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NSW Health

# Involuntary Drug and Alcohol Treatment

## Model of Care





- 1. Key definitions ..... 5
- 2. Introduction..... 8
  - 2.1. Legislation - Drug and Alcohol Treatment Act 2007 .....8
    - 2.1.1. Criteria for detention and treatment under the Act..... 9
  - 2.2. Principles of care ..... 9
  - 2.3. Culture and philosophy ..... 10
  - 2.4. Clinical objectives and outcomes..... 11
  - 2.5. The IDAT Model of Care..... 11
  - 2.6. Overview of the program components..... 12
- 3. Program delivery ..... 13
  - 3.1. Administrative matters..... 13
    - 3.1.1. Administration of Accredited Medical Practitioner (AMP) appointments .....13
    - 3.1.2. Official visitors ..... 13
  - 3.2. Intake..... 14
    - 3.2.1. Overview of application and assessment ..... 14
    - 3.2.2. Intake process flow ..... 15
    - 3.2.3. Screening and information gathering ..... 16
    - 3.2.4. Screening and information gathering checklist..... 17
    - 3.2.5. Referrals to the program ..... 18
    - 3.2.6. Patient information in screening and referral ..... 18
  - 3.3. Comprehensive assessment and assessment for a dependency certificate..... 19
    - 3.3.1. Conducting Assessment..... 19
    - 3.3.2. Issuing a dependency certificate ..... 20
    - 3.3.3. Waiting lists and prioritisation..... 21
    - 3.3.4. Order for Assessment..... 21
  - 3.4. Transport ..... 21
    - 3.4.1. Transport planning..... 21
    - 3.4.2. Transport modes ..... 22
    - 3.4.3. Inter hospital transfer and long-distance transport ..... 23
    - 3.4.4. Transport Officer ..... 23
  - 3.5. Admission and care coordination ..... 24
    - 3.5.1. Admission and induction to the treatment centre ..... 24
    - 3.5.2. Identification of a primary carer ..... 25
    - 3.5.3. Initial inpatient assessment ..... 25

3.5.4.	Assessment of mental health and suicide risk .....	26
3.5.5.	Multi-disciplinary team .....	26
3.5.6.	Identification of an IDAT Care Coordinator .....	27
3.5.7.	Identification of a Community Care Coordinator .....	27
3.5.8.	Review of the dependency certificate .....	28
3.6.	Care planning.....	28
3.6.1.	Overview.....	28
3.6.2.	The global care plan.....	29
3.7.	Monitoring treatment progress and outcomes.....	29
3.7.1.	Medically supervised withdrawal.....	29
3.7.2.	Ongoing intervention.....	30
3.7.3.	Structured interventions .....	30
3.7.4.	Other interventions .....	31
3.7.5.	Extension of the dependency certificate .....	32
3.8.	Discharge.....	32
3.8.1.	Discharge planning .....	32
3.8.2.	Assessment for suitability for discharge.....	33
3.9.	Community based treatment.....	34
3.10.	Implementing community based care.....	34
3.11.	On-going assessment and monitoring .....	35
3.12.	Planned step down of support.....	35
3.13.	Data collection for performance and outcome reporting.....	36
<b>4.</b>	<b>Patient issues and priority populations .....</b>	<b>37</b>
4.1.	Managing coerced patients .....	37
4.2.	Violence in the workplace.....	37
4.3.	Seclusion and restraint .....	37
4.4.	Granted leave of absence from the treatment centre .....	38
4.5.	Specific patient groups.....	38
4.5.1.	Older patients.....	38
4.5.2.	Patients with Acquired Brain Injury.....	38
4.5.3.	Patients who are Aboriginal and/or Torres Strait Islander.....	39
4.5.4.	Patients from Culturally and Linguistically Diverse backgrounds.....	40
4.5.5.	Patients with dependent children and child protection issues.....	40
4.5.6.	Patients experiencing or committing family and domestic violence .....	41
4.5.7.	Patients with criminal justice involvement .....	41



4.5.8. Patients who are pregnant.....	41
4.5.9. Patients who are homeless .....	42
4.5.10. Patients who are LGBTIQ+.....	43
<b>5. References .....</b>	<b>45</b>

## 1. KEY DEFINITIONS

<p>Accredited Medical Practitioner (AMP)</p>	<p>A medical practitioner, appointed by the Secretary, NSW Health, or delegate, under the <i>Drug and Alcohol Treatment Act (2007)</i>.</p> <p>The Act confers considerable powers and responsibilities to AMPs. Detention in a treatment centre is only allowed under the Act where an AMP has issued a dependency certificate in relation to the person.</p> <p>See <a href="#">Administration of Accredited Medical Practitioner (AMP) appointments</a></p>
<p>Community Care Coordinator</p>	<p>A health or social welfare professional identified as the IDAT patient’s main care coordinator 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 also works in consultation with the IDAT Care coordinator throughout the patient journey.</p>
<p>Dependency certificate</p>	<p>A certificate issued by an AMP under section 9 Drug and Alcohol Treatment Act (2007), where the AMP has assessed that the person meets the <u>criteria</u> to be detained for treatment under the Act.</p>
<p>Dependent Person</p>	<p>A person who is assessed by an AMP to be eligible for a dependency certificate.</p>
<p>Drug and Alcohol Treatment Act</p>	<p>The <a href="#">NSW Health Drug and Alcohol Treatment Act 2007</a> (the Act) provides the legislative basis for the program and includes related Regulations.</p>
<p>IDAT Care coordinator(s)</p>	<p>This responsibility is located at the IDAT Treatment Centre and may be shared across the multi-disciplinary team. The IDAT Care Coordinator:</p> <ul style="list-style-type: none"> <li>- Oversees and participates in the management and delivery of treatment and support during the inpatient withdrawal management phase of the program.</li> <li>- 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 facilitates completion of IDAT Outcome Tools.</li> <li>- Oversees the community based care component of the IDAT Program</li> </ul> <p>This role also works in consultation with the Community Care Coordinator throughout the patient journey from inpatient to community based care.</p>
<p>IDAT treatment centre / treatment centre</p>	<p>A health facility, declared by order of the Secretary published in the Gazette, to be a treatment centre under the Act. Sometimes referred to as ‘IDAT unit’.</p>
<p>Identified Patient (IP)</p>	<p>A person who is identified as potentially suitable for the program. The person may be identified by anyone. Once identified, the Treatment Centre,</p>

	<p>medical practitioner or ITLO may be contacted regarding getting the person assessed for the program.</p> <p>Note that the Act uses the term “person”, whereas this Model of Care document refers to a “patient”.</p>
Involuntary Drug and Alcohol Treatment (IDAT or ‘the program’)	<p>Involuntary treatment as an option of last resort for people with severe substance dependence. IDAT provides medically supervised withdrawal management and post-withdrawal assessment and treatment in a specialised treatment centre. This is followed by a voluntary community care component provided by the patient’s local health district for up to six months.</p>
Involuntary Treatment Liaison Officer (ITLO)	<p>An ITLO is a qualified health professional:</p> <ul style="list-style-type: none"> <li>- with significant experience (as judged by their supervisor) of providing direct drug and alcohol patient care and</li> <li>- trained to assess and screen persons who may be eligible for a dependency certificate under the Drug and Alcohol Treatment Act (2007)</li> </ul> <p>The ITLO:</p> <ul style="list-style-type: none"> <li>- Conducts screening, triage and brief assessment of Identified patients.</li> <li>- Works in partnership with medical practitioners to refer suitable patients and provide collated information to AMPs to support the assessment for a dependency certificate.</li> </ul> <p>*Note: a medical practitioner must make the referral for assessment for a dependency certificate. If the ITLO is a medical practitioner, they may make a referral.</p>
Least Restrictive Practices	<p>Practices that maximise the autonomy, rights, freedom, wellbeing and safe care of the person as much as possible while balancing healthcare needs and safety for all.</p>
Medical Practitioner	<p>A person registered to practise as a Medical Practitioner under the Health Practitioner Regulation National Law.</p> <p>Medical practitioners may request an accredited medical practitioner to assess a person for detention and treatment under the section 9 (1) of the Act. See <a href="#">Overview of application and assessment</a></p>
Model of Care (MoC)	<p>This current document. The MoC provides a resource for managers, clinicians and other key stakeholders involved in supporting and delivering the program.</p>
Primary Carer	<p>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.</p> <p>Where the patient is under guardianship, the guardian takes the role of primary carer.</p>



Referring service

A clinical service that has referred a patient to IDAT. Referrals are ideally made by a multidisciplinary team that are experienced in providing AOD treatment, and are committed to the patient's ongoing care post IDAT discharge.

## 2. INTRODUCTION

The Involuntary Drug and Alcohol Treatment (IDAT) program provides involuntary treatment as an option of last resort to people with severe substance dependence. The [NSW Drug and Alcohol Treatment Act 2007](#) provides the legislative basis for this program in terms of assessment, stabilisation and treatment of patients in an involuntary capacity, and outlines the criteria for admission into the program.

The aim of the IDAT program is to protect the health and safety of people with severe substance dependence who are at risk of serious harm while also safeguarding their human rights. IDAT provides medically supervised withdrawal management, and post-withdrawal assessment and treatment in a specialised treatment centres for up to 28 days in the first instance, and up to three months in cases of an extension granted by a Magistrate. This is followed by a voluntary community care component for up to six months, which acts as an adjunct to services provided by Alcohol and Other Drugs (AOD) services in the patient's local area.

IDAT is funded by the Ministry of Health as a statewide service and is delivered by two Local Health Districts (LHDs). Currently there are 12 gazetted beds across two hospital-based treatment centres: one at Royal North Shore Hospital campus with four beds (Northern Sydney LHD), and at Bloomfield Hospital campus in Orange with eight beds (Western NSW LHD).

The IDAT model of care (MoC) outlines the activities undertaken by LHDs to operationalise detention and treatment under the Act.

The MoC aims to:

- outline the processes of IDAT and enable program consistency across NSW.
- guide best practice AOD treatment for all IDAT clients
- assist clinicians and other stakeholders to interpret legislation as it relates to the program
- provide clarity on administrative and operational matters.

The MoC is supported by a suite of documents including the Act, fact sheets and forms, and locally developed protocols, policies, procedures and guidelines.

### 2.1. Legislation - Drug and Alcohol Treatment Act 2007

The Drug and Alcohol Treatment Act 2007 (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 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 treatment option of last resort. 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.

Section 3 of the Act states:

*(1) The objects of this Act are —*

*(a) to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety, and*

*(b) to facilitate a comprehensive assessment of those persons in relation to their dependency, and*

*(c) to facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal, and*

- (d) to give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare.*
- (2) This Act must be interpreted, and every function conferred or imposed by this Act must be performed or exercised, so that, as far as practicable —*
  - (a) involuntary detention and treatment of those persons is a consideration of last resort, and*
  - (b) the interests of those persons is paramount in decisions made under this Act, and*
  - (c) those persons will receive the best possible treatment in the least restrictive environment that will enable treatment to be effectively given, and*
  - (d) any interference with the rights, dignity and self-respect of those persons will be kept to the minimum necessary.*

### 2.1.1. Criteria for detention and treatment under the Act

Under the Act, detention in a treatment centre is only permitted where an Accredited Medical Provider has issued a dependency certificate in relation to the person.

Section 9(3) outlines:

- Essential criteria that **must** be met:
  - “A dependency certificate may be issued in relation to the person only if the accredited medical practitioner is satisfied —*
    - (a) the person has a severe substance dependence, and*
    - (b) care, treatment or control of the person is necessary to protect the person from serious harm, and*
    - (c) the person is likely to benefit from treatment for his or her substance dependence but has refused treatment, and*
    - (d) no other appropriate and less restrictive means for dealing with the person are reasonably available.”*
- Discretionary criteria which **may** be considered:
  - “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.”*

### 2.2. Principles of care

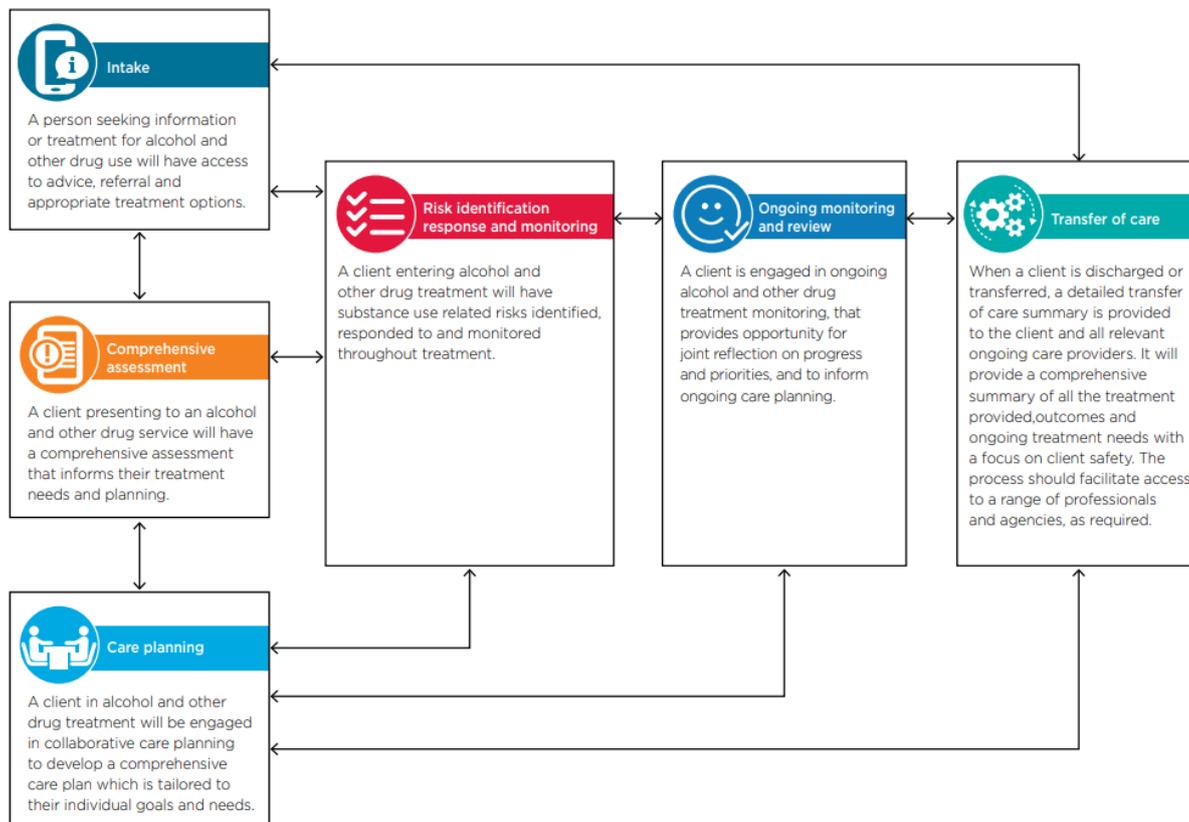
The [NSW Clinical Care Standards](#) outline the core elements of care that underpin treatment within NSW alcohol and other drug (AOD) treatment services. It is expected that IDAT treatment centres adhere to these standards, to the extent that is possible in the context of involuntary care.

1. Services are person centred
2. Services are safe
3. Services are accessible and timely
4. Services are effective
5. Services are appropriate
6. Services use their resources efficiently
7. Services are delivered by a qualified workforce

In addition, there are specific principles that are relevant to involuntary treatment:

1. Treatment should be delivered 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
2. There should be appropriate safeguards for the rights of people who are involuntarily detained, including the right to appeal their detention

Notwithstanding the involuntary nature of IDAT, treatment should - to the extent that it is possible - embrace the principles of trauma-informed-care, which are safety, trustworthiness, collaboration, empowerment, and respect for diversity.



### 2.3. Culture and philosophy

It is essential that the treatment centre's culture and philosophy are supportive and protective of staff and dependent patients.

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
- the provision of a structured program, underpinned by care planning and case coordination and trauma informed practice
- the importance of motivating patients to engage in post-withdrawal voluntary treatment, as an inpatient and in the community
- engagement of the patient and their primary carer, if appropriate, at all stages of treatment, 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.

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

## 2.4. Clinical objectives and outcomes

The clinical 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
- 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.

The 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 welfare needs, and through enhancing social and support networks.

## 2.5. The IDAT Model of Care

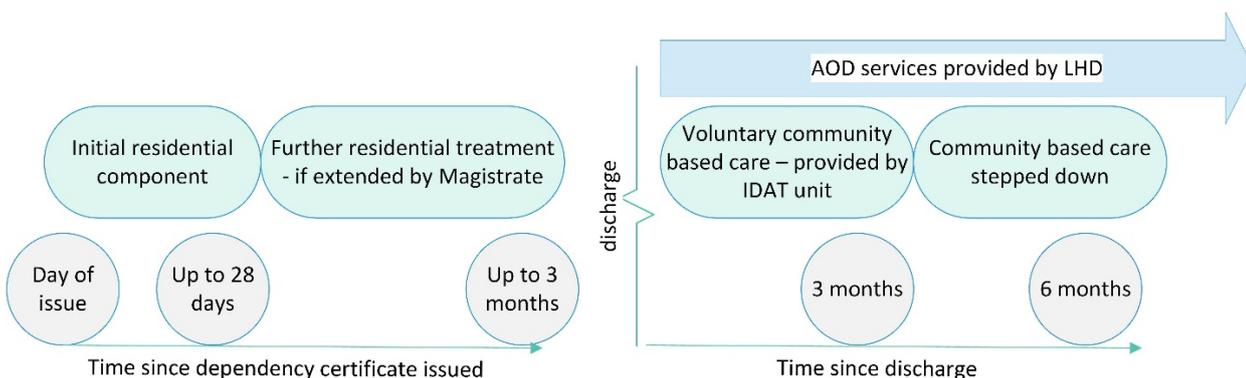
A summary of the program phases is included below:

Referral and screening	Initial information gathering Provision of advice or sign-posting to alternative treatment options
Assessment	Additional information gathering Assessment by Authorised Medical Practitioner Issue of dependency certificate or referral to alternative treatment option

Admission	<p>Transportation and admission to treatment centre</p> <p>Identification of Primary Carer</p> <p>Treatment plan and discharge plan</p> <p>Review of dependency certificate by magistrate</p>
Withdrawal	<p>Medically supervised withdrawal</p> <p>Continued assessment and monitoring</p>
Post-withdrawal treatment	<p>Continued implementation of treatment plan</p> <p>Ongoing assessment and monitoring</p> <p>Ongoing treatment- clinical and psychosocial</p> <p>Ongoing discharge planning including community based intervention plan</p>
Discharge	<p>Assessment of suitability for discharge</p> <p>Completion of treatment plan</p> <p>Finalisation of discharge plan</p>
Community based program	<p>Revision and implementation of community based intervention plan</p> <p>Ongoing assessment and monitoring</p>

## 2.6. Overview of the program components

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.



**Figure 1 Overview of IDAT components and indicative timeframe**

- 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 allows for a more detailed assessment of the cognitive and functional abilities of the patient. 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 voluntary **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 patient builds links and relationships with alternative community based treatment and support options.

### 3. PROGRAM DELIVERY

#### 3.1. Administrative matters

##### 3.1.1. Administration of Accredited Medical Practitioner (AMP) appointments

Section 7 of the Act provides powers to the Secretary, NSW Health to appoint AMPs. The appointment can be made to a specified person, for example 'Dr Edward Jenner' (S7(1) of the Act), or the holder of an office, such as 'Addiction Psychiatrist, IDAT North Sydney treatment centre' (S7(2) of the Act). Only medical practitioners may be appointed.

A template to record the appointment of an AMP is available from the Centre for Alcohol and Other Drugs. An operationally suitable end date should be recorded on the template to prevent temporary AMPs from maintaining their powers beyond their employment in an appropriate role at IDAT. Where a suitable end date is unclear, a default timeframe of 7 working days is acceptable.

Delegation of the Secretary's powers to appoint AMPs is described in the [Public Health Delegations Manual](#), part 9.12, as granted to the following roles:

- Chief Health Officer
- Executive Director, Centre for Alcohol and Other Drugs
- Director, Centre for Alcohol and Other Drugs. Clinical Services and Programs
- Director of IDAT treatment Centres

While delegates may appoint AMPs, they do not have the power to impose conditions for exercising the functions of an AMP (S7(3)) of the Act. This power must remain with the Secretary. Imposing a time limit on the appointment would not necessarily be considered imposing a condition on the AMP's function. Notes about delegation:

- A person acting in any of the roles above may exercise the delegation. They are to sign and indicate they are acting in the higher position.
- A delegate may not appoint themselves as an AMP.
- For more information about the administration of delegations, see the [Public Health Delegations Manual](#)

##### 3.1.2. Official visitors

Part 3 of the Act describes the legislated requirements for Official Visitors. Under the Act, two Official Visitors must visit each gazetted treatment centre 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 made aware of the Official Visitor program and that they may make a request to an AMP to see an Official Visitor. AMPs must inform an Official Visitor within 2 days of receiving any request.



## 3.2. Intake

### 3.2.1. Overview of application and assessment

Anyone can identify a person as potentially suitable for the program, however, a referral to an AMP must be from a medical practitioner (with the support of an ITLO).

Prior to making a referral/application, a screening and information gathering step determines if the patient is likely to meet the criteria for detention and treatment under the Act and collects evidence to support a potential application.

If the decision is made to proceed to an application/referral, the following forms are completed:

- Form 2 - completed by a medical practitioner, preferable one with ongoing clinical connection to the patient, and \*committed to their care post IDAT discharge; used to request that an Accredited Medical Practitioner (AMP) assess the patient for detention and treatment under section 9(1) of the Act.
- Form 3 - completed by a treating AOD clinician (ITLO, medical practitioner or other AOD staff) preferably with the coordinating support an ITLO and a treating team that are \*committed to the ongoing care of the patient after discharge from IDAT. It provides supporting information to be used by the AMP in conducting the assessment. The evidence provided should demonstrate how the patient meets the criteria.

Forms 2 and 3 must be submitted together before the AMP can conduct an assessment.

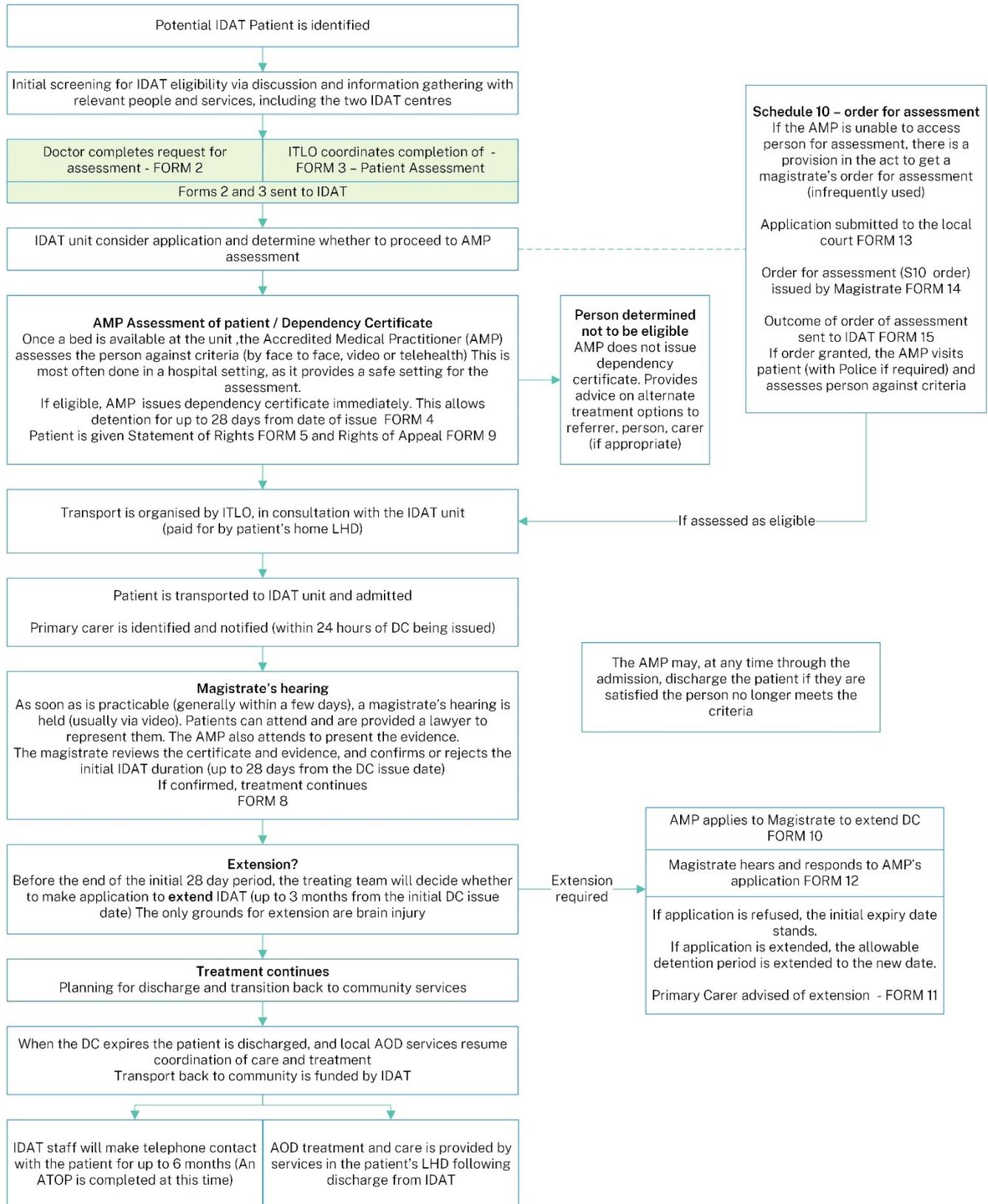
\*The patient's chance of meeting their treatment goals is greatly enhanced by being connected to a treating team that can meet their treatment needs pre and post IDAT admission.

If the patient meets all criteria for involuntary treatment, and there is a gazetted bed available, the patient is issued with a dependency certificate stating that they may be detained for treatment under the Act. Under section 14 of the Act, "the person must not be detained for treatment for more than 28 days after the day the certificate is issued". (See Issuing a dependency certificate)

If the AMP cannot access the patient to conduct an assessment, they may apply to a Magistrate for authority to visit the person to conduct the assessment (see Order for Assessment).

An AMP can apply to the Magistrate to grant an extension/s of the inpatient care period for up to three months in certain circumstances (see 'Extension of the Dependency certificate')

3.2.2. Intake process flow



### 3.2.3. Screening and information gathering

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

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 and family violence.

To determine if a referral should be made to an AMP, 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 NSW Police) involved with the patient.

It is not essential for the screening and assessment to involve contact with the patient, and this will not always be possible. However, involving the patient, to the extent it is possible, is recommended.

Multidisciplinary input is recommended to determine whether to refer to IDAT, 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.

Information gathered during this stage must be well documented and clearly linked to the decision to refer for a dependency certificate assessment.

To assist in identifying appropriate patients for referral to the IDAT program in accordance with the Act, refer to the table below.

Essential criteria under the Act	Example of how the criteria should be addressed in the referral	Examples indicating a patient is unlikely to meet the criteria
1. Patient has severe substance dependence	Evidence of: <ul style="list-style-type: none"> <li>tolerance and withdrawal</li> <li>attempts to cut down or control use that were unsuccessful</li> <li>continued use despite life threatening harm</li> <li>life dominated by use &amp; recovery.</li> </ul>	The patient: <ul style="list-style-type: none"> <li>has mild or moderate dependence</li> <li>no recent use</li> <li>is better managed under the Mental Health Act 2007.</li> </ul>
2. Care, treatment or control is necessary to protect the patient from serious harm	Evidence of the following that are causally related and/or exacerbated by the patient’s substance use: <ul style="list-style-type: none"> <li>severe and deteriorating physical or mental health issues and/or</li> <li>severe financial, legal or public health issues and/or</li> <li>severe impact on children and dependents.</li> </ul>	The patient: <ul style="list-style-type: none"> <li>is at high risk of suicide</li> <li>poses a risk to other patients</li> <li>is undergoing palliation</li> <li>is at high risk of absconding.</li> </ul>
3. The patient is likely to benefit	<ul style="list-style-type: none"> <li>Evidence of complex needs that would benefit from the care of a</li> </ul>	The patient has an unmanaged medical or

<p>from treatment but has refused treatment</p>	<p>multidisciplinary team. E.g. Cognitive impairment needing assessment that cannot be assessed while the person is using substances.</p> <ul style="list-style-type: none"> <li>The referring service proposes a detailed aftercare plan, showing preparation for its implementation, consultation with the patient and services to engage upon discharge.</li> </ul>	<p>mental health condition with a severity that is the primary condition and warrants treatment in a mental health unit or hospital.</p>
<p>4. There are no other less restrictive treatment options available</p>	<p>A comprehensive summary of the range of voluntary treatments (of varying modes and intensities) that have been attempted for treating the patient’s dependence over time, such as:</p> <ul style="list-style-type: none"> <li>voluntary admission for detox</li> <li>residential rehabilitation</li> <li>community based treatment</li> <li>day programs.</li> </ul>	<p>The patient:</p> <ul style="list-style-type: none"> <li>is engaged in, or willing to engage in, voluntary treatment</li> <li>has not attended a range of high-quality professional treatments</li> <li>has had prior IDAT admissions and ongoing reluctance to engage with services.</li> </ul>

**3.2.4. Screening and information gathering checklist**

The following information should be gathered to:

- Determine whether a referral to IDAT is the most appropriate, least restrictive treatment available,
- Provide supporting material for a dependency certificate assessment, should a referral be made,
- Inform possible treatment options.

Considering all elements during the screening phase is vital to the success of the entire treatment journey. If a referral is made, these details should be supplied on Form 3.

Gather/consider/notate:

- Current and previous history of drug and alcohol use:
  - Substance use past 3 months E.g. quantity, frequency, duration, route, last use.
  - Impact on functioning and capacity. Include emergency service and acute care utilisation and arrests
- Current and previous treatment history, including
  - Past treatment attempts, e.g. withdrawal management, rehab, counselling
  - History of withdrawal and previous complications
  - Willingness of the patient to engage in treatment voluntarily
  - Availability of less restrictive treatment options that can be accessed.

- Risk of harm to self and to others, including children.
- Psychosocial history, including employment, living situation, marital status, dependents, social supports, significant stressors, social and cultural issues and relevant socio-economic factors.
- Concerns with independent living, including mobility, cooking, self-care, continence, wandering.
- History of violence/aggression. Include recent thoughts/attempts to harm others.
- Current physical health, including:
  - pregnancy, allergies, current medication, seizures, epilepsy, head injury, blood borne viruses
  - Cognitive concerns, disabilities.
- Legal issues, such as relevant criminal history, current charges, pending court matters, and current orders or conditions. Pending charges should not preclude a patient from being accepted onto the program, 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).
- Identification of transportation needs should the patient be issued a dependency certificate. The ITLO is primarily responsible for organising transport.
- A proposed aftercare plan including:
  - How treatment will continue post discharge, (with services identified), e.g. residential rehabilitation, pharmacotherapy, self-help groups, prevocational / vocational programs.
  - How will the patient's welfare be supported? e.g. housing, social support, financial support and guardianship issues.
- If proceeding to referral, these details should be planned in partnership with the referrer/ referral service (if applicable) and the local AODS, including agreement on the continuation of treatment following the IDAT treatment centre admission.

### 3.2.5. Referrals to the program

Referrals are sent to the IDAT treatment centres as per [overview of application and assessment](#).

The referral is logged, recording the time, date and details of the referral. Treatment Centers should provide written acknowledgement to the referrer within a working day of receipt.

The AMP will determine whether there is sufficient information to assess the Identified Patient for a dependency certificate. If not, further information will be requested of the referrer(s). Contact details of local ITLOs will be provided to the requesting medical practitioner for liaison regarding further drug and alcohol screening and assessment needs.

Where the referral is made via non AOD specific clinicians, local AOD services should be engaged and kept up to date throughout the patient's treatment, in order to ensure continuity of care on discharge from IDAT.

### 3.2.6. Patient information in screening and referral

It may be appropriate to seek additional information from 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 patient does not meet the [eligibility criteria](#).

The ability to compile the necessary information for referral may involve disclosure of information regarding that patient to family members and carers (without the patient's consent). Disclosure of information is permitted in specified circumstances under section 47 of the Act, including where the

disclosure is made with a lawful excuse, such as under the *Health Records and Information Privacy Act 2002* (HRIPA) where it is believed to be necessary to lessen or prevent:

- a serious and imminent threat to the life, health or safety of the individual or another person, or
- a serious threat to public health or public safety.
- Due to the complexity of health concerns for those patients referred to IDAT, ITLOs may need to disclose information without consent for purposes of arranging treatment. This is permitted in instances where patients meet the above threshold.

Patients undergoing involuntary treatment have the right under section 13(2) of the Act, to nominate a person who is to be excluded from being given information about them.

### **3.3. Comprehensive assessment and assessment for a dependency certificate**

#### **3.3.1. Conducting Assessment**

The AMP assessment must take place as soon as practicable after referral.

The patient meets with an AMP face to face, or via virtual care, or other videoconference (with a preference for face to face in the first instance).

Face to face 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).

The AMP undertakes a comprehensive AOD assessment, building on the information provided at referral, 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
- 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 treatment 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, including inpatient and community based care.

Standardised, validated tools should be used wherever possible. [See examples.](#)

The overall assessment should be summarised and should identify:

- 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.

Note that, with regard to assessment of cognitive impairment, if the patient is issued a dependency certificate and admitted to the treatment centre, 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 use of the client group and the likely impact on functioning and capacity, it is not appropriate to undertake these types of assessment prior to a patient's withdrawal as the validity of the assessment outcomes will be limited.

### 3.3.2. Issuing a dependency certificate

Following the comprehensive assessment, if:

- a) as a result of the assessment, the AMP is satisfied that the patient meets the eligibility [criteria](#) specified in the Act and
- b) a bed is immediately available at the treatment centre

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 treatment centre.

Immediately following the issue of a dependency certificate, the following steps should be undertaken:

- AMP provision of both oral and written advice to the patient (and family members, carer or guardian, if appropriate) of their legal rights and rights to appeal
- identification in writing of the primary carer(s)
- identification of transport options and arrangement of transport to the treatment centre (See [Transport](#)).

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.

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 a treatment centre immediately, regardless of the appeal process. A successful appeal will lead to a revocation of a dependency certificate and an immediate discharge from the treatment centre.

### 3.3.3. Waiting lists and prioritisation

A patient should not be issued a dependency certificate if they cannot be admitted to a treatment centre 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.

Treatment centres 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.

Treatment centres 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.

ITLOs are required to coordinate treatment for patients that are awaiting admission and communicate with these patients regularly, where possible.

### 3.3.4. Order for Assessment

Section 10 of the Act makes provision for cases in which the AMP is unable to access the patient to undertake the AMP assessment. Under the Act, 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 any assessment under section 10, the AMP should provide written notice of the assessment having taken place to the person who made the Order.

On the occasion that a section 10 order is made where 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 appointed by the Secretary as an AMP. Conditions may be imposed on the appointment under section 7(3), such that the appointment is temporary, and/or that the legislated power is limited to conducting assessments under Section 10 and issuing a dependency certificate in such circumstances.

## 3.4. Transport

### 3.4.1. Transport planning

Upon issue of a dependency certificate the referring LHD is responsible for transporting the patient to an IDAT treatment centre as soon as is practicable. Transport needs are assessed on a case-by-case basis, based on the clinical presentation of the patient and distance to the treatment centre. The ITLO should ensure that transport is discussed as early as possible in the referral process.



The transport options should be discussed with the patient, referring clinician, the family, carers or public guardian, the local care coordinator or ITLO and the treatment centre where possible and practicable.

It is essential to manage the risk of patients experiencing serious complications including severe withdrawal symptoms during transport.

Key Questions for consideration when planning travel:

1. What is the level of risk during transportation of the following:
  - patient withdrawal. Consider the history of withdrawal for this person, such as a history of black outs or seizures. See NSW Health resources for [Clinical guidance for withdrawal from alcohol and other drugs](#) for more information about screening and assessment
  - a significant risk of harm to self or others
  - another medical emergency. If a risk of escalating to a medical emergency is identified, consider how rapidly the risk may escalate.
- Is the person medically cleared for travel?

Regardless of original patient level of risk identified, the patient's level of risk should be continually assessed throughout the journey and responded to appropriately, in consultation with the treatment centre staff.

### 3.4.2. Transport modes

Recommended modes of transportations include:

- Health Transport Unit or Patient Transport Service (PTS)
- Pre-booked NSW Ambulance Service, noting that an emergency ambulance service should only be requested in a life-threatening emergency. In emergencies patients are transported to the nearest clinically appropriate hospital, as determined by NSW Ambulance systems.
- Local Health District staff vehicle

Under Patient Transport Service (PTS) policy, the clinical care needs of the patient determine the particular class of transport service used and whether the patient's risk level and clinical needs are within the scope of PTS or NSW Ambulance.

For PTS, prior to transport, patients must have been assessed by a registered nurse or medical practitioner as having a 'low risk of deterioration'; patients are 'expected to remain within [Between the Flags](#)' criteria (or have documented alterations to calling criteria on the relevant NSW Standard Observation Chart where this is appropriate for the patient). Those booking transport should ensure they understand the level of care that can be provided for the class of transport being booked, for example, whether there will be any clinical staff on board capable of the level of monitoring required by the particular circumstances.

It is not recommended that patients arrive by public or private transport. This may only occur where all of the following criteria are met:

- Very short distance to receiving treatment centre, and
- With prior agreement of the receiving treatment centre, and

Where the patient has been assessed by the referring clinician to be a low risk for absconding, deterioration, distress and harm to self or others enroute.

In limited circumstances, and under sections 20 and 23 of the Act, NSW Police may apprehend a patient and transport to a treatment centre. Police assistance may be requested where there are

serious safety concerns if the person is taken to a treatment centre without the assistance of a police officer. While they are permitted under the Act to provide transport, in practice, police will usually only transport a patient to the nearest hospital.

### 3.4.3. Inter hospital transfer and long-distance transport

In some cases, a short inpatient admission prior to transport may be required to ensure the patient is medically stable for transportation. Any admission prior to transport is on a voluntary basis; patients may only be detained under the Act at a gazetted treatment centre, following the issue of a dependency certificate.

In these circumstances, or any other where any inter hospital transfer is required, a formal patient transport option, such as NSW Health Patient Transport Service (PTS) or NSW Ambulance should be used. A formal patient transport option should also be used for any long-distance travel to an IDAT treatment centre (i.e. not within metro Sydney),

The rationale for these requirements is to manage the risk of patients experiencing serious complications including severe withdrawal symptoms during transport.

As per formal practice all relevant policies must be followed, including those referring to:

- The assessment and management of any present or emerging clinical concerns
- Admission, clinical handover, transfer and discharge
- Recognition and management of patients who are deteriorating

Guidance is available to support staff in the recognition and management of withdrawal. See [Clinical guidance for withdrawal from alcohol and other drugs](#) .

The clinical accountability for the patient remains with the referring LHD until the patient arrives at the IDAT treatment centre. It may extend beyond this point if adverse events or situations arise where clinical care received within the referring LHD could have had an impact on the situation.

Communication failures and adverse outcomes can be more common when consumers receive care across Local Health Districts (LHD) or care across NSW Health and private facilities. When care is provided across services a formalised treatment plan involving all services providers should be in place.

### 3.4.4. Transport Officer

Section 20 of the Act stipulates that a transport officer may take a dependent person to or from a Treatment Centre.

Under the Act a 'transport officer' means:

- (a) a member of staff of the NSW Health Service,
- (b) a police officer,
- (c) a person of a class prescribed by the regulations, which include:
  - (i) staff of St Vincent's Hospital Sydney Limited,
  - (ii) staff of Northern Beaches Hospital,
  - (iii) persons employed or otherwise engaged by an entity that provides transport services under a contract for services with either St Vincent's Hospital Sydney Limited or Northern Beaches Hospital.

The Act stipulates that transport officers may use reasonable force and restrain the patient in order to transport them to the treatment centre. (See also ['Seclusion and restraint' section](#) regarding NSW Health Policy.)

The Act also provides a basis for the transport officers to undertake a frisk search and to remove items from the patient's possession that might present a risk of danger to themselves or others, or may assist them to escape during the transportation.

For transport of patients back to their home following discharge, also see [Discharge planning](#)

### 3.5. Admission and care coordination

#### 3.5.1. Admission and induction to the treatment centre

The patient will be received at the treatment centre by a member of the clinical team, as per the local treatment centre procedures. The dependency certificate should be included in the medical file 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.

Orientation should take place as soon as the patient is admitted to the treatment centre 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 treatment centre rules, will need to be repeated as the patient progresses through the treatment centre and as their cognitive capacity improves.

The purpose of orientation is to:

- admit and orient the patient to the treatment centre
- provide the patient and their nominated primary carer with information about the treatment centre, 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 treatment centre and the provision of the following specific information:

- The rules of the treatment centre, including roles and responsibilities of patients and staff, behavioural expectations, rules related to smoking on the premises, an overview of the structured day of the treatment centre, visiting hours, the role of and access to Official Visitors and procedures for complaints. 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.
- Overview of the program including the objectives (why the patient has been admitted), the stages of treatment (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.

### 3.5.2. Identification of a primary carer

Sections sections 16, 18 and 45 of the Act describe the legislative requirements around the nomination of a primary carer, and the conditions under which they must be notified or involved. Additional requirements are also described in this document.

Patients who are not under guardianship may nominate a person to be their primary carer, and may revoke or change the nomination at any time. Nominations, variations and revocations must be in writing. Where a patient is under guardianship, their guardian is their 'primary carer' for the purposes of the Act.

The primary carer must be notified within 24 hours after a dependency certificate has been issued.

If the patient is unable to nominate a primary carer on admission, they should be asked again at an appropriate time, but within 24 hours.

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. The primary carer may be a family member, carer, friend or another professional who is known to the patient.

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. 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 primary carer, by the treatment centre.

Section 13 (7) of the Act outlines two exceptions to the AMP's obligations regarding primary carers:

*(7) An accredited medical practitioner is not required to give effect to a nomination, or a variation or revocation of a nomination, if the practitioner reasonably believes—*

*(a) that to do so may put the dependent person, the nominated person or any other person at risk of serious harm, or*

*(b) that the dependent person was incapable of making the nomination, variation or revocation.*

### 3.5.3. Initial inpatient assessment

An initial assessment following admission to the treatment centre 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 treatment centre
- 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 treatment centre should include a nursing assessment and plan and review by a doctor. The assessment should be followed up by the admitting consultant, or their delegate consultant, within 24 – 48 hours following admission and will build on the assessment

undertaken to issue the dependency certificate. This initial assessment in the treatment centre 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 treatment centre 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 treatment centre.

Staff undertaking the initial assessment upon admission should:

- be non-judgmental, 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 treatment centre 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 is the responsibility of the program staff 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.

*Table 1: Examples of standardised tools for substance use, mental and general health and functioning*

Purpose/ domain	Standardised tools
Severity of Dependence	Severity of Dependence Scale
Global screening, assessment and outcome measures	The Australian Treatment Outcomes Profile (ATOP)
Quality of life	SF-12v2 – quality of life questionnaire
General mental health	The Kessler Psychological Scale (K-10)
Cognitive health	Montreal Cognitive Assessment (MoCA) Brief Executive functional Assessment Tool (BEAT)

### 3.5.4. Assessment of mental health and suicide risk

A key element of the initial assessment upon admission to the treatment centre is the assessment of mental health and suicide risk. Management of risk during the residential treatment stage should be documented in a risk management plan. Assessment of risk and revision of the risk management plan should be on-going throughout the residential treatment. See NSW Health policy [Clinical care of people who may be suicidal](#).

### 3.5.5. Multi-disciplinary team

The residential treatment stage is delivered by a multi-disciplinary care team. Clinical professionals involved in the care team may include:

- Accredited Medical Practitioner
- Addiction Medicine Consultant
- inpatient nursing staff
- other drug and alcohol workers
- clinical psychologists and neuropsychologists
- counsellors and/or therapists
- social workers
- occupational (and diversional) therapists
- other medical and clinical staff as indicated by care plan, e.g psychiatrists
- IDAT Care Coordinators
- peer workers
- Aboriginal health workers
- other allied health as needed such as dieticians, physiotherapist, pharmacist as needed

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 IDAT, reviewing and extending dependency certificates and upholding the rights of the patient.

The IDAT care team must provide updates to the community care coordinator throughout the residential treatment phase.

### **3.5.6. Identification of an IDAT Care Coordinator**

An IDAT care coordinator will be identified for the patient upon their admission to the treatment centre. This role is located at the treatment centre and may be shared across the multi-disciplinary team. This role has responsibility for the planning and management of care during the residential treatment stage.

The IDAT care coordinator should work closely with the community care coordinator to plan for discharge and enable continuity of care and support post discharge.

### **3.5.7. Identification of a Community Care Coordinator**

The community care coordinator is located in the Local Health District to which the patient will return following discharge. They are responsible for the coordination and /or delivery of the care plan in the community across the relevant health and social welfare services.

The person in this role will need to be identified on a case-by-case basis, ideally prior to admission to the treatment centre, taking into account where the referral originates and where the patient will return to post-discharge. The individual who acted as the ITLO may also take this role.

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 community care coordinator will need to be identified in discussion with the referrer, ITLO, IDAT staff, and the patient and / or their family.

It is important for the community care coordinator to establish a trusting, respectful relationship with the patient (and their family/carer if appropriate) before the patient is discharged into the community. This may require the community care coordinator to visit the patient at the treatment centre.

Depending on the availability of specialist drug and alcohol services in the local area, it is possible that the community care coordinator may not have professional drug and alcohol expertise, although this is not desirable. If this is the case the IDAT care coordinator(s) should identify appropriate governance and supervision to support the community 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 will need to engage regularly with the IDAT care coordinator (or other IDAT staff) to provide continuity and quality of care and support for the patient in the community.

The IDAT community care coordinator(s) 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.

### 3.5.8. Review of the dependency certificate

Sections 14 of the Act stipulates that dependency certificates must be reviewed by the Magistrate as soon as is practicable. The review must take place no more than seven days after the date of issues. 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. A solicitor will be appointed to represent the patient in these proceedings.

The AMP is responsible for ensuring that

- (a) *all appropriate medical witnesses appear before the Magistrate, and*
- (b) *other relevant medical evidence concerning the person is placed before the Magistrate.*

The review may be attended by the patient, their primary carer, the AMP and/or delegated treatment centre 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 treatment centre, noting the patient should have the option of staying on in the treatment centre as a voluntary patient if it is likely to be beneficial, should this be available. Gazetted involuntary beds should not be used in these cases.

## 3.6. Care planning

### 3.6.1. Overview

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. Guidelines for general AOD care planning are described in the [NSW Clinical Care Standards for Alcohol and Other Drug Treatment](#).

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 Care Coordinator, Community Care Coordinator, 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.

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 are being updated to articulate the appropriate use of the brokerage model for the IDAT program.

### 3.6.2. 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
- risk management
- post-withdrawal (inpatient)
- discharge plan
- community based treatment.

A care plan must:

- 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).

Throughout the residential treatment, 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.

See also [Extension of the dependency certificate](#).

## 3.7. Monitoring treatment progress and outcomes

### 3.7.1. Medically supervised withdrawal

The aim of withdrawal is to cease substance use (whether temporarily or permanently) and engage the patient in ongoing treatment and care. Supportive care is provided to minimise the risks associated with withdrawal and to reduce discomfort. Planning and coordinating post-withdrawal care is an integral part of the treatment process, including throughout withdrawal.

Additional guidance is provided in the document '[Management of withdrawal from alcohol and other drugs](#)' and the associated handbook.

An underlying principle of withdrawal care discussed in the guidance is that of patient collaboration; the patient has a right to choose from the range of treatment options. In practice, this may be challenging for IDAT patients, who are not being treated voluntarily. Regardless, this principle should remain a goal of clinicians; efforts to collaborate with the patient should be made wherever possible.



It is likely that patients being admitted may already be in withdrawal, depending on the timings of the preceding assessment for a dependency certificate and the subsequent transport to the treatment centre. 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.

Pharmacological treatment should be overseen by the AMP, with monitoring and supportive care undertaken by the inpatient care team.

### 3.7.2. 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 use, 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.

Additional 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 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 other care or service providers. 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. Changes in risk may arise as the patient engages in treatment and starts to address factors around their substance use.

Support, screening, testing and referral for treatment of blood borne viruses (HIV, Hepatitis B and C) are also part of AOD treatment and holistic care provision. In line with NSW Health guidelines, patients should be screened for blood borne viruses and offered testing and advice about treatment and vaccinations, if appropriate. Testing is voluntary.

### 3.7.3. Structured interventions

A range of structured interventions should be provided by treatment centre staff during the post withdrawal inpatient stage, as indicated by the global care plan. Interventions are delivered to encourage and reinforce positive behaviour change, support the patient, and to equip them with skills to make healthier lifestyle choices. The principles, processes and considerations for psychosocial interventions are discussed in [NSW Health Alcohol And Other Drugs Psychosocial Interventions Practice Guide](#).

Examples of structured interventions include

- advice, information and education about substance use, with a harm minimisation focus
- diversion and recreation activities
- occupational therapy or physiotherapy, if required
- counselling
- living and life skills, including cooking, cleaning and budgeting
- relapse prevention and active practice of relapse prevention skills during therapy
- family education and support
- education about treatment options available in the community, such as self-help groups (e.g. 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 and structured treatment should be matched to the needs and characteristics of the patient, taking into account the person's:

- cultural background
- language and literacy
- cognitive and physical functioning
- mental health (for example 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 treatment centre, a rotating program of group interventions should be developed. The rotating program should enable 'rolling starts', that is 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. However, 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.

### 3.7.4. 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 with the inpatient team.

### 3.7.5. Extension of the dependency certificate

Under section 35 of the Act, 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*

- a) additional time is needed to carry out treatment and to plan the person’s discharge*
- b) 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.

A lack of identified housing is not an appropriate reason to seek an extension. Issues of housing should be managed by other mechanisms. See Patients who are homeless.

## 3.8. Discharge

During this stage, the patient is discharged from the treatment centre and transitioned to the community based stage of treatment. Outcomes must be measured and recorded 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.

### 3.8.1. Discharge planning

Discharge is underpinned by a discharge plan, which is commenced at admission to the treatment centre, to ensure there is a continuum of care between the residential and community based components of the program.

The discharge plan should be coordinated by the IDAT care coordinator(s) 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. Care coordinators should them in discharge planning and choosing treatment/support options.

The discharge plan should be reviewed and revised throughout the residential 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. For example, a discharge plan should be updated if an appropriate place becomes available at a residential treatment program.

The discharge plan forms an integral part of the community based care component and includes goals, actions, timeframes and roles and responsibilities for continuity of care and support post discharge.

The discharge plan stipulates goals and activities at a point in time (at discharge, unlike the community based care activities and goals, which are staged over a number of months.).

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 residential rehabilitation
- transportation from the treatment centre (which is the responsibility of the LHD where the treatment centre is located). Transportation decisions should consider the capacity of the patient to undertake the journey safely, and the impact the journey may have on their recovery.
- 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 treatment centre.

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
- working with patient and carers to manage anxiety associated with discharge

### 3.8.2. Assessment for suitability for discharge

There are a number of circumstances in which a patient must be discharged from residential treatment:

- if the Magistrate revokes a dependency certificate at the initial review (s34(7))
- the dependency certificate has expired (s24(2)b)
- if the AMP is satisfied that the person no longer meets the [criteria for detention and treatment under the Act](#). (s24(2)a). In this case, the AMP must discharge the patient, and should record

that the patient no longer meets the criteria for detention and treatment under Section 9 of the Act in the patient file.

- if an AMP seeks to extend the dependency certificate, but this is not granted by the Magistrate. In this case the patient is discharged from involuntary treatment once the dependency certificate expires (s36(4)).

The AMP will undertake an assessment to determine suitability for discharge (except for cases where the Magistrate has revoked the initial dependency certificate at review). The assessment should involve input from the multi-disciplinary care team, 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 ongoing care (where the patient has consented for sharing this information). 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.

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

Patients who elect to continue with residential treatment in a voluntary capacity can be treated in a non-gazetted bed, where one is available.

### 3.9. Community based treatment

The community based component 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 residential treatment. 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 local treatment and support providers. It is acknowledged that some patients may require longer term management with no stepped down approach.

### 3.10. Implementing community based care

The IDAT care coordinator(s) and the community care coordinator are responsible for the development, implementation and review of the global care plan in the community. The IDAT care coordinator(s) and community care coordinator should negotiate the distribution of responsibility between them on a case by case basis.

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.

### **3.11. 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, and where possible, assess the patient using formal outcome tools ideally used during the residential treatment stay to monitor treatment progress.

### **3.12. 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 treatment centre. It is also essential from a resource perspective to maintain the capacity of the treatment centre to work with other patients.

For many patients, some form of ongoing 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.



### 3.13. Data collection for performance and outcome reporting

The NSW Minimum Data Set for drug and alcohol treatment services (MDS DATS) data collection provides consistent information about the clients and activities of NSW Health funded drug and alcohol treatment services. The collection, along with other information sources, is used to inform policy and strategies relating to the drug and alcohol treatment sector.

NSW Health Policy mandates that drug and alcohol services receiving NSW Ministry of Health funding for the provision of specialist services to people with alcohol and/or other drug and / or gambling problems, collect and report the NSW MDS DATS. Details are described in [‘Data Dictionary & Collection Requirements for the NSW MDS for Drug and Alcohol Treatment Services’](#). IDAT treatment centres are required to be compliant with these requirements.

## 4. PATIENT ISSUES AND PRIORITY POPULATIONS

### 4.1. Managing coerced patients

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

- apprehension/ambivalence to change, and lack of motivation to engage in treatment and interventions
- different views and expectations about goals regarding substance use and other psychosocial domains
- distressed and trauma based behaviours, 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 reluctance 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.

Throughout the treatment, motivational and educational intervention techniques should be employed establish and maintain motivation and engagement.

### 4.2. Violence in the workplace

NSW Health has a zero tolerance approach to violence and abuse, documented in the policy '[Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach](#)'. Threats or acts of aggression/violence during both the residential treatment and community based stages should be considered within the context of patient factor; strategies to manage this behaviour are outlined in the policy.

In some circumstances continued treatment of a patient cannot continue without significant, unacceptable risk to those involved. In accordance with the policy, this may result in a decision to discharge the patient. This option should only be considered when all other options have been investigated.

### 4.3. Seclusion and restraint

The NSW Health Policy Directive '[Seclusion and Restraint in NSW Health Settings PD 2020\\_04](#)' outlines the principles, values and procedures that underpin efforts to prevent, reduce and, where safe and possible, eliminate the use of seclusion and restraint in NSW Health settings. IDAT units must be compliant with the requirements of this policy.

Under the policy, 'acute sedation of a patient is not considered chemical restraint where it allows for assessment to be continued and treatment for the underlying condition to be commenced'. 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 (including any medication) of the dependent person's substance dependence.' Under the Act, medication must be prescribed in such a way as to not prevent the patient adequately communicating with persons engaged to represent them in regard to review or extension of the dependency certificate.

#### 4.4. Granted leave of absence from the treatment centre

Under the Act (s21), a patient may be granted leave of absence from the residential treatment 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. Under section 21(3) 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 treatment centre.

##### *Absconding*

If a patient absconds from the treatment centre, or does not return after a leave of absence, the AMP may request apprehension of the patient for them to be returned to the treatment centre. The treatment centre 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 treatment centre and every attempt is made to re-engage the patient in community based treatment.

#### 4.5. 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.

##### 4.5.1. 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. Refer to the NSW Health Alcohol and Other Drugs, Psychosocial Interventions Practice Guide, for approaches to enhance the effectiveness of interventions for older people.

##### 4.5.2. Patients with Acquired Brain Injury

Long term use 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 residential treatment 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 an extension of detention and treatment beyond 28 days, so that prioritised needs can be met before discharge. The Act specifically provides for this, see section “[extension of the dependency certificate](#)”.

#### 4.5.3. Patients who are Aboriginal and/or Torres Strait Islander

Dispossession, interruption of culture and intergenerational trauma has significantly impacted on the health and wellbeing of Aboriginal people. Alcohol and drug related harm further contributes to disparities in health and life expectancy between Aboriginal people and non-Aboriginal people. While the majority of Aboriginal people in Australia do not use illicit drugs and are not dependent on alcohol, alcohol and illicit drug use is associated with a number of health impacts and social harms that disproportionately affect Aboriginal and Torres Strait Islander people.

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

- the impact of intergenerational trauma, government policies, environment, access to substances, history, and social situations on substance use
- the importance of connection to family, community and Country, and the impact that separation or leaving Country may have on the individual, for example to undertake a residential 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 specific services for the patient to be engaged with upon discharge from the residential treatment stage of the program.

Culturally competent service delivery is enhanced by:

- links and partnerships with culturally-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.

#### 4.5.4. 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 NSW Health interpreters to effectively communicate with patients and / or their nominated primary carer
- differences in patterns of substance use amongst different populations
- different knowledge, norms and cultural values in relation to substance use
- differences in understanding that detention is a civil commitment, and not a criminal confinement. Patients who perceive they are in trouble, or criminal, may experience extra distress
- 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 use, 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 treatment centre 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 patients from a specific background justifies this.

#### 4.5.5. 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 IDAT and in considering community based case coordination and treatment post discharge from the treatment centre. The AMP is permitted by the Act to also consider the risk of serious harm to children in care of the patient and dependents of the patient in their assessment.

Identification of possible risks to children 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 use on parenting. In some cases, it may be appropriate for members of the care team to engage with family supports to support their parent capacity and relationships with their children.

In NSW, it is mandatory to report suspicions of all five recognised types of child abuse and abuse and neglect (i.e. physical abuse, sexual abuse, emotional abuse, neglect, and exposure to family violence). Reports can be made to the Department of Communities and Justice via the Child Protection Hotline.



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.

#### 4.5.6. Patients experiencing or committing family and domestic violence

In NSW, domestic violence routine screening for is mandated for women 16 years and over accessing alcohol and other drug services under the policy directive [Domestic Violence Routine Screening PD2023\\_009](#). This policy directive outlines the requirements under this policy, information about responding to reports, referral pathways, and links to available resources.

Staff should be aware of the impact that family and 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 family and domestic violence is particularly important in relation to discharge planning and the development and management of the community based care plan. If appropriate, a referral(s) should be made to specialist domestic violence services as part of the community based care plan.

#### 4.5.7. Patients with criminal justice involvement

Patient referred to IDAT may be involved in some stage of the criminal justice system. 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 any 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) effect on engagement in treatment.
- to recognise the potential impact on treatment outcomes, and a patient's safety and wellbeing, if treatment is curtailed as a result of a custodial sentence being passed. This is particularly important to consider during the residential withdrawal stage of the program, so that strategies can be put in place to work with any custodial requirements.

History of offences related to violence is not routinely available to Health staff. Any custodial or other sentence 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.

It should be noted that IDAT is not a sentencing option under the NSW Crimes (Sentencing Procedures) Act 1999.

#### 4.5.8. Patients who are pregnant

Use of drugs and alcohol during pregnancy can seriously affect the pregnant woman and unborn child and can lead to a range of developmental problems including fetal alcohol spectrum disorder. 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 use on the fetus (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 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 women with opioid dependence is maintenance because of the significant risk that withdrawal presents to the fetus. 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 IDAT is suitable for the person at that time.

An allocated IDAT care coordinator and daily allocated nurses work with the patient in initial engagement of the pregnant woman in the aims, structure and benefits of the program.

IDAT health professionals protect the mother and child's health by:

- Providing safe managed withdrawal from drugs and alcohol.
- Referring and collaborating with the local Substance Use in Pregnancy and Parenting (SUPPS) team while the patient is in IDAT. Liaison with the SUPPS team from the patient's local area continues throughout the admission.
- Referring and liaising with the Perinatal Mental Health Team, where required.
- Providing continuing care of the pregnancy throughout the admission, including antenatal appointments, scans and other relevant pregnancy care.
- Assessing and managing physical and mental health comorbidities with safe medication management where medication is indicated.
- Helping the patient understand the choices available for their pregnancy, to support their decision making that will best suit their current situation. Options may include abortion; adoption or foster care; or choosing to parent.
- Providing education on and facilitating contraception as per patient's choice.
- Providing sexual health and blood-borne virus screening. Domestic violence screening (mandatory for drug and alcohol clients) and providing appropriate support where relevant.
- Referring and collaborating with relevant community organisations while an inpatient (as required) and as part of the discharge planning process.

If the patient has a Department of Communities and Justice case worker, the IDAT care coordinator should liaise with the case worker to facilitate continuing care and support.

See [Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period](#) for further guidance.

#### 4.5.9. Patients who are homeless

Patients who are homeless or itinerant are at greater risk of harmful AOD use, may be more likely to have social networks that reinforce substance use and have fewer protective factors that

promote sustained abstinence, and mental and general health and wellbeing. It is a principle of care that patients should not be discharged from the residential treatment component of the program into homelessness, however homelessness is not adequate grounds for extension of a dependency certificate.

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. The primary responsibility for coordinating housing lies with the referring LHD, organised in collaboration with the treatment centre.

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.

#### 4.5.10. Patients who are LGBTIQ+

Evidence indicates there are higher rates of substance use in the lesbian, gay, bisexual, transgender, intersex, queer (LGBTIQ+) population when compared with the general population.

In responding to the needs of LGBTIQ+ people, it is important to acknowledge that it is not a homogenous group. Each group in the acronym holds unique health needs and experiences, and these need to be recognised and respected for each individual. Further, groups are not mutually exclusive (e.g., someone may be transgender and gay).

Some of the common experiences for LGBTIQ+ people and AOD use may include that:

- LGBTIQ+ people have significantly higher risk of mental and emotional distress, including depression and anxiety, self-harm, suicidal ideation, and attempted suicide.
- Substances are sometimes used to cope with marginalisation and discrimination.
- Much of social and cultural life in many LGBT communities is centred around licensed bars and clubs where alcohol is served and other drugs may be accessible.

Strategies for inclusive practice include:

- Ensuring health staff receiving education and training about LGBTIQ+ cultural competency, including the impact of stigma and discrimination.
- Using correct language and terminology about sexuality, gender and intersex variations is important to people who are LGBTIQ+, as these support recognition, trust and safety.
- Referring clients to LGBTIQ+ specialised health services or mental health services, where possible.
- Allowing people to describe their family or support network, recognising that this will be unique for each person and not holding judgement on its composition.
- Ensuring questions about sexual health do not make assumptions about sexuality, gender or intersex variations.



- Ensuring proper privacy and disclosure processes for gender, sexuality, HIV status and AOD use, in line with the [NSW Health Privacy Manual](#).
- Researching, endorsing and implementing approaches to consistently collect data on sexuality, gender and intersex variations, and engaging LGBTIQ+ people and frontline health staff in the co-design of collection processes, guidance and training.
- Seeking expert advice and guidance if unsure about how to approach aspects of LGBTIQ+ health care.

For more information on inclusive practice, see the [AOD LGBTIQ Inclusive Guidelines for Treatment Providers](#).

See also the [NSW Health LGBTIQ+ Strategy 2022-2027](#).

## 5. REFERENCES

### Legislation

- Drug and Alcohol Treatment Act 2007  
<https://legislation.nsw.gov.au/view/html/inforce/current/act-2007-007>

### NSW Health guidance and standards

#### AOD specific

- [AOD LGBTIQ Inclusive Guidelines for Treatment Providers](#)
- [Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period](#)
- [Clinical Care Standards for Alcohol and Other Drug Treatment](#)
- [Data Dictionary & Collection Requirements for the NSW MDS for Drug and Alcohol Treatment Services PF 2015\\_014](#)
- [Management of Withdrawal from Alcohol and Other Drugs Clinical Guidance and Handbook](#)
- [NSW Health Alcohol and Other Drugs, Psychosocial Interventions Practice Guide](#)

#### Other

- [Between the Flags system, a 'deteriorating patient safety net system'](#)
- [Clinical Care of People Who May Be Suicidal PD2022\\_043](#)
- [Domestic Violence Routine Screening PD2023\\_009](#)
- [Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach](#)
- [Privacy Manual for Health Information](#)
- [Public Health Delegations Manual](#)
- [Seclusion and Restraint in NSW Health Settings PD 2020\\_04](#)

### NSW Health Strategies

- [NSW Health LGBTIQ+ Strategy 2022-2027](#)

### Assessment and evaluation reports of IDAT

- Involuntary Drug and Alcohol Treatment Evaluation - [Cost Assessment Report](#)
- Involuntary Drug and Alcohol Treatment Evaluation - [Process Evaluation Report](#)
- Involuntary Drug and Alcohol Treatment Evaluation - [Outcome Evaluation Report](#)
- Involuntary Drug and Alcohol Treatment Evaluation - [Data Linkage Evaluation of Outcomes Report](#)