NSW Health

Clinical Care Standards: Alcohol and Other Drug Treatment

May 2020

NSW GOVERNMENT

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Contents

1. Foreword 2
2. Acknowledgements 3
3. Introduction 4
   - 3.1 What are Clinical Care Standards? 4
   - 3.2 Development of Clinical Care Standards for Alcohol and Other Drug Treatment 4
   - 3.3 Scope 5
   - 3.4 Context 5
   - 3.5 Approach to local implementation and monitoring 6
4. Vision and Principles of practice 7
5. Person-centred care 8
   - 5.1 Collaborative decision-making 8
   - 5.2 Involving carers, family members and significant others 8
   - 5.3 Cultural competence 8
   - 5.4 Stigma and discrimination 9
   - 5.5 Vulnerable populations 9
   - 5.6 Aboriginal people 9
   - 5.7 Culturally and linguistically diverse (CALD) populations 10
   - 5.8 Pregnant women 10
6. Standard 1: Intake 12
7. Standard 2: Comprehensive assessment 14
8. Standard 3: Care planning 16
9. Standard 4: Identifying, responding to, and ongoing monitoring of risk 18
10. Standard 5: Monitoring treatment progress and outcomes 20
11. Standard 6: Transfer of care 22

APPENDICES

- APPENDIX A: Proposed measures 24
- APPENDIX B: Readiness Toolkit 25
- APPENDIX C: Glossary 34
- APPENDIX D: Supporting documents 35
- APPENDIX E: Resources 36
- APPENDIX F: References 38

1. Foreword

The NSW Clinical Care Standards for Alcohol and Other Drug Treatment (*The Standards*) outline the core elements of care that underpin treatment within NSW alcohol and other drug (AOD) treatment services.

The Standards have been developed as a result of the excellent work of Professor Nicholas Lintzeris and the Clinical Outcomes and Quality Indicator (COQI) team, in partnership with the Centre for Alcohol and Other Drugs, NSW Ministry of Health, consumers, senior clinicians and addiction medicine specialists working in NSW government and non-government treatment services.

These standards apply to all drug and alcohol service treatment types and locations and do not identify specific interventions used in treatment. The intention is to detail the foundational elements of care, support clinical decision-making and complement rather than replicate other sources of information that guide the delivery of high-quality and safe treatment.

The Standards are consistent with the principles of value based healthcare in NSW and seek to ensure that people experiencing harms from alcohol and other drug use are not marginalised within the health care system. The key principles of value based healthcare and how outcomes align with value based healthcare are described below.

A note on language: This document is based on the principles of person-centred care. The term *client* is used to indicate people who are engaged with the AOD treatment system.

Health outcomes that matter:

The outcomes for each standard are based on evidence about what matters to people with a lived experience of alcohol and other drug use, in relation to receiving care. There is a focus on partnering with the client to regularly evaluate care, monitor risk and support positive outcomes throughout the client journey.

Experience of receiving care:

Clients and their families are at the centre of care. When providing services we will be working in partnership with clients and families to ensure satisfaction in the quality of care delivered. Care planning is centred on achieving client goals and identifying risks and barriers to treatment.

Experience of providing care:

The Standards have a strong focus on health equity, and on improving the experience of receiving health care. Clients want and need a system that they can engage with early, when they need treatment and that provides what they need when they need it. *The Standards* highlight what clients can expect at every step of treatment and how they can partner with providers to achieve their goals. The use of client experience measures is central to evaluating success.

Effectiveness and efficiency of care:

The Standards describe the systems of operation, at a service level, which are required to deliver effective and efficient care. Ongoing consultation with clients will be used to guide quality improvement initiatives, improve access and engagement in treatment services and programs. Integrating with service partners across the health sector and in primary health care will be essential to achieving positive health outcomes.

I recommend the use of these standards in the delivery of AOD treatment and wish to thank all those who contributed their advice, expertise, skill, and time in the development of the NSW Clinical Care Standards for Alcohol and Other Drug Treatment.

Yours sincerely

Dr Tony Gill
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Centre for Alcohol and Other Drugs, NSW Ministry of Health

2. Acknowledgements

The NSW Clinical Care Standards for Alcohol and Other Drug Treatment have been jointly developed by the Clinical Outcomes and Quality Indicators (COQI) Project Team and the Clinical Quality and Safety (CQS), Centre for Alcohol and Other Drugs (CAOD), NSW Ministry of Health (MoH).

We acknowledge the significant contribution of all stakeholders in the NSW Alcohol and Other Drug Treatment Sector, our colleagues in the Primary Health Networks (PHNs) and consumers in the development of these standards.

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We would like to acknowledge a number of Assistant Project Officers from the CQS, CAOD, MoH who have provided secretariat support to the working group and consultations: Jennifer Case, Eliza Quinert and Emelie Malmqvist.

The MoH would also like to acknowledge the Centre for Aboriginal Health for the review of *The Standards* and their support in developing the Aboriginal Health Impact Statement.

SESLHD and HNELHD Senior Clinicians

We would like to acknowledge the contribution of senior clinicians from SESLHD and HNELHD who contributed to the initial development of the Clinical Care Standards elements.

COQI Clinical Consultation Group

The COQI clinical consultation group consists of senior clinicians and service managers from local health districts (LHDs), non-government services and The Network of Alcohol and Other Drugs Agencies (NADA) who reviewed and further developed *The Standards* and provided essential advice on implementation. This group has also provided expert advice on the treatment elements of the broader COQI framework including but not limited to: clinician training, feedback on clinical significance of framework metrics, and implications for clinical pathways.

Participants in the NSW Clinical Care Standards Roadshows

The Clinical Care Standards Working Group held two metropolitan and a range of regional and rural roadshows and webinars to consult with drug and alcohol clinicians, managers and directors working in treatment services. These roadshows were supported by NADA and attended well by representatives from clinical services in the public and non-government sector, as well as representatives from the PHNs. All LHDs participated in the consultations and provided valuable feedback on the development of *The Standards* and issues to be considered in implementation.

Progress on the development of *The Standards* was also a focus of discussion at the NSW AOD Quality in Treatment Committee and the CAOD Drug Programs Council.

Consumers

We wish to acknowledge the significant contribution of peer workers and consumers who participated in focus groups and focused this work on ensuring person-centred outcomes. Acknowledgement is also given to the NSW Users and AIDS Association (NUAA) for their imput in the development of the final document.

3. Introduction

3.1 What are Clinical Care Standards?

Clinical Care Standards (CCS) are a set of statements about the treatment a client can expect when they seek treatment for a specific condition or health problem.

Within AOD, there is a range of treatment settings that clients can access in both the government and non-government sectors. These standards are applicable to all services and agencies providing AOD treatment.

The definition of a clinical care standard is outlined by the Australian Commission on Safety and Quality in Health Care (ACSQHC)[1] as:

> *'a small number of quality statements that describe the care patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway in line with current best evidence'.*
>
> *Each Clinical Care Standard:*
>
> - *helps people to know what care to expect for a particular clinical condition and helps them make informed decisions about treatment in collaboration with their health professional*
> - *provides guidance to health professionals so they can deliver quality care and have informed discussions about treatment options with their patients*
> - *sets out the components of care that health services can use to guide practice and monitor improvement in their hospitals and other services where the Clinical Care Standard is applicable.*

The CCS for AOD treatment, outlined within this document, have been developed in line with the ACSQHC definitions and framework for CCS and are linked to the core treatment processes in Electronic Medical Record (eMR) and refined by the Clinical Outcomes and Quality Indicators (COQI) Project. Consultation with the broad sector of treatment providers, including non-government organisation (NGO) and LHD services, ensured that *The Standards* are applicable for all people working to provide quality care to those seeking AOD treatment.

Accompanying each CCS is a *suggested standard measure* (see Appendix A) to assist local treatment services to monitor how well they implement the care described in *The Standards*. These measures are not a set of targets or mandatory indicators for performance management, rather a tool for quality improvement. The suggested standard measures support the implementation of *The Standards* and can assist quality improvement initiatives at a service level.

3.2 Development of Clinical Care Standards for Alcohol and Other Drug Treatment

The NSW Alcohol and Other Drug Service Clinical Outcomes and Quality Indicators Framework Project Team (COQI team) undertook the development of *The Standards* as part of their broader aim to develop a mechanism to describe the quality and outcomes of treatment for clients who enter treatment for drug and or alcohol use, answering the two key questions:

1. 'Is treatment delivered well?'
2. 'Do clients achieve good clinical outcomes?'

The team undertook an iterative co-development process, which included all NSW LHD AOD services, NGO representatives, MoH stakeholders, PHN representatives and AOD consumer workers. The treatment processes that align to *The Standards* were incorporated into the Drug and Alcohol Information System (DAIS) project for the eMR. This approach articulated the elements within each process to define *The Standards*. The NADA Practice Leadership Group (NPLG), and other representatives from the specialist AOD NGO treatment sector, reviewed *The Standards* and confirmed good alignment between the CCS and the routine elements of care provided to clients accessing treatment in the NGO sector, as outlined in the Non-Government Alcohol and Other Drugs Treatment Service Specifications and identified performance indicators.[2]

The aims of *The Standards* are to:

1. articulate the key elements of the core treatment processes, as identified by the treatment sector
2. provide a point of reference for measuring the current level of delivery of AOD treatment in relation to the standards and to inform the development of clinical analytics solutions to measure this
3. guide and support future quality improvement activities
4. inform the development of a workforce development strategy and clinical competency framework for the AOD treatment delivery.

3.3 Scope

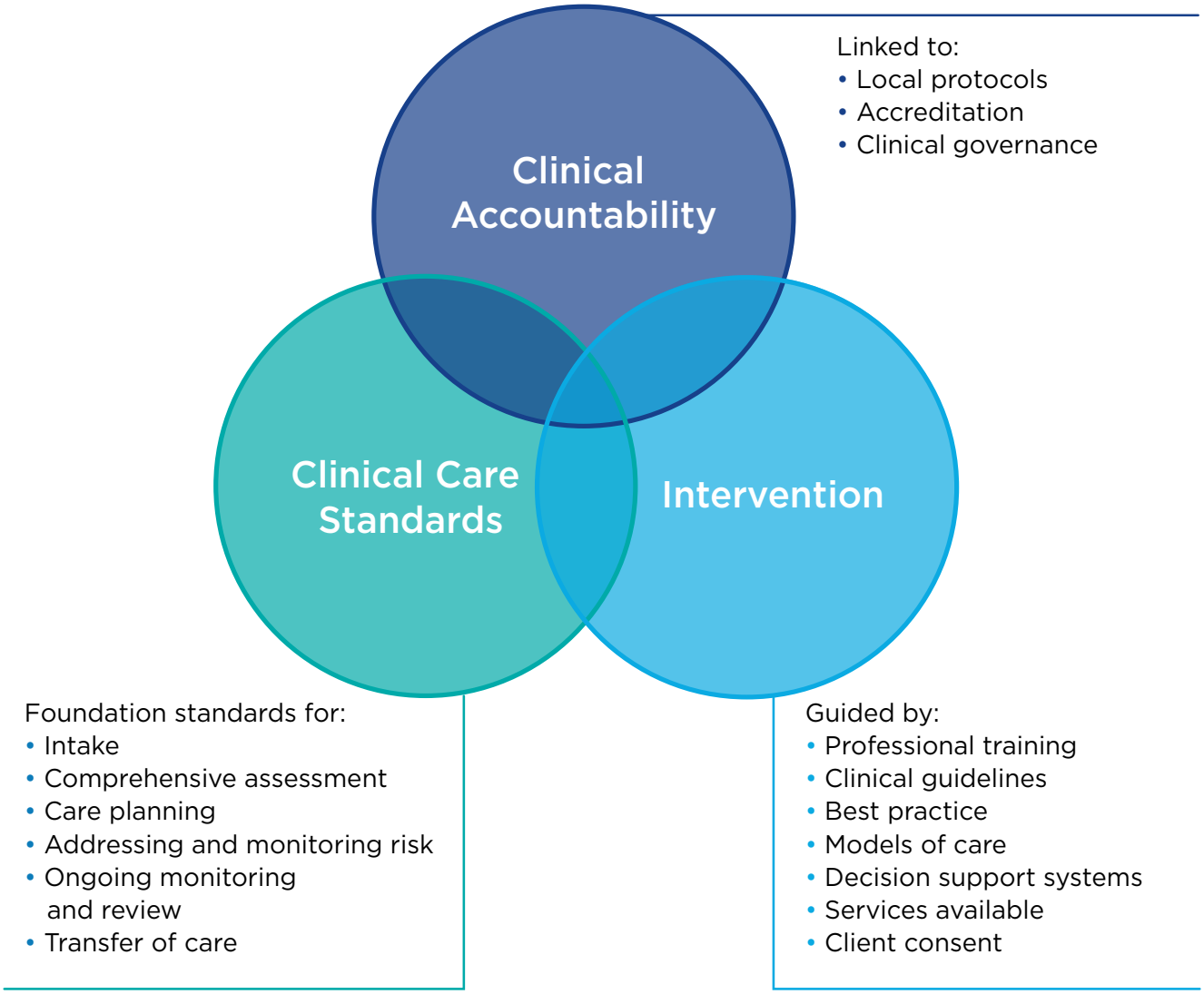
These CCS describe the processes of care that support service delivery in specialist AOD treatment services.

3.4 Context

The Standards describe the foundational elements of care that underpin essential practices in AOD treatment services. Clinicians can use these standards to ensure appropriate information is gathered to inform and support clinical decision-making. *The Standards* can be targeted to all AOD service types and locations however, they do not identify specific interventions used in treatment (e.g. type of counselling or medication intervention). *Refer to Figure 1.*

The intention of *The Standards* is to detail these foundational elements and complement, rather than replicate, other sources of information that guide the delivery of high-quality and safe treatment.

Figure 1



Key relevant sources include:

- NSW Ministry of Health clinical guidelines such as the NSW Clinical Guidelines: Treatment of Opioid Dependence 2018
- National Drug Strategy 2017-2026
- The National Quality Framework for Drug and Alcohol Services
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-29
- The Strategic Framework for Integrating Care (NSW Health 2018)
- Treatment services specifications for the NGO drug and alcohol specialist sector in NSW.

3.5 Approach to local implementation and monitoring

Individual services wanting to use *The Standards* for quality improvement and performance monitoring are encouraged to work with peers in the sector. These standards were developed through collaboration and consultation with clinicians, consumer workers, clients and service managers using an iterative approach. It is recommended that the implementation and monitoring of these standards continue with this approach to ensure consistency and resource efficiency.

It is proposed that the following practices underpin implementation and monitoring:

a. Encourage and resource local uptake and implementation to embed in practice
b. Coordinate and share implementation approaches, resources and learnings
c. Leverage expertise of the COQI team to support local initiatives
d. Ensure a coordinated approach to workforce development
e. Use and expand on existing infrastructure including the clinical information systems for data capture and reporting.

Treatment services may determine that there are times where it is clinically appropriate to deviate from elements outlined in *The Standards*. In these cases, there should be appropriate clinical governance and decisions should be documented in local business rules, identifying the circumstances where this may apply.

The following resources have been developed and are attached in the appendices to support local implementation:

- Proposed measures – Appendix A
  NB: The proposed measures identified are a way of supporting services to start monitoring their outcomes for quality improvement locally and will not be used as indicators of performance.
- Readiness Toolkit – Appendix B
- Supporting documents – Appendix C and D
- Resources – Appendix E

4. Vision and Principles of practice

People with alcohol and other drug-related harms experience person-centred, safe high-quality intervention and care

The principles of practice underpin all levels of AOD care and service delivery.

PRINCIPLE	PRACTICE
Principle 1 **Services are person-centred**	Services are provided within a trusted, inclusive and respectful culture that values and promotes a beneficial partnership between clients, their significant others and staff. The service respects diversity and is responsive to clients' needs and values. The experience of clients and their families is reflected in the service system.
Principle 2 **Services are safe**	Services are continuously improving outcomes by giving regard to the physical, psychosocial and cultural wellbeing of all clients, and minimising the risk of harm.
Principle 3 **Services are accessible and timely**	The service system is visible, accessible from multiple points of entry, equitable and timely. Clients experience care as welcoming, accepting, non-judgemental and responsive to their needs.
Principle 4 **Services are effective**	Services are holistic, evidence-based and supported by NSW Health endorsed standards, policies and guidelines. The service system attends to the diverse medical, psychological and social needs of clients. The continuum of care is integrated across NSW Health, primary care and non-government organisations to reduce fragmentation and optimise outcomes.
Principle 5 **Services are appropriate**	The service system provides a range of approaches to meet the diverse needs of clients. The experience of clients and their significant others is reflected in the service system. Clients are informed about and engaged in influencing, services, treatment and options in a clear and open way. The right evidence-based care is provided by the right providers to the right person, in the right place and at the right time, resulting in optimal quality care.
Principle 6 **Services use their resources efficiently**	Services maximise the use of available resources to deliver sustainable, high-quality care. Services ensure close alignment and integration across services and sectors to avoid duplication or omission of service.
Principle 7 **Services are delivered by a qualified workforce**	The workforce has the requisite skills, knowledge, values and attitudes to respond to clients' needs, and a capability and willingness to work across disciplines and sectors.

5. Person-centred care

Person-centred* care (defined by ACSQHC[3]) is *'health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers'.*

The Standards support the key principles of person-centred care (as defined by ACSQHC), namely:

- *treating patients with dignity and respect*
- *encouraging and supporting patient participation in decision-making*
- *communicating and sharing information with patients about clinical conditions and treatment options*
- *providing patients with information in a format that they understand so they can participate in decision-making.*

* This document refers to patient-centred care as person-centred care.

5.1 Collaborative decision-making

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

Central to the achievement of the goals outlined in the care plan are communication, planning and collaboration with the client and with the range of professionals or agencies supporting their care.

A multidisciplinary approach is particularly important to ensure that care is comprehensive and the wide range of physical, psychological and social health domains that may be affected have been considered in developing a collaborative treatment plan. It is crucial that the client is engaged in their treatment and has an understanding of how to link into additional support, if required.

5.2 Involving carers, family members and significant others

Clients should also be given the opportunity to involve carers, family members or significant others in their treatment. These people may know the client very well, and can often provide insights into the client's history, routines or symptoms, which may assist in determining treatment and ongoing support. Each statement in *The Standards* should be understood to mean that carers, family members or significant others have the opportunity to be involved in clinicians' discussions with clients about their care, if agreed to by the client. There may be occasions a client elects not to have their family or significant others involved; this should be respected.

5.3 Cultural competence

To ensure effective, safe and high-quality treatment it is essential that all health workers use culturally safe and respectful practices towards all population groups. Culturally safe and respectful practice requires knowledge of how one's own culture, values, attitudes, assumptions and beliefs influence one's interactions with people and families, the community and colleagues. It also requires understanding the impact that you as a health professional have on clients for whom you care.

Cultural competence includes:

- being aware that a person's culture will shape how they understand health and ill-health
- learning about the specific cultural beliefs that surround health conditions in the person's community
- learning how mental health conditions are described in the person's community (knowing what words and ideas are used to talk about the symptoms or behaviours)
- being aware of what concepts, behaviours or language are taboo (knowing what might cause shame).

Culturally safe and respectful practice involves:[4]

- understanding that only the person and or their family can determine whether or not care is culturally safe and respectful
- respecting diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among team members
- acknowledging the social, economic, cultural, historic and behavioural factors influencing health, at the individual, community and population levels
- adopting practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (e.g. based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs)
- supporting an inclusive environment for the safety and security of the individual person and their family and or significant others
- creating a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including clients and colleagues.

5.4 Stigma and discrimination

Stigma is a fundamental social cause of health inequalities.[5] It has been shown to worsen stress, reinforce differences in socioeconomic status, delay or impede help-seeking and lead to premature termination of treatment.[6] People who use alcohol and other drugs at a harmful level are particularly vulnerable to stigma and discrimination from within society, their communities and the health care sector. All health care providers have a responsibility to provide care that is free from stigma and discrimination, irrespective of the clients' use of alcohol and other drugs.

For people who use alcohol and other drugs, stigma is labelling and stereotyping, and can lead to their exclusion and rejection, with discrimination (i.e. the lived effects of stigma[5]) impacting the care and treatment that they receive. This may have a negative impact on their willingness to access assistance for future or ongoing treatment of health conditions; ability to receive quality therapeutic care and treatment from a broad range of health practitioners; and motivation to disclose their status of drug use, a history of injecting, or associated medical conditions.[7]

The knowledge gained from people with a lived experience of alcohol and or drug use has shown the positive and negative impact that health care providers can have on how clients feel about themselves and their capacity to have access to, and engage, in services.[8] Frontline service providers are often confronted with the complexities associated with alcohol and other drug use including risks to physical, psychological and social wellbeing. Many people who use alcohol and other drugs come into contact with treatment services either because of a harm or concern related to their substance use, or for other health issues – usually at a time of crisis.

5.5 Vulnerable populations

Discrimination and stigma associated with alcohol and other drug use is exacerbated when issues of substance use are discussed with populations who may be already marginalised or judged. Populations who are also vulnerable to harms associated with substance use may include people living in rural and remote communities, people with mental health issues, Aboriginal and Torres Strait Islander* people, culturally and linguistically diverse (CALD) people, people in contact with the criminal justice system, pregnant women, and lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI) people.

5.6 Aboriginal people

**In this document, Aboriginal and Torres Strait Islander people are referred to as Aboriginal people in recognition that Aboriginal people are the original inhabitants of the Australian state of NSW.*

The trauma experienced by Aboriginal people as a result of colonisation and subsequent policies, such as the removal of children, has reduced the capacity of Aboriginal communities.[9] The disruption of Aboriginal culture and the impacts on the cultural identity of Aboriginal peoples have had lasting effects, and continues to be passed from generation to generation. The cumulative effect of this trauma reduces the capacity of Aboriginal people to engage with their lives and communities, which leads to social disadvantage including in the areas of education, employment, income and overall position in society.[10] The social determinants of health and wellbeing disproportionately impact Aboriginal people.[11] These include educational attainment, occupation, income, early life, social exclusion, social capital, employment, housing, and residential environment.

Social and emotional wellbeing (which may be clinically referred to as mental health) is also linked to many external stressors such as serious chronic illnesses, higher mortality rates within Aboriginal families and communities, and criminal justice issues. These stressors may contribute to any deterioration in social and emotional wellbeing of Aboriginal Australians as well as to any alcohol or drug use.[11]

Discrimination and stigma associated with alcohol and other drug use are compounded when discussing these matters with Aboriginal people. Strong emotions like shame can trigger memories of the trauma itself. Shame may also prevent Aboriginal people and families from seeking and receiving support when they need it. Having a focus on building resilience in the community and cultural engagement is a critical element in healing.

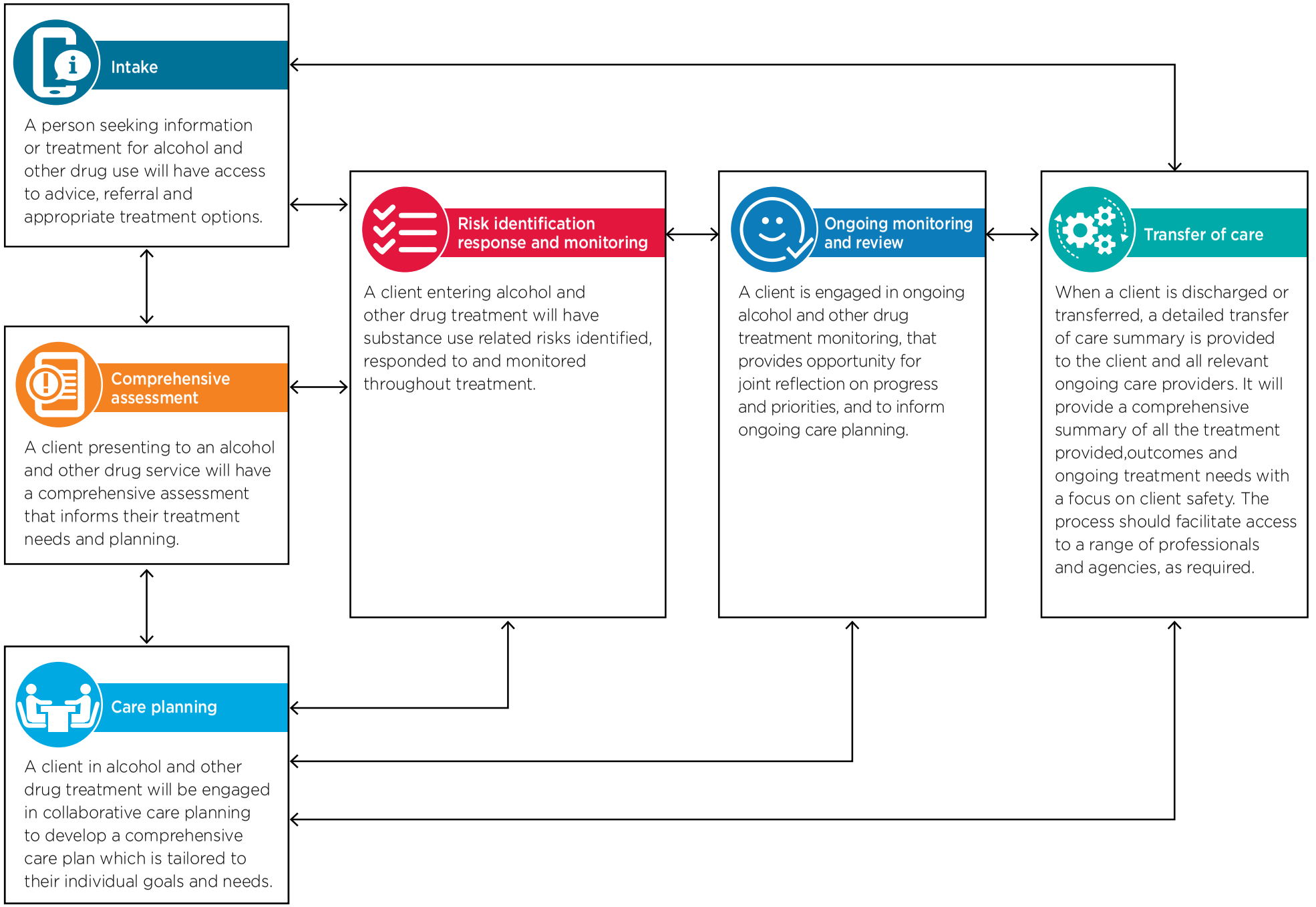
5.7 Culturally and linguistically diverse (CALD) populations

Culturally diverse populations may have varied experiences of alcohol and other drug use. Factors such as family stressors, unemployment, language barriers and lack of understanding of available services may make Aboriginal people and people from CALD communities more susceptible to harm related to alcohol and other drug use. Health professionals play a key role in identifying the holistic needs of their clients by assessing their physical, social and emotional health.

5.8 Pregnant women

Substance use during pregnancy may be associated with significant harm to mother and baby. Health professionals can make a substantial difference to the health of women and their babies by identifying and supporting women who use substances during pregnancy. Pregnancy may be a window of opportunity to motivate change and improve outcomes with appropriate support and treatment. It has been clearly identified in the literature that there is substantial stigma associated with substance use in pregnancy, and this is a barrier for women accessing support.[12] Alcohol and drugs are used by women across the population, from a wide range of backgrounds and ages. A safe and non-judgemental approach is required to encourage disclosure and enable assistance with psychosocial and pharmacological treatment as required.

Figure 2: Summary of standards



6. Standard 1

Intake

A person seeking information or treatment for alcohol and other drug use will have access to advice, referral and appropriate treatment options.

Intake is the initial contact between a person or referrer and the AOD treatment system. As it is often the first point of contact with treatment services, building rapport is important. Information is obtained through an intake interview to elicit key clinical information and facilitate access to the most appropriate service. The intake process also identifies the presence of any urgent or crisis issues requiring immediate action. The intake interview is not equivalent to a comprehensive AOD assessment.

Elements

1. An intake interview collects the following core information:
    a. Caller details
    b. Referral agent details
    c. Reason for referral
    d. AOD use
    e. Current and previous AOD treatment
    f. Risk and safety assessment, including risk of harm to self and others and high priority risk areas
    g. Medical and mental health issues
    h. Additional criteria for consideration for priority access to treatment.

2. Processing intake information:
    a. Identify urgent or crisis issues. If significant risks are identified by the intake officer, the intake officer should be proactive, which may include immediate referral to the appropriate service
    b. Assign assessment priority
    c. Provide information and resources according to need
    d. Facilitated referral including booking for an assessment, as appropriate. Optimal timeframes for client assessments are based on the overall priority level identified at the completion of the intake interview. These are classified as high, medium and low. High priority clients should be offered the earliest available assessment in line with local protocols. Local monitoring of time from intake to assessment is advised
    e. Referrers should be notified of the outcomes of the intake assessment.

Standard 1 – What this standard means in practice for:

Clients

People seeking treatment are to be involved in the plan for their care and gain an understanding of what options they may consider for treatment. Where appropriate, they should be given an appointment for a comprehensive assessment and contact details for follow up and be assisted with any urgent or critical issues that may present.

If a person becomes a registered client, information about health information privacy should be provided at this time.

Clinicians

- As intake is the first point of contact with the AOD service, particular emphasis should be made on engagement.
- Provide relevant information to help people understand the available AOD services and support them in decision-making about the most appropriate plan of action.
- Communicate the management of personal health information (i.e. health information privacy) to people prior to registration.
- Identify clients who are in crisis or who have urgent needs and risk factors, and devise and document a plan of action to manage any immediate issues of concern.
- Assess and triage the person in line with identified risk, and prioritise for comprehensive assessment accordingly.
- Ensure clients are provided with information to support their wellbeing until assessment.

Treatment services

- Ensure systems are in place to support prioritisation and transition of clients from intake to comprehensive assessment that is timely and supports engagement of the client in treatment.
- Ensure systems are in place to support clinicians to identify and assess risks, urgent and crisis presentations, and provide pathways to immediate care and support, if required.
- Ensure that staff understand their health information privacy responsibilities.
- Ensure systems are in place to support feedback to referrers.
- Ensure staff undertaking intake duties are suitably qualified and have appropriate training, supervision and support.

7. Standard 2

Comprehensive assessment

A client presenting to an alcohol and other drug service will have a comprehensive assessment that informs their treatment needs and planning.

It is essential for clients attending AOD treatment services to have a comprehensive assessment conducted at the start of treatment. The assessment seeks to gain a thorough understanding of the client's presentation. It explores what outcome(s) the client is seeking, their substance use, and related physical, psychological, social, and cultural considerations. It is also an opportunity to explore with the client, their strengths and any requirements that they may have to support engagement in treatment. Comprehensive assessment identifies what needs to be considered and included in the care plan.

Elements

1. Clients presenting to a AOD service will have a comprehensive AOD assessment that contains:
    a. The reason for presenting to the service
    b. A record of all psychoactive substances used in the past 28 days
    c. A record of all psychoactive substances used in the past 3 days
    d. A record of any other AOD treatment the client is currently participating in
    e. A record of whether there are any concerns with the client's social situation, mental health, and physical health and whether they would like any assistance from the treatment service
    f. Identification of risks that include those relating to the client's personal characteristics and circumstances, behaviours, and the substances used
    g. A formulation
    h. An initial treatment plan for management of substance use and associated issues.

Standard 2 – What this standard means in practice for:

Clients

When clients request treatment from an AOD service, an AOD clinician will carry out an assessment to identify their individual needs, priorities and treatment requirements. The assessment seeks to gain a thorough understanding of the client's current concerns and what they are seeking to achieve from treatment. The assessment will take into consideration the individual's family and medical history, current and past substance use, psychological health, social circumstances, and previous treatment history.

If any risks of harm are identified, the clinician will work with the client on strategies to assist with minimising those risks. As part of ongoing treatment, the client will be orientated to their rights and responsibilities.

Clinicians

- Engage in welcoming, rapport building and orientation to the service if applicable, taking into account a client's needs in terms of safety and responding to any concern or anxiety they have about accessing treatment at this time.
- Ensure the client fully understands their rights and responsibilities in line with legislative requirements and local protocols.
- Conduct a comprehensive assessment as a foundation for determining client goals, options for services, level of risk and their treatment plan.
- Assessment is completed using a range of clinical documents, assessment tools and templates tailored to the client's presentation, treatment setting and type of service being provided.
- Completion of a structured clinical review tool such as the Australian Treatment Outcomes Profile (ATOP)[13] or other validated tool early in the assessment allows for tailoring of the rest of the assessment process to the client's individual needs and risk domains. When repeated, it facilitates the engagement of clients and clinicians in monitoring of outcomes.
- The comprehensive assessment is followed by the development of a formulation. A formulation is a summary of the client's presentation, gained from the thorough assessment, which draws together important features to facilitate the development of a treatment plan. The main areas a formulation should cover are: summary of the presenting problem(s); the main concern; predisposing factors; precipitating factors; maintaining factors; and relationship between mental health problems and drug use.[14] A case formulation should also be able to identify current client strengths, resources and supports.
- Findings from the assessment and the range of treatment options are discussed with clients and significant others if appropriate and a treatment pathway is agreed. Immediate action is to be taken on any identified risks as indicated and required by legislation or if there is indication of a heightened risk of harm to self or others. Treatment pathways should also include ongoing engagement and support strategies.

Treatment services

- Ensure systems are in place that support clinicians to effectively assess clients in a timely manner. These include strategies for management of wait times, operational support and ensuring that locally agreed pathways for care are in place.
- Ensure that all health care workers are competent to conduct assessments, complete formulations, and use assessment documentation and tools.
- Ensure systems are in place to support health care workers to identify and assess all levels of risk and provide pathways to care and support.
- Treatment services may determine that there are times where it is clinically appropriate for a client to have an assessment that does not include all of the elements outlined here. In these cases, there should be appropriate clinical governance and documentation around the circumstances where this applies.

8. Standard 3

Care planning

A client in alcohol and other drug treatment will be engaged in collaborative care planning to develop a comprehensive care plan which is tailored to their individual goals and needs.

A care plan is a document where the client's short to medium-term goals regarding substance use, health and welfare are identified and recorded. A care plan should assist in improving the quality of treatment through enhanced communication by those involved in the delivery of care. It is used as a tool to engage clients in decision-making related to their substance use, health and welfare needs.

The care plan can also be used to improve communication with the range of service providers and carers involved in client care. It outlines treatment goals, actions to achieve the goals, the person(s) responsible for completing the planned actions and review dates.

Elements

1. A care plan is developed in collaboration with the client, and where relevant their carers/friends/family and other service providers.
2. The care plan should identify any issues or concerns, goals, actions, persons responsible and review time frames for the following domains: substance use, mental health, physical health, psycho-social, cultural, socio-economic, legal, or other related problems of concern to the client.
3. The client is offered a copy of the plan, and the communication and dissemination of the care plan is discussed with the client.

Standard 3 – What this standard means in practice for:

Clients

Following the comprehensive assessment, the clinician will work with the client to develop and document a care plan. This plan will identify any goals and any actions that have been agreed to support treatment and will be reviewed periodically throughout the client's care.

Clinicians

The care plan brings together the information collected in a comprehensive assessment and from the clinical formulation. It incorporates the collaborative plans for treatment developed with the client. It identifies plans for implementation and review and evaluation processes. This is achieved by:

- Engaging the client in the formulation of a care plan, in line with the elements embedded in this clinical standard.
- Delivering services in line with priorities outlined in the care plan.
- Liaising with other care providers, as required, and facilitate coordination of services to meet client goals.
- Periodically reviewing the progress and outcomes of each strategy outlined within the plan with the client.
- Ensuring that clients are offered a copy of their plan on development and when it is updated.

Treatment services

- Ensure clinicians are competent in all elements of developing and documenting collaborative care plans.
- Ensure systems and resources are in place to facilitate documentation of care plans and monitoring of outcomes.
- Systematically review compliance and develop pathways that will support clinicians to facilitate care and meet requirements of this standard.

9. Standard 4

Identifying, responding to, and ongoing monitoring of risk

A client entering alcohol and other drug treatment will have substance use related risks identified, responded to and monitored throughout treatment.

Assessing risk is an important part of AOD treatment. Identifying and responding to risk commences at intake and continues throughout treatment. There is a range of risk factors to be considered, including personal characteristics and circumstances, behaviours the client may be engaging in and risks associated with the substances being used. Core risks are risks that should be considered routinely for all clients in AOD treatment, regardless of the substances used or the treatment they are receiving. There is also a broad range of other risks and harms that should be considered depending on the clinical presentation.

CORE RISKS To be considered for all clients	NON-CORE RISKS Non-core risks to be considered based on individual presentation
• domestic and family violence	• deteriorating physical health
• child wellbeing	• significant cognitive impairment
• overdose, including poly sedative use	• injecting drug use risks (e.g. blood-borne virus transmission)
• complicated withdrawal history including withdrawal seizures and alcohol withdrawal delirium	• perinatal risks including during pregnancy and breastfeeding
• recent release from hospital or residential health setting (including residential rehabilitation) or a custodial facility (e.g. prison, remand, police cells)	• unstable or deteriorating mental health; psychosis/delirium
• risk of harm to self or others	• sexual health
• risk of homelessness or eviction	• fitness to drive

Elements

1. Identifying and responding to risk is an ongoing process and is completed at the initial assessment, periodically throughout treatment, and at discharge or transfer of care.
2. The frequency of planned review is determined by treatment type and clinical judgement, but not less than every 3 months.
3. Services should have a system for identifying and maintaining updated documentation of client risk levels, ideally using standardised and structured approaches to risk monitoring (e.g. ATOP, Domestic Violence screening, Child Protection). Client level of risk should also inform follow up procedures in the event of appointment non-attendance.
4. Risks need to be addressed through care planning and reviewed within the agreed timeframes. The use of structured clinical tools in risk monitoring (see element 3) can facilitate the ongoing review of risk and the effectiveness of risk mitigation strategies over time.

Standard 4 – What this standard means in practice for:

Clients

On engagement and throughout treatment, the client is assessed for any risks associated with their personal characteristics and circumstances, the behaviours they are engaging in, and risks associated with the substances being used. The treating clinician will discuss strategies to reduce the impact of harm to the client or any other persons. The clinician will work with the client to ensure that their wellbeing is sustained and that they are supported in their care.

Clinicians

Identification of risk

- Ensure that the client's risks are identified and documented.
- Ensure management strategies are discussed with the client and documented.
- Ensure the client is aware of risks, and understands what to do and who to contact to help manage identified risks.
- Ensure all clinicians involved in the delivery of care are aware of risks and understand the agreed strategies to support the client.
- Use the ATOP or other validated tool to identify a number of key risk practices such as injecting risks, homelessness, violence, psychological wellbeing and children in the client's care. These can fulfill many but not all aspects of routine risk monitoring.

Monitoring and response

- Regularly review and respond to identified risks, as well as identify new risks as they arise within ongoing monitoring of treatment progress. This includes ongoing assessment of physical health, mental health status and level of wellbeing.
- Ensure ongoing care plan is aligned to outcomes of periodic risk assessments.
- Record if the client identifies any issues with their social situation, mental health and physical health, and if there are problems, whether they would like any assistance from the service.
- Incorporate strategies to mitigate risks in the client's care plan.
- Escalate any identified risks outside scope of practice or responsibility.

Treatment services

- Ensure staff are competent in risk identification and strategies to support management of client risks.
- Ensure systems are in place to support clinicians in identifying and managing client risks.
- Develop pathways of care, partnerships and local protocols that support clinicians to respond to risks in a timely manner.
- Ensure systems are in place to monitor and track clinical incidents.
- Ensure pathways for escalation are in place and all staff are orientated to their accountabilities.

10. Standard 5

Monitoring treatment progress and outcomes

A client is engaged in ongoing alcohol and other drug treatment monitoring, that provides opportunity for joint reflection on progress and priorities, and to inform ongoing care planning.

Monitoring treatment progress and outcomes is an ongoing process and brings together the information collected in continuous assessment (including comprehensive assessment in Standard 2), care planning (Standard 3), identifying, responding to and monitoring risk (Standard 4), implementing the treatment plan, reviewing treatment progress, and discharge planning (Standard 6). It is an opportunity to partner with clients for joint reflection on progress and priorities, and informs the ongoing care planning.

Elements

1. Monitoring treatment progress and outcomes is an ongoing process.
2. Structured measurements of AOD-specific (e.g. ATOP, Severity of Dependence Scale [SDS]) and general health measures (e.g. Kessler 10 (K10), PROMIS, EUROHIS Quality of Life Scale 8 [EQoL-8]) and, investigations (e.g. Urine Drug Screens [UDSs], liver function tests, breath alcohol measurements) are incorporated at initial assessment, repeated periodically when appropriate throughout treatment, and at discharge or transfer of care.
3. Measurement of treatment progress coincides with and informs care plan review.
4. The frequency of review is determined by treatment type, risk factors and clinical presentation, and occurs at least every 3 months.
5. There are regular clinical reviews to assess ongoing risks and suitability of the treatment plan. The type, frequency and membership of clinical reviews is in accordance with the client's clinical needs, care plan and risk issues.

Standard 5 – What this standard means in practice for:

Clients

Clients are to be encouraged to give feedback and raise any matters of concern regarding their treatment at any time. A structured treatment review provides one opportunity for this.

AOD treatment services use a number of structured review tools on an ongoing basis to inform and monitor treatment. Tools used include ATOP, PROMIS, SDS or K10 (see Glossary) but are sensitive to change over time. Clients are encouraged to ask for the results of this monitoring and discuss these with the treating clinicians.

The treating clinician will regularly discuss treatment goals and review achievements. Any proposed changes will be outlined, and clients are to be fully engaged in any adjustments to their collaborative comprehensive treatment plan.

Clinicians

- Ensure treatment progress is monitored and documented as individually required, but at least every 3 months.
- Review treatment progress and provide feedback to clients, reflecting on what is working, and what needs to change.
- Use a structured clinical review tool (i.e. ATOP or other validated review tools) to facilitate treatment monitoring as this allows results to be reviewed over time with each individual client. In NSW public health services, treatment monitoring can be trended using the graphing feature in eMR. In the NGO sector, organisations may use NADAbase or other bespoke client management systems to share trends and data visualisations with clients.
- Update the care plan as a part of the treatment review and offer a copy to the client.

Treatment services

- Ensure systems are in place to undertake regular clinical review of all clients.
- Ensure systems are in place to receive and trend client feedback (e.g. complaint management systems/recording client experience of care).
- Ensure clinicians are suitably qualified and competent in the use of structured outcome measurement tools which are used in the service.
- Develop auditing procedures on use of clinical monitoring or outcome measurement tools such as the ATOP, or other outcomes measurement tools such as those in NADAbase.
- Set up systems to ensure workforce have sufficient resources to effectively reflect on individual treatment outcomes.
- Develop local protocols to facilitate case review and coordinated case management within AOD treatment settings and with relevant external agencies.
- Trend and analyse service level clinical data to improve client experience and outcomes of treatment.

11. Standard 6

Transfer of care

When a client is discharged or transferred, a detailed transfer of care summary is provided to the client and all relevant ongoing care providers. It will provide a comprehensive summary of all the treatment provided, outcomes and ongoing treatment needs with a focus on client safety. The process should facilitate access to a range of professionals and agencies, as required.

Transfer of care, including discharge, is a process of identifying and documenting a client's needs which includes information regarding engagement in treatment, relapse prevention and harm reduction information, as appropriate.

Transfer of care may be required at any time throughout the client journey in the AOD health system and may occur:

a. between treating clinicians or service providers
b. to other AOD community based services and agencies
c. on completion of the agreed treatment plan
d. to a client's own care.

A discharge summary is a tool to support communication in the transfer of care. The primary focus of these elements is upon transfer of care at the time of discharge from the AOD service.

Elements

1. Planning transfer of care is a process that is ongoing throughout the treatment encounter in partnership with the client. Where possible this includes jointly developing the discharge summary.
2. At the time of discharge from an AOD service, discharge summaries are sent to the appropriate stakeholders (e.g. client, referrer, primary care providers, health or other relevant care providers), as identified in the care plan.
3. Transfer of care is timely, and discharge summaries are completed as soon as practicable, preferably within 1 week of discharge.
4. Discharge summaries contain the following information:
   a. A description of the reason for presentation to the AOD service.
   b. The treatment provided by the AOD service during the treatment encounter including key timeframes if appropriate.
   c. For clients who are prescribed or dispensed medication by the service during the encounter, the following should be included, as a minimum:
      - a list of the medications prescribed or dispensed by the AOD service, that are current at discharge
      - changes made to medications by the AOD service
      - the ongoing plan for these medications
      - a statement noting that the client may be on other medications.
   d. How the client responded to treatment, including progress on goals, the new skills or understandings developed, and a description of quantitative outcome scores if relevant.
   e. A summary of current and ongoing concerns, risks, strengths and protective factors; and plans to monitor and address these which includes who is responsible.
   f. Recommendations for ongoing care needs, including the option to return to the AOD service in the future.

Standard 6 – What this standard means in practice for:

Clients

Before treatment at a service is ceased, the treating clinician will discuss with the client and any support people identified by the client, their ongoing management plans and the supports that they will need.

The plan will set out the client's goals for maintaining their wellbeing and prevent complications from any health, social and wellbeing matters that they may have developed. It will include ways that they can continue to work towards or maintain goals regarding their substance use, including to reduce the risk of relapse. The plan will describe any ongoing counselling, support and or medical intervention that may be required. The treating clinician will provide the client with information on community resources and other avenues for community support. The client is to be involved in the development of this plan, in a format that is easily understood, and be offered a copy. The client's general practitioner (GP) and other ongoing clinical providers will get a copy of the plan, with the client's permission.

If the client chooses to discontinue treatment early, they are to be given information that will support them in any ongoing support that they may require.

Clinicians

Discharge from service

Post-treatment goals should be identified with the client throughout the treatment process. Before the client leaves the service, their care plan is to be updated to include post discharge strategies including any self-management actions required. A copy of the updated care plan should be offered to the client when treatment is terminated.

Coordinate the provision of a discharge summary to the client's GP and any other ongoing clinical providers, as agreed to by the client.

Transfer of care between treating clinicians and service providers

This may occur at any point in the client journey. If on discharge from a treatment service, all elements of discharge planning should apply.

If there is transfer of care between clinicians or health care providers (within the same health district) a clinical handover is to be provided. As clinical handover is a routine process, it can be improved by the use of tools and techniques that standardise the process, while leaving room for situational variation. It is recommended that **ISBAR** is used as a communication tool for clinical handover.[15]

- **I**ntroduction
- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

Unplanned cessation of treatment

There are many reasons why clients may cease treatment prior to completion of their treatment plan. Under these circumstances, the aim is to maintain engagement with the client and ensure that they are aware of:

- opportunities to re-engage with services, as required
- strategies to manage and reduce health risks or harms with any continued substance use
- information to access alternative treatment services, community support and resources.

When discharges are unplanned, the client should be given appropriate information and advice to maintain their wellbeing as outlined in *The Standards.*

Treatment services

- Ensure clinicians are suitably qualified and competent in transfer of care processes and documentation.
- Ensure systems are in place so clinicians can:
  - readily access community support and referral information
  - develop an individualised care plan with the client prior to discharge
  - link easily to ongoing care providers and other agencies who will support the transition of care.
- In treatment services with an integrated treatment model, develop processes for a clinician to identify the clinician developing the discharge plan, and processes to ensure the correct information is included in the discharge summary for all components of the treatment provided.
- Ensure systems support clinicians in providing the discharge summary/plan to the client's GP and other ongoing clinical providers.
- Ensure clinicians are orientated to discharge processes and pathways of care, and adhere to defined timeframes.

APPENDIX A

Proposed measures

The AOD Treatment Clinical Care Standards Working Group has developed a set of measures to support clinical teams and treatment services to identify and address areas that require improvement at a local level. While these are not mandatory requirements, the monitoring and implementation of *The Standards* is a quality improvement process and will assist services in meeting some of their accreditation requirements. Measures need to be aligned to models of care.

Standard	Measure
Intake	i. The proportion of clients registered with a specialist AOD treatment service who have an AOD intake form completed on the day of registration.
Comprehensive assessment	i. The proportion of AOD clinicians who have been assessed as competent in conducting comprehensive assessments. ii. The number of days between intake (date of registration) and the comprehensive AOD assessment within a specialist AOD treatment service. iii. The proportion of encounters with a comprehensive assessment. iv. A measure of the quality of the comprehensive assessments (method of measurement to be determined).
Care planning	i. The proportion of AOD clinicians who have been assessed as competent in collaborative care planning. ii. The proportion of clients registered with a specialist AOD treatment service who have a collaborative care plan. iii. A measure of the quality of the collaborative care plan (method of measurement to be determined).
Identifying, responding to, and monitoring of risk	i. The proportion of clients who are screened at assessment for: – risk of harm to self or others – child wellbeing – domestic violence.
Monitoring treatment progress and outcomes	i. The proportion of AOD clinicians who have been assessed as competent in monitoring treatment progress and outcomes. ii. The proportion of clients registered with a specialist AOD treatment service who have an initial and subsequent ATOP or alternative standardised clinical review or outcomes measurement.
Transfer of care	i. The proportion of AOD clinicians who have been assessed as competent in transfer of care processes and documentation. ii. The proportion of clients registered with a specialist AOD treatment service who have a transfer of care/discharge summary. iii. A measure of the quality of the transfer of care/discharge process and documentation.

APPENDIX B
Readiness Toolkit

Readiness Toolkit

Clinical Care Standards: Alcohol and Other Drug Treatment

Table of Contents

INTRODUCTION

Purpose 26
How to use this Toolkit 26

SERVICE REVIEW CHECKLISTS

CHECKLIST 1: IMPLEMENTATION 27
CHECKLIST 2: OPERATIONAL 28
CHECKLIST 3: STANDARDS 30
Checklist: Standard 1 30
Checklist: Standard 2 30
Checklist: Standard 3 31
Checklist: Standard 4 31
Checklist: Standard 5 32
Checklist: Standard 6 33

Purpose

The Readiness Toolkit has been developed to assist service providers to support the implementation of the Clinical Care Standards (CCS) for Alcohol and other Drug (AOD) Treatment at a local service level.

How to use this Toolkit

This Toolkit has a range of checklists to support implementation in individual and networked AOD treatment services.

- CHECKLIST 1 is tailored to ensure that the standards are introduced and there is consistent knowledge, commitment and use of the standards to guide practice.
- CHECKLIST 2 has been designed to ensure a systematic approach to the operation of the standards in each service.
- CHECKLIST 3 outlines the requirements of the six core standards and should be used in context of:
  - identifying evidence where current practice meets the standard
  - quality improvement initiatives that will support the service to fully implement practice aligned to the standards.

Completing the implementation guide and checklists will:

- guide communication and strategies to implement standards
- support service managers to align operations to the requirements of the standards
- give service managers and clinicians a better understanding of how the service is currently connecting and delivering quality person-centred care across the range of treatment programs and services
- guide workforce development strategies and
- guide measurement of outcomes in service delivery.

Local services are encouraged to use this guide to support practice change and share learnings with each other. NSW Health has set up a mailbox to link service providers to support for implementation. Do not hesitate to contact on:

MOH-clinicalcarestandards@health.nsw.gov.au

CHECKLIST 1: Implementation checklist

Objective	Actions	Y/N	Improvement strategies	By: Whom /When
Accessibility	• CCS are circulated and made available online at each AOD treatment service.			
Commitment	• CCS are part of the framework for clinical governance and risk management within the service. • Service outcomes are measured and aligned to standards. • Quality improvement initiatives are aligned to improving adherence to CCS.			
Communication	• New employees are introduced to CCS as part of orientation. • Current employees are introduced to CCS through regular communication channels and staff forums. • CCS are discussed in clinical practice and review meetings as a benchmark for practice.			
Workforce development	• Services adapt core processes of care and CCS into existing education and workforce development initiatives. • Performance reviews identify areas for practice improvement in line with CCS.			
Local engagement and ownership	• AOD treatment services and teams use CCS Toolkit to identify areas for clinical and system improvements. • AOD treatment services identify local champions to support implementation of CCS.			
Local implementation and monitoring	• Local initiatives are implemented and monitored within current quality improvement work plans. • Outcomes of improvements are documented and reported through local governance structures.			

CHECKLIST 2: Operational system checklist

Operational requirements	Y/N	Improvement strategies	By: Whom / When
Standard 1: INTAKE Systems are in place to support: • prioritisation and transition of client from intake to comprehensive assessment • client engagement. Risk management pathways are in place and support escalation to immediate care and support, as required. Heath staff: • understand health information privacy responsibilities • attending to intake are suitably qualified and have appropriate training and support.			
Standard 2: COMPREHENSIVE ASSESSMENT Systems are in place to support: • ongoing engagement of clients waiting for treatment • identification of risk • effective referral and transfer of care, as required. Health staff: • are trained and competent in assessment, risk management and formulation • have systems and resources in place to facilitate documentation • have working knowledge of pathways for escalation and transfer of care • have documented local protocol in place, which identifies when a client may not need an assessment aligned to the key elements of this standard • document and link all decisions to an appropriate clinical governance framework.			
Standard 3: CARE PLANNING Systems and resources are in place to: • facilitate documentation of care plans and monitoring of outcomes • support clinicians to facilitate care and meet requirements of this standard. Health staff: • are competent in all elements of developing and documenting a care plan • systematically review care plans to ensure they reflect and adapt to changing client circumstances.			
Standard 4: IDENTIFYING, RESPONDING TO, AND ONGOING MONITORING OF RISK Systems and pathways are in place to: • document, report, monitor and track clinical incidents • support escalation of care. Health staff: • are trained and competent in identification, management and appropriate documentation of client risks • advise clients of risks and integrate strategies for mitigating risk into all processes of care • are orientated to their accountabilities.			

Operational requirements	Y/N	Improvement strategies	By: Whom / When
Standard 5: MONITORING TREATMENT PROGRESS AND OUTCOMES Systems are in place to: • undertake regular clinical review of all clients • receive and trend client feedback and measures of client experience • ensure treatment outcomes are regularly monitored (e.g. every 3 months at a minimum), reviewed with client, and incorporated into treatment care plans • ensure clinicians are suitably qualified and competent in the use of structured measurement tools used by the service to monitor outcomes • audit clinical practice and monitoring tools (e.g. through ATOP or other measures) • trend and analyse service-level clinical data to improve client experience and outcomes of treatment • ensure workforce has sufficient resources to effectively reflect on individual treatment outcomes. Local protocols are in place to facilitate case review and coordinated case management within AOD treatment settings and with relevant external agencies.			
Standard 6: TRANSFER OF CARE Health staff are: • orientated to transfer of care processes • aware of their accountabilities in facilitating effective transfer of care and provision of discharge summaries • suitably qualified and competent in transfer of care processes and documentation. Systems are in place so clinicians can: • readily access community support and referral information • develop an individualised care plan with the client prior to discharge • link easily to ongoing care providers and other agencies who will support the transition of care. Operational systems are in place to: • ensure effective clinical handover on transfer to another service • support development of discharge summaries and dissemination to client, GP and others as identified in the care plan in a timely manner • monitor timeframes for discharge processes, summaries and connection to referring agencies.			

CHECKLIST 3: Standards checklist

Standard 1: INTAKE

A person seeking information or treatment for alcohol and other drug use will have access to advice, referral and appropriate treatment options

Elements	Y/N	Actions or Evidence	By: Whom/When
In the intake interview the following core information is collected: a. Caller details b. Referral agent details c. Reason for referral d. AOD use e. Current and previous AOD treatment f. Risk and safety assessment, including risk of harm to self and others and high priority risk areas g. Medical and mental health issues h. Additional criteria for consideration for priority access to treatment.			
Processing intake information: a. Urgent or crisis issues are routinely identified b. Significant risks are identified and an immediate and active referral is made to the appropriate service c. All intakes are assigned an assessment priority d. Information and resources are tailored to individual needs e. Referral for assessment is facilitated and booked, as appropriate f. Timeframes for client assessments are based on the overall priority level identified at the completion of the intake interview g. Pathways are in place for ensuring high priority clients are offered the earliest available assessment h. There is monitoring of time from intake to assessment i. Referrers are notified of the outcomes of the intake assessment.			

Standard 2: COMPREHENSIVE ASSESSMENT

A client presenting to an alcohol and other drug service will have a comprehensive assessment that informs treatment needs and planning

Elements	Y/N	Actions or Evidence	By: Whom/When
Comprehensive AOD assessment contains: a. The reason for presenting to the service b. A record of all psychoactive substances used in the past 28 days c. A record of all psychoactive substances used in the past 3 days d. A record of any other AOD treatment the client is currently participating in e. A record of whether there are any concerns with the client's social situation, mental health, and physical health and whether they would like any assistance from the treatment service f. Identification of risks that include those relating to the client's personal characteristics and circumstances, behaviours and the substances used g. A formulation h. An initial treatment plan for management of substance use and associated issues.			

Standard 3: CARE PLANNING *A client in alcohol and other drug treatment will be engaged in collaborative care planning to develop a comprehensive care plan which is tailored to their individual goals and needs*			
Elements	**Y/N**	**Actions or Evidence**	**By: Whom/When**
The care plan is developed and documented in collaboration with the client, and where relevant their carers/friends/family and other service providers.			
The care plan identifies: • Any issues or concerns • Client goals • Actions to be taken • Persons responsible and review time frames for the following domains: substance use, mental health, physical health, psycho-social, cultural, socio-economic, legal, or other related problems of concern to the client.			
The client is offered a copy of the plan and the communication and dissemination of the care plan is discussed with the client.			

Standard 4: IDENTIFYING, RESPONDING TO AND ONGOING MONITORING OF RISK *A client entering alcohol and other drug treatment will have substance use related risks identified, responded to and monitored throughout treatment*			
Elements	**Y/N**	**Actions or Evidence**	**By: Whom/When**
Identifying and responding to risk is an ongoing process and is completed at: • the initial assessment • periodically throughout treatment • at discharge or transfer of care.			
The frequency of planned review is determined by treatment type and clinical judgement, but not less than every 3 months and is documented in the care plan.			
The service has a system for: • identifying and maintaining updated documentation of client risk levels • the use of standardised and structured approaches to risk monitoring, which include but are not limited to monitoring of core and non-core risks as outlined in the standard.			
The service has a system for identifying and maintaining updated documentation of client risk levels which informs follow up procedures in the event of appointment non-attendance.			
Risks are addressed in care planning and are reviewed within the agreed timeframes. Refer to standard for the use of structured clinical tools in risk monitoring (e.g. ATOP).			

Standard 5: MONITORING TREATMENT PROGRESS AND OUTCOMES *A client is engaged in ongoing alcohol and other drug treatment monitoring, that provides opportunity for joint reflection on progress and priorities, and to inform ongoing care planning*			
Elements	**Y/N**	**Actions or Evidence**	**By: Whom/When**
Monitoring treatment progress and outcomes is an ongoing process.			
Structured measurements of AOD-specific (e.g. ATOP, Severity of Dependence Scale [SDS]) and general health measures (e.g. Kessler 10 (K10), PROMIS, EUROHIS Quality of Life Scale 8 [EQoL-8]) and, investigations (e.g. Urine Drug Screens [UDSs], liver function tests, breath alcohol measurements) are: • incorporated at initial assessment • repeated periodically when appropriate throughout treatment • performed at discharge or transfer of care.			
Measurement of treatment progress coincides with and informs care plan review.			
The frequency of review is determined by treatment type, risk factors and clinical presentation, and occurs at least every 3 months.			
There are regular clinical reviews to assess ongoing risks and suitability of the treatment plan. The type, frequency and membership of clinical reviews are in accordance with the client's clinical needs, care plan and risk issues.			

Standard 6: TRANSFER OF CARE *When a client is discharged or transferred, a detailed transfer of care summary is provided to the client and all relevant ongoing care providers. It will provide a comprehensive summary of all the treatment provided, outcomes and ongoing treatment needs with a focus on client safety. The process should facilitate access to a range of professionals and agencies, as required*			
Elements	**Y/N**	**Actions or Evidence**	**By: Whom/When**
Planning transfer of care is a process that is ongoing throughout the treatment encounter in partnership with the client. Where possible this includes jointly developing the discharge summary.			
At the time of discharge from an AOD service, discharge summaries are sent to the appropriate stakeholders (client, referrer, primary care providers, health or other relevant care providers), as identified in the care plan.			
Transfer of care is timely, and discharge summaries are completed as soon as practicable; preferably within 1 week of discharge.			
Discharge summaries contain the following information: a. A description of the reason for presentation to the AOD service. b. The treatment provided by the AOD service during the treatment encounter including key timeframes if appropriate. c. For clients who are prescribed or dispensed medication by the service during the encounter, the following should be included, at a minimum: • a list of the medications prescribed or dispensed by the AOD service, that are current at discharge • changes made to medications by the AOD Service • the ongoing plan for these medications • a statement noting that the client may be on other medications. d. How the client responded to treatment, including progress on: • goals and problems • the new skills or understandings developed • description of quantitative outcome scores if relevant.			
ADDITIONAL SYSTEMS TO SUPPORT TRANSFER OF CARE • Post-treatment strategies are outlined in an updated care plan and given to the client • The ISBAR Tool is used when transferring care between clinicians and service providers (refer to standard) • When treatment is ceased by the client (unplanned) there are systems to ensure the client is aware of: – opportunities to re-engage with services, as required – strategies to manage and reduce health risks or harms with any continued substance use – information on accessing alternative treatment services, community support and resources.			

APPENDIX C

Glossary

TERM	DEFINITION
Alcohol and or other drug (AOD) use disorders	The presence of an alcohol or other drug use disorder is defined by DSM-5. The term is used interchangeably with 'substance use disorders' and includes the use of alcohol, benzodiazepines, cannabis, methamphetamines, cocaine and other stimulants, hallucinogens; heroin and other opioids; inhalants and tobacco.[16]
AOD treatment settings	Specialised services that are specifically designed for the treatment of AOD problems and include, but are not limited to, facilities providing inpatient or ambulatory withdrawal management, residential rehabilitation, maintenance pharmacotherapy treatment for opioid and alcohol dependence, counselling, support and case management services. These services may be in the government or non-government or private sector.[16]
AOD clinicians	All those who work in AOD treatment settings in a clinical capacity. This includes, but is not limited to, nurses, addiction medicine specialists, medical practitioners, psychiatrists, psychologists, counsellors, social workers, occupational therapists, pharmacist and other AOD workers.[16]
ATOP	The Australian Treatment Outcome Profile (ATOP) is a client reported assessment tool used to capture substance use, risk factors, health and wellbeing in the last 4 weeks at assessment and treatment review. This snapshot of clinical information is used for risk identification, care planning, treatment monitoring, and outcome measurement.
Clinical review	Clinical review is a multidisciplinary case review meeting to review the treatment progress and plans of clients currently in treatment. The frequency of review is determined by a range of criteria including risk, time in treatment, complexity and clinician concerns.
Comorbidity	In the context of alcohol and drug treatment, refers to a person who has coexisting substance use and mental health diagnosis[16] or substance use and other medical conditions.
EUROHIS Quality of Life Scale 8 (EQoL-8)	The World Health Organisation Quality of Life 8 questions (WHO QoL-8, also known as the EUROHIS QoL-8) was designed for use as a very short and concise quality of life instrument. The EUROHIS QoL-8 is a broad domain based measure that has applicability across the range of program types in the NGO drug and alcohol sector in NSW.[18]
ISBAR	ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the communication of critical information.[15]
Kessler 10 (K10)	The Kessler Psychological Distress Scale-10 (K10) is a scale of non-specific psychological distress. It was developed by Professors Ron Kessler and Dan Mroczek, as a short dimensional measure of non-specific psychological distress in the anxiety-depression spectrum, for use in the US National Health Interview Survey.
Opioid Treatment Program (OTP)	A program to provide pharmacotherapies for opioid dependent people, such as methadone maintenance or buprenorphine maintenance.[17]
OTP case flagging	A system of flagging client needs in relation to treatment intensity as outlined in the NSW Clinical Guidelines: Treatment of Opioid Dependence – 2018.[17]
Severity of Dependence Scale (SDS)	The SDS is a brief five-item screening measure of psychological aspects of dependence. The items are specifically concerned with an individual's feelings of impaired control over their drug taking and with their preoccupations and anxieties about drug taking. SDS scores range from 0-15 with higher scores indicating a higher level of dependence.[18]

APPENDIX D

Supporting documents

Refer and respond to care in line with relevant NSW Health clinical guidelines and policies which may include but is not limited to:

- GL 2008_011 Drug and Alcohol Withdrawal Practice Guidelines *(under review)*
- GL 2014_022 Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period
- GL 2018_019 NSW Clinical Guidelines: Treatment of Opioid Dependence
- GL 2008_009 Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines *(under review)*
- PD 2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health
- GL 2010_004 SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants
- PD 2020_010 Recognition and Management of Patients who are Deteriorating
- PD 2019_034 Incident Management Policy
- PD 2015_043 Risk management – Enterprise-Wide Risk Management Policy and Framework

A number of NSW Health guidelines and practice policies are currently under review at the time of writing these standards. Links to all current NSW Health Guidelines and Services can be found on the NSW Ministry of Health website.

The practices outlined in *The Standards* will support services to implement the National Quality Framework for Drug and Alcohol Treatment Services. This framework sets a nationally consistent quality benchmark for providers of drug and alcohol treatment services. It includes strong clinical governance requirements and a list of accreditation standards that drug and alcohol specialist treatment service providers must meet. The National Quality Framework is available from the Department of Health website.

APPENDIX E

Resources

YOUNG PEOPLE

- Youth Health and Wellbeing Assessment Guidelines, NSW Health.
- Working with Aboriginal and Torres Strait Islander Young People, Dovetail, QLD.
- Youth Support and Advocacy Service (YSAS).

HEEADSS ASSESSMENT

- Adolescent Health GP Resource Kit (link).

LESBIAN, GAY, BI-SEXUAL, TRANSGENDER AND INTERSEX

- ACON pride training and other resources including Language Guide.

PREGNANCY

- Health Education Training Institute (HETI) module: Antenatal Care for Alcohol Consumption During Pregnancy.
- Australian Government, Department of Health. Pregnancy Care Guidelines, 2019.
- SAFE START Strategic Policy.
- NSW Family and Community Services. Child Deaths 2014 Annual Report – Learning to improve services, 2014.
- National Health and Medical Research Council (NHMRC). Infant Feeding Guidelines: information for health workers, 2012.

MENTAL HEALTH

- Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings, 2018.
- Suicide Assessment Kit, National Drug and Alcohol Research Centre, 2012.

ABORIGINAL PEOPLE

- Breaking the Ice – Managing 'Ice' in the Family for Aboriginal Communities, (YourRoom, NSW Health).
- Healthy Spirit, Healthy Community. A Guide to Drugs and Alcohol within our Community (YourRoom, NSW Health).
- Australian Indigenous HealthInfoNet – Alcohol and Other Drugs Knowledge Centre.

CALD

- Working with diversity in alcohol and other drug settings, Network of Alcohol and other Drugs Agencies, 2014.
- Drug and Alcohol Multicultural Education Centre (DAMEC).

TRANSLATED RESOURCES ON YOURROOM WEBSITE

Please see below a list of translated resources on the NSW Health Your Room website:

- Alcohol Drugs Facts Booklet (in English)
- Alcohol Drug Facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Benzodiazepines Drug Facts – (English only)
- Breaking the Ice – Crystalline Methamphetamine Use in the Family (in English, Arabic, Vietnamese)
- Breaking the Ice – Harm Reduction
- Breaking the Ice – Treatment (in English, Arabic, Vietnamese)
- Breaking the Ice – Withdrawal (in English)
- Cannabis Drug Facts – (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Cocaine Drug Facts – (English only)
- Ecstasy Drug facts – (English only)
- Family Matters (in Arabic, Bosnian, Chinese, Croatian, English, Khmer, Korean, Lao, Macedonian, Punjabi, Russian, Serbian, Spanish, Thai, Turkish, Vietnamese)

- Fentanyl Drug facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- GHB – (English only)
- Hallucinogens – (English only)
- Heroin – (English Only)
- Inhalants – (English only)
- Ketamine – (English only)
- Methamphetamine (speed and ice) drug facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Nitrous Oxide Drug Facts (in Arabic, Chinese Traditional, Chinese Simplified, Hindi)
- Synthetic drugs – (English only)

DRUG & ALCOHOL SPECIALIST ADVISORY SERVICE (DASAS)

DASAS is a free telephone service (7 days/week, 24 hours/day) for health care professionals.

Sydney metropolitan (02) 9361 8006

Regional and rural NSW 1800 023 687*

* Please note: free call numbers are not free from mobile phones, except Telstra mobiles.

If you are worried about complexities in the client or person presenting to you, this is the opportunity to get advice and guidance immediately.

GENERAL RESOURCES

1. NSW Health has a range of publications and clinical guidelines on their website to guide practice.
2. NADA has a range of resources, publications and webinars on their website which support practice in the AOD sector.

APPENDIX F

References

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