IDAT Process Evaluation Final Report

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Acronyms list

A&D	Alcohol and drug
ACAT	Aged Care Assessment Team
ACE-R	Addenbrooke's Cognitive Examination
ADA	Alcohol and Drug Addiction Act
ADDA	Alcohol and Drug Dependency Act
ADDPA	Alcoholics and Drug Dependent Persons Act
AMP	Accredited medical practitioner
AMT	Alcohol Mandatory Treatment
AOD	Alcohol and other drug
APDC	Admitted Patient Data Collection
ATOP	Australian Treatment Outcomes Profile
ATSI	Aboriginal and Torres Strait Islander
BF	Bloomfield
CBT	Cognitive behavioural therapy
CHIME	Community Health Information Management Enterprise
CHOC	Community Health and Outpatient Care
CNC	Clinical Nurse Consultant
CTO	Community treatment order
DC	Dependency Certificate
DIM	Days in month
DPMP	Drug Policy Modelling Program
ED	Emergency department
EMR	Electronic Medical Record
FTE	Full time equivalent
GP	General Practitioner
HREC	Human Research Ethics Committee
HSC	Herbert St Clinic
IDAT	Involuntary drug and alcohol treatment
IP	Identified patient
ITLO	Involuntary Treatment Liaison Officer
LHD	Local Health District
LOS	Length of stay
MATISSE	Monitoring AOD Treatment Information System for Services Everywhere
MCS	Mental Health Composite Score
MH	Mental health
MMSE	Mini-Mental State Examination
MOC	Model of care
MOCA	Montreal Cognitive Assessment

MP	Medical Practitioner
MRN	Medical Record Number
NDARC	National Drug and Alcohol Research Centre
NEAF	National Ethics Application Form
NICE	National Institute for Health and Clinical Excellence
NMDS	National Minimum Data Set
NUM	Nurse Unit Manager
PCS	Physical Composite Score
QCT	Quasi-compulsory treatment
SAC	Senior assessment clinician
SDS	Severity Dependence Scale
SF-12	Short Form 12-item Survey
SSA	Site Specific Assessment/Application
SSDT	Severe Substance Dependence Treatment
TAFE	Technical and Further Education
UNSW	University of New South Wales
UPD	Unit per day

Executive summary

Context
The Drug Policy Modelling Program at the National Drug and Alcohol Research Centre was commissioned by the NSW Ministry of Health to conduct this process evaluation of the New South Wales Involuntary Drug and Alcohol Treatment (IDAT) Program, reflecting the first four years of the program. A separate outcome evaluation and costing work are underway. This executive summary reflects the findings of the process evaluation at the time it was conducted (from September to December 2016).

The NSW Drug and Alcohol Treatment Act 2007 (the Act) provides the legislative basis for the IDAT Program. The Act provides for the involuntary detention, treatment and stabilisation regime (for 28 days) for persons with severe substance dependence, with the stated aim of protecting the health and safety of such persons, while also aiming to address all human rights aspects that were the subject of criticism of the previous legislation.

The IDAT Program commenced in New South Wales in 2012 with two gazetted treatment units. One treatment unit has 4 IDAT beds, is located in Sydney as part of an existing voluntary detoxification unit at Herbert Street Clinic (HSC), Royal North Shore Hospital, Northern Sydney Local Health District. The other treatment unit has 8 IDAT beds, is located in Orange, as part of the Bloomfield (BF) hospital in Western NSW Local Health District. The choice of location aimed to ensure that both metropolitan and rural regions were covered.

Aim of the process evaluation
The process evaluation aimed to provide descriptive information about the program operations, its reach, strengths and weaknesses, patient progression though the model of care, and the feasibility and appropriateness of the model of care. In providing this description, it also aimed to evaluate whether the Act was being implemented according to how it was originally conceived, and the extent to which the implementation of the IDAT program was consistent with the Model of Care and the legislative basis for the program, at the time of the process evaluation.

Methodology
Data for this process evaluation were collected from the following sources: 1) the IDAT program database; 2) in-depth interviews with patients; 3) in-depth interviews with stakeholders; 4) observations of weekly staff meetings at the two IDAT Treatment Centres; and 5) documentary review (including legislative documents, and records by the Official Visitors), and review of a limited number of patient files.

A complete copy of the IDAT database was made available to the evaluators, covering the period from program commencement (31 May 2012) to 24 June 2016 (4 years). Twelve in-depth interviews with patients were conducted, proportionately balanced across the two treatment units. A total of 37 stakeholders were interviewed and written submissions were received from two stakeholders. Observation of four weekly staff meetings was conducted across two treatment units. Reviews were conducted of the Act, the Model of Care, and the Official Visitors' Books. Complete patients files of five patients were reviewed.

Across the five different types of data collected for the process evaluation, a number of quantitative and qualitative data analytic tools were deployed. For the quantitative data, descriptive statistics were used along with simple tests of associations to analyse the IDAT database. The qualitative data (in-depth interviews with stakeholders) were analysed according to standard qualitative data techniques. Analysis of the diversity or congruence of views was also undertaken.

Findings

The NSW Drug and Alcohol Treatment Act 2007

There are four eligibility criteria in order to determine a person's suitability for involuntary detention under the Act: a) Severe substance dependence; b) Potential for harm to self or others; c) Benefit from treatment; d) No other appropriate options. All four must be met with each person. Stakeholders noted that the eligibility criteria were subject to individual interpretation – which was regarded as both a strength (capacity for individual tailoring) and a potential weakness (insufficient clarity).

The Act provides fundamental safeguards to ensure patients' civil and human rights are addressed. It contains provisions to ensure that: 1) involuntary detention is a last resort; 2) the interests of the person are paramount; 3) the person will receive the best possible treatment in the least restrictive environment; and 4) any interference with the rights, dignity and self-respect of the person is kept to a minimum. The Act also contains provisions to ensure that a person and their primary carer are provided with clear information about their legal rights and their rights of appeal. There are good checks and balances in the process of deprivation of liberty, and the clinical processes (procedural requirements for patient referral) and legal processes (all the Dependency Certificates must be reviewed by a Magistrate, and Independent Official Visitors acting as an advocate on behalf of patients) occur independently from any political oversight.

A fundamental issue with the Act is the definition of 'treatment', and 'likely to benefit'. There is an important distinction between protection, stabilisation and assessment, compared to treatment. The objectives of the Act appear more concerned with the former: protecting an individual, stabilisation of the physical and mental state, comprehensive assessment and voluntary treatment engagement post program, versus the implication in the eligibility criteria that alcohol and other drug treatment is provided. The evaluators noted a tension between the former assessment, stabilisation, protection function and the latter treatment function, which goes to the heart of a number of themes arising from the process evaluation. There is significant pressure on beds (see waiting times section), and the provision of treatment (as opposed to protection, stabilisation and assessment) potentially increases the length of stay. In addition, the very existence of a delay to admission suggests that the immediate protection function may be compromised (someone assessed as in need of protection may no longer be in such a situation at the point in time that a bed becomes available). There is also some natural inclination for AOD clinicians within IDAT to want to (and be skilled at) providing AOD treatment interventions.

The conditions under which an extension to the Dependency Certificate can be granted under the Act are limited to those with acquired brain injury and impaired cognitive function ('drug and/or alcohol related brain injury'). The evaluators were unable to assess whether everyone who received an extension met the criteria. On the surface, it appeared a potential limitation to the legislation, with drug or alcohol related brain injury being only one of a number of potential reasons for seeking an extension to the DC.

The Model of Care

The Model of Care (MOC) provides a resource for managers, clinicians and other key stakeholders involved in supporting and delivering the Program. The MOC describes the principles, objectives, aims and the underpinning approach for the Program. The MOC represents an 'ideal' view of how IDAT should operate. The evaluation noted that the actual operations of the program varied from what was documented in the MOC. One example of this was the community treatment component (where limited 'aftercare' is the more apparent model in practice).

Numbers of referrals to the program

For the period from program commencement (31 May 2012) to 24 June 2016 (4 years), a total of 640 episodes of referral were recorded for IDAT. These 640 referrals reflected 529 unique patients, with 80 patients (15.12%) having two records (referred twice) and 31 patients (6%) having three records (referred three times). In the first year, referral numbers were low, as would be expected with a new program establishment. By the second year however, the rate of referral seemed to have stabilised (at 184 for year 2, 162 for year 3 and 181 for year 4). On average there was an almost equivalent referral rate between the two units – HSC received a total of 327 referrals over the period, and BF received a total of 313 referrals.

Referral sources

The majority of admitted patients were referred from a general health service (including general practitioners, hospital, and medical officer/specialist) at 59%; an alcohol and drug (AOD) treatment service (31%); and a mental health service (4.3%).

Rate of admission

Of the total of 640 episodes of referral, 342 resulted in admission to IDAT (following the issuance of a Dependency Certificate). The admission rates were slightly higher in year 1 (57% of all referrals), but since have stabilised to an average of 53%. This means that half of all referrals to IDAT did not result in an admission. Of those referrals that did not result in an admission, 202 referrals (31.5% of all referrals) were assessed as ineligible, and the remainder (96 referrals, representing 15% of all referrals) were assessed as eligible but not admitted (likely due to the bed availability and wait time – resulting in a second subsequent assessment at which time patients who were originally deemed eligible had received alternative treatment options).

Waiting times

The median waiting time for admitted patients was 15.5 days; with a mean of 27 days. The proportion of patients admitted on the day of referral was 9.8%. Almost 20% of patients attending IDAT waited more than 42 days before their admission. But 25% were admitted within 2 to 7 days after referral. The two IDAT units were extremely aware of the waiting time problem. The mere presence of waiting time seemed inconsistent with the intention of the Act, which is to provide protection and care for people at acute risk of harms.

In the context of demand exceeding supply, both of the IDAT units must engage in an ongoing, active patient prioritisation process. Stakeholders reported that patients were prioritised based on the needs, the extent to which the admission was deemed urgent (that is, the patient was highly likely to be harmed if not admitted), the fit between the Unit and the patient (where patients with serious mental health conditions could potentially benefit more from treatment at a psychiatric ward), and certain population groups (gender mix with existing patients).

Length of stay

The mean length of stay (LOS) across both units was 35.24 days (SD=22.80). The median LOS across both units was: 27.00 days (interquartile range from 24 to 49 days with the range from 0 to 138 days) and the modal LOS across both units was 27.00 days. The most common period of program retention was between 22 and 42 days (52.3%). The next most common category was an extension to the DC, received by 28.1% of IDAT patients. A relatively small proportion (19.6%) was discharged in under 21 days.

Completion rates

Of the 342 referrals that resulted in a patient being admitted into treatment, 63% (217) completed a full treatment episode and were discharged at the end of the treatment period, 3% (12) were

discharged after an initial extension period (i.e. Dependency Certificate was extended), 3% (9) were discharged after a subsequent, second extension period, 19% (66) were discharged early by the Accredited Medical Practitioner, 5% (16) were discharged early because the Dependency Certificate was not upheld by the Magistrate, 1.5% (5) absconded, and the exit status of 5% (18) was unclear.

Patient characteristics

IDAT patients in this period were an average age of 44 years, with 56% male, and 6.7% of ATSI origin. The majority were on some form of government support/pension (65%), 60% had attained year 11 or above, and about half had been married or in a de facto relationship. Alcohol was the principal drug of concern for the vast majority (83%), but more than half also had poly substance use. Across the IDAT program, the primary substance of concern for most admitted patients was alcohol (83.40%), followed by meth/amphetamines (9.09%), benzodiazepines (2.77%), heroin (1.98%) and cannabis (1.58%).

IDAT patients represented a complex group of alcohol and drug dependent patients. At admission, the majority of the patients (89% for HSC and 91.3% for BF) had a Severity of Dependence Scale (SDS) score of 3 and above, which meets the criteria for substance use dependence. At admission IDAT patients had a mean of 18.63 unit per day of alcohol consumption prior to admission. The majority of IDAT patients were presenting with physical health issue (73%), risk behaviour issue (66%) and psychiatric/mental health issue (42%).

A series of analyses were undertaken to compare the unique eligible patients (n=341) with those unique patients assessed but found to be ineligible (n=188), notwithstanding significant missing data. Eligible patients tend to be slightly older, less likely to be of ATSI origin, more likely to live alone, more likely to have alcohol as their primary drug of concern, and more likely to use poly drugs.

The treatment services provided

Both the stakeholders and the patients reported that the in-patient treatment component of the IDAT program was excellent, especially with regard to medical treatment and comprehensive assessment and care. The program offers patients the opportunity to engage in a comprehensive treatment program which addresses multiple issues: medical, psychiatric, addictions, and social issues, with a multi-disciplinary team and which includes aftercare planning.

In the Model of Care, aftercare is called 'community-based program', but the IDAT teams call it 'aftercare'. There is a lack of clarity in terminology. For some, 'aftercare' is (usually minimal) post-treatment support; for others aftercare implies the provision of the next stage of treatment[1]. For example, at BF, aftercare is more minimalist akin to assertive follow-up post-treatment and involves making a phone call to the patient. At HSC, the program is responsible for aftercare services for patients who live in Northern Sydney Local Health District because it is their local service. It is easier for this patient group because there are a lot more community-based treatment services in Northern Sydney, compared to rural areas.

These definitional issues notwithstanding, the extent to which aftercare services are being taken up by IDAT patients (which also speaks to whether IDAT changes the course of the person's addiction) was not able to be fully assessed in the process evaluation. Aftercare was the component identified by nearly all stakeholders as the most challenging part and also a weakness of the IDAT program. The challenges associated with provision of on-ongoing aftercare services for IDAT patients were reported to include:

- Limited human resource capacity within the IDAT team to do community outreach (especially for BF)

[1] This definition and terminology problem is not unique to IDAT

- Limited community-based service options for linking patients to community-care services
- Most IDAT patients are cognitively impaired and could be eligible for ACAT (Aged Care Assessment Team) housing but they are under 65 years of age so the option is limited.
- Limited availability of community-based services
- Limited housing and accommodation options.

Readmission

Of the total of 254 unique patients admitted to IDAT, 59 patients were admitted for a second (and a third episode of care) over the period under analysis. Comparing this group with those patients having a single admission to IDAT over the four year period under review, the analysis suggested that those admitted more than once were more likely to be younger, female, alcohol as the principle drug of concern, and with higher severity of dependence scores. At the same time, they were also less likely to be homeless, and had fewer physical health (and mental health) problems. Missing data prevented confident statistical analyses of these differences.

Transportation issues and the brokerage fund

Two categories of funds were provided for within IDAT: the Transport Fund was provided to each of the local health districts for coordination of transporting patients to IDAT units for admission. The Brokerage Fund was provided to each of the two hospitals where the two IDAT units are located. The Brokerage Fund can be used for a range of services to support and/or facilitate a patient's treatment, psychosocial welfare and recovery in the community.

Accessibility of both funds was identified as challenging. For the Transport Fund, in a number of LHDs, it was reportedly used for other purposes and was not made available to the referring ITLOs. As such, other existing transport funds (such as Patient Transport) were used in lieu. In other LHDs, funds were not spent because of lack of personnel who were able to take patients to the treatment units. For the Brokerage Fund, administrative difficulties local to the hospital accounts arrangements represented a barrier for the funds to be expended in a timely manner and this reportedly had critical flow-on effects on the continuity of patient care.

Families and primary carers

The critical role of a primary carer (potentially a family member) is identified in the IDAT Act. The Act stipulates that the primary carer must be notified within 24 hours after a Dependency Certificate has been issued as the primary carer should be informed of the patient's admission to the program, when they are on leave, if they do not return to the IDAT unit after leave, when their Dependency Certificate is extended, or when they are discharged and, where possible and appropriate, involved in the development of the care plan, particularly the community-based component of this plan.

A combination of the review of the Official Visitor reports, review of the patients' files, and the patient in-depth interviews suggested that nomination of primary carer was not attempted for a proportion of IDAT patients. It is likely that in many circumstances, the paperwork/formalities were completed when the patients were still physically and/or mentally unstable, rendering their ability to recall these events impaired. In other circumstances, the patients could not complete the primary carer nomination form for a range of practical reasons.

The evaluators observed that the IDAT patient group appeared to have few connections with family. Visits from family and loved ones while in the IDAT unit did occur but infrequently, made more difficult for many BF patients by the distance from their home community. Of the 12 patients interviewed, five reported close connections with family members and/or loved ones, including children, partners and parents. The other seven did not readily identify family support.

Bed occupancy rate

The bed occupancy rate (BOR) for IDAT (averaged over the four year period under review) was 86.2% for HSC and 60.1% for BF. Given that there was not a significant difference between the average LOS at BF compared to HSC, the much lower BOR for BF was likely due to two factors: 1) more limited staffing levels compared to HSC; and 2) referring services unable to find patients by the time admission could be offered.

Staffing level

As we understood it, there were three separate decision-makers involved in the local LHD staffing profile for IDAT: for the allied health staff, the staffing profile (and availability) was determined by the hospital Allied Health Director; for the medical staff it was determined by the hospital Clinical Director, and for the nursing staff it was determined by the hospital Director of Nursing. The current staffing profile was somewhat difficult to determine for each of the IDAT treatment units. This was partly because of the complex local LHD processes that occurred to determine a daily staffing profile.

The extent to which the hospital prioritises the staffing rosters for IDAT over and above all the other hospital wards was not known. Based on a number of assumptions and calculations, we calculated the current staffing profile to be 16.3 FTEs for BF and 16.2 FTEs for HSC. It is important to note that the low staffing profile for BF (in relation to the number of beds) was not due to lack of funding. It was reportedly due to decisions made by the hospital administration (likely based on the hospital policy on staff:patient ratio).

It was difficult to make an assessment of the appropriateness of the current staffing level at each of the two treatment units because many factors needed to be considered: 1) the number of beds; 2) the patient profile of each treatment unit (more patients admitted to BF were homeless, had serious physical health conditions, and mental health issues); 3) challenges in connecting patients to community-based services upon discharge for rural areas compared to urban areas; 4) efficiencies of scale (for HSC with the combined voluntary detoxification unit with IDAT); and 5) HSC team had responsibility to provide aftercare services for patients returning to Northern Sydney LHD.

In addition, the evaluators noted that there were many demands on staff time over and above the provision of central IDAT program functions. These included:

- Responding to enquiries from other health professionals, families and others;
- Much time spent on administrative work given the complexity of patients;
- Guardianship applications (for patients with mental health issues).

Human rights and coercion issues

There are various human rights protections built into the NSW Drug and Alcohol Treatment Act 2007 with a strong aim to address all human rights aspects that were the subject of criticism of the previous legislation (the Inebriates Act 1912).

Overall, all stakeholders interviewed (particularly the Magistrates and the Official Visitors) confirmed that the safeguards that are set out in the Act are properly exercised in practice. The stakeholders interviewed also stated that interpretation of the legislation through the model of care and implementation was more consistent with contemporary values regarding human rights and dignities of severely substance dependent people. The majority of the interviewed patients were aware of their rights and strongly felt that their rights were protected. All patients expressed that coercion into IDAT was justified and worked in their best interests. With regard to experience with the Magistrate hearing process, all interviewed patients expressed positive opinions of the procedure in the sense that their concerns were properly addressed by the Magistrate.

Perceptions of strengths and weaknesses

The balance between involuntary detention, human rights, and health care was identified by the majority of stakeholders as a significant strength of IDAT. As intended by the legislators, the program is not simply a short-term detention program focussed solely on protecting an individual from harm, but it also provides the opportunity to change harmful alcohol and other drug behaviours into the future. However, achieving this balance between protection and AOD treatment is challenging and gives rise to some contradictions within the program (e.g. eligibility criteria based on risk of immediate harm to self or others versus the likelihood of benefit from AOD treatment). Nonetheless, the achieved balance was a significant strength, as perceived by stakeholders and other jurisdictions who are seeking to emulate this model.

While acknowledging that the fundamental purpose of the procedural requirements involved in the referral process is to ensure good checks and balances are in place in the process of deprivation of liberty, the majority of the ITLOs identified that the administratively cumbersome referral process was a weakness, along with the lack of aftercare provision and follow-up.

From the clinical perspective, stakeholders identified that the program provides high standards of medical treatment accompanied by comprehensive assessment and care, which is another strength of the program. The program offers the patients the opportunity to engage in a comprehensive treatment program which addresses multiple issues. Ironically, such a comprehensive and high standard of care was reportedly identified as lacking in the community.

While some stakeholders felt that the program was well-resourced (from a budget allocation point of view, and relative to other AOD treatment services), other stakeholders noted the lack of resources as one of the weaknesses. This lack of resources was reportedly due to the cumbersome administrative process within hospital administration rather than a lack of budget. The complexity of staffing in a unit that is part of a larger LHD system (with priorities other than IDAT) was noted. In a similar context, the required administrative processes (hospital bureaucracy) in order to spend the brokerage funds were identified as a weakness.

In relation to the length of the program (28 days as specified in the Act), on the one hand this was perceived as a strength in terms of a relatively short time for the deprivation of liberty (with the option to cease earlier than 28 days) but it was regarded by some stakeholders as insufficient time to achieve the comprehensive assessment, stabilisation, treatment and aftercare planning for a substantial proportion of patients.

The largest weakness, identified by almost every stakeholder, was access to beds. The significant waiting time for patient entry was perceived to be a substantial issue for the program, especially in the context where these waiting patients were highly vulnerable and had been assessed as being at risk to themselves or others, and requiring protection.

Data issues

For monitoring and accountability purpose, from the onset of the program a comprehensive data collection system was established to enable ongoing monitoring and evaluation of the program. The IDAT database was developed to capture both administrative data (including referral, admission and discharge, and Magistrate review) and a comprehensive suite of outcome data (at assessment, admission, at discharge, 1 month, 3 month and 6 month post discharge).

A number of issues were identified in relation to data pertaining to the IDAT program. These were:

- Data collection and the use of paper-based forms
- Missing data and outcome data
- Database

These various issues largely surround two key aspects: responsibility and resources. The responsibility for data collection and data entry was not clear, and relatedly, the resources for this task were reportedly insufficient. Only 29% of all admitted patients had data for the 1-month follow-up. This dropped to 21% at 3 months, and 18% at 6 months. For HSC 40% of the patients were contacted at 1 and 3 months (with lower number at 6 months). For BF the percentage of patients who were contacted at 1, 3 and 6 months was very small (by 6 months, only 6% had been contacted).

For this reason, the evaluators could only use the administrative data for the purpose of this report. It was not possible to analyse the outcome data because the sample was not representative (it is highly likely to over-represent the success of the program).

Conclusions

Involuntary detention for the purposes of drug and alcohol treatment is a complex matter, which requires balancing the risks to the individual against their human rights. Whilst recognising the infringement on human rights associated with involuntary detention and treatment, the majority of the stakeholders (including patients) interviewed for this process evaluation believed that the NSW IDAT program is an appropriate last resort option, which balances involuntary detention with human rights and health care.

The key issue identified in this process evaluation was the extent to which the IDAT program should focus on the provision of comprehensive alcohol and other drug treatment versus providing immediate medical care (including detoxification) when people are at acute risk of harm to themselves. The provision of comprehensive alcohol and other drug treatment is associated with a program capacity problem – represented by the current waiting times, and reflecting the low acceptance rate (approximately 50% of referrals are admitted), which is then associated with disincentives to refer, alongside resource-intensive pre-program assessment and referral procedures. Furthermore, the community aftercare component of the program appears not to have been implemented as originally envisaged in the Model of Care. If the focus is on acute resolution of immediate health issues, then the uneven aftercare implementation is less of a concern.

With only a very small number of non-completions and reportedly comprehensive and high quality care provided within IDAT, it is expected that patient outcomes will be positive. However, this process evaluation did not assess patient outcomes; the outcome study underway (2016 to 2019) will be an independent, comprehensive assessment of the treatment outcomes associated with the NSW IDAT program.

1. Introduction and context

The concept of compulsory treatment was founded on the 1960s notion that some people who use drugs are motivated for treatment, while others are not [1]. Those who are not motivated for treatment may require some lever to facilitate treatment entry. This lever is often referred to as 'rational authority' and entails a mandatory, but not punitive, requirement to attend treatment.[2] Compulsory treatment aims to force treatment commencement among involuntary clients and provide an opportunity for therapeutic benefits to take effect [3]. Laws relating to compulsory treatment have been established in response to a range of conditions, including 'mental illness, developmental disabilities, sexual and violent offences, some dually diagnosed conditions and A&D use and dependence' [3]. Here we distinguish between 6 main models: diversion programs; court-mandated treatment; civil commitment; centre-based compulsory rehabilitation; quasi compulsory treatment; and incarceration-based treatment. The model of direct relevance to IDAT is civil commitment, but we provide brief details of all six models.

Generally, compulsory treatment (for alcohol use and substance use/dependence) refers to interventions where individuals are forced (or coerced) into treatment as a result of a legal order (in the context of most developed countries) or administrative sanction (in the context of developing countries, particularly East and Southeast Asian countries). In the main, and as will be seen in this brief literature review, compulsory treatment models pertain to criminal law (and thus to drug offending or drug-related offending). Most research on involuntary treatment has come from this frame of reference.

An international review found that as of 2009, 69% of a sample of countries (n=104) had criminal laws allowing for compulsory drug treatment [4]. While most often consisting of forced inpatient treatment (i.e., individuals are placed under the care and supervision of treatment institutions), compulsory treatment can nevertheless be designed as outpatient treatment as well, either using an individualised treatment or group-based model that can include psychological assessment, medical consultation and behavioural therapy [5, 6]. There is considerable variability in the ways in which compulsory treatment is implemented internationally, with substantial differences in the people targeted, levels of legal coercion, the point in proceedings at which it is imposed, and whether consent needs to be given [7, 8].

In many developed countries, including the United States and Australia, the focus of compulsory treatment is on people who use drugs charged with drug use offences (with the act of using illicit drugs an offence itself) while most European countries focus on illicit drug users who have been arrested for various crimes. In many countries (e.g., United States, Spain, Italy, the Netherlands), courts can impose sentences that include a requirement to enter drug treatment. In some countries (e.g., Britain and Holland), offenders might be encouraged to seek treatment as soon as they are arrested. In others (e.g., Austria, the Netherlands), the prosecutor may encourage the offender to enter treatment by suspending proceedings on the condition that he or she enters treatment. During the sentence, compulsory treatment can be applied, as it is in Italy, by releasing offenders from prison on condition that they enter drug treatment. In most European countries, entry to treatment depends on the consent of the offender, who is given the somewhat constrained choice of either entering treatment or serving another punishment (such as imprisonment). However, in Austria, Germany and the Netherlands, the courts can also impose sentences that send criminals to a treatment centre, without the person's consent to enter treatment.

By comparison, the approach to compulsory treatment taken in most East and Southeast Asian countries (China and Vietnam included) and some regions including Latin America and Eastern Europe is much stricter. People who use drugs who have broken the law (by using illicit drugs) can be

compelled to be detained in a compulsory rehabilitation centre for up to two years without either consent or due process [7, 9]. In most East and Southeast Asian countries, compulsory treatment mostly consists of residential, long-term and abstinence-based treatment in facilities that resemble prisons, located in remote areas. International observers have expressed concern with respect to evidence that compulsory treatment centres in East and Southeast Asia appear to incorporate approaches generally unsupported by scientific evidence (such as forced labour work or shaming), and employ harsh physical punishment for individuals who relapse into drug use [10, 11]. Therefore, many commentators [12-15] criticise this approach and question the legitimacy of the term 'treatment' used to describe this approach, suggesting that the 'detention' should be a more appropriate term.

Differences in compulsory systems make it harder to compare them, but do offer the opportunity to examine what types of compulsory treatment are more effective with which type of person. For this reason, some scholars distinguish compulsory treatment from coerced treatment, whereby compulsory treatment refers to interventions where the individual is forced to enter treatment primarily as a result of a legal order, that is, either a civil commitment or an order disposing of a criminal case, without a choice. In contrast, coerced treatment refers to people being given the choice between entering treatment for their drug using behaviour or facing legal sanction, such as imprisonment [16]. The most widely known example of coerced treatment is court-mandated treatment, where a choice is given between compulsory drug treatment or prosecution.[17]

Given the complexity in structure and arrangements of compulsory treatment approaches and the diverse characteristics of the targeted participants served by each of these approaches, Table 1 provides a conceptual schema that facilitates the comparison of the six most commonly discussed compulsory treatment approaches with the aim to provide a conceptual framework for distinction. They are: *a) diversion programs; b) court-mandated treatment; c) civil commitment; d) centre-based compulsory rehabilitation; e) quasi-compulsory treatment; and f). incarceration-based treatment.* It can be seen that the majority of compulsory treatment approaches are covered under some form of criminal law and pertain to offending (with the exception of civil commitment). Seven features are described in Table 1 for the treatment approaches: 1) the nature of offence committed (drug offence or drug-related offence); 2) freedom of choice (choice between compulsory treatment or prosecution); 3) treatment duration; 4) treatment setting (community-based versus institution-based); 5) freedom of movement during treatment; 6) types of treatment services provided; and 7) the scale and development of the approach. It should be recognised that any descriptive typology is likely to miss the complexity of the individual experience of treatment, which depends on much more than the legal and clinical protocols in place [8]. As such, treatment options presented in Table 1 are not mutually exclusive. For example, the legislative status varies from country to country [1]. In Australia, although possession and use of illicit substances, and public drunkenness, are criminal offences, alcohol and drug dependence itself is not a crime, nor is it subject to criminal justice system intervention unless associated with an offence. Similarly, in the U.S., alcohol and drug dependent persons are not viewed as offenders, although criminal conduct such as the possession and sale of illicit substances can be prosecuted [1]. In addition, in the literature, the term 'offender' refers to both 'drug offender' and 'drug-related offender'. Drug offenders are people who use drugs, possess drugs or traffic drugs, and drug-related offenders are people who commit a criminal behaviour to support their drug use [18]. The text in this section of the report will follow this convention. The following sections will provide brief descriptions for each of these approaches. It is important to note that most of the approaches described below focus on illicit drug use/dependence. Measures for mandating treatment for alcohol-dependent people (non-offenders) are somewhat embedded in *civil commitment* approach.

Diversion possibilities exist throughout criminal justice proceedings for offenders to be diverted into treatment and can apply to both 'drug offenders' and to 'drug-related offenders'. People are given a choice between compulsory treatment and prosecution. Diversion can occur at the early stages of criminal proceedings (i.e. pre-arrest or pre-trial) or later stages (i.e., post-sentence). Depending on the severity of the committed offence, referral could involve offenders being diverted into treatment as an alternative to being processed any further [7] or given a warning/education session [18]. Diversion could be offered through multiple avenues: police diversion, court diversion or specialist drug court diversion. Alternatively, offenders may be required to complete a treatment program before sanctions are lifted or may be mandated to seek treatment in lieu of incarceration or as a condition of probation [19]. The goal of diversion programs is to re-direct drug-related offenders away from the judicial process with the aim to provide treatment, reduce imprisonment rate and save public resources [20, 21]. Diversion programs across countries and across states within one country vary within the justice system (police versus court based), eligibility criteria, drugs targeted, diversionary discretion, referral procedures, interventions and penalties for non-compliance [22]. If the choice of compulsory treatment is made, the treatment duration can be from one session to three months or one year, depending on the types of referral [18].

Court-mandated treatment (a.k.a. drug court) is one type of *diversion* and is defined by the New South Wales Standing Committee on Social Issues [23] as 'the treatment of an offender, required by a court order'. It usually occurs where the offender's drug dependence has contributed to the offending criminal behaviour. In its simplest form, a drug court uses the power and authority of a magistrate to keep a drug-related offender in treatment, providing rewards for successes and sanctions for failures [24]. Depending on the structure of the drug court, successful completion may be accompanied with dropping the charges that brought the person before the court (pre-plea/ diversionary court) or expunging the drug-related offence from the record (post-plea court) [24]. Drug courts were introduced in the US in the late 1980s [25] and by the turn of the 21st century had become the contemporary compulsory treatment model employed in many Western countries [7]. There is suggestive evidence from quasi-experimental study designs that drug courts reduce recidivism in the short term of one to three years [26-29]. However, the effects on recidivism (assuming them to be causal) are modest [30].

Civil commitment is one type of compulsory treatment imposed on people who are severely dependent on alcohol or drugs such that their substance dependence impairs their decision-making capability. Civil commitment allows them no choice in the matter. For example, New Zealand's *Alcoholism and Drug Addiction Act 1966* provides for compulsory detention and treatment of people who use illicit drugs and people who are severely dependent on alcohol for up to two years and is used to commit approximately 200 people per year [23]. The New Zealand Act is under review and is about to be replaced by an Act very similar to the NSW Act except that the initial period of detention is 56 days rather than 28 days[2]. In the United States, civil commitment does exist but it cannot be readily distinguished from offence-based detention, the key criterion being that they are either unwilling or unable to control their alcohol or substance abuse, or to obtain services on their own [31]. In Europe (except Sweden), although once a popular strategy, civil commitment is no longer heavily relied upon due to human rights concerns [32, 33].

Centre-based compulsory rehabilitation in East and Southeast Asian settings is presented separately from civil commitment in the context of developed countries because the concept of 'treatment' in Asian countries is different from developed countries. By the definition of "choice" (treatment for drug offenders with no freedom of choice), the compulsory treatment approach that has been widely used in East and Southeast Asia in the last two decades falls into this category even though the governments of East and Southeast Asia do not use this language. The language used is

[2] Personal communication provided by Dr Leon Nixon, IDAT Program Director at Bloomfield Hospital.

'centre-based compulsory rehabilitation' or 're-educational centers approach'. Specifically in countries such as China, Vietnam, Thailand, Malaysia, Cambodia, Laos, Myanmar and the Philippines, it is still the most dominant approach in dealing with people who use illicit drugs [10] who are processed through an administrative order for illicit drug use behaviors, rather than a legal order through the criminal justice system designed for drug-related offenders as is the case in most developed countries. The 'rehabilitation' strategies in compulsory centers focus mainly on moral teaching, basic health care services, 'cold turkey' detoxification, forced labour work (in the belief that labour work will directly aid in drug dependency treatment, for example, by sweating out toxins) [10]. Although an accurate estimate of the total number of people detained in compulsory centers throughout East and Southeast Asia is difficult to determine, it has been reported that in 2013 more than 550,000 people were detained in over 1,000 centers in the above-listed eight countries [12, 34]. None of the other forms of compulsory treatment currently exists in East and Southeast Asia, except for Malaysia where a court-ordered mechanism has been used occasionally for people who are confirmed as people who use drugs by the police [35].

Quasi-compulsory treatment (QCT) is a term typically used in European literature, and is defined as 'the treatment of drug-dependent offenders that is motivated, ordered, or supervised by the criminal justice system and takes place outside regular prisons' [8]. QTC is in essence the European version of the American drug court system [36] even though the QCT arrangements in each country differ [37]. In most contexts, the offender's consent to enter treatment is required and the offender is given a choice of either going into treatment or imprisonment for the committed offence. Quasi-compulsory treatment may be applied at any stage of the criminal justice system [8] and therefore has a broader meaning and includes all types of coercive treatment that are mandated through the criminal justice system. In Europe, QCT is applied in a variety of ways. England uses sentences which enable courts to order an offender to enter treatment for a specified period as an alternative to some other sentence, usually imprisonment. In Austria, Germany and Switzerland, legal arrangements are in place that can broadly be described as 'therapy instead of punishment', with the possibility to suspend prosecution or sentence on the condition that the offender enters treatment. In Italy, prison sentences of no more than 4 years, or the last 4 years of a longer prison sentence, can be replaced by a period in judicially supervised drug treatment but require the informed consent of the offender. This is in contrast to the Dutch SOV system, in which offenders may be placed in treatment institutions without their consent. European arrangements for QCT differ from the drug courts established in many states of the U.S., in that they are not limited to drug offenders and are often used for persistent offenders, who would be excluded from several of the American drug court systems [37].

Given the uniqueness of QCT, evidence of effectiveness can only be sought from studies that evaluate the effectiveness of compulsory treatment programs specifically defined as QCT in Europe. In general, studies – predominantly from English-speaking countries – tend to agree that QCT can be effective in reducing substance use and crime, and that it can improve health and social integration. They suggest that QCT is at least as effective as voluntary treatment [38-40] and that legal compulsion can improve retention in treatment. In contrast, literature from other countries (e.g. Germany and the Netherlands) tends to be more pessimistic about the effectiveness of QCT [8]. The challenge is QCT arrangements among countries differ in the stage at which people are encouraged to begin treatment, the level of compulsion used, and the types of crimes that are of focus [36, 41]. These methodological and political differences among various countries might explain the limited international comparisons of QCT arrangements [37]. In order to overcome this challenge, a European multimethod, multicentre study was conducted in 2009 [37]. The study was able to confirm that QCT was at least as effective as voluntary treatment, with higher reduction of substance use found for inpatient-treated participants compared to outpatient-treated participants. For

reduction of crime and retention rate, study results were similar between QCT and voluntary groups, after controlling for various factors.

Incarceration-based treatment in developed countries (presented in the last column) is one modality of compulsory treatment provided in in-patient settings (versus out-patient, community-based settings) and is generally nested within a broader criminal justice-oriented response to drug-related harms. The reason incarceration-based treatment in developed countries is presented in a separate column is because 'boot-camp' is one of the four treatment sub-types and has characteristics that resemble those of the compulsory treatment approach in East and Southeast Asia. As such, empirical research on 'boot-camp' approaches could be generalized to compulsory treatment in East and Southeast Asian settings if all other intervention features are also similar.

Table 1: Conceptual schema facilitating the comparison of compulsory and/or coerced treatment approaches

Types	**Diversion**	**Drug Court**	**Civil commitment in developed countries**	**Center-based compulsory rehabilitation in Asian setting**	**Quasi-Compulsory Treatment (European context)**	**Incarceration-based treatment in developed countries**
Nature of offence committed	Both drug offence and drug-related offence [18]	Medium to high risk criminal offence: drug possession, property offences, driving while under influence, felony [42]	No offence required. Intervention is based on evidence of self-harm [7]	Drug offence; intervention is based on positive urine screen [43]	Minor to medium risk criminal offence: drug possession, property offences [44]	Serious criminal offences such as robbery, felony where sanctions have to be mandated; and for repeat drug-related offenders
Freedom of choice	A choice is given between treatment and prosecution	A choice is given between treatment and prosecution	No choice	No choice	A choice is given between treatment and prosecution	A choice is given, most of the time in exchange for an early release
Treatment duration	Can be 1 session, or range from 3 months to one year, depending on types of referral [18]	Most drug courts require a minimum program length of one year [45]	14 days to 6 months (12 months in some extreme circumstances) [46]	Approximately 2 years	Average 15 months, with minimum of 12 months [44]	Duration of sentencing for criminal behaviors committed as decided by the court
Treatment setting	Mostly at community-based treatment facilities	Can be inpatient or outpatient settings depending on choice of individual and assessment by clinical staff, mostly drug-free interventions	Both facility-based and community-based [7]	Center-based (facility-based in remote areas)	Can be inpatient or outpatient settings depending on choice of individual and assessment by clinical staff [44]	Prison-based
Freedom of movement	Yes (but with requirement of scheduled reporting for urine testing)	Yes (but with requirement of scheduled reporting for urine testing).	To a limited extent [46]	No	Yes (but with requirement of scheduled reporting for urine testing)	No
Types of treatment	Drug dependence treatment services	Drug dependence treatment services that	Medical services (detoxification,	Moral teaching, law education, labor	Drug dependence treatment services	Four sub-types: 1) Therapeutic

Types	Diversion	Drug Court	Civil commitment in developed countries	Center-based compulsory rehabilitation in Asian setting	Quasi-Compulsory Treatment (European context)	Incarceration-based treatment in developed countries
services provided	that are available in the community, mostly outpatient services the option of choice	are available in the community, mostly outpatient services and residential rehab/TC	substitution treatment) and psychosocial services (therapeutic community, 12-steps, drug counseling)	work, structured daily activities, basic health care	that are available in the community, with a combination of outpatient and inpatient services	communities; 2) methadone treatment; 3) counseling; 12-step programs 4) boot camp [47, 48]
Scale and development	Large scale, increasing globally	Large scale. In December 2011, there were 2,400 drug courts in the US (Huddleston and Marlowe, 2011). In Australia, as of 2007 drug courts had been established in all but two jurisdictions with 9 programs in total [18]	Small scale, becoming less popular [7]	Large scale, peak development during 2000–2010, scale being maintained [12]. In 2004, China had 583 centers for 300,000 people [49] and Vietnam had 121 centers for 60,000 people [50].	Large scale in Europe. In England, since 2001 annual average 8,500 entries to compulsory treatment imposed by court [36]	Large scale, popular since early 20th century [48]

Definition in the context of the NSW Drug and Alcohol Treatment Act 2007

According to the categories and definitions above, the Drug and Alcohol Treatment (IDAT) Program under the NSW Drug and Alcohol Treatment Act 2007 is a form of civil commitment. The terminology used in the NSW Act is "involuntary (detention and) treatment" instead of the term "civil commitment". Therefore, for the remainder of this section, the term "involuntary treatment" and "civil commitment" might be used interchangeably.

The effectiveness of drug and alcohol involuntary treatment

In the context of the NSW Drug and Alcohol Treatment Act 2007, the literature review in this report focuses on the evidence of effectiveness of alcohol and other drug (AOD) involuntary treatment (civil commitment). In addition, as explained previously, the legislative basis and the legal framework in mandating people who are drug or alcohol dependent are different between developed countries and developing countries (in South East Asia and Latin America). Therefore, the review of the literature in this report only focus on studies conducted in developed countries on involuntary treatment (or civil commitment) for drug and alcohol dependent people who are not necessarily involved with the criminal justice system.

Wild and colleagues [40] completed a systematic review and considered compulsory treatment for substance dependence broadly. The authors reported on 18 quantitative comparative and longitudinal studies. Eight related to legal mandates (mainly involving drug-related offenders being mandated or coerced to treatment through the criminal justice system), five were formal mandates (via coercion outside the criminal justice system, e.g., via the employer, welfare system), three were informal mandates (family, group persuasion), and two were mixed mandates (employers, informal family, court mandated). None of these studies was relevant for the context of the NSW Act, primarily because they related to coercion of drug-related offenders identified through the criminal justice system. With respect to the body of research that exists, Wild et al. (2002) reported that mandated treatment generally demonstrated better outcomes compared to non-compulsory treatment in terms of treatment process (uptake of treatment following referral). Results indicated more equivocal results for retention rates with 6/11 studies reviewed by Wild et al. (2002) reporting higher participation for clients receiving compulsory treatment than those receiving non-compulsory treatment. In terms of illicit drug use outcomes, two of eight studies found superior outcomes for clients receiving compulsory treatment compared with voluntary treatment, whilst the other six studies reported no difference in benefit. Wild et al. (2002) also noted that most empirical research had employed non-equivalent comparison groups at baseline, with those receiving mandatory treatment more likely to be drug-related offenders. They argued that such population differences could bias results at outcome.

A review of Australian legislation, key informant interviews, and reference group consultation was included in a discussion document by Pritchard and colleagues [7]. Three reviews were identified: two systematic reviews of studies of coercion for drug-related offenders [8, 51], and a narrative review by [40] (discussed in previous paragraph). Commenting specifically on research relating to civil commitment of drug-offenders, Pritchard et al.'s review concluded that long term effectiveness has not been evaluated, with only some, mainly anecdotal, evidence suggesting that civil commitment for short periods can be effective in minimising harm. That is, to provide short term involuntary care in life threatening circumstances is justified. While alcohol and drug dependence is generally viewed as a chronic condition, acute emergency situations do occur, and if civil commitment is one mechanism to prevent deaths and minimise harm, then it can be considered to play a useful role. Nevertheless, the authors of the review suggested that there may be other

mechanisms that are as effective, or more so, as compared with compulsory treatment but this has not been robustly investigated.

The UK National Institute for Health and Clinical Excellence (NICE) review [52] undertaken by the National Collaborating Centre for Mental Health was a guideline on drug misuse. A sub-topic within this review related specifically to residential/inpatient legally coerced treatment interventions across the spectrum of compulsory treatment. The authors reported on evidence from a single systematic review [40] (discussed in previous paragraph). The NICE review argued that any negative outcomes for legally mandated treatments could be due to the nature of the difficulties of those entering mandated treatment when compared with those in voluntary treatment, rather than the compulsory nature of their referral/treatment per se.

The New Zealand Ministry of Health commissioned a review of the Alcohol and Drug Addiction Act (ADA) 1966 by Broadstock et al. (2008) with the goal to inform decision making on interventions for alcohol and drug dependent non-offenders. The authors reported on evidence from four reviews: [7, 40, 52] and [1]. Broadstock et al. (2008) concluded that the area of compulsory treatment for people who are mandated purely on the basis of their alcohol use or illicit drug use has attracted very little research attention and that based on the results from their review, there is no reliable evidence pertaining to the effectiveness of compulsory residential treatment for this population compared with any other treatment approach.

The data resulting from the four most current literature reviews outlined above were surprisingly sparse, compared to the current magnitude of AOD compulsory treatment for offenders in many countries, including the United States, Australia, New Zealand, and Sweden. Reviews of the field have consistently reported the lack of research on AOD involuntary treatment in non-offender population, and conclusions have often been drawn from expert opinions, stakeholder interviews, case studies, and largely anecdotal reports. It is therefore not possible to draw conclusions from the current evidence base about whether AOD involuntary treatment in non-offender populations is likely to be more or less effective than non-mandatory treatment modalities for people with substance dependence.

What other jurisdictions are doing?
In Australia, civil commitment legislation for substance dependence exists in New South Wales, Victoria and Tasmania, while the Northern Territory has involuntary treatment orders for alcohol and volatile substance dependence. Other states and territories of Australia do not have specific equivalent legislation, but it is under active consideration in Western Australia. The specific legislations are listed below:

Victoria	*Severe Substance Dependence Treatment Act 2010* (Vic)
New South Wales	*Drug and Alcohol Treatment Act 2007* (NSW)
Tasmania	*Alcohol and Drug Dependency Act 1968* (Tas)
Northern Territory	*Alcohol Mandatory Treatment Act 2013* (NT) (AMT Act)

Table 2 below summarises these comparisons by the following categories: 1) objects of the legislation; 2) criteria for detention and treatment; 3) time for detention and treatment; and 4) human rights safeguard measures.

Victoria

The current Victorian legislation on involuntary treatment is the *Severe Substance Dependence Treatment Act 2010* (SSDT), which came into effect on 1 March 2011. The main provisions of the SSDT are that it grants adults with the power to lodge an application for a detention and treatment order, which if granted, enables a person to be detained and treated to enable medically assisted withdrawal from severe substance dependence, for up to 14 days. All persons subject to a detention or treatment order under the SSDT have access to legal representation and advocacy support through the Public Advocate and Victorian Legal Aid. There are also provisions for a discharge and case management plan (s36). This is to be developed in conjunction with the person on the detention and treatment order. However, the focus on service upon discharge is very limited.

An application for a detention and treatment order must contain a medical recommendation by a prescribed registered medical practitioner and they must consult and seek a second opinion from a senior clinician at a drug and alcohol treatment centre. Once the assessment has been completed a person can lodge an application with the Magistrates Court. The person subject to the detention and treatment order will then be granted the right to obtain legal representation. A hearing must be held within 72 hours of the filing of the application, and the person who is subject to the application has the right to appeal.

Once a court order is made, the person is given a priority listing on the waiting list to access a treatment service. The legislation provides that a person can only be placed on a detention and treatment order for a maximum of fourteen days. This differs somewhat from the previous Act *(the Alcoholics and Drug Dependent Persons Act 1968 - ADDPA)*, which allowed the court to make a treatment order for a maximum of seven days, with a provision for the treatment centre to apply for an additional seven day extension.

The SSDT Act also differs from the ADDPA in that it introduces a set of guidelines which affect the operation of treatment centres and provides for greater involvement of a person throughout all stages of their treatment. As part of the SSDT provisions, a person entering a treatment facility is given the right to nominate a person to act to protect their interests. This nominated person may act as an advocate and provide support and assistance to the person receiving treatment for their dependence. The Office of the Public Advocate also plays an important role in the administration of this legislation. Acting as an independent voice, the public advocate visits and supports the person subject to the detention and treatment order with the aim of assisting them in exercising their rights (*Severe Substance Dependence Treatment Act 2010* and Parliament of Victoria, *Severe Substance Dependent Treatment Bill 2009*, Second Reading Speech 2010).

Northern Territory

The Alcohol Mandatory Treatment Act 2013 (NT) (AMT Act) commenced on 1 July 2013. It is stated in the legislation that the Act is a health based legislative framework for the mandated assessment, treatment and aftercare of people who chronically misuse alcohol and who are either unlikely or unable to voluntarily access treatment option. The Act also aims to stabilise and improve the health and social functioning of people, restore their capacity to make decisions about their alcohol use and personal welfare, and improve their access to ongoing treatment.

Clients in the system are clinically assessed and an independent Tribunal then decides their best treatment option. Income management orders can also be applied. An individual treatment plan is developed for each person, with components varying according to the needs of the person and the

kind of programs and approaches offered by different agencies. An aftercare plan is negotiated at the end of treatment to support reintegration.

The AMT system is aimed at people who are chronically drinking and publicly intoxicated. The *Police Administration Act 1981* (NT) provides that, where a person is apprehended by police 3 times for public intoxication over 2 months, they must be referred by a senior assessment clinician (SAC) in accordance with the AMT Act. Under the AMT Act, the SAC – who is not required to be a medical doctor – must assess the individual within 96 hours and then request a mental health assessment or make an application to the Alcohol Mandatory Treatment Tribunal. The tribunal is not required to follow the SAC's assessment report recommendations, but can make a mandatory treatment order in relation to the person if they meet the same criteria used by the SAC [53]. The AMT treatment period does not exceed 3 months. It is important to note that the AMT system is the only system in Australia that sets income management orders and allows a treatment service to charge persons under AMT for consumables. Some commentators regard the AMT as a criminal justice rather than health or medical response per se (triggered by the process of arrest) and speculate that one effect of this is that the program focusses (problematically) on Aboriginal people [3].

Tasmania

The current Tasmanian *Alcohol and Drug Dependency Act 1968* (the ADDA) makes provision with respect to the treatment and control of persons suffering from alcohol or drug dependency. The main aim of the ADDA was to provide for a separate legislative regime for the treatment of alcoholism partly because of the absence of a serious drug problem in Tasmania in the 1960s. Until the ADDA's development, alcohol dependent people who were unresponsive to social pressures and who required hospitalisation were sent to mental hospitals under an involuntary order pursuant to the *Mental Health Act 1963*. At the time, the consensus of opinion appeared to be against alcohol and drug dependency being coupled with mental illness and a suggestion was made that a separate Act should be introduced to cover these cases [54].

Under the ADDA, an involuntary application must be made with the support or recommendation of a practitioner, and a person may be detained for up to fourteen days after admission on the basis of an application that is made with such support or on recommendation. The detention may be extended for up to six months if the "appropriate medical officer" (the superintendent of the treatment centre or a medical practitioner directed by the superintendent to examine the patient) issues a certificate to that effect. A person's detention may also be extended for subsequent six month periods if the medical officer deems this to be necessary and in the interest of the patient's health or safety or the protection of others. A person who is being detained, or his or her relative, may apply to the Alcohol and Drug Dependency Tribunal (the Tribunal) for the person's discharge from the treatment centre. Other than that, there are limited provisions to protect the patients' human rights and legal rights. A discussion paper for the review of the Tasmanian Alcohol and Drug Dependency Act 1968 on behalf of the Tasmanian Department of Health and Human Services states that "The ADDA is deficient in its adherence to international human rights principles in a range of respects. In particular the ADDA does not require a person's detention to be provided in the least restrictive manner; it does not clearly establish what a detained person's rights are and there is a lack of oversight around detention decisions."[54]

[3] Personal communication provided by Dr Leon Nixon, IDAT Program Director at Bloomfield Hospital.

Published results on the NSW IDAT program

At the point of undertaking this process evaluation, no formal evaluation of the NSW IDAT had been conducted. Indeed, this is the purpose of this process evaluation and the subsequent outcome evaluation. However, practitioners within the NSW IDAT program have reported data on a sample of IDAT patients[55]. Specifically, they found that at six-month follow-up relapse to previous levels of drinking occurred in 11 patients (27.5%); five (12.5%) were lost to follow-up; 13 (32.5%) were abstinent and seven (17.5%) continued to drink alcohol but at a reduced amount and frequency. Death was reported for four patients (10%), two from acute gastrointestinal haemorrhage, one from accidental overdose and one from traumatic injury when intoxicated. This work was based on a small sample (n=40 patients), and without a comparison group. The process evaluation reported herein does not address patient outcomes, but the associated outcome study (due for completion in 2019) will provide data on patient outcomes.

Table 2: Objects of the legislation, criteria for detention, time limit and human rights safeguards

	Objects	**Criteria**	**Time limit**	**Human rights safeguards**
NSW	To provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety To facilitate a comprehensive assessment of those persons in relation to their dependency. To facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal To give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare (s3(1))	A person may have a dependency certificate issued against them if: the person has a severe substance dependence; and care, treatment or control is necessary to protect the person from serious harm; and the person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and no other appropriate and less restrictive means for dealing with the person are reasonably available. (s9(3))	28 days with possible extension to up to 3 months (s14(a)).	A person must not be detained in a treatment centre under this Act unless an accredited medical practitioner has issued a dependency certificate in relation to the person (s7)
Victoria	To provide for the detention and treatment of persons with a severe substance dependence where this is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health (s1(a)). To enhance the capacity of those persons to make decisions about their substance use and personal health, welfare and safety (s1(b)).	person must be 18 years old (s8(1)); and have a severe substance dependence; and because of the person's severe substance dependence, immediate treatment is necessary as a matter of urgency to save the person's life or prevent serious damage to the person's health; and the treatment can only be provided to the person through the admission and detention of the person in a treatment centre; and there is no less restrictive means reasonably available to ensure the person receives the treatment. (s8(2))	14 days (s20(3)).	All of the objects of the Act must be performed so that detention and treatment is a last resort; and human rights and any interference with the dignity and self-respect of a person who is the subject of any actions authorised under this Act are kept to the minimum necessary. (s4)

Tasmania	(Tasmania Act does not contain an objects/principles section)	An admission application may be made in respect of a patient on the grounds - (a) that he/she is suffering from alcohol dependency or drug dependency to a degree that warrants his detention in a treatment centre for medical treatment; and (b) that it is necessary in the interests of his health or safety or for the protection of other persons that he be so detained. (s24) Period of detention in place of safety: Where a person has been conveyed to a place of safety under this Part he/she may, during the period of 72 hours following that conveyance, be detained in any place of safety, and during that period may be conveyed from one place of safety to another by a police officer or a welfare officer. (s60)	6 months from the date of admission (s27(1)).	A discussion paper for the review of the Tasmanian *Alcohol and Drug Dependency Act 1968* on behalf of the Tasmanian Department of Health and Human Services states that "The ADDA is deficient in its adherence to international human rights principles in a range of respects. In particular the ADDA does not require a person's detention to be provided in the least restrictive manner; it does not clearly establish what a detained person's rights are and there is a lack of oversight around detention decisions."
NT, AMT Act	The objects of this Act are to assist and protect from harm misusers of alcohol, and other persons, by providing for the mandatory assessment, treatment and management of those misusers with the aim of (s3): stabilising and improving their health; and improving their social functioning through appropriate therapeutic and other life and work skills interventions; and restoring their capacity to make decisions about their alcohol use and personal welfare; and improving their access to ongoing treatment to reduce the risk of relapse	The following are the criteria for a mandatory treatment order in relation to a person: (a) the person is an adult; (b) the person is misusing alcohol; (c) as a result of the person's alcohol misuse, the person has lost the capacity to make appropriate decisions about his or her alcohol use or personal welfare; (d) the person's alcohol misuse is a risk to the health, safety or welfare of the person or others (including children and other dependants); (e) the person would benefit from a mandatory treatment order;	A period not exceeding 3 months (s49(2)(b))	Not specified

		(f) there are no less restrictive interventions reasonably available for dealing with the risk mentioned in paragraph (d). (s10)		

1.1 Aims of the process evaluation

In February 2016 the NSW Ministry of Health engaged the Drug Policy Modelling Program (DPMP) at the National Drug and Alcohol Research Centre (NDARC) to conduct an evaluation of the IDAT program. The evaluation has three components: a process evaluation, an outcome evaluation and cost assessment. This report is the output of the process evaluation.

The evaluation team for the process evaluation was Dr Thu Vuong, Prof Alison Ritter and Dr Marian Shanahan. An Advisory Committee convened twice during the process evaluation and included the following representatives:

- Debbie Kaplan/Tanya Merinda - Manager, Alcohol and Other Drugs, Ministry of Health
- Adrian Dunlop - Chief Addiction Medicine Specialist, Ministry of Health
- Larry Pierce - CEO, Network of Alcohol and Drug Agencies (NADA)
- David Rogers - District Manager, Drug and Alcohol Services, Mid North Coast Local Health District (MNCLHD)
- Andrew Taylor - Clinical Nurse Consultant, Drug and Alcohol, Hunter New England LHD (HNELHD)
- Gaylene Bawden - Involuntary Treatment Liaison Officer (ITLO), Mid North Coast Local Health District (MNCLHD)
- Anthony Jackson - Operations Manager, Drug and Alcohol, South Eastern Sydney Local Health District (SESLHS).

The process evaluation aimed to provide descriptive information about the program operations, its reach, patient progression though the model of care, and the feasibility and appropriateness of the model of care. In providing this description, it also aimed to evaluate whether the NSW Drug and Alcohol Treatment Act 2007 is being implemented according to how it was originally conceived, and the extent to which the implementation of the IDAT program is consistent with the Model of Care and the legislative basis for the program.

The questions that the process evaluation sought to address included:

- What is the profile of referred patients? What proportion of people referred is admitted? What are the differences in profile of admitted and non-admitted patients? What is the profile of people who have been referred who opt for voluntary admission?
- What is the profile of patients accepted for treatment, in terms of age, gender, residential location, circumstances precipitating referral, primary substance abused, severity of substance abuse, co-morbidities? (What is the profile of those referred, but not admitted?)
- To what extent do IDAT transport funds enable access to the service? What is the profile of people referred utilising IDAT associated transport funds?
- Tracking implementation: progression through model of care
- What is the length of stay (range, median, mean); and other characteristics of patients discharged < 14 days, <28 days, at 28 days?
- What is the pattern of medical services utilised during detention?
- What is the profile of patients known to make the transition to community care services? What is the pattern of community services utilised?
- Is the program reaching an appropriate target group? That is, is it the case that the program is used by patients with serious health risks [to patients themselves or others], severe substance dependence and after rejection of voluntary treatment?
- Do the key stakeholders consider each of the key program elements feasible and appropriate in terms of achieving the objectives of the program?

- What are the perspectives of patients and their carers regarding the value of IDAT? Is it acceptable? Do they perceive that it reduces harm?

What specific issues or changes do key stakeholders propose, in order to improve the feasibility, appropriateness or effectiveness of the model of care?

1.2 Outline of report

The next chapter provides the methodology for the process evaluation. This is then followed by two descriptive chapters: the first describing the Act, and the next describing the Model of Care documentation.

The fifth chapter provides the analysis of the IDAT database, a quantitative review of the throughput, patient characteristics and other quantitative data analysis derived from the formal administrative record.

The sixth and final chapter uses the qualitative data collected through the stakeholder interviews to analyse the operations of the program. In the first instance, the Act itself was examined in light of the stakeholder views. This is then followed by analysis of the program operations though the stakeholders' perceptions, including the processes for program entry, the treatment provided, the aftercare and then a series of issues such as transportation, brokerage fund and so on.

2. Methodology

Ethics approvals for the conduct of the process evaluation were obtained.

- Full NEAF application approved by the Northern Sydney LHD HREC on 14 July 2016, approval number HREC/16/HAWKE/159.
- UNSW HREC for non-LHD data collection: approved on 7 September 2016, approval number HC16633.

Site-specific application (SSA) for five LHDs:

- Illawarra Shoalhaven LHD approved on 16 August 2016, approval number DT16/86213;
- Western NSW LHD (Bloomfield Hospital) approved on 18 August 2016, approval number SSA/16/GWAHS/117;
- Hunter New England LHD approved on 19 August 2016, approval number not applicable;
- South Eastern Sydney LHD approved on 30 August 2016, approval number 16/G/271;
- Northern Sydney LHD (Royal North Shore Hospital) approved on 26 September 2016, approval number SSA/16/HAWKE/300.

Data sources

Data for this process evaluation were collected from the following sources: 1) the IDAT program database; 2) in-depth interviews with patients; 3) in-depth interviews with stakeholders; 4) observations of weekly staff meetings at the two IDAT Treatment Centres; and 5) documentary review (including legislative documents, and records by the Official Visitors, namely the Official Visitor Book – Official Visitor Review), and review of a limited number of patient files.

The IDAT database

The IDAT database was developed by the Ministry of Health for the purpose of facilitating ongoing internal quality improvement and evaluation of the IDAT program. The IDAT database includes 17 different data tables. Seven data tables refer to administrative data obtained during the assessment and treatment phase (including referral, admission and discharge, and Magistrate review). Ten other data tables refer to outcome data for different time-points (at assessment, admission, at discharge, 1 month, 3 month and 6 month post discharge). The outcome measures aim to allow for both tracking and evaluation of outcomes. By program design, the core outcome tools are required to be administered at 5 time-points across the delivery of the IDAT program for an average patient (at admission, prior to discharge, 1 month, 3 months and 6 months after discharge).

For the process evaluation, a complete copy of the IDAT database was made available to the evaluators, covering the period from program commencement (31 May 2012) to 24 June 2016 (4 years).

Review of documents

The purpose of the documentary review was to ensure that the evaluators were familiar with all aspects of the program as documented, such that comparisons can be made between the documents (the Act vs the Model of Care) and the actual practice. Actual practice was collected through the database, and interviews with stakeholders and with patients. The following documents were reviewed:

- Drug and Alcohol Treatment Act 2007: under which the IDAT program was established.
- The Model of Care for IDAT program.
- Case conference reports (for selected patients).
- Complete patient files (for selected patients).
- Report of the Official Visitors.

Interviews with IDAT patients

In-depth interviews with IDAT patients aimed to ask about the patients' experience and perceptions about their alcohol and drug use, their experience with the process of being admitted to IDAT, their treatment and care received while in IDAT, perceptions of the strengths and weaknesses of the IDAT treatment program, and any issues of ethics and rights, and expectations versus the reality of the program. A total of 12 in-depth qualitative interviews were conducted.

In-depth interviews with stakeholders

In-depth interviews with stakeholders focused on the features, strengths and challenges they experience through their engagement with the implementation of the IDAT program. The main stakeholders involved in aspects of IDAT program implementation were identified as:

- NSW Ministry of Health
- Involuntary Treatment Liaison Officers (ITLOs) from 5 LHDs referring to IDAT units
- Accredited Medical Practitioners
- Mental Health, Drug and Alcohol Directors from each of the 2 sites
- Medical Directors from each of the 2 IDAT units
- Staff members from each of the 2 IDAT units
- Aftercare providers/community care coordinators (including NGOs)
- Magistrates from each of the 2 sites
- Official Visitors from each of the 2 sites

A detailed semi-structured interview schedule (which was tailored to the role of the stakeholder interviewed) was prepared that covered a range of topics including perceptions of the program overall (strengths and weaknesses); degree of consistency between documentation and practice; ethical and issues concerned with rights; referral processes and other procedural operations; the ways in which IDAT community brokerage and transport funds are used; and issues concerned with efficient program operation, smooth transition for patients, their carers and perceptions of appropriateness of the program (fit between patient group and services offered). A copy of the stakeholder interview schedule is attached at Appendix A.

A total of 37 stakeholders were interviewed and written submissions were received from two stakeholders between September 2016 and November 2016. The list of the names of the stakeholders who were interviewed is not provided here to avoid any breach of confidentiality. The pool of interviewees, however, covered all the above categories of stakeholder. Notes were taken during the interviews and the conversations digitally recorded to assist with ensuring the accuracy of the notes.

Data analysis

Across the five different types of data collected for the process evaluation, a number of quantitative and qualitative data analytic tools were deployed. For the quantitative data, descriptive statistics were used along with simple tests of associations to analyse the IDAT database. The qualitative data (in-depth interviews with stakeholders) were analysed according to standard qualitative data techniques. Specifically, the recorded interviews were reviewed and transcribed where required. The text was analysed against pre-determined content (for example with reference to the transport fund: all comments pertaining to the transport fund were collected, then summarised and analysed for the main messages). Analysis of the diversity or congruence of views was also undertaken.

3. The NSW Drug and Alcohol Treatment Act 2007

Background to and setting of the Act

In New South Wales (NSW) involuntary treatment had previously been provided under the Inebriates Act 1912. However, a review of that Act, recommended at the 2003 Summit on Alcohol Abuse and subsequently conducted in 2004 by the Parliament of New South Wales Standing Committee on Social Issues, concluded that the Inebriates Act was "fundamentally flawed" and recommended that it be "immediately repealed"[56]. As a result of this review, the Drug and Alcohol Treatment Act 2007 replaced the Inebriates Act 1912 and provides the legislative basis for the involuntary detention, treatment and stabilisation regime for persons with severe substance dependence, with the stated aim of protecting the health and safety of such persons, while also aiming to address all human rights aspects that were the subject of criticism of the previous legislation. Under the new legislation, the Involuntary Drug and Alcohol Treatment Program (the IDAT program) was developed to "provide short term care, with an involuntary supervised withdrawal component, to protect the health and safety of people with severe substance dependence who have experienced, or are at risk of, serious harm and whose decision making capacity is considered to be compromised due to their substance use"[56].

Purpose and objectives of the Act

The objects of the NSW Drug and Alcohol Treatment Act 2007 are:

a) *to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety, and*
b) *to facilitate a comprehensive assessment of those persons in relation to their dependency, and*
c) *to facilitate the stabilisation of those persons through medical treatment, including, for example, medically assisted withdrawal, and*
d) *to give those persons the opportunity to engage in voluntary treatment and restore their capacity to make decisions about their substance use and personal welfare.*

In addition, the "Act must be interpreted, and every function conferred or imposed by this Act must be performed or exercised, so that, as far as practicable:

a) *involuntary detention and treatment of those persons is a consideration of last resort, and*
b) *the interests of those persons is paramount in decisions made under this Act, and*
c) *those persons will receive the best possible treatment in the least restrictive environment that will enable treatment to be effectively given, and*
d) *any interference with the rights, dignity and self-respect of those persons will be kept to the minimum necessary."*

Eligibility criteria for a Dependency Certificate

The criteria for the issue of the dependency certificate are:

- *the person has a severe substance dependence, and*
- *care, treatment or control of the person is necessary to protect the person from serious harm, and*
- *the person is likely to benefit from treatment for his or her substance dependence but has refused treatment, and*
- *no other appropriate and less restrictive means for dealing with the person are reasonably available.*

Safeguards to ensure patients' civil and human rights are addressed under the Act
The Act contains provisions to ensure that:

- involuntary detention is a last resort
- the interests of the person are paramount
- the person will receive the best possible treatment in the least restrictive environment
- any interference with the rights, dignity and self-respect of the person is kept to a minimum.

The Act also contains provisions to ensure that a person and their primary carer are provided with clear information about their legal rights and their rights of appeal. All Dependency Certificates must be reviewed by a Magistrate as soon as possible after issuing.

Independent Official Visitors have been appointed to inspect the Treatment Centres regularly, to act as an advocate on behalf of patients if required, and to provide reports to the Minister for Health.

How the Act works
Under the NSW Drug and Alcohol Treatment Act 2007 (hereinafter referred to as 'the Act'), the decision to detain a person in the first instance is a clinical one, made by a medical practitioner. The person may be detained and treated initially under a Dependency Certificate without the need to wait for a formal application to and order by, a court. The process is that a medical practitioner may request an accredited medical practitioner (AMP, who are specific to the context of the Act) to assess a person for detention and treatment under the Act. After assessing the person, the AMP may issue a 'Dependency Certificate', stating the person may be detained for treatment under the Act for the period stated in the certificate.

Importantly, under section 9(5) of the Act, if a dependency certificate is issued, 'the person may be detained in accordance with the certificate for treatment under this Act'. Therefore the certificate gives the authority to detain. The AMP may have regard to any serious harm that may occur to children in the care of the person or dependents of the person.

The maximum period for which a dependency certificate may be issued is 28 days, although this is subject to reduction or extension for up to three months, by the Magistrates Court on the review. The extension for up to three months is on application by an AMP for up to three months from the day of first admission if the practitioner is satisfied that:

- the dependent person is suffering from drug or alcohol related brain injury; and
- additional time is needed to carry out treatment and to plan the person's discharge; and
- the practitioner presents, with the application, a proposed treatment plan to be followed during the additional time granted.

There is provision for 'transport officers' to take dependent persons to or from a treatment centre, powers of search and apprehension, and for police assistance to take dependent persons to and from a treatment centre.

Under the Act, there is also no requirement for a Court or Tribunal to authorise initial detention or treatment. These are clinical decisions, but the Magistrates' Court is responsible for reviewing the issue of dependency certificates and extending them. A person aggrieved by an order or determination of a Magistrate under Part 4 may appeal against the order or determination to the Civil and Administrative Tribunal under Part 4 of the NSW Act.

An AMP must, as soon as practicable (within 7 days) after the certificate is issued, bring the person before a Magistrate for a review of the issuing of a certificate. The review by the Magistrates Court is compulsory. At the Magistrates Court hearing, the Magistrate must consider relevant information in

deciding whether a person meets the criteria in section 9 of the Act, including the clinical reports and recommendations of the AMP who has examined the person, any proposed further treatment for the person, the likelihood the treatment will be of benefit to them, the person's views, and any cultural factors relating to the person that may be relevant to the determination. It is mandatory that the patients are represented by a legal representative. The Magistrates Court decision may be appealed to the Civil and Administrative Tribunal.

There are various human rights protections built into the NSW Drug and Alcohol Treatment Act, for instance in relation to the information to be given to the dependent person and their carer. The Act provides for Official Visitors, whose role is that of a general inspector and advocate for client issues in the system as a whole.

4. Model of Care document

The objects of the Act form the basis for the Model of Care for the implementation of the IDAT Program. Specifically, the Model of Care provides a resource for managers, clinicians and other key stakeholders involved in supporting and delivering the Program. The Model of Care describes the principles, objectives, aims and underpinning approach for the Program and broadly defines the way in which the Program is delivered, to facilitate consistent implementation and assist clinicians and other stakeholders to interpret legislation as it relates to the Program [56]. The Model of Care contains specific protocols regarding the medical management and psychosocial interventions during treatment.

The IDAT program has two components: the involuntary inpatient treatment (28 days and up to 3 months) and voluntary community-based aftercare component (6 months). The Model of Care involves 7 stages of a patient journey and outlines activities to be undertaken, timeframes for activities and roles and responsibilities of staff and the identified patient and their primary carer. The seven stages are used here to describe the Model of Care documentation.

Referral and Screening
Referrals to an Accredited Medical Practitioner (AMP) for assessment for a dependency certificate can only be received from Medical Practitioners, such as, but not limited to, general practitioners, emergency doctors and psychiatrists. Once the AMP at the Treatment Centre has received a referral from a Medical Practitioners, a determination will be made as to whether there is sufficient information (a local comprehensive assessment) for the AMP to assess the identified patient for a Dependency Certificate. If not, further screening and a comprehensive assessment at the local level will be requested of the Medical Practitioners and local Involuntary Treatment Liaison Officer (ITLO). Contact details of local ITLOs will be provided to the Medical Practitioners for liaison regarding further drug and alcohol screening and assessment needs.

An ITLO conducts screening, triage and assessment to a standard of, and in liaison with, the Medical Practitioners, Treatment Centre and AMPs to determine if a person should be recommended for referral for assessment by an AMP for a Dependency Certificate. An ITLO is a qualified professional either doctors or nurses who are trained for IDAT assessment, has at least five years' experience of providing direct drug and alcohol patient care and the skills to screen persons who may be eligible for a Dependency Certificate under the Drug and Alcohol Treatment Act (2007). Across NSW, there are more than 100 ITLOs who have been appointed and trained by the Ministry of Health. It is not necessary for the screening assessment to involve contact with the patient, although this may occur if the patient is already a patient of the ITLO, medical practitioner or the AMP. The referral application involves 3 forms to be filled out: 1) Form 1 by an ITLO to request a medical practitioner for a referral; 2) Form 2 by the medical practitioner; and 3) Form 3 is a Comprehensive Assessment by the ITLO. It is important to note that an aftercare plan is required to be included in the Comprehensive Assessment. As such, the ITLO has a critical task in working with the referring team and/or the community drug and alcohol worker to develop the aftercare plan. If the identified patient does not yet have a community case manager, one needs to be identified and included in the Comprehensive Assessment.

Assessment
The Model of Care states that "Dependency Certificates should only be issued if the patient meets all eligibility criteria and if there is a bed available immediately at the inpatient unit". If a bed is available, upon receiving the complete referral application, the AMP in consultation with his/her IDAT team will conduct an assessment to identify the level of dependency and immediate risk to the

patient, to establish the level of need an individual may have and what interventions are required to address these needs. This comprehensive assessment builds on the screening and triage assessment of the ITLO, which might include the following information:

- current and previous history of drug and alcohol use and impact on functioning and capacity;
- current and previous treatment history, including history of withdrawal and previous complications;
- current overview and history of physical and mental health;
- psychosocial issues that need to be addressed, e.g. homelessness;
- involvement in the criminal justice system and details of bail or community sentencing conditions and pending court dates. This is noting that the patient should be accepted onto the program if charges are pending, except in cases of significant violence or sexual offences (i.e. behaviours that put staff and other patients at risk of harm by the patient);
- risk of harm to self and to others, including children living with the patient;
- other risk factors, such as pregnancy;
- willingness of the patient to engage in treatment voluntarily;
- availability of less restrictive treatment options that can be accessed;
- identification of key significant others, e.g. family, carer, guardian;
- identification of community care coordinator (to coordinate care post discharge from the inpatient phase of the Program);
- identification of a GP;
- identification of transportation needs should the patient be issued a dependency certificate and does not reside near the IDAT inpatient unit.

If the patient is assessed as eligible for the IDAT Program, the ITLO and the referring team will be informed of the outcome of the eligibility of the patient.

The AMP will issue a Dependency Certificate if they are also satisfied that:

- the patient is not willing to undertake voluntary treatment, and
- involuntary care will not introduce new serious harms or exacerbate existing harms to the patient, and
- involuntary care is highly likely to result in reduced, safer substance use or abstinence over an extended period following discharge, or
- involuntary care is highly likely to facilitate engagement with ongoing care following discharge, and
- involuntary care has a good prospect of significantly ameliorating harm to the patient and improving their quality of life, and
- there is a bed available immediately at the inpatient unit.

This means that the Dependency Certificate will only be issued if: 1) there is a bed available immediately at the inpatient unit; and 2) the patient meets all eligibility criteria. If a bed is not immediately available, the patient will be placed on the waiting list. If a patient is not considered suitable for a Dependency Certificate assessment the reasons for this decision are explained to the referrer and ITLO, and alternative treatment/intervention options are suggested.

If it is not possible to access a patient for assessment of suitability for a Dependency Certificate (e.g. if the patient refuses to come into a clinic and won't let anyone in their house), Section 10 of the Act can be used. An application is made to a Magistrate to legally authorise the AMP to visit and assess the person in relation to issuing a Dependency Certificate. The order may also authorise another person to assist the AMP in conducting the assessment, e.g. a police officer.

Admission
If the patient meets all the eligibility criteria for involuntary treatment and a bed is available, a face to face (or video-conference) meeting between the patient, the referring team member and the AMP is to be arranged, to take place as soon as possible. This is the final assessment of the patient for the AMP to determine whether the patient should be issued a Dependency Certificate for detention and treatment under the Act.

If a Dependency Certificate is issued, the Act provides for the patient to be immediately detained in order to be transported to the inpatient unit.

Immediately following the issue of a Dependency Certificate, the following steps should be undertaken:

- provision of advice to patient (and family members, carer or guardian, if appropriate) of their right to appeal;
- identification in writing of the primary carer(s);
- identification of transport options and arrangement of transport to the Unit.

The patient will be received at the unit by a member of the clinical team, as per the local unit procedures. All paperwork and administration tasks will be completed and a medical record will be requested, or commenced, for patients who do not have a medical record number in the LHD in which the Program is located. Information gathered during the referral, screening and assessment for the Dependency Certificate should also be included in the medical file, as should the Dependency Certificate and any documentation pertaining to court orders.

A court hearing by the Magistrate should occur within 7 days of admission.

Orientation should take place as soon as the patient is admitted to the unit, unless the patient's mental or physical state prevents them from engaging in the induction activities.

The purpose of orientation is to:

- admit and orient the patient to the unit;
- provide the patient and their nominated primary carer with information about the unit, including expectations regarding behaviour;
- provide information to the patient and their nominated primary carer about their rights in relation to the program, including the process for reviewing and extensions of the Dependency Certificate and their right to appeal.

Identification of a primary carer: The Act stipulates that a patient may nominate a person to be their primary carer under the Act. The primary carer should be informed of the patient's admission to the program, and, where possible and appropriate, involved in the development of the care plan, particularly the community-based component of this plan. The primary carer may be a family member, carer, friend or another professional who is known to the patient. This may include the patient's Public Guardian, if applicable and appropriate. The Act stipulates that the primary carer must be notified within 24 hours after a Dependency Certificate has been issued. If the patient is unable to nominate a primary carer on admission, they will be asked again at an appropriate time, but within 24 hours.

Withdrawal
This stage provides a medically supervised withdrawal for admitted patients before further medical and psychosocial interventions and support can be provided to address other aspects and consequences of substance misuse. The aim of withdrawal is to initiate abstinence and attain patient

safety while frequently monitoring the individual and providing appropriate care when necessary. Planning and coordinating post-withdrawal care is an integral part of the treatment process, including throughout withdrawal. This stage involves a number of aspects, including assessment for withdrawal to inform the development of a withdrawal management plan, supervised withdrawal (including psychosocial and pharmacological interventions) and monitoring.

Post withdrawal Treatment

During this stage, ongoing intensive support and interventions are provided to address the patient's bio-psychosocial needs and to assist them to move towards improved substance misuse, health (physical and mental) and social functioning outcomes. This involves further and on-going assessment, continued development and review of the care plan and the provision of a range of structured medical, psychological and other interventions and supports, delivered by a multi-disciplinary team. A key principle of care post withdrawal is the involvement and engagement of the patient (and their primary carer if appropriate) in all aspects of care planning and review.

With regard to assessment of cognitive impairment, further assessment will be undertaken to consider capacity, neurological, bio-psychosocial and physical functioning to inform a comprehensive care plan (global care plan). Due to the extensive history of substance misuse of the client group and the likely impact on functioning and capacity it is not appropriate to undertake these types of assessment prior to withdrawal as the validity of the assessment outcomes will be limited.

A range of structured interventions will be provided by Program staff during the post withdrawal inpatient stage, as indicated by the global care plan, to reinforce changes in behaviour and to support the patient and equip them with skills to make healthier lifestyle choices. These might include:

- structured psychosocial interventions, including cognitive behavioural therapy (CBT), coping skills training, contingency management;
- counselling, e.g. trauma or grief counselling;
- living and life skills, including cooking, cleaning and budgeting, in preparation for re-integration into the community;
- relapse prevention and active practice of relapse prevention skills during therapy;
- advice, information and education about substance misuse

All structured interventions should be underpinned by motivational and engagement approaches, such as motivational interviewing, to encourage the development of insight and to develop more effective life skills.

Discharge

During this stage, the patient is discharged from the inpatient unit and transitioned to the community-based stage of the Program. The IDAT outcome tools are required to be completed prior to discharge. Discharge may be back to the patient's community, to another identified and agreed community, to a residential rehabilitation setting or to another inpatient setting, for example, if the patient requires admission to an acute health or mental health unit for further treatment. Discharge is underpinned by a discharge plan, which is commenced at admission to the inpatient unit, to ensure there is a continuum of care between the inpatient and community based components of the Program.

The discharge plan should be coordinated by the inpatient case manager, IDAT transfer of care coordinator and community care coordinator in consultation with the multi-disciplinary care team. Discharge planning must include liaison with community-based providers, such as residential treatment facilities and specialist community services, to negotiate access to services post discharge.

A discharge summary should be developed and made available to the community care coordinator and other professionals who will be involved in the patient's on-going care. This should include an overview of the patient's treatment as an inpatient and should provide details of current medications and any areas of ongoing concern.

As part of discharge planning, primary case coordination responsibility transfers from the inpatient case manager to the IDAT Transfer of Care Coordinator (based in the IDAT Unit) and the Community Care Coordinator. Either the Transfer of Care Coordinator or the Community Care Coordinator are identified as the main case coordinator and this will be determined on a case by case basis and take into account factors such as patient's area of residence and treatment support needs. Ideally, this should be marked by a formal discharge case conference, involving the patient, and should be documented in the discharge plan and summary.

The IDAT transfer of care coordinator and where possible the community care coordinator should assist the inpatient team in physically supporting the patient (and family) at discharge, in managing anxiety associated with discharge and in implementing and monitoring the community-based care.

Community based Program

The community based component of the Program provides support and interventions to encourage continued healthy lifestyle choices, to continue to work towards goals and to address and manage the risks of relapse after the patient has been discharged from the inpatient phase of the Program. This stage responds to the need for long term, comprehensive and holistic supports to achieve sustained behaviour, psychosocial, health and wellbeing outcomes.

While this post discharge community-based component of the Model of Care is a crucial phase of comprehensive treatment, it is important to note that this is not an involuntary component and therefore relies on the patient's willingness to engage.

This component of the Program provides support and interventions for up to six months; the first few weeks involve intensive case management and support and the remaining support involves a stepped down approach. Over this time, support decreases in intensity and frequency as the patient builds links and relationships with alternative community based treatment and support providers. It is acknowledged that some patients may require longer term management with no stepped down approach.

The IDAT transfer of care coordinator and the community care coordinator are responsible for the development, implementation and review of the global care plan in the community. They are also responsible for the completion and recording of the outcome tools at three time intervals across the community care component of the Program. How responsibility is distributed is to be negotiated between the transfer of care coordinator and community care coordinator on a case by case basis.

Treatment and support needs that are identified including housing, health care and community and vocational pursuits may require brokerage funding.

It is important that the care coordinators support the patient in the community to work towards a goal of successfully exiting the Program. This is important to encourage the patient to be independent of the Program and to continue to improve their quality of life. It is also essential from a resource perspective to maintain the capacity of the Program to work with other patients.

For many patients, some form of on-going support may always be required, as a result of limited functioning and capacity. It is important that these patients are supported to access appropriate mainstream services.

To work towards successful exit, there should be a planned step down of the intensity and frequency of support by the care coordinators. This should be undertaken in consultation with the patient and their family / carers and should occur at a pace that is acceptable to the patient. It is essential that appropriate links and relationships with other community based services, including specialist and mainstream services, are in place before the step down occurs to prevent the risk of disengagement and relapse.

5. Quantitative analysis: IDAT database and administrative records

The IDAT Program commenced in New South Wales in 2012 with two gazetted treatment units. One treatment unit has 4 IDAT beds, is located in Sydney as part of an existing voluntary detoxification unit at Herbert Street Clinic (HSC), Royal North Shore Hospital, Northern Sydney LHD. The other treatment unit has 8 IDAT beds, is located in Orange, as part of the Bloomfield (BF) hospital in Western NSW LHD. The choice of location aimed to ensure that both metropolitan and rural regions were covered.

This chapter draws on the IDAT database that was developed to monitor the administrative aspects, the patient throughput and the outcome of the IDAT program. The IDAT database was obtained from the IDAT Data Manager on 25 July 2016 in order to analyse:

- The numbers of patients and the patient flow
- The lengths of stay
- The waiting periods (time between referral and admission)
- The patient characteristics
- Comparisons between those admitted and non-admitted on demographic characteristics
- The outcome data at 1, 3 and 6 months

The IDAT database is a relational database, with 17 different data tables. Seven data tables refer to administrative data obtained during the assessment and treatment phase (including referral, admission and discharge, and Magistrate review). Ten other data tables refer to outcome data for different time-points (at assessment, admission, at discharge, 1 month, 3 month and 6 month post discharge). It is a complex arrangement for simple data analysis, with multiple entries for the same individual patient depending on the number of admissions for the same patient, the number of responses to one data field, the number of time-points for which data for a single patient is available, and different linking mechanisms across data tables (some need to be linked by ID, some need to be linked by MRN, some need to be linked by InterviewID, and some need to be linked by more than one of these 3 identifiers in a certain order). There are also substantial missing data. This section of the process evaluation report provides our analysis of the available data. At the end of this chapter there is discussion of the challenges and issues associated with the data, database and recording of outcomes.

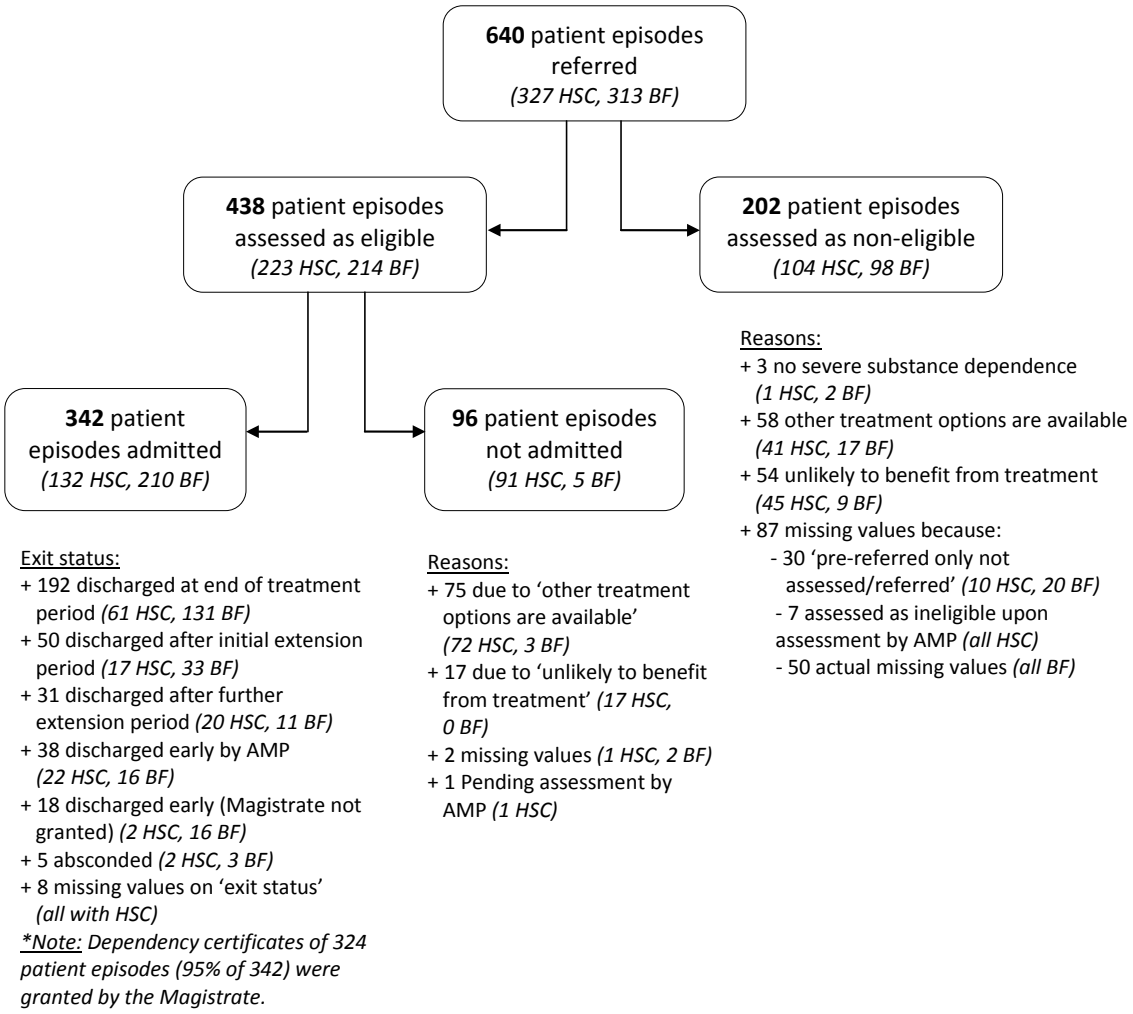
5.1 IDAT patient flows and admission rates

There are more records than unique patients in the IDAT database as a patient can be referred, assessed or admitted to the program more than once. The IDAT database provides a total of 640 valid records, each representing a patient episode for the period from 31 May 2012 to 24 June 2016 (4 years) for both IDAT treatment units. A total of 529 unique patients are identified from these 640 records, with 80 patients (15.12%) having two records (referred twice) and 31 patients (6%) having three records (referred three times).

For some analyses, it is appropriate to use the N=640 (such as for admission rates, length of stay). For other analyses, it is more appropriate to use the unique patients (such as analyses of demographic characteristics). We specify whether the N=640 (episodes) or the n=529 (unique patients) are used throughout the below.

Figure 1 shows the flow of admission to IDAT (N=640).

Figure 1: IDAT patient flows



Note: The Exit status given in Figure 1 was as recorded in the database. These do not match the data in Table 8 (Section 5.4: Length of Stay) due to discrepancies between data fields. See detailed explanation at the beginning of Section 5.4.

Figure 1 describes the flow of all 640 patients who have been referred to the IDAT program from the commencement of the program to 24 June 2016, with an almost equal number of referrals to each of the two IDAT program units. Of the total of 640 patients, 202 were assessed as ineligible. Of the 438 referrals assessed as eligible, 96 referrals resulted in the patients not being admitted into treatment with most of these (91) at Herbert Street Clinic. It is assumed that this is due to the bed availability and wait time – resulting in a second subsequent assessment at which time patients who were originally deemed eligible had now received alternate options (note: other treatment options were found for 75 of the 96 patient who were eligible but not admitted).

Of the 342 referrals that resulted in the patient being admitted into treatment, 63% (217) completed a full treatment episode and were discharged at the end of the treatment period, 3% (12) were discharged after an initial extension period (i.e. Dependency Certificate was extended), 3% (9) were

discharged after a subsequent, second extension period, 19% (66) were discharged early by the AMP, 5% (16) were discharged early because the Dependency Certificate was not confirmed by the Magistrate (15 cases were with Bloomfield), 1.5% (5) absconded and the exit status of 5% (18) was unclear.

A Dependency Certificate was issued for 324 episodes of care over the four year period (95% of the admitted patient episodes).

Table 3: Number of episodes referred and admitted: 2012-2016 (N=640)

		Year 1 (31 May 2012 - 31 May 2013)	**Year 2 (1 June 2013 - 31 May 2014)**	**Year 3 (1 June 2014 - 31 May 2015)**	**Year 4 (1 June 2015 – 24 June 2016)**	**Total**
Number of referred episodes	HSC	76	89	78	84	327
	BF	37	95	84	97	313
	Total referred	113	184	162	181	640
Number of admitted episodes (and % of referred episodes)	HSC	39 (51.32%)	36 (40.45%)	30 (38.46%)	27 (32.14%)	132 (40.37%)
	BF	26 (70.27%)	61 (64.21%)	60 (71.43%)	64 (65.97%)	210 (67.09%)
	Total admitted (%)	65 (57.52%)	97 (52.72%)	90 (55.56%)	91 (50.28%)	342 (53.44%)

Note:

1. Seven (7) referrals with records "pending assessment by AMP" (all from HSC) are included in the table but counted as "referred episodes".
2. HSC referrals: The 327 referrals represent 269 unique patients as some patients are referred to the program more than once. Of the 269 unique patients, 49 of these patients were referred to the program a second time, and 9 of the 269 unique patients were referred to the program a third time (269*1) + (49*1) + (9*1) =327. A total of 18.22% (49/269*100) of referrals are second referrals and 3.35% (9/269*100) are third referrals to the program. As such, overall 21.56% (18.22+3.35) of first referrals results in a subsequent referral to the program.
3. BF referrals: The 313 referrals represent 260 unique patients as some patients are referred to the program more than once. Of the 260 unique patients, 31 of these patients were referred to the program a second time, and 22 of the 260 unique patients were referred to the program a third time (260*1) + (31*1) + (22*1) = 313. A total of 11.92% (31/260*100) of referrals are second referrals and 8.5% (22/260*100) are third referrals to the program. As such, overall 20.42% (11.92+8.50) of first referrals results in a subsequent referral to the program.
4. The table does not show separate data for episodes or unique patients a) assessed as eligible for admission, b) assessed as ineligible for admission or c) eligible, but not admitted to the program.
5. HSC admissions: A total of 95 unique patients were admitted, and 29 of the 95 unique patients were re-admitted.
6. BF admissions: A total of 159 unique patients were admitted, and 30 of the 159 unique patients were re-admitted.
7. HSC + BF admissions: A total of 254 unique patents were admitted to both treatment units (159+95). The number of unique patients who were re-admitted (once or twice) to both treatment units was 59 (30+29). These numbers are used for data in Table 15.

The data in Table 3 (pertaining to all referrals, and as per Figure 1), reveal a number of features:

- In the first year, referral numbers were low, as would be expected with a new program establishment. By year 2 however, the rate of referral seemed to have stabilised (at 184 for year 2, 162 for year 3 and 181 for year 4).
- The admission rates were slightly higher in year 1 (57% of all referrals), but have since stabilised to an average of 53%. This means that half of all referrals to IDAT do not result in an admission.

- On average there is an almost equivalent referral rate to the two units – HSC receiving a total of 327 referrals over the period, and BF receiving a total of 313 referrals.
- On the surface the admission rate for HSC (40%) is lower than the admission rate for BF (67%) but this is due simply to the number of available beds – 4 beds at HSC and 8 beds at BF.

5.2 Waiting time: IDAT database analysis

The waiting time was calculated by subtracting the admission date from the referral date[4]. Table 4 shows that the median waiting time for admitted patients was 15.5 days; at HSC (19 days) it is longer than BF (14 days)[5]. The proportion of patients admitted on the day of referral was 9.8%. While the proportion of patients who are admitted on the day of referral and within 7 days of referrals are similar for the two treatment units, it appears that a higher proportion of patients at BF are admitted within 28 days compared to HSC.

Table 4: Waiting time from referral date to admission date (in days): unique patients, first admission only

	Total	**HSC (n=95)**	**BF (n=159)**
Mean/(SD)	27.42 (35.93)	31.49 (42.52)	24.98 (31.23)
Median/(range)	15.50 (0-265)	19.00 (0-265)	14.00 (0-185)
% of patients admitted on the day referral was received	9.8	10.5	9.4
% of patients admitted within 2-7 days from date of referral	24.8	23.2	25.8
% of patients admitted within 8-28 days from date of referral	35.1	31.6	37.1
% of patients admitted within 29-42 days from date of referral	11.0	11.5	10.7
% of patients admitted within > 42 days from date of referral	19.3	23.2	17.0

Almost 20% of patients attending IDAT waited more than 42 days before their admission. But 25% were admitted within 2 to 7 days after referral and 9.8% were admitted on the day referral was made.

[4] Waiting time was calculated based on the data of unique patients; because it is likely that patients who are re-referred to IDAT might have a different wait time.
[5] Median statistics are reported because the data are highly skewed, as evidenced by histograms.

Figure 2: Days in waiting time for unique patients admitted to HSC for first admission only (n=95)

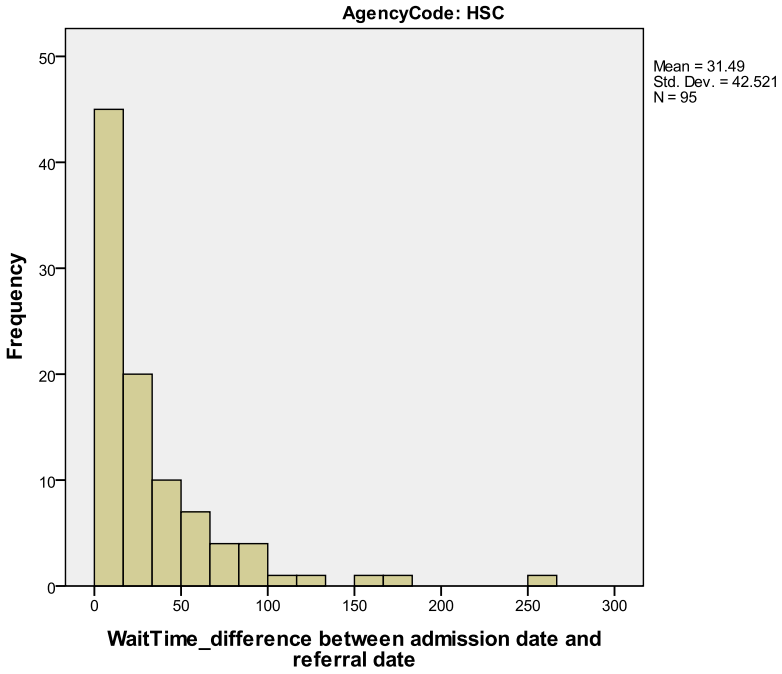
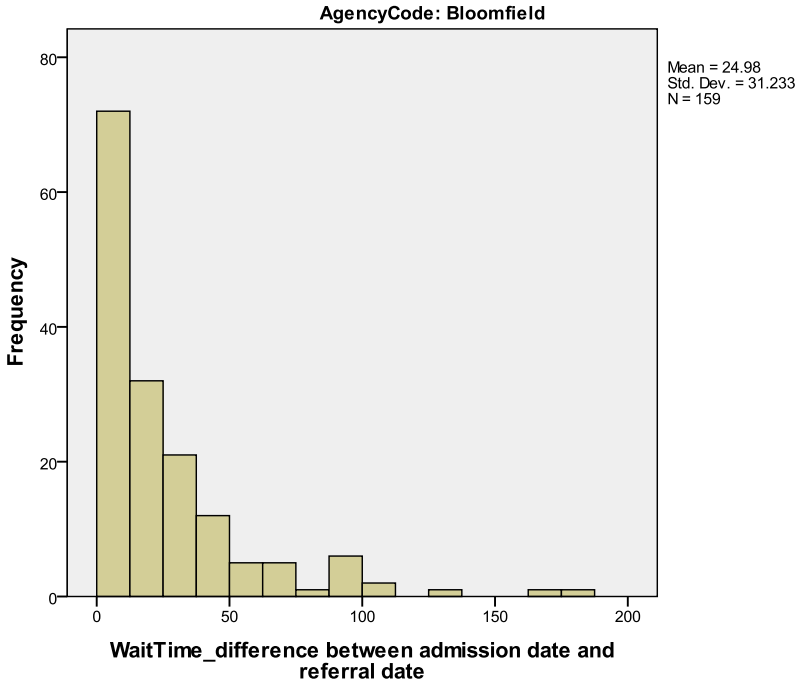


Figure 3: Days in waiting time for unique patients admitted to BF for first admission only (n=159)



5.3 Referring LHDs and referral sources

The LHDs which referred patients to the IDAT program is given in Table 5.

Table 5: Sources of referrals (LHDs): by treatment unit (n=513, unique referred patients, n=16 missing data)

LHD	Unique referred patients for both units (n=513)		Unique referred patients for HSC (n=259)		Unique referred patients for BF (n=254)	
	Number	**%**	**Number**	**%**	**Number**	**%**
1. CCLHD (Central Coast)	17	3.31	9	3.47	8	3.15
2. FWLHD (Far West)	2	0.39	0	--	2	0.79
3. HNELHD (Hunter New England)	26	5.07	6	2.32	20	7.87
4. ISLHD (Illawarra Shoalhaven)	43	8.38	25	9.65	18	7.09
5. MLHD (Murrumbidgee)	27	5.26	2	0.77	25	9.84
6. MNCLHD (Mid North Coast)	25	4.87	10	3.86	15	5.91
7. NBMLHD (Nepean Blue Mountains)	10	1.95	4	1.54	6	2.36
8. NNSWLHD (Northern NSW)	23	4.48	2	0.77	21	8.27
9. NSLHD (Northern Sydney)	105	20.47	97	37.45	8	3.15
10. SESLHD (South Eastern Sydney)	54	10.53	45	17.37	9	3.54
11. SNSWLHD (Southern NSW)	26	5.07	6	2.32	20	7.87
12. St Vincent's	21	4.09	17	6.56	4	1.57
13. SWSLHD (South Western Sydney)	33	6.43	17	6.56	16	6.30
14. SYDLHD (Sydney)	27	5.26	14	5.41	13	5.12
15. WNSWLHD (Western NSW)	67	13.06	1	0.39	66	25.98
16. WSLHD (Western Sydney)	7	1.36	4	1.54	3	1.18
Total	513	100.00	259	100.00	254	100.00

Note: Missing value = 16 (10 with HSC). Therefore, the denominator is the valid data.

As can be seen from above table, the most common referring LHD was NSLHD (20.47% of unique patients), followed by Western NSW (13.06%). Unsurprisingly, these are the two LHDs with the actual IDAT inpatient units. The spread of the referrals differs between the two IDAT units: HSC has 37.45% of its referrals from its home LHD, whereas BF has 25.98% of its IDAT referrals from its home LHD (suggesting a wider spread for BF than HSC). Some LHDs are referring very few patients, notably Far West (0.4%), Nepean Blue Mountains (1.9%) and Western Sydney (1.3%). While geographical distance (and population size) might be possible explanations for such a low referral rate from Far West LHD, the possible explanation for a low referral rates from NBMLHD and WSLHD is not clear.

Table 6 provides the details of the referring LHD for only those patients admitted to IDAT (n=254). Again, given the location of the IDAT units and the referral rates (Table 5), Northern Sydney (17.7%) and Western NSW (15.4%) had the highest rate of admitted patients. Likely due to larger number of beds, the treatment unit in BF admitted patients from both rural LHDs and metropolitan LHDs, and had at least one admitted patient from every LHD. HSC on the other hand did not admit any patients from four LHDs: FWLHD, NBMLHD, WNSWLHD and Northern NSW LHD.

Table 6: Admitted patients - referring LHDs (n=254, unique admitted patients)

LHD	Unique admitted patients for both units (n=254)		Unique admitted patients for HSC (n=95)		Unique admitted patients for BF (n=159)	
	Number	%	Number	%	Number	%
1. CCLHD (Central Coast)	8	3.1	1	1.1	7	4.4
2. FWLHD (Far West)	2	0.8	--	--	2	1.3
3. HNELHD (Hunter New England)	14	5.5	2	2.1	12	7.5
4. ISLHD (Illawarra Shoalhaven)	8	3.1	7	7.4	1	0.6
5. MLHD (Murrumbidgee)	15	5.9	1	1.1	14	8.8
6. MNCLHD (Mid North Coast)	10	3.9	1	1.1	9	5.7
7. NBMLHD (Nepean Blue Mountains)	6	2.4	--	--	5	3.1
8. NNSWLHD (Northern NSW)	18	7.1	--	--	18	11.3
9. NSLHD (Northern Sydney)	45	17.7	41	42.1	5	3.1
10. SESLHD (South Eastern Sydney)	22	8.7	17	17.9	5	3.1
11. SNSWLHD (Southern NSW)	17	6.7	3	3.2	14	8.8
12. St Vincent's	12	4.7	8	8.4	4	2.5
13. SWSLHD (South Western Sydney)	19	7.5	8	8.4	11	6.9
14. SYDLHD (Sydney)	15	5.9	5	5.3	10	6.3
15. WNSWLHD (Western NSW)	39	15.4	--	-	39	24.5
16. WSLHD (Western Sydney)	4	1.6	1	1.1	3	1.9

Note: no missing data.

5.4 Lengths of stay

Data were complete for LOS for the full sample of admitted patient episodes (N=342, see figure 1). Two approaches to LOS calculations were used: firstly a continuous variable calculated by subtracting 'ExitDate' from 'AdmissionDate'; secondly a categorical variable classified according to exit/discharge status.

LOS continuous variable

The mean LOS (across both units) was 35.24 days (SD=22.80). The median LOS (across both units) was: 27.00 days (Interquartile Range=24-49 and range from 0-138 days) (Table 7) and the modal LOS (across both units) was 27.00 days (Figure 4). In comparing the two units, the mean length of stay for patient episodes at HSC was 38.12 days (median at HSC 28 days, range 0-138),whereas the mean LOS at BF was 33.43 days (median at BF 27, range 1 to 87). This suggests little difference between the two units in terms of average lengths of stay (see Figure 5 and Figure 6 below).

Table 7: Summary of Length of Stay Statistics

Statistics	Both units	HSC	BF
Mean (SD)	35.24 (22.80)	38.12 (27.15)	33.47 (18.43)
Median (range)	27.00 (0-138)	28 (0-138)	27 (1-87)

Figure 4: Length of stay for patient episodes of both treatment units

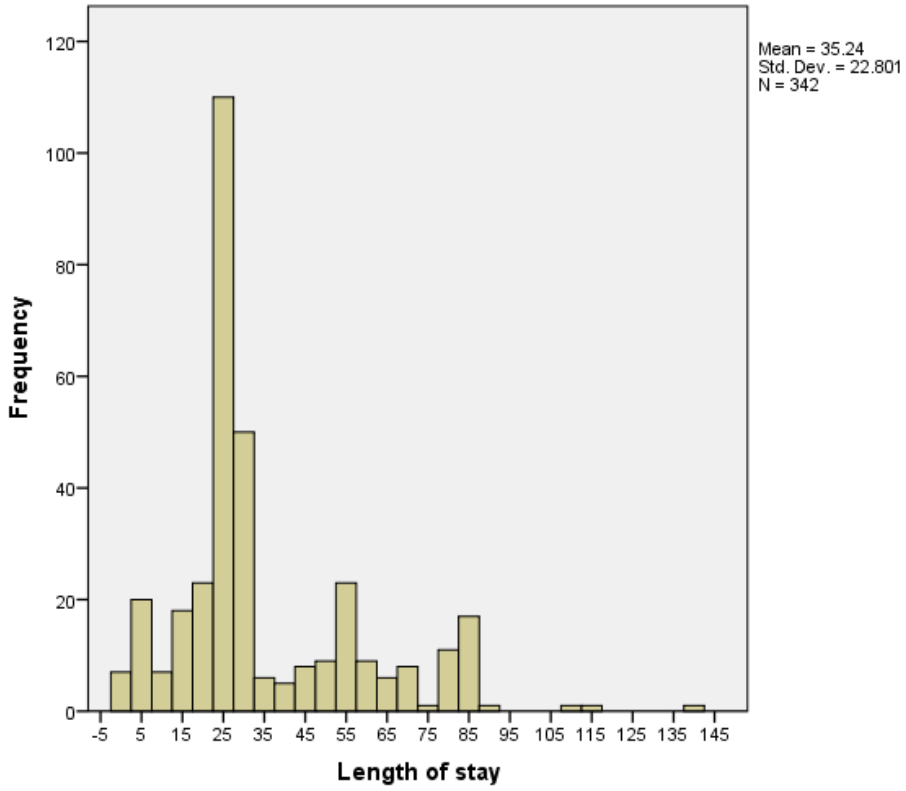


Figure 5: Length of stay for HSC patient episodes

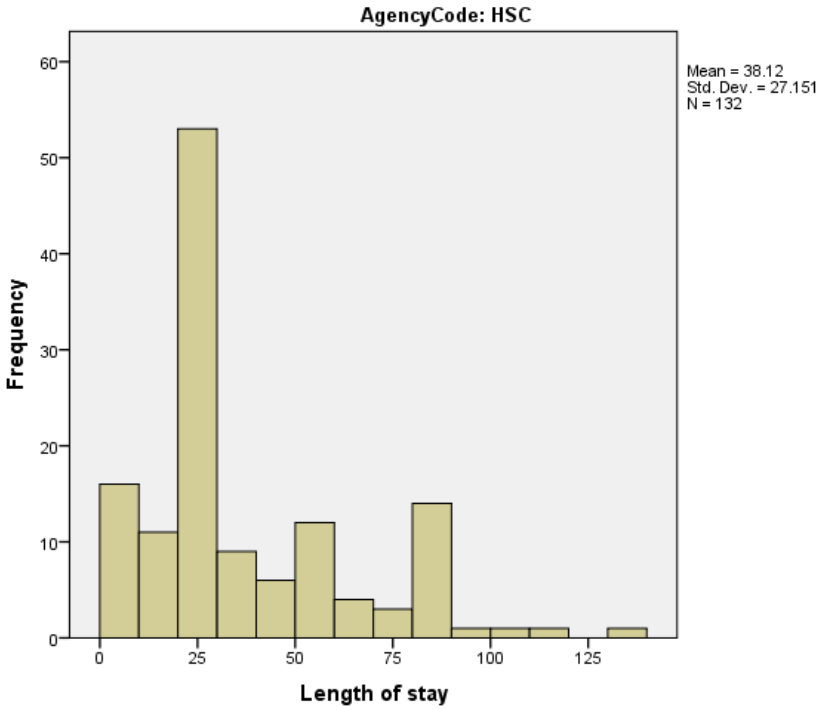
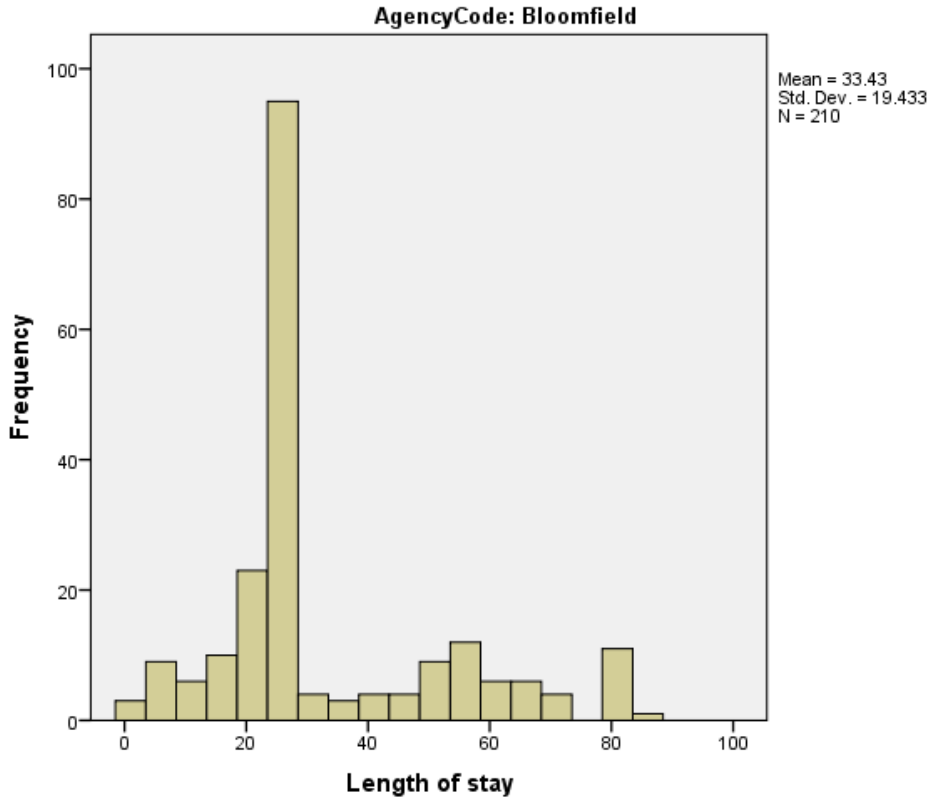


Figure 6: Length of stay for BF patient episodes



LOS: categorical variable

The Exit/Discharge status list includes the following:

Description	Days
Discharged at end treatment period	28
Discharged early (Magistrate not granted)	<28
Discharged after initial extension period	56
Discharged after further extension period	84
Discharged early (by AMP)	Various
Absconded	Various

Approximately 20% of the recorded exit/discharge status did not correspond with the date derived LOS. This issue was discussed with the IDAT Data Manager for advice, who confirmed the issue and suggested this was evidence of poor quality data entry for the 'exitstatus' field. It was also suggested that the dates entered are more likely to be correct than the exit status. We reconciled the two different data sources by cross-checking the data fields 'DCissueDate', 'InitialDCendDate", and 'ExtendedToDate', with the ExitStatus to eventually have a completely corresponding LOS and ExitStatus.

The Act specifies up to 28 days as the LOS, although an extension can be applied for.
For the purpose of analysing LOS categorically, we used the reconciled 'exitstatus' data, which were recoded into three mutually exclusive categories:

1) Discharged early (Magistrate not granted), or discharged early by AMP, or absconded with length of stay ranging from 0-21 days;
2) Discharged at end of treatment period with length of stay ranging from 22-42 days;
3) Discharged after the Dependency Certificate (DC) extension period with length of stay ranging from 43-90 days.

Table 8: Length of stay: categorical data (episodes)

LOS categories	% of patient episodes: Total	% of patient episodes: HSC	% of patient episodes: BF
Discharged early (0-21 days)	19.6% = 67 of 342	22.0% = 29 of 132	18.1% = 38 of 210
Discharged at end of treatment (22[6]-42 days)	52.3% = 179 of 342	46.2% = 61 of 132	56.2% = 118 of 210
Discharged after DC extension (43-90 days[7])	28.1% = 96 of 342[8]	31.8% = 42 of 132	25.7% = 54 of 210

Table 8 shows that the most common period of program retention is between 22 and 42 days (52.3%). The next most common category is an extension to the DC, received by 28.1% of IDAT patients. A relatively small proportion (19.6%) was discharged in under 21 days.

[6] The cut-off of 22 days is driven by the reality that there is a strong level of consistency across the data of two treatment units in that LOS of 22+ days corresponds highly with the recorded ExitStatus of 'Discharged at end of treatment', and that can occur at less than 28 days.

[7] A small proportion of patient episodes have LOS longer than 90 days, probably due to waiting for availability of aftercare services to be discharged to (i.e. residential rehab or housing)

[8] Three HSC patient episodes had LOS of 138 day, 115 days and 108 days. Checking of other data fields suggest that this might not be due to data entry error. These three patient episodes are included in group 3 (discharged after DC extension period).

5.5 Bed occupancy rates

The bed occupancy rate is a measure of utilisation of the available bed capacity. It indicates the percentage of beds occupied by patients in a defined period of time. For this analysis we used the period of 4 years. It is computed using the following formula[9]:
BOR= (Total number of inpatient days x 100)/(Total number of bed days during the 4-year period)
Where,

- Total number of inpatient days = the total number of inpatient days of all admitted patients, including readmitted patients in 4-year period;
- Total number of bed days = number of beds × 1,460 days;

For HSC, with 4 beds and 5,032 inpatient days (number of episodes x LOS), the bed occupancy rate was 86.2%.

For BF, with 8 beds and 7,020 inpatient days, the bed occupancy rate was 60.1%.

An ideal bed occupancy rate is around 90%[10]. Everything else equal, programs that have a longer LOS can usually achieve a higher bed occupancy rate because the turnover is slower. There was not a significant difference between the average LOS at BF compared to HSC.

The bed occupancy rate should also take into consideration patient complexity. It appears that BF admits more patients with acute physical health and mental health issues (see Table 14 and text underneath Table 14), which may partly account for the lower bed occupancy rate because more staff time would be needed to care for an individual patient. But it is more likely to be driven by staffing levels on any one shift. For example, if there is not enough staff time to provide quality standard of care to eight (maximum number of patients in BF) complex patients in any given week at BF, new patients may not be admitted. Therefore, even though a bed is available and there are patients on the waiting list, a new patient might not be admitted due to concern that a standard level of care might not be provided. In addition, bed occupancy rate is strongly driven by limitations in local referring services who often cannot find patients by the time admission can be offered.

5.6 Patient profiles: admitted patients (n=254)

The remainder of this section concentrates on describing the patient profiles for those patients admitted to IDAT over the course of the four years. The referral sources for the admitted inpatients (n=254) are given in Table 9.

[9] Usman, G., Memon, K. N., & Shaikh, S. (2015). Bed occupancy rate and length of stay of patients in Medical and allied wards of a tertiary care hospital. *Journal of Ayub Medical College Abbottabad*, *27*(2), 367-370.
[10] Op cit

Table 9: Referral Sources, admitted patients (n=254, unique patients)

Referral sources	Total (n=254)		HSC Admitted patients (n=95); missing = 1		BF Admitted patients (n=159); missing = 0	
	Frequency	%	Frequency	%	Frequency	%
Family and child protection service	0	-	-	-	-	-
Family member/friend	3	1.2	1	1.1	2	1.3
General practitioner	15	5.9	6	6.3	9	5.7
Medical officer/specialist	76	29.9	23	24.2	53	33.3
Non-residential alcohol and other drug treatment agency	66	26	45	47.4	21	13.2
Non-residential community health centre	6	2.4	4	4.2	2	1.3
Non-residential community mental health centre	4	1.6	1	1.1	3	1.9
Other hospital	59	23.2	4	4.2	55	34.6
Other non-health service agency	0	-	-	-	-	-
Other residential community care unit	3	1.2	3	3.2	-	-
Psychiatric hospital	5	1.9	1	1.1	4	2.5
Residential alcohol and other drug treatment agency	13	5.1	5	5.3	8	5.0
Residential community mental health care unit	2	.8	-	-	2	1.3
Self	1	.4	1	1.1	-	-

Notes:

*Numbers may not sum to 100% due to rounding

** There was a question about the possibility of self-referral. It is possible. During November 2016, a patient at HSC referred herself from the detox voluntary unit to IDAT and got admitted to IDAT.

The majority of admitted patients were referred from a medical officer/specialist (29.9%) followed by a non-residential AOD treatment agency (26%), and then "other hospital" (23.2%). Very few admitted patients were referred by a family member or friend (1.2%), non-residential community MH centre (1.6%), community health centre (2.4%) or psychiatric hospital (1.9%). Indeed, if the referral sources for admitted patients are categorised into: 1) a general health service (including GP, hospital, and medical officer/specialist; 2) an AOD service; and 3) a MH service, the corresponding referral percentages are: 59% (5.9+23.2+29.9); 31% (26+5.1); and 4.3% (1.6+1.9+0.8). Clearly general medical is the highest referrer for admitted patients (see later, discussion of extent to which ITLOs are already managing these patients). There are key differences between the two facilities in terms of referral sources: 1) BF gets 34.6% of their referrals from "other hospitals" versus 4.2% for HSC; 2) HSC gets 47.4% of theirs from "non-residential alcohol and other drug treatment agency" compared to 13.2% at BF. We appreciate this is the official data. There might be many cascading pressures from multiple sources prior to the point of formal referrals.

Table 10 provided the demographic characteristics of the admitted patients to the IDAT program, as recorded in the IDAT database. The average age was 44 years, with 56% being male, and 6.7% were of ATSI origin. The majority were on some form of government support/pension (65%). 60% had attained year 11 or above, and about half had been married or in a de facto relationship. Alcohol

was the principal drug of concern for the vast majority (83%), but more than half also had poly substance use.

The data analysis suggests that patients admitted to the two treatment units have similar profiles pertaining to most demographic characteristics (Table 10). However, patients admitted to BF seem to be more likely to be homeless and to have 'other supported housing' and less likely to have 'privately owned or rented house/flat' compared to patients admitted to HSC. There is evidence that a higher proportion of patients admitted to BF were poly substance users (for both two substances and three substances) even though both groups had similar rate of alcohol as the primary drug of concern. There is also evidence to suggest that a higher proportion of patients admitted to HSC ever injected drugs compared to patients admitted to BF, although this interpretation should be done in the context of the high level of missing data for this variable for HSC patients.

Table 10: Demographic profile of IDAT admitted patients (n=254, unique patients)

Profile variables	Total	HSC (n=95)	BF (n=159)	Difference between two groups (tests and p-values)
Age (mean)	44.56	43.23	45.35	t=1.52; p=0.22
Gender (male %)	55.90	54.70	56.60	X^2=0.08; p=0.77
ATSI origin (%)	6.70	3.20	8.80	X^2=3.04; p=0.08
Living alone (%)	49.20	46.30	50.90	X^2=0.51; p=0.48
Type of accommodation (%) *(missing values = 2, all in HSC patients)*				
Privately owned or rented house/flat	69.00	81.70	61.60	X^2=12.01; p<0.01*
Homeless/no usual residence	12.70	9.70	14.50	
Other supported housing	18.30	8.60	23.90	
Marital status (ever married or in de facto relationship) (%) *(missing values = 12, of which 11 in HSC patients + 7 recorded as 'not stated/inadequately described', of which 6 are in HSC patients)*	49.60	48.70	49.70	X^2=0.02; p=0.89
Principal income (%) *(missing value = zero)*				Conducting categorical test on this variable is not meaningful because of small % of two categories
No income	3.90	2.10	5.00	
Employed (full-time or part-time)	5.20	4.30	5.70	
Pension (aged, disability)	65.40	63.20	66.70	
Temporary benefit	20.50	21.10	20.10	
Education (year 11 or higher including TAFE, trade or tertiary) (%) *(missing values = 35, of which 15 in HSC patients, 20 in BF patients + 48 recorded as 'inadequately described', of which 42 are in HSC patients)*	60.2	71.1	57.1	X^2=2.39; p=0.12
Alcohol as principal substance of concern (%)*(missing values = 1 BF patient)*	83.40	78.90	86.10	X^2=2.18; p=0.14
Poly substance use (2 substances or more) (%) *(missing value = zero)*	69.70	30.50	93.10	X^2=110.16; p<0.001*
Poly substance use (3 substances or more) (%) *(missing value = zero)*	43.70	16.80	59.70	X^2=44.49; p<0.001*
Ever injected drugs (%) *(missing values = 51, of which 44 in HSC patients)*	29.60	43.10	25.00	X^2=6.03; p=0.01*

Note: for some variables, missing data are high, result may be unreliable.

Table 11 below presents data for the admitted patients with reference to the primary substance of concern (the data source for primary substance of concern is drawn from data sheet DD-3). Across the IDAT program, the primary substance of concern for most admitted patients is alcohol (83.40%), followed by meth/amphetamines (9.09%), benzodiazepines (2.77%), heroin (1.98%) and cannabis (1.58%).

Table 11: Principal drug of concern among admitted patients

Principal drug of concern	**Total**		**HSC** *(n=95)*		**BF** *(n=159, missing=1)*	
	cases	%	Cases	%	cases	%
Alcohol	211	83.40	75	78.95	136	86.08
Meth/amphetamine	23	9.09	13	13.68	10	6.33
Benzodiazepine	7	2.77	3	3.16	4	2.53
Cannabis	4	1.58	2	2.11	2	1.27
Heroin	5	1.98	1	1.05	4	2.53
Methadone	1	0.40	1	1.05	0	0.00
Morphine	2	0.79	0	0.00	2	1.27
Total	253	100.00	95	100.00	158	100.00

The two data sources that provide data on severity of substance abuse are the Severity of Dependence Scales (SDS) and the Australian Treatment Outcome Profile (ATOP). Table 12 presents *at admission* data on severity of abuse of the principal drug of concern based on the SDS for admitted patients. Table 11 shows that the mean SDS scores for patients admitted to both treatment units are high and nearly identical (8.95 for HSC and 8.33 for BF) and the majority of the admitted patients (89% for HSC and 91.3% for BF) had a SDS score of 3 or above, which meets the criteria for dependence of alcohol and other substances.[11]

Table 13, *at admission* data on severity of alcohol dependence based on the ATOP for the admitted patients, shows that patients admitted to HSC had a lower mean unit per day of alcohol on a typical day of alcohol use during the 4 weeks prior to admission (mean UPD=11.74), compared to patients admitted to BF (mean UPD=22.18). Data on the number of days in month (DIM) that alcohol use was self-reported during the 4 weeks prior to IDAT admission confirmed the difference in heavy use, with a mean of 11.78 DIM for HSC patients compared to a mean of 15.95 DIM for BF patients.

[11] References for cutoff points of SDS scores:
Lawrinson, P., Copeland, J., Gerber, S., & Gilmour, S. (2007). Determining a cut-off on the Severity of Dependence Scale (SDS) for alcohol dependence. Addictive behaviors, 32(7), 1474-1479.);
Gossop, M., Darke, S., Griffiths, P., Hando, J., Powis, B., Hall, W., & Strang, J. (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. Addiction, 90(5), 607-614.

Table 12: Severity dependence scale (SDS) scores on principal drug of concern at admission: for admitted patients

Total *(n=254, missing=34)*	**HSC** *(n=95, missing=13)*	**BF** *(n=159, missing=21)*
Mean=8.56 Median=9.00 SD=3.98 Range: 0-15 Patients with SDS score >3= 90.5%	Mean=8.95 Median=9.00 SD=4.19 Range: 0-15 Patients with SDS score >3= 89.0%	Mean=8.33 Median=9.00 SD=3.86 Range: 0-15 Patients with SDS score >3= 91.3%

Notes: List-wise descriptive statistics were used. An SDS score of 3 or above has been determined as optimal for characterising dependence for alcohol and other substances (see footnote).

Table 13: Severity of alcohol use scores at admission based on ATOP: for those reporting alcohol consumption

Total *(n=254, missing=23)*	**HSC** *(n=95, missing=15)*	**BF** *(n=159, missing=8)*
UPD Alcohol: Mean=18.63 Median=16.00 SD=16.20 Range: 0-80	*UPD Alcohol:* Mean=11.74 Median=7.00 SD=14.19 Range: 0-72	*UPD Alcohol:* Mean=22.18 Median=20.00 SD=16.08 Range: 0-80
DIM Alcohol: Mean=14.53 Median=15.00 SD=10.09 Range: 0-28	*DIM Alcohol:* Mean=11.78 Median=14.00 SD=9.56 Range: 0-28	*DIM Alcohol:* Mean=15.95 Median=19.00 SD=10.14 Range: 0-28

Notes:
**UPD = unit per day; DIM = days in month.*
*** The means and medians DIM were low because most patients were spending some time in a hospital prior to being admitted to IDAT.*

Some description of the types of presenting issues for the IDAT patients can be ascertained from the details of the case management issues (as recorded in sheet DD-5) that were identified as part of the assessment. Table 14 provides the number of issues identified for the admitted group (n=204, missing data for 50 patients).

The majority of the admitted patients (94% of 204 for which data were available) had at least one of the following case management issues: *'Physical health/medical'*, *'Risk behaviour management'*, *'Psychiatric/Mental Health'*, *'Family, parenting and relationships'*, and *'Housing'*. 78% of the admitted patients (159 out of 204) had two case management issues, 57% (116) had three case management issues, 25% (51) had four case management issues and 11% (23) had five recorded case management issues.

Table 14: Case management issues for admitted patients

Case management issues	Total	HSC Admitted patients *(n=95, missing=49)*	BF Admitted patients *(n=159, missing=1)*
Education/training/literacy	12	2	10
Employment	35	6	29
Family, parenting and relationships	46	8	38
Housing	45	18	27
Physical health/medical	149	32	117
Psychiatric/Mental Health	86	14	72
Risk behaviour management	134	26	108
Financial	27	4	23

Note: A proportion of patients have more than one case management issues. Therefore, the data in Table 14 sum to more than the number of patients.

As can be seen in the above table, the most commonly presenting issue is physical health, followed by risk behaviours and psychiatric/mental health. The extent of physical health can be estimated from the above: for HSC, 69.56% (24/46[12]) admitted patients have serious physical health conditions and for BF, 74.05% (117/158) admitted patients have serious physical health conditions. The extent of mental health co-morbidity can be estimated from the above: for HSC, 30.43% (14/46[13]) admitted patients have mental health co-morbidity and for BF, 45.57% (72/158) admitted patients have mental health co-morbidity.

5.7 Re-admissions

As noted earlier (see Table 3) there were 59 patients admitted for a second IDAT and a third episode of care over the period under analysis. When this group (n=59) are compared with those patients having a single admission to IDAT over the four year period under review (Table 15), we observe that those people admitted more than once are more likely to be younger, female, alcohol as the principal drug of concern, and with higher severity of dependence scores. At the same time, they are also less likely to be homeless, and to have fewer physical health (and mental health) problems. Missing data prevents confident statistical analyses of these differences.

[12] Using 46 as the denominator given missing value=49 (out of 95).
[13] Using 46 as the denominator given missing value=49 (out of 95).

Table 15: Comparison of those patients who were readmitted (n=59) with those with a single admission (n=195)

Description	Single admission (n=195)	Re-admission (n=59)
Age (Mean/SD)	45.18 (11.51)	42.47 (12.59)
Gender (Male) (%)	56.90	52.50
Homelessness (%) *(missing values = 50, of which 34 in single admission patients)*	23.10	15.30
Psychiatric/mental health problem (%) *(missing values = 50, of which 34 in single admission patients)*	44.70	32.60
Physical health problems (%) *(missing values = 51, of which 35 in single admission patients)*	75.00	67.40
Principal drug of concern (%) *(missing data = zero)*		
Alcohol	80.00	91.50
Methamphetamine	11.30	1.70
SDS scores (Mean/SD) *(missing values = 38, of which 29 in single admission patients)*	8.23 (3.88)	9.64 (4.05)
ATOP for alcohol *(missing values = 28, of which 19 in single admission patients)*		
UPD Alcohol (mean/SD)	18.42 (16.71)	19.84 (16.00)
DIM Alcohol (mean/SD)	13.88 (10.42)	16.96 (8.91)
UPD Amphetamine/ Methamphetamine (mean/SD)	0.87 (4.59)	0.02 (0.14)
DIM Amphetamine/ Methamphetamine (mean/SD)	1.56 (5.11)	0.37 (2.49)
SF12 *(missing values = 31, of which 23 in single admission patients)*	43.83 (10.52)	42.54 (8.73)
PCS (Physical Composite Score) (mean/SD)	38.34 (11.93)	32.99 (12.39)
MCS (Mental Health Composite Score) (mean/SD)		
MOCA (mean/SD) *(missing values = 59, of which 36 in single admission patients)*	23.53 (4.79)	23.97 (3.58)
ACE-R (mean/SD) *(missing values = 159, of which 128 in single admission patients)*	82.99 (15.42)	80.93 (10.60)
MMSE (mean/SD) *(missing values = 181, of which 114 in single admission patients)*	26.06 (6.42)	26.44 (3.44)

5.8 Relationship between early discharge, end of treatment period discharge (28 days) and DC extension

In addition to the above analysis of the readmissions to IDAT, we also sought to ascertain whether those admitted IDAT patients who were discharged early, and those who stayed for 28 days were different to those patients who had an extension of the Dependency Certificate. The available demographic and drug use data are limited for such a comparison, and the level of missing data is also a concern for reliable interpretation of the results. The findings are given in Table 16.

Table 16: Profile description of three groups (group 1=33 admitted patients discharged early; group 2=143 admitted patients discharged at end of 28 days; and group 3 = 78 admitted patients discharged after DC extension period)

Profile variables	Group 1: early discharge (n=33)	Group 2: discharged at end of 28 days (n=143)	Group 3: DC extension (n=78)
Age (mean/SD)	41.55 (12.39)	45.01 (11.47)	44.99 (12.12)
Sex (male) (%)	63.60	59.40	46.20
Homelessness (%) *(missing values = 8 for group 1, 26 for group 2 and 16 for group 3)*	24.00	22.20	35.50
Physical health problems (%) *(missing values = 8 for group 1, 27 for group 2 and 16 for group 3)*	72.00	71.60	77.40
Mental health problems (%) *(missing values = 8 for group 1, 27 for group 2 and 16 for group 3)*	52.00	44.40	33.90
Principal drug of concern *(missing values = zero)*			
Alcohol (%)	89.47	89.76	76.71
Amphetamine/Methamphetamine (%)	5.26	5.51	9.59
SDS scores (Mean/SD) *(missing values = 13 for group 1, 17 for group 2 and 8 for group 3)*	8.70 (3.73)	8.65 (4.02)	8.36 (3.96)
ATOP *(missing values = 13 for group 1, 11 for group 2 and 4 for group 3)*			
UPD Alcohol (mean/SD)	19.75 (19.62)	19.98 (14.43)	16.05 (18.02)
DIM Alcohol (mean/SD)	15.15 (10.32)	15.47 (9.45)	12.80 (11.24)
UPD Amphetamine/Methamphetamine (mean/SD)	1.05 (4.47)	0.77 (4.91)	0.43 (1.33)
DIM Amphetamine/Methamphetamine (mean/SD)	2.10 (6.85)	1.14 (4.53)	1.32 (4.23)
SF12 *(missing values = 12 for group 1, 12 for group 2 and 7 for group 3)*			
PCS (Physical Composite Score) (mean/SD)	46.65 (10.14)	42.87 (10.14)	43.85 (10.09)
MCS (Mental Health Composite Score) (mean/SD)	38.34 (12.84)	36.93 (13.38)	37.09 (11.88)
MOCA (mean/SD) *(missing values = 16 for group 1, 35 for group 2 and 8 for group 3)*	22.94 (3.88)	24.27 (4.58)	22.77 (4.65)
ACE-R (mean/SD) *(missing values = 26 for group 1, 90 for group 2 and 43 for group 3)*	80.57 (12.31)	82.47 (15.69)	82.60 (12.22)
MMSE (mean/SD) *(missing values = 26 for group 1, 100 for group 2 and 55 for group 3)*	26.43 (4.65)	26.26 (5.09)	26.00 (6.75)

Note: the denominators are the number of cases with valid data.

There appears to be some gender differences, with women more likely to have a DC extension than males (who in turn were more likely to be discharged early). Unsurprisingly a DC extension[14] was associated with a higher proportion of patients who were homeless (this confirms that one of the challenges is discharge planning for those who do not have accommodation). In addition, a DC extension is associated with greater physical problems, but fewer mental health problems. Methamphetamine as the principal drug of concern appears to be more commonly associated with a DC extension.

[14] The legal basis for a Dependency Certificate extension is alcohol-related or drug-related brain injury (see "How the Act works' section on page 34.

5.9 Differences between eligible and ineligible patients

A series of analyses were undertaken to compare the unique eligible patients (n=341) with those patients assessed but found to be ineligible (n=188). Table 17 provides the results.

In the first instance, the amount of missing data should be noted. The variables for which missing data were extensive (and hence the statistical test may not be reliable) are: living alone, type of accommodation, marital status, and educational attainment and ever injected drugs. Across these variables, most of the missing values occur for ineligible patients because it is suspected that the IDAT units prioritise collecting and entering data for the admitted patients. Excluding these variables, the results suggest that eligible and ineligible patients have different profile. Specifically, eligible patients tend to be slightly older, less likely to be of Aboriginal origin, more likely to live alone, more likely to have alcohol as their primary drug of concern, and more likely to use poly drugs. The data analysis suggests that the ineligible patients are more likely to have injected drugs. The preliminary finding regarding Aboriginal people being less likely to be admitted (statistically significant difference between eligible and ineligible patients) is worthy of further investigation.

Table 17: Comparison of profile of eligible and ineligible unique patients (total=529)

Profile variables	Eligible patients (n=341)	Ineligible patients (n=188)	Difference between two groups (tests and p-values)
Age (mean) *(missing values = 9, all in ineligible patients)*	44.48 (12.17)	42.20 (12.61)	t=2.00; p=0.046*
Gender (male %) *(missing values = 8, of which 7 in ineligible patients)*	56.2	63.00	X^2=2.26; p=0.13
ATSI origin (%) *(missing values = 12, of which 8 in ineligible patients)*	6.80	13.30	X^2=6.01; p=0.01*
Living alone (%) *(missing values = 115, of which 100 in ineligible patients)*	47.00	32.1	X^2=5.75; p=0.02*
Type of accommodation (%) *(missing values = 133, of which 123 in ineligible patients)*			
Privately owned or rented house/flat	72.20	76.90	X^2=1.55; p=0.46
Homeless/no usual residence	12.70	13.80	
Other supported housing	15.10	9.20	
Marital status (ever married or in de facto relationship) (%) *(missing values = 156, of which 123 in ineligible patients)*	51.00	50.80	X^2=0.001; p=0.98
Principal income (%) *(missing values = 123, of which 114 in ineligible patients)*			Conducting categorical test on this variable is not meaningful because of small % of two categories
No income	3.60	2.70	
Employed (full-time or part-time)	5.10	8.10	
Pension (aged, disability)	61.10	56.80	
Temporary benefit	20.20	14.90	
Education (year 11 or higher including TAFE, trade or tertiary) (%) *(missing values = 327, of which 176 in ineligible patients, with most recorded as 'inadequately described')*	61.60	83.30	Statistical test was not conducted for this variable due to substantial level of data missingness
Alcohol as principal substance of concern (%) *(missing values = 79, of which 76 in ineligible patients)*	85.50	73.20	X^2=8.78; p<0.01*
Poly substance use (≥2 substances) (%) *(missing values = 66, of which 64 in ineligible patients)*	57.50	35.30	X^2=17.66; p<0.0001*

Poly substance use (3 substances or more) (%) *(missing values = 66, of which 64 in ineligible patients)*	34.80	17.70	X^2=12.54; p<0.0001*
Ever injected drugs (%) *(missing values = 262, of which 140 in ineligible patients)*	31.10	54.20	X^2=9.22; p<0.01*

Analyses to examine program entry bias

One of the issues raised by stakeholders has been to query the extent to which certain patient groups may be less likely to be admitted to IDAT. One example given to the evaluators was homelessness (also discussed elsewhere) where perceptions have varied about whether homelessness would be a reason not to admit a patient. It is difficult to obtain hard data to examine this question but it is possible to review the extent to which admitted patients differed from those referred to the program on the identified case management issues. For example if 80 referred patients had homelessness issues, but only 40 admitted patients had homelessness issues, it would suggest some operation of selection procedures. While the data are not ideal for this purpose, we have done some indicative analyses, see Table 18.

For the majority of case management issues, between 90% and 100% of patients with those case management issues identified at the referral stage, ended up admitted to the program. But for housing issues, 71% of those with housing as an identified issue were admitted. For psychiatric and mental health problems, 65% of those referred with these issues were admitted.

Comparisons between the two units can be made (see Table 18). HSC appeared to admit a lower proportion of people presenting with employment (75% of those referred) and family, parenting and relationship issues (62% of those referred) than BF. On physical health, HSC also admitted a smaller proportion than were referred (78%). For mental health issues, consistent with stakeholder perceptions, BF admits a greater proportion of referred patients with mental health problems (70% of those referred) than HSC (47% of those referred). There also appears to be a difference in terms of risk behaviours, with BF admitting a greater proportion who present with this issue at referral (99%) than HSC (65%). The higher admission rate of patients with psychiatric/mental health conditions is consistent with comments made by a number of ITLOs and aftercare providers that *"BF is a bit more welcoming in accepting mental health patients".* It is expected that BF would admit a higher proportion of patients with risk behaviour management compared to HSC because BF is a more secure unit.

It should be noted that these data (derived from the case management issues at assessment) are not ideal for this kind of analyses, but do provide an overall picture which lends support to the notion that BF tends to admit more complex patients than HSC.

Table 18: Comparison of referred and admitted patients on case management issues

Case management issues	Total			HSC			BF		
	Referred	Admitted	*% admitted to referred*	Referred (n=269, missing=192)	Admitted (n=95, missing=49)	*% admitted to referred*	Referred (n=260, missing=101)	Admitted (n=159, missing=1)	*% of admitted to referred*
Education/training/ literacy	12	12	*100%*	2	2	*100%*	10	10	*100%*
Employment	37	35	*95%*	8	6	*75%*	29	29	*100%*
Family, parenting and relationships	51	46	*90%*	13	8	*62%*	38	38	*100%*
Housing	63	45	*71%*	26	18	*69%*	37	27	*73%*
Physical health/medical	159	149	*94%*	41	32	*78%*	118	117	*99%*
Psychiatric/ Mental Health	133	86	*65%*	30	14	*47%*	103	72	*70%*
Risk behaviour management	149	134	*90%*	40	26	*65%*	109	108	*99%*
Financial	30	27	*90%*	7	4	*57%*	23	23	*100%*

5.10 Data issues

The original expectations for IDAT included comprehensive data collection such that ongoing performance monitoring and evaluation of the program could be facilitated. This expectation has not been met. As noted in the analysis of the IDAT database, there are substantial missing data.

IDAT is subject to the Minimum Dataset Requirement guidelines for NSW, which lists the required fields. These required data fields include: basic patient identification, admission and discharge dates, demographic details, and some substance use details (substance type, method of use, case management issues).

We were advised that *"The IDAT database allows for collection of one of the standard datasets for Drug and Alcohol (NSW D&A Minimum Data Set – although only Herbert St utilised this from the IDAT database. Bloomfield obtained their MDS from CHIME)".*
A number of issues were identified in relation to data pertaining to the IDAT program. These were:

- Data collection and the use of paper-based forms;
- Missing data and outcome data;
- Database.

These various issues largely surround two key aspects: responsibility and resources. The responsibility for data collection and entry is not clear, and relatedly, the resources are reportedly insufficient.

Data collection via paper-based forms
At present, the assessment for entry into IDAT is all paper-based. There are two forms to be completed by the ITLOs (Forms 1 and 3) and one by a Medical Practitioner (Form 2). This is in contrast to the shift to electronic records throughout Health. The ITLOs found the paper-based system *"laborious".* It was not clear to them why existing online/electronic hospital forms could not be used (with the use of some kind of download of the relevant fields for IDAT). The complexity of the electronic records in NSW is noted, for example not all hospitals have EMR and it is beyond the scope of this evaluation to assess each of the electronic record systems that are available and assess suitability for IDAT. But this is an important task if ongoing data about the IDAT program performance is required.

As we understand it, two of NSW Health's source data systems or applications are Community Health Information Management Enterprise (CHIME) and CERNER. During the study period from 31 May 2012 to 24 June 2016 (the period that the data from the IDAT database was available for), Bloomfield used CHIME to collect all National Minimum Data Set (NMDS) items, and Herbert St Clinic used MATISSE, an interim collection system, developed by the Ministry of Health, to collect all NMDS items. In the second half of 2016 both Bloomfield and Herbert St migrated to the CERNER CHOC state wide build. In 2017, NMDS items can be extracted from CERNER-CHOC and CHIME-CHOC.

Community Health and Outpatient Care (CHOC) is a program which helps build data and documentation into the two source systems, i.e. CERNER and CHIME. CHOC facilitates community collected data into CHIME EMR, and into CERNER EMR. CHOC has been implemented across eight community health clinical services. E.g. Drug and Alcohol, Mental Health, Aboriginal Health.

IDAT inpatient data at Bloomfield is collected in iPM-PAS, and in CERNER – PAS at Herbert St Clinic. This inpatient data is included in the Admitted Patient Data Collection (APDC).

Missing data and outcome data

Missing data are extensive for the admissions and treatment period as well as for the 1, 3 and 6 month outcome data. Addressing the referred and admitted patient episodes first, there are three 'groups' of patients (based on episode data): those assessed as ineligible (n=202); those assessed as eligible but not admitted (n=96) and those patients admitted to the program (n=342) (See Figure 1).

There are missing data across these three groups. The ineligible group (n=202) has the highest amount of missing data, with 50 of the 202 (25%) missing the reasons why the person was determined to be ineligible. For the patients deemed eligible (both admitted and non-admitted patient episodes), the full assessment should technically be available, including demographic, drug use and health data from the initial assessment (Forms 1, 2 and 3).

For admitted patients (based on first admission only), there was no missing data for length of stay (calculated as it is from date of admission to date of discharge, n=254). Discharge status was also available for almost all patients (there were 8 missing data points for exit status).

The follow-up data (at 1, 3 and 6 months) was designed to include the following:

- Principal drug of concern (DUC)
- Severity of Dependence Scale (SDS)
- ATOP
- SF12
- Mini Mental State Exam (MMSE)
- Addenbrooke's Cognitive Examination- Revised (ACE-R)
- Montreal Cognitive Assessment (MOCA)
- AOD treatment engagement (last 4 weeks)
- Engagement with other health providers (last 4 weeks)
- Contact with police (last 4 weeks)
- Guardianship order (last 4 weeks)

This would have provided a comprehensive suite of outcome data points at 1, 3 and 6 months post the IDAT inpatient admission. The intention, as we understand it, was that these were paper-based forms, which were to be completed by the aftercare provider and/or ITLO if the ITLO was providing ongoing care. A package was to be sent to the aftercare provider for completion, the package then completed with the patient and returned to the IDAT unit, where the IDAT unit team then entered the data into a database and forwarded it to the IDAT data custodian.

In the Model of Care (page 60), it is stated that "Existing health data systems should be used to capture and provide required data and information. This is specified in a core set of data items, which provides the base level of information required for reporting, planning, performance monitoring, evaluation and accountability. Specific data sets and reporting arrangements will need to be negotiated with community-based services delivering community-based interventions to discharged patients." The outcome data collection (at 1, 3 and 6 months) is currently done by the Outreach Team of each of the treatment units by contacting patients over the phone (for BF) and over the phone and face-to-face for HSC.

Substantially, these mechanisms have failed, as indicated by the proportion of patients who were contacted at 1, 3 and 6 months post inpatient admission (Table 19).

Table 19: Extent of follow-up outcome data (1, 3 and 6 months post discharge)

	Total %	HSC %	BF %
1-month post discharge	28.7%	41.5%	20.9%
3-month post discharge	21.0%	40.9%	8.3%
6-month post discharge	18.1%	36.8%	6.0%

Note: % calculated from the total admitted patients who had reached the 1, 3 and 6 months post-discharge time-points at time of process evaluation.

As can be seen, only 29% of all admitted patients have data for the 1 month follow-up. This drops to 21% at 3 months, and 18% at 6 months. For HSC, 40% of the admitted patients were contacted at 1 and 3 months (with lower number at 6 months). For BF, the percentage of patients who were successfully contacted at 1, 3 and 6 months was very small (by 6 months, only 6% had been contacted). There is little point analysing these data for any outcome indications, because the sample is not representative (indeed, it is highly likely to over-represent the success of the program).

In addition to the lack of contact with the majority of patients at 1, 3 and 6 months, even for those patients who were contacted, the full suite of outcome measures noted above were not available. For example, the ATOP had the highest completion rate amongst those (the minority) contacted at 1, 3 and 6 months, but other outcome tools such as the ACE-R and police or guardianship orders were largely missing.

The reported reasons for the failure to collect and enter follow-up data include:
- The package of forms not being sent to the aftercare provider;
- The aftercare provider failing to complete the forms;
- The aftercare provider failing to return the forms; and
- The data not entered once the forms returned.

The likely higher completion rate for HSC (although still below 50% of patients) is likely explained because the IDAT team are also the aftercare providers for those patients in the Northern Sydney LHD, whereas for BF, they are not aftercare providers for many patients in Western NSW LHD.

In addition, stakeholders advised that resources were limited and a priority was given to existing patient care, rather than data entry for past patients. That the system is reliant on paper-based completion of forms and time-consuming data entry, with many points of possible failure, as noted above, it is perhaps unsurprising that this aspect of the IDAT program has failed.

There is a further consideration here in relation to the overall aims of the IDAT: given that the Act (see later section) and some stakeholders see the primary purpose to be assessment, stabilisation and protection, rather than AOD treatment per se, the outcome measurement should match the program goals. Is there an expectation that there will be differences six month post-IDAT on substance use measures (as implied by the collection of ATOP for example)? The IDAT may be being held to account for outcomes which they are not resourced for, nor ones which are regarded as the primary purpose of the program.

Database

The relational (MS Access) database is very difficult to interrogate, and is not amenable to analysis. Substantial recoding and data cleaning were required in order to establish a database for the process evaluation work which represented both episodes and unique patients. Linked to all the above, a key question is what are reasonable requirements for data from such a program? What is the minimum dataset that would be required to monitor the program?

5.11 Staffing levels

The Ministry of Health supplied the evaluators with the allocated staffing profile for each of the two IDAT units. This allocated staffing profile has not changed since the inception of the program, and is given as part of Table 20 (left column).

The process by which these staffing profiles were determined is not known to the evaluation team. As can be seen above, there are differences between the two programs in terms of the profile and numbers of FTE (noting that BF has 8 beds, and HSC 4 beds).

The current staffing profile was somewhat difficult to determine for each of the units. This is partly because of the complex local LHD processes that occur to determine a daily staffing profile. As we understand it, there are three separate decision-makers involved in the local LHD staffing profile for IDAT: for the allied health staff, the profile (and availability) is determined by the hospital Allied Health Director; for the medical staff it is determined by the hospital Clinical Director, and for the nursing staff it is determined by the hospital Director Nursing.

> "*If we separate our funding entirely so we are the actual employer of the nurses rather than being part of the hospital overall …. That would be the only way we get around that one (shortage of nurses and well-trained nurses being pulled away).*" (IDAT team member)

The extent to which the hospital prioritises the staffing rosters for IDAT over and above all the other hospital wards is not known.

An additional factor was a regular pool of staff for IDAT:

> *"If we had the staff we are supposed to have and had some system of back-up for when people are on leave or sick and are able to maintain and nurture a cadre of nurses who want to be nurses and who want to be here and enjoy being mixed medical and psychiatric nurses, then our staffing level would work."* (IDAT team member)

Based on a number of assumptions and calculations, the current staffing profile for the two units is provided as part of Table 20 (right column). The nursing staff profile in the below table was derived from the following calculations:

Nurse hours for BF:
Weekday: 2 nurses on shift of 8 hours + NUM
Weekend: 6 patients or more 3 nurses, less than 6 patients 2 nurses on duty
With the assumption that there are always 6 patients or more, the nursing hours per week will be as below:
= (2 nurses * 3 shifts * 8 hours * 5 days) + (3 nurses * 3 shift * 8 hours * 2 days)
= 384 hours
= 9.6 FTEs (each FTE is 40 hours working a week).

Nurse hours for HSC:
From 0700 hrs - 1330hrs: 4 nurses on the floor all the time for both patients groups
From 1300hrs - 2200hrs: 3-4 nurses on the floor all the time for both patients groups
From 2130 hrs - 0730hrs: 2 nurses on the floor all the time for both patients groups
With the assumption that because IDAT patients are much more medically unwell, 2 nurses are always on floor for IDAT patients on weekdays, and 1.3 nurses are on the floor for IDAT patients on weekend, the nursing hours per week will be as below:
= (2 nurses * 3 shifts * 8 hours * 5 days) + (1.3 nurses * 3 shifts * 8 hours * 2 days)
= 302.4 hours
= 7.56 FTEs (each FTE is 40 hours working a week).

Analysis of the staffing levels needs to take into account the number of beds and the patient profile of each treatment unit: analysis of the IDAT database suggests that a higher proportion of patients admitted to BF are homeless, have serious physical health conditions, and have mental health issues compared to patients admitted to HSC (see Table 14). In addition, connecting IDAT patients to community-based services for BF patients is believed to be more challenging given rural and regional areas are not as well-resourced as metropolitan areas. Finally, at HSC the unit is both for IDAT patients and voluntary detoxification patients, and as such staffing levels are not necessarily clearly split between the two patient groups on the same unit (efficiencies of scale). In addition, the HSC team need to provide aftercare outreach (visiting patients in their homes) for patients returning to NSLHD area. This involves time and workload not only for the two members of the outreach team but also for the Director and the CNC in terms of clinical follow-ups.

Table 20 summarises the Ministry of Health allocations and the current profile across both units. The current staffing level for BF is 16.3, lower than the allocated FTEs by 1.6. The current staffing level for HSC is 16.2, higher than the allocated FTEs by 2.6.

Table 20: Ministry of Health IDAT staffing profile compared to current operational staffing profile

Bloomfield	**FTE allocated by the MOH**	**Current FTE**	
Aboriginal Worker (Q1)	0.5	Senior D&A Outreach Worker	1.0
Diversional Therapist (X4)	0.5	Occupational Therapist	0.5
Psychologist (Y1)	0.5	Psychologist	0.5
Social Worker (S1)	0.5	Social Worker	1.0
Nurse Unit Manager (NUM)	1.0	Nurse Unit Manager	1.0
Enrolled Nurse	3.8	Enrolled Nurse	
Registered Nurse (NR)	7.0	Registered Nurse	9.6
Clinical Nurse Consultant (CNC)	0.5	n/a	
Ward Clerk / Admin (WA)	0.5	Admin Assistant	0.5
Career Medical Officer (MC)	0.5	Medical Officer	1.0
Staff Specialist (MH)	0.5	Addictions Specialist/Director	0.5
Information Worker (WG)	0.1	Pharmacist	0.5
Social Worker (S1)	2.0	Dietitian	0.2
Total FTE	**17.9**		**16.3**
Herbert St Clinic	**FTE allocated by the MOH**	**Current FTE**	
Nurse Unit Manager (NUM)	1.0	Nurse Unit Manager (NUM)	0.5
Staff Specialist (MH)	0.5	Consultant Psychiatrist	0.2
Registrar (R1)	0.6	Resident Medical Officer	0.3
Social Worker (S1)	0.5	Intern	0.3
Occupational Therapist (X5)	0.5	Psychiatry Registrar	0.4
Clinical Psychologist (Y1)	0.5	Clinical Nurse Consultant	1.0
Administrative Officer (WA)	0.5	Administrative Officer	0.5
Registered Nurse (NR)	5.0	Registered Nurse	7.6
Registered Nurse (NR)	2.5	Outreach staff/nurses	2.0
Social Worker (S1)	0.5	Social Worker	1.0
Occupational Therapist (X5)	0.5	Occupational Therapist	1.0
Clinical Psychologist (Y1)	0.5	Clinical Psychologist	1.0
Staff Specialist (MH)	0.5	Consultant Psychiatrist/IDAT Director	0.4
Total FTE	**13.6**		**16.2**

Note: the exact role description and sequence of role description as listed in the document provided by the Ministry of Health were used for this table (for example, there are two rows for Registered Nurse for HSC).

The evaluation team noted that there are many demands on staff time over and above the provision of central IDAT program functions. These includes:

- Responding to enquiries from other health professionals, families and others[15];
- Much time spent on administrative work given the complexity of patients, absconding patients, requests for extensions, activities (i.e. taking individuals walking in ground or to town) for those cognitively unable to participate in treatment program/group activities. Staff often need to take patients to town to purchase clothing, especially the homeless who arrive in one set of clothes only;
- Guardianship applications (for patients with mental health issues).

It is not clear whether there is an appropriate benchmark to use for the IDAT staffing profile. Possibly the staffing profile of an acute, secure mental health unit may be used as a proxy to benchmark, but the IDAT program also involves the provision of more usual AOD treatment - whereas acute secure mental health facilities are much more focussed on stabilisation and assessment. (This again points to one of the tensions for IDAT between assessment, stabilisation and protection versus AOD treatment functions). The observations above also make clear that the IDAT staffing profile could not be based on a AOD treatment service per se, for example, an AOD treatment service is highly unlikely to be commencing guardianship orders, or managing the level of physical health and mental health complexity.

Management at the HSC IDAT program stated that the current staffing levels were good for the inpatient care component. For aftercare and data collection/entry, they indicated a need for more staff.

For Bloomfield, there was consensus in the team that the current staffing levels for allied health and administrative support is not sufficient, resulting in the cancellation of group activities at times and lack of one-on-one counselling. The lower bed occupancy rate at BF would also suggest a problem with staffing levels.

A further concern at BF was the movement of nursing staff. The evaluators were told that nursing staff who are IDAT-trained are often "pulled away to do other things" and replaced by nurses that are not IDAT trained.

In the stakeholder interviews with BF team members, the evaluators were provided with recommendations for changes to the BF staffing profile for IDAT. This included:

- Psychologist position: changing from part-time to full-time;
- Occupational Therapist position: changing from part-time to full-time;
- Administrative Assistant: changing from part-time to full-time (given the amount of admin work + data entry is higher with higher number of patients);
- Allied Health Assistant: a new position to assist the workload of the allied health staff.

One stakeholder also explained the reasons for the discrepancy between actual staffing level and the MOH allocated staffing level:

> *"Because unfortunately we are part of a major hospital that has a nursing problem and they see our nurses just as a part of a larger pool of nurses and we have a major difficulty in Orange in actually getting enough nurses all round. And part of it is that they rely very heavily on agencies' nurses and agencies' nurses usually had heard that IDAT is a very interesting place to work and*

[15] It was noted that ADIS was envisaged to be the point of contact for such queries but a stakeholder noted that ADIS was unable to respond to a specific query. A centralised single point of contact was recommended by ITLO stakeholders.

say that "I want to work in IDAT". So our staff therefore are pulled to work somewhere else where most people don't want to go to. That is what happens. It is a hospital issue, where the hospital is always way below nursing level." (IDAT provider)

"We have challenges due to staff shortage with nursing staff and the OT role and psychologist. We've also been missing an Allied Health Assistant for a long time. This means that our patients, due to nurses being short of staff don't get to access other things on campus that other mental health patient do, such as ceramics, women's group, men's group, escorted walking, cycling…." (Allied Health team member)

6. Qualitative analysis of program

The qualitative analysis was undertaken in light of the quantitative data from the database analysis (see previous chapter), documents of relevance to the program and its operation, and the stakeholder interviews.

6.1 Analysis of the Act governing the IDAT program

In the first instance, it is noted that the NSW Drug and Alcohol Treatment Act 2007 is currently regarded as model legislation[57], providing the best balance between deprivation and liberty and the level of care that the targeted patient population require. Other jurisdictions, such as Western Australia, are actively aiming to achieve a similar program modelled on the NSW legislation.

As noted above, there are four eligibility criteria in order to determine a person's suitability for involuntary detention under the Act. All four must be met with each person. Stakeholders noted that the eligibility criteria were subject to individual interpretation – which was regarded as both a strength (capacity for individual tailoring) and a potential weakness (insufficient clarity). Here we examine each of the four in turn.

a). Severe substance dependence: A person has a 'severe substance dependence' in accordance with the Act if the person:

- has a tolerance to a substance; and
- shows withdrawal symptoms when the person stops using, or reduces the level of use of, the substance; and
- has lost the *capacity to make decisions* about his or her substance use and personal welfare due primarily to his or her dependence on the substance.

The requirement that the person 'has lost the capacity to make decisions about his or her substance use and personal welfare due primarily to his or her dependence on the substance' is of practical importance for the comprehensive assessment by the ITLOs and the referring team and determination if a patient is eligible for IDAT (by the AMP and subsequently the magistrates). It is notable that the NSW and Victorian legislation makes reference to decision making and capacity, a construct that is absent from other such civil commitment legislation. This approach is similar to capacity/mental health legislation that is currently in place in the United Kingdom.[58] (page 16).

Neither the DSM-IV nor the ICD-10's diagnostic guidelines for dependence syndrome are referred to. The equivalent legislation in other Australian jurisdictions (Victoria, Tasmania) or other countries (New Zealand, Sweden) are also not currently using the DSM-IV or the ICD-10's diagnostic guidelines as the criteria for severe substance dependence [57]. This might be due to the nature of the IDAT program and the context of involuntary treatment in that: 1) 50% of the time the ITLOs do not see the patient for an assessment; and 2) with the possible lack of insight and impaired cognitive capability, patients who might be eligible for IDAT would not necessarily be providing responses to the DSM-IV or the ICD-10 diagnostic questions in a way that they could be categorised as severely dependent on alcohol/drugs. In other word, the DSM-IV or the ICD-10's diagnostic might be more appropriate for patients who seek help (i.e. in voluntary treatment context). The third criterion (lost capacity to make decisions) is similar to the Victoria Severe Substance Dependence Treatment Act's requirement that the person be 'incapable of making decisions about his or her substance use and personal health, welfare and safety due primarily to the person's dependence on the substance'.

b). Potential for harm to self or others: The potential for harm to self or others is part of the current criteria for a Dependency Certificate. This criterion makes clear that a central purpose of the Act and involuntary detention is for the purposes of protecting a person from serious harm to themselves or to others. This assessment is conducted at different time-points as a way of undertaking checks and balances: prior to program entry by the referring team/ITLO; part of the assessment for issuing a Dependency Certificate by the AMP; and is reviewed by a Magistrate within 7 days of the Dependency Certificate.

c). Benefit from treatment: The Act specifically includes a benefit criterion, which implies that deprivation of liberty and decision-making autonomy would not be justified without a real likelihood of benefit to the patient. Despite a comprehensive definition of the intended patient group and the principles that apply to decisions to detain and treat patients, there is potential confusion about the notion of 'treatment benefit'. Some stakeholders suggested that this third criterion is too vague with regard to how to define "likely to benefit from treatment". For instance, questions were raised whether some people have been too unwell to be likely to benefit. In the meantime, a number of other stakeholders thought it good that the criteria are not too proscriptive to allow for some level of flexibility in determining the suitability of patients who could be accommodated and treated within existing resources.

These considerations, however, reside in a fundamental issue for IDAT, and that is the definition of "treatment". Here there is an important distinction between protection, stabilisation and assessment compared to treatment. The objects of the Act appear more concerned with the former: protecting an individual, stabilisation of the physical and mental state, comprehensive assessment and voluntary treatment engagement post program, versus the implication in the eligibility criteria that alcohol and other drug treatment is provided. Stakeholders appear to understand that there is tension between the former assessment, stabilisation, protection function and the latter treatment function. For example: *"the essential role of IDAT is a good multi-disciplinary assessment...rather than treatment"* (IDAT provider); and the reality that *"not much treatment is possible".* (ITLO)

Views are divided on this: for example the Official Visitors in BF noted that patients need more treatment interventions, counselling and support:

> *"The medical side of it is very good. It is the allied health side of it that needs a lot of work. That is why we keep hearing about boredom. ….. There are not allied health staff to run these groups consistently because the nursing staff need to attend to the acute duties they are doing… And so patients will want more work on relapse prevention and very worthwhile topic. They are seeking knowledge, education, and what they can do to prevent relapse… There is an opportunity lost for a lot of this stuff."* (Official Visitors)

In addition the Model of Care (the procedural document prepared by the Ministry to accompany the Act and which specifies in detail the care elements) makes clear that AOD treatment is a primary function of the program. And this is confirmed in some of the stakeholder interviews, who hold the same view, as expressed below:

> *"We struggle to take people who don't have an aftercare plan. In fact, we wouldn't accept someone without an aftercare plan because there is no point of admitting them as they can't be followed up as the 6-month requirement for aftercare. And that's part of the Model of Care from the Health Department."* (IDAT provider)

While this may seem a somewhat trivial matter, it actually goes to the heart of a number of themes arising from the process evaluation. There is significant pressure on beds (see waiting times section), and the provision of treatment (as opposed to protection, stabilisation and assessment) potentially increases the length of stay. In addition, the very existence of a delay to admission suggests that the

immediate protection function may be compromised (someone assessed as in need of protection may no longer be in such a situation at the point in time that a bed becomes available). There is also some natural inclination for AOD clinicians within IDAT to want to (and be skilled at) providing AOD treatment interventions.

There is no ready way to reconcile the tension and ambiguity in the Act about protecting safety, stabilisation and assessment versus the provision of AOD treatment. In this context then, the assessment of "likely benefit" takes on different meanings. In the context where AOD treatment is the key object of the program, then likely to benefit from AOD treatment will be assessed as the capacity and willingness to make behavioural changes, and to ensure that the environment to which the patient is returning has capacity to support abstinence (or at least reduced use). It is in this context that homelessness and cognitive impairment may be regarded by some as an exclusion criterion, because someone without cognitive capacity or in precarious accommodation circumstances is not likely to benefit from AOD treatment.

> *We are now trying to exclude patients with alcoholic dementia and severe cognitive impairment because they can't benefit from treatment. And what they need is placement in the community, not an IDAT order. So we are increasingly looking at cognitive test."* (IDAT provider)
>
> *"If we send people home to a community without a home, we set them up for failure."*
>
> The issue of homelessness provides a useful case in point. The extent to which homelessness is seen as an exclusion criteria (because unlikely to benefit) has shifted over time. For example: *"[it] was very clear that our Model of Care said that we won't take homeless people."* (IDAT team member)

Compared to:

> *"We don't turn people down because they are homeless. I think it is actually a 'cop-out' because they are often homeless because their addiction is out of control."* (IDAT team member)

The above discussion highlights the differences of opinion on this issue, and the different underlying assumptions about the definition of 'likely to benefit from treatment', which speak to the contradictions in the IDAT paradigm. It is perhaps unsurprising that there is a diversity of opinion about this third criterion given the ambiguity inherent in the extent to which "likely to benefit from treatment" is understood in the context of AOD treatment and behavioural changes to reduce consumption and harm, versus benefiting from being removed from an immediate high risk environment where the person is at risk to themselves or to others.

d). No other appropriate options: The fourth eligibility criterion specified in the Act is 'no other appropriate and less restrictive means for dealing with the person are reasonably available.'

None of the stakeholders interviewed raised any concern about this eligibility criterion. Review of patient files shows that evidence gathered for this eligible criterion centres around a combination of several of the following:

- Previous failed attempts at use of medications;
- Multiple prior detoxes in hospitals/forensic hospitals followed by relapse in drinking alcohol;
- Multiple previous voluntary rehab treatment with poor attendance and outcome;
- All other appropriate and less restrictive means for dealing with the person have been exhausted and the person continues to make an ill-informed decision to use

alcohol/substances despite the negative consequences (i.e. drug driving charges, ED admissions) and continues to refuse any less restrictive care reasonably available to them;
- Refusal of all other less restrictive interventions but at significant risk of harm to self and others when drinking and using meth and required a period of time to allow him to re-focus and recover; and/or
- All other restrictive treatment options have been exhausted.

Some stakeholders stated that the mention of IDAT was useful in the context of patients who had failed voluntary treatment or were otherwise non-compliant. As reported by stakeholders, this strategy sometimes works well in that the patients engage better in voluntary treatment. However, if they continue to disengage and/or resist voluntary and less restrictive treatment options despite serious health consequence to self and other, an IDAT referral will be made as a last resort option.

> *"In my experience, approximately three quarters of patients will elect for voluntary treatment when they are informed that IDAT is being considered for them. … My preference is to mention the possibility of IDAT to patients as soon as possible, as the possible loss of freedom is often a motivator to engage in voluntary treatment. …Some patients are able to see that they are struggling to manage their substance use with voluntary treatment, and agree that there would be some value in IDAT. These patients usually ambivalently agree to an admission when a bed is available."* (ITLO)

In-depth interviews with patients confirmed that this criterion is very well understood by the patients:

> "*I'd had numerous relapses on alcohol and I kept ending up in hospital ER, ICU, mental health. And hospitals and doctors just got sick of me and referred me to IDAT. The doctor at the hospital just told me that I was going to IDAT and at the time I thought that it was a good thing. I've been to IDAT before and this was my second time. I thought to myself 'thanks God, my relapsing is over."* (Patient)

Specification of "28 days"

There are divided opinions among the stakeholders on whether 28 days is long enough for IDAT patients with a higher proportion believing 28 days is not long enough.

Those stakeholders who regarded 28 days as insufficiently long argued that most of the IDAT patients are complex patients and sometimes *"the moment the patient steps in the door of the unit, the staff already have to spend time on an application for extension of the DC (ITLO)",* putting a lot of pressure on staff to spend time on paperwork, hence less time to do clinical work. They think that the more appropriate time should be 56 days to prevent time to be wasted on paperwork, and for those patients who do not need to stay longer they can be discharged earlier than 56 days. The 56 days is more meaningful to allow for pre and post assessment of cognitive and neurological functioning to assist in determination of the next logical and feasible treatment pathways/strategies for patients *"…understanding that we cannot even do an adequate neuro-psych assessment or cognitive assessment until they are 6 weeks post substance use. And so where are we going to keep them in an acute facility for 6 weeks?"* (ITLO). In addition, the unexpected consequence of the 28 days is that it is only long enough for various assessments to be done, leaving not much time for meaningful "treatment" such as CBT, motivational interviewing, and therapeutic group activities[16]. This is the case for the treatment unit in BF (partly due to lack of allied health staff hours, discussed in the staffing level section).

[16] Note: this again links to differing views about the extent to which IDA is AOD treatment or assessment and stabilisation only.

On the other hand, the stakeholders who thought that 28 days was an appropriate length of detention under the Act argued that this length of time is sufficient to ensure that resources are used responsibly, *"to prevent the treatment facility from being a dumping ground for patients that are a huge burden on the system. It actually then becomes a treatment facility rather than a holding facility".* Two other stakeholders believe that 28 days is actually right because *"a lot of patients are really engaging during that time. They don't necessarily need longer. For those who are cognitively impaired they definitely need longer time and they can get an extension".*

As noted elsewhere (Section 5.4), the average length of stay in the IDAT program to date is a median of 27 days, and a statistical mean of 35 days. This would suggest that most of the patients stayed for 28 days. However, one indication that the LOS may be too short is the proportion of patients for which an extension of the DC is applied for. The data (see Table 8) revealed that 28.1% of IDAT patients received an extension to the original Dependency Certificate.

Other issues

The Act requires that one of the two Official Visitors has to be a medical doctor, which according to stakeholders is challenging because it is very hard to find a medical doctor for this responsibility unless they are retired. A stakeholder felt that there is no need for an Official Visitor to be a medical doctor: the reason this was a requirement in the D&A Treatment Act is because it mirrored the Mental Health Act in this respect. The MH Act has been revised and this requirement is no longer active. Consideration could be given to doing the same for the D&A Treatment Act. On the day the evaluators conducted the interview with the Official Visitors at BF which occurred on the same day with the regular visit to the treatment unit, the medical doctor Official Visitor was not able to attend due to family circumstances *"so neither of us are a medical doctor. So in a sense we are violating the act. But if we are not conducting the visit today because our colleague Official Visitor who is a medical doctor is not available, we are also violating the Act. We are violating the Act either way".*

The conditions under which an extension to the Dependency Certificate can be granted under the Act are limited to those with acquired brain injury and impaired cognitive function ("drug and/or alcohol related brain injury"). This poses challenges, for example in the case of a pregnant woman, or those with other complex psycho-social presentations requiring more time. We were unable to access data (patient clinical records) to assess whether everyone who received an extension met the criteria (but we suspect this has not necessarily been the case). On the surface, it appears a potential limitation to the legislation, with drug or alcohol related brain injury being only one of a number of potential reasons for seeking an extension to the DC. A comprehensive neuropsychological assessment in theory is therefore required for anyone being assessed for an extension (especially given the specificity of "drug/alcohol related brain injury", as opposed to any form of cognitive impairment). At the same time, defining clearly the basis for an extension provides protections for human rights and a clear rationale for involuntary detention.

6.2 Other relevant legislation

As part of the process evaluation, we explored whether other existing legislation could be applied to the IDAT patient group. There was strong consensus that a program like IDAT needs to be under a separate Act from Mental Health because drug and alcohol treatment and mental health are different disciplines, with a different focus (noting overlap of patients).

> *"Look the reality is it is a completely different patient population and different treatment requirement and being under Mental Health Act, their focus is on severely mentally ill patients, some of whom have D&A issues. Our focus is on severely drug and alcohol*

> *dependent patients, a lot of whom have MH issues but not severe. … very different patient populations, very different treatment needs, very different model of care."* (IDAT provider)

The Drug and Alcohol Treatment Act can act in concert with the Mental Health Act such that a person with both acute mental health and alcohol or drug issues can be managed across the two legislative frameworks, as explained by one stakeholder:

> *"OK so somebody becomes suicidal or becomes mentally ill and they are being held under the D&A Treatment Act, they are taken off the D&A Treatment Act and put under the MH Act. And you can't be under both at one time. So we can actually put the DC on hold and then when they are cleared and no longer can be held under a MH Act, they can resume being held under the D&A Treatment Act."* (ITLO)

Another highly relevant piece of legislation is the Guardianship Act. A number of IDAT patients become subject to a guardianship order as part of their IDAT treatment. Guardianship can become a challenge because it takes a lot of time to arrange for guardianship. Once in guardianship, the public guardian needs to be informed and they need to agree on the aftercare options before the patient can be discharged. We were told that there are a number of situations where the inpatient stay needs to be continued due to lengthy negotiations between the treatment team and the public guardians.

A field in the IDAT database (data table DD-17) provides data on guardianship, indicating if a patient has a guardianship order in place or whether one has been applied for. However, it is not possible to know whether the guardianship was in place prior to or commenced during IDAT. In addition, the data were recorded for 4 BF patient episodes and 104 HSC patient episodes (with 89 recorded as 'no order in place'). Therefore, it is not possible to assess the magnitude of administrative workload required for guardianship application by the IDAT team.

Option for community treatment order (CTO)

The evaluation team was informed that most people subject to a Compulsory Treatment Order under the NSW Mental Health Act receive a Community Treatment Order. Under these orders, the clinician at the community-based service manages or coordinates care for the person. There is intensive community-based support if required - for example there may be daily home visits for administration of medication or other matters. For other persons there may be less frequent visits, if their condition is stabilising or responding to treatment.

Most of the stakeholders consulted referred to this as a potential option for consideration under the Drug and Alcohol Treatment Act, allowing a person to be compulsorily treated in the community without the need for detention as an inpatient. They thought this option should be available as an alternative and/or an adjunction to detention at the treatment centre.

> *"It would make life a lot easier if we had CTO to follow-up afterwards. Also, it makes a lot of sense to have outreach for those people who perhaps don't need to be held under the Act but need to go through the same process to get treatment in a less restrictive environment."* (ITLO)

"I think a CTO would greatly enhance the scope of involuntary treatment, as it would allow for a greater mix of inpatient and outpatient management" (ITLO). Also, it could potentially allow for a shorter period of admission for some patients. Once the patient is stabilised through withdrawal, medical and psychiatric treatment could be continued in the community. And this then potentially could free more beds because in-patient length of stay will be shortened. At the same time many of the stakeholders raised concerns over the current lack of infrastructure for a CTO scheme for IDAT in

NSW. Firstly, in the Mental Health Act, if a patient breaches a CTO, they could be subject to readmission to a mental health facility. This is not currently possible within IDAT because of the lack of beds across the state. Secondly, mental health services are well-resourced with community teams who are responsible to reinforce the CTO while this workforce is lacking for drug and alcohol services. A number of stakeholders stated that there is no "case management" for D&A services in NSW: "*So I think for us, we do it well here because [staff name] and I decided from the beginning before we started this program that we needed to have an aftercare component because we knew that there would be a significant number of patients from our area being referred in and we knew that it would be very difficult to coordinate care in D&A services because there isn't case management" (IDAT provider)*. Thirdly, even when the first and second factors are resolved, a CTO scheme means that it is mandatory for the community AOD worker or team to enforce patients to engage in community-based treatment services which are currently not even readily accessible for voluntary patients (i.e. long waiting list for residential rehab). This then raises the concern of who is more worthy of the limited community-based treatment slots: the voluntary patients or the involuntary patients?

> *"Well, this is something again you'll find people on both sides. My personal view is that they (CTOs) are useful. Unfortunately, they are useful not for the reasons that people may think. I think they are useful because if a person is in psychiatry or in mental health and they are on community treatment orders, it means the resources have to be allocated for their care. So in an ideal system, those resources would be available anyway, and you wouldn't need a community treatment order. But here, they become the most prioritised patients so they get the resources that are needed."* (Drug and Alcohol Clinical Director)

6.3 Human rights and coercion issues

There are various human rights protections built into the NSW Drug and Alcohol Treatment Act 2007 with a strong aim to address all human rights aspects that were the subject of criticism of the previous legislation (the Inebriates Act 1912). The Act 2007 emphasises that the rights of the patient are paramount and that this is a last resort treatment option. The Act also sets out stringent eligibility criteria. Specifically, in setting the eligibility criteria, the Act requires that involuntary treatment is only considered as the last resort treatment option after all other less restrictive treatment avenues have been exhausted and that involuntary treatment is likely to bring about a reasonable prospect of sustainable client benefit, sufficient to justify the infringement on human rights associated with detention and involuntary treatment. The Act sets out the process of screening, assessment, involuntary detention and treatment, the role of Accredited Medical Practitioners (AMPs), assessment criteria and the rights of appeal to ensure that the rights of the identified patients are protected throughout the process. The Act also contains provisions to ensure that a person and their primary carer are provided with clear information about their legal rights and their rights of appeal[17]. All Dependency Certificates must be reviewed by a Magistrate as soon as possible (within 7 days) after issuing. The patients are always represented by a legal representative during the review of the Dependency Certificate conducted by the Magistrate. Under the legislation, two independent Official Visitors must visit each gazetted inpatient unit at least once per calendar month to inspect the centre, to ensure that patients' rights are protected and they have appropriate standard of treatment and care, to act as an advocate on behalf of patients if required, and to report identified matters to the Minister for Health for further investigation. Patients and their primary carers should be notified of the Official Visitors Program and be advised of their rights to contact an Official Visitor.

[17] Although this might not be a realistic option because it is not covered by Legal Aide.

Overall, all stakeholders interviewed (particularly the Magistrates and the Official Visitors) confirmed that the safeguards that are set out in the Act are properly exercised in practice. The stakeholders interviewed also stated that interpretation of the legislation through the model of care and implementation is more consistent with contemporary values regarding human rights and dignities of severely substance dependent people (compared to the old Inebriates Act).

While acknowledging the high standard of treatment and care for patients at IDAT, the Official Visitors noted some concerns (through review of the Official Visitor's Book of the two treatment units and interviews with the Official Visitors). For example it was noted by the Official Visitors that some patient files do not have a record to indicate that a primary carer has been nominated. In one case a patient was discharged and then readmitted right after discharge (ie not what is intended in the Act). But the Official Visitor did not feel that it was done to the detriment of the patient.

While the Official Visitors reported to the evaluators that patient rights are protected and the medical standard and care is always delivered, they are concerned for the dignity of the patients for the following reasons:

- Due to lack of Allied Health staff, there is concern that patients' experience (insufficient program activity). The Allied Health Assistant position was trialled for a period and the trial was successful. The Allied Health Assistant was able to assist in taking the patients out for a walk on a daily basis, taking the patients out on escorted leave to Orange town for shopping, running group activities, or taking the patients to AA meetings. However, the position was discontinued with no reason given. This has resulted in cancellation of group activities (with no explanation given to the patients). This issue has been brought up by the Official Visitors to the hospital management but it had not been resolved by the time the evaluators interviewed the Official Visitors *"It was like broken records. We were told that the position has been approved and it has been with Finance but we were told that three months ago".*
- Unlike patients in HSC, who have access to a kitchen to practice their cooking and access to food of choice, patients at BF have to *"take what they are given"* (quote by OV). They do not have a menu choice and like other patients in BF hospital they are given *"snap frozen food from Sydney"* and *"apples from China".* The flip side is that patients at BF have access to a dietitian who sits down and works with them on diet that is best suited to their medical condition and their health.
- Patients at BF are allowed only one cup of tea or coffee during meal time. They are not allowed to make tea or coffee themselves because it involves hot water (rules of mental health institutions). We were told that this was not for want of trying and that the IDAT team attempted to introduce an urn to allow patients to make tea and coffee but this was defeated by the nurses' union via the risk management system. *"Food is not necessarily a rights issue but it is more related to patients' perception of dignity"*. In addition, all the bedrooms and bathrooms are locked during meal time or tea time and patients are not allowed to be dismissed until all cutlery is counted (rules of mental health institutions). The Official Visitors for HSC stated that complaints about food are very common when they do monitoring of mental health facilities but IDAT patients at HSC do not complain about food.

Role of the Magistrates

The hearing process that the Magistrates exercise was different across two treatment units: in HSC, the Magistrate always conducted the hearing in person at HSC while the Magistrate in BF did it via video link. The Magistrate in HSC believed that conducting the hearing face-to-face would make a big difference because "*in the hearing process that I am involved in, it is a very difficult and traumatic time for the persons involved."* The Magistrate in HSC also believed that the hearing was done as *"an empowering process"* in that *"They wanted to be heard. They wanted to have their*

concern voiced in that forum". And as a result of this empowering process, most of the patients who opposed the Dependence Certificate at the beginning of the hearing process eventually agreed that treatment at IDAT was done for their benefit and consented to engage in treatment. This suggested that the role of the Magistrate was critically important not only on the legal process but also important in motivating the engagement of the patient at the beginning of the treatment program.

The Magistrates who worked with both treatment units confirmed that they had confirmed all the DCs or extensions of DC under their review. However, the IDAT database indicated that on 15 occasions, a Magistrate did not confirm 14 DCs at BF and one DC at HSC. Interviews with IDAT team members at one of the IDAT units confirmed that on occasions the DCs were not confirmed by the magistrates, primarily on the basis that the patients maintained their opposition to being admitted to IDAT. When a DC was not confirmed, the patient was discharged immediately. The evaluation team were advised that this had resulted in poor outcomes. By way of example: a patient returned to excessive drinking straight away and was transported to the ED the next day due to gastrointestinal bleeding. This patient was subsequently readmitted to IDAT and on this second time the DC was confirmed by the magistrate. This example provides a specific illustration of the challenge of walking the thin line between respecting the patient's autonomy and applying measures to protect them from harms.

In in-depth interviews, all patients were asked about their perceptions of whether their civil and human rights were protected throughout the process of referral to IDAT and while in IDAT. All but one patient interviewed felt that their rights were respected. All interviewed patients were aware of their rights with regard to access to the Official Visitors. All the interviewed patients confirmed that the Magistrate review occurred within 7 days from admission. All patients expressed the view that coercion into IDAT was justified and worked in their best interests. With regard to experience with the Magistrate hearing process, all interviewed patients expressed positive opinions of the procedure:

> *"My understanding was that the Magistrate hearing was an informal procedure. It was very positive. Clearly I wasn't left confused or feeling in any way… After the initial month, the doctor here made it clear they were sort of in support or was leaning towards advising or recommending at least another month or two and I was already hoping and anticipating in my next opportunity in any type of consultation with the doctor as to my own wish to stay for that month or two. So there was no conflict at all within me. So therefore my attitude was to 'OK this is the formality'. I found the Magistrate extraordinarily compassionate and very clearly altruistic and seriously wishing the best outcome for all concerned... I left feeling quite touched."* (Patient)

In summary, across the above three sections, a number of challenges and inconsistencies reflected across the Act, the Model of Care and the program operations have been identified. One of these is the difference between acute protection versus AOD treatment. The paradigm which is the basis for the Act and the IDAT program is that by involuntarily detaining someone who has refused voluntary care, is substance dependent and is at risk of serious harm to themselves or at risk of causing harm to any dependents under their care, this has the potential to change the course of the person's addiction. There is not level 1 or 2 evidence for this – so it is an underlying assumption. This demonstrates the difference from MH – where involuntarily detention is solely a protective function, and once the acute risk of harm has passed, the person is discharged without expectation that it will have changed the long-term course of the mental health illness. It is precisely this aspect (changing the future course of addiction, prevention of future harm) that underpins the current IDAT program – which balances both acute care and AOD treatment. Yet, this also then bumps into the problem of waiting time (if one leans towards the acute functions of the Act), and bed availability and resources for the AOD treatment component if one leans towards the AOD treatment function.

6.4 Waiting time: supply and demand

At the time of the process evaluation, there were 19 patients on the waiting list for BF and 10 patients on the waiting list for HSC. As noted above, the average wait time prior to admission is 27 days, with 19% of patients waiting more than 42 days prior to admission. This seems to fly in the face of the intention of the Act, which is to provide protection and care for people at acute risk.

Stakeholders expressed significant concerns about the waiting time:

> *"It is an outrage; very often the community and family members expect the procedure for IDAT admission is similar to a mental health admission. We often have to spend a lot of time to explain the difference. It is very hard to have to explain to a desperate family that they might have to wait for months for an IDAT bed and the application might be knocked back."* (ITLO)

> *"IDAT [is] for patients whose needs are immediate…. but waiting for 4 weeks, 6 weeks and sometimes 2 months for a bed then leaves open a level of risk ."* (ITLO/Social Worker)

> *"It is very worrying that we've got people on the waiting list who are very unstable and very unsafe."* (IDAT provider)

The evaluators were told that ITLOs are not referring because of the long waiting list:

> *"I would normally ring the Unit and talk to them about what their waiting lists are like. Is it worthwhile doing the IDAT assessment right now when we know that the patient potentially can't be admitted for 2-3 months?"* (ITLO)

The two IDAT units are extremely aware of the waiting time problem, and have a "juggling act on a daily basis". The waiting list is not managed on a "first in best dressed" basis. Rather, it is based on the level of acute problems presented. This is similar for both treatment units. On average, meetings occur weekly to determine which patient is next on the waiting list (see below 'patient prioritisation'). This process is continuously changing, so a prospective patient initially ranked 1 on the list, may be subsequently moved down if a more urgent, acute case joins the list.

ITLOs in the metropolitan LHDs are referring patients to both treatment units at the same time. The intake workers of both treatment units need to communicate with each other before they make a decision on issuing a DC for a patient. Coordination of prospective IDAT patients across multiple services, who may be simultaneously seeking an IDAT admission was noted:

> *I am sending an email to all CNCs of Drug Health services, East, West, South and SSWAHS that an active application is current for [named patient], in case she starts presenting to other services, as this is what she did last admission.* (ITLO email)

The complexity of coordinating the assessment, the bed availability and the Dependency Certificate signature is highlighted in the following exchange, an example which occurred during the process evaluation:

> From an ITLO to an IDAT unit: *"I understand beds cannot be held and do not expect them to….I have been asked to confirm if I call to verify bed availability when a particular patient is an inpatient at [mental health facility], can I access that bed please. … [Temporary AMP] will not sign DC unless patient is an inpatient.*

What happens while they wait? Sometimes, a patient chooses voluntary treatment during the waiting period. At other times, the patient appears to get lost in the system. The evaluators were advised that there had been cases of mortality while on the IDAT waiting list – an example where the

consequence of the wait list was severe. If the prospective patient is acutely unwell, a regular hospital admission, or being 'scheduled' under the Mental Health Act are possible. However, use of the Mental Health Act for patients waiting for IDAT may be resisted by mental health services.

It was not immediately clear to the evaluators who is responsible for managing patients on the IDAT waiting list. At what point does the IDAT team take over the clinical governance? It appears that this occurs at the point when the Dependency Certificate is issued, so that before then it is the ITLOs or referring team.

> *"One of the challenges in the referring end is who would take the responsibility in locating the patient when a bed is available. Is it the ITLO or the regular D&A worker."* (ITLO)

There are two crucial issues:

- how to reduce the waiting time; and
- management of patients while on the waiting list

Waiting times may be reduced through:
1. changes to the program (eg reduce the LOS, refocus on stabilisation, improve care transfer);
2. increasing the number of beds;
3. reducing the inflow (eg. by making the entry criteria more strict);
4. using alternate mechanism for patients who don't get in within 7 days (MH Act);
5. establishing two different types of beds: acute and sub-acute;
6. increasing BF bed occupancy to 90%.

These are not mutually exclusive. All of them to some extent speak to the issue of the type of program that IDAT is – whether it is a stabilisation and assessment program (while the patient requires protection from themselves or for others) or whether it is an AOD treatment program. If the former becomes the primary focus, it is possible that the LOS would be reduced, thereby freeing up more beds (although it is not certain that this would be the case, as it appears that complex social and welfare circumstances are a primary reason for extended LOS). Some extended LOS is due to lack of voluntary NGO residential rehabilitation services. Consideration of greater investment in the voluntary treatment sector, and/or specific residential rehabilitation beds for IDAT patients in aftercare (that are separately funded) may be worth pursuing. In theory this would reduce the LOS in the IDAT beds and hence reduce the waiting time. Some proportion of patients are definitely ready for discharge but are waiting for a place in a voluntary service.

> *"So it depends really on whereabouts the patient is discharged to. If they are discharged to the Western NSW area you are looking at one or two drug and alcohol workers for a very large area. So they are stretched, very stretched to deal with our complex clients we are putting back there. Then there are people who might be referred back to the cities and they are well-resourced."* (Allied Health IDAT team member)

It is not immediately clear that increasing the number of beds within the existing units is sensible. Stakeholders noted both the transportation issues and the geographical equity. For these reasons it may be preferable to establish a third IDAT unit in another LHD. However, in the absence of the outcome and cost evaluation (pending over the next two years), it would be premature to make this decision now. It would also be wise to consider all aspects of this process evaluation and resolve some of the operational matters identified herein, prior to any expansion.

Reducing the entry flow into the program does not seem reasonable in light of the program demand (see earlier sections of this report). At present the Act carefully crafts the entry criteria such that they are neither under- nor over-inclusive.

The use of alternate mechanisms for people who have to wait more than 7 days is plausible. This would mean that anyone not admitted within 7 days of referral must be placed elsewhere. The MH Act has the potential to be used here, but would require that admitting rights for AOD AMP's or Addiction Medicine Specialists into MH units, and it assumes bed availability.

A reconfiguration of the beds, drawing a distinction between "acute" IDAT beds (for those physically unwell, in withdrawal, during the stabilisation phase) and "sub-acute" IDAT beds for those who still require residential care but have now moved to the "AOD treatment" part of the program was one idea expressed by stakeholders. This could be the same provider (i.e. HSC and BF) or another provider (such as an NGO). Patients who are suitable for step-down, and do not need medical observation could be moved to these "sub-acute" beds. Sub-acute beds would be less expensive than IDAT beds. However, this would require a legal framework (i.e. a CTO) to keep the patients there (because it is still one form of involuntary treatment).

This process evaluation noted the bed occupancy rate at BF (60%). If the Bed Occupancy Rate for BF could be raised to 90%, there would be an additional 31 admissions (episodes) per annum (assuming an average LOS of 28 days per admission). Their current yearly number of admissions (episodes) is approximately 90 (with varying LOS). The reasons for the current bed occupancy rate include the limited staffing levels at BF (so these would need to be increased), but also the transport problems, where it can take a few days to actually physically arrange for the patient to be transported (while the bed is held). A 90% occupancy rate could be achieved if: 1) the staffing levels increase; 2) the transportation issues can be resolved; and 3) the issues of locating and getting people to video facilities for assessment after a long wait on the waiting list can be improved[18].

Admissions currently occur only on weekdays because admission requires the presence of a medical doctor. Increasing admissions to occur across 7 days would also increase the bed occupancy rate but may not be feasible.

Even in an ideal situation, a period of time between the assessment and admission is likely to occur. Clear clinical governance arrangements for these patients is essential, given how high risk they are. The options for managing people on the waiting list include that the IDAT teams become actively involved in managing patients on the waiting list (with appropriate additional resources); that ITLOs take on this function; and/or the referring team is responsible for the patient until such time as the Dependency Certificate is issued. None of these are necessarily ideal and each has advantages and disadvantages. If IDAT becomes the responsible body, the physical geography becomes problematic (especially for BF). But the advantages of the IDAT program taking on this role include the opportunity for further assessment, development of rapport, capacity to reprioritise, possibly refer to voluntary treatment through this process and entry can be streamlined. If it was an ITLO function - these are often not the patient group that would be managed usually, so no real connection. However, the advantage of the ITLOs is that it would facilitate the aftercare planning and provide some level of continuity post IDAT. The referring team is best placed to take on this function, but when the patient is in an emergency department (ED), for example, it is not clear how this could occur.

[18] Often by the time assessment by video link can be arranged, the identified patient has "gone to ground" and the local police cannot find them or cannot get them to assessment. The referring team/IDAT team often have to wait until they re-present to hospital.

6.5 Program entry

The processes required for program entry, as befits a compulsory program, can be lengthy. The ITLOs spoke of the work involved in gathering the evidence and the data required in order to prepare the paperwork. On average, there was a consensus that it takes 8-10 hours to complete one referral application for one IDAT patient (min 4 hours, max 3 days).

In some cases it was reportedly difficult to collect enough medical data, but this appeared to depend on the individual circumstances of the ITLO. For example, those ITLOs located within hospitals appear to have more ready access to the required medical records. On the other hand, some data are sensitive, and difficult to obtain.

> *"I have been refused access to information. Actually even with FACS (Family and Community Services), so I had to go back through their 16A Form. I actually had to go through four layers of people who were involved in it whereas the services who were supporting him (the patient) in the community had a copy of this information."* (ITLO)

Another example provided was in relation to an Aboriginal Health Service, which refused access to data. Problems with access to assessment data from third parties appeared to be more common in the rural/regional areas than in the metropolitan areas. Overall though, of those interviewed for the process evaluation, few ITLOs claimed that they had problems collecting data from other agencies.

The paper-based forms were raised as a concern (see also elsewhere, using of electronic medical records). According to those interviewed, Forms 1, 2, and 3 are somewhat repetitive. Form 1 is supposed to be done by an ITLO to request a MP to do the official referral/assessment. Form 2 is the "doctor to doctor" form (from MP to Accredited Medical Partitioner) and Form 3 is the Comprehensive Assessment done by ITLO. Currently, only Forms 2 and 3 are used.

An aftercare plan is required as part of the entry process (as specified in the Model of Care). Without an aftercare plan (with the name of a designated case manager/care coordinator in the community) the IDAT unit will not consider the referral application. Some ITLOs said that they could not find a case manager for the patient so they put their name into this field and would "worry about it later". One member of the IDAT team in BF said that there are instances where they contacted the case manager for arrangement of aftercare plan for patients but the case manager had moved on. In some instances the ITLO are developing an aftercare plan for someone who has not been engaged in treatment for many years, and not someone who is engaged with their current AOD treatment services. While there is sound logic to the importance of an aftercare plan prior to IDAT entry, there are some obvious problems with this requirement as well. Firstly, the Model of Care states that the ITLO is to work with the referring team to develop the plan, but the 'referring team' may be an ED or a general health service. In these cases the identification of a community case manager is extremely difficult. Secondly, the aftercare plan prior to admission is not developed in consultation with the patient, and the patient may also not be in a fit state to consider options. In any case, the development of an aftercare plan without patient input is not regarded as best practice. Thirdly, in some cases (not able to be quantified) the ITLO preparing the assessment does not physically see the patient highlighting the challenge of generating an aftercare plan in the absence of any direct contact with the patent. Finally, patient needs may change substantially during the IDAT admission, so pre-admission aftercare planning is somewhat misplaced.

According to some stakeholders, many of these issues around program entry (access to data and aftercare planning) arise because the original vision for the IDAT program was that people who are eligible for IDAT have been involved in AOD services, and/or are part of the regular or usual case load of ITLOs. This does not appear to be the case. In reality most patients have not been engaged in

AOD treatment and they have been identified because they are in and out of ED multiple times. It is difficult to ascertain the proportion of the potential patient group which are already connected with the ITLOs. The database notes that 23% of the referrals come from "other hospital" and 30% come from a "medical officer/specialist" (see Table 8). The database does not record ED (but it is assumed that ED referrals are coded under "medical officer/specialist" as this is most likely). While we cannot assume that all these referrals are completely unknown to the ITLOs, it is highly likely that some proportion of this 50% is unknown to the ITLOs.

This is reinforced to some extent by the numbers of potential patients who are not physically seen by the ITLOs. We could not quantify this proportion. The MOC notes "It is not necessary for the screening assessment to involve contact with the patient" which does raise the question of the extent to which the ITLO is likely to be able to engage with the patient as part of her/his regular caseload.

A key question that the evaluators sought to answer was the extent to which the referred patients are already part of an ITLO's regular client load/patient group. We could not ascertain this from a quantitative point of view. Most ITLOs interviewed for the process evaluation said that if IDAT did not exist, they or other AOD workers in the community would have to work with the patients (who would be eligible for IDAT) at some point in time, but this had consequences for workload.

> *"If these patients had nowhere else to go I would still be working with them. That's true. But I would also prioritise my time: what work I did with them and what work I needed to do with other patients (who are not potentially eligible for IDAT)."* (ITLO)

> *{IDAT work] separates you away from the unit in the ward. … If I am doing an ITLO application, I will be leaving other patients."* (ITLO)

The Accredited Medical Practitioner must issue the Dependency Certificate, and this requires face-to-face or video conferencing. Stakeholders noted problems with video-conferencing: either equipment not available, or not working (when available).

> *"…I do not have the ability at this time to coordinate video conferencing for IDAT applicants. [Named of organisation] is reportedly an option though likely to be a no [due to] risk assessments of external persons accessing the inpatient mental health unit."*

The evaluation team cannot confirm that every patient was seen face-to-face or via video-conferencing prior to the issuing of the DC. In at least one in-depth interview with a patient, the patient could not recall the meeting with the AMP (although given mental state issues likely at the time this may not be unusual).

Some ITLOs have to spend a lot of their time educating stakeholders about IDAT, explaining to the referring medical doctors, family members and other medical professionals about IDAT. There appear to be misconceptions in the broader community that sending someone to IDAT is the same as sending someone to a mental health hospital. The two fundamental differences are that: 1) a bed for a mental health patient can be made available right away while the wait time for IDAT could be months; and 2) the amount of work required by the ITLO to gather the evidence to justify the eligibility criteria for IDAT is more demanding compared to that for a mental health patient.

Finally, while 127 ITLOs underwent training in September 2014, according to the IDAT database only half (66) are active referrers to the IDAT program, with a total of 414 referrals. This suggests that each of the active ITLOs have made 6.27 referrals on average since the inception of the program. This is somewhat consistent with the estimate provided by the ITLOs who participated in the stakeholder interviews that on average, one ITLO makes 3-4 referrals per year (ranging from 1 to 8).

Overall, there is significant concern amongst those interviewed for the process evaluation about the extensive procedural requirements that must be navigated before a referral can be completed and considered for a DC, and delays in treatment associated with those procedural requirements. While the imposition of procedural requirements assists to ensure detention and treatment is a consideration of last resort and to minimise limitations on a person's human rights, stakeholders favoured streamlining procedural requirements to ensure the administrative work preceding a DC is not impeded by unnecessary procedural barriers.

6.6 Admission

As noted elsewhere, two critical issues preceding admission are transportation of patients to the IDAT sites, and the waiting time prior to admission. These are dealt with separately in other sections of this report.

Patient prioritisation

In the context of demand exceeding supply, the IDAT units must engage in an ongoing, active patient prioritisation process. Stakeholders reported that patients were prioritised based on need, the extent to which the admission was deemed urgent (that is, the patient was highly likely to be harmed if not admitted), the fit between the Unit and the patient, and certain population groups, as described in the following:

> *"We go through the referrals that have been fully worked up. We come to the intake meeting. We look at Section 9 criteria, the aftercare, housing issues, we also look at the environment here whether the patient is going to be suitable for this particular environment with its limitations (security for patients with absconding risk), whether it is going to be problematic or if so should they move to Bloomfield. And then we make a determination of whether to accept them in principle or not …. And we also need to make a decision around who is actually #1 and #2 on the waiting list and that could be very difficult. Sometimes, it could be very clear because there is someone who is the most acutely unwell patient in the sense that those who we are very worried are going to die within next week or two if they don't come in here. We would try and prioritise those patients immediately. Pregnant women, we prioritise them as well. We also look at issues around "first come, first serve" so if someone is on the waiting list for many months, and then they got accepted but then they dropped off the waiting list because they went on to voluntary treatment but now they are back to the waiting list. We tend to prioritise them if we could because we already accepted them previously. Otherwise, it is just a juggling act."* (IDAT team member)

Patient prioritisation also takes into account other factors. As discussed earlier under the Act, there is potential ambiguity with reference to the "likely to benefit from treatment" criterion, providing the potential for programs to be selective about patient prioritisation. This may result in decisions that appear to be prejudicial against those who are homeless, or in other ways deemed less "likely to benefit from treatment". In addition patient prioritisation occurs in the context of the current profile of patients on the unit – because of the complex presentations, and need for some stability in the unit, the process of prioritising and selecting patients is subject to considerations beyond the individual patient presentation (ie the therapeutic milieu at the time). Another example noted during the process evaluation was gender – the gender mix of the current inpatient caseload.

Once a bed becomes available, the ITLOs reported to the evaluators that they are given very little time to arrange for patient transport and admission, resulting in the possibility that the bed is given to another patient. The IDAT units usually wait up to a week for the ITLO to arrange to get the patient to an assessment.

The notion of a centralised intake team, across both programs was raised by stakeholders. One issue is that the same patient can be referred to both units simultaneously (see earlier) and this is less than ideal. In addition, the operation of differential criteria is perceived to be occurring. A centralised intake would maximise the likelihood of the best match between the patient and the unit. In addition, a centralised intake system could also attend to the waiting time (ensuring safety of patients during this period). However, it is not clear which service could provide a centralised intake function. If it was a third party (such as ADIS) the clinical flexibility around patient prioritisation would be lost (and the units would not have control over the admission). It could be a designated function of one of the two IDAT units, but this would again leave the other unit without control over admissions. Therefore, coordination between the two units may be preferable. A protocol could be developed such that one unit could advise the other when a referral was received.

6.7 IDAT inpatient interventions/treatment

Stakeholders noted that the IDAT program was very comprehensive, not only providing health and mental health assessment and treatment, withdrawal and drug and alcohol interventions but also many welfare services including guardianship orders, and meeting other social welfare needs of patients.

Once the patients are admitted, the first phase is detoxification (which lasts 7-10 days) for those patients who have not undergone withdrawal prior to admission (the majority of patients undergo detoxification in the treatment units). A comprehensive physical and medical assessment is undertaken, with priority given to treatment of any medical conditions. Medical care for the consequences of alcohol dependence, such as peripheral neuropathy and liver disease were reported as well-managed. There were also a small number of female patients who had been pregnant during their admission, requiring significant pre-natal care during their stay. Medical treatment is reported to be very good at both sites. The patients also report very positive experiences of the medical treatment. No concerns about medication were raised with the evaluators. No Serious Adverse Events were noted in the review of the Official Visitors records[19].

> *"When I first came [to IDAT], my feet were numb and tingling and I hardly walked. I had to sit on a wheelchair to have breakfast but now it's all good just for the four weeks. They are much better now, they still have a bit of a tingle feeling but compared to what they were, ah… my goodness me…"* (Patient)

Once the withdrawal is completed, a cognitive and psycho-social assessment can be undertaken. For those cognitively capable, they are asked to participate in group work activities with the aim of helping the patients to gain insights into their drug and alcohol use problem and to motivate change. The provision of this AOD treatment is undertaken in the context of a highly complex patient load. This includes active psychosis, aggressive behaviours, and people who are acutely mentally unwell.

The Model of Care lists a comprehensive drug and alcohol intervention program:

- structured psychosocial interventions, including cognitive behavioural therapy (CBT), coping skills training, contingency management;
- counselling, e.g. trauma or grief counselling;
- living and life skills, including cooking, cleaning and budgeting, in preparation for re-integration into the community;
- relapse prevention and active practice of relapse prevention skills during therapy;
- advice, information and education about substance misuse.

[19] The BF Official Visitors reports were incomplete.

As raised elsewhere in this report, the extent to which the IDAT program is regarded as an assessment, stabilisation and coordination function post-withdrawal versus a comprehensive AOD treatment intervention is unclear. At BF, there is a desire to provide the above array of AOD treatment interventions, but there were a number of reasons identified by the stakeholders that prevented this occurring:

- some patients may not benefit from these interventions after 7 days because their cognitive functioning is still impaired;
- for patients willing to participate, sometimes it is not possible to deliver these services due to limited staffing levels;
- the way the facility is designed at BF makes it difficult to deliver 1:1 interventions. There is no separate room for counselling (although the bedrooms are single rooms).

"Sometimes if the Multi-function room is occupied, I will need to do the assessment with the patient in their own bedroom and it is difficult because it is very distracting for the patient." (Allied Health staff member)

At HSC it appears that the above AOD treatment interventions are provided, notwithstanding adjustments for those patients with cognitive impairment. However, allied health staff turnover (for IDAT) was identified as an issue which inhibits the provision of the above treatment interventions. The mix of voluntary and involuntary patients at HSC is also very difficult to navigate around and a "constant" source of tension in terms of different models of care and access to different levels of resources. These issues have been recognised as a "huge challenge" and difficult to resolve despite trying many different strategies.

> *"And I think the burn-out rate with staff [for IDAT] is relatively high compared with detox. We are going to appoint our third Social Worker. And we've had two consultant psychiatrists who work with IDAT. They moved on. They find that it is a high burn-out area. It is very challenging work."* (IDAT team member)

There are ongoing assessment and care planning functions throughout the inpatient stay. Preparation for application of extension of the DC is required for those who are more seriously cognitive impaired, particularly alcohol-related brain injury. Guardianship orders may also be required for some patients. The staff works with the patients on the development of a global care plan which comprises 7 elements (substance use, physical health, mental health, socioeconomic, psychosocial, legal and other).

At both treatment units, escorted and unescorted leave is available for IDAT patients. Decisions on which patients should receive escorted and unescorted leave are made as a strategy to test their capability to cope with triggers in real life.

There are examples of patients having absconded from both treatment units. The IDAT database indicates absconding associated with 5 patient episodes (See Figure 1: 2 absconding events at HSC and 3 at BF). It is not clear whether these 5 absconding events were only related to patients who did not complete the inpatient treatment period in IDAT (never returned to the unit) or whether this included patients who absconded but then returned or were forced to return by the police and then eventually complete inpatient treatment. HSC is a less secure facility than BF. The evaluators were told that patients at HSC can abscond by jumping over the fence, by sneaking out through the gate when they have a visitor, or by not returning after unescorted leave. For BF, patients can abscond when on escorted leave (eg doing grocery shopping with the IDAT program staff in town), or by not returning to the unit after unescorted leave.

Most stakeholders believe that IDAT is equipped with the infrastructure to manage patients with dual diagnosis, either within the treatment unit or in collaboration with the mental health/psychiatric ward within the hospitals. However, a number of stakeholders have challenges referring patients with dual diagnosis to IDAT.

> *"A lot of clients suffer dual diagnosis …. And one thing we have noticed is that they [the IDAT units] find it very difficult to take on clients with severe mental illness. …. And psychiatric services would not admit those clients. They are not eligible for psychiatric services and we believe that we need to treat their drug and alcohol use to make sure we can help them into health but we often find those clients falling through the gap."* (NGO aftercare provider)

6.8 Discharge and aftercare

While still under inpatient treatment, the IDAT treatment team review and work with the patient on the aftercare plan, which is often based on the one developed by the referring team. It is very likely that circumstances have changed from the time of referral so the aftercare plan could be changed substantially.

The "IDAT transfer of care coordinator" is a position identified in the Model of Care[20], but this position is not specifically identified in the current IDAT program operations. The IDAT staff at HSC work as a team across all patients, and tasks vary for different people all the time. At BF there are two staff members with this role (the outreach AOD worker and the social worker).

The Model of Care notes that only a discharge letter back to the ITLO or the referring team is required. Interviews with patients confirmed this in practice. In addition to the discharge letter, a comprehensive aftercare plan (recovery plan) was also sent back to the referring team for continuity of care.

> *"My recovery plan is so much better here compared to in other places [rehabs]. Here they make sure you have a [recovery] plan and the plan goes to my GP, my mom [primary carer] and my drug and alcohol worker."* (Patient)

Yet, the highly valuable assessment work that has been conducted during the inpatient stay with IDAT could be better shared with future treating clinicians.

The Model of Care does not specify that a discharge summary be returned to the ITLO except where the ITLO happens to be the community care coordinator. This means that the ITLOs feel like they have put all this initial effort in, without any knowledge of the subsequent outcome. It would be a good practice to send a copy of the discharge summary to every referring ITLO, irrespective of the ITLO's engagement in ongoing care.

In the Model of Care, aftercare is called "community based program", but the IDAT teams call it 'aftercare'. There is a lack of clarity in terminology. For some, 'aftercare' is (usually minimal) post-treatment support; for others aftercare implies the provision of the next stage of treatment[21]. For example, at BF, aftercare is more minimalist akin to assertive follow-up post-treatment and involves making a phone call to the patient. At HSC, the program is responsible for aftercare services for patients who live in NSLHD because it is their local service. It is easier for this patient group because there are a lot more community-based treatment services in Northern Sydney, compared rural areas.

[20] It is also noted that the position of "IDAT inpatient case manager" is not a position which happens in reality in the IDAT program. Rather a team approach is observed in relation to inpatient case management.
[21] This definition and terminology problem is not unique to IDAT

These definitional issues notwithstanding, the extent to which aftercare services are being taken up by IDAT patients (which also speaks to whether IDAT changes the course of the person's addiction) was not able to be fully assessed in the process evaluation. In the IDAT database, there are data fields designed to collect data on utilisation of aftercare services by IDAT patients (DD-15 and DD-16). However, the level of missing data for aftercare data is substantial (see Table 21):[22]

Table 21: The level of missing data on aftercare services received

	# of episode records available	# of expected records
HSC:		
1 month	33	132
3 months	31	132
6 months	27	132
BF:		
1 month	5	210
3 months	0	210
6 months	0	210

For patient episodes where aftercare data were recorded, the range of AOD services includes:

- Pharmacotherapies (buprenorphine, methadone, naltrexone, disulfiram);
- Day program rehabilitation;
- Inpatient/residential withdrawal;
- Outpatient consultation; and
- Residential rehabilitation.

The range of other health services includes: GP, community mental health, ED presentation, hospital admission, and outpatient specialist services.

With reference to outreach or assertive follow-up, resources for this function are required:

> *Most services do not have assertive outreach model and that is what you need for this patient group. You can't just wait around for them to get on the phone and come in because they won't. You need to get on the phone. You need to give them flexible appointment times or sometimes you got to go and meet them at their homes or coffee shops."* (IDAT team member)

Aftercare was the component identified by nearly all stakeholders as the most challenging part and also the weakness of the IDAT program. This is reportedly due to:

- Limited human resource capacity within the IDAT team to do community outreach (especially for BF);
- Limited options for linking patients to community-case services;
- Most of IDAT patients are cognitively impaired and could be eligible for ACAT (Aged Care Assessment Team) housing but they are under 65 years of age so the option is limited. Although ACAT provides options for young people the ACAT team often refuse to conduct ACAT assessment for IDAT patients due to various possible reasons;
- The need for more community based services;
- Housing and accommodation issues.

[22] Again, there is likely to be a lack of clarity regarding who is responsible for these data – is it the IDAT teams, who may have no ongoing contact with the majority of patients post-discharge, or is it the referring team, or is it the aftercare provider? If the last option, is there are mechanism in place to obtain these data?

The following services were identified by the stakeholders in relative order of need/importance:

1. Stepdown program/Day program;
2. Housing/accommodation;
3. Residential rehab;
4. Assertive outreach;
5. Counselling/psychiatrist.

There were different opinions about what proportion of IDAT patients want to engage in aftercare: some stakeholders felt that only 50% are willing to engage, other stakeholders indicated it was higher than 50%. In the absence of clarity about whether this refers to assertive follow-up or the provision of ongoing AOD treatment post discharge, it is difficult to assess. In the quotes below, there is a mixture of aftercare and assertive follow-up:

> Proportion of patients saying yes to engagement in community aftercare:
> *"Well they all say yes when they leave but not all of them follow through. They all say yes to aftercare because that is an exit, that is the way out of the unit but some of them don't. Probably 10% of them don't allow us to see them at all. Most of them would allow us to come and follow them up to some degree."* (IDAT team member)

> Could you please talk about the coordination of aftercare services for IDAT patients generally?
> *"So I think for us, we do it well here because [staff member's name] and I decided from the beginning that we needed to have an aftercare component because we knew that there would be a significant number of patients from our area being referred in and we knew that it would be very difficult to coordinate care in D&A services because there isn't case management. So we put some money in the budget to actually cover aftercare workers and to have an aftercare plan. So I think as best as one can, it is hard to follow up these patients, they go around they disappear, they decease but a significant number of people do allow us to follow them up. So we do pretty well with it because we have an Aftercare Team."* (IDAT team member)

6.9 Brokerage fund

The Brokerage Fund can be used for a range of services to support and/or facilitate a patient's treatment, psychosocial welfare and recovery in the community. The funds are to be mainly used as part of the 'community based' voluntary component of the IDAT program, which patients may be involved in for 3-6 months after their involuntary treatment period. The funds can also be used as part of the involuntary part of the program as required[23]. Examples that were encountered during the process evaluation included: accommodation (eg a hotel room), furniture storage fees, travel costs to return home, client fees for residential rehabilitation, fee gaps for private specialists, pharmaceuticals that are not subsidised under the Pharmaceutical Benefits Scheme, food, travel costs associated with attending aftercare and follow-up appointments with health care providers, purchasing furniture to set up a new house, and dental care while in inpatient treatment. On average the allocation is $6,000 per patient per episode.

> *"The Brokerage Fund is a reasonably untested approach in D&A so we always recognised that there could be challenges in implementing the Brokerage Fund. And I know there were some issues with accessing and the process of accessing Brokerage Fund earlier on so we did develop a Brokerage Guideline which is attached to the Model of Care to help guide the*

[23] Page 2 of the Brokerage Funding Guideline.

> *issues around what the money can be used for and also a mechanism to justify access to that money. Because obviously when money goes to a district, there is not so much quarantine any more as it used to be so we want to make sure that it is clear that this fund can be used for whatever is in the guideline."* (NSW Ministry of Health)

Some administrative difficulties local to the hospital accounts arrangements were noted. For example, at BF signatures are required from five successive levels of management, which sometimes takes 6-8 days. For HSC, it seems less challenging to get approval to use the brokerage fund. A concern with the administrative aspects of the Brokerage Fund is the extent to which it is controlled by the hospital administration compared to the local IDAT program. It was alleged that IDAT Brokerage Funds may have been "misused" by a hospital, but no evidence to assess the veracity of this claim was provided to the evaluators.

Stakeholders reflected on the use of the brokerage funds, which provide opportunities to support a number of different aspects of clients/patients recovery. But this also gave us a window into a broader but more subtle issue raised in stakeholders' interviews – philosophical differences between staff members pertaining to how brokerage should be reasonably used; setting boundaries with patients; and the therapeutic alliance and philosophical approach to behavioural interventions.

On the reasonable use of brokerage funds, some stakeholders felt that the use of the brokerage funds may encourage or facilitate a sense that the patients are dependent on the program, and may hinder opportunities for patients to become independent. For example, prior to admission to IDAT a patient had supported housing in the LHD where he was referred from. However, upon discharge, the brokerage fund was used to provide him one month of hotel accommodation while finding another housing option because the previous supported housing option was assessed as not conducive to successful recovery because a lot of drug dealing was occurring in this place. The issue here is that some staff believed that funds were not being spent sensibly and that in this situation the patient should go back to where he had come from. We were told that funds are limited, and should be spent on things that are clearly justifiable. It was also argued that it is unrealistic to expect that public supported housing is a perfect environment with no drug dealing and using.

On the issue of boundary, some team members believed that a clear boundary is critical in a therapeutic relationship and that high levels of interpersonal engagement were either unnecessary for the therapeutic endeavour, and/or potentially counter-productive for future autonomy. *"I would never eat with the patients at the BBQ. The only time I would have a meaningful conversation with the patients is when we are in a therapeutic session"* (Psychologist). Other staff clearly felt very comfortable conversing with clients in informal settings.

On the issue of therapeutic alliance, the development of a strong therapeutic alliance between patient and staff underpins rehabilitation efforts but can be perceived by some staff to jeopardise future independence and autonomy. This appeared to represent cultural differences between staff: some of the view that strong therapeutic alliances and high levels of interpersonal engagement between patients and staff were to be encouraged as part of the rehabilitative effort; with other staff of the view that high levels of interpersonal engagement were either unnecessary for the therapeutic endeavour, and/or potentially counter-productive for future autonomy.

These differences in cultures are often found in healthcare programs that work over longer periods of time with a patient group, and where the patient group also displays features of dependence. Indeed, a transfer of the substance dependence onto the clinical program dependence is not uncommon. There are no right or wrong answers here – balancing the intensity of the therapeutic alliance with the need to facilitate autonomy in the medium to long term is a key challenge for all

clinicians working in programs such as IDAT. In light of this, it is critical that these issues are discussed and managed adequately in such a way that staff members accept their differences rather than perceive these as conflicts, which in turn can have negative impact on staff morale and subsequently high staff turnover. *"I have never worked with such a fractured team like this in my career" (IDAT team member).* This potentially might have negative impacts on patient care.

6.10 Transport fund and transport

According to the Ministry of Health, a specific IDAT transport fund is allocated to each LHD with an annual allocation of $19,000 per LHD, irrespective of distance from the IDAT units or patient referral numbers. It is clear that a flat rate allocation to each LHD is inequitable when the pattern of referring LHDs is examined (see section 5.3, Table 5).

Many ITLOs claimed that they were not aware that a transport fund is available for each LHD for transporting patients into IDAT treatment centres. One said that he found out about the fund by accident. Some are aware that the fund exists and did some investigation but were told by their LHD manager that it was not available and was already used for something else.

As noted by one stakeholder to the evaluation:

> *"There is confusion about paying for transport. If the patient is admitted from community or from an outpatient clinic, I have been told that the Drug & Alcohol Service is responsible for the hundreds/thousands of dollars this trip costs. If it is done from a hospital, I have been told by Nurse Managers that they are unhappy because the cost will come out of their budget. Also, air ambulances cost much more than road transport, which often increases administrative anxiety about admissions."* (ITLO)

Despite obvious best intentions, transport of patients to the IDAT units is a major issue. Even when the transport fund is used, there are other important clinical and practical constraints. Geographical distance is one example: the need to transport some patients from the metropolitan area to BF was noted. It is difficult to manage to get a patient under IDAT order into an airplane or in some towns, there are only two policemen in the whole town so they cannot leave town for one IDAT patient.

In addition, patient transport has very strict guidelines, including these noted by SESLHD:

- Transporting patients by air ambulance if the distance is greater than 250km. All SESLHD facilities are at least 260km (to BF unit in Orange), and unless a great deal of negotiations takes place, patients are collected from a facility & driven to Bankstown airport then flown to Orange where IDAT clinicians take them to the facility. For patients who are highly anxious, resistant or in withdrawal, a plane journey creates a number of risks and can be very distressing for the patients.
- Patient transport services will not drive all the way to Orange. The Patient Transport department SESLHD uses will only go as far as the Blue Mountains, and another ambulance service is required to meet them there and take over the journey. If this ambulance is called away on an urgent matter, the patient transport service is potentially left waiting in Katoomba with an involuntary patient for several hours. This jeopardises the admission, and places the patient at risk of absconding in an area they are not familiar with.

6.11 Families and primary carers

The critical role of a primary carer (potentially a family member) is identified in the IDAT Act. The Act stipulates that a patient may nominate a person to be their primary carer under the Act. The primary carer should be informed of the patient's admission to the program, when they are on leave, if they

do not return to the IDAT unit after leave, when their Dependency Certificate is extended, or when they are discharged and, where possible and appropriate, involved in the development of the care plan, particularly the community-based component of this plan. The Act also contains provisions to ensure that a person and their primary carer are provided with clear information about their legal rights and their rights of appeal. Specifically, the Act stipulates that the primary carer must be notified within 24 hours after a Dependency Certificate has been issued[24]. If the patient is unable to nominate a primary carer on admission, they will be asked again at an appropriate time, but within 24 hours.

The evaluators could not determine what proportion of the IDAT patients had a primary carer identified, but the data lent themselves to suggesting that for a number of IDAT patients, a primary carer was not nominated.

> *"I don't remember being asked to fill out a form to nominate a primary carer. I am in frequent contact with my mom and I tell her about how things are going when I am here."* (Patient)

The Official Visitors (based on data from the Official Visitors' Book and from in-depth interviews) observed the lack of primary carers being noted in patients' files. The evaluators were provided with patients' files for the last five admissions at HSC (but not BF). Out of those five cases, four had a primary carer nominated and one as noted *"refused to nominate a primary carer"*. Twelve patients participated in the in-depth interviews, of whom only four identified that they were asked to provide name and contact details of a primary carer. The other eight patients were confident that they were never asked to provide these details. One of the eight patients said that she was in regular contact with her family while in IDAT but that was because she initiated the contact. Cross-checking with patients' files was possible for one of the eight patients. The file indicated that the primary carer form for this patient was completed.

It is likely that in many circumstances, the paperwork/formalities were completed when the patients were still physically and/or mentally unstable, rendering their ability to recall these events impaired. In other circumstances, the patients could not complete the primary carer nomination form for a range of practical reasons. For example, one patient did not remember the phone number of her nominated primary carer (her mother) and was unable to gain access to her mobile phone to retrieve it[25].

The evaluators observed that the IDAT patient group appeared to have few connections with family. The IDAT database noted that 50% of the IDAT patients lived alone. Visits from family and loved ones while in the IDAT unit did occur but infrequently, made more difficult for many BF patients by the distance from their home community.

> *"You have to remember that my son is living in Campbelltown. He can't come to see me. But we are in frequent contact over the phone."* (Patient)

Of the 12 patients interviewed, five reported close connections with family members and/or loved ones, including children, partners and parents. The other seven did not readily identify family support (by way of example, one had experienced the recent death of his partner; another had children all living overseas).

[24] Section 17 of the Act: "An accredited medical practitioner must, not later than 24 hours after the dependency certificate has been issued, take all reasonably practicable steps to notify the primary carer of the dependent person that the person has been detained."

[25] Mobile phones of all IDAT patients were kept in a safe in the nurse station. The patients can retrieve access to their phones if justified and if a nursing staff is available.

6.12 Strengths and weaknesses

All the stakeholders interviewed for the process evaluation were invited to comment on the strengths and weaknesses of the IDAT program.

The balance between involuntarily detention, human rights, and health care is a significant strength of IDAT. As intended by the legislators, the program is not simply a short-term detention program focussed solely on protecting an individual from harm, but rather it provides the opportunity to change harmful alcohol and other drug behaviours into the future. Achieving this balance between protection and AOD treatment is challenging and gives rise to some contradictions within the program. Nonetheless, it remains a significant strength, as perceived by stakeholders and other jurisdictions who are seeking to emulate this model.

> *"It allows patients who don't want to engage in treatment, aren't engaged in treatment, it allows them a place and a space where they can recover enough to make informed decision about whether they want to engage or not."* (Drug and Alcohol Clinical Director)

At the same time, the capacity and opportunity to provide "active" alcohol and other drug treatment may be limited, especially in the context of significant pressure on beds, plus the perforce deprivation of liberty.

While some stakeholders felt that the program was well-resourced (from a budget allocation point of view, and relative to other AOD treatment services), other stakeholders noted the lack of resources as one of the weaknesses. This lack of resources was due to the cumbersome administrative process within hospital administration rather than a lack of budget. The complexity of staffing in a unit that is part of a larger LHD system (with priorities other than IDAT) was noted. In a similar context, the required administrative processes (hospital bureaucracy) in order to spend the brokerage funds were identified as a weakness.

Stakeholders noted good checks and balances in the process of deprivation of liberty, and these clinical and legal processes occur independently from any political oversight.

From the clinical perspective, the medical treatment and the comprehensive assessment and care that are provided is a strength. The fact that it offers the patients the opportunity to engage in a very comprehensive treatment program which addresses multiple issues: medical, psychiatric, addictions, social, with a multi-disciplinary team which includes a comprehensive aftercare plan.

> *"People are brought to a stage of clarity where they can see that they need more help. These people would not engage voluntarily by definition and if they did go to voluntary treatment they did not stay very long and they never get to that state of clarity to understand there is hope and another way of dealing with things and support to be able to do that. So the length of time is critical."* (IDAT provider)

The aftercare planning and provision was, however, identified as a weakness by a number of stakeholders. The lack of a Community Treatment Order option was noted, along with the lack of resources for voluntary AOD treatment in the community. There is no step-down program. *"There's a whole raft of aftercare gaps".*

In relation to the length of the program (28 days as specified in the Act), on the one hand this is perceived as a strength in terms of a relatively short time for the deprivation of liberty (with the option to cease earlier than 28 days) but it is regarded by some stakeholders as insufficient time to achieve the comprehensive assessment, stabilisation and care planning for a substantial proportion of patients.

Another strength of the program is the dedicated team of people (IDAT Team), the commitment of staff, the skills and general belief in what they are doing.

The administratively cumbersome referral process was identified as a weakness, along with the lack of discharge information being returned to all ITLO/referring teams irrespective of the continuing care plan. The process by which a patient is assessed and gains access is hampered by the fact that there are only two IDAT sites, one of which is in a rural area and has specific challenges in relation to patient transport. If there were more IDAT sites (which includes the option of IDAT beds in existing drug withdrawal facilities rather than stand-alone new units), patient access and smooth entry processes may be achieved.

The largest weakness, identified by almost every single stakeholder, was access to beds. The significant waiting times for patient entry is perceived to be a substantial issue for the program, especially in the context where these waiting patients are highly vulnerable and have been assessed as being at risk to themselves or others, and requiring protection.

There were some weaknesses specific to IDAT site raised by stakeholders. In BF, the environment is considered too restrictive (according to some stakeholders), with operations mirroring a secure mental health unit that may not be most suited to, or in the best interests of some IDAT patients. At BF, counselling rooms and space for therapeutic activities is lacking (despite a modern facility). At HSC, the unit itself is very old and tired, it looks run-down and uncared for and does not provide the kind of respectful physical environment that should be provided for this (or any) AOD program.

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Appendix A: Stakeholders interview schedule

Roles of stakeholders	Remarks
MINISTRY OF HEALTH	
Manager, Clinical Policy, Alcohol and Other Drugs Centre for Population Health	
WESTERN NSW LHD	
Clinical Director, Mental Health, Drug and Alcohol	
IDAT Director	
Acting Nurse Unit Manager	
Magistrate	
Two Official Visitors	
Social Worker	
Psychologist	
Occupational Therapist	
Outreach Worker/Drug and Alcohol Worker	
Aftercare provider (Lyndon Rehabilitation)	NGO
NORTHERN SYDNEY LHD	
Director of Mental Health, Drug and Alcohol	
Director of Drug and Alcohol Services	
IDAT Clinical Director	
Nurse Unit Manager	
Clinical Nurse Consultant	
Intake Worker	
Assertive Outreach Worker 1	
Assertive Outreach Worker 2	
Occupational Therapist	
Clinical Psychologist	
Clinical Psychiatrist	
Two Official Visitors	
Magistrate	
Aftercare provider 2 (New Horizons)	Non-governmental
Aftercare provider 3 (Homeless Health)	Non-governmental
ITLOs	
ITLO 1 (based in Orange)	Western NSW LHD
ITLO 2 (based in Cowra)	
ITLO 3 (Based in Dubbo)	
ITLO 4	Hunter New England LHD
ITLO 5	Illawarra Shoalhaven LHD
ITLO 6	
ITLO 7	South Eastern Sydney LHD
ITLO 8	
ITLO 9	
Two written submissions from ITLOs based at Langton Centre in SESLHD	