a supportive environment
- upholding rights and maintaining dignity of patients
- cultural competence.

All staff involved with patients on the Program should have experience and skills of working with substance misuse patients, with multiple and complex needs.

Staff from other government agencies involved in this stage will also need to have a range of relevant skills and experience, specific to their role in supporting the Program. For example, police officers involved in staying with the patient until they are transported to the inpatient unit should ideally have experience of working with intoxicated, aggressive and uncooperative patients and will need to demonstrate safe management of these individuals. Specific required skills and experience for non-health staff will need to be identified and agreed with relevant government agencies and are not discussed further in this Model of Care.

[^29]: Sections 14 and 34
[^30]: Action 34
[^31]: However, it should be noted that involuntary beds should not be used for voluntary patients.
2.4. Medically supervised withdrawal

Overview: This stage provides a medically supervised withdrawal for admitted patients before further medical and psychosocial interventions and support can be provided to address other aspects and consequences of substance misuse.

The aim of withdrawal is to initiate abstinence and attain patient safety while frequently monitoring the individual and providing appropriate care when necessary. Planning and coordinating post-withdrawal care is an integral part of the treatment process, including throughout withdrawal.

This stage involves a number of dimensions or aspects, including assessment for withdrawal to inform the development of a withdrawal management plan, supervised withdrawal (including psychosocial and pharmacological interventions) and monitoring.

Development of the withdrawal management plan

Information to inform the assessment for withdrawal will have been gathered during the AMP’s assessment for a Dependency Certificate and may be further supplemented by the initial assessment undertaken at admission. The withdrawal management plan will draw on this information to:

- predict and consider any risks that could occur while the patient is withdrawing, based on an assessment of drug use, health issues and previous complications with withdrawal
- match the patient with a withdrawal treatment approach that maximises their safety and provides the most effective and economical options for their management
- identify and address any barriers to withdrawal and any specific needs which may interfere with a successfully completed withdrawal
- consider the use of medication to provide symptomatic relief, treat complications and co-existing conditions and to reduce the intensity of the withdrawal
- consider the use of supportive care to minimise the environmental stimuli that may exacerbate withdrawal symptoms and to enhance the patient’s ability to complete withdrawal successfully
- identify and develop strategies to help the patient cope after withdrawal.

The withdrawal management plan should be incorporated in the global care plan for the patient and should be shared and discussed with the multi-disciplinary care team and with the patient and their primary carer, if appropriate.

Supervised withdrawal

Supervised withdrawal should be undertaken in line with the NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines.

The guidelines state that the overriding principles of matching withdrawal treatment interventions and managing withdrawal are that:

- the intervention is safe for the patient
- the intervention is only recommended if it is likely to succeed
- the patient has a right to choose from the range of treatment options. In practice, this may not be appropriate for Program participants, who do not have the capacity to make an informed choice when they are admitted to the Program.

---

32 NSW Health (July 2008) op.cit p.3
33 ibid.
34 ibid p.15
It is likely that patients being admitted to the Program will already be in withdrawal, depending on the timings of the preceding assessment for a Dependency Certificate and the subsequent transport to the inpatient unit. In this case, care must be taken to promptly identify the withdrawal, minimise the risk of complications, manage the withdrawal symptoms and stabilise the patient’s presenting medical and psychiatric condition.

It is also likely, given the patient group that patients participating in the Program may require withdrawal for polydrug use, or selective withdrawal in cases where a patient is using a prescribed maintenance drug while misusing other substances. This should be considered in the development and implementation of the withdrawal management plan.

Pharmacological treatment should be guided by the severity of the withdrawal and the drug or drugs from which the patient is withdrawing. Specific prescribing regimes, including monitoring, routine observations and appropriate supportive care are provided for each drug type in the *NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines* 35. Pharmacological treatment should be overseen by the AMP, with monitoring and supportive care undertaken by the inpatient care team.

Supportive care should be provided hand in hand with monitoring of the physical signs and symptoms of withdrawal. The key elements of supportive care are 36:

- providing information to the patient to allay fear and anxiety
- managing the environment to minimise stress, maintain safety and privacy and ensuring the patient is physically comfortable
- providing reassurance to the patient and their primary carer, including positive encouragement and feedback on progress
- introducing coping skills, such as relaxation techniques, appropriate diet and methods to reduce cravings.

Throughout withdrawal, the care team should also work with the patient to encourage behavioural changes that allow them to develop a positive attitude. This includes supporting the patient to express their emotions and discuss their experience in a safe and supportive environment. Approaches for working with challenging patients are discussed in section 3.1. At appropriate times throughout acute withdrawal, staff may remind the patient about their rights and about the rules and expectations of the Program.

**Monitoring withdrawal**

Withdrawal must be monitored in line with clinical guidelines and depending on the severity of withdrawal. As well as offering supportive care, monitoring involves the AMP and the nursing staff undertaking and recording frequent observations.

Routine observations include examination of general appearance of the patient and presence of withdrawal symptoms (such as sweating, tremor, agitation and coordination) and recording baseline observations such as respiration, pulse, temperature and blood pressure.

In addition, standardised withdrawal scales, provided in the clinical guidelines 37, should be used to systematically measure the severity of withdrawal, to complement clinical assessment and to identify change during the withdrawal. It is also important to continue to monitor the patient’s mental health state and risk of harm to self and others as this may change during acute withdrawal.

Progress of withdrawal should be reported to multi-disciplinary care team meetings, as required.

As the patient completes withdrawal, the patient should be encouraged and supported to participate in the structured day of the inpatient unit. For example, they may be supported to attend group programs, if this is appropriate.

---

35 Ibid pp. 21-58
36 Ibid p.17
37 Ibid pp.67-90
Required skills, knowledge and experience

In addition to those outlined in sections 2.3, the following competencies are required to deliver this stage of the Program:

- prescribing and review of pharmacotherapies, including controlled drugs
- dispensing of pharmacotherapies
- monitoring of consumption of pharmacotherapies
- identification and management of complications and risks during withdrawal.

Administrative, management and other skills and knowledge outlined in section 2.3 are also applicable.

2.5. Post withdrawal inpatient treatment

Overview: During this stage, ongoing intensive support and interventions are provided to address the patient’s bio-psychosocial needs and to assist them to move towards improved substance misuse, health (physical and mental) and social functioning outcomes.

This involves further and on-going assessment, continued development and review of the care plan and the provision of a range of structured medical, psychological and other interventions and supports, delivered by a multi-disciplinary team. A key principle of care post withdrawal is the involvement and engagement of the patient (and their primary carer if appropriate) in all aspects of care planning and review.

Continued implementation and review of the global care plan

Throughout the inpatient stay, the care plan will be reviewed and further developed to better reflect the patient’s needs and goals, which are likely to change as the patient progresses through the Program.

This care plan should be reviewed and revised with the patient (and their primary carer, if appropriate), who should be assisted to articulate goals and to work with the care team to achieve these.

The care plan will address the domains across all stages of the IDAT patient journey as identified in section 2.3, ‘Commencement of care plan’.

The inpatient team is responsible for managing the post withdrawal (inpatient) care and for coordinating the multi-disciplinary care required to implement the plan. All team members have a role in motivating the patient to engage appropriately and actively in care planning and in structured interventions.

Multi-disciplinary case conferences should be held weekly, or more often if required. These should be attended by all Program staff, including the community care coordinator where possible (this may involve the use of teleconferencing facilities). Other professionals may be invited to attend the meeting, as appropriate, to discuss particular aspects of the care plan. The discharge plan and community based care should continue to be developed throughout the sub-acute inpatient stage.

The multi-disciplinary Program team, including the IDAT inpatient case manager and the IDAT transfer of care coordinator, should engage with the community care coordinator to develop the treatment and support needs for the patient post discharge. This should also include consideration of the use of brokerage funds to facilitate the required treatment and support in the community.

Ongoing Intervention

Following the completion of medically supervised withdrawal, further assessment will be required to inform the post withdrawal (inpatient) care, to identify needs which may have changed since admission, and to consider other interventions and treatment that may be required.

A range of assessments will need to be completed by various members of the multi-disciplinary care team. Outcomes of the assessment should be shared with the care team to inform the post
withdrawal (inpatient) care and to ensure that the care can be implemented in a coordinated, integrated way.

Assessments should be undertaken in relation to substance misuse, health (including mental and physical), neuropsychological functioning and social functioning. Assessments should not only identify needs and outcomes, but should also be used as an approach to establish rapport with the patient and to encourage engagement in treatment.

As well as the core outcome tools outlined in section 2.3, standardised tools should be used to undertake assessments and measure outcomes to:

- provide valid assessments
- increase accountability
- enable assessment of outcomes and monitoring of the degree of change achieved over time
- ensure consistency in assessments undertaken by different practitioners
- enable comparison of outcomes for quality management and continuous improvement purposes.

Examples of standardised screening and assessment tools that could inform the post-withdrawal care are provided in the table below. Further information is available in the Network of Alcohol and Other Drug Agencies (NADA) 2009 publication, commissioned by NSW Health, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*.

### Table 1: Examples of standardised tools for substance misuse, mental and general health and functioning

<table>
<thead>
<tr>
<th>Purpose/ domain</th>
<th>Examples of standardised tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of addiction</td>
<td>Severity of Alcohol Dependence Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Severity of Dependence Scale</td>
</tr>
<tr>
<td>Global screening, assessment and outcome measures</td>
<td>Addiction Severity Index</td>
</tr>
<tr>
<td></td>
<td>Maudsley Addiction Profile</td>
</tr>
<tr>
<td>General drug and alcohol use</td>
<td>Drug Abuse Screening Tool</td>
</tr>
<tr>
<td></td>
<td>Alcohol, Smoking and Substance Involvement Screening Test</td>
</tr>
<tr>
<td>Craving measures</td>
<td>Cocaine Craving Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Penn Alcohol-Craving Scale</td>
</tr>
<tr>
<td>General health and functioning</td>
<td>Short-Form health Survey</td>
</tr>
<tr>
<td></td>
<td>Life Skills Profile</td>
</tr>
<tr>
<td>General mental health</td>
<td>Kessler Psychological Distress Scales</td>
</tr>
<tr>
<td></td>
<td>Brief Psychiatric Rating Scale</td>
</tr>
<tr>
<td>Specific mental health screening</td>
<td>Impact of Events Scale</td>
</tr>
<tr>
<td></td>
<td>Beck Inventory</td>
</tr>
<tr>
<td>Positive mental health</td>
<td>Scales of Psychological Well-being</td>
</tr>
<tr>
<td></td>
<td>Recovery Assessment Scale</td>
</tr>
</tbody>
</table>

*Source: adapted from NADA (2009)*

A range of other assessments, tests and approaches may also be required, including:

- neurological assessments to assess various aspects of perceptual, motor, verbal, memory and cognitive functioning

---

specific assessments and tests relating to particular client groups, e.g. older patients (i.e. risk of falls, hearing tests) and pregnant women (e.g. prenatal examinations)

• medical examinations and tests to identify physical health issues

• identification and strength of relationships and appropriate social networks

• functional assessment of skills of daily living and self care capacity

• semi-structured interviewing to gather specific information and address particular concerns

• assessment of other welfare issues, such as assessments for public housing and income support or benefits.

A number of these assessments and tests will require input from specialist health or other workers, following a referral from the Program, for example the public guardian officer, or a homelessness officer.

It is important to continue to monitor the patient's mental health and risk of harm to self and others throughout their participation in the Program. This enables staff to manage changes in risk that may arise as the patient engages in treatment and starts to address factors leading to and resulting from their substance use.

In line with NSW Health guidelines\(^\text{39}\), patients may also be offered screening for HIV, and hepatitis B and C and offered counselling and advice about treatment and vaccinations, if appropriate. Testing is voluntary.

**Structured interventions**

A range of structured interventions will be provided by Program staff during the post withdrawal inpatient stage, as indicated by the global care plan, to reinforce changes in behaviour and to support the patient and equip them with skills to make healthier lifestyle choices. These might include:

• structured psychosocial interventions\(^\text{40}\), including cognitive behavioural therapy (CBT), coping skills training, contingency management

• harm minimisation / reduction

• advice, information and education about substance misuse

• diversion and recreation activities

• occupational therapy

• counselling, e.g. trauma or grief counselling

• living and life skills, including cooking, cleaning and budgeting, in preparation for re-integration into the community

• relapse prevention and active practice of relapse prevention skills during therapy

• family education and support

• self help groups (such as Alcoholics Anonymous, Narcotics Anonymous).

All structured interventions should be underpinned by motivational and engagement approaches, such as motivational interviewing, to encourage the development of insight and to develop more effective life skills.

As with matching withdrawal regimes, intensive, structured treatment should be matched to the needs and characteristics of the patient, taking into account their:

• cultural background

• language and literacy

\(^{39}\) NSW Health (July 2008) op.cit p.18

• cognitive and physical functioning
• mental health problems, for example, high levels of anger, anxiety or depression
• previous treatment experience
• personal preferences.

Structured interventions should include both individual and group-based modalities.

To maximise the available time and physical space in the inpatient unit, a rotating program of group interventions should be developed. The rotating program should enable ‘rolling starts’ but care should be taken to ensure that a patient receives a required intervention even if the rotating program timetable does not align to the patient’s length of stay. For example, if a care plan identifies that a patient would benefit from information on nutrition and the group session is scheduled for after the expiry of the patient’s Dependency Certificate, efforts should be made to provide the information, in an alternative way, before discharge.

Other interventions

A range of other interventions will also be required to address the patient’s needs and achieve goals specified in the care plan. These may include:

• treatment of and support for:
  - medical conditions
  - co-morbid mental health problems
  - neurological disorders

• interventions to support social rehabilitation, to assist reintegration into the community. This might include:
  - advocacy and liaison with relevant community-based services (both primary and secondary)
  - advocacy and practical assistance to secure adequate housing and maintain acceptable living standards
  - practical assistance to access income support and benefits
  - enhancement of leisure time
  - restoration of relationships with family and friends
  - considering and facilitating engagement in education and vocational training and / or employment
  - arranging a public guardian.

Some of the interventions may require a referral to other specialists and professionals. Referrals and feedback should be discussed by the inpatient team.

Extension of the Dependency Certificate

An AMP may apply to extend the length of the Dependency Certificate if:

• “they are satisfied that the person is suffering from a drug or alcohol-related brain injury, and
• additional time is needed to carry out treatment and to plan the person’s discharge

---

41 i.e. a person can attend a group intervention at any time rather than waiting for a ‘start’ date. Using this approach, the rotating program should not be based on a stepped intervention where each session builds on previous sessions.

42 Section 35
they present, with the application, a proposed treatment plan to be followed during the additional time granted”.

A request for extension should be based on a comprehensive assessment of the on-going needs of the patient, identification of outcomes that have already been achieved and those that have still to be achieved and a consideration of whether the patient continues to meet the criteria for detention under the Act (outlined in section 1.2). Consideration should also be given to the accommodation options available to the patient on discharge; for example, as a matter of principle a patient should not be discharged from the inpatient unit into homelessness.

**Required skills, knowledge and experience**

In addition to those outlined in section 2.3, the following additional competencies are required to deliver this stage of the Program:

- competencies relating to the provision of specific group or one to one interventions, such as CBT, counselling, harm minimisation, living and life skills
- provision of education and information
- undertaking reflective practice to improve care and outcomes for the patient, to improve personal professional knowledge and practice, and to contribute to improved knowledge and professional practice of others
- provision of and participation in supervision and clinical review
- supporting and reinforcing behaviour change
- facilitating social reintegration
- contribution to the development and implementation of discharge plans
- working with other agency officers e.g. housing, public guardian.

Competencies will vary according to the role each team member undertakes as part of the multi-disciplinary care team and based on their professional specialty. However, all staff involved with patients on the Program should have experience and skills for working with substance dependent patients, with multiple and complex needs.

Administrative, management and other skills and knowledge outlined in section 2.3 are also applicable.

### 2.6. Discharge

**Overview:** During this stage, the patient is discharged from the inpatient unit and transitioned to the community-based stage of the Program. The IDAT outcome tools are required to be completed prior to discharge.

Discharge may be back to the patient’s community, to another identified and agreed community, to a residential rehabilitation setting or to another inpatient setting, for example, if the patient requires admission to an acute health or mental health unit for further treatment.

**Discharge planning**

Discharge is underpinned by a discharge plan, which is commenced at admission to the inpatient unit, to ensure there is a continuum of care between the inpatient and community based components of the Program.

The discharge plan should be coordinated by the inpatient case manager, IDAT transfer of care coordinator and community care coordinator in consultation with the multi-disciplinary care team. Discharge planning must include liaison with community-based providers, such as residential treatment facilities and specialist community services, to negotiate access to services post discharge.
It is essential that the patient and their primary carer are made fully aware of options for treatment and support after discharge and are strongly involved in discharge planning and choosing treatment/support options.

The discharge plan should be reviewed and revised throughout the inpatient stage of the Program, to reflect changes in the patient’s needs and goals, to update timeframes for discharge and to account for changes in capacity of community and other services to take on the patient’s care upon discharge.\(^{43}\)

The global care plan allows for the treatment goals within each domain across the post withdrawal (inpatient) care, discharge and community-based care components to be fully integrated in order to enable a continuum of care. The discharge plan forms an integral part of the community-based care component (described in section 2.7) which includes goals, actions, timeframes and roles and responsibilities for continued care and support post discharge.

Whereas the community-based care activities and goals are over a number of months, the discharge plan stipulates goals and activities at a point in time (at discharge). The discharge plan is guided by and guides the development and implementation of the post-withdrawal (inpatient) care, as interventions that are provided during the inpatient stage must support the patient to work towards a successful, planned discharge and to sustain changes post discharge.

The discharge plan should identify:

- likely date for discharge
- areas of concern or risk that are yet to be addressed
- location to which the patient will be discharged, including geographical location and accommodation options
- the community care coordinator
- social and support networks available to the patient on discharge
- existing links to specialist and non-specialist services that are available in the community, such as GPs, mental health services, drug and alcohol services
- the possibility of engagement in further residential rehabilitation
- transportation from the unit
- immediate activities to take place upon discharge, such as appointments with services.
- treatment and support needs that may require brokerage funding, including transportation from the unit.

As a priority, discharge planning will identify the patient’s accommodation arrangements in the community and work with the patient, their families, public housing and/or other specialist and non-specialist providers to ensure that the patient has suitable accommodation on discharge.

Discharge planning should also involve:

- working with the patient’s primary carer and significant others to prepare them for the discharge and to support them to be able to support the patient appropriately in the community
- establishing or maintaining links with other community-based services to inform community-based care and to set up initial appointments post-discharge.

---

\(^{43}\) For example, a discharge plan will be updated if a place becomes available at a residential treatment program.
Assessment for suitability for discharge

There are a number of circumstances in which a patient can be discharged from the inpatient stage of the Program:

- if the Magistrate revokes a Dependency Certificate at the initial review\textsuperscript{44}
- the Dependency Certificate has expired
- “if the AMP is satisfied that\textsuperscript{45}:
  - a person’s continued presence at the treatment centre will not achieve the purpose for which they were detained
  - the person no longer meets the criteria for detention under the Act”

In this case, the AMP would record in the patient file that the patient no longer meets the criteria for Section 9 of the Act and the patient would be discharged.

- if an AMP seeks to extend the Dependency Certificate, but this is not granted by the Magistrate\textsuperscript{46}. In this case the patient is discharged once the Dependency Certificate expires.

For discharge that is not a result of a revocation of a Dependency Certificate, the AMP will undertake an assessment to determine suitability for discharge. This should involve input from the multi-disciplinary care team and from the patient and their primary carer.

A discharge summary should be developed and made available to the community care coordinator and other professionals who will be involved in the patient’s on-going care. This should include an overview of the patient’s treatment as an inpatient and should provide details of current medications and any areas of ongoing concern.

Discharge should be notified to the reviewing body as soon as possible, if discharge occurs prior to the planned expiry date of a Dependency Certificate.

Prior to discharge (or as soon as is practicable) the discharge plan and summary should be finalised and signed by the AMP.

Transfer for case management responsibility

At discharge, primary case coordination responsibility transfers from the inpatient case manager to the IDAT transfer of care coordinator and the community care coordinator. One of these roles will be identified as the main case coordinator and this will be determined on a case by case basis and take into account factors such as patient’s area of residence and treatment support needs. Ideally, this should be marked by a formal discharge case conference, involving the patient, and should be documented in the discharge plan and summary.

The IDAT transfer of care coordinator and where possible the community care coordinator should assist the inpatient team in physically supporting the patient (and family) at discharge, in managing anxiety associated with discharge and in implementing and monitoring the community-based care.

Required skills, knowledge and experience

Competencies, skills, knowledge and experience for this stage are as identified in sections 2.3 and 2.5. In addition, staff involved in this stage must either have an understanding of the local service system into which the patient is being discharged, or must be able to acquire this knowledge in order to support the implementation of the discharge and community-based care.

---

\textsuperscript{44} Section 34(7)
\textsuperscript{45} Section 24
\textsuperscript{46} Section 36
2.7. Community based treatment

Overview: The community based component of the Program provides support and interventions to encourage continued healthy lifestyle choices, to continue to work towards goals and to address and manage the risks of relapse after the patient has been discharged from the inpatient phase of the Program. This stage responds to the need for long term, comprehensive and holistic supports to achieve sustained behaviour, psychosocial, health and wellbeing outcomes.

This component of the Program provides support and interventions for up to six months; the first few weeks involves intensive case management and support and the remaining support involves a stepped down approach. Over this time, support decreases in intensity and frequency as the patient builds links and relationships with alternative community based treatment and support providers. It is acknowledged that some patients may require longer term management with no stepped down approach.

Implementing community based care

The IDAT transfer of care coordinator and the community care coordinator are responsible for the development, implementation and review of the global care plan in the community. They are also responsible for the completion and recording of the outcome tools at three time intervals across the community care component of the Program. How responsibility is distributed is to be negotiated between the transfer of care coordinator and community care coordinator on a case by case basis.

The community based care is continually revised and evolved over the duration of the Program to reflect the patient’s changing needs and goals. The development of patient goals for treatment and support in the community commences at admission to the inpatient unit as part of the global care plan and continues to be refined throughout the patient’s treatment as an inpatient. It is finalised prior to discharge, in line with the discharge plan, and is then continually monitored and reviewed as part of community based support. In some instances the global care plan may be commenced as early as screening and assessment, including goals for community-based care, this is encouraged wherever appropriate.

The domains of the care plan should be completed for community-based care as they are for post withdrawal (inpatient) care and are described in section 2.3 and 2.5. Additionally, the care plan should encourage the patient to set short, medium and long term goals for the community, with the idea being to achieve milestones over time that contribute to long term, sustainable changes in substance misuse, mental and physical health, neurological functioning and social functioning.

Activities to implement the care plan once the patient has been discharged should include:

- referrals and negotiation of interventions and supports, based on need
- sharing information and assessments and undertaking joint working with a range of services, with the consent of the patient
- establishing case conferencing meetings to manage and review the plan
- continued intensive motivational interviewing and assertive, proactive follow up to try to increase patient’s level of motivation and engagement
- continued relapse prevention and harm minimisation interventions and appropriate re-engagement if a patient relapses
- flexible engagement with the patient, that adapts to the patient’s changing situation and circumstances over time. This may lead to more or less frequent contact with the patient over time: For example, more support may be required during a period of anxiety or stress for the patient and less will be required if the patient accesses a residential facility.
- Identification of treatment and support needs that may require brokerage funding including housing, health care and community and vocational pursuits. (Appendix 2 IDAT Brokerage Guidelines)
On-going assessment and monitoring

Progress against short, medium and long term goals and outcomes should continue to be monitored so that changes can be made to the care plan as required. Monitoring involves undertaking:

- formal assessments, completing the outcome tools where possible to continue to measure change in areas of identified need and risk
- informal assessments, for example to consider levels of engagement and motivation and to respond accordingly to improve these.

As far as possible, it is important that formal assessments are consistent with those used by the inpatient team, to be able to consider (and demonstrate to the patient) the level of change over time through the whole course of the Program. This includes the continued collection and recording of the IDAT outcome tools at 1 month, 3 months and 6 months post inpatient discharge. Consistent, comparable measurement is also useful for monitoring and evaluation purposes.

Interventions and supports

A range of interventions and supports should be considered for the patient, based on their needs and goals, including:

Table 2: Examples of possible supports and services for patients post discharge

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Universal services</th>
<th>Specialist services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mainstream health</td>
<td>Specialist drug and alcohol — including residential and community based services, and those provided by government and non-government organisations</td>
</tr>
<tr>
<td></td>
<td>Aboriginal health</td>
<td>Inpatient and community mental health</td>
</tr>
<tr>
<td></td>
<td>Child and family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Legal and advocacy</td>
<td>Psychological services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Domestic violence Psychological services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self help groups</td>
</tr>
</tbody>
</table>

The IDAT transfer of care coordinator and the community care coordinator will be responsible for identifying patient needs and making referrals to relevant services to support implementation of the care plan in the community. This will require the care coordinators to have a good understanding of the available services and the service systems (e.g. eligibility criteria and referral pathways) in their area.

Planned step down of support

It is important that the care coordinators support the patient in the community to work towards a goal of successfully exiting the Program. This is important to encourage the patient to be independent of the Program and to continue to improve their quality of life. It is also essential from a resource perspective to maintain the capacity of the Program to work with other patients.

For many patients, some form of on-going support may always be required, as a result of limited functioning and capacity. It is important that these patients are supported to access appropriate mainstream services.

To work towards successful exit, there should be a planned step down of the intensity and frequency of support by the care coordinators. This should be undertaken in consultation with the patient and their family / carers and should occur at a pace that is acceptable to the patient. It is
essential that appropriate links and relationships with other community based services, including specialist and mainstream services, are in place before the step down occurs to prevent the risk of disengagement and relapse.

**Required skills, knowledge and experience**

Competencies, skills, knowledge and experience for this stage are as identified in sections 2.3, 2.5 and 2.6.

During this stage, it is particularly important that managers and clinical supervisors in the community have competence and experience in supporting team members to work with the target client group. This may require supporting their team members to extend their scope of practice and creating strong, appropriate professional support networks. This is particularly important in cases where the community care coordinator does not have extensive experience of working with patients with a history of chronic substance dependence and / or co-morbidity and who may be challenging to engage.
3. Patient management issues and specific patient groups

3.1. Patient management issues

The target group for the Program comprises individuals who are likely to present management challenges to inpatient and community-based Program staff. The following procedures and interventions may be required in order to provide effective treatment under the Act.

Managing coerced patients

Patients admitted to the inpatient unit are coerced, in that admission and participation in medically supervised withdrawal is involuntary. Working with coerced patients raises significant issues in relation to:

- resistance to change and lack of motivation to engage in treatment and interventions
- different views and expectations about goals regarding substance misuse and other psychosocial domains
- behavioural issues, such as aggression and anger towards staff and other patients and self-harm, including suicide attempts.

A guiding principle in the planning and implementation of coerced care should be that utmost precaution is taken not to exacerbate the harms affecting the patient or to introduce new serious harms.

Unless motivation and resistance to change is addressed, it is unlikely that the patient will engage in treatment and interventions post withdrawal as an inpatient or after discharge to the community, leading to relapse and the potential for worse health, mental health and psychosocial outcomes. It is recognised that motivating and engaging patients with severe cognitive impairment and severe mental illness may be difficult.

Examples of the risks resulting from poor engagement at discharge include:

- re-instatement of substance use with rapid intensification to pre-admission levels, potentially resulting in overdose as a result of reduced tolerance
- other physical, neurological or psychiatric complications arising from sudden reversal of neuroadaptation followed by sudden reinstatement of substance dependence
- worsened hopelessness if substance use is re-instated
- vilification of the patient by family/significant others if the intervention fails to facilitate and sustain significant change.

During withdrawal, behavioural issues will need to be addressed through robust assessment, e.g. of the risk of self-harm, appropriate supervision and use of approaches and processes described below.

During and after withdrawal, if the patient remains unmotivated and unresponsive, motivational and educational intervention is required prior to more intensive treatment being commenced. Where possible, motivational interviewing techniques may need to be employed throughout all stages of the Program to maintain motivation and engagement.

The community-based care plan should continue to use motivational techniques where possible and consider the required frequency and intensity of contact between the patient, the case coordinator and other key workers to ensure that the patient remains motivated and engaged.
Managing the client group

Patients undertaking medically supervised withdrawal are likely to present patient management challenges as they experience states that might include anxiety, agitation, panic, confusion, disorientation, hallucinations, anger and aggression. This is particularly the case for coerced patients who may experience higher levels of anger and resentment as well as the physical and psychological symptoms of withdrawal. For the safety of patients and staff and to facilitate better engagement in withdrawal and post withdrawal treatment it is therefore important that the care team are able to effectively manage and support patients accessing the Program.

Approaches that staff could take to achieve this include:

- staff having a calm, reassuring, confident and non-confrontational manner
- explaining reality and perceptual errors as required
- reducing stimulation and managing the number of people attending to the patient
- clear and easy to understand explanations of treatment, processes and other aspects of the Program
- approaches that minimise risk of self harm and harm to others and removing or minimising sources of concern or anger
- providing frequent and obvious supervision
- acknowledging the patient's feelings and being flexible to meet their needs, within reason.

Program staff, particularly inpatient unit staff, should have appropriate skills and experience to be able to work effectively with patients in the context of an involuntary, coerced treatment Program. Patients participating in the Program may also demonstrate aggressive and violent behaviour. NSW Health has a Zero Tolerance to Violence and Abuse Policy. Threats or acts of aggression/violence during both the inpatient and community-based stages will be considered within the context of patient factors and the unit and the community based case worker should employ appropriate aggression and violence management techniques.

In accordance with the Zero Tolerance to Violence and Abuse Policy non-compliance will result in discharge from the Program where such behaviour:

- indicates that the treatment available through the Program is not beneficial to the patient, or
- cannot be contained /managed appropriately to prevent risk of harm to the patient, other patients or staff.

De-escalation

Involuntary Treatment Program staff should be briefed and trained to manage difficult patients. They should know local and statewide protocols for managing difficult patients and be familiar with local security arrangements.

A sedation, seclusion and restraint policy for involuntary drug and alcohol treatment settings has been developed, however the use of the options is not mandatory, rather it is at the discretion of the treating team. De-escalation techniques may be employed by the staff/unit if preferable.

Section 15 of the Act allows for an AMP to give, or authorise the giving of treatment as the practitioner thinks fit for the treatment of the dependent person’s substance misuse. In extreme cases this might include the sedation or restraint of a patient who is in a state of acute distress or who requires chemical and/or physical restraint for effective management and the seclusion of patients who present a risk to themselves or others.\(^{47}\)

---

\(^{47}\) NSW Health (2) (July 2007) Seclusion Practices in Psychiatric Facilities. Sydney: NSW Health
The use of IV sedation and restraint for Involuntary Drug and Alcohol Treatment patients is articulated in a NSW Health Directive developed specifically for the Program\(^{48}\).

If sedation, seclusion or restraint is used with a patient, their primary carer(s) should be notified as soon as possible.

**Intravenous Sedation**

Intravenous sedation should only be used as a last resort, if no other less restrictive options are available and the safety of staff and patients must be paramount at all times. All attempts should be made to persuade the patient requiring sedation to accept oral or intramuscular medication. The decision to use intravenous (IV) sedation must be approved by the patient’s treating AMP and must only be carried out at a safe location with appropriate equipment and staff support and by appropriately qualified staff.

Staff should be aware of the potentially detrimental effect that the use of sedation, seclusion and/or restraint may have on their therapeutic relationship with the patient and that it may dissuade the patient from seeking future medical treatment for their substance dependence.

**Seclusion**

Seclusion must be approved by the AMP, or the nurse in charge of a shift and notified to the AMP. Seclusion must only be for the length of time required to address the risk of harm to the patient or others. It must only take place if there are sufficient staff available\(^{49}\), and only staff who are trained in aggression management/physical intervention strategies should be involved in the seclusion procedure.

Seclusion should not be used if the patient is suicidal or actively self harming, if the patient has lost consciousness or if there are clinical or medical conditions requiring physical proximity/monitoring by staff. In addition, it should not be used as a punishment or as a management strategy as a result of lack of staff, noting that the human rights and dignities of the patient is a priority.

Care should be taken in secluding older patients, patients with a history of trauma and patients from an Indigenous background, as the seclusion may place these individuals at increased risk.

**Restraint**

For the purposes of the Program, restraint should be taken to mean physical restraint by the care team staff, security staff or by a restraint device. Restraint should be used when other appropriate measures to manage the patient have failed and can only be undertaken to ensure the safety of that patient or of others who may be at risk. It should be applied for the minimum amount of time necessary and must take into account the principle of care in the least restrictive manner. Patients should only be restrained if they have previously undergone a physical examination and there are no identified reasons why restraint may cause physical harm.

If restraint is required in response to a psychiatric emergency, staff in attendance may initiate restraint. At the first practical opportunity the AMP and nurse in charge of the Unit at the time of the incident must be notified. For restraint not associated with a psychiatric emergency, authorisation for the use of restraint must be given by the AMP, following a multidisciplinary team discussion, to ensure it is the most appropriate form of management.

**Debriefing and consideration of care**

After sedation, seclusion or restraint, the patient, other patients, staff, and primary carers and other significant others should be offered an interview and debriefing, including an explanation as to why the intervention was used, and given the opportunity to consider their feelings about it. Patients who are sedated, secluded or restrained should be offered an opportunity to engage in

---


\(^{49}\) This may require assistance from other units to ensure staffing numbers are adequate.
collaborative planning of future interventions, for example through the development of a patient safety plan, so as to avoid further use of the intervention.

The reasons for sedation, seclusion and / or restraint of a patient should be considered by the care team, with input from the patient, to consider strategies to address precipitants to the behaviour which led to the use of sedation, seclusion and / or restraint, and/or involvement of security.

**Granted leave of absence from the inpatient unit**

Under the Act, a patient may be granted leave of absence from the inpatient stage of the Program on compassionate, medical or other grounds. The decision to grant a leave of absence and the period of leave is made by the AMP on a case by case basis and is documented in the patient’s medical records. To grant a leave of absence the AMP must be satisfied that, as far as is practicable, “adequate measures have been taken to prevent the person from causing harm to him or herself and others” during the absence from the unit.

**Abscondes**

If a patient absconds from the inpatient unit, or does not return after a leave of absence, the AMP may apprehend or request apprehension of the patient for them to be returned to the inpatient unit. The patient may be apprehended by an AMP or other suitably qualified patient, a police officer and / or a person assisting any of these people. Police are requested to apprehend or assist in apprehending patients who have absconded if there are serious concerns relating to the patient’s or another person’s safety.

The unit should inform the primary carer(s) and the Program team of an absence without leave as soon as possible.

If the patient is not able to be apprehended, they are discharged from the inpatient unit and every attempt is made to re-engage the patient in community-based treatment.

### 3.2. Specific patient groups

Specific groups of patients have particular needs that must be considered, and which may require support from other relevant government or non-government providers.

A number of the approaches identified for specific patient groups are central to the general approach for all patients accessing the Program but are noted to be of particular relevance to a specific patient population.

**Patients with co-morbidity**

A significant number of patients referred to and admitted to the Program are likely to have co-morbid mental or physical health issues. It is likely that the extent of the issues may not become apparent until withdrawal has commenced or been completed.

**Co-morbid mental health issues**

The nature of co-occurring mental health problems and substance misuse is complex and there are a number of inter-dependent aspects to be considered, such as severity of issues, type of mental health problem and nature, type and history of substance misuse. Generally the prognosis for patients with co-morbidity is poorer than for those without co-morbidity, linked to:

- higher rates of relapse

---

50 Section 21
51 Section 21(3)
52 Sections 22 and 23
Model of Care Involuntary Drug and Alcohol Treatment Program  Version 5

- increased hospitalisation
- increased risk of illness and injury, including increased rates of self harm and suicide attempts
- more hostile and aggressive behaviours
- poorer psychiatric and physical outcomes and increased risk of side effects
- housing instability
- poorer levels of social functioning, e.g. criminality, poverty, violence and marginalisation
- lower levels of compliance with treatment and interventions.

In order to effectively assess and manage patients with co-morbid mental health issues, the Program should:

- undertake comprehensive assessment of mental health issues, recognising the impact of intoxication on the outcomes of assessments (such as the Mini Mental Status Exam)\(^{55}\)
- use a patient centred approach that focuses on empowering the patient to manage their own life to their full potential; this involves assisting the patient to identify their own needs and goals
- offer non-judgemental assessment and treatment
- use a staged approach to treatment, comprising engagement and relationship building, persuasion, including gentle challenges and motivational strategies, active treatment, and relapse prevention
- establish and maintain strong links to specialist psychiatric services, with relevant mental health professionals involved in the multidisciplinary care team and in the case planning and management.

If a patient becomes acutely mentally unwell during their inpatient stay (following the withdrawal period), they should be transferred to an appropriate mental health inpatient unit. This is considered to be a granted leave of absence to undertake other medical treatment for a period of time. Should a mental health condition become the primary diagnosis, the patient may be discharged from the Program only if they are to be admitted for treatment by a mental health inpatient unit. The Addiction Medicine consultant may remain involved in the patient’s care in relation to the management of their substance misuse.

All staff working in the inpatient unit should have the relevant skills and experience to work with co-morbid patients. Community-based case coordinators should also have relevant skills to work with co-morbid patients, as required.

**Co-morbid physical health issues**

Long term, chronic substance dependence is likely to have a significant impact on a patient’s physical health. While some health conditions may be known prior to admission, other physical complications may arise from acute reversal of neuroadaptation and / or its immediate aftermath and / or may be identified following withdrawal, having been masked while the patient was intoxicated.

If a physical health issue is known, or identified, a referral should be made to an appropriate specialist. This should be articulated in the patient’s post withdrawal (inpatient) care plan. Specialists managing medical conditions should work closely with the Program care team to ensure that all care is coordinated and supported and that there are no contraindications that may put the patient at risk. It is particularly important that specialists are consulted as required prior to

\(^{55}\) Note that the NSW Clinical Guidelines state that the MSE “can be conducted on anyone who is conscious, including those who are intoxicated… though the outcomes of the exam will change when it is repeated at a time the patient is not intoxicated”. (NSW Health (2009), ibid p. 8)
commencing withdrawal to consider and manage possible complications that may arise as a result of a co-morbid physical condition.

Physical health issues requiring follow up and ongoing intervention and management should also be incorporated in the discharge plan and community-based care plan.

**Patients with Acquired Brain Injury**

Long term misuse of substances can lead to an acquired brain injury (ABI) or alcohol related brain injury (ARBI), which can result in medical difficulties, altered sensory abilities, impaired physical abilities and ability to think and learn, altered behaviour and personality and impaired ability to communicate. Working with a patient with ABI or ARBI has implications for the Program in terms of:

- required assessments to consider neurological disorders, cognitive ability and daily functioning
- recognising that an ABI or ARBI may be masked by intoxication and will only become apparent after withdrawal
- securing additional support services to assist the patient with daily living and to secure appropriate benefits and allowances
- adapting program and intervention content and delivery and ensuring routine support during the inpatient stay is appropriate
- providing additional information and support to family members to address their concerns establish a post-discharge support system
- involvement of the Office of the Public Guardian, if appropriate
- specific consideration of post-discharge accommodation options so the patient is not placed at risk
- consideration of relevant post discharge interventions and support and identification of the local agencies able to deliver these.

In addition, it is likely that a patient with ABI or ARBI will require longer Dependency Certificates so that prioritised needs can be met before discharge. The Act specifically provides for this by stipulating that an AMP can apply for an extension of the Dependency Certificate (which must be reviewed by the Magistrate within 7 working days) if they are satisfied that the patient is suffering from an ABI or ARBI and needs additional time for treatment and discharge planning.\(^{56}\)

**Patients with dependent children and child protection issues**

It is important to consider the risk of harm to dependent children (and children residing with the identified patient) in undertaking screening and assessment for the Program and in considering community-based case coordination and treatment post discharge from the inpatient unit. This is recognised both by the Legislation\(^{57}\) underpinning the Program and in clinical practice guidelines for drug and alcohol treatment.\(^{58}\)

Health care workers have a duty of care to notify the Department of Community Services\(^{59}\) if they consider the safety, health and wellbeing of children and young people, including unborn babies, to be at risk, either physically, emotionally, or mentally or as a result of neglect or abuse.

---

56 Section 35(a)
57 Section 10(4)
58 NSW Health (July 2009) ibid p.14
The duty to report risk of harm overrides the duty to maintain patient confidentiality. If disclosure is made during the course of an assessment or provision of treatment this must be addressed immediately with the patient and the roles and responsibilities of the professional to report the disclosure must be explained.

A report to the Department of Community Services should not lead to an end in a therapeutic relationship with the patient (if at all possible, or a decision not to commence a therapeutic relationship). Instead, the care plan, particularly the community-based care plan, should address the impact of substance misuse on parenting. In some cases it may be appropriate for members of the care team to engage with Whole of Family Teams, Child Protection or Family Services to support interventions that improve parenting capacity and that work with at risk families. In this case, the role of the drug and alcohol professional should be to provide information to other professionals about managing problematic substance use and as well as continuing to work with the patient to address their misuse.

**Aboriginal and Torres Strait Islander patients**

The impact of substance misuse is recognised to be more significant for people from Aboriginal and Torres Strait Islander backgrounds and for their communities. Aboriginal and Torres Strait Islanders are over represented in NSW opioid treatment programs, are more likely than non-Indigenous Australians to consume alcohol at hazardous levels and are more likely to be at risk of long-term, alcohol related harm.

Effective assessment and management of patients from Aboriginal and Torres Strait Islander backgrounds should consider:

- the impact of government policy, environment, access to substances, history, social situations and patient choice on substance use
- the importance of connection to family and community and the impact that separation may have on the individual, for example to undertake an inpatient withdrawal
- previous negative experiences of the patient with drug and alcohol and other health and human services.

Key principles of working in a culturally appropriate way with Aboriginal and Torres Strait Islander people include:

- being respectful, sensitive, flexible and non-judgmental
- building a trusting and open relationship, that does not simply focus on the clinical issue at hand
- engaging with and treating the patient in the context of their family and community and involving family and community members in care planning.

All staff working with Aboriginal and Torres Strait Islander people in the Program must be able to provide culturally competent treatment and care. A care team for an Aboriginal or Torres Strait Islander patient should ideally include a professional from an Aboriginal drug and alcohol or health service. Discharge and community-based care planning should identify culturally appropriate services for the patient to be engaged with upon discharge from the inpatient stage of the Program.

**Patients from Culturally and Linguistically Diverse backgrounds**

Assessment and treatment of patients from Culturally and Linguistically Diverse (CALD) backgrounds will require consideration of:

- the use of interpreters to work with CALD patients and / or their nominated primary carer
- differences in patterns of substance use amongst different CALD populations

---

60 NSW Health (April 2007) *Clinical guidelines for nursing and midwifery practice in NSW Sydney: NSW Health* p. 12
• different knowledge, norms and cultural values in relation to substance use
• expectations and pressures of family and community in respect to substance use and the impact this may have on the patient’s motivation and the role of the family and community in providing support to the patient
• the patient’s experience of separation, trauma, grief and /or post traumatic stress and the links to substance misuse, particularly for patients from refugee populations
• the validity of standardised assessment tools that have not been adapted and validated for different cultural groups.

While all inpatient and community based professionals should be aware of cultural diversity and should be able to respond in a culturally appropriate way, specific support may need to be considered to meet identified needs of specific patients. This may require links to and joint working with relevant cultural services, negotiated on a case by case basis. Consideration may be given to the establishment of specific cultural positions within the Program if the number of CALD patients justifies this.

In addition, consideration should be given to the use of interpreters to work with CALD patients and / or their nominated primary carer and the availability of documented materials in different languages.

Patients experiencing or committing domestic violence

Domestic violence often occurs in the context of problematic substance use. Under the *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines*\(^{61}\) health services routinely ask women over 16 years about domestic violence at home.

While the Program should not specifically address domestic violence issues, either for the victim or the perpetrator, staff should be aware of the impact that domestic violence may have on a patient’s:
• mental and emotional state
• involvement in legal matters
• support networks in the community, including accommodation.

The presence of domestic violence is particularly important in relation to discharge planning and the development and management of the community-based care plan. If required, a referral(s) may be made to specialist domestic violence services as part of the community-based care plan.

If asked to provide reports to the courts in matters related to domestic violence, Program staff should only report on matters pertaining to the drug and alcohol treatment aspects of their role with the patient.

If the Program is aware that children and young people, or unborn babies are involved in domestic violence incidents, there is a duty of care for this to be reported to the Department of Community Services.

Older patients

Older people referred to the Program are likely to experience a number of issues that should be considered in assessment and management of treatment, including\(^{62, 63}\):
• increased vulnerability to the effects of substances and to the side effects and illnesses associated with substance misuse, including increased risk of delirium

---

\(^{61}\) NSW Health (July 2009) ibid p.14  
\(^{62}\) NSW Health (May 2008) *Drug and Alcohol Psychosocial Intervention professional Practice Guidelines*  
Sydney: NSW Health p.60-61  
\(^{63}\) NSW Health (July 2008) op.cit p.16.
• concomitant physical illnesses
• potentially longer period of use and dependence
• challenges in establishing a comprehensive drug taking history if memory problems are present and limitations in standardised assessment tools that can be used in this context
• challenges in psychosocial treatment if memory problems are present
• more limited ability to cope in the community as a result of a combination of age and substance on functioning and reduced number of suitable, safe accommodation options upon discharge from the inpatient phase of the Program
• more complications during withdrawal and increased likelihood of falls and associated injuries during withdrawal
• vulnerability if admitted to treatment programs with a predominantly younger patient group
• increased risk of suicide
• history of loss and grief that may require psychosocial interventions.

Patients with criminal justice involvement

There are strong links between committing offences and misuse of substances. It is possible that identified patients referred to the Program may be involved in some stage of the criminal justice system. For example, identified patients may be awaiting trial or sentencing, may be on parole or a suspended or community sentence or may yet to be apprehended and charged for a previous crime. Others may recently have been released from prison or their release may be pending.

Involvement in the criminal justice system should be noted during screening and assessment for a Dependency Certificate and throughout engagement with the Program for the following reasons:
• to consider the pending charge of violent and/or sexual offence in determining acceptance onto the program due to risk of harm to others.
• to consider the stress and emotional impact of legal proceedings and the (positive or negative) affect on engagement in treatment
• to recognise the potential impact on treatment outcomes, and a patient's safety and wellbeing, if involvement with the Program is curtailed as a result of a custodial sentence being passed. This is particularly important to consider during the inpatient withdrawal stage of the Program. The patient may be managed in a number of ways such as delaying discharge to complete withdrawal or transferring to a prison hospital.

History of offences related to violence is not routinely available to health staff. Any custodial or other sentence which has been completed is not to be used as a justification for inclusion to or exclusion from the program.

It should be noted that engagement in the Program is not a sentencing option under the NSW Crimes (Sentencing Procedures) Act 199964. It should also be noted that criminal history, legal status and / or current involvement in the criminal justice system should not be a cause for prioritisation or exclusion from the Program.

Pregnant patients

Use of drugs and alcohol during pregnancy can seriously affect an unborn child and can lead to a range of abnormalities and developmental problems. To manage and minimise the risk to the mother and unborn child, an effective response should include:

• integration with specialist antenatal and obstetric care, with relevant professionals involved as part of the multi-disciplinary team and the care planning and management
• involvement of child protection services if there are concerns of serious risk to the child once born
• education of the impact of substance misuse on the unborn child (and on the child, once born)
• elements of a community-based care plan that establishes strong links to relevant community-based services, such as child and maternal health programs, those that support the development of living and life skills and parenting skills and those that address any socioeconomic issues that are present
• engagement of partners or significant others, if appropriate, to reinforce the messages provided during treatment and to encourage continued abstinence.

The preferred treatment for pregnant opioid users is maintenance because of the significant risk that withdrawal presents to the foetus. If an opioid dependent pregnant woman is referred to the Program, careful consideration, with involvement of the AMP and an obstetric specialist, will be needed to determine whether the Program is suitable for the person at that time.

Homeless or itinerant patients

Patients who are homeless or itinerant are at greater risk of substance misuse, may be more likely to have social networks that reinforce substance misuse and have fewer protective factors that encourage sustained abstinence and promote mental and general health and wellbeing. It is a principle of care that patients should not be exited from the inpatient component of the Program into homelessness.

If the patient does not have appropriate accommodation on discharge, this must be identified during the screening and assessment stages and addressed immediately when the patient enters the Program. Options include:
• seeking a place in a residential rehabilitation program
• securing public/community housing
• securing accommodation in specialist homelessness services (e.g. boarding houses or shelters, although this is least desirable in terms of supporting the patient to achieve long term outcomes)
• identifying options for independent living in private rental
• identifying family or friends who will provide accommodation.

Brokerage funds can be utilised to facilitate housing upon discharge. The AMP may apply to extend the length of a Dependency Certificate in order to allow time to secure appropriate accommodation, noting this is not a provision in the legislation and may not be accepted by the Magistrate.
4. Governance and quality management

4.1. Clinical governance

The NSW Health Clinician’s Toolkit defines clinical governance as:

“The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.

A quality Program is underpinned by:

- clear and accountable management structures that provide the systems and environment in which quality care can be delivered
- personally accountable and responsible clinicians who deliver quality care within the quality systems that have been established.

This section describes the clinical governance arrangements that are required to be in place to deliver a quality Program and that support and encourage continuous improvement to enhance patient care.

Critical relationships

Relationships between management, clinical teams and clinical staff is critical at all levels and quality care requires integration between individuals and teams, while recognising different roles and responsibilities in planning, managing and delivering the Program.

A number of auspice arrangements exist to manage and deliver the Program, with the involvement of statewide NSW Health inpatient services and Referring Network, as well as local health, Aboriginal health and community service organisations. Other cross-government agencies, such as the Department of Attorney General and Justice and the NSW Police Force, are also key partners in supporting the Program. Effective and supportive relationships are therefore critical at:

- a statewide level between government agencies to ensure shared understanding and commitment to the Program (to enact the Legislation) and to agree roles and responsibilities, established through an Interagency MoU
- at a statewide level between gazetted inpatient units and Referring Network to manage demand and share learning and good practice
- at a statewide level between NSW Health and the funded Program providers to manage, monitor and review the Program to facilitate effective, value for money service delivery
- within the Program to facilitate multi-disciplinary care for patients with complex and multiple needs and to enable continuity of care and sustained outcomes after discharge from the inpatient stage of the Program
- at a regional level to ensure shared regional understanding and to reinforce roles and responsibilities of regional government agencies and others, underpinned by the statewide MoU
- at a local level to facilitate referrals to the Program and to enable continuity of care for patients returning to a local area after the inpatient stage of the Program.

Particular auspice arrangements will also necessitate particular critical relationships. For example, where a Program is co-located with a voluntary inpatient withdrawal service, care must be taken to ensure that the different culture, philosophy and practice of the two treatment models do not place staff or patients at risk, and that quality care is still enabled.

---

The relationship between the Program team and the community-based case manager is also critical and unique. The Program team is a consistent, specifically employed group of professionals with clearly defined job descriptions relating to the Program management and delivery. By contrast the community based case manager is likely to be employed by a locally based drug and alcohol or other program and to be identified to provide case management as and when a referral to the Program is received from that local service system. This has a number of implications:

- the case manager may not be aware of the Program initially and will not be held accountable for delivery of the Program in the same way
- new relationships will need to be established between the Program team and each community based case manager (unless multiple referrals are received from the same location over a period of time)
- education and support may need to be provided to each new community based case manager to enable them to understand and implement the model of care
- underpinning culture, philosophies and approaches may not be aligned, particularly if the community based case manager is not a drug and alcohol professional.

Therefore, the relationship between the Program team and the community based case manager/managers (and their employing organisation) will have to be managed on a case by case basis, in recognition of the different contexts and roles and responsibilities of the professionals involved.

**Elements of quality clinical care**

The following elements are required to deliver quality clinical care for patients on the Program:

- implementation of a range of assessment and evidence based treatment strategies. It is recognised that the evidence base for involuntary drug and alcohol treatment is limited for this patient group and there is a responsibility for the Program to contribute to further research and evaluation in this sector. This is discussed in section 4.3.
- a care planning approach that involves the patient and assists the patient to work towards their identified goals
- integration between professionals to provide a multi-disciplinary approach, over a range of settings to address the patient’s complex and multiple needs and to support them to achieve goals
- formal and informal clinical reviews for patient progress through treatment, to be used to support care, as well as to inform learning and to improve practice
- effective and accurate recording and maintenance of patient files, including multi-disciplinary assessments and summaries and clinical notes.

**Clinical risk management**

A critical component of clinical governance is the management of risk and clinical safety. This involves establishing a system in which errors are minimised, creating a culture which focuses on learning and improvement rather than blame and ensuring that management of risk is an integral part of continuous improvement.

This is achieved through proactive and reactive identification of risk, through monitoring and flagging of administrative data, incident reporting, management of sentinel events, audits and clinical reviews. Strategies and systems must be in place to support these activities. This includes an appropriate administrative data management system and monitoring and reporting mechanisms.

---

This Model of Care, relevant NSW Health and other guidelines, and local policies and procedures must underpin the Program delivery to provide the basis for quality care and to support the minimisation and management of risk. Adherence to these is also important to enable statewide consistency and equity of access to identified persons who are suitable for detention under the Act. This is further enabled through establishing and monitoring key performance indicators, discussed in section 4.3.

**Culture and philosophy**

To manage risk and deliver quality care within the Program context and in recognition of the particular complexity of the patient group, it is essential that the Program culture and philosophy are supportive and protective of staff and dependent patients.

The culture and philosophy of the Program must be well recognised and reinforced by all members of the multi-disciplinary team, particularly where the Program is co-located with another program. Specifically, the culture and philosophy of the program should include:

- a recognition of the rights and dignity of patients who are detained under the Act and the role of the courts in upholding these rights
- an involuntary focus on withdrawal to achieve abstinence
- the provision of a structured program, underpinned by care planning and case coordination
- the importance of motivating patients to engage in post-withdrawal treatment, as an inpatient and in the community
- engagement of the patient and their primary carer, if appropriate, at all stages of the Program, to the extent possible given the patient’s capacity
- a multi-disciplinary team approach where care is coordinated and integrated, across a range of settings, to achieve outcomes for dependent patients
- an open, learning culture in which risks can be identified without blame and addressed transparently and effectively
- regular case and professional reflection to contribute to a learning culture and continuous improvement.

**Internal governance and management structures**

To enable quality care, it is important that Program staff work together as a team, acknowledging the different roles and responsibilities each team member has in relation to management and delivery of the Program and in governance and supervision processes.

Team structures, and management and supervision arrangements need to reflect the following elements of the Program model:

- the multi-disciplinary care team employed to manage and deliver the Program
- the community based care manager and identified key workers from community-based drug and alcohol, health and other services
- coordinated care and involvement of other specialist and other professionals to implement and manage the patient’s care plan.

As a principle of the model of care, weekly team meetings should be conducted that include all inpatient Program staff and the community-based case manager where possible (this may include the use of tele - health and tele - conferencing facilities). These meetings should focus on operational and quality management issues.

In addition, regular case conferences regarding specific dependent patients should also be undertaken, involving the multi-disciplinary Program team and other professionals as appropriate.
Clinical supervision

Clinical supervision is an important component of quality care. It is the responsibility of all professionals to actively engage in clinical supervision to facilitate the delivery of quality care and to develop professionally.

Formal and informal clinical supervision is an important mechanism for professional and workforce development and can be used to provide support and debriefing opportunities. It can be used to reinforce effective clinical practice, address issues specific to a professional’s involvement in a patient’s care, develop skills and knowledge, promote ethical and professional practice and identify strategies to address workload issues. Clinical supervision should be scheduled regularly and should be conducted in groups as well as individually.

The most appropriate supervision structures may fall outside the Program team, depending on the professional affiliation of a team member. For example, it is appropriate for Program Social Workers to receive professional supervision from a more senior Social Worker and this may require supervision by a professional who is not involved in delivering the Program.

Effective governance and management arrangements for the community-based component of the Program will need to ensure that supervising professionals are familiar with the Program, the patient group and the role that their staff undertake as part of the Program, even if they are not directly involved in the management or delivery of the Program.

Line management

Formal and informal line management are part of the governance arrangements for the Program and:

- ensure that procedures are occurring in line with Program and state-wide policies
- ensure that workforce development issues are met and that opportunities are provided to achieve this
- reinforce the culture and philosophy of the Program and create and promote a supportive environment
- provide consultancy and, at times, direction to professionals.

Non clinical staff

A range of non clinical staff are also involved in supporting the Program, including, for example, Magistrates, Public Guardians and Housing officers. Appropriate line management and professional supervision structures will also need to be in place to support these professionals in delivering the Program. This is not covered in this Model of Care.

Complaints and Official Visitors

The Program should have a clearly publicised complaints and grievance process that is explained to patients and their primary carers at various stages throughout their involvement in the Program. Details should be provided about the different procedures relating to the inpatient to community based elements of the Program.

Under the legislation\(^\text{67}\), two Official Visitors must visit each gazette inpatient unit at least once per calendar month to inspect the centre, make enquiries about the treatment and detention of patients under the Act and report matters for further investigation. Patients and their primary carers should be notified of the Official Visitors Program and be advised of their rights to contact an Official Visitor.

\(^{67}\) Section 29
4.2. **Staffing and workforce development**

All staff employed within the Program must have the appropriate skills and the knowledge required to fulfil their role and responsibilities. This extends to staff who undertake the community-based case management role to support continuity of care.

Professional staff must demonstrate competence aligned to their professional affiliation and must also have experience and training, where necessary, in management of drug and alcohol co-morbid, complex patients. The Program team should also include staff with competence and experience of specific aspects of care that are unique to the Program and patient group. These are identified in section 3.1 and include working with coerced patients and managing difficult and aggressive behaviour, including, for example, the use of sedation, seclusion and restraint.

Recruitment and retention of staff is recognised as challenging in this sector. To minimise these challenges and the impact on quality care, the Program should have in place strategies that support workforce development, including:

- attraction and recruitment strategies
- retention strategies that provide a framework for reward and recognition
- professional learning and development, including induction and orientation, ongoing training and clinical supervision
- availability and encouraging use of evidence-based guidelines and models of care
- maintenance and promotion / education of professional standards
- monitoring scope of practice.

Furthermore, to support staff, there should be adequate access to tools such as computers and information technology, and physical surroundings should be supportive of clinical teams delivering care and should provide a safe work environment.

**Accredited Medical Practitioners**

The Act confers considerable powers and responsibilities to AMPs to implement the provisions in the legislation and to detain patients under the Act.

A statewide Referring Network seeks to formalises the selection and training of AMPs in relation to the Act and establishes the clinical framework within which referring persons exercise their duties and responsibilities.

A Referring Network of medical practitioners is also important to ensure that people across New South Wales have access to prompt assessment for a Dependency Certificate and that there is consistency and accountability in decisions to issue Dependency Certificates.

AMPs can be any professional with the appropriate competence to make clinical decisions about severity of dependence and likely benefits of detention and treatment under the Act. This might include addiction medicine specialists and trainees, psychiatrists, psychiatry registrars, specialist consultants, neurologists, nurse practitioners and Clinical Nurse Consultants.

**Cultural competence**

As identified in section 3.2, Program staff need to be able to deliver culturally appropriate care and responses to patients from Aboriginal and from CALD backgrounds. This may require additional training and development of staff as new patients from these background are admitted to the Program.

Culturally competent service delivery is also enhanced by:

- links and partnerships with cultural-specific programs and services in the community
• involvement of an appropriate advocate from the patient’s community in the care team, if required

• ensuring that the physical setting and practical delivery of Program elements is sensitive to the patient’s cultural (and religious) background.

4.3. Quality management and continuous improvement

A number of key elements are required to enable management of quality and to support continuous improvement to better meet patient outcomes.

In NSW, the NSW Patient Safety and Clinical Quality Program provides the framework for significant improvements to clinical quality. Like all health services, the Program will be required to comply with this framework. Key components of the quality framework are:

• systematic management of incidents and risks
• an information management system
• clinical governance units in each area health service
• a quality assessment program for all public health organisations
• the establishment of the Clinical Excellence Commission68.

Performance monitoring and reporting

Ongoing performance monitoring is important to monitor performance over time, against agreed indicators or measures and in line with practice standards. Performance monitoring has two main purposes:

• As an on-going, continuous improvement tool to assesses the efficiency, effectiveness, and other aspects of the Program to identify what is working well and areas where improvements are needed

• To ensure an appropriate level of accountability, that identifies whether the program is delivering what is intended, in terms of levels of service (quantity), quality, efficiency and effectiveness. The purpose of this is to ensure that Government funds are being spent efficiently and effectively.

Monitoring and management of the performance of the Program comprises the following:

• regular performance measurement against a defined set of key performance indicators, covering outcomes, and outputs and services, and capacity.

• periodic, in depth performance assessment, analysis, or evaluation on specific areas to provide the basis for continuous improvement

• less frequent external audits, perhaps every three years or so, to form the basis of a service improvement plan

• regular reporting of results of performance monitoring and evaluation – both NSW Health and publicly.

Establishing and monitoring key performance indicators will provide a snapshot of the Program’s performance against a number of indicators that will lead to enhanced service delivery and outcomes for dependent patients and for Government.

Key performance indicators by their nature should focus on variables that are easily measured and are in the control of the unit, and provide an indication of whether the Program is meeting program objectives.

68 NSW Health (2005) NSW Patient Safety and Clinical Quality Program Sydney: NSW Health
Key performance indicators should be negotiated between NSW Health, other Government departments or ministries and agencies funded to manage and deliver the Program. Initially, key performance indicators should aim to measure input, activity and processes. Over time, measures and indicators should be negotiated that identify change in short term and long term outcomes for patients, the Program and Government.

Indicative key performance indicators that could be established initially include:

- per cent of identified patients referred and assessed for a Dependency Certificate
- time taken to admit a dependent patient to the inpatient unit from time of referral
- per cent of patients discharged from the inpatient unit who have achieved change in the domains of substance misuse, physical and mental health, neurological function and social functioning (measured using standardised tools to identify change over time)
- per cent of patients who actively engage in community-based treatment at one month, three months and six months post discharge from the inpatient unit
- per cent of patients who remain abstinent at one month, three months and six months post discharge from the inpatient unit
- per cent of patients who are re-referred and readmitted to the inpatient stage of the Program
- number of people employed, housed, socially reconnected
- reduction in emergency department presentations.

These, and future outcome measures, should be reported on and monitored through an appropriate information technology data system and through feedback from patients and staff.

Robust information technology and data systems

Quality assurance must be supported by robust data systems to provide information and support accountability. Strong data collection is important to:

- inform decisions about Program planning and delivery (such as managing demand)
- monitor the performance of the Program
- ensure that outcomes are being achieved for patients accessing the Program and for Government stakeholders
- ensure the best use of resources.

Existing health data systems should be used to capture and provide required data and information. This is specified in a core set of data items, which provides the base level of information required for reporting, planning, performance monitoring, evaluation and accountability. Specific data sets and reporting arrangements will need to be negotiated with community-based services delivering community-based interventions to discharged patients.

Evaluation and research

Evaluation, review and research is an important approach to assess and improve quality. With a general lack of research and evaluation into outcomes for a severely dependent, coerced client group and for this type of model of care, it will be important for the Program to participate in further evaluation and research projects. Engagement in these projects should be seen as an opportunity for identifying lessons learnt and for improving the Program to achieve better client outcomes rather than as a punitive approach to identify poor practice.

On 21 November 2012, the General Purpose Standing Committee No. 2 self-referred an Inquiry into the effectiveness of current alcohol and drug policies with respect to deterrence, treatment and rehabilitation.
One of the recommendations of the Committee concluded that the evidence base supporting involuntary treatment is still developing and therefore an evaluation of the efficacy of the IDAT program, once it has been operating for a reasonable period of time, would be appropriate. An evaluation of the Program should consider processes (i.e. operation, governance, structures etc) and outcomes (for patients, families, services, the community and government) at the following levels:

- at an individual patient level
- at a whole of Program level

to determine the extent to which the Program has achieved outcomes for individuals and what has significant contributed to or hindered this.

Effective assessment, using standardised tools, accurate documentation and strong data management and reporting are essential to inform robust evaluation.

Cost benefit analysis of people receiving and not receiving involuntary drug and alcohol treatment would also demonstrate effectiveness and relevance of the Program.
5. References

The following references have been used to inform the Model of Care. All web site references were viewed between July and September 2011.

- Drug and Alcohol Treatment Act 2007
- Memorandum of Understanding for the Involuntary Drug and Alcohol Treatment Trial
- Mental Health Act Codes for Legal Status Code Set 2009/10
- NSW Drug and Alcohol Program, Centralised Intake Guidelines, June 2004 (47).
Model of Care Involuntary Drug and Alcohol Treatment Program  Version 5


## 6. Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td>Global Care Plan</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>IDAT Brokerage Guidelines</td>
</tr>
<tr>
<td>Appendix 3</td>
<td>IDAT Transport Guidelines</td>
</tr>
<tr>
<td>Appendix 4</td>
<td>IDAT Outcome Tools</td>
</tr>
</tbody>
</table>