EVALUATION REPORT

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Withdrawal Management Initiative

PREPARED FOR

CENTRAL & EASTERN SYDNEY PHN

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EXECUTIVE SUMMARY

Meeting the withdrawal management needs of prospective WHOS clients prior to admission via traditional pathways had been increasingly observed as a barrier to care for WHOS TC programs. This was complicated for potential clients through changes in the admission criteria for inpatient withdrawal management services in and around Sydney, alongside a reduction in available beds in these services. Coinciding with this 'bottleneck' in traditional care pathways was a significant number of clients exhibiting unplanned withdrawal upon admission to WHOS.

Employing specialist withdrawal nurses was considered as a means for assessing potential withdrawal needs prior to admission, whilst providing onsite capacity to manage mild to moderate withdrawal processes, as well as residual withdrawal symptoms. It was expected this initiative would also increase the capacity of the service to manage other physical and mental health needs that may impact withdrawal. The intention was therefore to reduce barriers to admission by mitigating the need for withdrawal management offsite, therefore improving access to and transition into care.

This evaluation sought to assess improvements in client outcomes and initial engagement resulting from the introduction of specialist withdrawal nurses at WHOS residential TCs in Sydney.

The introduction of specialist withdrawal nurses within the WHOS TCs has resulted in meaningful improvements in the quality of individual client care.

1. Clients and staff reported more efficient provision of client care and responsiveness to need, resulting in an overall sense of safety for clients

2. Clients reported experiencing the withdrawal nurses as accepting, understanding and compassionate, which contrasted with the stigma experienced during other instances of receiving medical care, and built trust between clients and the treatment service

3. Clients reported notable alleviation of discomfort due to withdrawal and associated mental and physical health symptoms, which minimised their desire to leave early in the program

4. Staff reported that increased nursing capacity across the nursing staff resulted in the capacity for more proactive and holistic nursing practices, likely supporting the above points

In addition, quantifiable outcomes include:

1. A significant increase in the proportion of clients with withdrawal symptoms managed onsite - now over half of all clients admitted to WHOS
2. A significant increase in the average number of withdrawal reviews per client
3. A reduction in the overall number of client presentations at an emergency department

These improvements have been achieved in the context of a significant increase in the proportion of clients admitted to WHOS citing methamphetamine (ice) as their principal drug of concern. Methamphetamine withdrawal is associated with protracted withdrawal symptoms that may last for weeks to months, peaking in the second week of withdrawal. Having such positive views of client care being noted by clients at all stages of the program, as well as by staff, is meaningful within this context.

As with any new initiative, minor practical challenges have been encountered, the alleviation of which would further streamline service to clients through improving operations. While outside this funded project's brief some staff stated that these challenges, mostly complex are best resolved with a separate dedicated withdrawal space for more difficult withdrawal presentations within proximity to all TCs. This was proposed with view to minimising the impact of an individual's withdrawal on themselves and on other clients, whilst improving monitoring and management of individual withdrawal needs early in their stay.

Of note, the withdrawal nurse positions have been funded to accommodate clients with low to moderate withdrawal needs. However, this does not mitigate all instances of clients developing difficult or more intensive withdrawal post admission. In addition, with increased incidences of withdrawal from methamphetamine, there is the potential for withdrawal presentations to be increasingly varied and more intense than expected. The benefits of this initiative are thus best built upon through further improvements that allow for greater capacity to manage the individual needs of clients and to minimise any negative impacts on each individual and the wider therapeutic community. Therefore, investigation into the feasibility of WHOS providing withdrawal

WITHDRAWAL MANAGEMENT PLANS FOR ALL CLIENTS
18 months prior – 11.5%
18 months following – 40.9%
July - December 2018 – 51.8%

management at a more complex level (i.e. between low to moderate presentations and hospital based inpatient withdrawal management) for the above client complexities when they arise is required.

INTRODUCTION

BACKGROUND

WHOS residential Therapeutic Community (TC) programs are a social model of residential rehabilitation employing a treatment model known as 'community-as-method' (De Leon, 2000). WHOS run four residential Therapeutic Community (TC) programs on a large site in Sydney, managing the unique needs of different populations with relation to their substance use. These comprise of a men's program, a women's program, an opioid substitution-to-abstinence program, and an opioid substitution stabilisation program.

Staff in these programs identified gaps in getting prospective clients' withdrawal management needs met prior to entering treatment, and in managing unplanned or residual withdrawal symptoms following admission. WHOS therefore identified the need to actively assess and monitor withdrawal needs of clients applying for a place in a WHOS TC program and to manage the withdrawal needs of the different populations served by these programs.

DESCRIPTION OF THE PROJECT

In order to address these issues, WHOS employed specialist withdrawal nurses. These new positions provided capacity for onsite withdrawal management for clients with low to moderate withdrawal needs, minimising impact on external services where withdrawal is not of a complex nature. They also provide capacity to manage unplanned or residual withdrawal symptoms to provide a more comfortable transition into care. This initiative was identified as a way to reduce significant barriers to treatment that many individuals experience when trying to gain support to deal with their substance misuse. With changing practices, criteria for admission, and reduced capacity in many medically managed inpatient withdrawal management programs, one significant barrier was the need to gain access to inpatient withdrawal prior to admission.

THE PROJECT

Specialist withdrawal nurses to provide increased capacity for onsite management of low to moderate withdrawal.

Whilst withdrawing onsite, clients are provided with a gentle introduction to the basics of a TC program to assist early engagement. Early engagement is critical to increasing retention, which improves longer term outcomes (Beckwith et al, 2015; Goethals et al, 2015; Meier et al, 2006). In conducting assessments for withdrawal needs, the withdrawal nurses are also able to identify other medical or mental health needs, particularly those likely to complicate the withdrawal process or disrupt comfortable transition into the TC program. They can then liaise with other nursing staff and external services to proactively manage the client's transition into WHOS, or to other services where this may be more appropriate. This process of 'assertive linkage' has been shown to improve the likelihood of engagement in a peer-based program (Manning et al, 2012; Timko & DE Benedetti, 2007).

The purpose of introducing the withdrawal nurse was therefore to assess clients' potential for experiencing withdrawal and the possibility of managing symptoms onsite, whilst identifying any other physical and mental health needs that may impact the withdrawal process and therefore transition into care.

EVALUATION

PURPOSE AND SCOPE

The purpose of this evaluation is to assess improvements in client outcomes, and initial engagement with the Therapeutic Community program, since implementation of this initiative. The focus will thus be on clients' transition of care into a WHOS TC program and retention in the early phase of treatment. Treatment elements of the program are not within the scope of this evaluation.

The evaluation particularly focused on client engagement and included the views of clients in terms of the extent to which the nurse has been able to manage their withdrawal needs and any medical and mental health barriers to engagement in the program. Historically, this consumer group is a marginalised population that has been without a voice in service processes and improvements, and this process is considered an important aspect of the evaluation.

METHODOLOGY

A mixed methods design has been employed, combining qualitative data obtained from interviews with key stakeholders, namely clients and staff, with quantitative data obtained from the WHOS client information management system. The strength of a mixed method approach is greater contextualisation of results. Quantitative outcomes are better understood in the context of qualitative analysis of client and staff interviews and can, in turn, give weight to client and staff perceptions. This design was used to assess the impact of the withdrawal nurse role on transition of care into WHOS. It was also used to identify mechanisms of change for improvements to the service and client needs addressed as a result of the introduction of a specialist withdrawal nurse role.

Data collection

Qualitative data were collected through semi-structured interviews with 12 clients and 8 staff members, which were conducted by an external Research and Evaluation Consultant.

Interviews with clients asked them to discuss their experience in the process of transition into care, with a focus on their interactions with the withdrawal nurse, the types of needs the withdrawal nurse addressed, the benefits clients saw to having a withdrawal nurse onsite, and any ways in which this aspect of the service could be improved. Interviews included clients whose length of stay at the time of the interview ranged from a few days up to five months. Interviews also represented a variety of withdrawal pathways, including clients who had their entire withdrawal process managed on site at WHOS, clients whose withdrawal was unplanned, and clients who had the acute phase of their withdrawal process managed during an inpatient stay at an external service but with residual withdrawal symptoms at admission to WHOS. One client's withdrawal process was managed through a medication reduction regime by their doctor in consultation with a WHOS withdrawal nurse prior to admission, with unexpected residual withdrawal symptoms still present at admission.

Interviews with staff asked about changes in service provision for clients of WHOS resulting from onsite access to a specialist withdrawal nurse, changes to their own work practices to support clients in withdrawal and explored benefits and suggestions to improve client care. Interviews were conducted with a range of TC staff including intake workers, program staff and a TC manager, as well as a withdrawal nurse and clinical nurse managers. Some of these staff had only been employed since the introduction of the withdrawal nurse roles so could only comment on benefits to their role and suggestions for improvement.

In terms of quantitative data, client treatment data was exported from the WHOS client information management system. The withdrawal nurse commenced at the end of the second quarter in 2017. Data analysed related to episodes commencing between 1 January 2016 and 31 December 2018, capturing six quarters either side of the commencement of the withdrawal nurse position. These data included main drug of concern, dates for assessment, admission and discharge, whether or not a client required a withdrawal management plan onsite including for residual withdrawal, and client appointments including services provided by various external service providers.

Data analysis

Client and staff interviews were analysed separately using thematic analysis (Braun & Clarke, 2006). The analysis took an inductive approach to analysing patterns of meaning, or themes, within the data. Core themes were identified for both client interviews and staff interviews and were highlighted with relevant quotes from the interviews.

Analysis of client treatment data were performed using a standard statistical package (SPSS 26.0). The conventional significance level of $p < .05$ was used to assess statistical significance. Chi-squared tests and independent t-tests were used to assess differences in outcomes prior to the commencement of the specialist withdrawal nurses as compared with outcomes following introduction of these roles.

CLIENT CHARACTERISTICS

In the 18 months from 1 January 2016 until the end of June 2017, 681 clients were admitted across the four WHOS Therapeutic Communities. In the following 18 months until 31 December 2018, 682 clients were admitted.

Number of Admissions

1 Jan 2016 to 30 Jun 2017 – 681

1 Jul 2017 to 31 Dec 2018 – 682

In terms of client demographics, there was a gender split of 60.8% male, 39.0% female, with 3 clients (0.2%) identifying as transgender. The average age of clients admitted to WHOS in Sydney was 36 years, with client ages ranging between 18 and 65 years. This age distribution is standard for Australian TCs (Best et al, 2016). The gender breakdown however was somewhat different to what is standard for eastern Australian TC programs (Best et al, 2016) but similar to rehabilitation services across New South Wales (AIHW, 2019). A recent large multi-site TC set in the eastern states of Australia (Best et al, 2016) indicated a gender split among clients of five TCs of 67.9% male and 31.8% female, with 0.3% another gender identity, while rehabilitation services across NSW in the same period averaged 61.0% male, 38.8% female and 0.2% another gender identity.

Changes in client presentation

There were no significant changes in gender or age distributions following the introduction of the withdrawal nurse. For the opioid substitution TCs, there was also no significant change in the main drug of concern. Heroin continued to be the primary substance for three out of every four clients (76.1%), and for a further 15.4% it was a prescription opioid. The primary substance for the remaining 8.5% of clients included a variety of different substances.

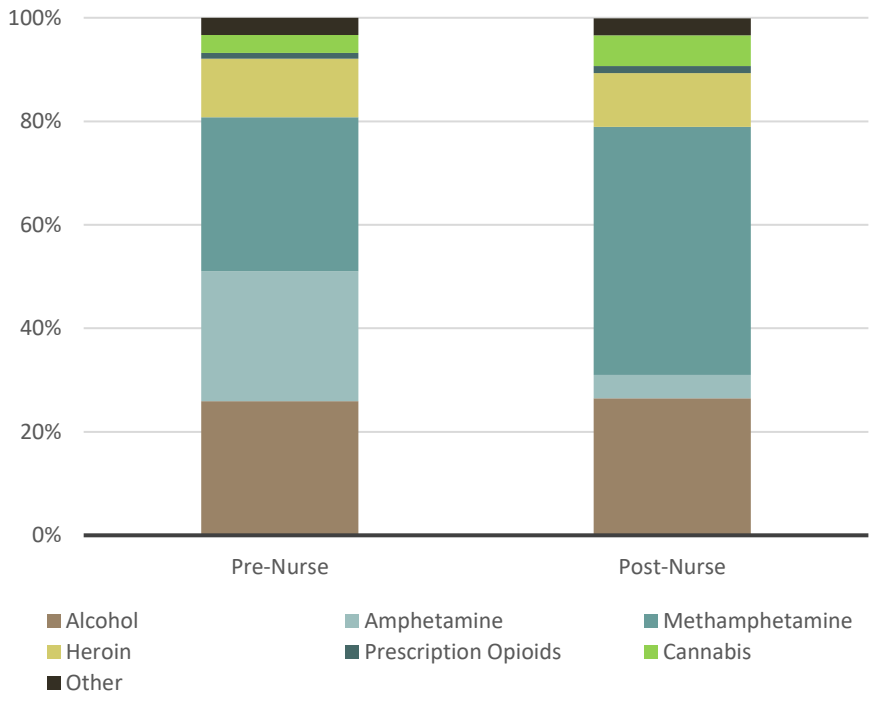

Figure 1. Percentage of clients in gender-based TC programs by main drug of concern

Within the gender based TCs, however, there has been a significant increase ($p < .001$) in the proportion of clients whose main drug of concern is methamphetamine (ice) to almost half of all clients (47.9%), as seen in Figure 1. This is higher than the state average in a similar period (2017-18). Across NSW, any amphetamine was the principal drug of concern in 41.8% of rehabilitation episodes (AIHW, 2019).

FINDINGS

CLIENT IMPACT INDICATORS

Impact indicators considered differences in client outcomes prior to having withdrawal nurses as part of the WHOS service as compared to outcomes since commencement of the withdrawal nurses.

Time to admission

Overall, there was no significant change in time to admission from the preliminary assessment for a place in the TC program (p = .487). Prior to the withdrawal nurse role, the average time to admission was 26.2 days compared to an average of 27.7 days post-nurse.

While seeing a reduction in the time to admission is desirable, this is not entirely determined by the activities of the withdrawal nurses. Admission is dependent to some degree on the readiness of the client to be admitted to the program, for example having provided necessary information, and to some degree on a bed being available for a client on the waiting list. Even when these two criteria are met, a client may not be able to attend or be admitted at the agreed time for various reasons, such as accident or injury, transportation issues, or intoxication. Another admission date will then be negotiated.

Episodes involving onsite withdrawal management

Following the introduction of the withdrawal nurse positions, there was a highly significant increase in the percentage of clients with a withdrawal management plan upon admission (p < .001).

WITHDRAWAL MANAGEMENT PLANS IN PLACE

18 mths prior – 11.5%
18 mths after – 40.9%
Jul – Dec '18 – 51.8% %

In the 18 months prior to the introduction of the withdrawal nurse positions, 11.5% of clients admitted to a TC program at WHOS had a withdrawal management plan. In the 18 months following the introduction of the withdrawal nurses, this increased to 40.9% of clients. In the final 6 months of 2018, more than half of all clients admitted to WHOS had a withdrawal management plan upon admission (see Figure 2).

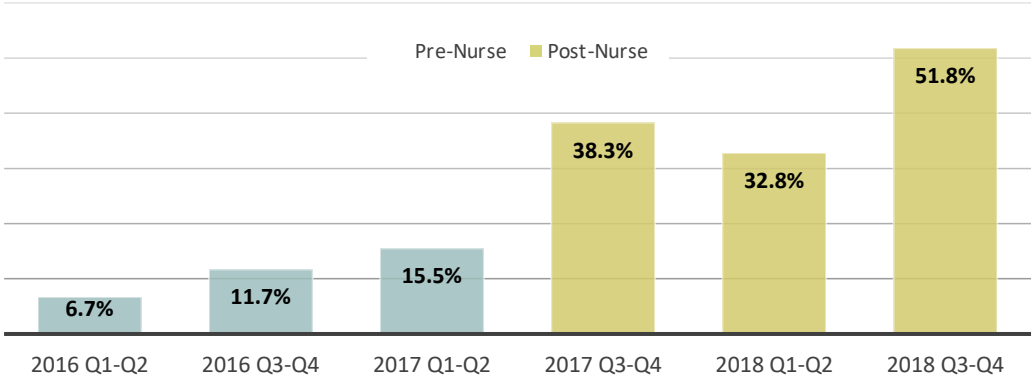

Figure 2. Percentage of clients with a withdrawal management plan at admission

The proportion of clients with a withdrawal management plan upon admission varied by primary substance, with the biggest increase in clients admitted in relation to their use of cannabis, followed by heroin and amphetamines (see Figure 3). This includes plans for the management of the acute phase of withdrawal as well as the management of residual withdrawal symptoms, which was more often the case with clients being admitted for alcohol use. Due to the potential medical risks associated with the acute phase of alcohol and benzodiazepine withdrawal, clients who were likely to experience such a withdrawal process were still referred to an inpatient detox facility or given the option to gradually reduce their benzodiazepine dose in conjunction with a doctor prior to being offered a bed. Only low to moderate withdrawals were managed onsite at WHOS.

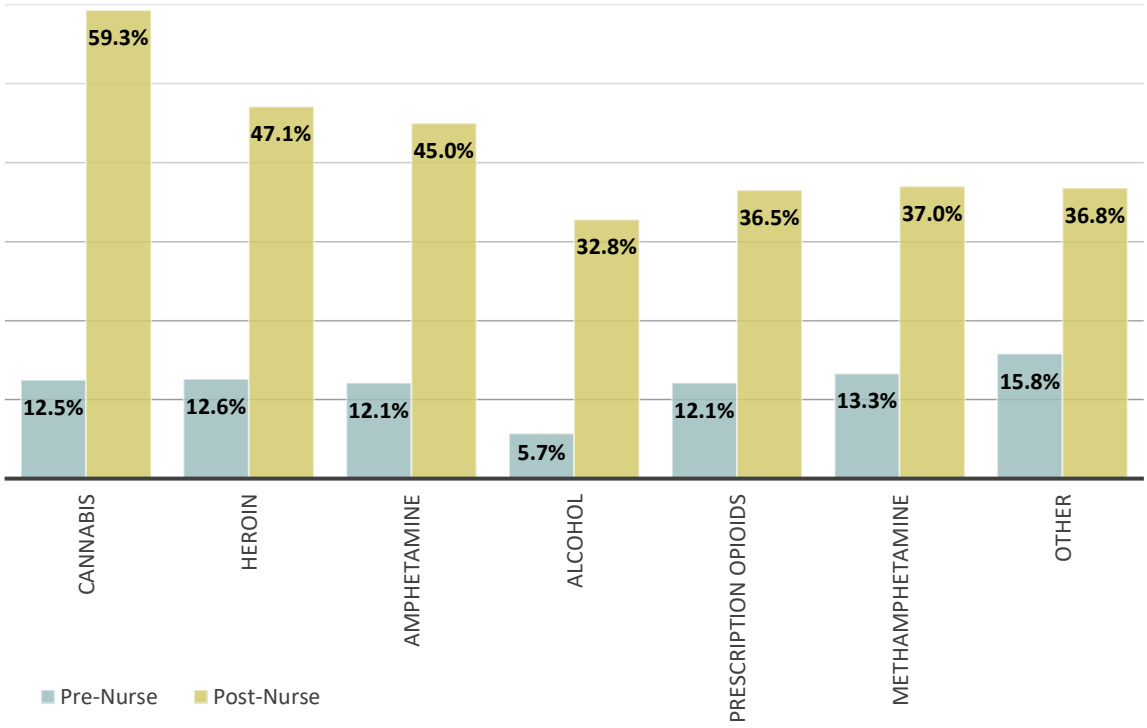

Figure 3. Percentage of clients by primary substance with a withdrawal management plan

CLIENT INTERVIEWS

Themes arising from interviews with clients revealed several benefits to clients having a specialised withdrawal nurse onsite. The overarching theme was a sense of safety due to having trained professionals with specialist knowledge onsite. Themes contributing to this overall sense of safety are described in more detail below and included the unpredictability of withdrawal symptoms, fear of withdrawals, risk of leaving, feeling comfortable, regularity of check ins, acceptance and understanding, and holistic medical support. These themes were interrelated.

Further to this, some clients also discussed the benefits of going through the withdrawal process in a Therapeutic Community program, the contribution specialist withdrawal nurses had made throughout the transition into care to foster engagement with the program, and the significant

differences they noticed in comparing a previous admission to the program - when there was no withdrawal nurse onsite - with their current admission. When asked if there was any way in which the withdrawal nurse roles could improve on the service provided, every single client immediately responded with only positive sentiments towards the nurses and emphasised the importance of the help they provide.

Safety

In interviews with clients, the word 'safe' was used by every client in relation to the withdrawal nurses. Clients highlighted feeling safer knowing medical assistance was readily available.

One client, who had had a previous admission at WHOS a number of years prior, discussed the difference in his experiences between having withdrawal nurses onsite in his most recent admission compared to previous admissions.

Another client went through withdrawals from ice (methamphetamine) for the first time during this admission, which she described as " *emotional*" more so than physical. She was not aware that there were withdrawal nurses onsite, because there had not been in her previous admission ten years prior, "*then once I got here and found that out, I just felt so relieved to be here and just happy to know that, like, the struggle was over, if that makes sense. The struggle was over, and I was safe.*"

Unpredictability of withdrawal symptoms

Many clients stated an important reason for having a withdrawal nurse onsite was that the severity, timeframe, and range of withdrawal symptoms a person experiences can be unpredictable. Having a trained professional onsite to monitor and manage symptoms was considered a necessity to manage any risk during withdrawal and made clients feel safer and more comfortable.

"Didn't have anything like that last time. It's massively different and it's massively helpful… you feel heaps safer, and you feel supported, and you feel cared for. They're very caring, all of the nurses here, and I feel they go the extra mile to make sure that you're safe and that you're OK".

"*Because, when I go through withdrawals, I get hallucinations and things like that. If something like that happened, the next step would obviously be, like, an emergency room and there's really no way to predict that without some sort of experienced detox nurse or like, you know, withdrawal nurse who can monitor for that sort of thing.*"

"*I've seen several people come in here having said that they haven't used, that they've successfully detoxed, and I've seen them come in and clearly they, umm, are full of sh*t; they've been using right*

up until that point. If you didn't have a detox nurse here, I feel that, from a duty of care standpoint, like, people could die, realistically… It's just risk management."

Although it is important to note that not all clients will underreport their substance use, and that some may simply struggle with recalling the details of their use, this situation had been the case for one client, who was admitted having not disclosed the full extent of his use prior to admission.

"*Before I came in I was using a lot of, um, ice and pills (benzodiazepines) and that, but I didn't say that because, when I came in, they said, I have to be clean (drug-free) to get in [TC program]… I didn't want to tell them I was on pills and that just before I came in so lied about it and said 'no'." And then "Yeah, when I got here, I seen (sic) the nurse and that's when I came clean and I said I was using a little bit out there. I didn't sort of go right into it, but I said I was using.*"

Clients recognised that even a trained withdrawal nurse may not be able to predict symptoms, especially where information as to the extent of a client's use is incomplete.

"*Because you don't know. People come in here, they tell you all sorts of, you know, stories. You don't know until the drugs start to leave the body what the actual story is. So, you don't know, so you need them (withdrawal nurses) there, on call.*"

Fear of withdrawal

Some clients said that they were scared of going through withdrawals. One client admitted to the opioid substitution-to-abstinence program had used heroin in addition to her prescribed dose and had trouble getting into an inpatient withdrawal program prior to WHOS. She was left to withdraw at home, where she said she "*failed miserably*":

"*I was very nervous when I come (sic) here. I didn't think I'd make it this far, you know, because I was very scared to withdraw and, you know, I never knew that I'd get help with it; I thought, you know, I'd just be sick as in bed.*"

Another client had been through the withdrawal process a number of times but with less support previously. At the time of the interview, he was five months into his stay and in a more senior role in the program.

"*…because it's scary [withdrawing], and um, when you feel safe to do it, you don't necessarily want to run [away]... cause it's hard… like, and I've done it before. I was only on methadone for two years this time, but then we've got people here who have been on it for 20 years and are terrified of it.* [INTERVIEWER: Of the withdrawal?] *Yeah. Like, it hurts... It physically hurts and it emotionally hurts*".

Risk of leaving

Many clients raised the risk of leaving, stating they thought they would have left had there not been medical staff onsite to monitor their withdrawal symptoms and to provide support through the process and relief through various medications.

One client applied to the opioid substitution-to-abstinence program to be managed through their reduction of their opioid substitution medication but had also been using ice and cannabis. She did not think she would have withdrawal symptoms from her ice use, and she had never experienced withdrawal from ice before, so she was not prepared for the types of symptoms she experienced.

"*It's been beneficial to me because, if they (withdrawal nurses) weren't here, I probably would have left because I didn't know what was going on, and I didn't, I wouldn't have had access to the medication to help me get through that uneasiness process, yeah.*"

The withdrawal nurses are clearly aware of this risk and one client stated that the nurse he saw specifically addressed the issue of engagement by asking about "*…any issues that stopped me from participating or made me think of leaving.*"

Feeling comfortable

The withdrawal nurses helped clients feel comfortable to stay in the program in a number of ways. Not only did they feel comfortable physically as a consequence of medication to manage any symptoms, but they reported feeling comfortable being around people whilst they were in such a vulnerable state due to this medical support. Clients also reported feeling comfortable with the nurses themselves and with having them onsite to manage medications.

"*They've gone above and beyond I think, you know, to make sure my stay here's comfortable and they've checked in with me to make sure I'm still comfortable, that I don't need to increase medication or, you know, nah they've been excellent, definitely.*"

"It does help and they've made my life a hell of a lot easier, definitely, because I was scared I'd withdraw and end up leaving here, you know, and go on to use, but because of the help I've stayed and got through it…" **and** ***"Like I said, if I wasn't on that medication to help me detox, I would have left and used. A hundred percent, I would have left and used."***

"They had my best interests at heart. It wasn't about them; they weren't judgemental, I didn't feel like I was being victimised. That's how I feel when I'm going to a medical centre (whispers: 'junkie') - that stigma. Don't get that here... They, their empathy speaks, umm, they don't, they don't look down at you, they don't look down their nose at you. They're very compassionate, a lot of time (for you). They treat you like a person. You don't get that at a medical centre."

Regular check ins/accessibility

One of the clear benefits of having withdrawal nurses onsite was their ability to check in regularly with clients to monitor their response to medications and the progress of withdrawal symptoms, particularly where there was greater concern for a client's wellbeing. This was appreciated by clients and helped them to feel safe and cared for.

"I've had a lot of contact with the nurses here. They've been excellent. I think practically every day I've seen her and, if I haven't been called to the office, she's come here and pulled me to the side to talk to me about how I'm going with the withdrawal symptoms and stuff."

Acceptance and understanding

People who used illicit substances, and particularly who inject drugs, are subject to pervasive social stigma from all areas in society, including from medical professionals (Lloyd, 2013; Neale et al, 2008; van Boekel, Brouwers, van Weeghel & Garretsen, 2015). It was therefore significant to clients to feel that the withdrawal nurses understood their experience and their medical needs related to their substance use and were non-judgemental in providing appropriate care. Clients reported experiencing the nurses as kind and compassionate, and this helped them to feel comfortable and to trust the nurses' professional judgement.

"She was always happy and smiling and cheerful, and made me feel at ease, umm, asked me numerous times if I had any questions that she could possibly help with, umm, once again, very compassionate and understanding and caring and I feel comfortable, at ease, yeah."

Holistic medical support

> ***"Well if the (withdrawal) nurses weren't here, there would be a lot of people that wouldn't stay because there's people in here that have got, um, they've got issues with mental health, um, they've got issues with, um, like, personal injuries from using needles and all that for a long time so it's not just about the hanging out (withdrawal symptoms)."***

This level of understanding and ongoing support was evident in the withdrawal nurses' approach to assessment and client wellbeing. The support clients received also included the medical management of mental health concerns contributing to substance use or revealed through the withdrawal process. A transgender client, whose first language was not English, reported that she suffered significant social anxiety that had contributed to her ongoing substance use. In addition to her withdrawal symptoms, she was provided with medication to manage the anxiety that contributed to cravings.

"…the Xanax I use every day, you know, just to socialise with my friend or even with my close friend, or when I step out from my house I need it, because otherwise I wouldn't be able to go out at all… Back then, I couldn't cope with my problem at all… so the first day that I got here I just, I got a chance to see the nurse here and then she prescribed me, um, she talked to me about what's going on, like, my background history and background details like what's going on, what drugs you use, all things like that… and then, after that I just went to [name] medical centre to see the doctor… and then I start medication [INTERVIEWER: for just withdrawal or all sorts of things?] All sort of things. Yeah so withdrawal and the anxiety issue as well."

Evident through clients' accounts such as this was that the withdrawal nurses listened to clients concerns and were able to follow through to ensure these concerns were managed appropriately, throughout the withdrawal phase and with the view to preventing relapse. This helped clients to stay in, and engage more fully with, the TC program.

> ***"It was only the first week I felt tired, very tired, yeah, but the thing is the activities here just kept me up and more energy and apart from that the medication helps me too"***

Withdrawing in a TC

Some clients reported they found it easier to go through the withdrawal process within the TC environment than in other settings. A key aspect of a TC program is to engage clients in all aspects of a shared living situation in addition to traditional therapeutic groups and educational activities. The support of their peers, meaning other clients, and that they were kept busy throughout the day helped clients "push through" their withdrawal symptoms.

"*I've found this is the easiest place to do it. …it's the peers that help us get through it… with detox, um, actually they keep us busy so we don't think of the detox, if that makes sense… and plus with medication it sort of relieves a lot of the symptoms as well so it's the easiest rehab I've found to do it. Doing it just in general is going to be a hard thing but it's less of a blow doing it here because of the medication and plus the structure.*"

Engagement through transition into care

Having the withdrawal nurses available and involved as part of the intake and assessment process not only reduced the risk of people leaving once they had been admitted, but also helped clients engage with the program earlier by streamlining the intake process.

One client said he felt that it was harder going through the withdrawal process in an inpatient detox then transitioning to a TC afterwards because of the withdrawal from the withdrawal medications. Having a withdrawal nurse at WHOS working with both him and his doctor to manage a gradual reduction from benzodiazepines through to admission was therefore a more positive experience, allowing him to feel supported through the transition into care.

"You know, it made it easier in a way. You don't have to go through that process of ringing up detoxes. You know, it gives you more time to build a connection with this place and to feel, you know, kind of build-up that relationship."

"*And even in detox, like, it can be, it can be harder… Like, what I've found harder in detoxes, so going from a detox to a rehab the other times I've been here is, they will dose you up on medication… so when you come off that you won't have seizures but you feel really bad for some time…so if you go from a rehab straight to here it's a really big shock… but the way I did it is I could do it slower. It's not as sharp. And then you come in here and you're once again you're supported through it, and it eases, I've found it easier... I've found going to rehab straight from detox sometimes really hard because you're left feeling crap, detoxing, hanging out (withdrawing), especially if you don't have detox nurses...*"

Comparison with previous admissions

It was very useful to be able to speak to a number of clients who had experienced a WHOS program in the years prior to having withdrawal nurses onsite. It is important to state that having a previous admission to WHOS was not an indication that the program had been ineffective for these clients. Often clients returned either having developed an addiction to a different substance or following a significant and difficult life event, like the ending of a marriage. It was a positive sign that a person was willing to re-engage with WHOS as it meant the service had been beneficial for them previously ("*I was drinking quite heavy and so forth and I sat with myself for less than a minute and I picked up the phone and I rang these guys cause I know them well and they know me and they said 'look, there's a bed here for you' so it was awesome*"). Clients were often able to ask for help sooner after relapse as well ("*I was only on methadone for two years this time*"; "*it was probably the shortest relapse I've had, about six and a half months, seven months, and I've been here nearly two months [this time]*").

These clients were able to compare their previous experiences with their most recent experience of being admitted to one of the TC programs and all stated that it was a much better experience having withdrawal nurses onsite (*"it's improved humongously, and made it heaps better for the residents and probably as well for the staff*").

This difference in experience was similar to that of another client, who had last been through the program ten years prior for problems with a different drug.

"*There's more help and assistance with the withdrawal part of it, whereas ten years ago they didn't have that. You sort of had to cold turkey it. Well, not cold turkey it – there was help there – it was just a bit more, there was no medication or as much help, and there was no help onsite, so you had to wait, you know, two days. Like if I got sick on the Friday I had to wait till the Monday and then, by the Monday, I was OK because I had two days of withdrawals. But ten years ago I wasn't on the ice – it was just heroin and pot… but this time I was on the 8 mg [of suboxone] and I had the ice addiction and the pot habit so they gave me the detox medication for the ice and the pot, which helped with the anxiety and the paranoia and all that other kind of stuff that I was going through, that I didn't even know, I didn't even know that was happening. So, they just put me on the one medication three times a day and it fixed pretty much everything.*"

STAFF INTERVIEWS

Themes arising from interviews with staff revealed the benefits of having specialist withdrawal nurses onsite and the challenges of implementing the capacity for onsite withdrawal, with some suggestions for further service improvements around provision of this service.

Benefits

Staff observed a number of benefits to clients that echoed those expressed by the clients themselves, in terms of their capacity for service provision and the impact on client wellbeing. TC program staff also expressed benefits to their role from having specialist withdrawal nurses onsite.

Improved client care

Staff noted that, through regular medical monitoring as part of the withdrawal process, the withdrawal nurses are able to pick up additional mental health and physical health issues sooner and manage clients' care appropriately. This need had also been raised in client interviews, with clients stating this additional support with a range of health concerns had helped them to feel safer and more comfortable through their withdrawals and as they transitioned into WHOS, and meant they had stayed in the program.

"...because along with the withdrawal comes a whole lot of other things that nurses can recognise in terms of, you know, their physical health, their mental health so, you know, those sorts of things are getting monitored, you know, from Day One."

"*They're coming in with lots of other health issues as well. We're having to refer them... I'm constantly sending people to the dental hospital in Sydney, who are absolutely wonderful with us, but a lot of that can get done by the withdrawal nurses as well to support us with that stuff, because it's part of their withdrawal. They come in here, they're in significant dental pain and, unless you resolve it, they're going to either want to seek their own pain relief... or they're going to leave. So, the withdrawal nurse helps us with that as well.*"

The immediacy of attention to clients' needs was therefore a key improvement noted by many staff. It was not just in relation to identification of physical and mental health issues underlying or revealed through the withdrawal process. As was also noted by clients, staff reported that some clients underreport or misreport their substance use prior to admission. This may not always be intentional, but the result is that their withdrawal symptoms following admission become more intense than either they or any of the staff expected. Having a withdrawal nurse onsite and available quickly is therefore seen as an important "safety net".

"*I think it's (having withdrawal nurses onsite) really critical, especially for the people that do come in that, you know, for whatever reason, they might not have disclosed exactly what they have been using... but I think that, you know, to be able to capture that quickly and have those people treated quickly and assessed quickly and reviewed quickly can really avoid some potential, um, disasters that can affect not only them but the whole community, the whole TC community.*"

Improved care pathways

This immediacy of assessment and treatment for unexpected withdrawal symptoms is in contrast to previous practice in similar circumstances, which was that intake or program staff would need to work with a detox service to get the client admitted there urgently. This had the potential to disrupt the client's transition into care. This may not be as much of a concern for someone experiencing significant withdrawal symptoms as, at that point, the client is often more concerned about simply getting through the withdrawal symptoms.

"Benefit? Maybe it's quicker, if I've got beds, to get someone in here, rather than the detox going 'I can't get them in for another week or two' and then they're there for a week – we're 15, 18 days away before the client gets here. So, the benefit is, is that we're going to detox them here onsite, we could get them here within two days... depending on bed availability and so on, so it shortens the amount of time the client's out there waiting, where they're at risk."

Direct transfer to an inpatient detox service was not always possible, however. To mitigate risk in such cases, the onsite nurse available previously reported she could work with a doctor to have appropriate withdrawal medications prescribed.

"*Or at that point we tried to get them into a detox and we just couldn't… so in that case I would send them to the doctor's and get a script for [medications]…*"

Now a withdrawal nurse can assess, monitor and manage the client's withdrawal onsite in the majority of cases, with a withdrawal nurse also available on weekends to ensure continued support. As one intake worker noted, "*I guess it puts a lot less pressure on the hospital system*".

Bypassing the traditional detox-to-rehab pathway has potential benefits to clients, facilitated by having the withdrawal nurses onsite. "*What it means is we don't lose people back to drugs because we can get them in a bit quicker.*"

It is important to note that 'getting them in quicker' does rely on the availability of beds. On the other hand, fast-tracking an admission when a bed is available is not always better for the client, or desirable in some cases where clients may need time to prepare for a long inpatient stay. However, provided their withdrawal needs can be supported onsite, it is beneficial to be able to provide care quickly where a potential client's life circumstances are unstable, putting them at risk. Having a withdrawal nurse onsite thus expands the options available during transition into care.

Improved nursing practices

From the perspective of nursing staff, having specialist withdrawal nurses as part of the assessment and intake process increased their capacity to allow them to provide more proactive and more holistic care.

With the introduction of the withdrawal nurse roles, there is considerably more capacity to provide not only medication but also supportive care. Supportive care refers to brief counselling related specifically to withdrawal, including techniques such as motivational interviewing, providing anxiety management strategies, or encouraging sleep hygiene, as well as education on withdrawal processes and symptoms. One of the withdrawal nurses summed up her practice:

"*The main thing is making people feel comfortable, so they stay and get the most out of what they're here to do, which is work on changes and triggers of use and all that kind of stuff… And once again the anxiety side of things is a big thing so going over all those simple things and also, you know, the actual withdrawal process – how long it's expected, what it does to your brain, what it does to your body… so that people have an understanding of, you know, 'why do I feel my moods are up and down? why can't I sleep? why do I feel like this? why do I feel depressed?' …and it's giving them an understanding of why they feel like this and letting them know that it's not always going to be like that… and you will start to feel better and your body will get back to an equilibrium so it's just, supporting people through that is just as important as giving people medication.*"

This is consistent with experiences reported by the clients themselves. As reported by the withdrawal nurse, the aim in doing so is to retain clients through withdrawal and beyond. In client interviews about their experience, this education and support was considered critical to them staying in the program.

One of the withdrawal nurses with extensive experience in outpatient withdrawal management reported that managing clients' withdrawals within a TC was better for clients as it meant that she was able to consider a longer-term treatment plan. Not only is this consistent with the recommendations in clinical practice guidelines for withdrawal management from methamphetamine, but she reported that made the role more fulfilling for her, personally and professionally.

"*Like, I was just talking to a girl in the waiting room. She came in with so many problems. She came in detoxing from ice, she was really really unwell, she'd been to hospital multiple times. We supported her through her onsite detox here and she's still here seven months later. Amazing. And I would never have thought, to be honest, in the beginning. I was a bit like 'eh, I don't know, she's been through so much…' You know? Yeah, it's good; it's a fulfilling role.*"

"I think it alleviates a lot of the stress around, um, making those decisions because I think if I were put into that position of determining whether a person needed to go to a detox or not, I would probably always play it on the safe side and say 'go to a detox first'."

It was clear the TC program staff valued the withdrawal nurses and gave a number of reasons why having the withdrawal nurses onsite was so important in supporting their role. A key reason was that the withdrawal nurses have medical knowledge that TC staff do not have and can ask questions that TC staff would not know to ask. This was seen as beneficial to the staff in a range of ways that ultimately benefited clients.

For clients who do go to an inpatient withdrawal unit first, the withdrawal nurses can liaise with the medical staff at that service, or with GPs and other medical services, for information regarding the person's health status and medical history. Not only do they know what to ask for, but they also know how to interpret that information.

"*The other area where I utilise the withdrawal nurses is to contact the detoxes. So, I have a client who's coming up from [other city] on Monday for admission. He's been in a private service down there for four weeks, it's a four-week program… I then get [withdrawal nurse] to ring that service and speak with the nurses and she'll get, all the obs charts and his medical background and his medications and check all that side of things. Because we can send medical and mental health profiles (forms) there and they're sent back [completed] by a doctor, and you can somewhat read them as a layman, but she'll prod for other things that I might, um, that's outside of my scope.*"

Having different knowledge bases can provide two different but complementary perspectives on prospective clients, meaning a staff member and a nurse can pick up what the other might have missed. This can lead to clients being assessed more thoroughly.

"*I think that, if I didn't have them there, it would be a little bit trickier at times because they have the experience and clinical knowledge, and perhaps I could look at somebody and think they're OK but there might be something I might miss; sometimes there might be something a nurse might miss. D'you know what I mean. So, working together I think is a really good relationship.*"

Working together also helps TC program staff via incidental learning: "*I think it's just increasing my awareness of what to look for, what the possible signs could be, how you could assist someone… I think we almost expect people to start off running, and these people aren't capable to start off running; they need extra sleep, they need to make sure they're hydrated, they need just that little extra, I suppose, care and monitoring for those first few days while they're in here.*" For staff, as for clients, this gave a sense of overall safety in the assessment process through improved risk management. Working together in this way helped to let staff know that the withdrawal nurses

are supporting the aims that TCs have for clients early in their program, specifically client stabilisation.

Opportunities

In implementing the specialist withdrawal nurse roles opportunities for WHOS services and the withdrawal nurses to better support the needs of clients experiencing withdrawal were identified. They are seen as things that can be fixed.

Medical and other health professionals share office space and time between them within the professional services area within WHOS. This is not necessarily an impediment to client privacy, and the withdrawal nurses often go to the TCs to monitor and follow up with clients, but finding space is an extra consideration nurses need to take into account when conducting an initial assessment for a new client admission.

As noted in interviews with program staff within each TC, there is increased awareness that clients in withdrawal may need additional rest, hydration and care. TC staff and management have tried to accommodate the need for a quiet space during the day for 'time out' for clients to rest or sleep, preferably somewhere clients can be observed and monitored easily.

Impact on the TC Community

As reported by staff and clients, withdrawal nurses can respond to clients quickly and can alleviate symptoms to some degree or put a plan in place., however the withdrawal nurses are not available overnight and the TCs are still the place where the person will spend most of their time.

"*Most of the time it works well because it's mild, residual detox – they're ok. But if the person's in significant detox, we can't handle it. It's beyond the scope of what we can offer here.*"

Intake assessment process

It is important to note that, although such situations do occur they are less common and clients, staff and nurses see this as resulting from the quality of information given during the assessment process.

Managing a more severe withdrawal process is not only beyond the scope of the TCs but also beyond the scope of the withdrawal nurse role.

"*...they're not safe for us to monitor here because we're not, you know, there's not a medical person here all the time*"

Speaking to the intake workers of each TC, it was clear that there were both similarities and differences between the services in their intake processes. This may speak to the unique needs of each client group, the l approach taken by each TC and how the withdrawal nurse role was integrated as part of that process and how the two work together.

The intake assessment process is therefore a key part of ensuring a smooth transition into care, even if a prospective client is ultimately referred to an external inpatient withdrawal service first for the management of more severe withdrawal symptoms

Improvements

Getting the balance right appeared to be the overarching theme when discussing improvements to the onsite withdrawal nurse function.

There was consensus among the staff for the need to create a space with dedicated withdrawal beds for clients that is separate to the TCs. Considerations for how this might operate varied, yet several themes emerged highlighting ways in which a separate withdrawal space would further enhance the success of the withdrawal nurse role.

Increased withdrawal capacity

The most significant benefit staff saw to having a dedicated withdrawal space onsite was the increased capacity to manage a variety of withdrawal needs. The capacity for better monitoring throughout the day was seen as key to managing the more difficult and unplanned withdrawal presentations, including allowing the admission of clients who presented for admission intoxicated.

"*Ideally, you know, it would be great to have an onsite detox facility that's, like, medical so that, you know, we could take more people that needed an onsite detox and, you know, care for them similar to a detox in a hospital.*"

Managing the more difficult and unplanned presentations was seen as distinct from managing high risk and severe withdrawals, such as those associated with alcohol and benzodiazepines, which can be fatal in some cases. Managing these high-risk withdrawals was not seen as feasible, at least not in the short term, as it would require far more resources than are currently available.

ADDITIONAL OUTCOMES

Withdrawal reviews

Following the introduction of the withdrawal nurse positions, there was a very large increase in the number of withdrawal reviews conducted, from 54 reviews prior to the withdrawal nurses to 664 reviews, as seen in Figure 5. While this is in line with the significant increase in withdrawals managed onsite, this also represents a significant increase ($p < .001$) in the number of reviews per withdrawal client, from an average of less than one review (0.7 reviews) per client prior to the withdrawal nurses, to an average of 2.4 reviews per client following commencement of the withdrawal nurses.

Withdrawal Reviews

Each client receives on average 2.4 reviews by the withdrawal nurses

Clients are now receiving considerably more attention in relation to their withdrawal symptoms and clients who had previously been admitted to WHOS have noted significant improvements in their experience of care. Better and more responsive care during the transition into treatment likely contributes to the overall sense of safety and comfort expressed by clients.

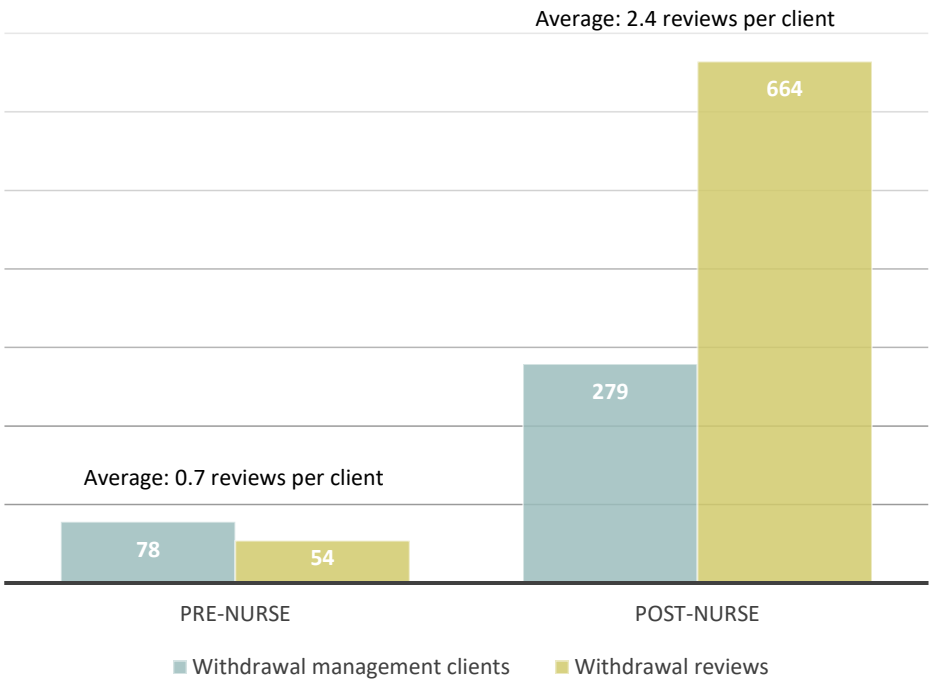

Figure 4. Number of withdrawal management clients and withdrawal reviews, pre- vs post-nurse

Hospital emergency department presentations

The number of clients requiring presentation at an emergency department (ED) has reduced by one third with the introduction of the withdrawal nurses, from 27 presentations in the 18 months prior to the introduction of the withdrawal nurses to 18 presentations in the 18 months following.

These results, alongside reports from both clients and staff, suggest that having onsite withdrawal nurses means that WHOS are better able to manage physical and mental health issues during withdrawal to reduce the likelihood these issues will reach crisis point, thus reducing the impact on emergency services. This also contributes to a reduction in access blocks, identified as an issue nationally (Crawford et al, 2014).

SUMMARY

The introduction of specialist withdrawal nurses has shown clear benefits to both staff and clients. Clients report multiple benefits that vastly improved their experience of care, particularly for those with previous experience of an admission to WHOS. There was a clear benefit in promoting clients' sense of safety and comfort through various aspects of the supportive care provided, which assisted client engagement in the program and mitigated any impulse to leave. Some clients also found the program activities a helpful distraction from their symptoms.

Both clients and staff reported improvements in the admissions process and in care pathways, reducing barriers for clients to access the services provided by WHOS and providing a more supported experience of withdrawal from admission. Having medical professionals involved in the assessment process and as a client transitions into care has also meant staff feel safer and more comfortable in their decisions around client care, knowing that there is medical support onsite should clients need it.

These improvements have been noted alongside a notable increase in the proportion of clients seeking treatment for methamphetamine use in recent years. The post-acute phase of withdrawal for methamphetamine is prolonged and involves symptoms that are largely psychological in nature (NSW Department of Health, 2008; Queensland Health, 2012; Turning Point, 2018). An increase in not only clients managed onsite for withdrawal but also these more complex presentations saw no increase in the proportion of clients who left against advice in the initial critical two-week period for engagement (Beckwith et al, 2015).

Having specialist withdrawal nurses onsite to manage a range of withdrawal processes, alongside mental or physical health problems impacting this process, has likely had a positive effect on clients' longer term physical and mental health

Having specialist withdrawal nurses onsite to manage a range of withdrawal processes, alongside mental or physical health problems impacting this process, has likely had a positive effect on clients' longer term physical and mental health, as suggested by the drop in Emergency Department (ED) presentations. This may also be due to the withdrawal nurses proactively following up with clients through their period of withdrawal, identifying related medical and mental health issues and coordinating management of these issues with the nursing team so that clients do not need emergency intervention. In addition, simple explanations for various symptoms offered by nurses through supportive care practices also helps increase health literacy among clients, which has ongoing benefits to health outcomes and quality of life (Jayasinghe et al, 2016).

Although difficult to capture statistically, that clients reported being more comfortable to engage with medical professionals where they would not have previously is also likely to reduce the burden on the crisis system longer term. Stigma towards people who use illicit drugs can be felt in

interactions with others and this has a negative effect on engagement with health services (Neale, Tompkins & Sheard, 2008) and the wellbeing of those who are subject to stigma (Luoma et al, 2007). Being assessed and supported by a non-judgemental, accepting, and validating medical professional can therefore have a positive effect on quality of life and increase the likelihood of help-seeking in the future.

Together, these results suggest the addition of specialist withdrawal nurse positions has had a positive effect on the care and wellbeing of clients. These positions have greatly reduced the need for the use of inpatient withdrawal services for lower risk withdrawals, has taken some of the pressure off crisis services, and is thus a positive contribution to the broader health system. More simply, however, there were high levels of satisfaction among clients in relation to the specialist withdrawal nurses and their transition into a WHOS program, and clients had only positive comments to make regarding the support provided to them.

CONCLUSIONS AND RECOMMENDATIONS

CLIENTS REPORTED

the benefits of having withdrawal management nurses available:

I. **Increased feelings of safety**
II. **Responsive service**
III. **Client confidence in WHOS ability to meet their needs**

The aim in introducing specialist withdrawal nurses at WHOS site in Sydney was to assess clients' potential for experiencing withdrawal and the possibility of managing symptoms onsite in the case of low to moderate risk withdrawal symptoms. In doing so, the aim was also to identify any physical and mental health needs that may impact a client's withdrawal to improve transition into care.

Clients' reports particularly have highlighted how valuable this service has been to them, giving them an overall sense of safety through increased responsiveness to a range of needs, alongside increased confidence of intake staff in WHOS capacity to manage a range of client needs onsite. There have been significant improvements to client care in both processes and outcomes around transition into care, thus this is an important addition to WHOS services, and it is recommended that it continue to be provided to clients.

While a number of program staff expressed greater confidence in dealing with more complex presentations with a dedicated resource to draw on, and some clients found program activities helpful in taking their attention away from their symptoms, both TC staff and the nurses felt that there was a need for a separate dedicated withdrawal space to manage the more difficult presentations.

One issue raised is the concern among some TC staff about the impact these more difficult withdrawal presentations have on other clients in the programs, having a separate dedicated

withdrawal space was seen as a means by which to allow nursing staff to better monitor and manage the withdrawal symptoms of clients for whom there was a greater level of concern as there is the potential for withdrawal symptoms to be varied and more intense than expected, particularly from methamphetamines (Queensland Health, 2012; Turning Point, 2018). Finally, there is the potential for clients to present intoxicated, thus a dedicated withdrawal space would provide a safe 'sobering up' area where these clients can be monitored and re-assessed as needed, however this is outside the scope of this project.

The initiative evaluated here demonstrates success in providing a systemic solution to address access barriers

The initiative evaluated here demonstrates success in providing a systemic solution to address access blocks within inpatient withdrawal services and Emergency Departments. Access blocks are often addressed within an emergency department by attempts to better triage incoming patients or free up hospital beds (Crawford et al, 2014), rather than solutions that may reduce crisis presentations, and the need for hospitalisation, in this case for withdrawal management. Addressing withdrawal needs alongside physical and mental health concerns during transition into care has been shown here to reduce the need for withdrawal management through external inpatient withdrawal services and to reduce the likelihood of crisis presentations. It is therefore recommended that expansion of this initiative be considered for other residential rehabilitation programs, initially targeting regional areas with limited access to both emergency departments and residential detoxification facilities.

It is therefore recommended that withdrawal within a longer residential program be considered best practice in the management of methamphetamine withdrawal

Lastly, and of note, the approach to withdrawal management modelled in this initiative is also in line with AOD Withdrawal Guidelines in a number of jurisdictions regarding psychostimulant withdrawal, which recommend integrating care between the acute and post-withdrawal services and ensuring treatment for withdrawal is not restricted to the 1-2 weeks of the acute phase only (NSW Department of Health, 2008; Queensland Health, 2012; Turning Point, 2018). It is therefore recommended that withdrawal within a longer-stay residential program be considered best practice in the management of methamphetamine withdrawal.

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