ALCOHOL AND OTHER DRUG (AOD) SERVICES – MODEL OF SERVICE (COMPANION DOCUMENT)

Queensland Health

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For more information contact:
Mental Health Alcohol and Other Drugs Branch, Department of Health, PO Box 2368, Fortitude Valley BC, QLD 4006, email ED_MHAODB@health.qld.gov.au, phone 3328 9538.

An electronic version of this document is available at
http://qheps.health.qld.gov.au/mentalhealth/

Contents

Purpose of this document

This model of service aims to provide a detailed description of the alcohol and other drug (AOD) services within the Queensland public health service system, located within Hospital and Health Services' (HHS). The model of service describes the target population for public AOD treatment, as well as the functions, operation and governance of the service. It also includes hyperlinks to resources that inform AOD practice including policy, standards, protocols and guidelines.

This model of service draws upon the following documents:

1. Queensland AOD Treatment Services Delivery Framework (2015)
2. Queensland Health Clinical Services Capability Framework v3.2 (2016)
3. Suite of 5 x AO3 posters depicting Queensland AOD Sector (2016)

The AOD sector seeks *"The provision of effective, evidenced-informed prevention, treatment and harm-reduction responses that build a Queensland community with the lowest possible levels of alcohol, tobacco and other drug related harm"* (MacBean et al, 2015).

This document is a companion document to the suite of 5 AO3 posters describing the Queensland AOD sector and seeks to complement and support the delivery of high quality and safe AOD services by providing information that allows greater transparency about public AOD services for clients, families, significant others, service partners, staff, managers and service planners. The document contents are sourced from reference documents, broad consultation and expert opinion from staff, service users and families and significant others. The document does not replace clinical judgement or Hospital and Health Service specific patient safety procedures.

The intended outcome of the development and implementation of the model of service is:

- the delivery of safe, high quality, integrated, and evidence driven AOD care
- improved knowledge of how to access and navigate through AOD services
- a client and carer centred, recovery-based continuum of care
- a more informed and supported AOD workforce
- enhanced supervision of the clinical and non-clinical workforce
- increased knowledge and understanding of other service components
- consistency and streamlining of service delivery across public AOD services in Queensland
- enhanced service development, evaluation and review
- stronger service partnerships.

1. What does the service intend to achieve?

Specialised AOD treatment services in Queensland public health settings aim to provide people with a range of accessible client-focused and evidenced based AOD interventions to reduce harms to individuals, families and the community.

This includes the provision of comprehensive, specialised and effective multidisciplinary AOD assessment and treatment services.

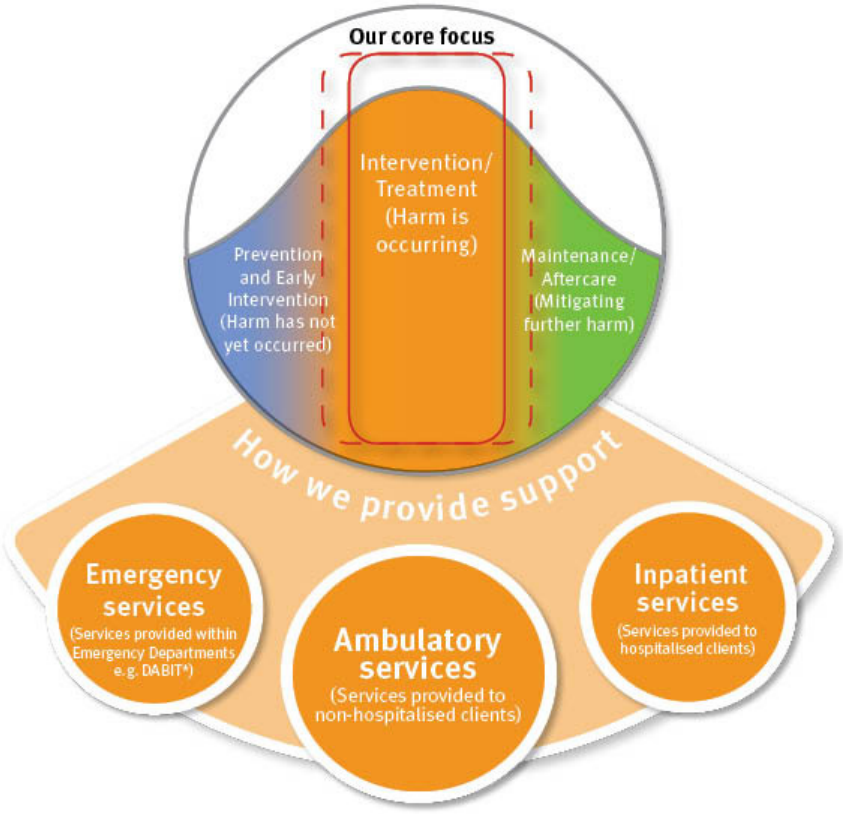
As detailed in the Queensland AOD Treatment Service Delivery Framework (2015) the full spectrum of AOD services encompass three main components:

1. Prevention and early intervention
2. Intervention / Treatment
3. Maintenance / Aftercare

HHS AOD services exist within the spectrum of integrated mental health, alcohol and other drug and other health services. While many individuals' will continue to access mainstream services, expertise is required in the assessment, diagnosis, monitoring and treatment of people who have significant substance use disorders that requires specialist intervention.

These services are provided within a harm minimisation approach that emphasises individual strengths, building resilience and enhancing opportunities for social inclusion.

The primary role of an HHS AOD service is to focus on the intervention / treatment phase, as this is where harm most significantly occurs. In terms of prevention and early intervention and maintenance / aftercare the HHS AOD service will generally be collaborating with partners, except where the local service system is unable to support community needs in which case the HHS will lead the delivery of services as available.



The Queensland Health AOD services module CSCF v3.2 defines the broad services areas generally applicable to HHS AOD services and details minimum criteria requirements within each specific service area. These service areas are defined as follows:

Ambulatory services – those services delivered to non-hospitalised clients and may include services at outpatient clinics, day programs, and Queensland Health community based AOD services including specialist AOD service areas such as the Needle and Syringe Program (NSP), sexual health, immunisation services; screening, assessment and brief interventions; pharmacotherapy programs; substance withdrawal; and psychosocial interventions.

Emergency services – those services delivered to clients presenting via emergency departments, with key features of the service including, but not limited to:

- Appropriate mechanisms to assist in the identification and management of people at risk of harm, and/or those experiencing substance use related harm
- Access to specialist advice on problematic substance use
- Processes to refer clients experiencing problematic substance use into appropriate treatment and/or care options

Inpatient AOD services – those services both acute and non-acute delivered to hospitalised clients, either on an elective or emergency basis. This may include planned inpatient withdrawal or unplanned emergent withdrawal, as well as consultation liaison services within general and specialist hospital inpatient units.

The key functions of an HHS AOD service include:

- the assessment and screening of a wide range of clients, including those with complex and unclear aetiology;
- provision of support for primary care and other providers, solo workers and/or small teams to undertake comprehensive AOD assessments, via consultation and liaison service provision;
- provision of expertise for the community, in the assessment, diagnosis, monitoring and treatment of people who may have a substance use issue or disorder, or comorbid AOD and mental health issues;
- provision of service delivery that is as convenient as possible to the individual or those affected by individuals experiencing significant AOD issues;
- to ensure ease of accessibility, in a timely manner, to specialist AOD interventions;
- arranging, co-ordinating and supporting access to a range of services for individuals affected by substance use issues, to ensure seamless service provision; and
- exploring and providing a range of suitable interventions in conjunction with a range of core partners.

The HHS AOD service functions go towards:

- assisting to reduce the client's levels of harmful substance use;
- assisting to reduce the client's, family and/or significant others' and communities' experience of AOD related harm;
- building the client's capacity to better understand and manage their own health and wellbeing;
- supporting clients, families and significant others across the broad continuum of care, including facilitating smooth transition to other appropriate services when appropriate;
- provision of harm reduction strategies and options;
- decreasing stigma and discrimination within the local community as well as reducing barriers to social inclusion;

- providing high quality, outcome-focussed care to people who have a substance use issue or disorder; and
- working with older people to develop their personal support systems and to live within their community.

The HHS AOD service will be able to:

- provide information, advice and support to families and significant others;
- deliver specialist AOD screening, triage and assessment through consultation liaison by HHS AOD service staff with mental health, primary health, community based services and other services;
- provide specialised AOD assessment and management plans that contain a comprehensive multi-factorial risk assessment;
- deliver AOD health promotion, prevention and early intervention programs;
- establish effective, collaborative partnerships with internal health services/teams (e.g. mental health), local health services/teams, external service providers (e.g. GPs and NGOs) and community groups;
- establish a detailed understanding of local resources for the support of individual's directly and indirectly affected by substance use;
- appropriately involve individual's and their families and /or significant others in all phases of care and support them in their navigation of the AOD system;
- provide culturally capable AOD services to Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse (CALD) clients;
- convey hope, optimism and education in the management of substance use issues and harm reduction to clients, their significant others and the wider community; and
- promote and advocate for improved access to general health and the primary health networks for people with experiencing problems related to substance use.

2. Who is the service for?

HHS AOD services work with individuals who are directly or indirectly affected by their own or another's AOD use. Overall, they provide clients with access to a comprehensive AOD assessment and a range of specialist interventions, in partnership with the broader AOD sector.

The HHS AOD services are funded and staffed to provide services to clients of all age groups, with specialist programs funded in specific areas [e.g. Hospital Alcohol and Drug Services (HADS) at Royal Brisbane and Women's Hospital; Alcohol and Drug Information Services (ADIS); and Indigenous, youth (ADAWS; Hot House) and homelessness-specific teams in certain areas].

3. HHS AOD treatment types

HHS AOD services work both with individuals, as well as with family and significant others, as appropriate. The primary role of an HHS AOD service is to focus on the intervention / treatment phase, as this is where harm is most likely to be occurring acutely.

The core treatment types of HHS AOD services are defined in Table 1.

Table 1: HHS AOD Treatment Type Definitions

Treatment Type	Definition
Information and education	No treatment or intervention provided other than the provision of information and education
Intake, Triage and Assessment	A process to determine if engagement with a client is appropriate based on their needs, what treatment and support options are available in the service system, whether the client is voluntary or coerced and whether the client has additional needs related to their age, ability, gender, sexuality or cultural background.
Withdrawal Management	The provision of medically assisted care for clients assessed as requiring an alcohol or other drugs withdrawal process.
Inpatient unplanned	The provision of withdrawal management when admitted as an emergency for acute severe withdrawal symptoms or other reasons into the inpatient setting (e.g., mental health, medical or surgical settings) when concurrent AOD withdrawal occurs.
Inpatient planned	The provision of a planned episode of 'high' level of withdrawal management. It is the preferred setting for those assessed as having a high risk of complex or severe withdrawal symptoms or co-morbidity.
Ambulatory (outpatient or home based)	The provision of short term withdrawal management or support to people who do not require, or no longer require, inpatient withdrawal management. Suitable for

	those assessed as suitable for withdrawal with low predicted withdrawal complexity but requiring medical intervention and supports. Outpatient programs are inclusive of individual and day based programs. Home based refers to occasions where staff are providing services in the home setting.
Psychosocial interventions	
Brief Interventions	A one-off structured intervention between 5 and 60 minutes in length, which involves a brief or basic assessment and provision of information and feedback.
Individual counselling	Establishment of a therapeutic relationship utilising a structured, intentional, conversational method to assist clients to identify and resolve personal, social or psychological difficulties.
Group Work	Structured groups for individuals seeking help with their AOD use, facilitated by clinicians, includes both therapeutic and psycho-education based groups.
Rehabilitation	Not provided in HHS AOD services
Residential	An intensive treatment program conducted in a residential setting typically offering a mixture of one-to-one, group and peer support work and team/community building processes. Includes Therapeutic Community programs that utilise the 'community as method' approach
Non-residential	An intensive AOD day program that provides an alternative to residential rehabilitation. Participants do not live on site, while completing the programs, so that connections with family, friends and community can be maintained throughout the rehabilitation period.
Medical Interventions	The provision of AOD related medical interventions including pharmacotherapies, withdrawal management (see above), BBV screening, vaccination and treatment, and medical assessment, intervention and referral for a range of physical and psychological conditions.
Medically Assisted Treatment for Opioid Dependence (MATOD)	Clinically supervised replacement of the opioid drug of dependence with a legally obtained, longer lasting opioid that is administered to reduce or eliminate withdrawal symptoms and cravings (e.g., buprenorphine and methadone)
Alcohol pharmacotherapies	The use of medication to support abstinence, moderated drinking, or harm reduction for individuals with alcohol dependence or harmful use.
Smoking cessation therapy	The administration of medications to reduce or eliminate withdrawal symptoms and tobacco craving.
Comorbidity screening, referral and management	Screening, intervention and referral of a range of comorbid presentations that required medical interventions (e.g., depression, anxiety, Hepatitis vaccination and management, chronic disease, persistent pain).
Consultation Liaison	Provision of advice and support to clients and health professionals at the interface between the AOD sector and the broader health sector, usually in hospital or community health settings.

Harm Reduction	
Primary needle and syringe programs	Provision of a full range of sterile injecting equipment alongside harm reduction interventions such as Blood Borne Virus (BBV), vein care, safe disposal and referral information.
Secondary needle and syringe programs	Provision of basic sterile injecting equipment only, distributed by non-NSP staff or through vending machines.
Naloxone provision	Provision and training in the administration of naloxone to opioid users as an overdose death prevention strategy.
Blood borne virus advice, screening and treatment	Provision of information and intervention regarding BBVs and available screening and treatment options
Peer Support and Education	Provision of support and education about AOD to individuals or groups by peers.
Forensic Services	
Police and/or court diversion programs	Provision of designated one –off assessment and brief intervention sessions for clients referred by Queensland Police or by a Queensland Magistrates Court via Queensland Court Referral (QCS) or QMERIT.
Services/programs for people involved in the criminal justice system	Provision of services or programs for those referred through the criminal justice system (e.g., prison programs, community corrections).

NOTE:
Evidenced informed AOD treatment and/or interventions incorporate treatment planning, review and outcome measurement.

4. What does the service do?

The key components of HHS AOD services are defined here. These components are essential for the effective operation of HHS AOD services.

Table 2: Key components and elements of an HHS AOD service.

4.1 Working with other service providers

Key elements	Comments
4.1.1 Strong partnerships will be developed with other local health and AOD service providers, general practitioners (GP's) and other relevant community support services.	This includes clear and regular contact and communication processes for all phases of client care. Memorandum of understanding (MOU) / formal agreements are developed where appropriate. Advice, education and support for staff from other services on AOD issues are provided. Joint assessment and planning for the development of programs, with a particular

Key elements	Comments
	emphasis on consultation and liaison services, to better meet client' needs. Services are provided in partnership with the client, family and significant others as well as a range of other government and non-government organisations (NGOs).
4.1.2 When more than one service provider is involved in service delivery, the HHS AOD service will initiate and participate in discussions regarding which service will adopt the role of lead agency.	
4.1.3 There will be active engagement with primary health care providers to meet clients' general health care needs.	Shared care arrangements with GP's are encouraged.
4.1.4 Larger HHS AOD teams, through formal linkages, provide external support and advice to solo workers and / or small teams.	
4.1.5 The HHS AOD services will engage the assistance of services for clients with specific sensory impairments, dual disability, language/communication barriers or cultural diversity issues.	Certain population groups require specific consideration and collaborative support by HHS AOD services. This includes people from Culturally and Linguistically Diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander people, people in rural and remote areas, prisoners, homeless people, people with disabilities, and families and significant others. Examples of potential sources of assistance and information for AOD services: Queensland Health interpreter services Indigenous psychological services Aboriginal and Torres Strait Islander cultural capability framework 2010-2033 http://www.damec.org.au/ http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/asylum-seeker-refugee-guide.pdf

Key elements	Comments
4.1.6 A strong partnership will be initiated and maintained with mental health services and dual diagnosis co-ordinators.	These partnerships will be supported by local protocols that: • enhance communication • promote shared planning and decision making; and • utilise an exchange of knowledge and expertise. The detection of mental health issues in this group will prompt specialist assessment of mental health, inclusive of risk and integrated care planning. http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/qh-dd-clinician-tool-kit.pdf

4.2 Referral, access and triage

Key elements	Comments
4.2.1 All new service referrals will be made to the HHS AOD services through a single point of entry.	Clear information regarding referral processes, including service entry criteria will be available to referrers. Referrals will generally be made during normal working hours directly to the relevant HHS AOD service. After hours' referrals only available within those services available outside of normal working hours (e.g. HADS, ADIS and DABIT) Referrals may come through self-referral / walk-ins; GP / primary health services; NGO / community controlled services; clients' social support network; other internal HHS services; across HHS AOD services; other government departments; and the court and law enforcement system.
4.2.2 Internal referrals can be made following initial screening and assessment by any part of the integrated mental health and AOD services.	
4.2.3 All referrals will be reviewed for assessment of needs and risk.	There will be a clear triage system for prioritisation of referrals based on risk, individual need and local capabilities.
4.2.4 Consideration is given to engaging the most suitable form of initial intervention,	This collaborative effort includes joint assessment and the specialist role in client

Key elements	Comments
such as primary care providers and NGOs prior to care by the HHS AOD service.	care, with a particular emphasis on consultation and liaison services by the HHS AOD service.
4.2.5 Outreach approaches will be utilised to enhance client access.	HHS AOD services utilise outreach approaches to locate and/or provide treatment to clients. Importantly, outreach is not an intervention in and of itself. Rather it is a non-agency based approach to working with clients in order to facilitate interventions.

4.3 Assessment

Key elements	Comments
4.3.1 Assessments will be prompt and timely.	
4.3.2 The assessment will cover the full bio-psycho-social continuum.	Team members undertaking the assessment will endeavour to look at the person's situation holistically. Assessments will examine the presenting problems, the person's social and cultural profile, as well as their functional, medical and mental health profile.
4.3.3 The initial assessment will include a measure of dependence, tolerance and any withdrawal symptomatology	
4.3.4 Assessment will involve input from key service providers, family and significant others where appropriate.	Consent to involve family and significant others will be sought in every case. Information sharing will occur unless a significant barrier arises, such as inability to gain appropriate lawful consent. Hospital and Health Boards Act 2011 – Part 7 Confidentiality Family Sensitive Practice: http://nceta.flinders.edu.au/nceta-workforce-development-resources/fs http://dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx
4.3.5 Engagement will occur with an Aboriginal and Torres Strait Islander	Where an Aboriginal and Torres Strait Islander AOD worker is not available, identification of

Key elements	Comments
AOD Worker or Hospital Liaison Worker (where available) to support and assist with the facilitation of a comprehensive assessment of identified and consenting Aboriginal and Torres Strait Islander clients.	an appropriate and recognised Aboriginal and/or Torres Strait Islander person maybe integral in addressing the cultural needs of the client. http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/abor-alcohol-drug-handbook.pdf http://dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx
4.3.6 Assessment will be guided by developmentally appropriate strategies for young people. Young people under 18 years must be assessed as 'Gillick Competent' before initiating treatment. Where possible, young people should be provided services in dedicated spaces away from older client groups to ensure maximum safety.	http://dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx
4.3.7 Physical and oral health must be routinely considered within an assessment.	All efforts will be made to ensure clients have a nominated GP and provide consent for sharing of information. Clients will be actively supported to access primary health care and health improvement. Potential physical health problems will be identified and discussed with the GP and/or dentist.
4.3.8 Assessment of the client's mental health status, inclusive of risk and history will be undertaken upon each presentation to the service.	Assessment settings need to be appropriate and time allocation adequate and sensitive to the individual Queensland Health dual diagnosis clinical guidelines Queensland Health dual diagnosis clinician toolkit
4.3.9 All assessment processes will be documented and integrated into a case formulation and treatment / care plan.	Clients will be an active participant in the development of their treatment / care plan.

Key elements	Comments
4.3.10 The outcome of assessments will be communicated to the individual and other stakeholders promptly.	Communication will occur in either writing or verbally with all services making a referral.

4.4 Clinical review

Key elements	Comments
4.4.1 All new referrals to the HHS AOD service will be reviewed and discussed at allocation.	All new assessments will be presented to enable appropriate allocation within the team The Team Leader or appropriate delegate will take responsibility for ensuring that assessments and management plans are documented clearly and that a process is in place to ensure that any onward referral is completed. All service providers involved will be considered, and where possible included, in care planning and review processes.
4.4.2 A formal case review for every client will be conducted by the multidisciplinary team (MDT) on a regular basis, frequency as determined by the team. Additional formal case reviews will be conducted where indicated, for example in the event of crisis, change of consumer goals or discharge.	The reviews will be of a multi-disciplinary nature and will be clearly documented in the clinical record. Changes in treatment throughout the course of care will be discussed, as required, by the team and actions will be agreed to and assigned to specific clinicians. All documentation will be recorded in the clinical record with reference to the initial care review summary.
4.4.3 Ad hoc formal case reviews will occur to address complex clinical issues and following a critical event, as required.	A case review will provide an in-depth review with a set agenda. All clinical discussions and notes from the review will be recorded in the clinical record. Outcomes from a case review will be communicated with all relevant stakeholders including client, significant others and key service providers, as appropriate.
4.4.4 All case reviews will be documented in the client's clinical record.	Actions will be agreed to and changes in treatment discussed by the team and recorded. Documented details to include date, time, author/s and contributing team members (name

Key elements	Comments
	and title), clinical issues raised, updated care plan, and those responsible for actions.

4.5 Clinical interventions

Key elements	Comments
4.5.1 All aspects of service will reflect the development of collaborative relationships between clients and staff.	The HHS AOD service will demonstrate a focus on strengths, connectedness, personal involvement, personal choice and empowerment and increasing confidence in accessing the system.
4.5.2 Clients will be supported to access a range of bio-psycho-social interventions and rehabilitation services which meet their individual needs.	Interventions will be based on harm minimisation principles. Multidisciplinary input will be provided to optimise client outcomes. Clinical interventions will demonstrate evidence informed practice. Interventions will include relapse prevention programs/techniques.
4.5.3 A range of service types will be available dependent on client presentation, choice and needs.	A range of therapeutic interventions are delivered by HHS AOD services. These interventions are tailored to the individual's needs.
4.5.4 Psychosocial interventions will range from brief intervention through to more specialised treatments (provided on an individual and/or group therapy basis).	These treatments will predominantly be provided in outpatient clinics and hospitals.
4.5.5 Medically Assisted Treatment for Opioid Dependence (MATOD) will be offered as per the Queensland Guidelines	https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/medicines/drugs-of-dependence/qotp-clinical-guidelines.pdf http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/matod-questions-answered.pdf
4.5.6 Withdrawal management interventions will be conducted as per the Qld Guidelines	http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/qld-alcohol-drug-withdrawal-cpg.pdf

Key elements	Comments
4.5.7 Medication will be administered, prescribed and monitored as indicated by clinical need and will involve shared decision making processes between the treating team and the client.	Antipsychotics and other psychotropic medication will be prescribed in accordance with Queensland Health clinical practice guidelines. Regular supervision and monitoring of oral medicines will be available. Strategies to improve compliance with medication regime must be in place. Monitoring of medication side effects will be routinely conducted.
4.5.8 Interventions to improve the physical health of clients will be routinely provided (BBVs etc).	All clients will receive information about physical health issues and screening for BBVs. Clients will be supported to access primary health care and health improvement services. All clients should be actively engaged with a GP and dental services.
4.5.10 Interventions should be conducted in a developmentally appropriate framework, identifying specific needs of the client. This may include, but is not limited to, the specific needs of young people, pregnant women and older persons as relevant.	Young People: http://dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx Women and Pregnancy http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/identifying-women-at-risk-atod.pdf http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/perinatal-substance-use-qcg.pdf Older persons http://nceta.flinders.edu.au/society/alcohol-and-drug-use-ageing-populations/
4.5.11 Education and information will be provided at all stages of contact with the service.	This will include a range of components (e.g. education/information about substance use, harm reduction strategies, rehabilitation options, the journey within the service, other care options, medications, support services, etc).
4.5.12 Evidence based psychological treatments will be available to clients.	Psychosocial interventions available will include cognitive behavioural therapy, motivational enhancement, mindfulness and acceptance and

Key elements	Comments
	commitment therapies.  AOD therapies.pdf The MDT will have the skills to provide the most appropriate clinical intervention, solution focussed problem solving and stress management activities.
4.5.13 Clients will be supported to access a range of bio-psycho-social interventions which address their individual needs. Efficacy of treatment and progress will be reviewed, at least every three months.	A range of evidence based intervention and techniques may be utilised to reduce the severity of symptoms of withdrawal and dependence.
4.5.14 Options to access evidence informed rehabilitation will be available according to individual needs.	This includes rehabilitation to gain skills for activities of daily living, including: personal care, home maintenance, community access, employment, and social skills. Referral pathways and options will be readily available.

4.6 Harm Reduction

Key elements	Comments
4.6.1 Measures to minimise the harms that a person may experience as a result of their substance use	Primary and secondary needle and syringe programs https://www.health.qld.gov.au/qnsp/ http://qheps.health.qld.gov.au/metrosouthmentalhealth/docs/preventative_team/qnsp-program-policy.pdf Information and education around areas such as safe use, vein care etc. Availability of naloxone, including training in peer administration.

4.7 Team approach

Key elements	Comments
4.7.1 A MDT approach will be provided.	Each client will be allocated a clinician. The majority of clinical cases will be known to the majority of team members. The client and significant others will be informed of the multidisciplinary model.
4.7.2 Clear clinical and corporate leadership will be provided for the team.	
4.7.3 Caseloads will be managed to ensure effective use of resources and to support staff to respond to referrals in an effective manner.	
4.7.4 Discipline specific skills and knowledge will be utilised as appropriate in all aspects of service provision.	

4.8 Case co-ordination

Key elements	Comments
4.8.1 Case coordination is an essential element of an integrated service delivery system, ensuring that each client is able to access the services they need, when they need it, and with one clinician accountable for enabling service provision.	Smaller HHS AOD services may provide short term case coordination in order to develop a care plan which can then be continued by a primary care provider.
4.8.2 All clients will have an assigned clinician.	Other key service providers involved in the client's care should also be identified in the clinical record.
4.8.3 GPs may provide primary consultations and participate in joint case management and development of a care plan.	In rural and remote areas, GPs are often the first point of contact and may have limited or no specialist AOD service contact. Specialist involvement may be provided directly in the local area or through outreach (fly/drive in/out), telehealth services or through a combination of these.

Key elements	Comments
4.8.4 The frequency of contact for clients will vary, dependent on assessed clinical need.	Capacity for increased frequency of contact (e.g. during the initial engagement period) will be built into the clinician's schedule. Frequency of contact may be reduced as part of discharge planning and as identified in the individual's treatment / care plan.
4.8.5 Effort will be made to assertively link clients into appropriate services where their care needs cannot be met by the HHS AOD service.	

4.9 Treatment / Care planning

Key elements	Comments
4.9.1 The AOD HSS clinician is responsible for the development, co-ordination and regular review of the treatment / care plan in consultation with the MDT and in collaboration with the client, their significant others and other service providers.	Review of the treatment / care plan will occur at regular intervals as part of the formal case review, or earlier if clinically indicated.
4.9.2 Every effort will be made to ensure that treatment focuses on the client's own goals.	Where conflicting goals exist (e.g. for clients receiving involuntary treatment through the forensic system) this will be clearly outlined and addressed in a way that is most consistent with client's goals and values.
4.9.3 An individual treatment / care plan is developed with each client.	Clients are strongly encouraged to have ownership of their treatment / care plans. Changes to the treatment / care plan will be discussed with the client and any other relevant stakeholders.
4.9.4 Treatment / care planning is undertaken in consultation with clients, their significant others, and in collaboration with other service providers.	

4.10 Continuity of care

Key elements	Comments
4.10.1 Clear information as to how to contact the service and other relevant supports across a 24 hour, 7 days a week period is provided to clients, significant others and referral sources.	This may be via the support offered via the ADIS 24/7 phone line. Team publications and relevant information documents will include this information from a broader perspective.
4.10.2 The client's treating or primary clinician will be identified in the clinical record. Communication will be maintained throughout HHS AOD service provision.	The process for sharing information will be explicitly documented for each case. Strategies to ensure continuity of care include good communication, co-ordination, collaboration, and continual reassessment between the MDT, the client, significant other, primary care providers and other providers of care. *Hospital and Health Boards Act 2011* – Part 7 Confidentiality Right to information and information privacy *Guardianship and Administration Act 2000*
4.10.3 If ongoing care is not required after initial assessment, the clinician who conducted the assessment will be responsible for effectively managing all associated communication and documentation processes.	All clients referred to the HHS AOD service will be reviewed by the team.
4.10.4 Contact frequency will be dependent on individual client need.	Capacity for increased frequency of contact (e.g. the engagement period) will be identified at allocation and on an ongoing basis at review.
4.10.5 A team response is provided for all planned interventions.	Provision of intervention occurs during the hours of service operation.

4.11 Transfer/transition of care

Key elements	Comments
4.11.1 Disengagement with a HHS AOD service will not occur until the receiving team/service has made contact and scheduled a first appointment with the client.	Procedures for internal transfers will be clearly written, and receiving teams will make strenuous efforts to establish contact within a reasonable time period for all involved. The time period will be individually determined at a local level between the referring and the receiving team/s.

Key elements	Comments
4.11.2 A written and verbal handover will be provided on every transfer occasion.	
4.11.3 Clients and their significant others will be informed of transfer procedures.	

4.12 Discharge/external transition of care

Key elements	Comments
4.12.1 Clients will be discharged promptly, dependent on the individual treatment / care, when they have graduated to needing less intensive care and have supports in place to manage in the community.	Discharge planning will be a routine component of each clinical review process, with the decision to discharge being at the discretion of the MDT.
4.12.2 The discharge plan will include a relapse prevention plan and service re-entry plan, given the chronically relapsing nature of substance dependence.	
4.12.3 Comprehensive liaison and handover will occur with all other service providers who will contribute to ongoing care. Ongoing service providers will be involved in discharge planning.	All clinicians are responsible for ensuring that discharge letters are sent to key health service providers (e.g. GP) within one week of discharge. Discharge letters need to be comprehensive and indicate diagnosis, treatment, progress of care, recommendations for ongoing care and procedures for re-referral. Relapse patterns and risk assessment/management information will be provided where available. Follow up direct contact with ongoing key health service providers (e.g. GP or NGO) is recommended and should be recorded in the clinical record.
4.12.4 Clients will be encouraged to actively contribute to discharge planning.	Family and significant others will be directly involved in discharge planning. Where clients are lost to follow up, there will be documented evidence of all assertive follow up attempts to contact the client.

4.13 Collection and use of data, record keeping and documentation

Key elements	Comments
4.13.1 The HHS AOD service will enter and review all required information National Minimum Data SET (NMDS) into an approved information system in accordance with approved state-wide and HHS business rules.	Currently this is ATODS-IS as detailed in the ATODS-IS User Manual: http://qheps.health.qld.gov.au/mentalhealth/atodsdocs/atodsis-user-manual.pdf
4.13.2 It is recommended that AOD HHS utilise routine outcome measures as identified by the HHS	Outcomes data is presented at all formal case reviews and will be an item agenda on the relevant meeting agendas. Results of outcomes are routinely discussed with clients. Outcomes data is used with clients to: • review progress and • plan future goals in the treatment / care plan.
4.13.3 All contacts, clinical processes and recovery and relapse prevention planning will be documented in the client's clinical record, as per HHS business rules.	Progress notes will be consecutive within the clinical record according to date.
4.13.4 Clinical records will be kept legible and up to date, with clearly documented dates, times, author/s (name and title) and clinical progress notes. All documentation will include client information labels (or equivalent details).	Personal and demographic details of the client, their significant others/s and other health service providers will be up to date.
4.13.5 Local processes will monitor the quality of record keeping and documentation (including written external communications), and support the relevant skill development.	
4.13.6 There will be a single AOD clinical record for each client, within each HHS AOD service.	The written record (if present) will align with any electronic record.

4.14 Working with families and significant others

Key elements	Comments
4.14.1 Family and significant others will be involved in the AOD care as much as possible. Significant effort will be made to support this involvement.	Information sharing will occur unless a significant barrier arises, such as inability to gain appropriate lawful consent. *Hospital and Health Boards Act 2011 – Part 7 Confidentiality* Right to information and information privacy *Guardianship and Administration Act 2000*
4.14.2 Families and significant others will be offered education and support regardless of consent from the client. The needs of families and significant others must be routinely addressed.	Identification of families and significant others and their needs is part of the assessment process and is included in care planning. Family Sensitive Practice: http://nceta.flinders.edu.au/nceta-workforce-development-resources/fs http://dovetail.org.au/i-want-to/open-the-good-practice-toolkit.aspx

4.15 Client engagement and participation

Key elements	Comments
4.14.1 Greater involvement of Queensland public health AOD service clients in all levels of participation is essential to fulfilling *National Safety and Quality Health Service Standard 2: Partnering with Consumers*, as well as meeting the strategic objectives set out in the *Department of Health Strategic Plan 2014 – 2019*.	
4.14.2 Individuals who use substances and AOD services need to be able to participate in all levels of decision making related to their health care regardless of the legal status of the substances used.	Project Gauge: http://insightqld.org/project-gauge/

4.16 Preventative focus

Key elements	Comments
4.15.1 Measures that stop or delay the uptake of alcohol and/or other drugs and protect against progression to more frequent or regular use amongst at risk populations.	Work in a range of settings, including: communities, educational settings, licensed premises and surrounds, workplaces and organisations, social, cultural and sporting groups, and a range of government and non-government organisations.
4.15.2 Population based focus within the community	Key areas of focus include: • strengthening community action through partnerships and capacity building • supporting state-wide social marketing • promoting healthy policy and legislation • developing personal skills of the population / community • creating supportive physical and social environments • raising awareness • advocating for alcohol, tobacco and other drug prevention.

5. Key Service Stakeholders

- Specialist AOD Non-Government agencies (including Aboriginal and Torres strait Islander community controlled organisations) - provide a complementary range of services and coordinate care with our services where appropriate.
- Other HHS services – provide treatment to clients who may also require AOD services (e.g. Mental Health, Hospital Inpatient and Sexual Health, etc.).
- Primary Health – these services include GPs and Aboriginal Medical Services and are often the first to identify people who may need AOD services.
- Other Non-Government Organisations – these services include community managed mental health, housing, welfare services etc., who provide a range of other essential support.
- Private providers – these services include private psychiatrists, private hospitals as well as rehabilitation facilities and may work with HHS AOD services to provide clinical care.
- Queensland community – provides valuable feedback on our service provision and allows for more responsive service delivery as resources allow.
- Other Government Departments – often identify people who are experiencing AOD related issues (e.g. Child Safety, Community Corrections, Housing, etc.).

Of particular note is the different relationship with specified government agencies where referral is part of a legislative/regulatory system. These relationships require particular focus given the impact upon service delivery and the need for additional funding streams, given the coerced nature of referral and the subsequent engagement and options available, coupled with the potential for displacement of other service users.

6. Caseload

Caseload sizes need to consider a range of factors, including complexity of need, local population and demography, size of that particular team, the needs and function of other services available within the HHS, current position vacancies within the team, and skill mix of the team.

7. Workforce

AOD services are delivered through multidisciplinary teams with expertise in AOD issues and provide specialist expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions.

In smaller regional, rural and remote communities AOD services are often provided by solo positions based within community mental health services where service capacity does not enable designated teams.

Each service will vary in size depending on local needs. Final decisions concerning staff mix need to be made by individual services. In areas which have mental health and AOD services but are too small in demographic terms to host specialist AOD resources, there is a need for close partnerships and linkages with larger AOD services.

The staffing profile for AOD services is comprised of a multidisciplinary mix of staff providing a variety of interventions. Treatment is provided by a range of professionals including doctors, nurses, allied health staff, and indigenous health staff. Involvement of and access to peer workers is strongly encouraged and can be facilitated by the integrated mental health and AOD service. Additionally, the multidisciplinary team is supported by administrative officers who assist with the day to day operations of the AOD services.

The effectiveness of AOD services is dependent upon an adequate number of appropriately trained clinical staff. The complexity of client care needs requires the provision of continuing education programs, clinical supervision and other appropriate staff support mechanisms. AOD services undertake evidence based recruitment and retention strategies such as providing clinical placements for undergraduate students, including entry level positions, encouraging rotations of staff from other areas of the integrated mental health and AOD service and supporting education, clinical supervision and research opportunities.

8. Clinical governance

Each AOD service has a designated Director and/or Team Leader to provide operational and clinical governance within their delegation.

Clear clinical, operational and professional leadership will be established and communicated to all stakeholders.

The following needs to be accounted for:

- The direct management and operational governance of the service to ensure appropriate services are delivered equitably and efficiently and team performance indicators are achieved. This includes operational management, resource and administrative management, systems maintenance, staff supervision including performance development, and liaison with other internal HHS services, external organisations and community groups.
- The provision and responsibility for clinical governance and demonstrate committed clinical leadership by maintaining a culture of continuous learning and service improvement.

In the AOD services, formal multidisciplinary team review meetings will be held regularly to review progress, address complex clinical issues, discuss discharge planning and manage caseloads.

9. Hours of operation

The community AOD services operate during normal business hours and those operating within public hospital's will determine operating hours for services such as Consultation Liaison and DABIT based on local need and resource limitations.

10. Staff Training

Staff will be provided with continuing education opportunities, clinical supervision and other support mechanisms to ensure that they are clinically competent.

All new staff should complete a local orientation / service induction within the first month of commencing employment, and then encouraged to access any subsequent professional training in order to be fully competent to perform their duties. This should be accompanied by a rigorous and detailed performance Appraisal and Development plan and engagement with formal supervision where appropriate.

Training is based on best practice principles and will be underpinned by the harm minimisation framework. Teams are encouraged to make the relevant components of their training available to their service partners.

AOD staff should have access to suitable training and induction in order to ensure that they are guided by the following set of sector and workforce values:

- Being informed by evidence
- Professionalism

- Ethical practice
- Accountability and transparency
- Confidentiality and privacy
- Cultural security
- Collaborative practice
- Innovation and creativity
- Commitment to safety
- Commitment to excellence
- Commitment to achieving outcomes and results; and
- Commitment to continuous quality improvement

Training should include (but not be limited to):

- triage and assessment training
- clinical and operational skills/knowledge development (including AOD generic and discipline specific training needs)
- basic life support
- principles of the service (including cultural awareness and training, safety, challenging stigma and discrimination etc.)
- clinical case formulation and case note writing skills
- medication management
- harm reduction principles
- substance-specific responses
- client focussed care planning and collaborative goal setting
- detection and management of co-occurring mental health problems
- aggressive behaviour management training
- response to emergencies
- engaging and interacting with other service providers, including statutory departments
- risk and suicide assessment, and associated planning and intervention
- client engagement and participation
- cultural capability training
- population-specific approaches (e.g. young people, older persons, pregnant and parenting etc.), and
- routine outcome measurement training.

In house training/education will reflect local demands, challenges and needs. However, consideration is given to further improving skills and knowledge in teamwork, case formulation, communication, record keeping and the local model of service.

11. HHS AOD services function best when:

- there is an explicit attitude that AOD treatment works and that although dependence is a chronically relapsing condition, individuals can be assisted to avoid or reduce a range of physical, psychological and social harms
- harm minimisation principles are incorporated into the culture, attitudes and values
- caseloads are regularly reviewed and assertively managed
- there is an adequate skill mix, with senior level clinical expertise and knowledge being demonstrated by the majority of staff.
- regular team/service evaluation measures team performance and client outcomes
- staff are provided with adequate professional support and training
- individuals, their family and significant others and other service providers are involved in all aspects of care
- strong internal and external partnerships are established and maintained; and
- there is participation in research and evaluation to promote service quality and innovation.