



WCDHB Rata AOD Service Provision Framework Treatment Flowchart

Version

1

Process	Tasks/Standards	Who	Forms
Assessment Process			
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> Does the client arrive for appointment? </div> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="border: 1px solid black; padding: 5px; width: 100px; text-align: center;">No</div> <div style="border: 1px solid black; padding: 5px; width: 100px;">Contact Client</div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="border: 1px solid black; padding: 5px; width: 100px; text-align: center;">Yes</div> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px; height: 150px;"> Treatment as per treatment care plan </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px; text-align: center;"> Review process </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <ul style="list-style-type: none"> Call client and document outcome If unable to contact client by phone, send letter with new appointment If no response from client, contact referrer if applicable and advise of outcome After 3 consecutive DNA's review with MDT for discharge </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Preparation</p> <ul style="list-style-type: none"> Obtain file Review assessment and treatment/recovery plan Review any additional information </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>First follow up after assessment</p> <ul style="list-style-type: none"> Re-cap assessment and findings Review events subsequent to last contact Review mental status/medications if any/substance use Review risk assessment and record in clinical notes Review goals and develop/revise treatment care plan as necessary Arrange for next appointment if required If appropriate observe/collect urine for analysis If appropriate provide laboratory form for liver function/other tests as per standing order Discharge planning needs identified Arrange for next appointment if required Provide copy of treatment care plan if appropriate Discuss referral if necessary (e.g. CMH, MMH, OST, residential treatment, psychiatrist, etc) </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Post visit</p> <ul style="list-style-type: none"> Document session in clinical notes Liaise/consult with other staff/other agencies/family as necessary Action any recommendations e.g. make any referrals Return file to central file </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Preparation</p> <ul style="list-style-type: none"> Obtain and review file If home visit - as per Home Visit Safety Protocol </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Subsequent follow ups</p> <ul style="list-style-type: none"> Review events subsequent to last contact Review mental status/medications and substance use/related issues Review risk assessment and record Discuss results of any drug screens, tests, etc. Check progress towards goals Monitor/review goals and note any changes in priority or blocks to progressing/achieving Revise recovery plan as necessary Clarify roles and responsibilities Arrange and confirm next appointment if required </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p>Post visit</p> <ul style="list-style-type: none"> Update clinical notes Liaise/consult with other staff/other agencies/family as necessary Action any recommendations, make referrals Review/discuss case with MDT Document any significant change If applicable, send progress note to GP Return file to file room </div>	<p>Clinician/ key worker</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Assessment form, recovery plan, discharge plan form, clinical notes etc.</p>