[Insert organisation name/logo]

CLIENT CLINICAL MANAGEMENT POLICY

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***Note\****

*This policy template has been developed to meet the needs of a diverse range of services and includes items for consideration.*

***Not all content will be relevant to your service.******Organisations are encouraged to edit, add and delete content to ensure relevancy.***

*All material provided by the Network of Alcohol and other Drugs (NADA) is for guidance purposes only. NADA does not accept legal responsibility for the implementation of this document within services.*

*All notes (like this one) should be considered and deleted before finalising the policy, and the contents list should be updated as changes are made and when content is finalised.*

*\*Please delete note before finalising this policy.*

***Note\****

*To update the contents list when all content has been finalised, right click on the contents list and select ‘update field’, an option box will appear, select ‘Update entire table’ and ‘Ok’.*

*To use the contents list to skip to relevant text, use* ***Ctrl and click*** *to select the relevant page number.*

*\*Please delete note before finalising this policy.*

**TABLE OF CONTENTS**

[CLIENT CLINICAL MANAGEMENT POLICY 1](#_Toc206581722)

[SECTION 1: CLIENT CLINICAL MANAGEMENT POLICY 3](#_Toc206581723)

[1.1 Policy statement 3](#_Toc206581724)

[1.2 Purpose and scope 3](#_Toc206581725)

[1.3 Definitions 4](#_Toc206581726)

[1.4 Principles 6](#_Toc206581727)

[1.5 Outcomes 6](#_Toc206581728)

[1.6 Roles and Responsibilities 6](#_Toc206581729)

[1.7 Policy implementation 7](#_Toc206581730)

[1.8 Risk management 7](#_Toc206581731)

[SECTION 2: SERVICE APPROACH 8](#_Toc206581732)

[2.1 Overview of treatment approaches 8](#_Toc206581733)

[2.2 Overview of intervention approaches utilised 9](#_Toc206581734)

[2.3 Client consent 10](#_Toc206581735)

[2.4 Case notes 10](#_Toc206581736)

[2.4.1 Case notes records 11](#_Toc206581737)

[2.4.2 Case notes audit 11](#_Toc206581738)

[SECTION 3: INTAKE 12](#_Toc206581739)

[3.1 Client information 12](#_Toc206581740)

[3.1.1 Eligibility and access criteria 12](#_Toc206581741)

[3.2 Client intake 12](#_Toc206581742)

[3.2.1 Elements of intake 13](#_Toc206581743)

[SECTION 4: COMPREHENSIVE ASSESSMENT 14](#_Toc206581744)

[4.1 Elements of comprehensive assessment 14](#_Toc206581745)

[SECTION 5: CARE PLANNING 14](#_Toc206581746)

[5.1 Elements of care planning 15](#_Toc206581747)

[SECTION 6: IDENTIFYING, RESPONDING TO, AND ONGOING MONITORING OF RISK 15](#_Toc206581748)

[6.1 Elements of risk 15](#_Toc206581749)

[6.1.1 Identification of risk 16](#_Toc206581750)

[6.1.2 Monitoring and response 16](#_Toc206581751)

[SECTION 7: MONITORING TREATMENT PROGRESS AND OUTCOMES 16](#_Toc206581752)

[7.1 Elements of treatment monitoring 16](#_Toc206581753)

[SECTION 8: TRANSFER OF CARE 17](#_Toc206581754)

[8.1 Elements of transfer of care 17](#_Toc206581755)

[8.2 Unplanned cessation of treatment 18](#_Toc206581756)

[SECTION 9: REFERRALS 18](#_Toc206581757)

[9.1 Referral process 18](#_Toc206581758)

[9.2 Receiving a referral 19](#_Toc206581759)

[9.3 Making a referral 19](#_Toc206581760)

[9.4 Developing and maintaining referral pathways 19](#_Toc206581761)

[9.5 Demand management 19](#_Toc206581762)

[SECTION 10: REFERENCES 21](#_Toc206581763)

[10.1 Supporting documents 21](#_Toc206581764)

[10.2 Related policies 21](#_Toc206581765)

[10.3 Legislation 22](#_Toc206581766)

[10.4 Other resources 22](#_Toc206581767)

## SECTION 1: CLIENT CLINICAL MANAGEMENT POLICY

### 1.1 Policy statement

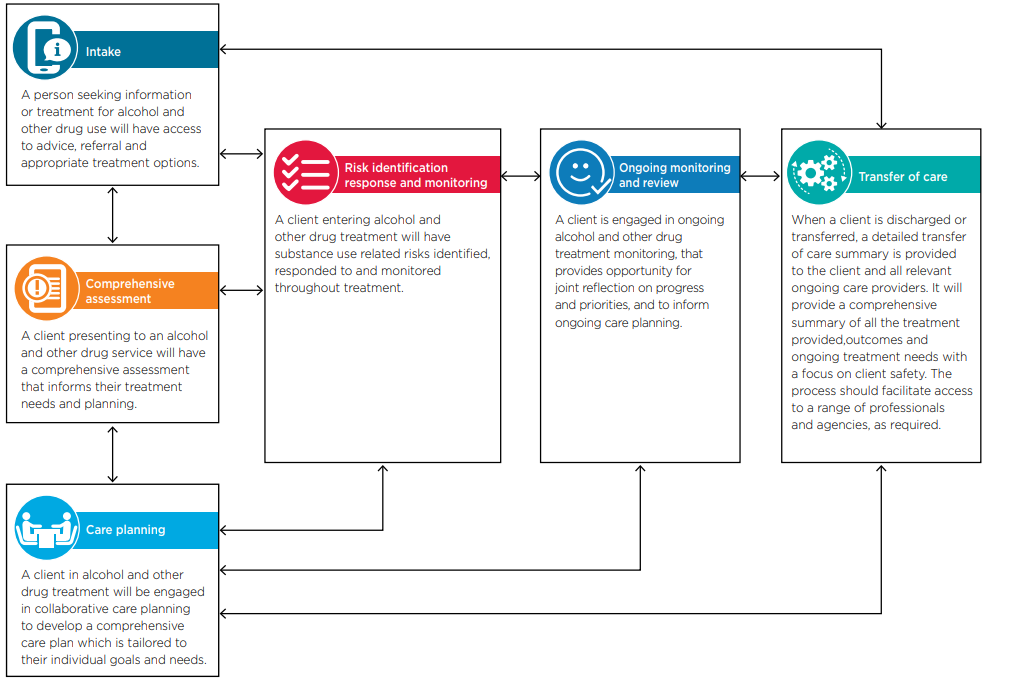
**[Organisation name]** is committed to providing consistent, evidence-based and inclusive client management and administrative practices. Effective client interventions and administrative processes are a priority for the organisation to support clinical intervention and comprehensive client care.

### 1.2 Purpose and scope

The purpose of this policy is to guide clinicians and managers in the provision of the core elements of care for clients engaged in alcohol and other drug treatment. In addition, this policy aims to provide guidance in developing and implementing client administration practices that are efficient, fair and consistent to respond effectively to existing and potential clients of **[insert organisation name]** and their needs.

This policy applies to all client services and programs, and all staff involved in client management. It does not prescribe specific treatment interventions, counselling techniques, pharmacology, or medications.

This policy is supported by the application of the NSW Health Clinical Care Standards (the “Standards”) for Alcohol and other Drug treatment (see flowchart below) and refer to the pdf [NSW Health Clinical Care Standards](https://www.health.nsw.gov.au/aod/Publications/clinical-care-standards-AOD.pdf) for further details.



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.

### 1.3 Definitions

|  |  |
| --- | --- |
| **Intake** | 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. |
| **Comprehensive assessment** | The assessment is conducted at the commencement of treatment and 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. |
| **Care planning** | 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 assists 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. |
| **Case notes** | A chronological record of interactions, observations and actions relating to a particular client. |
| **Consent** | Approval of a specific question that is voluntary, informed and current. Consent can only be provided by a person with capacity to make decisions. |
| **Identifying, responding to and ongoing monitoring of risk** | 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. |
| **Monitoring treatment progress and outcomes** | 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 ongoing care planning |
| **Evidence-based**  **practices** | The conscious, conscientious and explicit application of the best available research and evidence-informed clinical work practices. |
| **Transfer of care** | 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. |
| **Safety plan** | A plan designed in collaboration with the client that includes assessment of risk (such as suicide, self-harm, DFV, use of substance risks) and a clear plan of action to follow. |
| **Screening** | Screening tools are used to identify client needs and provide information and referral as required in areas such as suicide, domestic and family violence and blood born viruses. |

### 1.4 Principles

**[Organisation name]** adheres to the following principles of good practice outlined below:

* Client interventions are informed by the Standards and best practice.
* Clinical care work is orientated by respect for client diversity, cultural needs and inclusive practice
* Person-centred services are provided consistently and equitably across the organisation by skilled, qualified, and informed staff.
* Client interventions aim to reduce drug and alcohol related harm to individual
* Clinical administration processes are integral to the client’s experience and are conducted via consultation and collaboration with the client, and where appropriate, with the client’s family.

### 1.5 Outcomes

* Person-centred treatment provided to clients positively influencing health, interpersonal and welfare outcomes and improved wellbeing.
* Clients are involved in individual client treatment and interventions, and broader organisational development decisions as appropriate.
* Staff knowledge and practice in the delivery of treatment is maintained.
* Practices are aligned with the Standards.
* Care for clients is improved through partnerships with other services where appropriate.
* **[Organisation name]** provides and implements client administration practices that are systematic, compliant with legislation and quality standards, informative and protects the interests and rights of the client, as well as those of the organisation.
* Staff members implement and respond to intake, assessment and treatment interventions based on client need, choice and informed consent.

### 1.6 Roles and Responsibilities

|  |  |
| --- | --- |
| **Board of Directors** | * Endorse the Client clinical management policy * Ensure compliance with the Client clinical management policy * Familiarise themselves with legislative requirements of the Client clinical management policy. |
| **CEO/Manager** | * Comply with the Client clinical management policy * Familiarise themselves with legislative requirements of the Client clinical management policy * Monitor the implementation and review of the Client clinical management policy Ensure and monitor staff competence and compliance with the Client clinical management policy * Collate/report information on adverse client events as required. * Operational decision-making is informed by this policy. * Provide professional support and supervision to staff; ensure staff receive appropriate training, supervision and debriefing to comply with this policy * Collate/report information on adverse client events as required. * Review/support the review of clinical processes. |
| **Program services/ Clinical staff** | * Comply with the Client clinical management policy * Familiarise themselves with legislative requirements of the Client clinical management policy * Support operational decision-making relating to this policy. * Identify “at risk” clients, notify management and act in accordance with any risk management requirements in providing duty of care. * Maintain knowledge of the current evidence-based interventions available to clients. * Participate in regular external clinical supervision. * Where appropriate, maintain registration requirements with relevant associations and/or peak bodies. |

### 1.7 Policy implementation

This policy is developed in consultation with **[organisation name]** staff and endorsed by the Board.

The Client clinical management policy is part of staff orientation processes, and all staff, Board members and volunteers are responsible for understanding and adhering to the Policy.

This policy is referenced in other relevant policies and supporting documents to ensure that it is actively used.

Specific monitoring and implementation activities undertaken include:

* Client feedback as a standing item on staff meeting agendas, where issues are raised and addressed
* Intake and assessment meetings
* Regular client file audits
* Reviews of reasons for client discharges
* Referral follow-ups and regular communication with referral stakeholders.

### 1.8 Risk management

Staff responsible for the clinical management of clients are adequately trained, supported and supervised to use evidence-based approaches and interventions.

Staff are aware of relevant legislation and duty of care provisions through induction, training and an assessment of their competencies prior to undertaking duties. All staff are supported to recognise the limits of individual roles and competencies and actively facilitate links to further levels of care where necessary.

The clinical administration aspects of this policy are informed by and comply with relevant legislation, including the *Privacy Act 1988* (Cth), *Health Records and Information Privacy Act 2002* (NSW) and *Public Health Act 1991* (NSW). For more information relating to privacy and confidentiality, refer to the Privacy policy and the Communications policy.

This policy is included in the **[insert organisation name]** policy review schedule, where it is scheduled to be reviewed every **[Insert frequency]** at a minimum, or following significant operational, policy or legislative requirements.

## SECTION 2: SERVICE APPROACH

**[Organisation name]** has a “no wrong door” approach and where possible provides information to prospective clients to facilitate an informed decision on the treatment option that is right for them. Interventions are informed by best practices and the expertise of the lived/living workforce.

### 2.1 Overview of treatment approaches

***Note\****

*Please edit, add, and/or delete the approaches that are relevant to your organisation below and delete those that are not appropriate to your activities.*

*Note: this list is not exhaustive and should be modified to suit your needs.*

*\*Please delete note before finalising this policy*

**[Insert organisation name]** provides services based on the following treatment philosophies and approaches:

1. **Integrated care:** Refers to the provision of interventions and treatment for co-occurring drug and alcohol and mental health problems by a single worker, team or program or the provision of treatment by two or more staff members, teams or programs in collaboration.

1. **Harm reduction:** Forms part of a comprehensive approach to harm minimisation. These strategies aim to minimise harm arising from drug and alcohol use, while people continue to use drugs.

1. **Abstinence-based:** Abstinence-based approaches aim to support clients living a drug-free lifestyle.

1. **Case** **management:** Involves additional support to help clients access housing, Centrelink training, employment, linkages with mental health and physical health services.

1. **Family inclusive practice:** Providing meaningful support and appropriate referrals for families, as well as their involvement and participation in the planning, care and treatment of clients when requested by the client. Working with family and carers is an essential part of a comprehensive response to working with people with drug and alcohol problems.

1. **Therapeutic community model:** The therapeutic community (TC) model emphasises an approach to treatment that addresses the psychosocial and other issues behind the use of substances. The community is thought of both in the context and method of the treatment model where both staff and other residents assist the resident to address their drug dependence.

1. **Outreach model:** Involves workers meeting clients where they are at. Services can include providing information, counselling, referrals, and health interventions.

1. **Extended and continuing care:** Extended and continuing care or aftercare is provided following discharge/exit from the service. Contact with clients through extended care can be used to prompt a step-up or step-down from treatment when needed.

1. **Client/consumer participation:** Is the process of involving clients in decision-making about health service planning, policy development, setting priorities and qualities issues in the delivery of services.

### 2.2 Overview of intervention approaches utilised

**[Insert organisation name]** utilises the following intervention approaches:

***Note\****

*Please add detail on the range of approaches relevant to your organisation below, along with any detail on who can administer different approaches (e.g. if training or qualifications are required).*

*\*Please delete note before finalising this policy.*

1. Brief interventions
2. Motivational interviewing
3. Contingency management
4. Intensive psychosocial therapies, for example, cognitive behavioural therapies (CBT), acceptance and commitment therapy (ACT), emotion regulation, dialectical behaviour therapy (DBT), self-help groups
5. Self-help materials
6. Group-work

***Note\****

*For more detail on specific psychosocial interventions used with substance using clients please see the NSW Health Drug and Alcohol Psychosocial Interventions (2023) listed under Section 10 – Resources.*

*\*Please delete note before finalising this policy*

### 2.3 Client consent

**[Insert organisation name]**’s potential and existing clients must provide informed consent. Informed consent is given verbally and/or in writing and is valid for **[insert timeframe]**. Where the client encounters the organisation through a third-party referral, consent is confirmed directly with the client before commencing the referral, intake and/or assessment process.

Consent is documented on client intake forms and client file notes.

***Note\****

*NADA members and users of NADAbase are required to comply with the National Privacy Act including the 10 National Privacy Principles (1998- revised 2011), National Privacy Act and the NSW Health Records and Information Privacy (HRIP) Act (2002).*

*Before administering any questions via NADAbase, you must inform clients that steps will be taken to protect the privacy of their personal information. Forms for staff outlining requirements of privacy protection and client consent are provided below.*

[*Privacy and consent for clients*](https://nada.org.au/wp-content/uploads/2021/01/privacy_and_consent_handout_for_clients_v2.docx)*[DOCX]*[*Data reporting agreement*](https://nada.org.au/wp-content/uploads/2021/01/NADAbase-Data-Reporting-Agreement-Mar-2019.docx)*[DOCX]*

*\*Please delete note before finalising this policy*

### 2.4 Case notes

The organisation ensures that staff are appropriately trained and supported to implement and maintain quality case notes processes.

Case notes are implemented to:

* Record therapeutic processes
* Establish a tangible record of client contact, interactions and experiences over time
* Record the client’s progress in reaching their treatment goals
* Provide a basis for client treatment plan and review form and continuity of care
* Provide a way of communicating with other professionals about clients
* Promote reflective practice in terms of reviewing and adjusting treatment strategies over the course of treatment
* Provide accountability to clients, organisations and the legal system, should the case notes be subpoenaed
* Assist with clinical supervision and training purposes
* Be used as a memory refresher

#### 2.4.1 Case notes records

**[Insert organisation name]** collect chronological written/electronic records of all interactions with clients to inform treatment. Case note documents are generally brief, objective, non-judgmental and are an accurate description of the nature and content of the interaction.

At **[insert organisation name]** case notes are recorded on the case notes template and attached to the client treatment plan on the client file. Client files are located **[insert location of** **client files]**. Only authorised staff members have access to client files.

Staff members are to record case notes following an interaction with a client within **[specify** **amount of time]** hours.

Guidelines for writing case notes are **[adapt depending on type of file, eg CRM or paper based]**:

* Record the client’s full name at the top of every page
* Record the date and time of contact, length of session, session number and type of interaction
* Record the name and job title of the staff member completing the notes (and if handwritten, the worker’s signature)
* Save the records in chronological order
* Write notes that are brief, clear and easy-to-read, do not use abbreviations
* Write in black or blue pen that cannot be easily smudged or erased
* If unsure about the accuracy of something the client has said, state, “The client reported that…”
* Record professional observations and assessments free of unfounded personal opinions or judgements
* Ensure that all opinions are supported by evidence
* Focus on the client’s purpose and goals and the interventions used to achieve these
* Check for spelling, grammar, sentence structure and punctuation
* Never delete or black out mistakes
* Ensure that all mistakes have a line drawn through them and are initialled and dated
* Avoid leaving spaces between entries or within case notes, as these can be interpreted as being unfinished

#### 2.4.2 Case notes audit

Case note audits are conducted to ensure **[insert organisation name]** meets its legal, clinical and professional obligations in relation to case notes. Case note audits may be carried out simultaneously to client file audits. Refer to the Service and program operations policy for more information on client file audits.

The case notes audit processes ensure that staff professional development needs are identified and any gaps in knowledge can be addressed.

## SECTION 3: INTAKE

**[Insert organisation name]** ensures that access, intake and assessment of existing and future clients are equitable and consistent throughout the organisation services and programs by implementing the following processes and practices.

### 3.1 Client information

**[Insert organisation name]** believes that clients have the right to make choices about their treatment options. The provision of appropriate, accurate, and timely information will assist them in making informed and knowledgeable decisions. To ensure clients are informed, **[insert organisation name]** produces and maintains an updated *Client orientation pack*, which is provided in hard copy and explained verbally prior to and upon admission to check clients’ understanding of the service's needs.

#### 3.1.1 Eligibility and access criteria

**[Insert organisation name]** has specific service and program criteria; the eligibility and access criteria are clearly communicated to potential clients and referrers. These include:

* XXXX
* XXXX
* XXXX

***Note\****

*For more details on* [NSW Health Clinical Care Standards](https://www.health.nsw.gov.au/aod/Publications/clinical-care-standards-AOD.pdf) *under Section 10, Resources. This process may follow a different structure in your organisation; however, the elements would remain the same. For example, intake and comprehensive assessment may overlap.*

*\*Please delete note before finalising this policy*

### 3.2 Client intake

Intake is the initial contact between a person or referrer and the service. As it is often the first point of contact with the treatment service, 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.

Following referral, the designated clinician from **[insert organisation name]** should contact the client within XX days to complete the intake interview. Where the clinician has been unable to contact the client after three attempts, they should discuss with the team and document the decision. The referrer should be contacted to inform them of the outcome.

While a client may have provided consent verbally at intake, the clinician should now provide a copy of the rights and responsibilities, explain privacy and confidentiality and how their data is utilised. Consent is documented on client intake forms and client file notes. For more information about consent, refer to **section 2.3** in this policy.

#### 3.2.1 Elements of intake

An intake interview **[insert organisation name]** collects the following core information:

* Caller details
* Referral agent details
* Reason for referral
* AOD use
* Current and previous AOD treatment
* Risk and safety assessment, including risk of harm to self and others and high priority risk areas e.g. Medical and mental health issues
* Additional criteria for consideration for priority access to treatment.

Processing intake information:

* 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
* Assign assessment priority
* Provide information and resources or a brief intervention according to need
* Facilitate 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;high, medium and low priority. High priority clients should be offered the earliest available assessment in line with local protocols.
* Referrers should be notified of the outcomes of the intake assessment.

**[Insert organisation name]** ensures 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.

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. Staff are required to understand their health information and privacy responsibilities and are suitably qualified with access to appropriate training, supervision and support.

## SECTION 4: COMPREHENSIVE ASSESSMENT

It is essential for clients attending **[Insert organisation name]** 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 an opportunity to build a rapport with the client and to support their engagement in treatment. Comprehensive assessment identifies what needs to be considered and included in the care plan.

### 4.1 Elements of comprehensive assessment

Clients presenting to [**Insert organisation name]** will have a comprehensive AOD assessment that contains:

* The reason for presenting to the service
* A record of all psychoactive substances used in the past 28 days
* A record of all psychoactive substances used in the past 3 days
* A record of any other AOD treatment the client is currently participating in
* 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 in accessing other services
* Identification of risks that include those relating to the client, their circumstances and substance use
* A summary that facilitates the development of a treatment plan
* An initial treatment plan for management of substance use and associated issues

## SECTION 5: CARE PLANNING

[**Insert organisation name]** ensures that systems and resources are in place to facilitate documentation of care plans and monitoring of outcomes for clients who are in treatment.

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. It assists 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 wellbeing. 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.

### 5.1 Elements of care planning

* A care plan is developed in collaboration with the client, and their carers/friends/family and other service providers if relevant.
* The care plan identifies 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 areas the client wishes to focus on.
* The client is offered a copy of the plan, and the communication and dissemination of the care plan is discussed with the client.

## SECTION 6: IDENTIFYING, RESPONDING TO, AND ONGOING MONITORING OF RISK

Assessing, identifying and responding to risk is an essential part of AOD treatment that commences at intake and is ongoing. There are a range of risk factors to be considered. Core risks are those 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 to be based on individual presentation** |
| Domestic and family violence | Deteriorating physical health |
| Child whereabouts and wellbeing | Significant cognitive impairment |
| Overdose, poly substance use | Blood born virus risks |
| Withdrawal history and complications | Perinatal risks during pregnancy and breast feeding |
| Recent release from hospital, mental health facility or custody | Deteriorating phsychological health |
| Risk of harm to self or others | Sexual health |
| Risk of homelessness or eviction | Fitness to drive |

### 6.1 Elements of risk

* 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.
* The frequency of planned review is determined by treatment type and clinical judgement, but not less than every 3 months.
* [**Insert organisation name**] has a system for identifying and maintaining updated documentation of client risk levels and uses standardised and structured approaches to risk monitoring (e.g. ATOP, Domestic Violence screening, Child Protection). A client’s level of risk should also inform follow up procedures in the event of appointment non-attendance.
* Risks need to be addressed through care planning and reviewed within the agreed timeframes. The use of structured clinical tools in risk monitoring (see section 3.2.1) can facilitate the ongoing review of risk and the effectiveness of risk mitigation strategies over time.

#### 6.1.1 Identification of risk

* Client’s risks are identified and documented.
* Management strategies are discussed with the client and documented.
* The clinician and the client discuss to ensure the client is aware of risks and understands what to do and who to contact to help manage identified risks.
* All clinicians involved in the delivery of care are aware of risks and understand the agreed strategies to support the client.
* Use the XXX (relevant outcome measure for your organisation) to identify key risks

#### 6.1.2 Monitoring and response

* Risks are regularly reviewed and responded to, as well as new risks identified as they arise within the ongoing monitoring of treatment progress. This includes ongoing assessment of physical health, mental health status and level of wellbeing.
* The care plan is aligned with the outcomes of the periodic risk assessments.
* Any issues identified by the client are recorded around their social situation, mental health and physical health, and whether they would like any assistance.
* Strategies to mitigate risks are incorporated in the client’s care plan with their assistance.
* Any risks that are identified as outside scope of practice or responsibility are escalated in accordance with organisational procedure.

## SECTION 7: MONITORING TREATMENT PROGRESS AND OUTCOMES

At [**Insert organisation name**] monitoring treatment progress and outcomes is an ongoing process as it brings together the information collected in continuous assessment including comprehensive assessment, care planning, identifying, responding to and monitoring risk, implementing the treatment plan, reviewing treatment progress, and discharge planning.

It is an opportunity to partner with clients for joint reflection on progress and priorities and informs their ongoing care planning.

### 7.1 Elements of treatment monitoring

* Structured measurements of AOD-specific (e.g. ATOP, Severity of Dependence Scale [SDS]) and general health measures (e.g. Kessler 10 (K10), EUROHIS Quality of Life Scale 8 [EQoL-8]) and investigations (e.g. Urine Drug Screens [UDSs], breath alcohol measurements) are incorporated at initial assessment, repeated periodically throughout treatment according to the organisation’s outcome measures procedure.
* 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.
* Staff participate in regular clinical reviews to assess ongoing progress 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.

## SECTION 8: TRANSFER OF CARE

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 occur when a client:

* moves to another clinician or service provider
* is referred to other AOD community-based service and agency
* completes the agreed treatment plan, or
* discharges to their own care.

### 8.1 Elements of transfer of care

At **[Insert organisation name]** planning transfer of care is a process that is ongoing throughout the treatment episode in partnership with the client and includes jointly developing their discharge summary.

At the time of discharge from the service, a discharge summary is sent to the appropriate stakeholders (e.g. client, referrer, primary care providers, health or other relevant care providers), as identified in the client’s care plan.

Transfer of care is timely, and discharge summaries are completed within 1 week of discharge.

Discharge summaries contain the following information:

* A description of the reason for presentation to the service.
* The treatment provided by the service during the treatment episode including key timeframes if appropriate.
* For clients who are on medication a list of the current medications is included
* Description of quantitative outcome scores if relevant.
* A summary of current and ongoing concerns, risks, strengths and protective factors
* Recommendations for ongoing care needs, including the option to return to the service in the future

### 8.2 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 the service
* strategies to manage and reduce health risks or harms with any continued substance use, (such as fit packs or naloxone/overdose information, depending on service type)
* information to access alternative treatment services, community support and resources.

## SECTION 9: REFERRALS

The purpose of the referral process is to support clients to access and connect with services that meet their needs.

All referrals made to another service or received by **[insert organisation name]** should be agreed to by the potential or existing client before they are made. Client consent should be obtained to receive or request any type of information about the client.

**[Insert organisation name]** provides referral alternatives to clients when required.

Clients may be referred to or by a range of individuals or organisations in several ways, including referrals made in person, by telephone, using a referral form, letter or email. All referrals are guided by the Referral Form, which records the following information:

* Client contact details and information
* Source and reason of referral
* Drug and alcohol information
* Mental health information
* Other relevant health information
* Concerns and recommendations
* Client consent and agreement
* **[Insert other details included on your organisation referral form]**
* **[Insert other details included on your organisation referral form].**

### 9.1 Referral process

When necessary, referral of clients to other health and social services occurs. Staff at **[insert organisation name]** proactively assist the client to co-ordinate and negotiate service delivery to ensure continuity across service sectors. Referrals are discussed with the client, and any concerns are addressed.

* Consent or written permission is sought from the client before contact with the new agency is made
* The client is supported until an appointment with the new organisation is arranged and it is established that the referral was successful
* Warm referrals are initiated where possible to support the client through the process.

The referral process could occur as part of the transfer of care or as part of care planning and documented in the client management system. Upon transfer of care or discharge, the type of service the client is referred to would be indicated when the episode of treatment is closed.

### 9.2 Receiving a referral

**[Insert organisation name]** records and assesses referrals and ensures responses are provided to the relevant person in XXX time.

The **[insert organisation name]** process of receiving referrals from other organisations is communicated online and in hard copy. The information contains the following information:

* Brief organisation overview
* Services and programs priorities areas and access criteria
* Information required from the referral source
* Referral form
* **[Insert other details included in your organisation referral information pack]**
* **[Insert other details included in your organisation referral information pack].**

### 9.3 Making a referral

**[Insert organisation name]** makes active referrals to other organisations, based on the client’s needs and consent. Staff take an active role in checking if the referral has been successful to facilitate further support for the client when needed.

### 9.4 Developing and maintaining referral pathways

**[Insert organisation name]** establishes effective networks and referral pathways by:

* Providing clear and up-to-date information on eligibility, priorities and other referral information
* Having reciprocal arrangements partner agencies
* Developing and reviewing memorandums of understanding or service level agreements with other agencies to facilitate referral partnerships
* Maintaining clear documentation and records of referral processes.
* Attending local interagency meetings and other network meetings

### 9.5 Demand management

Where demand for services/programs exceeds capacity, **[insert organisation name]** has a client demand management strategy in place.

Potential clients are provided with:

* Notification, including the reasons and details of the approximate waiting period
* Ongoing support through [insert method of support name, e.g. day program, outreach staff, arrangement with other service]
* Information about other available services and referral process
* [**Insert other action to follow when clients** **are unable to be given an appointment].**

## SECTION 10: REFERENCES

### 10.1 Supporting documents

**Clinical risk management**

* Client orientation pack (sample list)
* Client overdose risk management plan
* Home visiting risk management plan
* Mental health related episodes risk management plan
* Opioid overdose response

**Client assessment and plans**

* Client waiting list
* Client intake form
* Client assessment form
* Case management plan
* Treatment plan and review
* Client referral form

**Client exit**

* Client exit summary form
* Certificate of achievement

**Case notes**

* Case notes
* Case notes audit
* Case notes audit schedule
* Case notes audit evaluation

### 10.2 Related policies

* Safer spaces policy
* Child protection and reporting policy
* Clinical governance policy
* Clinical Supervision Policy
* Work health and safety policy
* Communications policy
* Human resources policy
* Service and program operations policy

### 10.3 Legislation

* [*The Health Records and Information Privacy Act 2002* (NSW)](https://legislation.nsw.gov.au/view/html/inforce/current/act-2002-071)
* [*Children and Young Persons (Care and Protection Act 1998* (NSW)](https://legislation.nsw.gov.au/view/html/inforce/current/act-1998-157)
* [*Ombudsman Act 1974* (NSW)](https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1974-068)
* [*Privacy Act 1988 (Cth)*](https://www.legislation.gov.au/Series/C2004A03712)
* [*Privacy Amendment (Enhancing Privacy Protection) Act 2012*](https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r4813)
* *[Public Health Act 1991](https://legislation.nsw.gov.au/view/whole/html/inforce/2008-01-01/act-1991-010)* [(NSW)](https://legislation.nsw.gov.au/view/whole/html/inforce/2008-01-01/act-1991-010)

### 10.4 Other resources

* [NSW Health Clinical Care Standards:AOD treatment](https://www.health.nsw.gov.au/aod/Publications/clinical-care-standards-AOD.pdf)
* [Alcohol and Other Drugs Psychosocial Interventions practice guide](https://www.health.nsw.gov.au/aod/resources/Publications/nsw-health-psychosocial-interventions.pdf)