THE HOSPITAL DRUG AND ALCOHOL CONSULTATION LIAISON

MODEL OF CARE

NSW GOVERNMENT | Health

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EXECUTIVE SUMMARY

Approximately 28.4% of Australians consume alcohol at risky levels (>4 standard drinks on one occasion) at least once a month and 20.1% are at lifetime risk of harm (>2 standard drinks per day AIHW 2011). The prevalence of substance use disorders in Australia is 5.1% of people aged 16-85 years (National Survey on Mental Health and Wellbeing 2007). Alcohol consumption accounts for 3.3% of the total burden of disease and injury in Australia (Begg 2007).

Drug and alcohol related problems contribute significantly to acute hospital admissions. International and Australian hospital evidence indicates that up to 35% of people presenting to Emergency Departments may have problematic substance use. Emergency department re-attendance and re-injury rates are disproportionately affected by substance use and these presentations often have a significant impact on ED and hospital resources.

Hospital Drug and Alcohol Consultation Liaison services have a key role in the assessment and management of drug and alcohol related conditions during hospital presentations and/or during care. The central aim of Hospital Drug and Alcohol Consultation Liaison (HDA-CL) is to enhance the safety, clinical outcomes, quality and efficiency of services for patients with substance use disorders in hospital settings.

Early engagement, appropriate treatment and referral can assist in minimising complications arising from substance use. HDA-CL can enable this by providing advice regarding the management of drug and alcohol related issues for referred patients, and through enhancing the capacity of generalist health providers to address drug and alcohol issues in their routine clinical work. HDA-CL services can also assist in discharge planning for those patients that require ongoing D&A treatment.

This Model of Care provides a framework for the delivery of HDA-CL by describing the range of clinical services and activities that HDA-CL services should ideally provide in order to ensure that patients with substance use disorders receive appropriate and coordinated care. This includes principles for referral, advice around managing specific populations, and guidance for quality and safety activities and monitoring of service delivery.

GLOSSARY

ADIS	Alcohol and Drug Information Service – phone-based service providing general information to the general community and health professionals
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islander
Attending team	The team that made the referral to HDA-CL and retains primary responsibility for patient management
CHERE	Centre for Health Economics Research and Evaluation
CERNER	An inpatient clinical information system
CL	Consultation Liaison
CNC	Clinical Nurse Consultant
CUPS	Chemical Use in Pregnancy Service, a specialist service for pregnant women
D&A	Drug(s) and Alcohol
DA-CL	Drug and Alcohol Consultation Liaison
DASAS	Drug and Alcohol Specialist Advice Service – phone-based service offering specialist advice to health professionals
DIPS	Drugs in Pregnancy Service, a specialist service for pregnant women
ED	Emergency Department
FACS	Family and Community Services, lead government agency for child protection
HDA-CL	Hospital-based Drug and Alcohol Consultation Liaison
IIMS	Incident Information Management System, data system recording behavioural or other incidents
ISBAR	Clinical handover system; an acronym for Identification, Situation, Background, Assessment, Recommendations
KPI	Key Performance Indicator
LHD/N	Local Health District/Network, geographic region of Government health coverage
MHDAO	NSW Government Mental Health and Drug and Alcohol Office
MHCL	Mental Health Consultation Liaison
MOC	Model of care
MOH	Ministry of Health

NEAT	National Emergency Access Targets: anyone presenting to a public hospital emergency department will be admitted, referred for treatment or discharged within four hours of presentation
NDARC	National Drug and Alcohol Research Centre
OST	Opioid Substitution Treatment
OTP	Opioid Treatment Program
p.a.	per annum/year
QI	Quality Improvement
RCA	Root Cause Analysis
RCT	Randomised Controlled Trial
SUD	Substance Use Dependence

PURPOSE OF DOCUMENT

The Drug and Alcohol Consultation Liaison Model of Care (**MOC**):

- defines the components of Drug and Alcohol Consultation Liaison services in the hospital sector (HDA-CL), including clinical service delivery, workforce development and clinical governance activities
- identifies governance arrangement, key relationships required to deliver effective HDA-CL services
- identifies information and data issues for HDA-CL activity
- provides a framework for enhancing the availability and quality of HDA-CL within the hospital system.

The Model of Care identifies the role of Hospital DA-CL services for:

- general acute hospital settings, including Emergency Departments,
- specialist areas of the hospital system, including Mental Health, Women's, Children's and Aged Care services
- services in regional and rural hospital settings
- the role of extended or after hours HDA-CL services.

Local implementation of the MOC will need to be tailored to the resources available, HDA-CL resources, local governance arrangements, population and clinical demands.

The MOC does not provide clinical recommendations or guidelines regarding D&A clinical interventions (e.g. screening or assessment, brief interventions, withdrawal or intoxication management, management of concurrent medical, pain and/or mental health conditions). Clinical guidelines regarding D&A interventions are available elsewhere and include those listed at *Appendix A - Key Documents*.

METHODOLOGY FOR DEVELOPING THE MODEL OF CARE

A Working Group was established to advise on the development of the Model of Care (MOC) for Hospital D&A Consultation Liaison (HDA-CL) services, to review the literature and evidence base, and identify key implementation issues. Membership included a range of clinicians and service managers with expertise in hospital DA-CL services, including specialist medical and nursing professionals, with representation of clinicians with experience in metropolitan, regional and rural hospital settings, in providing extended or after-hours CL services, and with specialist mental health and pregnancy CL services. Content was developed by A/Professor Nicholas Lintzeris supported by a project team from the Mental Health and Drug and Alcohol Office. Members are listed at *Appendix B*. Acknowledgement is also made of the research of Associate Professor Lucy Burns and Ms Kerryn Butler from the National Drug and Alcohol Research Centre in informing this document.

BACKGROUND: DRUG AND ALCOHOL PRESENTATIONS IN HOSPITAL SETTINGS

1. The impact of drug and alcohol use in hospital presentations

Approximately 28.4% of Australians consume alcohol at risky levels (>4 standard drinks on one occasion) at least once a month and 20.1% are at lifetime risk of harm (>2 standard drinks per day AIHW 2011). The prevalence of substance use disorders in Australia is 5.1% of people aged 16-85 years (National Survey on Mental Health and Wellbeing 2007). Alcohol consumption accounts for 3.3% of the total burden of disease and injury in Australia (Begg 2007).

Drug and alcohol related problems contribute significantly to acute hospital admissions, of which alcohol accounts for the majority of substance related admissions and bed-days (Collins and Lapsley 2008). In their analysis of the economic costs of substance use in Australia, Collins and Lapsley estimated the impact of substance use on hospital admissions, bed days and total costs (Table 1). Whilst tobacco clearly was related to the most deaths, alcohol resulted in more hospital bed days, and greater total hospital costs.

Table 1. Alcohol and drug related deaths, hospital bed-days and related costs in Australia in 2003. Adapted from Collins and Lapsley 2008.

	Deaths	*Hospital bed days*	*Hospital costs ($M)*
Tobacco	14,901	753,618	669.6
Alcohol	1,057	916,934	693.9
Opioids	228	22,463	13.1
Cannabis	1	7,287	3.1
Amphetamine-type stimulants	17	5,288	3.4
Licit, combined, unspecified	483	40,811	23.0

Alcohol abuse costs the health system in NSW approximately $87.3 million annually (NSW Auditor General 2013).

A. EMERGENCY DEPARTMENTS

International and Australian hospital studies (Charalambous 2002; Indig et al 2010; Rivara et al 1993) indicate that there is a high prevalence of substance misuse in people presenting to Emergency Departments, up to 35% of presentations overall.

These figures are supported by the Evaluation of Hospital Drug and Alcohol Consultation Liaison Services in NSW, 2014, by the National Drug and Alcohol Centre, University of NSW, and the Centre for Health Economics and Evaluation, University of Technology (NDARC and CHERE 2014). This evaluation found that of 1,615 people surveyed who presented to NSW hospitals,

35% screened positive as requiring a drug or alcohol intervention. This figure includes re-admissions for the same patients as well as new admissions. The patients were recruited from eight NSW hospitals over a ten day period from rural regional and metropolitan areas. The patients consented to be screened for drug and alcohol, and to have their medical record numbers matched for follow up research. The Evaluation found that only 1% of the presentations were identified by hospital staff as having a primary diagnosis related to alcohol, and that there was significant under identification or reporting of secondary diagnoses related to alcohol.

A recent study of alcohol related presentations found that at least 13.8% of presentations to Emergency Department in Australia were alcohol related, with alcohol related presentation numbers in some Emergency Departments as high as one in three (Egerton-Warburton et al 2014). This study confirms that alcohol-related presentations to EDs are currently underreported.

Drug and alcohol related ED presentations impact on ED resources, contributing to high rates of re-attendance. For example:

- heavy alcohol use is associated with a range of medical conditions, including gastroenterological, neurological, cardiac and psychiatric disorders, and harm to self (suicide) or others (trauma, domestic violence).
- alcohol or other substance use may mask major underlying injury or conditions, which can be more difficult and costly to treat when detected late.
- intoxicated patients may be aggressive, uncooperative, and are often poor historians, complicating diagnosis and management.
- individuals with substance use disorders are more likely to be repeat ED attenders, often due to trauma, associated medical conditions, and/or self harm attempts, and place a considerable burden upon ED resources. Emergency department re-presentation and re-injury rates are also affected by drug and alcohol use (Althaus et al 2011; Harvard et al 2008; Rostenberg et al 1995).

A randomised controlled trial (RCT) of frequent presenters with problematic alcohol use, to ‘’individualised care plans” versus “usual care”, showed a 58% reduction in ambulance call outs in the care plan group (Witbeck et al 2000). In a pre-post comparison, individualised care plans for D&A frequent presenters resulted in reduction of ED presentations from a median of 26.5 p.a. to 6.5 per annum (Pope et al 2000).

B. HOSPITAL ADMISSIONS

Australian data indicates that the prevalence of risky or problematic drinking that contributes to hospital admissions is significant (Roche et al 2006). Foy et al 1995 identified that 15-20% of hospital admissions in a Newcastle teaching hospital had an alcohol disorder, 8% of admissions were at of risk of alcohol withdrawal, but only 4.3% of those with problematic alcohol use were identified by the treating clinicians. Up to a quarter of inpatients at Royal Prince Alfred Hospital self-reported drinking alcohol at risky levels based on NHMRC criteria (Shourie et al 2007).

Comparable findings of the prevalence of risky or problematic drinking contributing to alcohol admissions have been reported in a review of United Kingdom hospital studies (approximately 20% of admissions had alcohol disorders; Charalambous 2002), and in the USA (22-26%

hospital admissions between 1950 and 1992 were alcohol-related in Muller 1996). Drug and alcohol use disorders can also complicate hospital admissions. For example, undiagnosed or poorly managed alcohol withdrawal can (a) unnecessarily prolong hospital admissions (e.g. surgery being deferred or delays in discharge planning), and (b) progress to life-threatening conditions such as delirium tremens, which often requires intensive interventions (such as ICU admissions) and prolonged length of stay. Rubinsky (2012) found that those patients who screened positive for risky alcohol use in the year before surgery had longer postoperative hospital length of stay, more ICU days and increased probability of return to the operating room in the thirty days after surgery.

2. RESPONDING TO DRUG AND ALCOHOL CONDITIONS IN HOSPITAL SETTINGS

A number of strategies have been proposed to address substance use and its impact in hospital settings.

A. INCREASING IDENTIFICATION OF SUBSTANCE USE ISSUES IN HOSPITAL SETTINGS: SYSTEMATIC SCREENING.

As outlined above, there is poor identification of substance-related disorders (e.g. problem or dependent drinkers) in most health settings where formal screening is not undertaken. Audits conducted in NSW hospitals indicate that clinicians (nursing and/or medical staff) identify alcohol disorder in less than a third of cases compared to brief systematic screening (Foy and Kay,1995; Shourie et al 2007). Rates of identification of other drug use, particularly illicit drug use, has not been examined, but is probably even lower given the associated stigma.

B. DELIVERY OF BRIEF INTERVENTIONS IN HOSPITAL SETTINGS

The National Alcohol Treatment Guidelines recommend the delivery of brief interventions to problem drinkers/substance users in Emergency Department and inpatient hospital settings (Haber et al 2009). Systematic reviews of the impact of brief interventions in hospital settings indicates that brief interventions in ED are effective in reducing subsequent alcohol-related injuries and re-presentations, but there is contradictory evidence about the effect of brief interventions in hospital settings. Some studies found that interventions in Emergency Departments were not effective in reducing heavy alcohol consumption in the subsequent 12 months or longer (Freyer-Adam et al 2008; Harvard, Shakeshaft et al 2008; Saitz, Paifal et al 2007).

Other studies have found that screening and brief interventions delivered in Emergency Departments were effective in reducing the number of drinking days per week and number of drinks per occasion of drinking (Cherpitel et al 2010; D'Onofria 2012). The key may be in referrals for treatment for those assessed as requiring an intensive intervention.

An independent evaluation of Drug and Alcohol Consultation Liaison Services in NSW found that the services reduced re-presentations for patients. Their patients tended to be those who had

been frequent presenters to Emergency Departments. This reduction in re-presentations represented significant cost savings for hospitals (NDARC and CHERE 2014).

A Cochrane review of brief interventions for heavy alcohol users in hospital wards found that patients receiving brief interventions have a greater reduction in alcohol consumption compared to those in control groups at six month and nine month follow up but this was not maintained at one year (McQueen et al 2011).

Hospital Consultation Liaison may have a longer term impact on substance use. Observational studies suggest a reduction in substance use (e.g. Fleming et al 1995), although outcomes are largely linked to participation in treatment following discharge. An independent evaluation of Drug and Alcohol Consultation Liaison Services (NDARC and CHERE 2014) found that there was a different pattern to primary care and prescription usage after patients had been seen by these services, which suggests that these patients may be more appropriately treated in primary care settings after an DA-CL intervention.

Services that are similar to D&A CL are available in the United Kingdom. Drug and Alcohol Specialist drug and alcohol clinicians are available in over seventy percent of Emergency Departments, nearly half of Emergency Departments regularly ask patients about alcohol, and up to ninety six percent offered help or advice about alcohol (Drummond et al 2014). A randomised control trial of screening and brief interventions offered in England found that there were positive outcomes for screening and very brief interventions in Emergency Department settings, but not for more intensive interventions in the Emergency Department setting (Drummond et al 2014).

Trauma Centres in the United States have had mandated screening and brief interventions since 2005. A randomised control trial comparing intervention sites where staff had oneday training in motivational interviewing compared to sites where screening and brief interventions were mandatory but no training was provided for staff found that patient outcomes at twelve months were improved in the intervention sites (Zatzick 2014).

Several states in the United States have introduced Screening, Brief Interventions and Referral to Treatment (SBIRT) in trauma centres, with very high uptake rates (up to ninety seven percent). The prevalence of alcohol problems identified through this screening is approximately twenty-two percent (Johnson 2013).

C. ESTABLISHMENT OF HDA-CL SERVICES

Drug and Alcohol CL services have a key role in the assessment and management of drug and alcohol related conditions during hospital presentations, in facilitating discharge planning for those patients with substance use disorders that require ongoing treatment, and play a key role in education and training of the generalist health workforce regarding drug and alcohol issues.

An independent evaluation of Drug and Alcohol Consultation Liaison Services in NSW found that incidents were reduced in a majority of hospitals after the introduction of Drug and Alcohol Consultation Liaison Services (NDARC and CHERE 2014). This suggests that the services assist in the management of behaviourally disturbed patients either directly with patients and improved

patient outcomes, or indirectly through assisting in building the capacity of other hospital staff to respond to these issues.

The Evaluation found that HAD-CL services in NSW were effective in reducing re-presentations and re-admissions, and in preventing an increase in average length of stay in ED over time. This represented cost savings to the hospitals (NDARC and CHERE 2014).

The Evaluation also found that HDA-CL can increase the identification of drug or alcohol issues. Increased and early identification of those at risk of alcohol withdrawal reduces withdrawal complications. Foy and Kay (1997) identified that detection and treatment within the first 24hrs of admission was the most important element in preventing complications such as seizures and delirium (3 times higher rate complications if detected greater than 24 hours after admission). Complications resulted in a median 4 days extra hospital stay compared to uncomplicated withdrawal.

Drug and alcohol interventions can reduce the length of stay in hospital. An RCT examining the effectiveness of addressing alcohol use pre-operatively in surgical patients reduced post-operative complications and hospital length of stay (Tonnesen et al 1999).

D. ENHANCING LINKAGES BETWEEN ACUTE CARE SETTINGS AND DRUG AND ALCOHOL TREATMENT SERVICES

Given the chronic nature of dependence disorders, long term changes in substance use are improved by participation in longer term treatment for substance use. Effective treatments are available for alcohol and opiate dependence disorders, including pharmacological and psychological services. Hospital Drug and Alcohol CL services can facilitate better linkages with local alcohol and drug treatment services.

Patients with severe alcohol or drug dependence often require a brief period of hospitalisation for the assessment or management of acute medical or psychiatric conditions. However, once medically stable, many patients can be transferred to a less intensive setting (e.g. outpatient or residential withdrawal service) in order to complete alcohol or other drug withdrawal, or stabilise in longer term treatment (e.g. stabilise opioid medications). Close links between acute hospital settings and community D&A services, (e.g. detoxification and Opioid Treatment Program services), enables the level of care to match patient needs, facilitating timely hospital discharge.

An evaluation of an Outpatient Department Addiction Medicine Clinic at Liverpool Hospital (Scopelliti et al 2008) demonstrated that a hospital based outpatient clinic was an effective strategy to facilitate discharge planning and link patients to ongoing D&A Services in the community.

SECTION A-OVERVIEW OF HDA-CL SERVICES

DEFINITION HDA-CL

Hospital Drug and Alcohol Consultation and Liaison (HDA-CL) services are defined as specialist D&A services operating in hospital settings providing consultation - advice regarding the management of D&A related issues for referred patients, and liaison - enhancing capacity of generalist health providers to address D&A issues in their routine clinical work. An essential characteristic of HDA-CL service is that they provide services to patients under the care of another treatment team during the period in hospital, that is, not under the primary care of a D&A specialist service.

It should be noted that other D&A services are provided in hospitals that are not considered part of HDA-CL. These include services to patients who are admitted into hospital under a D&A Clinical Specialist (e.g. for complicated withdrawal presentation) and patients that are seen by D&A services in Hospital Tier 2 Outpatient Clinics or in community D&A services co-located on hospital premises (non-admitted patients). Whilst these services may be provided by staff who also work in an HDA-CL role, they are not HDA-CL services and are not considered within the scope of the HDA-CL MOC.

AIMS AND OBJECTIVES OF HDA-CL

The central aim of HDA-CL is to enhance the safety, clinical outcomes, quality and efficiency of services for patients with substance use disorders in hospital settings, using a consultation liaison (CL) model.

The objectives of a HDA-CL are:

1. To facilitate and enhance the provision of *clinical care* to patients with D&A issues in hospital settings.
2. To participate in *care coordination activities* aimed at coordinating clinical services across multiple teams or disciplines.
3. To enhance the capacity for general hospital staff to identify and manage drug and alcohol related presentations through *capacity building activities*, such as mentoring, Grand Rounds, and consultation with staff.
4. To participate in *quality improvement and clinical governance activities* that improves the safety, quality and efficiency of health care provision for patients with D&A issues in hospital. This includes participation in the development and implementation of policies, procedures, guidelines and business rules; and participation in quality improvement, research and evaluation activities.

HDA-CL ACTIVITIES

HDA-CL services provide specialist assessment, advice and recommendations regarding the management of patients with significant D&A related issues under the care of another attending team in a hospital setting. The responsibility for patient management lies with the primary team, including whether to accept and act on the advice provided by the HDA-CL service. The HDA-CL

service has the responsibility to provide practical and evidence-based advice in accordance with D&A clinical standards, in order to facilitate high quality patient care.

In order to meet the objectives of the service, HDA-CL teams engage in the following activities:

a. Provide clinical interventions for referred patients in acute hospital settings
b. Participate in care coordination activities across treatment providers
c. Participate in governance and quality improvement activities, including the development, implementation and review of policies and procedures, guidelines, business rules, patient safety, quality improvement, clinical governance, research and evaluation activities
d. Participate in workforce development activities, including training and mentoring of general hospital staff.
e. Document clinical and non-clinical activity

Clinical interventions within the HDA-CL model can be categorised into 4 primary clinical functions:

1. *Assess patient and identify D&A related issues in response to a referral request.*
2. *Provide feedback to the referring primary team, with recommended actions or interventions*. These may include recommendations regarding medication regimens, monitoring and supportive care, investigations and referral to other services - such as other hospital teams (e.g. Mental Health, Pain, Social Work), or service providers in the community (e.g. D&A services, general practitioners, Family and Community Services (FACS).
3. *Implement interventions in collaboration with the primary treating team*. It is essential that interventions and action plans are coordinated between clinical teams; HDA-CL should not routinely implement treatment plans (e.g. prescribing medications, ordering investigations, making referrals) without discussing management plans with the primary treating team, and establishing who will take responsibility for the proposed management plans. HDA-CL can have a key role in coordinating care across different teams within hospital, and between hospital and community providers.
4. *Documentation and data collection*. HDA-CL clinicians will clearly document any findings, recommended actions and interventions in patient's hospital clinical records, and ensure that HDA-CL recommendations can be clearly identified by other treatment providers and administrative staff (e.g. coders).

Whilst the focus in this section is on the delivery of clinical interventions, there are clearly opportunities to combine clinical roles with capacity building for staff (small group or individual training, mentoring) and clinical governance functions, consistent with the objectives of HDA-CL service.

The range and level of HDA-CL services will relate to available resources, governance arrangements, hospital size and location.
HDA-CL services are generally available across different sized hospitals in metropolitan, regional or rural settings. HDA-CL staff in regional/rural or smaller hospitals may provide consultation services to outlying hospitals on a part-time basis (e.g. on designated days), as required following referral, and/or using remote technologies such as telephone, videoconferencing, telehealth.

The evaluation of DA-CL services in NSW found that patients who screened in the survey as requiring an intensive intervention for alcohol or other substances were more likely to present either in the afternoon or slightly later in the evening, on all days of the week. This group was more likely to arrive by ambulance, public transport or police/correctional services vehicle and is more likely to present in the afternoon or slightly later in the evening than other patients (NDARC and CHERE 2014). This information may assist hospitals to plan hours of available of HDA-CL services.

Alternative mechanisms for accessing urgent D&A services or support need to be identified for times where HDA-CL services are not available. HDA-CL should ensure that hospital staff are aware of how to access urgent support. Support is available from the on-call Local Health District (LHD) D&A specialist and the phone-based Drug and Alcohol Specialist Advice Service (DASAS) for advice to health professionals and the Alcohol and Drug Information Service (ADIS) for the community and health professionals.

HDA-CL services should disseminate information and instructions for hospital staff on when and how to directly access community based or hospital outpatient D&A clinics (e.g. local LHD telephone D&A intake lines, outpatient clinics), how to refer directly to these services, or how to access general information regarding D&A services (e.g. ADIS).

HDA-CL Services in regional / rural settings are often faced with a number of additional challenges compared to metropolitan settings. In rural areas, fewer staff, difficulty attracting qualified DA-CL staff, lack of access to specialist D&A services determines that HDA-CL time is also spent on the clinical care of community-based patients, many of whom have come into contact with the HDA-CL as in-patients. Rural/regional HDA-CL staff often provide services across a number of hospitals, and provide a range of other D&A services to outpatients, such as case management, ambulatory withdrawal management, assist with OST Programs and manage specialist D&A Out-Patient Clinics such as the Medical Specialist Outreach Assistance Program. As a consequence, there is often less time routinely available for quality improvement and workforce development activities. HDA-CL is often limited to set days in different hospitals or provided by telephone.

Strategies to address these issues include:

- Building the capacity of available staff to independently manage D&A patients or manage patients with HDA-CL consultation (face-to-face or phone-based) resulting in increased staff confidence to manage less complex patients independently. This includes development of clear procedures and protocols for management of patients with D&A issues. The development of clinical competencies for generalist D&A staff will assist in building the capacity of the D&A workforce.
- Development of clear communication channels and promotion of the service to hospital staff, with a focus on providing phone-based consultation if the HDA-CL is unable to visit the hospital. Hospital staff should have contact details for specialist D&A support for times when HAD-CL services are not available, including on-call Addiction Medicine specialists, the LHD/N D&A Clinical Director, and the statewide Drug and Alcohol Specialist Advisory Service.

Ideally, HDA-CL services will be available to specialist departments including Mental Health, Aged Care, Women's and Children's services. These services are increasingly located as Departments within general hospital campuses. Each of these Departments typically span acute and subacute hospital, and community based services and settings. HDA-CL services are confined to providing services for referred patients in acute hospital settings.

The Model of Care for HDA-CL services presupposes that the HDA-CL is integrated within a broader network of D&A services with access to a range of clinical referral pathways (including inpatient and ambulatory withdrawal services, outpatient counselling, case management and support services, opioid substitution services, residential rehabilitation services and self-help programs).

ACCESSING D&A CLINICAL ASSISTANCE IN HOSPITAL SETTINGS

Each HDA-CL service should identify and widely communicate processes and pathways for hospital staff to refer or seek assistance regarding the management of patients with D&A problems.

REFERRING PATIENTS TO HDA-CL SERVICES

The following principles apply to the referral of patients to HDA-CL services.

All referrals to HDA-CL services should comply with Clinical Handover principles (ISBAR). These are mandatory for all NSW Health services, and comply with National Safety and Quality Standards for Health Care Services.

See *Appendix A* for Clinical Handover references

a. Each referral should include the following information:

- **Identification** of the referrer (identify self, role, location)
- **Situation** (statement of the diagnosis, reason for admission, current problem)
- **Background** (clinical background)
- **Assessment** (clear statement of current problem)
- **Recommendations** (what do you want the HDA-CL service to do, and within what time frame?)

b. The time of the referral must be documented for medico-legal purposes, team communication and assessment of HDA-CL service performance.

c. The mechanism for referral to HDA-CL (telephone, paper form, electronic records) is to be determined locally to suit local conditions and resources. Usual response times by the HDA-CL service should be communicated to referring services, recognising that this may vary for each form of communication (e.g. emails or data system 'flags' may only be checked once daily, impacting response time). HDA-CL should notify hospital services if there are expected interruptions to the service (e.g. holidays, staff illness).

d. Following receipt of the referral, HDA-CL services will review the request, and any relevant clinical documentation, and prioritise the urgency of seeing the patient. In some circumstances, HDA-CL may not see the patient (e.g. only advice is required, patient regularly absent from ward), and the HDA-CL may consult directly with the treating team.

Given the diversity of HDA-CL resources available across different hospitals, it is not possible to identify an appropriate 'state-wide' target response time for HDA-CL service to respond to a service referral.

Efforts should be made to collaboratively develop, review and improve HDA-CL referral processes to ensure the system of receiving and making referrals (including feedback to/from referrers) is effective. It is the responsibility of HDA-CL to ensure that the system developed is not overly bureaucratic or cumbersome, and encourages staff to access HDA-CL when needed.

ACCESSING URGENT, ON-CALL AND AFTER HOURS D&A ASSISTANCE

HDA-CL services may have limited hours of operation, and partial availability in smaller hospitals. HDA-CL staff should ensure that generalist staff are aware of the HDA-CL operating hours and contact details. Alternative mechanisms for accessing urgent D&A services or support need to be identified and HDA-CL should ensure that hospital staff are aware of how to access urgent support. Support is available from the on-call Local Health District (LHD) D&A specialist and the phone-based Drug and Alcohol Specialist Advice Service (DASAS) for advice to health professionals and the Alcohol and Drug Information Service (ADIS) for the community and health professionals.

Accessing or referring to outpatient and community based D&A services

Not all referral of hospital patients to outpatient D&A services need to be facilitated or coordinated by HDA-CL services, and more efficient referral to outpatient D&A services may be achieved by hospital staff referring the patient directly.

RANGE OF CLINICAL INTERVENTIONS PROVIDED BY HDA-CL

SPECIALIST DRUG AND ALCOHOL ASSESSMENT

HDA-CL services conduct specialist D&A patient assessments tailored to:

- the reason for presentation or admission to hospital
- the reason for referral to HDA-CL
- the available resources (staff qualification, time available, setting).

The assessment may include history, examination and investigations of the following key domains:

- assessment of substance use (with focus on recent patterns of use) including pattern and frequency, route of administration and time and date and amount last used
- identification of substance use disorders or complications, such as withdrawal (e.g. past withdrawal symptoms), dependence, tolerance, intoxication, drug-drug interactions

- past and current D&A treatment interventions
- impact of substance use on medical, psychiatric or social issues, particularly the reason(s) for presentation to hospital
- identification of high risk factors linked to the patient's substance use (e.g. mental health diagnosis, suicide risk assessment, child protection, domestic violence, homelessness, nutrition, adherence to treatment plans)
- review of patient's medications (safety concerns including drug-drug interactions, overdose, diversion, iatrogenic dependence)
- review of investigations
- patient's goals or expectations regarding their substance use and treatment
- discharge planning (including linkages with relevant D&A, medical and social services).

  Where issues are identified by the HDA-CL team that need to be addressed (e.g. other medical or psychiatric issues, child protection, homelessness), HDA-CL staff will notify the primary treatment team, and the roles of different service providers will be clarified).

SCREENING AND BRIEF INTERVENTIONS

Brief interventions can be delivered by appropriately trained generalist hospital staff, over one to three sessions, each lasting from 5 to 30 minutes. Their aim is to inform patients that they are drinking (or using substances) at levels with increased risk of developing substance-related problems, to encourage patients to change their patterns of substance use so as to reduce that risk, and to seek further assistance should they be unable to moderate their use.. HDA-CL services have a key role in:

- supporting hospital executives, senior managers and governance structures in designing and implementing routine drug and alcohol screening for emergency and elective admissions.
- assisting hospital staff in establishing, training and mentoring, implementing and coordinating D&A screening and brief interventions for patients with mild-severity substance use (i.e. experiencing harm or at high risk of drug-related harm, but who do not meet dependence criteria) or pregnant women using any amount of alcohol or drugs. This is particularly relevant in departments with a high prevalence of patients with substance use disorders, such as ED and Mental Health (MH), and with staff regularly engaging with pregnant women.
- The HDA-CL team can also play a key role in providing staff training and quality improvement activities (e.g. guidelines, audits).
- providing brief interventions for those patients identified as not requiring, or not consenting to, more intensive D&A interventions. This will often include patients with D&A problems who are not 'ready' to address their substance use. In such circumstances, HDA-CL staff may use brief motivational enhancement techniques to engage the patient

in addressing aspects of their substance use, with the aim of reducing harm and engaging the patient with D&A or other services in the community.

MANAGEMENT OF PATIENTS WITH DEPENDENCE TO ALCOHOL, PHARMACEUTICAL OR OTHER DRUGS

Patients with substance use disorders experience a range of medical and social harms from their substance use. They often require specific interventions to address their dependence during hospitalisation, including withdrawal interventions, opioid substitution treatment, relapse prevention medications and psychosocial interventions. They require close coordination of D&A treatment interventions following discharge to ensure continuity of care. HDA-CL can assist with:

Alcohol dependent patients

- Management of withdrawal and related complications (seizures, delirium, hallucinations, suspected Wernicke's Encephalopathy, behavioural problems), compliance with clinical guidelines, policies and procedures or local business rules;
- Initiation of relapse prevention medications for alcohol dependence that can usually occur during hospital admissions (naltrexone, disulfiram, acamprosate);
- Management of health and social complications of heavy and regular alcohol use.

Opioid dependent patients

- Patients in opioid substitution treatment (methadone, buprenorphine, buprenorphine-naloxone). Whilst general hospital teams should be able to safely manage routine continuation of opioid substitution treatment (OST), HDA-CL services should be consulted in circumstances where patients are initiating, recommencing (following missed doses), discontinuing OST medications, or where there are concerns regarding adverse events, drug-drug interactions, or patient safety
- Patients experiencing opiate withdrawal
- Patients with persistent unsanctioned opioid use in hospital (e.g. injecting heroin, unsanctioned prescription analgesic use)
- Patients with significant pain management issues
- Patients with recent opioid antagonist (naltrexone) exposure.

Patients with unstable dependence or abuse of pharmaceutical drugs –notably prescription opioids, benzodiazepines.

- HDA-CL can advise on medication regimens, stabilisation and withdrawal interventions, alternative management approaches and discharge planning
- Can work in conjunction with and provide assistance to hospital-based Pain and Mental Health teams.

Nicotine dependent patients and smoking cessation

- HDA-CL team can advise and assist in smoking cessation and nicotine replacement interventions for patients referred to HDA-CL services for other indications (e.g. concurrent alcohol dependence). However it is beyond the scope of HDA-CL service to provide smoking cessation interventions to all hospitalised patients with no other D&A issues or reason for referral.
- The HDA-CL team can also play a key role in providing staff training and quality improvement activities to assist in smoking cessation (e.g. guidelines, audits).

Cannabis, stimulants, synthetics and other drugs

- Referral to appropriate services such as specialist Cannabis or Stimulant clinics, outpatient services and mental health services. HDA-CL team can provide advice on withdrawal management

ADVICE ON MANAGEMENT OF SPECIAL PATIENT POPULATIONS AND RELATED ISSUES

There are particular patient populations with DA issues that routinely come into contact with HDA-CL services. These include:

PATIENTS WITH SEVERE OR PERSISTENT PROBLEM BEHAVIOURS RELATED TO THEIR SUBSTANCE USE

HDA-CL may assist the primary treating team in identifying or responding to difficult behaviours that may be related to a patient's substance use. HDA-CL workforce have skills in addressing behaviours that many general hospital staff find confronting or difficult (e.g. medication seeking, alcohol or other substance use, aggression).

HDA-CL can play an important role in identifying triggers of behaviours (e.g. intoxication, agitation in withdrawal, pain, cognitive impairment, social factors), assist in developing and implementing treatment care plans, and in communicating with the patient and carers.

ADVICE ON MANAGEMENT OF ACUTELY INTOXICATED PATIENTS

HDA-CL has a limited role in responding to intoxicated presentations. They may provide assistance to the treating team in their assessment of the patient and advice regarding monitoring, prevention of aggression and management of any underlying substance use disorders. However, HDA-CL services cannot admit, constrain or detain patients and it is usually inappropriate to consider longer term D&A treatment plans (e.g. withdrawal or rehabilitation treatment) whilst the patient is intoxicated. Once the patient is no longer intoxicated, the need for referral to HDA-CL can be reassessed.

Referral of intoxicated patients to HDA-CL may be appropriate where:

- the patient requires admission to hospital (for clinical indications other than intoxication) and where there is a diagnosis or high suspicion of drug or alcohol dependence

- there is an unclear diagnosis of a presenting problem that may require hospital admission and where HDA-CL is requested to assist in assessment and diagnosis
- the patient is known to frequently present and the coordinated management plan notes that HDA-CL should be contacted on patient presentation (e.g. pain management patient).

PATIENTS WITH CONCURRENT MENTAL HEALTH AND DRUG AND ALCOHOL PROBLEMS

Many patients in ED and general inpatient wards have concomitant mental health and drug and alcohol problems, and will often require services from and coordination between both HDA-CL and MH-CL teams.

Both HDA-CL and MH-CL services have important roles in discharge treatment planning, aiming to ensure that patients access appropriate services following discharge. Coordination between HDA-CL, MH and general hospital teams can be facilitated by the participation in multi-disciplinary team meetings and case coordination meetings (e.g. meetings to review frequent re-presenters), particularly with ED departments and other key hospital departments/teams.

Clinical Guidelines regarding the management of patients with both mental health and D&A issues is described in the *NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings 2009* (known as the NSW Comorbidity Guidelines) and the Commonwealth *Guidelines on the Management of Co-occuring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings* (reference at *Appendix A– Key Documents*). D&A and MH services should ensure appropriate training, patient referral pathways and coordination forums occur to ensure implementation of these guidelines. The NSW Comorbidity Guidelines identify the range of clinical D&A interventions that MH services should be able to provide (e.g. assessment, management of uncomplicated withdrawal, management of opioid substitution treatment, brief interventions).

PAIN MANAGEMENT

Pain management can be difficult to achieve in:

- patients with substance use disorders, particularly those with opioid dependence (including prescribed opioid substitution medications, unsanctioned illicit or pharmaceutical opioid use)
- patients with drug-drug interactions that may complicate the safety or effectiveness of prescribed opioids (e.g. hepatic CP450 enzyme inducers/inhibitors that may impact on opioid metabolism; sedatives such as alcohol, benzodiazepines)
- patients with significant aberrant opioid medication behaviours, including escalating doses, using by unsanctioned routes and behavioural disturbances.
- Whilst pain management is the primary responsibility of the attending team, HDA-CL can play an important role in (a) consulting with the treating team regarding patients for whom

pain management has been difficult to achieve, (b) training staff about opioid medication and related pain management strategies and (c) coordinating care following discharge. The HDA-CL service should establish and maintain a close working relationship with hospital Pain-CL teams, where available.

ABORIGINAL AND TORRES STRAIT ISLANDERS

In collaboration with Aboriginal Liaison Workers or Aboriginal Health Workers, HDA-CL has a role in educating generalist staff regarding the high prevalence of substance use and related harms in Aboriginal and Torres Strait Islander populations, and strategies to prevent or address D&A related harm, including engagement in appropriate D&A interventions. HDA-CL staff should disseminate information regarding culturally appropriate referral services, such as Aboriginal Community Controlled Health Organisations (ACCHO) or Aboriginal Maternal and Infant Health Service (AMIHS) (particularly sites with dedicated Aboriginal D&A and MH staff). Available resources and services include the Handbook for Aboriginal Alcohol and Drug work (2012) and those at the Australian Indigenous Health Infonet and the Aboriginal Health and Medical Research Council.

PERINATAL SERVICES

All health professionals should comply with the *NSW Health Clinical Guidelines for the Management of Substance Use in Pregnancy, Birth and the Postnatal Period* (reference at *Appendix A*).

The guidelines state that staff should routinely provide brief interventions on substance use in pregnancy (particularly zero alcohol) and substance use in minors. SAFESTART has been implemented in maternity services, and involves training in screening for drug and alcohol and mental health issues in pregnant women.

Some hospitals will have access to specialist drug and alcohol services for pregnant women, such as Substance Use in Pregnancy and Parenting Service (SUPPS) or Drugs in Pregnancy Services (DIPS) that will provide D&A assessment, antenatal care and referral during the perinatal period, with some services providing extended postnatal follow up and outpatient clinics. Where there is an absence of specialist perinatal D&A teams, the general HDA-CL team can often provide the necessary D&A interventions and support during hospital admissions.

HDA-CL services may facilitate training of maternity and generalist staff in delivering brief interventions, providing information regarding substance use and available treatments in pregnancy, and facilitating referral pathways to specialist D&A services for those with more complex problems.

HDA-CL must comply with the mandatory reporting guidelines and protection procedures (see *Appendix A*) for health workers.

CHILDREN AND YOUNG PEOPLE'S SERVICES

Children and adolescent services should identify and manage substance use issues in their patient population and are best placed to respond to treatment of minors. Where substance use in minors is identified in hospital presentations, HDA-CL teams can support services in addressing complex DA presentations. Treatment interventions (e.g. counselling approaches) need to be modified in young patients to reflect different stages in their development. HDA-CL services have a valuable role in establishing clinical referral pathways and workforce development initiatives (e.g. training and implementation of screening systems) between D&A services and child and adolescent services.

CHILD PROTECTION AND DOMESTIC VIOLENCE ISSUES

Routine screening for child protection and domestic violence issues are mandatory. All health care workers have a duty of care under the *NSW Children and Young Persons (Care and Protection) Act 1998* (*Appendix C*) to notify the Department of Family and Community Services (FACS) whenever they suspect that a young person or child (when born or in utero) may be at risk of serious harm currently or when born, either from substance use in pregnancy, domestic violence, abuse, neglect or other factors. When necessary, this duty overrides the duty to maintain patient confidentiality.

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

All adult health services, including HAD-CL, have a key role to play in identifying and responding to child wellbeing and child protection concerns because the cause of the abuse or neglect is frequently parental or carer illness behaviour, earlier life experience, or disadvantage or deprivation. In working with parents and carers to address the context of the lives of children within their families, NSW Health services focus in particular on those parental or carer factors that increase vulnerability including chronic and complex health needs, substance use , mental illness, and the impact of historical trauma and disadvantage.

Substance use alone is not an indicator for a child protection report to the Child Protection Helpline (telephone 133 627). However, the safety, welfare and wellbeing of children, including unborn children is a consideration in all drug and alcohol interventions for adult patients and pregnant women.

Work to promote child wellbeing and protection is provided optimally when the parents or carers of the child or young person are actively engaged in working towards sustainable change in their own lives and strengthening their parenting capability.

HDA-CL staff should liaise closely with the treating team until the child protection report is documented or report directly, using the mandatory reporter guide, to Family and Community Services if a report has not been made in a timely manner. Where treating teams have differing assessment of child protection risks, HDA-CL should document their assessment and discuss the case with their line manager or clinical supervisor.

For further information, refer to Appendix A:

- Child Wellbeing and Child Protection Policies for NSW Health The Mandatory Reporter Guide

ELDERLY POPULATIONS

Substance use, particularly alcohol and pharmaceutical use, and related problems (e.g. falls, drug-drug interactions, cognitive impairment) is an emerging and significant issue in older populations.

Substance use may be identified during a hospital presentation, and HDA-CL can provide an opportunity to address D&A issues in hospital and to engage the patient with suitable services in the community following discharge.

Treatment interventions (e.g. medications used for withdrawal or pain management, counselling approaches) may need to be modified in older patients reflecting their potential for reduced tolerance, altered pharmacokinetics (impaired metabolism, drug-drug interactions) and concomitant medical or psychiatric conditions, including memory or other cognitive impairment.

In addition to direct consultation services, HDA-CL services can have an important role in establishing clinical referral pathways and workforce development initiatives (training and implementation of screening systems) between D&A services and Aged Care services.

PEOPLE WITH AN INTELLECTUAL DISABILITY

Although people with an intellectual disability are less likely to use substances than the general population, those people with an intellectual disability who use substances are more likely to abuse substances (Didden, Embregts, van der Toorn & Laarhoven, 2009). This group is at greater risk of complications from drinking because they tend to be prescribed medications for other conditions, such as seizures, metabolic disorders, and co-occurring mental illness that might negatively interact with alcohol and drugs (Slayter, 2010 and Quintero, 2011). When a person with ID also has a mental illness or a dual diagnosis, the estimates of co-occurring substance abuse range from 7% to 20% (Sinclair in Quintero 2011).

Assessments and brief interventions with people with an intellectual disability need to be tailored to the type and degree of their disability. People with an intellectual disability often have limited communication and cognitive skills making it difficult to give an accurate history, follow instructions or fully comprehend and act on the information in a brief intervention. There needs to be a concerted effort to collaborate and ensure continuity of care between inpatient and community D&A and disability services, and particularly carers who ensure a level of D&A and medication monitoring and may give a more accurate history (Taggart, 2006). Clinical notes and handovers are key in assuring consistency in treatment for a person who may not be able to optimally communicate their D&A history and needs. HDA-CL should work with D&A and generalist staff to analyse and address barriers to people with intellectual disability accessing D&A services and to raise the awareness that people with intellectual disabilities may use D&A and, as with other patients, should be assessed for D&A use.

HDA-CL can advise D&A staff to consider the following as good practice:
Simplify the materials: Books, pamphlets and signs may not be suitable for people with limited reading ability. Drawings or short videos may be useful.

- Repetition and checking for comprehension: After introducing a concept, rephrase and repeat and check for comprehension.
- Use of a teaching approach: Keep explanations or presentations short. Patients can be easily distracted so minimise movements, whispering and other distractions. Avoid analogies and metaphors.
- Use of a strength-based approach to treatment including adapting treatment to a person's disability, motivational techniques, explicit behaviour contracts with logical consequences, adjusting leisure activities and modifying treatment goals to fit the person.
- A practical concrete approach to counselling including role plays and a focus on applying techniques in the real world.
- Interagency coordination: Treatment plans need to be holistic including employment, recreation, social isolation and physical abuse.

INVOLUNTARY DRUG AND ALCOHOL TREATMENT PROGRAM

The *Drug and Alcohol Treatment Act 2007* provides the framework for involuntary D&A treatment through the Involuntary Drug and Alcohol Treatment Program (IDAT) for severely substance dependent people who consistently refuse or do not complete treatment voluntarily, who have lost the capacity to make decisions about their drug and alcohol use and personal welfare, are at risk of harming themselves or others and would benefit from treatment at a secure treatment centre. At the time of publication, there are two designated IDAT Units (North Sydney and Orange).

HDA-CL services may be involved in identifying and referring hospital patients for specialist assessment for an IDAT. HDA-CL should be familiar with the eligibility criteria for detention and treatment under the Act and the IDAT Model of Care.

Details about training, IDAT and the Act are available from local Involuntary Treatment Liaison Officers (ITLOs) within each LHD (contact local D&A Services), and provided on the NSW Ministry of Health website and in the links below:

- link to IDAT training; visiting http://lms.acwa.asn.au/login/index.php the generic user name is: idat and the password is ccwt1
- link to law: http://www.austlii.edu.au/au/legis/nsw/consol_act/daata2007249/
- link to information on IDAT including contact details for centres: the website will be updated in 2013; Information is available from ADIS http://yourroom.com.au/Helplines/alcohol-drug-information-service-adis-nsw.html

DOCUMENTATION AND DATA COLLECTION

HDA-CL staff should be trained on standardised clinical documentation, for communication with other clinical services and administrative purposes. HDA-CL entries in the patient clinical records need to be easily recognised and identifiable to other clinicians and coders (e.g. use of a stamp, coloured labels or electronic flags) identifying HDA-CL involvement. See *Appendix E* for a suggested minimum data set collection

COORDINATION AND REFERRAL ACTIVITIES

Care coordination activities are aimed at coordinating clinical services across multiple teams or service providers. Care coordination improves the safety, quality and efficiency of clinical services, ensuring the roles of different teams are identified and communicated. Care coordination activities may enhance the efficiency of hospital service delivery, such as faster responses in ED settings, reduced length of stay for patients, and prevention of unnecessary hospital re-admissions. Examples of strategies include:

- Development and coordination of care plans for patients with D&A issues, including discharge planning. Activities may include case conferences for extended or long stay inpatients, clinical multidisciplinary team meetings (e.g. frequent re-presenter meetings with ED, MH, toxicology services), coordination across MHCL, Pain CL, ED and HDA-CL teams, coordination with community based D&A services
- Coordination and communication with carers and families. This may also include advocacy role for patients regarding D&A issues
- Hospital avoidance programs, typically operating from ED settings and provide coordinated care plans for frequently presenting patients, coordinating services in both hospital (e.g. ED, PECC, primary admitting team, Consultation Liaison teams, outpatient clinics) and community based services (e.g. primary care providers, Mental Health, D&A, Housing, Aged Care, Community Nursing, Chronic Care Programs).
- Where LHD/N has D&A hospital admission capacity, the HDA-CL service can be an important mechanism for identifying the need for, and coordinating the D&A admission or transfer of care to the D&A specialist team.

Effective referral pathways are an integral aspect of case coordination. HDA-CL services may be involved in referring patients to other hospital or community based services (e.g. D&A, other health or welfare services) where this is coordinated with the primary treating team in the hospital. It should be noted that patients can be referred directly to community-based D&A services by primary treating teams and HDA-CL have a role in establishing and promoting utilisation of these pathways by all staff. HDA-CL services should ensure that such referral pathways are clearly disseminated across the hospital. These are described in section *4.2.1.* Referrals to community based D&A services should be clearly documented on Discharge or Transfer of Care Summaries by the treating team.

QUALITY IMPROVEMENT AND CLINICAL GOVERNANCE ACTIVITIES

A key role of HDA-CL services is to participate in quality improvement and clinical governance activities that improves the safety, quality and efficiency of health care provision for patients with D&A problems in hospital.

POLICIES AND GUIDELINES

HDA-CL has an important role in ensuring the development, implementation and review of relevant NSW Health and local LHD policies, clinical guidelines and business rules that relate to the management of D&A related conditions in hospital settings. This requires links with local clinical governance units, clinical streams and workforce (medical, nursing, allied health) units.

The HDA-CL service should also maintain effective relationships and links with key management and governance systems within the general hospital. These include:

- Senior hospital governance structures, notably Executives, Clinical Councils, Clinical Governance Units, and Performance Units
- Key Clinical Streams or Departments within LHD/Ns such as Mental Health, Emergency, Medicine, Women's Health, Surgery
- Links with professional and workforce development units (Nursing, Medicine, Allied Health) to enhance professional standards and training opportunities in D&A issues across the hospital.

Policies, guidelines and business rules should be available that address the following areas:

- Referral pathways to D&A services, including referral to HDA-CL, in and outpatient D&A, after-hours, and community based D&A services
- Management of alcohol and other drug withdrawal
- Nicotine treatment for dependent patients
- Opioid substitution treatment in hospitalised patients.
- Pain management in patients in opioid substitution treatment.
- Assessment and referral to Involuntary D&A Treatment program
- Management of patients with mental health and D&A issues. Local implementation of the *Guidelines for the Management of Co-occurring Mental Health Conditions in Alcohol and Other Drug Treatment Settings* for management of patients with mental health and D&A issues.
- Policies on routine or targeted screening for substance use disorders
- *NSW Health Clinical Guidelines for the Management of Substance Use in Pregnancy, Birth and the Postnatal Period*
  http://www.health.nsw.gov.au/mhdao/programs/da/Pages/substance-use-during-pregnancy-guidelines.aspx

PATIENT SAFETY SYSTEMS AND RISK MANAGEMENT

HDA-CL services participate in a range of patient safety systems to enhance the safety and quality of patient care. These include Incident Information Management System (IIMS), Root Cause Analysis (RCA) and other sentinel event review processes, such as Mortality and Morbidity Meetings. HDA-CL services are to maintain links to local Clinical Governance Units and D&A governance pathways.

QUALITY IMPROVEMENT AND RESEARCH ACTIVITIES

HDA-CL should participate in Quality Improvement (QI) activities that aim to enhance the safety, quality or efficiency of services. QI include mechanisms for enhancing consumer participation and feedback (e.g. consumer surveys, patient liaison officers, complaints mechanisms), staff consultation and feedback (e.g. staff surveys, meetings or forums regarding service improvements), review of clinical service delivery, including clinical audits of practice, evaluation projects and participation in local QI processes (e.g. committees, working groups).

HDA-CL may also participate in research activities, including investigator roles, subject recruitment, delivery of research-related interventions, data collection and data management, analysis, reporting and dissemination roles. All research activity must comply with NSW Health Research Policy Directives such as *Research - Authorisation to Commence Human Research in NSW Public Health Organisations* (PD2010_056) and *Research in NSW Public Health Organisations* (GL2011_001).

CAPACITY BUILDING

HDA-CL has a key role in capacity building of general hospital staff in identifying and responding to patients with substance use disorders. In order to be most effective, D&A training and education needs to be:

a. integrated into general workforce and education strategies across the hospital, general training opportunities (such as hospital grand rounds, orientation programs for new staff), and profession based training programs for nursing, medical and allied health (including psychology, social work and pharmacy) workforces in hospitals

b. targeted to particular groups or teams within the hospital (e.g. ED, Social Work Department, MH Unit), addressing local service requirements

c. opportunistically provided to individual or small groups of clinicians, based around HDA-CL referrals and clinical scenarios, through case discussion and mentoring by HDA-CL staff

d. based on identified needs of staff

Capacity building needs across the hospital may be identified through mechanisms such as training needs assessments, including review of clinical information systems (e.g. to identify departments with high volume or lower than expected numbers of patients identified as D&A users and/or referrals to HDA-CL and other D&A services), review of RCA and IIMS data (to identify changes in behavioural incidents), review of the types of substances used and

demographics of D&A patients (Aboriginal, pregnant, age, gender), and quality improvement and clinical governance activities, (e.g. staff surveys and QI projects).

Areas of clinical management that are commonly identified in drug and alcohol capacity requirement assessment are:

- Overview of substance use disorders, investigations, interventions and how to obtain support in addressing D&A issues
- Screening (including effective questioning), assessment and referral
- Delivering brief interventions (including answering D&A questions)
- Managing intoxication
- Identification and management of substance dependence and withdrawal, particularly benzodiazepines, cannabis and alcohol
- Overview of opioid substitution treatment
- Addressing mental health and drug and alcohol comorbidity
- Pain management in patients using substances
- Substance use in pregnancy
- Smoking cessation, including Nicotine Replacement Therapy (NRT), and referral to community resources and services

In order to facilitate the provision of training for generalist workers, it is recommended that a central repository of standardised training resources for hospital based clinicians be developed and made available to HDA-CL services. This should enable a more efficient approach to the development and dissemination of high quality training resources that can be delivered by HDA-CL services. These resources should have identified learning objectives, and use contemporary approaches to delivering and evaluating professional education.

The impact of capacity building may be measured through routine data collection or time-limited quality improvement projects using proxy indicators. Potential proxy indicators include the number of referrals from ED/wards/clinics to HDA-CL and other D&A services (linked to referral pathways), the numbers of D&A patients identified and their demographics (linked to screening and assessment). Links to hospital governance and management structures

The HDA-CL service should also maintain effective relationships and links with key management and governance systems within the general hospital. These include:

- Senior hospital governance structures, notably Executives, Clinical Councils, Clinical Governance Units, and Performance Units
- Key Clinical Streams or Departments within LHD/Ns such as Mental Health, Emergency, Medicine, Women's Health, Surgery

- Links with professional and workforce development units (Nursing, Medicine, Allied Health) to enhance professional standards and training opportunities in D&A issues across the hospital.

RURAL, REGIONAL AND REMOTE SETTINGS

HDA-CL Services in regional / rural settings are often faced with a number of additional challenges compared to metropolitan settings. In rural areas, fewer staff, difficulty attracting qualified DA-CL staff, lack of access to specialist D&A services determines that HDA-CL time is also spent on the clinical care of community-based clients, many of whom have come into contact with the HDA-CL as in-patients. Rural/regional HDA-CL staff often provide services across a number of hospitals, and provide a range of other D&A services to outpatients, such as case management, ambulatory withdrawal management, assist with OST Programs and manage specialist D&A Out-Patient Clinics such as the Medical Specialist Outreach Assistance Program.. HDA-CL is often limited to set days in different hospitals or provided by telephone.

Strategies to address these issues include:

Building the capacity of available staff to independently manage D&A patients or manage patients with HDA-CL consultation (face-to-face or phone-based) resulting in increased staff confidence to manage less complex patients independently. This includes development of clear procedures and protocols for management of patients with D&A issues. The development of clinical competencies for generalist D&A staff will assist in building the capacity of the D&A workforce.

Development of clear communication channels and promotion of the service to hospital staff, with a focus on providing phone-based consultation if the HDA-CL is unable to visit the hospital. Hospital staff should have contact details for specialist D&A support for times when HAD-CL services are not available, including on-call Addiction Medicine specialists, the LHD/N D&A Clinical Director, and the statewide Drug and Alcohol Specialist Advisory Service.

APPENDIX A - KEY DOCUMENTS

- **Nursing and Midwifery Clinical Guidelines – Identifying and Responding to Drug and Alcohol Issues (2008).**
  http://www.health.nsw.gov.au/policies/gl/2008/GL2008_001.html

- **Guidelines for the Treatment of Alcohol Problems and Quick Reference Quick Reference Guide to the Treatment of Alcohol Problems** (Companion Document to the Guidelines for the Treatment of Alcohol Problems. NSW Health). Haber P, Lintzeris N, Proude E & Lopatko O (2009).
  http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/2C3FC9166082567DCA257260007F81F8/$File/alcprobguide.pdf

- **NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines NSW Health. Mental Health and Drug and Alcohol Office (2008).**
  http://www.health.nsw.gov.au/policies/gl/2008/pdf/gl2008_011.pdf

Aboriginal and Torres Strait Islanders

- **Handbook for Aboriginal Alcohol and Drug work (2012)**

Child Protection

- **NSW Health Policy Directive PD2013-007 Child Wellbeing and Child Protection Policies for NSW Health**
- **The Mandatory Reporter Guide**
  http://sdm.community.nsw.gov.au/mrg/app/summary.page

Clinical Handover

- **Agency for Clinical Innovation**
  http://www.aci.health.nsw.gov.au/publications/acute_care_taskforce/Safe_Clinical_Handover.pdf
- **NSW Health Clinical Handover—Standard Key Principles PD2009_060**
  http://www0.health.nsw.gov.au/policies/pd/2009/PD2009_060.html
- **Clinical Excellence Commission**
  http://www.cec.health.nsw.gov.au/resources/nsqhs/standard-6).

Mental Health

- **NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings 2009**
- **Guidelines for the Management of Co-occurring Mental Health Conditions in Alcohol and Other Drug Treatment Settings.** Mills K, Deady M, Proudfoot H, Sannibale C, Teesson M, Mattick RP & Burns LA National Drug and Alcohol Research Centre, University of New South Wales (2009).
  http://ndarc.med.unsw.edu.au/sites/ndarc.cms.med.unsw.edu.au/files/ndarc/resources/Comorbidity%2BGuidelines_0.pdf
- **Comorbidity of Mental Disorders and Substance Use: A Brief Guide for the Primary Care Clinician. Drug and Alcohol Services South Australia** Gordon A (2008)
  http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FE16C454A782A8AFCA2575BE002044D0/$File/m71cov.pdf

Prenatal, Perinatal, Postnatal, Children and Youth

- **Mental Health and Drug & Alcohol Office (2014). NSW Health Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period**
- **Mental Health and Drug & Alcohol Office (2008). NSW Health Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues.** NSW Health. http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_001.pdf
- **Mental Health and Drug & Alcohol Office (2007). Nursing & Midwifery Management of Drug and Alcohol Issues in the Delivery of Health Care**. NSW Health. http://www.health.nsw.gov.au/policies/pd/2007/PD2007_091.html

Psychosocial

- **Psychosocial Interventions Professional Practice Guidelines. NSW Health Mental Health and Drug and Alcohol Office (2008).** http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf

Residential

- **Drug & Alcohol Treatment Guidelines for Residential Settings. NSW Health Mental Health and Drug and Alcohol Office (2007).** http://www.health.nsw.gov.au/pubs/2007/pdf/drug_a_guidelines.pdf
- **NSW MERIT Residential Treatment Guidelines. NSW Health Mental Health and Drug and Alcohol Office (2007).** http://www.health.nsw.gov.au/policies/gl/2007/pdf/GL2007_010.pdf

Youth

- **Mental Health and Drug and Alcohol Office 2013. Substance use and young people framework. NSW Health**.

APPENDIX B – DRUG AND ALCOHOL CONSULTATION LIAISON MODEL OF CARE WORKING GROUP MEMBERSHIP

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  Senior Policy Officer
  Mental Health and Drug and Alcohol Office
- Sunara Fernando
  (former) Acting Senior Policy Officer
  Mental Health and Drug and Alcohol Office

APPENDIX C - REFERENCES

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APPENDIX E

Data collection for D&A CL is being developed around the following indicators:

- **Detailed itemised financial reporting for all expenditure**:
  - **staff costs**
  - **transportation**
  - **goods and services**
  - **other costs**
- **No. of closed episodes**: A Service Episode is delivered within the one setting at the treatment service agency or one of its service delivery outlets. It consists of one Main Service Provided and one Principal Drug of Concern/Gambling. It has a defined Date of Commencement of Service Episode and, for closed episodes, a defined Date of Cessation of Service Episode. It may be delivered by one or more providers.
- **No. of episodes by principle drug of concern**: A Service Episode may only consist of one Main Service Provided and only one Principal Drug of Concern/Gambling. If the client is receiving more than one Main Service Provided, concurrent episodes are required for each of these services.
- **Total number of full time equivalent staff employed on drug and alcohol consultation liaison**.
- **Hospital/facility code**: The Facility Identifier is the same as the one used for MDS data set reporting. It is the Identifier for the drug and alcohol agency.
- **Total number of occasions of service/service contact by drug and alcohol consultation liaison** (an occasion of service is an interaction between one or more health care professionals with one or more patients, for assessment, consultation and/or treatment intended to be unbroken in time) **to:**
  - **Emergency Departments**
  - **Inpatient drug and alcohol services**
  - **Outpatient clinics**
- **Total number of referrals made from drug and alcohol consultation liaison staff to:**
  - **Outpatient drug and alcohol services:** This is defined as all drug and alcohol services that are delivered in a non-inpatient setting**, and could include home or community based support settings.**
  - **Inpatient drug and alcohol services:** This is defined as all drug and alcohol in-patient settings that offer beds, and could include withdrawal management services or residential rehabilitation services.
- **Total number of referrals to drug and alcohol consultation liaison services from:**

- Emergency Departments
- Medical wards
- Surgical wards
- Women's wards
- Children's wards
- Mental Health
- Aged Care
- Psychiatric Emergency Care Centre
- Outpatient clinics

The following level of information may also useful for recording D&A CL Activity:

- MRN
- Date and time of contact
- Duration of contact
- Service contact duration
- D&A CL provider type
  a. Doctor
  b. Nurse
- Simple or complex contact
- Stay number
- DOB
- Sex
- Aboriginal and Torres Strait Islander status
- Postcode of residence
- Homelessness
- Date of presentation to hospital
- Reason for presentation to hospital
- Pregnant Yes/no
- Date and time of referral to D&A CL
- Date and time of first consultation by D&A CL
- Drugs of concern:
  a. primary
  b. secondary
- Service contact date
- Service contact type:

a. Direct care-providing clinical interventions, clinical documentation, interaction with family and carers
b. Indirect care—case co-ordination activities, consultation with staff, multidisciplinary team and case conference meetings, referral to other services

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