CHCAOD009
Develop and review individual alcohol and other drugs treatment plans

Release 1

Learner guide

Aspire learning resources

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Aspire Version 1.2

Aspire learning resources

Version control and modification history

Version	Release date	Modification
Release 1, version 1.1	April 2017	First release
Release 1, version 1.2	February 2019	Minor corrections as part of our continuous improvement program

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CHCAOD009 Develop and review individual alcohol and other drugs treatment plans Release 1

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Contents

Before you begin

This learner guide is based on the unit of competency *CHCAOD009 Develop and review individual alcohol and other drugs treatment plans*, Release 1. Your trainer or training organisation must give you information about this unit of competency as part of your training program. You can access the unit of competency and assessment requirements at: www.training.gov.au.

How to work through this learner guide

This learner guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the learner guide you need to read, and which practice tasks and learning checkpoints you need to complete. The features of this learner guide are detailed in the following table.

Feature of the learner guide	How you can use each feature
Learning content	▶ Read each topic in this learner guide. If you come across content that is confusing, make a note and discuss it with your trainer. Your trainer is in the best position to offer assistance. It is very important that you take on some of the responsibility for the learning you will undertake.
Examples and case studies	▶ Examples of completed documents that may be used in a workplace are included in this learner guide. You can use these examples as models to help you complete practice tasks and learning checkpoints. ▶ Case studies highlight learning points and provide realistic examples of workplace situations.
Practice tasks	▶ Practice tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which practice tasks to complete.
Video clips	▶ Where QR codes appear, learners can use smartphones and other devices to access video clips relating to the content. For information about how to download a QR reader app or accessing video on your device, please visit our website: www.aspirelr.com.au/help 
Summary	▶ Key learning points are provided at the end of each topic.
Learning checkpoints	▶ There is a learning checkpoint at the end of each topic. Your trainer will tell you which learning checkpoints to complete. These checkpoints give you an opportunity to check your progress and apply the skills and knowledge you have learnt.

Foundation skills

As you complete learning using this guide, you will be developing the foundation skills relevant for this unit. Foundation skills are the language, literacy and numeracy (LLN) skills and the employability skills required for participation in modern workplaces and contemporary life.

The following table outlines specific foundation skills noted for your learning in this learner guide.

Foundation skill area	Foundation skill description
Learning	▶ Understanding your job role, organisational procedures and legal responsibilities ▶ Managing your work and seeing how well you are going and making goals for yourself at work ▶ Seeking professional development opportunities for continuous improvement
Reading	▶ Understanding how documents are presented and being able to navigate through documents ▶ Understanding industry- and job-specific terminology ▶ Interpreting key information in relevant documents ▶ Understanding routine workplace checklists and documentation
Writing	▶ Planning, drafting and writing reports and documents ▶ Communicating through written letters, email and online ▶ Recording progress; reporting incidents
Oral communication	▶ Clarifying instructions ▶ Providing information ▶ Supporting others through encouragement, negotiation and conflict resolution ▶ Using body language to model desired behaviour and responding to others' body language
Numeracy	▶ Calculating costs, weights, measurements of height and distance ▶ Interpreting measurements
Teamwork	▶ Working well with other people by cooperating, collaborating, encouraging and building rapport
Planning and organising	▶ Planning your workload and commitments ▶ Implementing tasks ▶ Completing work on time ▶ Knowing how to deal with hazards and risks
Making decisions	▶ Understanding and applying decision-making processes ▶ Reviewing the impact of your decisions
Problem-solving	▶ Identifying problems ▶ Working out how to fix a problem using problem-solving processes and reviewing the outcome
Innovation and creation	▶ Recognising opportunities to develop and apply new ideas ▶ Generating ideas by thinking of new ways to do something ▶ Making suggestions to improve work

Foundation skill area	Foundation skill description
Technology and digital literacy	▶ Efficiently using digitally based technologies and systems correctly and safely ▶ Accessing, organising and presenting information ▶ Using equipment correctly and safely

What do you already know?

Use the following table to identify what you may already know. This may assist you to work out what to focus on in your learning.

Topic	Key outcomes	Rate your confidence in each section
Topic 1 Consider the types of treatment and services to be provided	1A Interpret presenting issues and requirements from the person's assessment	☐ Confident ☐ Basic understanding ☐ Not confident
	1B Consult the person to identify interaction and relationship of presenting issues, health and demographic profile	☐ Confident ☐ Basic understanding ☐ Not confident
	1C Identify the need for referral and collaboration with other services	☐ Confident ☐ Basic understanding ☐ Not confident
	1D Identify and consult with other professionals or specialists	☐ Confident ☐ Basic understanding ☐ Not confident
	1E Explain the purpose of the treatment plan and roles of different people	☐ Confident ☐ Basic understanding ☐ Not confident
	1F Consult the person about readiness to develop the treatment plan	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 2 Determine treatment goals and strategies	2A Discuss desired outcomes, priorities and long-term goals	☐ Confident ☐ Basic understanding ☐ Not confident
	2B Identify barriers and/or cultural factors that may impact goals	☐ Confident ☐ Basic understanding ☐ Not confident
	2C Inform the person about different services and support options	☐ Confident ☐ Basic understanding ☐ Not confident

Topic	Key outcomes	Rate your confidence in each section
	2D Help the person evaluate and select strategies to achieve goals	☐ Confident ☐ Basic understanding ☐ Not confident
	2E Determine and prioritise preferred actions	☐ Confident ☐ Basic understanding ☐ Not confident
	2F Confirm the person's ability to meet the logistical demands of strategies	☐ Confident ☐ Basic understanding ☐ Not confident
	2G Establish timelines for goals and consider overlap by different services and support	☐ Confident ☐ Basic understanding ☐ Not confident
	2H Agree on the type and frequency of interactions	☐ Confident ☐ Basic understanding ☐ Not confident
	2I Consult with the person to identify informal support network and role in treatment plan	☐ Confident ☐ Basic understanding ☐ Not confident
	2J Record goals and strategies in the individual treatment plan	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 3 Review the person's progress	3A Regularly review the person's progress against goals and action plans	☐ Confident ☐ Basic understanding ☐ Not confident
	3B Monitor, record and report the person's progress	☐ Confident ☐ Basic understanding ☐ Not confident
	3C Negotiate and record revised action plans and timelines in the treatment plan	☐ Confident ☐ Basic understanding ☐ Not confident
	3D Accurately record revisions in the individual treatment plan	☐ Confident ☐ Basic understanding ☐ Not confident
	3E Negotiate the person's exit from the program and provide support	☐ Confident ☐ Basic understanding ☐ Not confident
	3F Review the outcomes of interventions with your supervisor and/or colleagues	☐ Confident ☐ Basic understanding ☐ Not confident

Topic 1

In this topic you will learn how to:

1A **Interpret presenting issues and requirements from the person's assessment**

1B **Consult the person to identify interaction and relationship of presenting issues, health and demographic profile**

1C **Identify the need for referral and collaboration with other services**

1D **Identify and consult with other professionals or specialists**

1E **Explain the purpose of the treatment plan and roles of different people**

1F **Consult the person about readiness to develop the treatment plan**

Consider the types of treatment and services to be provided

Individual alcohol and other drugs (AOD) treatment plans are developed through comprehensive alcohol and other drug assessment and are usually completed by the assessment worker. Treatment plans and assessments must be comprehensive and clearly documented so they can be easily referred to and interpreted by other parties. Workers must interpret the presenting issues and co-occurring factors from a person's assessment that may inform a treatment plan.

The worker's role is to consider and advise the person of all the services and treatment options that are available and may be suitable for the person. Collaborate with the person regarding their readiness to change, their perceived goals and their needs. Consider the legal and ethical factors that underpin AOD work and how these impact your organisation's policies and procedures, as well as your individual practice when working with individuals to develop a treatment plan.

1A Interpret presenting issues and requirements from the person's assessment

A person's information and history forms the basis of assessment and subsequent treatment plan. This information may come from consultation with the individual and/or from external referral information such as reports from a general practitioner (GP), mental health clinician, housing worker or family members. Interpreting a person's assessment results requires you to understand the person's short-, medium- and long-term needs and also recognise the issues that remain unsolved and determine how these needs might be met.

Accurate interpretation of assessment results helps you to provide concise and tailored feedback to the person and appropriately match the person's information with internal and external agency information. This contributes to the development of a treatment plan that is suited to the person's presenting issues, goals and readiness to change.

The person's assessment

Adverse or dependent substance use is a complex issue. It can be caused by many factors, and the consequences of dependency can be equally diverse for different people.

Substance use issues are frequently accompanied by other issues, including:

- medical conditions such as liver disease and bloodborne viruses
- mental health issues such as depression, anxiety, psychosis and trauma-related experiences
- psychosocial issues including difficulties with a person's relationships, work and living arrangements
- legal issues.

Holistic assessment

A holistic and comprehensive assessment brings all factors to light. It determines appropriate ways to assist and support the person in managing these issues, with the aim of developing a streamlined and coordinated approach. It also aids the early identification of health issues and helps you to match the person's needs with programs and services available within and external to your organisation. Individual needs can range from urgent crisis situations, such as the risk of harm to the person or others, to dealing with withdrawal symptoms and long-term health and lifestyle issues.

People affected by AOD dependency may be unable or unwilling to talk openly about issues. The way an assessment is conducted can affect how accurate and complete the information you collect is. An effective assessment style can lead to a better match between the person and available services and supports.

Present issues and requirements

People with substance use issues may seek support voluntarily, at the encouragement or insistence of others, or mandated as part of court or legal requirements. There is often a defining moment or triggering factor that has brought them to speak to someone about their concerns. This is commonly known as the presenting issue and asking a person, 'What has brought you here today?' or, 'How can I help you today?' will often give you an initial picture of the presenting issue that has led them to seek treatment.

The presenting issue may not necessarily be the biggest issue or the most urgent issue, but it can give a good indication of the person's motivation level to change their behaviour.

Here are examples of how presenting issues can be interpreted.

Bob's motivation

Bob says his reason for attending the assessment is, 'My wife is really angry and said she'd leave me if I didn't stop smoking weed'.

His presenting issue is external pressure from his wife because his cannabis use is impacting the relationship.

Bob's motivation to change his behaviour is moderate because it is driven from an external pressure rather than from Bob himself. Bob may be considering changing his cannabis use, but someone else has prompted him to attend the AOD service.

Jenny's motivation

Jenny says her reason for attending the assessment is, 'I was recently hospitalised with pancreatitis and the doctor recommends I stop binge drinking'.

Her presenting issue is external pressure from the doctor because her drinking may be impacting her health.

Jenny's motivation to change her behaviour is high because it is driven by external (doctor) and internal pressures (the pain and fear Jenny experienced when ill and hospitalised) and the value she places on her health.

Why people seek AOD support services

AOD services have scope to see people on a voluntary basis or as part of the legal requirements placed on an individual. Referrals may come from courts of law as part of a community-based sentence or parole requirements, as a diversion program from police and through child protection agencies. Referrals form part of the presenting issue but will also inform both the individual and the support worker of the requirements of the assessment/treatment. For example, a person may be required to attend four sessions of drug and alcohol counselling for their cannabis use as part of their corrections order, and not adhering to these requirements may result in incarceration.

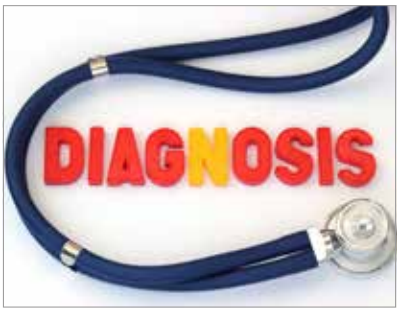
Voluntary attendance

- Be clear and honest about the person's needs and motivation level and support them to set goals that are meaningful to them. For example, the person may not be interested in abstaining from their cannabis use but they may be open to looking at ways to reduce their use to nights only. They may also identify a need to see a GP for a thorough health assessment and look at nicotine replacement therapy options for their tobacco use.
- By using a person-centred (or client-centred) approach and providing a safe and supportive environment for the individual to meet their needs, they are more likely to engage with the service again on a voluntary basis in the future.

Mandatory attendance

- When a person attends a service in a mandated capacity, be clear about your reporting obligations and the limitations to confidentiality that may occur.
- Some agencies require you to report attendance only without any need to report on the content of the sessions while others will require you to share your completed assessment report. Police and child protection services may subpoena your entire file and have you testify in a court of law regarding your work and assessment of the person.
- Always consult with your supervisor or manager about what the reporting requirements are when working with mandated individuals.

Information and terminology used in assessments



The AOD sector has terminology and jargon that is specific to the field. Phrases such as 'illicit substance', 'drug use history', 'dual diagnosis' and 'pre-contemplative stage' are not used in everyday life. An understanding of the terminology used in AOD assessments will ensure accurate interpretation of the information being presented and provide a good grounding to develop a comprehensive and appropriate treatment plan to meet the individual's needs.

The use of language changes over time. For example, until recently it was common practice to refer to people as 'alcoholics' or 'schizophrenics', whereas today it is considered more respectful to use person-centred language such as 'person with an alcohol dependence' or 'person living with schizophrenia'.

If you are unsure of language used in reports or files, always ask for clarification.

Legal substances

Identify whether the substance the person is taking is an illicit (or illegal) substance or a legal substance such as tobacco, alcohol or prescription and over-the-counter (OTC) substances. Ask about all types of substances that the person is taking.

Legal substances refer to substances that can be acquired legally. Tobacco and alcohol and OTC medications are substances that are readily available and purchased.

Sometimes individuals don't consider the legal substances as important or harmful as the illegal substances they take. Use of any drug always carries some risk, especially if the person takes a combination of substances. Assessments must consider all substances and the associated risks to the person.

The following are legal substances.

Tobacco

Cigarettes, cigars, pipe tobacco, chewing tobacco and snuff contains nicotine (and many other toxic chemicals) that is a stimulant drug and speeds up messages between brain and body. It affects people differently but is highly addictive and all tobacco use is harmful. Tobacco usually causes the person to feel alert yet relaxed and reduces appetite. Short-term negative effects include coughing, bad breath, feeling faint, and stomach cramps. Long-term health risks include suppressed immunity, infertility, asthma, stomach disorders, cancer, stroke and heart, circulatory system, eye and brain diseases.

Alcohol

Alcohol is a depressant drug that slows down messages between the brain and body. It affects people differently but usually causes slower reflexes, a sense of relaxation and increased confidence. Misuse can cause confusion, memory loss, nausea, loss of consciousness, coma and death. Long-term health risks include suppressed immunity; infertility; depression; cancer; heart, liver and brain damage; and foetal alcohol spectrum disorders.

Over-the-counter (OTC) substances

Using OTC products such as paracetamol, vitamins, herbs and cold and flu medications can result in misuse, abuse and dependence on the substance and can adversely affect the person's health.

The Therapeutic Goods Administration propose that some OTC medicines that contain codeine should be reclassified as prescription only medication. This ruling is currently pending but is expected by June 2017.

Prescription drugs

Prescription medications refer to substances that are acquired with a prescription through consultation with a GP or health professional. Common prescription medications to ask about include benzodiazepines (Valium, Xanax, diazepam), anti-psychotic medications (such as Seroquel), opiate based medications (such as methadone, oxycodone and codeine) and pharmacotherapy or opiate replacement therapy. Clarify with a person if the substances they are taking are prescribed or not (are they purchasing it from someone illegally or using someone else's medications?), and whether they are taking the medication as prescribed.

Illegal substances

Illegal or illicit substances are drugs that are illegal to make, sell, purchase, possess or use in Australia. The use of illicit substance increases the legal risks of the person using them. Using illicit substances also increases the risk of harms associated with poor quality control of the drug itself and the potential for associated high-risk lifestyle factors such as driving while drug-affected, associating with dealers etc.

Common illicit drugs include cannabis and amphetamine type stimulants (ice or crystal meth and so on), heroin and hallucinogens (acid, LSD). There is a wide range of different illicit substances, methods of use, effects and associated risks. For more information about specific illicit substances, visit the Australian Drug Foundation website: http://aspirelr.link/adf-drug-facts.

Here are some examples of common illicit substances.

Cannabis

Cannabis is a depressant drug which is usually smoked or eaten. Effects include feeling relaxed or sleepy and slower reflexes. Short term health risks include blurred vision, increased heart rate, low blood pressure and mild anxiety and paranoia. Long-term health risks include memory loss, low infertility, mood swings, dependence and asthma and cancer if smoked with tobacco. Individuals with a family history of mental illness may also have a higher risk of anxiety, depression and psychotic symptoms.

Amphetamines

Amphetamines are stimulant drugs that speed up messages between the brain and body. They may be in powder, tablet or capsule form and some are legally prescribed. Illegally produced amphetamines may be mixed with other, often toxic, substances. They are usually swallowed, injected, smoked or snorted. Effects include feeling happy, confident and energetic with increased sex drive, feeling itchy and scratching. Short-term health risks include increased heart rate and breathing, teeth grinding and reduced appetite with a risk of overdose which can result in fits, stroke, heart attack and death. Long-term health risks include extreme weight loss, anxiety, paranoia, depression, psychosis, heart and kidney problems and dependence. There is also increased risk of contracting hepatitis and HIV/AIDS if injecting.

Heroin

Heroin is a depressant drug which is usually injected into a vein or smoked or snorted. Effects include intense pleasure, pain relief and relaxation. Short-term health risks include confusion, slowed breathing and heart rate, vomiting, reduced appetite and sex drive. Long-term health risks include heart, lung, liver and brain damage, vein and skin damage if injecting, and dependence. There is also increased risk of contracting hepatitis and HIV/AIDS if injecting.

Information and terminology: substance use

Below is an overview of common language that is used in an AOD assessment relating to substance use.

A pattern of use

Pattern of use refers to how a person uses a substance; the amount, frequency and length of time someone has used a particular drug or substance.

Casual – experimental, recreational and situational use

Individuals may use substances occasionally or because of a specific situation.

Experimental use
Usually the first stage of substance use, experimental use is associated with youth experimenting with drugs and alcohol as they explore the world and its boundaries. Dangers arise with combining substances, engaging in high-risk activities such as unsafe sex.

Recreational use
Recreational use refers to a person occasionally using drugs or substances at casual and social events such as parties or concerts. Dangers include risk of overdose or serious health complications if the person binges or uses multiple substances at the same time.

Situational use
Drugs and substances are used to cope with the demands of a specific situation or to alleviate an issue; for example, truck drivers taking amphetamines to stay awake during long haul trips, students taking speed to stay awake to finish assignments or people drinking alcohol to alleviate social anxiety.

Dependent use

Dependent use is defined by the World Health Organization as the person having at least three of the following:

- A strong compulsion to take the substance
- Difficulty in controlling substance-taking behaviour, such as when to take it, when to stop taking it and how much to take
- Experiencing withdrawal symptoms when ceasing to take the drug
- Evidence of tolerance; that is, requiring more of the drug to experience the same effect originally obtained at lower doses.
- Increased amount of time taken to obtain the drug or recover from its effects
- Persisting with drug use despite clear evidence of harmful consequences to health, relationships, finances and livelihood

Harmful and hazardous use

Harmful use means substance use that is causing damage to health; for example, not using safe injecting practices causing hepatitis.

Hazardous use refers to an increased risk of harmful consequences to the user such as social, physical or mental health issues. For example, if a person drinks alcohol or takes drugs and then drives a vehicle, which increases the risk of harm to themselves and others.

Intensive use

Intensive use refers to a person heavily taking a substance over a short period of time, such as drinking a lot of alcohol at home before going out (may also be described as bingeing or binge-drinking).

Substance misuse and abuse

The main difference between substance misuse and substance abuse usually relates to the person's intentions when using the substance; accidental or uninformed use versus purposeful, intended use. Both can be harmful.

Substance misuse generally refers to a person using a substance for purposes it is not intended for, not following medical instructions or taking more of the substance than is required to meet the medical need. An example is taking more than the prescribed dose of sleeping pills. Substance misuse also includes using medication prescribed to another person; accepting prescription medication from a friend.

Substance misuse typically means the person does not have a prescription for what they are taking and use it in a way other than it is prescribed; to experience feelings associated with the substance; using a substance to 'get high'.

Substance abuse refers to a pattern of use that leads to significant impairment or distress as manifested by one or more of the following:

- Dependency and addiction
- Failure to fulfil major role obligations such as going to work or school
- Use in situations which are physically hazardous
- Recurrent substance-related legal issues; for example, a number of drink-driving charges
- Continuing to use despite persistent or recurrent social or interpersonal issues such as relationship or family breakdown, family violence, and termination of employment due to substance use

Information and terminology: dual diagnosis

Dual diagnosis is a type of comorbidity and refers to the presence of both substance misuse and a psychiatric disorder. Dual diagnosis is very common in individuals with substance dependencies. Alternative terms that are used to describe dual diagnosis include 'comorbidity' or 'co-occurring conditions'. For example, 'Tim is a 47-year-old with a 20-year history of alcohol dependence and co-occurring depression'.

Many professionals refer to a dual diagnosis in terms of the 'primary' condition. This is the issue or disorder that is thought to have occurred first. In some cases, the primary condition triggers the development of the secondary issue. For example, a person with depression might take alcohol in excessive quantities to help them cope with severe depressive episodes.

Terms used to describe dual diagnosis:

- Primary substance abuse (the drug or alcohol use has precipitated the mental illness, such as marijuana-induced schizophrenia)
- Primary psychiatric disorder (the mental illness existed prior to dependency issues and AOD use is a reactive attempt to cope with distress or pain caused by the mental illness)
- Dual primary diagnosis (when there does not appear to be a clear link between the two issues that coexist)

Information and terminology: stages of change

The Transtheoretical or the Stages of change model was first developed by James Prochaska and Carlo DiClemente in 1982 as a guide to determine a person's readiness to change their behaviour. The model also proposes strategies that can be adopted to guide the individual through different stages. The questions that appear on a standard comprehensive assessment form are often based around the stages of change that the person has reached within the Stages of change model.

The use of stage-based terminology is common in comprehensive assessments and you should understand what each stage means to inform your interpretation of the assessment and prepare for treatment planning. The following shows characteristics and common examples of these stages within the context of the AOD sector.

The stages are outlined below.

Pre-contemplation

The person is not considering change.

Example statements:
'I was forced to come here. I'm not telling you more than I have to.'

'I can't stop using right now. My life is too complicated.'

Contemplation

The person is ambivalent. There is an awareness of the need for change, but they are not yet ready to invest time, money or energy into the process.

Example statement:
'I know I should give up, but I've tried before and nothing seems to work.'

Preparation

The person is trying to make changes and is planning for change.

Example statements:
'I came here to get help, but I want to know what that involves before I make any decisions.'

'I've moved away from the group of kids who were pressuring me to use, but I still can't seem to kick the habit.'

Action

The person is actively taking steps to change.

Example statements:
'I've seen my doctor and he's given me a lot of information about the methadone program.'

'I've come to get help and I will do whatever is needed to get drugs out of my life.'

Maintenance

The person is committed to sustaining new behaviour.

Example statement:
'I haven't used for six months. It's been tough and I need some more help to get through the difficult times.'

Relapse

The person has relapsed and returned to old patterns of behaviour. The process starts again.

Example statement:
'I tried rehab, but I went straight back to using after I got out.'

Interpret requirements from the assessment

Interpreting a person's assessment results means gaining an understanding of the person's short-, medium- and long-term needs. It also involves recognising the issues that remain unsolved and determining how these needs might be met.

An accurate interpretation of the assessment results helps you match the person's information with internal and external agency information. It also helps you identify urgent issues that require an immediate response and issues that can be discussed further, planned for and strategies that can be implemented to meet their needs.

Consult the person to identify and assess their needs, goals, past experiences and support resources. Consider the following.

Critical needs

Critical needs constitute an immediate or serious threat to the person's health, safety or wellbeing and must be addressed immediately. Critical needs also extend to others, such as the public or family members. You need to obtain emergency assistance to deal with this crisis as soon as it is identified.

Assessment information that could be interpreted as the person having critical needs includes:

- lack of basic needs (no accommodation or food)
- evidence of serious illness that may or may not be life threatening
- indications or threats of potential self-harm or suicide
- evidence of actual or threatened abuse or harm to others, including strangers or family members
- actual or threatened serious criminal behaviour
- evidence of an acute episode of mental illness that might present a risk to safety of the person or others

Depending on the issue and your organisation's policies and procedures, acting on this information may include:

- reporting to your supervisor
- calling emergency services such as police or an ambulance
- calling a crisis assessment and treatment (CAT) team
- arranging for emergency accommodation or food vouchers
- arranging for an urgent medical or psychiatric assessment
- arranging for hospitalisation.

Short-term needs

Short-term needs might not require immediate attention, but may be dealt with shortly after the assessment, either by your own organisation or by contacting another agency or service.

Assessment information that could be interpreted as the person having short-term needs includes:

- a non-urgent health concern or ongoing medical symptom
- evidence of pre-existing or undiagnosed dual diagnosis, such as confusion or hallucinations that do not seem to be related to drug use
- evidence of poor health, hygiene or nutrition
- anxiety or distress regarding the current situation
- risks to health, such as poor injecting technique or risk of overdose due to increasing tolerance to the drug.

Short-term needs might be interpreted and addressed by discussing and arranging options such as:

- counselling
- medical assessment or referral to a health centre
- a mental health assessment
- referral to other allied health assessment; for example, dietitians, physiotherapists
- providing financial assistance, such as food vouchers or payment of bills through community organisations and charities
- providing information about safer drug-taking behaviours such as accessing injecting rooms.

Medium term goals

Assessments often ask individuals to consider what they want to achieve from accessing the service. Many of these goals can be achieved in the following weeks or months.

Assessment information that informs a person's medium-term goals includes:

- reasons for wanting to change
- increasing signs of dependence with a desire to cut down drug use
- eliminating drug use altogether
- addressing relationship or social issues
- managing legal issues.

Interpreting the person's goals can lead to discussion and action relating to:

- increasing the person's level of motivation by using motivational interviewing techniques
- considering treatment options that suit the person's needs, such as withdrawal programs, self-help, methadone programs or counselling.

Long-term goals

Long-term goals require significant planning and preparation if they are to be met. Long-term goals can help you and the person to look ahead and review the support mechanisms that are available to make long-term changes.

Assessment information used in the development of a treatment plan may include strategies to:

- control other issues such as gambling
- improve physical or mental health
- improve their financial situation
- maintain abstinence.

Interpreting this information can help you determine whether to:

- help the person to plan for long-term changes
- provide information about reducing or stopping drug use
- refer the person to other services, such as legal aid, relationship counselling and health services.

History

The person's past experiences can tell you a lot about their current or future needs. The person's history can flag the need to take additional precautions or measures to ensure health, safety and wellbeing. It can alert you to what has worked in the past and what has not, and it can tell you about the person's preferences.

Assessment information pertaining to a person's history include:

- past, ongoing or current comorbidities
- pre-existing dual diagnosis
- past experiences with treatment options, and their level of success
- social and financial factors that have affected the person's drug use and treatments in the past (triggers).

Knowledge and interpretation of the person's history can help you to:

- determine whether to refer the person for review of medical or mental health conditions
- understand the most appropriate options for future treatment of AOD issues
- understand other potential issues, situations or triggers that might occur during treatment
- prepare for severe withdrawal symptoms during treatment.

Support network

Details about the person's existing support structure or network can help you understand and plan for the person's possible treatment needs.

Assessment informs you about a person's existing support structure, including:

- a supportive family or friends who are concerned about the person and will help them to achieve their goals
- cultural factors such as attitudes of the person's family towards their drug use
- the person being isolated or having poor social support
- maladaptive or harmful relationships, such as with other drug users who cannot or will not support the person's need for change.

The interpretation of this information can help you determine whether to refer the person for:

- counselling
- additional supports or services
- changes to accommodation or living arrangements.

Example

Interpret presenting issues and requirements from the person's assessment

AOD worker Sally meets with Amy for an assessment. Amy self-referred to the drug and alcohol agency because she is 'sick of feeling terrible all the time' and 'has had enough of drugs'. The presenting issue does not give enough information about Amy but completing a comprehensive assessment gives Sally further insight into her circumstances, which are as follows:

- Amy smokes cannabis and uses cocaine but only when she is with her friend George.
- George and Amy are both unemployed.
- Amy says she is unhappy with the way her life has turned out and would like to attend a training course in hospitality and hold down a job.
- George has been negative and critical of Amy's ability to make a change in her life. He abuses her emotionally, calling her fat and lazy. Amy feels that her self-esteem has been affected by this abuse.
- Amy depends on George for money for drugs. He is involved in dealing drugs.
- Amy has successfully completed withdrawal programs, but tends to immediately resume cocaine use. She claims that her return to using is a direct result of constant pressure from George.

Sally interprets that Amy's pattern of drug use is situational or recreational. She determines that Amy has a substance abuse issue due to the negative impact it is having on her psychological health, employment, relationships and finances. Sally's interpretation of these results show that several factors will probably have an impact on Amy's potential for treatment and future success. One of the factors for relapse seems to be her emotional and financial dependency on George. Treatments such as counselling and withdrawal programs should take into account that Amy's future depends on her gaining self-confidence and financial independence.

Sally talks to Amy about plans for temporary accommodation and hospitality training options. Amy agrees to undertake a residential withdrawal program and enrol in a hospitality training program. While involved in the residential withdrawal program, she also agrees to consider plans to reduce her chance of relapse. Together they start to develop a treatment plan to reflect their discussions.

Practice task 1

Read the case study, then answer the questions that follow.

Case study

Harriet is seeking support services and reports the following drug use history. She currently smokes cannabis daily and is being admitted into a detox program next week. She has previously used methamphetamines with friends at parties but gave up nine months ago. She smokes 15–20 cigarettes daily and does not wish to explore options to quit smoking. She also binges on alcohol every second weekend but 'it's not a big deal and I can take it or leave it'.

1. What terminology would you use to describe Harriet's pattern of cannabis, methamphetamines, tobacco and alcohol use?

2. What does the information provided and Harriet's language tell you about her stage of change regarding her cannabis, methamphetamine, tobacco and alcohol use?

3. You can find out a lot about a person's circumstances just by asking about one aspect of their life. Why might where a person lives and who they live with play a significant role in interpreting their needs and treatment planning? Give two examples.

4. Use the internet to research and provide definitions of the following terms as they relate to AOD work: abstinence, blood alcohol level, detoxification, tolerance and toxicity.

Click to complete Practice task 1

1B Consult the person to identify interaction and relationship of presenting issues, health and demographic profile

Assessment and treatment planning are two key skills in AOD work settings. The worker needs to identify the interaction and relationship between the presenting issues at the point with a person's health and demographic issues. Giving the person individual and tailored feedback regarding their substance use issue and the impact it currently has (and has the potential to have) on their life is an important part of preparing a treatment plan. All individuals have different needs but understanding how people from specific groups and populations may engage with and respond to drug and alcohol services and treatment will help you and the organisation tailor the support given to each person.

Provide feedback to the person

Feedback is commonly provided to the person after an assessment has been interpreted and documented. Feedback involves talking to the person about the types of options and considerations arising from your assessment interpretation. This is a crucial time for talking about change with the person.

The person is central to providing feedback. The aim is to discuss the assessment and make decisions about how the person wants to move forward. The person also needs to consider what aspects of their family and social support require strengthening before they can facilitate and undergo change.

Feedback provides the person with an interpretation of the information gathered and draws links and relationships between the person's substance use and other aspects of their life. The aim of your feedback is to help the person to develop a greater awareness concerning their drug use and to make decisions about it. Always seek responses to your feedback from the person using active listening techniques. Guide the person towards talking and thinking about the issues further, rather than attempting to provide them with answers. Reflect and re-state the person's own responses to encourage them to delve deeper and clarify their standpoint.

Interactions and relationships between different factors

Gathering information does not give the person insight into the interactions between their presenting issues and other factors of their presentation. This requires feedback and open dialogue between the worker and the person; finding opportunities to help make links for the person between their substance use and the impact it is having

on other areas of their life. It is also opportune to look at motivating and protective factors as well as the person's strengths that can be drawn upon when planning for appropriate treatment.

Here are some factors that may interact and affect the person.

Health

Medical and nursing staff who work in rehabilitation centres and other AOD settings are often required to enlist the support of front-line AOD workers to collect information and data about the person's health. This may occur during both the assessment phase and treatment phase of their contact with an organisation.

Detailed health assessments are often relevant for individuals with AOD issues because they may be at a higher risk of poor nutrition, poor medical and dental treatment, and a range of health conditions related to their substance abuse. In addition, a thorough health check performed by trained medical personnel helps determine the person's appropriateness for various AOD treatments, including drug substitution programs.

Methods used to collect this information include:

- questioning the person about their health status
- collecting reports and referrals from external health professionals
- making observations of the person's appearance and behaviour.

Family and social relationship status

The influences that the person is subject to in their family setting are important determinants about the person's current drug status. Decisions about the person's treatment options will be greatly influenced by the support or discouragement that is likely to occur from the person's significant relationships. For example, individuals seeking AOD services and whose family is supportive of their need to change will sometimes be at an advantage in terms of treatment success over those individuals whose significant others are also continuing users.

Questions that can open a discussion about the person's family influences in relation to AOD use include asking about the person's relationship with their family and the family's attitude to drugs and alcohol.

You are usually required to determine significant people who can support the person through the rehabilitation process, and identify relationships that are difficult or unhealthy, or that prevent the person from seeking help and maintaining treatment programs.

Employment and financial status

AOD dependence is often strongly tied to the person's financial state. Many people who use drugs and alcohol require a significant income to support their dependency. Conversely, the effects of AOD use can often be incompatible with maintaining employment in traditional or professional settings.

Questions to determine a person's employment and financial status include:

- 'How does your AOD use affect your current job role?'
- 'How do you support yourself and your family?'
- 'How do you support the drug habit?'
- 'What sacrifices do you consistently make to support your use of the drug, such as poor diet?'
- 'Do you need additional support for your family while you seek help?'

Legal status

An assessment of the person's current legal status will help you and other workers meet the person's individual needs, such as legal aid or counselling. This includes questioning the person about current offences, charges pending, bail conditions and the circumstances surrounding the charges or offences. The person may also be involved in family court; for example, due to child custody arrangements. It is also important to determine the person's attitude towards past and current offences, charges and court orders.

Psychological status

Potential mental health issues and barriers to treatment can be identified during your comprehensive assessment. This can be done by asking the person questions and using standard tools to determine the person's psychological and emotional state.

Assessment forms usually have some general questions pertaining to psychiatric history as well as an area to record the person's presentation. This is called a mental state examination.

General questions include:

- 'Have you ever been treated for psychiatric conditions, such as depression, anxiety or schizophrenia?'
- 'What treatment did you receive? Hospitalisation, medication, counselling?'
- 'Are you on any medication? Can you tell me how much you take and for what condition it is prescribed?'

A mental state examination allows the assessor to record how the person presents at that point in time. It is a tool used to collate information on verbal and nonverbal cues to assist with diagnosis and case formulation. It covers areas such as:

- physical presentation
- emotional presentation
- cognitive state.

Demographic profiles and factors affecting support work with people from specific groups

Drug and alcohol abuse exists across all sectors of our society. There is no one type of person that typically fits the description of a drug- or alcohol-dependent person.

Individuals affected by drugs and alcohol issues:

- speak languages other than English
- are teenagers or older people
- have different cultural or religious beliefs and traditions, such as food and clothing preferences
- practise professional careers or are unemployed
- come from homeless or disadvantaged backgrounds, or hold highly privileged financial status
- have a completely different set of social morals and values to you
- are male, female or transgender
- are single or have same-sex or heterosexual partners
- are Indigenous or from a range of other cultural backgrounds
- may speak languages other than English.

Community services core values

Alcohol and other drugs work, and the community services sector more broadly, is based on a set of core values and principles that must underpin all your work practices. It is the role of the worker, organisation and sector to ensure that services are available and accessible for anyone regardless of their age, gender, ethnicity, race, sexual preference or disability. Demographic information can inform your assessments but remember to avoid stereotyping people and always treat the person as an individual.

Every individual has rights:

- to be treated with respect and dignity
- to equal opportunity and social justice
- to be as self-determining and independent as possible.

Demographic factors and risks

A person's demographics (age, sex, education, marital status, religion, race) can be indicators to the potential risks and harms associated with their substance use. Each person has a range of characteristics that in and of themselves change the overall experience of drug use. A 15-year-old boy will experience a different set of risks using the same substance and amount than a 40-year-old man. A male and female of the same age are going to respond differently to drinking the same amount of alcohol. A person's education level is going to play a factor in their capacity to address their substance use.

Consider the needs of different population groups in order to effectively support them through the assessment, make referrals and develop a treatment plan and any intervention strategies. The following information is by no means exhaustive and may not apply to every individual within this population.

Men

Generally speaking, men are less likely to seek help and support for health concerns; this is true for seeking treatment for medical or physical concerns, psychological or mental health issues. However, evidence suggests that men make up the majority of individuals seeking support from drug and alcohol agencies. There are also particular risks that in general are higher for men, which may mean opportunistic and targeted risk assessment is important at every stage with men.

Recognise the role that gender may play in the person and worker relationship. Men from some cultures may find it difficult to discuss an AOD issue with a female worker or make the therapeutic alliance difficult to build. Men should have the option of speaking with a male worker if this is more culturally sensitive. Alternatively, certain gender stereotypes of masculinity can cause some men to find it difficult to disclose personal or sensitive information to another male. There may be times when a male requests a female worker for this reason. While some services do not have the human resources to employ both male and female workers, consult with your supervisor or manager when deciding who would be best suited to work with this male.

Men overall are more likely to:

- experience alcohol or other drug issues throughout their life time, drink alcohol in excess, use illicit substances and die by substance-related means
- attend at the encouragement or insistence of a loved one or professional or attend as part of legal or criminal proceedings
- experience a greater sense of external motivation to make changes to their substance use issue.
- consider suicide or self-harm and die by suicide at a higher rate than women, usually using more 'fatal' means of suicide (hanging, car accidents)
- benefit from a flexible approach or delivery model to access AOD assessment and support
- benefit from assessments being conducted at general health centres rather than an AOD agency.
- benefit from assessing risk and discussing harm reduction strategies from the commencement of your work
- benefit, especially initially, from concrete and practical behavioural strategies to address substance use.

Women

Overall women are less likely to access AOD treatment than men, going against the gender norms of help-seeking behaviour. There are issues specifically or globally more pertinent to women when considering how to support them as individuals. Major life events and transitions including pregnancy, motherhood, menopause, family violence and social and economic disadvantages may have a distressing or negative impact on women and should be considered when assessing and planning for treatment. Women should be given the option of gender-specific residential services (detox and rehab) if they are available. They may also respond well to engaging in support groups more so than men.

Gender can play a role in the relationship that is built between a person receiving support services and the worker. It may be important to consider the woman's cultural background. In some cultures females seeking support may not be allowed to speak with or work with a male professional. It may also be a cultural norm that males are required to escort the female to their appointment and be a witness to the interaction between the woman and the worker. If the worker or agency has knowledge that a woman has a history of trauma, particularly in regards to family violence and sexual abuse perpetrated by a male, it may also be deemed appropriate – if not necessary – that a female worker is appointed to support the person.

Children and pregnant women

Issues relating to a family or caring role can be of particular concern for women seeking support. Important considerations need to be taken when working with a mother or a pregnant woman to ensure they are encouraged to access support while keeping the safety of any child in their care in mind. Women more so than men are often concerned about how accessing support and treatment may impact their parenting role or the worker's duty of care to contact protective services. Anyone (male or female) who is a parent or in a caring role should be fully informed and aware of the worker's duty of care, and that any risk to the child is assessed. Supervisors and managers are in the best position to determine a child's level of risk relating to parent substance use and it may not always be the case that child protection services need to be contacted.

It may be important to refer a woman to specialist services if the needs being presented are out of your individual or agency's scope of practice. For example, if a woman is pregnant or becomes pregnant during the work with the AOD service, specialist services may be referred to. Family violence crisis and support services may also be consulted if a person discloses feeling unsafe in her home due to violence.

Young people

When young people are accessing AOD support services, consider their specific needs, their developmental stage, family involvement and legal and ethical obligations.

For a comprehensive overview on working with youth with AOD issues, Youth Drugs and Alcohol Advice (YoDAA) have put together a Youth AOD Toolbox, which is easily accessible at: http://aspirelr.link/youth-aod-toolbox.

Here are some key issues to consider when providing AOD services to young people.

Definition of young people

The definition of a 'young person' in relation to AOD treatment varies from state to state and in some case, within the same state based on funding criteria. 'Young person' may mean anyone aged under the age of 16, under the age of 18, up to the age of 21 or up to and including the age of 25. As a general rule, special considerations need to be made when supporting a young person and planning their treatment.

Developmentally appropriate approach

Young people will require developmentally appropriate screening, assessment, feedback and interventions. This may include screening out young people who display developmentally normative experimental substance use with few other complicating factors; for example, using cannabis or ecstasy once or twice or drinking occasionally but with good social, school and family supports. There is broader scope for brief intervention with young people, and assertive outreach may be required for disengaged or hard-to-reach youth.

Family involvement

Assess the young person in the context of their family. Your agency and practice may place higher importance on family inclusive approaches in the assessment, treatment planning and intervention stages of the young person's involvement in services, depending on the age of the young person and whether they are living at home or not. There would also be times when involving family members is inappropriate due to current or past neglect, abuse or violence within the family system.

Legal and ethical considerations

Privacy and duty-of-care requirements specific to the worker's involvement with a young person needs to be specified from the beginning of engagement to ensure young people are aware of their rights and the limitations of confidentiality.

Older people

Historically, limited research has been completed in the area of older people and AOD issues; however, a growing body of evidence and practice wisdom highlights the need for special considerations to be made for elderly people to ensure appropriate and accessible support.

For more information on working with older people with AOD issues, read Preventing and reducing alcohol- and other drug-related harm among older people: a practical guide for health and welfare professionals. You can access this via the NCETA website at: http://aspirelr.link/reducing-aod-harm-in-older-persons.

Here are some key issues to consider when providing AOD services to older people.

Attitudes and misconceptions

The attitudes and misconceptions of both the worker and the older person may be barriers for that individual to receive adequate support. Both parties may believe that it's 'too late' to address and change an older person's substance misuse. There is also a long-held belief for some that we would not want to deprive elderly people their pleasures or vices in older age, regardless of the harm it may be causing them to their physical and mental health as well as relationships and psychosocial indicators.

Medical conditions

Older people overall will have a greater degree of medical complexity due to chronic illness, of which substance use may or may not have been a contributing factor. This may mean that AOD issues are not identified as a primary concern or any concern to those involved in their care, though it may have worsening or complicating effects on the medical conditions that the person is living with. It is also important for cognitive impairment to be considered for older people, including acquired brain injury (if substance use is long-term and chronic), dementia or memory loss. Support work and interventions should take into consideration a reduced cognitive capacity.

Potential cognitive issues

Due to an older person's potential cognitive impairment, it may also be important to consider longer and more flexible engagement. Mobility and physical limitations may also need to be taken into consideration. Home visits, transport and access to communication aids may be necessary options to increase the capacity for a person to engage in treatment.

Family involvement

The shift in family dynamics as older age approaches can cause difficulties in individuals having ownership over their treatment goals. There is often a role reversal of the parent–child relationship, with adult children taking on a caring role, and embarrassment or shame associated with accessing AOD treatment with their children's knowledge may create a barrier for the older person. There is also a potential for family members to collude with each other and seek support from the worker to set the agenda for the older person's treatment. Family support services or family inclusive work should be encouraged, and any concerns you have about an older person's capacity to make decisions or potential elder abuse should be brought to your supervisor or manager for review.

Aboriginal and/or Torres Strait Islander people

Indigenous communities in Australia face considerable issues associated with drugs such as alcohol and tobacco, cannabis and, more increasingly, amphetamines. Isolation, unemployment, poor living standards and lack of appropriate medical and education facilities are all contributing factors. While many Aboriginal and Torres Strait Islander people do have access to health and education services, these services do not always consider the cultural needs of Indigenous people.

If the person chooses to access mainstream services of if mainstream services are not available to them for any given reason, it is imperative that workers undergo a level of cultural awareness and competency to work with Aboriginal and Torres Strait Islanders, through individual research, professional development or through their supervision learning goals.

Here are some key factors in cultural competency when working with Aboriginal and Torres Strait Islander people.

Culturally appropriate services

In an AOD context, Aboriginal and Torres Strait Islander peoples should always be given the choice to access culturally-specific workers and services if they are available to them. For example, Aboriginal Community Controlled Health Organisations (ACCHO) provide ongoing care and support for Indigenous Australians with alcohol and other drugs issues. These culturally appropriate services include sobering-up units, mobile patrol assistance into remote communities, and home and community care programs that serve local community members.

Culturally safe environment

Ensure a welcoming and safe physical environment; ensure Aboriginal and Torres Strait Islander flags are visible, display Indigenous artwork if appropriate and always ask a person if they identify as Aboriginal or Torres Strait Islander in a way that they are aware they can answer truthfully when asked. Provide Indigenous-friendly literature and resources as appropriate.

Community obligations

Community and cultural obligations will often take priority over attending appointments or engaging in services; this should be taken into consideration when working with people from this population.

Trauma-related issues

Specific trauma related issues need to be taken into consideration when working with ATSI populations; the impact of colonisation, the stolen generation, government involvement in their lives, displacement from their lands and other hardships.

Family

When asking about family, understanding and consideration of the broad concept of family and kinship rules for Aboriginal and Torres Strait Islander peoples must take place.

Culturally and linguistically diverse people

AOD workers must take care to recognise and respond appropriately to individual and cultural differences when supporting culturally and linguistically diverse (CALD) individuals. Taking some time to research the cultural background of the person you are supporting may go a long way in ensuring they receive appropriate and respectful care from you and the organisation you work for.

When working with people who have difficulty communicating because English is not their first language, it is necessary to take the time to learn how best to communicate with that individual. For example, you may find that the person can communicate in writing, by sign language, nonverbal cues or even by drawing. You may also find that once you get to know a person better, you begin to understand what they are saying even though they may have trouble pronouncing some words.

Here are some suggestions for specific aspects to research when working with another culture.

What to research about a culture you are working with

- The impact of gender roles on cultural background and whether a male or female worker will be best suited to the person
- Stigma associated with substance use among the cultural and family community of the person and how this may limit a person's capacity to be supported by loved ones
- How to change communication styles and behaviours to suit the culture of the people you are working with

Interpreters

Interpreter services are needed where a language barrier exists between you and the person. It is best to seek additional support before any further discussion or assessment takes place. The sensitive nature and legal ramifications of AOD assessments require the use of a professional interpreter rather than bilingual family members or unqualified staff members. For example, individuals may worry about confidentiality and their reputation within their community or there may be difficulty translating some terminology accurately.

Interpreter services are usually available either in person or over the telephone. Check with your organisation's procedures for arranging to access the service.

Always introduce yourself and the person to the interpreter. Position yourself and the person so that you can maintain eye contact with each other, rather than with the interpreter. Look at and speak to the person rather than to the interpreter. Try to speak naturally and develop a rapport through appropriate gestures, body language and non-judgmental speech, just as you would when talking directly to any other person.

Ask the interpreter which type of interpreting they use; the main types of interpreting services are simultaneous and consecutive, both of which are described here.

Simultaneous interpreting

Simultaneous interpreting means that your speech is translated and spoken by the interpreter while you continue to speak. This is a refined skill that only highly trained professionals can perform correctly. Sometimes using this method can cause some words to be lost during the translation.

Consecutive interpreting

Consecutive interpreting means that the interpreter waits until you have finished each sentence or phrase and then translates the information while you pause before beginning the next sentence. If they use consecutive interpreting, roughly establish the number of sentences that you can say before pausing.

Example

Consult person to identify interaction and relationship of presenting issues, health and demographic profile

Christina is completing an assessment and developing a treatment plan for Barry, a 78-year-old male who was referred to a drug and alcohol service by his GP for suspected dependent use of opiate-based pain medication. Barry was first prescribed OxyContin when he was discharged from hospital after major heart surgery. His GP is concerned that Barry has been on the medication for a number of months and, despite advising him of the risk of dependence, Barry has been coming back more frequently for repeat scripts. Barry is embarrassed to be at the service and states, 'I would die if the wife knew I was here!' Barry smokes 15–20 cigarettes a day and enjoys 4–6 beer cans a night – a significant increase since retiring three years ago. Barry has had one drink-driving charge in the past and is retired from working a trade. He reports no mental health issues but says, 'I get down since finishing work, and I'm not sure what to do with myself'.

Christina provides feedback to Barry about his use of OxyContin in addition to his tobacco and alcohol use. She discusses the risks associated with tolerance and overdose on opiate-based medications and alcohol. She outlines the impact that continued use of these substances will have and how they will exacerbate his current physical health. Christina asks Barry if she can consult with his GP to get a full history of his medical issues and all medications that he is on and discuss a reduction regime. She provides Barry with some brochures on alcohol and opiate-based medication. Christina discusses the benefits of family involvement and Barry agrees to take a brochure so he can discuss it with his wife if he wishes. Christina assures his privacy and suggests they review involving his wife in the next appointment. Christina provides Barry with information about his local Men's Shed for social connection.

Practice task 2

1. Briefly describe why a person's education level may impact their experience of drug or alcohol issues and their treatment plan.

2. Research online resources about working with AOD issues in the LGBTI community. List two potential considerations that need to be made when working with this group.

3. What are two potential concerns to consider when using interpreters?

Click to complete Practice task 2

1C Identify the need for referral and collaboration with other services

The community services sector is a complex network of professionals and organisations that assist people with a range of issues in many different ways. Referring individuals to other services can help them to receive the assistance that is the best possible fit for their individual circumstances.

Referrals should not be undertaken without the active participation and understanding of the person. Encouraging them to become involved in determining what services best suit their needs can help them to feel empowered and can lead to a more thorough and targeted treatment plan.

Issues beyond the scope of AOD services

By consulting within your team (colleagues, senior workers, managers and so on) and other professionals and managers about their services, you will gain knowledge about the limitations of your organisation and other AOD services. As a result of your discussions and investigations, you may discover various issues and services that are outside of your organisation's or the AOD sector's scope. Some examples of these services are listed below. In larger organisations, some of these specific services might be available, but only from staff with particular qualifications or seniority. For example, your organisation might employ mental health professionals who are able to counsel and treat individuals with severe mental illnesses.

Issues that may be beyond the scope of your service

- Assisting individuals to access welfare payments
- Giving the person legal or financial advice
- Assisting with other lifestyle concerns such as gambling
- Addressing health concerns
- Seeking housing and employment
- Treating individuals who are aggressive or violent

Referrals: emergency and high-risk situations

Concerns and risks specific to the person may mean that a referral to a more specialised or crisis service is required, either by law or duty of care. There may be legal and ethical obligations placed on you to report real or potential risk as a result of the person's behaviour, such as sexual assault and domestic violence. You have an obligation to act in a way that reduces this risk as far as possible. In some cases, this means that you must call the police to prevent the person from carrying out dangerous, illegal or violent behaviour.

Your organisation will have policies relating to other situations in which you are required to call the police and other emergency services. These include when threats or violence are directed at staff.

Here are some common risk situations that you may need to address in AOD settings.

Health emergency or potential risk

In a health emergency, your first response should be to call an ambulance. In situations where the person is unwell but not in immediate danger, referral to a doctor or emergency room at the local hospital is usually appropriate, within the guidelines of your policies and procedures.

Risk of self-harm

Individuals presenting with a risk of self-harm may present as stressed, anxious, scared or calm. The effect on workers is often an increase in stress and anxiety and fear of saying the wrong thing. By assessing the risk and ensuring continuing support, the person is likely to appreciate the ongoing nature of your work. Even though you may need to refer or ask for consultation or support from other workers or services, by keeping the person informed of your actions and concerns and by following up on referrals, you maintain your role and rapport with the person.

Options for seeking help for a person who is at risk of self-harm include:

- asking your supervisor for assistance
- calling a mental health professional who works within your organisation to urgently assess and counsel the person
- referring the person to an external service or professional such as a psychologist or psychiatrist
- arranging for a visit from crisis assessment and treatment teams (CAT).

Mandatory reporting of children at risk

In some Australian states and territories it is mandatory for an AOD worker to report actual or suspected physical or sexual child abuse to the police or government authorities. In these situations, the AOD worker has a legal obligation to report the situation.

In areas where reporting is not mandated (or compulsory), there are moral and ethical grounds for AOD workers in your organisation to report child abuse to supervisors or to the relevant department in your state or territory. It is not necessary to inform the person that you will be making this report, and it can sometimes be made anonymously. However, most services would encourage the issue to be brought up and worked through with the person.

Concerns can be raised by contacting the appropriate authority in your state or territory. Telephone helplines can also be of assistance to you and individuals receiving support services if you are unsure how to proceed in a situation of risk. These services can provide advice, counselling and information about assistance in your local area.

Some councils and community organisations provide assistance with crisis intervention, such as emergency accommodation, crisis counselling, self-help groups and legal support for families at risk of domestic violence.

Referrals: financial and lifestyle issues

Individuals might have financial and accommodation issues linked to chronic dependency. Emergency relief and assistance is available in several forms for times when the person does not have enough money to cover living expenses.

Your knowledge of the services available in your area of work will develop over time as you network and have contact with them. Service directories are available in hardcopy and online to assist with getting to know types of services and their criteria for access.

Some examples of other support services are listed below.

Examples of internal/external support options

- Charities and other community organisations that can provide food vouchers, food hampers, transport vouchers, goods such as clothing or bedding and other forms of material aid
- Government departments such as Centrelink
- Information services provided by some AOD agencies
- Gambling help services such as telephone help lines and counselling services funded by state and federal governments
- Banks or financial services that might provide short-term relief from mortgage payments in exceptional circumstances, negotiate debts or recommend consolidation of loans
- Employment agencies who provide training and job skills for people who are recovering from AOD dependence

Referrals: legal issues

AOD users are more likely than the general population to be involved in the justice system, facing charges such as drug possession and other crimes related to their drug use. Legal assistance might also be required for a range of other issues, including child custody and divorce law. Expert and low-cost legal advice and advocacy can be provided through legal aid centres, or the person can be referred to private law firms.

Referrals: non-urgent health issues

With an increased focus on providing coordinated services to individuals with comorbidity and dual diagnosis, many AOD organisations have close links with health and mental health services. Some organisations employ mental health professionals and other allied health workers within the service itself. If your organisation offers the services of an in-house health professional, you are likely to have established procedures for internally referring and accessing professional assessment from these staff.

Some services, including specialist doctors and psychiatrists, might require a referral from a primary health professional, such as a general practitioner (GP), before the person can access the service.

External services/professionals to assist with health issues include:

- community health centres; these provide low cost medical, dental, mental health and allied health services
- women's health services
- private general practice clinics
- allied health practices, such as physiotherapists and dentists
- natural therapies clinics who employ naturopaths and remedial massage therapists
- private mental health practices who employ psychologists
- health and mental health information services
- emergency telephone counselling services such as Lifeline.

Referrals and inter-agency collaboration

It is essential that you are familiar with your organisation's policies and procedures relating to referral before actually making a referral on a person's behalf or assisting them to do so. Investigate the rules and processes relating to whether you are qualified to make a referral or whether this is a task that must be completed by your supervisor or a senior member of staff.

Processes for referrals vary greatly, and you will find that referral processes are determined not only by your own service, but by the individual referral policies of the external organisations.

The steps involved in making a referral for a person include:

- collecting information about the referral process of the organisation that you will be referring the person to
- gaining the person's consent
- writing a referral letter, making phone calls or assisting the person to do these things
- sharing confidential information with external services.

Example

Identify need for referral, and collaboration with other services

Claire has recently completed a short-term residential detox program for long-term dependent cannabis use. Her AOD worker Andy knows that Claire is at a high risk of relapse as Claire continues to spend a great deal of time with friends who smoke cannabis and reports 'everyone I know uses'.

Claire has also indicated that she initially started using cannabis to manage her anxiety that has never been managed through medication or psychological/mental health support. She is worried the symptoms of her anxiety may lead her to start smoking again. Andy discusses a number of options with Claire to address some of the underlying causes and triggers to use cannabis again.

With Claire's consent, Andy links her in with a weekly peer support group for people who have recently made changes to their substance use to increase Claire's social networks to people who don't use cannabis. He contacts Claire's GP. After consultation, the GP refers Claire to a psychiatrist for a one-off bulk billed psychiatric assessment to clarify Claire's diagnosis and make recommendations for medication. Finally, to help Claire set goals regarding her anxiety, Andy completes a referral to Neami National, an organisation that provides psychosocial support and rehabilitation to people with identified mental illness.

Practice task 3

1. Name one potential benefit and one potential risk of providing an individual with details of referral options and leaving it to them to follow up.

2. Name one potential benefit and one potential risk of completing a referral on behalf of the person receiving support services.

3. Research and record the phone number of your local mental health Crisis Assessment Treatment Team (CATT) or mental health triage service. What is the role of a CATT service?

Click to complete Practice task 3

1D Identify and consult with other professionals or specialists

Individuals with AOD issues can present with a range of complications and complexities that are often difficult to tease out. One's knowledge of AOD issues, emerging substances and drug trends, and evidence-based practice will be dynamic and always changing. Staying updated on current and specialist AOD information and consulting with other health professionals and specialists is a crucial part of a worker's role.

Specialist AOD information

Acquiring knowledge and expertise in the AOD sector does not end with the completion of a course of study. AOD workers need to keep up to date with current developments and issues in the field. They can do this by attending workshops, undertaking further training, talking to colleagues and other community service workers, reading current literature in the field and checking websites related to AOD issues.

Here are three websites that are useful for keeping up to date in the AOD sector:

- The Australian Drug Information Network (ADIN) at: https://aspirelr.link/adin provides a central point of access to quality Internet-based alcohol and drug information provided by prominent organisations in Australia and internationally.
- The Alcohol and Drug Foundation (ADF) at: http://aspirelr.link/adf provides newsletters, fact sheets, research reports and other evidence-based information to keep workers in the field informed.
- National Centre for Education and Training on Addiction (NCETA) at: https://aspirelr.link/nceta is an internationally recognised research centre and workforce development resources for the alcohol and other drug field.

Professionals or specialists

Consult with other professionals or specialists about issues you are unsure about or if a person presents with issues you have not encountered before. This may be a presentation of co-occurring substance use issues and mental illness, a poly-drug use presentation that is unusual, or medical complexities that require further consultation and clarification.

There are a number of ways you might be able to consult with professionals and specialists to gain further information or insight about a person's presentation. Here is some more information.

Health professionals involved in the person's care

- With the person's consent, contact any other health professionals that are involved in their care; for example, the person's psychiatrist, mental health case manager or GP. Health professionals who have already worked with the person may have valuable information and be familiar with the person's history and support needs.

Health professionals within your organisation

- You may work in an organisation where a range of health professionals also work and they may be able to provide you with the consultation and clarification that you need. Examples and mental health social workers, psychiatrists, addiction medicine specialists and nursing staff.

Existing networks

- Your team or organisation may have already established strong relationships with other sectors. For example, you might contact mental health services or a local GP practice that regularly provide secondary consultation with your team.

New networks

- Developing relationships and links with local specialists and health professionals is a great way to network with other services and seek out advice when you need. You could consult with other health professionals over the person's de-identified information to seek clarification about their presentation. De-identifying information ensures the person's privacy and confidentiality are not breached.

Local mental health services

- Your local mental health triage service may be able to provide non-urgent consultation about a person's presentation.

Clinical advisory hotlines

- Another helpful phone number for Victoria, Tasmania and the Northern Territory is the Drug and Alcohol Clinical Advisory Service (DACAS), a 24-hour, 7-days-a-week phone service run by Turning Point. DACAS provides clinical advice to health professionals who are seeking clarification and advice about the clinical management of people with alcohol and other drug issues. DACAS consultants are Addiction Medicine Specialists who will respond to your phone call within one hour for secondary consultation.

Example

Identify and consult with other professionals or specialists

National and state peak bodies are a great source of drug and alcohol news, new and emerging issues in the field and opportunities for workforce or professional development opportunities. Peak bodies relevant to AOD issues include the following:

- Victorian Alcohol and Drug Association (VAADA) – http://aspirelr.link/vaada
- Western Australian Network of Alcohol and Other Drug Agencies (WANADA) – http://aspirelr.link/wanada
- South Australian Network of Drug and Alcohol Services (SANDAS) – http://aspirelr.link/sandas
- Network of Alcohol and other Drugs Agencies (NADA - NSW) – http://aspirelr.link/nada
- Queensland Network of Alcohol and other Drug Agencies (QNADA) – http://aspirelr.link/qnada
- Alcohol, Tobacco and Other Drug Association ACT (ATODA) – http://aspirelr.link/atoda
- Alcohol Tobacco and Other Drugs Council Tasmania Inc. (ATDC) – http://aspirelr.link/atdc
- Northern Territory Council of Social Service (NTCOSS) – http://aspirelr.link/ntcoss
- Australian Injecting and Illicit Drug Users League (AIVL) - http://aspirelr.link/aivl

Practice task 4

1. Maryam has received a comprehensive assessment for Polly, who presents with a 15-year history of cannabis dependence and a co-occurring diagnosis of schizophrenia. Maryam will be working with Polly to develop and implement a treatment plan for treatment. Being new to the AOD field, Maryam has not previously worked with anyone with a diagnosis of schizophrenia. Suggest two things Maryam could do to increase her confidence in working with Polly.

2. When might an addiction medicine specialist (AMS) be a more suitable person to consult than a GP?

3. Spend some time looking at your state peak body website or, if you prefer, look at the peak peer body for Australia, the Australian Injecting and Illicit Drug Users League (http://aspirelr.link/aivl). List three articles, resources or links that you can read to increase your knowledge in a particular area. If there is a free mailing list or e-Newsletter available, take this opportunity to sign up.

Click to complete Practice task 4

1E Explain the purpose of the treatment plan and roles of different people

An AOD treatment plan is a comprehensive document that incorporates many aspects of a person's substance use goals in the context the drug and alcohol service system. A good treatment plan commences when a person first makes contact with a service and is continually reviewed and referred to until the point of discharge from the system. It includes a range of different tasks and processes including goal setting, referrals, other services involved, consent and confidentiality, case management and care coordination arrangements as well as feedback, monitoring and review mechanisms.

Treatment plans work most effectively when all parties are aware of the process and their role in the development and implementation of the plan. This includes you as the worker, the organisation you work for, other workers and services involved and, of course, the person themselves.

Be aware of key areas to develop a successful treatment plan:

- The role of each person in the plan
- Your own scope of practice
- Organisational policies, procedures and guidelines for treatment planning
- State and federal policies and strategic frameworks
- How the treatment plan fits within a solid evidence base and service system structure
- How to keep up-to-date with current industry practice
- Ethical practice, including human rights and anti-discrimination principles
- Issues regarding risk, duty of care and mandatory reporting
- Privacy and confidentiality and record-keeping requirements.

Plan and develop the treatment plan

Treatment plans may have commonalities but you should consult with your organisation's policies, procedures and guidelines on the specific requirements for treatment plans.

In the AOD field, every person receiving support services has an individualised treatment plan. The plan should contain agreed options as to the type of treatment and intervention to be offered to the person. These agreed options, particularly concerning the intervention strategies that may be contained in the treatment plan, are designed to meet agreed outcomes or goals. The treatment plan may include relevant information about the intervention from other community services via referral, doctors or other professional reports, or from the person's family or support network.

Treatment plan information

Treatment plans contain a range of treatment goals, all of which are devised in conjunction with the person. Plans use a biopsychosocial model, which aims to prevent and lessen health and wellbeing complications by providing the person with support from a team of appropriate specialists.

Treatment plans are negotiated with each person. The person's involvement and decision-making is actively encouraged; however, the important consideration of a person's ambivalence is not often reflected in the treatment plan. At certain stages, the person may have an awareness of the need for change, as reflected in the treatment plan, but the person may not yet be ready to invest time, money or energy into the process.

The treatment plan may include information regarding detoxification. There may be notes in the plan concerning contact information and policies of nearby treatment centres as well as an overview of their programs and details of how the centres proceed with detoxification.

The treatment plan includes valuable information, such as the points listed below.

Valuable information contained in the treatment plan

- Materials regarding safe housing (such as supporting accommodation) or similar places once in-patient treatment has been completed, if applicable
- Information regarding the location, rules and other important details of facilities may have been gathered and outlined in the treatment plan or notes related to the plan
- Names and telephone numbers of various relevant counsellors for referral during the recovery journey
- Relevant programs or other recovering AOD support meetings.(consider the individual's preferences, such as people preferring support programs directly tied into their faith)
- How family and friends can aid in the person's recovery and the people that the person should avoid interacting with, such as heavy drinkers or drug users
- Notes about monitoring the person's progress, such as mutual decisions on how often and at what stages check-ups will be made and in what manner

Roles of people in the process

The development of a treatment plan is a collaborative process between the worker and the person. Other workers within the organisation or external agencies may be involved in the development and implementation of the treatment plan, and clarify the roles, rights and responsibilities of all parties contributing to the plan.

As an AOD worker, you must have a clear understanding of your role, responsibilities, level of authority and how to work as a team member. You have a duty of care to work in an ethical way and to follow your employer's policies and procedures. This helps you provide effective services in accordance with your organisation's charter or service delivery goals.

Understand the obligations of your role

You must have a clear understanding of the legal framework relevant to your work role. This knowledge helps you to work safely in an AOD environment while supporting people's rights.

Your responsibilities are documented in your job role or position description, which is provided when you are first employed. This document outlines the role, the duties and the line of reporting for your position. It briefly describes what the organisation expects from you and how this links to the organisation's goals and objectives. It also describes the interrelationships with other people or departments and the resources, training and experience necessary to carry out your job role. As an employee, you are accountable to your employer for the duties outlined in your position description.

You may find that you are faced with situations that you do not have the experience or training to cope with. In these circumstances, you should remain calm and ask for help. Recognise your own limitations and do not feel ashamed about having to ask for help. Your supervisor and organisation would expect that you ask for help as this is a responsible action. You can use these experiences to learn more about your job and identify areas where you need additional training and support. You can also refer to relevant written documentation to guide you in clarifying and understanding the obligations, scope and limitations of your role. Examples of these documents are outlined below.

Position description

- Your position description outlines the tasks you are expected to carry out as part of your job. You must make sure that you work within these boundaries and do not take on tasks that are assigned to other workers or that are outside the scope of your role.

Organisational policies and procedures

- Each organisation has policies and procedures that:
  - outline the types of services on offer
  - specify how these services are delivered
  - indicate what people are eligible to receive services.
- You have a responsibility to follow organisational guidelines when providing services. This means that you may need to seek assistance from other people both within and outside of the organisation. Sometimes, you may need to refer individuals to other services.

Relevant codes of ethics or conduct

- Relevant codes of ethics or conduct provide guidelines about professional practice and ethical behaviour. Know how the standard of conduct and ethics applies to the work that you do and how they relate to individuals and relevant parties.

Your training and qualifications

- The training you undertake equips you to work in a particular role and at a specific level. Over time, you will gain experience and knowledge and may take on positions of greater responsibility, but you should always take care that you do not perform tasks that you are not trained or qualified to do.

Rights of AOD workers

Workers employed to provide support services in community services, including AOD settings, have rights and responsibilities.

Here is a list of employee rights and how you can uphold the rights of your co-workers.

Employees' rights	How to respect employees' rights
A safe workplace	Carry out your work in a positive and courteous manner.
A workplace free from harassment and discrimination	Adhere to organisational policies and procedures.
Access to a grievance (complaint) process	Contribute to the work of the team.
Wages in accordance with the award rates	Offer help when needed.
A clearly defined job role	Only undertake tasks that you are qualified to do or that are part of your job description.
Warnings about unsatisfactory work so as to avoid unfair dismissal	Take responsibility for your own work and actions, seek advice when necessary and show initiative in the way you conduct yourself.
Clear directions and training	Carry out your work in a positive and courteous manner.

Rights of individuals receiving support services

Individuals use your service because they have a need and your job is to help them meet their needs and, in doing so, respect their rights as individuals. Individual needs must be assessed in consultation with other relevant stakeholders such as family members and professional workers involved with the person. Each AOD service organisation must provide individuals with a statement of their rights and responsibilities when they join a service. You should ensure that you understand the person's rights and responsibilities and support them to exercise their rights.

The following outlines the individual's rights and how you can uphold their rights.

Individual's rights	How to respect the individual's rights
▶ To be treated with respect and dignity ▶ To have their personal information maintained in a confidential and secure manner ▶ To receive effective, quality services in a safe environment ▶ To be able to access services that are equitable and free from discrimination ▶ To have their individual needs addressed including social, cultural and other issues such as mental health or disability taken into consideration ▶ To be fully informed of the available services and be provided with options ▶ To participate in making decisions that affect them ▶ To be informed about the process for making complaints and to be assisted in this process if necessary ▶ To use the services of an advocate if necessary	▶ Maintain and respect the independence, privacy and dignity of the person. ▶ Provide quality services. ▶ Deliver services to the person in a safe manner. ▶ Respond to the diverse social, cultural and physical experiences and needs of the person. ▶ Inform individuals about available services and options. ▶ Inform individuals about their right to make complaints and use advocacy services. ▶ Inform individuals about their responsibilities as a service user.

Legislation, policies, procedures and guidelines for individual treatment plans

Treatment planning is a key task in the AOD field, and as with all other clinical components of AOD work, workers must take into account the legal and ethical obligations of the sector and how they are to be applied to each task. You need to be familiar with and understand how legislation, industry standards, codes of conduct and organisational policies and procedures must be applied in your day-to-day duties. Organisations develop policies and procedures that are based on the laws relevant to their work. Everyone working in the AOD field must comply with the legal requirements and policies of their organisation.

AOD and other community services workers need to have a thorough understanding about laws relating to drugs in their state as well as laws that relate to community work in general, such as privacy and anti-discrimination. This knowledge helps them to perform their role within legal and ethical boundaries.

Federal legislation underpins work in the sector Australia-wide, while state legislation can mean agencies are bound by different laws depending on where they are located.

Commonwealth legislation relevant to AOD work

- *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (Cth)
- *Privacy Act 1988* (Cth)
- *Work Health and Safety Act 2011* (Cth)
- *Customs Act 1901* (Cth)
- *Freedom Of Information Act 1982* (Cth)
- *Age Discrimination Act 2004* (Cth)
- *Disability Discrimination Act 1992* (Cth)
- *Sex Discrimination Act 1984* (Cth)
- *Racial Discrimination Act 1975* (Cth)

Federal versus state legislation

The federal and state governments have a range of laws that regulate drug use and supply. The *Customs Act 1901* (Cth) is the principle Act covering the trafficking, exporting and importing of drugs.

Drug laws in Australia distinguish between those who use drugs and those who supply or traffic drugs. Courts impose penalties including heavy fines and prison sentences, for anyone found guilty of supplying or dealing in illegal drugs and sentences reflect the degree of harm a particular drug may cause. People dealing in heroin are likely to be dealt with more harshly than someone dealing in marijuana.

Along with federal or Commonwealth laws, you should also be familiar with drug-related laws that vary from state to state. For example, Victoria has the *Drugs, Poisons and Controlled Substances Act 1981* (Vic.). To find the relevant laws for your state or territory, check your state government legislation page or refer to a legal information resource such as AustLII (Australasian Legal Information Institute) at: http://aspirelr.link/austlii.

Each state and/or territory has laws governing:

- drug distribution
- drug possession
- drug manufacture
- drug advertising
- drug consumption or use.

Policy frameworks

Ensure the work you complete individually and within your organisation is in line with the state and federal directions for drug and alcohol issues and treatment. To do this effectively, you need to understand the range of policy frameworks and strategies that underpin the current climate.

The Australian Government's policy directives regarding legal and illegal drugs are part of the National Drug Strategy 2017–2026. Each state and territory government also has a drug strategy.

Information on the National Drug Strategy is available at: http://aspirelr.link/national-drug-strategy.

Policy frameworks: harm minimisation

All of the strategies within the National Drug Strategy 2017–2026 are based on the harm minimisation approach, which has been the leading approach in Australia since 1985.

There are three main harm minimisation policy and program areas as outlined below.

Focus of harm minimisation policies
Supply reduction Use of law enforcement strategies to reduce or disrupt the supply of illicit drugs
Demand reduction Use of strategies to reduce demand for and prevent the uptake of harmful drugs
Harm reduction Use of strategies to reduce drug-related harm for individuals and communities

Organisational policies and procedures

Every AOD organisation is going to place a different level of importance on treatment planning. A best practice approach to treatment planning is one that is supportive at every level of the organisation. All AOD agencies commonly support a person-centred model of care. Part of this model includes ensuring individuals are able and encouraged to determine their goals and contribute to the development of a treatment plan.

Unlike an Act of legislation, which is written into the law, a policy is developed by the organisation itself, and outlines their own particular requirements, processes and rules in keeping with legislation. Policies can take the form of practical guidelines for ensuring that the legislation is followed. Like an Act, a policy must always be followed carefully and exactly. They can include processes that your own organisation feels is the safest way to follow these laws, given its own unique differences, such as staffing, resources, forms for reporting and recording, and the setting, such as home or residential support.

While it is not expected that you read every Act of legislation relating to your job role, it is very important that you read and are familiar with your organisation's policies. In most cases, following policy means that you are also following the law. Policies and procedures may be accessed via a printed copy, such as a policy folder, or online, such as via the organisation's intranet. If you can't locate the policies, ask someone to show you where they are kept.

Work health and safety

On 1 January 2012, the *Work Health and Safety Act 2011* (Cth) came into effect, replacing the *Occupational Health and Safety Act 1991* (Cth). This model legislation was developed by the Commonwealth government to harmonise work health and safety laws across Australia.

The object of the harmonisation of work health and safety laws, according to the Explanatory Memorandum – Model Work Health and Safety Bill (Safe Work Australia, 2010) is to:

- protect the health and safety of workers
- improve safety outcomes in workplaces
- reduce compliance costs for business
- improve efficiency for regulatory agencies

The Commonwealth health and safety regulator is Comcare, which can be accessed at: http://aspirelr.link/comcare.

Region	Health and safety legislation	WHS regulator
Commonwealth	*Work Health and Safety Act 2011* (Cth)	Comcare: http://aspirelr.link/comcare
Australian Capital Territory	*Work Health and Safety Act 2011* (ACT)	WorkSafe ACT: http://aspirelr.link/worksafe-act
New South Wales	*Work Health and Safety Act 2011* (NSW)	SafeWork NSW: http://aspirelr.link/safework-nsw
Northern Territory	*Work Health and Safety Act 2011* (NT)	NT WorkSafe: http://aspirelr.link/worksafe-nt
Queensland	*Work Health and Safety Act 2011* (Qld)	Workplace Health and Safety Queensland: http://aspirelr.link/worksafe-qld
South Australia	*Work Health and Safety Act 2012* (SA)	SafeWork SA: http://aspirelr.link/safework-sa
Tasmania	*Work Health and Safety Act 2012* (Tas.)	WorkSafe Tasmania: http://aspirelr.link/worksafe-tas
Victoria	*Occupational Health and Safety Act 2004* (Vic)	WorkSafe Victoria: https://aspirelr.link/worksafe-vic
Western Australia	*Occupational Safety and Health Act 1984 (WA)*	WorkSafe WA: http://aspirelr.link/worksafe-wa

WHS in an AOD work setting

AOD workers have a responsibility to be aware of their organisation's work health and safety (WHS) and emergency procedures to maintain their own safety and that of individuals and co-workers.

Work health and safety legislation and community services standards require employers to provide a safe work environment. However, everyone in a workplace is responsible for their own safety and the safety of others. You have a duty of care to protect the safety and wellbeing of individuals and take reasonable steps to provide a proper standard of service, taking into account their medical, ethical, religious and social needs.

People working in the AOD sector must know how to manage difficult or challenging behaviours and how to protect their personal safety and the safety of others.

AOD workers may often find themselves in situations that may result in a risk to their own safety because of the individuals they provide support services to.

Risks may arise from:

- individuals who are intoxicated by drugs and/or alcohol
- individuals who have a co-existing serious mental illness.

These individuals may display aggressive and threatening behaviour due to intoxication or because they are experiencing the symptoms of acute mental illness, including delusions and hallucinations.

Intoxication happens when a person is under the influence of one or more drugs. Intoxication affects a person's ability to make decisions, to be rational, to think clearly, to perceive events accurately and to control their emotions and impulses.

Keep safe

Whether a person is making threats because they are intoxicated or a person is behaving in an agitated or aggressive manner due to mental illness, the same principles apply to managing the situation. In both cases, the safety of yourself and others should be your primary concern.

Make sure that you know the signs and symptoms of intoxication and acute mental illness, the person's history and any mental health conditions they may have and your organisation's policies and procedures regarding challenging behaviour and intoxication.

You will need to document the incident in the person's case notes and may also be required to fill out an incident report. You should also be given the opportunity to debrief with a supervisor or counsellor to discuss any personal concerns or practical implications that have arisen as a result of the incident. Fears that an incident could have been prevented or that the action taken was inappropriate are frequently cited after such events and the availability of debriefing is important to ensure that such fears are addressed.

Understand and always follow your organisation's guidelines regarding managing aggressive and threatening behaviour. This will help you meet your duty-of-care obligations and to protect yourself. Here are some guidelines to keep in mind.

Basic safety guidelines

- Ensure your personal safety and the safety of others; ask others to leave the room, stay near an exit or put a barrier between yourself and the person threatening you.
- Call colleagues for assistance and, if necessary, call the ambulance, mental health service or police.
- Use the duress alarm if one is available and the situation warrants it.
- Try to calm the person by talking slowly and calmly.
- Ask the person what their needs are and how you can help them.

- Encourage the person to talk and listen respectfully.
- Find out what drugs, if any, the individual has taken, how much and how long ago.
- Ensure the person is in a low stimulus environment.
- Make sure you don't do anything to threaten or alarm the person.

Legal and ethical considerations and how these are applied in organisations and individual practice

The AOD sector is a demanding field of work where workers are confronted with a range of sensitive and complex issues. The person–worker relationship is a complex one that requires the worker to walk a fine line between offering support and maintaining the professional boundaries of the relationship. Having ethical guidelines in place helps workers to consider these issues and make informed decisions appropriate to their work role. Most ethical codes state that it is not appropriate for a worker to engage in a relationship with a person outside of the service, to give and receive gifts or favours, or to be involved in any activity that may cause harm to individuals.

Meeting the legal requirements of your position:

- Know and comply with the relevant legislation.
- Comply with organisational policies and procedures.
- Act in accordance with your organisation's code of ethics.
- Know the person's rights and always act in their best interests.
- Meet your duty of care; take reasonable care to ensure the safety of others.

Ethical considerations

Ethics are principles that guide your decisions and actions in a way that ensures you are safeguarding the rights and interests of the people in your care. Working in accordance with ethical principles and values requires workers to think carefully about how they should address their workplace and legal obligations, as well as the person's rights and needs.

Here are examples of some of the ethical issues workers may face in an AOD work setting.

Common ethical issues

- Working with people who are under the influence of drugs or alcohol and the consequences of their behaviour, such as abusing or threatening other people
- Dealing with interpersonal conflicts at work
- Balancing the rights of the individual with the rights of the community
- Working effectively with individuals who are involved in criminal activities, such as prostitution and theft, that may be in conflict with your own values
- Working with individuals who engage in risky behaviour such as intravenous drug use

Codes of conduct

A code of conduct is a set of rules that underpins the professional practice and provision of care. Most organisations have their own codes of conduct, and professions such as nursing, social work, psychology and counselling and also have professional codes of ethics. A code of conduct ensures that people working in a particular organisation or profession understand the ethical conduct and behaviour expected of them and have guidelines for making decisions about ethical issues in their work.

There is currently no overarching national Alcohol and Other Drug Workforce Code of Conduct but some states and many individual organisations have developed one for their workforce.

Codes of conduct help workers align their own values with professional practice. For example, a worker may not agree with a person's lifestyle but ethical practice requires that they adopt a non-judgmental stance in order to provide effective services for the person.

Codes of conduct provide a framework for practice and ethical decision-making. They cannot cover every situation a worker may face but they can provide general guidelines to support workers in making decisions and conducting themselves in a professional manner.

Below are some of the basic steps involved in making ethical decisions.

Basic steps in ethical decision-making:

- Practise self-reflection and discuss issues with supervisors and colleagues.
- Learn the principles of ethical decision-making.
- Define the issue and identify the ethical principles that apply to the situation.
- Get the facts and if necessary collect additional information in order to become fully informed about the issue being considered.
- Refer to your organisation's code of ethics and/or other standards that apply to the issue as well as relevant legislation, policies and practices including workers' duty of care.
- Consider who will be affected by the decision and identify any potential conflicts of interest.
- Consider all options and discuss these with the appropriate people.
- Think about how the decision can be justified; for example, is it made in the best interests of the person or is it the best decision that can be made with the available information?
- Make the decision after considering all relevant information.

Codes of practice

Codes of conduct paint a broad picture underpinned by a set of values that all AOD services uphold and feed in the continual process of ethical decision-making. Codes of practice are more specific guidelines on best practice in the clinical skills and components of drug and alcohol work. They generally set out in the form of clinical guidelines or treatment guidelines and are often written by government departments, peak bodies or developed by drug and alcohol agencies who have been funded for specific project work or who have a particularly interest and expertise. They are based on current evidence of best practice in the field. You may also be able to access hard copies of guidelines by consulting with colleagues, checking your agency's resources or contacting the organisation that first wrote them who may be able to post you a copy.

Practice standards

Practice standards are set out by government departments as part of their overall safety, quality and accreditation agenda. Practice standards are developed to ensure consistency across organisations in what they mean by 'counselling', 'residential withdrawal', 'case management' etc. It helps to ensure that the work that organisations are being funded to do is within the scope of the organisation and the individual employee. Practice standards help regulate the sector industry and this feeds down into worker's individual practices and day-to-day tasks. Ultimately, practices standards help to ensure that people receive a high-quality, professional evidence-based service regardless of where they live or which agency they attend.

Unlike other sectors, the drug and alcohol sector does not yet have national practice standards; however, at the time of writing, a national project led by Turning Point Alcohol and Drug Centre was underway called The AOD Quality Framework Project – the development of a quality framework for Australian Government funded drug and alcohol treatment services.

Below are a few state-specific examples of practice standards for the AOD sector, which can be accessed online:

- Western Australia: http://aspirelr.link/wanada-strategic-plan
- Victoria: http://aspirelr.link/aod-service-standards
- New South Wales: http://aspirelr.link/nada-policies

Human rights and discrimination

The term human rights covers a range of assumptions and values about the right of every individual to social, political, economic and cultural equity, justice and freedom. In terms of community services and AOD work, this means that every person has a right to health, a reasonable standard of living, and to be respected and valued as an individual.

Human rights are reflected in legislation and if you violate these rights you are breaking the law.

Everyone has the right to be treated with respect. Anti-discrimination legislation makes it illegal to treat people differently or unfairly based on their age, race, gender, sexual preference, marital status, physical or intellectual impairment. If you find that you have trouble working with a particular person, you should talk about it with your supervisor. It is also unethical to withhold an identified service from individuals.

For more information about Australia's position on human rights, see the Australian Human Rights Commission website at: http://aspirelr.link/human-rights-commission.

Australia supports a number of international human rights declarations and conventions including:

- the Universal Declaration of Human Rights
- the Convention on the Rights of the Child
- the Convention on the Rights of Persons with Disabilities.

Obtain informed consent

Informed consent ensures the person receives all the relevant information in a form that is most appropriate to them. A person's ability to make decisions may be impacted by temporary capacity issues, limited English, intellectual disability or pressure from family or others.

People should be supported to make decisions regarding the types of treatment and intervention they wish to participate in, within their capacity, and to review these decisions regularly. Where the person is unable to make a decision, a family member, guardian or significant other will be asked to make the decision. If no one is available, a public guardian may be appointed to this role.

All individuals have the right to be informed and make decisions about the services they receive. Informed consent means that a person is given relevant and sufficient information for them to make an informed decision about participating in the development of a treatment plan.

The person must have enough information to make an informed choice about contributing to proceeding with the treatment plan. Do not assume that you know what a person needs. Never begin a treatment plan without first providing the person with sufficient and relevant information or without first asking for the person's consent to proceed.

Obtaining informed consent involves:

- discussing all aspects of the treatment plan with the person
- listening to and respecting the person's wishes and opinions
- using effective communication skills.

Privacy, confidentiality and disclosure, including limitations

Privacy refers to a person's ability to control access of others to themselves, their space and their possessions, including information about themselves. Privacy also means taking steps to avoid embarrassment and humiliation. The way workers interact with people and manage confidential information can have a significant impact on a person's dignity, rights and choices, opportunities and access, self-concept, self-esteem and wellbeing. You need to respect and value the person's privacy.

Confidentiality is about data or information – not people – and refers to managing access to private information. Confidentiality provisions restrict an individual or organisation from using or disclosing information about a person that is outside of the scope for which the information was collected.

Confidentiality refers to both written and verbal information.

Written information	Verbal information
▶ Case notes and medical information	▶ Telephone calls
▶ Contact details of the person	▶ Meetings
▶ Incident reports and meeting minutes	▶ Consultations
▶ Letters, emails and faxes pertaining to the person	▶ Case conferences
▶ Treatment plans or goals and individual reviews	▶ Informal discussions
▶ Applications for funding, brokerage or programs referrals	

Protect the person's privacy and confidentiality

Individuals accessing AOD support services entrust a great deal of information to services and workers. In return, you must make every effort to ensure this trust is not misused in any way. Help protect the interests of individuals by not passing on information to people who are not entitled to it or discussing individuals outside of the work setting. Remember to file personal documents securely as soon as you have finished with them.

The person's right to confidentiality and privacy is one of the central values of all health and community services work. You must always respect and safeguard a person's personal information. There are some instances in which you are required to disclose information as part of your duties; for example, if the person is being referred to another service you may need to provide specific information. In this case, you must obtain written consent from the person to pass on their information.

Other exceptional times that you may be required to disclose private or confidential information may include:

- being compelled by law; for example, if the person has a reportable disease or a court order is presented
- a person's interests require disclosure; for example, they have threatened suicide or harm to another person
- a duty to the public; for example, there is public threat or concern.

Privacy and confidentiality policies and procedures

All community services organisations and government services must have privacy and/or confidentiality policies and procedures. Depending on the organisation, these policies and procedures must be based on either the *Privacy Act 1988* (Cth) or state and territory privacy laws. These laws contain directives about respecting the person's privacy and how information can be collected, stored and used. Your organisation will have policies and procedures in place regarding confidentiality and privacy and you have a legal and ethical obligation to understand and follow these at all times.

An organisation's privacy statements must contain information about how the service manages personal information. Services must explain how information is used.

Services must specify:

- the type of personal information that is collected and held
- why the information is needed
- how the information is collected
- how the information will be used
- how it can be disclosed
- who can access the information.

Duty of care

When involved in any stage of supporting a person with AOD issues in a professional capacity, duty of care is extremely important. Duty of care is the legal requirement of employers, employees and others to follow safe and healthy work practices at all times. A duty of care exists when someone's actions or failure to carry out an action could be expected to negatively affect another person. You are required to use your professional judgment and experience when making decisions about the most reasonable action to be taken in certain situations.

Here are things to consider and ways in which to fulfil your duty of care.

Factors to consider

- The risk of harm and the likelihood of the risk occurring
- The type and degree of harm that may occur
- The precautions that could be taken
- The professional standards and legislation regarding the issue
- The policies and procedures of the organisation

Fulfil your duty of care

- Adhere to all reasonable directions given by your employer.
- Act in a way that a reasonable person in your position would be expected to act.
- Avoid misusing equipment or substances.
- Manage safety risks within the service.
- Adhere to your duties as outlined in your job description.
- Write up all necessary records and documentation promptly and accurately.
- Be aware of the person's rights and make sure the person also knows their rights.
- Use your common sense.

Duty of care breaches

The standard expected of you is the standard a reasonable person would provide when working in the AOD or community services sector. For example, you are breaching your duty of care if you do something that a reasonable person would not have done in a similar situation. Coordinators and managers have a special duty of care to make sure that others in their team are trained and understand their own duty-of-care obligations.

As an AOD worker, it is your legal responsibility to take reasonable care and provide the correct standard of service to all individuals, taking into account their various needs.

If you breach your duty of care, you could be charged with negligence and you may need to compensate the person for any damages they suffered as a result of your actions or inactions. Generally, the employer is held responsible for staff negligence but this does not exclude individuals from liability. It is simply an acknowledgment that employers have some responsibility for the action of their employees.

A negligence action must demonstrate:

- you had an obligation to provide care to a particular standard for a person
- the harm or injury was caused, either directly or indirectly, by the breach of duty of care (that is, if it were not for carelessness, the damage would not have occurred)
- the person experienced actual harm or injury
- the harm was reasonably foreseeable in the circumstances.

Dignity of risk

There are inherent risks that are associated with alcohol and drug use. No drug use is completely safe and there will always be risks to consider when assessing a person who uses substances and supporting them to make a change. For someone to move forward and make changes it means they may need to take some risks. A balance must always be made between duty of care and allowing the dignity of risk. The concept of 'dignity of risk' allows the person the right to self-determination and personal choice about their care and taking steps in which there may be calculated risk. People have the right to make their own choices about their life, even if workers believe the choices may increase the risk of that person's health or wellbeing. You need to allow the person to make decisions based on what works for them, their priorities and their level of tolerance.

Determining the difference between duty of care and dignity of risk comes with consultation from colleagues, experience in the field and a solid grounding in person-centred care. Ask colleagues and supervisors and assess each situation as it arises.

Here are some examples.

Examples of dignity of risk
Ensure people who inject drugs know where needle syringe programs are to collect injecting equipment; this reduces risks of bloodborne viruses and vein damage
A person choosing to address their methamphetamine use and seeking to abstain from it, but choosing to continue using cannabis
A person setting a goal for controlled drinking when their level of dependence would suggest that abstinence would be a safer option

Children in the workplace

Children of individuals who are using substances and attending a drug and alcohol service must always be taken into consideration whether or not they are present with the worker. There may be circumstances in which a worker has direct contact with children of people who use substances; an infant or toddler may attend an assessment or appointment with the parent, children may be present at an outreach or home visit to the person's house. You may come into contact with children if you work in a residential facility where children are welcome to either visit or stay with their parents during their admission. It is good practice not to discuss traumatic issues or matters of a sensitive nature with a young child present.

More likely, a worker will not have direct contact with a person's children. Information may come from a range of different sources and mediums about the person's children. This may come in the form of phone calls from protective services or other services, information specifically volunteered by the person about the children, or secondary information that you may need to gather based on what you already know and what gaps you may need to fill in.

Be alert to any concerns that you hear or become aware of when working with an individual regarding the welfare of their child. Be supportive of the person and remain of a viewpoint that 'substance use does not make you a bad parent'. Report any concerns you have regarding a child's safety to your supervisor for discussion and action if necessary.

Mandatory reporting

In some Australian states and territories it is mandatory for an AOD worker to report actual or suspected physical or sexual child abuse to the police or government authorities. In these situations, the AOD worker has a legal obligation.

Legislation is being reviewed regularly, with significant changes still to take place as a result of recent Royal Commission proceeding in 2015. For example, in 2015 the Failure to Disclose offence was introduced into Victorian legislation as an amendment to the *Victorian Crimes Act 1958* (Vic). This imposes a legal obligation for all adults to report to Victoria Police any reasonable belief that child under the age of 16 is victim of a sexual offence perpetrated by an adult. Failure to disclose the information to police is now a criminal offence with very few exceptions.

Some councils and community organisations provide assistance with crisis intervention, such as emergency accommodation, crisis counselling, self-help groups and legal support for families at risk of domestic violence. Telephone helplines can also be of assistance to you and the individual if you are unsure how to proceed in a situation of risk. These services can provide advice, counselling and information about assistance in your local area. Concerns can be raised by contacting the appropriate authority in your state or territory.

For further information on your mandatory reporting requirements, visit the Child Family Community Australia website at: http://aspirelr.link/mandatory-reporting-child-abuse.

Records management

Most organisations have their own procedures for writing up treatment plans, case notes or documenting information about individuals receiving support services.

Here are some of the general principles of documenting people's information.

Accuracy and clarity

Records must be accurate and written in a way that can be clearly understood by others. Always check what you have written to make sure it is clear and that the report includes your name, signature, and the date and time you wrote it.

Objectivity

Write only facts about what you see, hear and do. Avoid personal opinions and feelings, and illustrate your points with factual descriptions of behaviour. If you do not have all the facts about a situation, make sure that you make this clear and do not infer that you know more than you do. If you are reporting what someone else has said, use direct quotes as much as possible.

Language

Use bias-free language and a neutral tone as far as possible. Avoid using clichéd or emotive language and slang. Remember that the person may read your report.

Completeness

Reports should contain relevant information. This may include both positive and negative information and include notes about behavioural changes or observed indicators of risk.

Timeliness

You should write your reports as soon as possible after contact with the person to ensure accuracy and to make sure the person's records are kept as up to date as possible.

Alterations

Any alterations made to your records should be done neatly and initialled. Never change what someone else has written.

Privacy

Make sure completed documents are filed appropriately, such as in a locked filing cabinet or a password-protected file.

Example

Explain the purpose of the treatment plan and roles of different people

The Department of Health Victoria has developed the Victorian AOD Client Charter (2011), an excellent example of a charter that is underpinned by the Victoria Charter of Human Rights. This document covers rights and responsibilities of people receiving support services and employees, discrimination, privacy and confidentiality, disclosure, duty of care, codes of conduct, practice standards and workplace health and safety.

Here are some examples.

Service user rights

As a person using Victorian AOD services, you have the right to:

- be provided a service in a safe environment
- be provided a service in a fair, honest, non-judgmental manner
- be provided a service that is friendly and respectful
- be given adequate information on all available services/treatments
- participate in all aspects of service provision
- have information about you kept confidential unless disclosure is otherwise authorised
- be provided with a timely and effective service that responds to your needs
- make a complaint and have that complaint addressed efficiently
- be provided culturally sensitive services that take into account your values and beliefs.

Service user responsibilities

As a person using Victorian AOD services, you have the responsibility to:

- be familiar with your rights and responsibilities as a person using Victorian AOD services
- contribute to maintaining a safe environment in the service you use
- treat others with respect and courtesy
- participate in the treatment process to the best of your ability
- follow the organisational complaints process; if you are not satisfied you can make an external complaint to the Department of Health or the Health Services Commissioner.

Agency responsibilities

The responsibilities of agencies providing AOD services in Victoria are to:

- treat individuals with respect, dignity and courtesy
- provide an accessible service that takes into account individual and cultural diversity
- plan and develop treatment plans and strategies in collaboration with individuals
- achieve and maintain appropriate standards of proficiency and participate in ongoing professional review and development
- provide services in a safe environment and ensure that duty of care is maintained
- ensure the person's information is kept confidential unless disclosure is otherwise authorised
- provide adequate information to individuals about organisational and independent complaints processes
- adhere to relevant professional and AOD codes of conduct and ethics
- comply with the Victorian Charter of Human Rights.

Link to the charter

Victorian alcohol and other drug client charter resource
You can find an online and PDF copy of the Victorian alcohol and other drug client charter at: http://aspirelr.link/aod-vic.

Practice task 5

1. The National Drug Strategy has an overall philosophy of harm minimisation. Three key categories within harm minimisation are supply reduction, demand reduction and harm reduction. List one strategy for each category.

2. In your own words, describe the term ‘dignity of risk’.

3. List two reasons why such high importance is placed on documentation.

Click to complete Practice task 5

1F Consult the person about readiness to develop the treatment plan

Individuals who attend your service do so for a number of reasons. They may have been required to seek help as part of a court order, or there may be pressure from loved ones to address their substance misuse. There may be financial, social or heath pressure that motivates a person to seek help. These reasons do not always indicate that the person is ready to undergo the demands of intensive treatment or get by without using their substance of choice. Gain an understanding of the individual's readiness to develop a treatment plan. A variety of means to gain this understanding can be used; listening for phrases or language from the person that suggest their readiness to change, interpreting information from the assessment completed and using a person-centred approach to communication.

Check that the person is ready to develop a treatment plan

Encouraging the person to participate in treatment programs and other forms of support can be challenging, particularly for a person whose lifestyle is centred on their drug use.

Understanding the demotivating factors in the person's life can assist you to determine approaches that provide valid and attractive reasons for seeking support.

The person's ambivalence toward change can be related to many different issues, as listed below.

Factors that may affect a person's ambivalence
▶ Fear of losing social groups
▶ Lack of family and peer support
▶ Concern about how they will cope physically and emotionally without the drug
▶ Lack of confidence in their ability to change, often brought on by strong, deep-seated feelings of failure and self-doubt
▶ Ambivalence about their physical and mental health
▶ Dread of the symptoms of withdrawal
▶ Previous unsuccessful attempts

A person-centred approach to treatment planning

A person-centred or client-centred approach proposes that the person is the expert of his or her own experience. It suggests a treatment plan will be more successful if it considers the person as an individual, rather than just another person with an AOD dependency issue. It recognises that it is the person's needs that should determine the kind of support they require. Using this approach requires you to listen carefully and take the person's level of motivation, opinions and preferences into account while you ask questions and provide information.

The person-centred approach underpins a technique called motivational interviewing, in which the conversation is directed to exploring changing behaviours. It uses open questions, affirmations, reflections and summaries to prompt the person to talk about their drug use, and can be very effective with AOD-dependent individuals.

Encourage the person to share questions or concerns that they might have about the development of the treatment plan. If you sense that the person might be holding back negative feelings about seeking treatment or following up on a goal or task that has been added to their plan, you can often discover the reasons for this by asking open questions and encouraging an honest response.

Variables to inform the treatment plan goals

Service providers must consider a range of personal variables when deciding on developing an appropriate treatment plan. Personal variables relate to the person's individual needs and differences. Variables range from the severity of the person's addiction, to personal circumstances such as those related to housing, physical and mental health, financial and legal issues and the availability of social support. They also relate to the person's motivation for starting treatment and their ability to set goals for what they want to achieve.

Referring to the assessment and discussions with the person will provide a clear picture of what the person's individual needs and circumstances are. The person's own preferences should always be taken into account. Some people may be reluctant to engage in longer-term treatment or interventions while others will identify a need for a multifaceted approach to their treatment.

An assessment of the person's needs should pinpoint individual variables.

Assessment should identify individual variables such as:

- History of AOD use including the types of drugs used, patterns and circumstances of use and the degree of dependence
- History of attempts to cease drug use and/or withdrawal attempts and the severity of symptoms experienced
- History of treatments and treatment settings, including which had the least success and which the most
- Level of motivation
- Barriers that may impinge on successful treatment such as an unsupportive social environment
- Mental health status, including any co-existing conditions
- Social support network
- Personal circumstances such as the person's employment, housing, financial and legal situation.

Case management/care coordination

Case management involves service coordination for individuals with complex needs, including AOD dependence. Case managers work to identify the individual's needs and coordinate services and resources to meet those needs.

The purpose of case management is to improve coordination and continuity of services for people. For example, if a person has a dual diagnosis of substance misuse and a mental health condition, the case manager will coordinate the provision of services in both areas and may also provide some direct individual service delivery, such as counselling.

Activities involved in case management:

- Counselling and other direct service activities
- Assessing, planning and reviewing progress
- Coordinating service delivery for individuals across a range of services

Interventions

An intervention is a purposeful activity designed to prevent, reduce or eliminate AOD use at an individual, family, peer, community or societal level. This can range from interventions that target the individual, such as an informal chat between a youth worker and a young person about smoking, to strategies that target the whole population; for example, a change in state legislation to reduce the availability of alcohol. Interventions may be short-term and brief or longer-term.

Brief treatments and interventions

- Brief interventions are provided in between one to four sessions of between five and 30 minutes, usually in an opportunistic fashion where the person has not sought out treatment but an issue has been identified during screening. Brief interventions may also take place throughout and at the completion of the assessment if a person has not identified goals for further treatment or is pre-contemplative about making a change to their substance misuse.
- Evidence-based research has found that motivational interviewing techniques make this a very effective method of instigating behavioural change. Use this technique in a manner that is supportive and non-judgmental of the person or their choices.

Longer-term treatment and interventions

- When developing a treatment plan, assessing a person's motivation and capacity to make changes will determine the types of treatment and interventions that are discussed and goals that are set. An individual may only require one or two types of treatment to support their goals while others may find a multifaceted approach is going to give them the best chance to make sustainable change.
- Some interventions will run concurrently to each while others may not commence until another treatment or intervention has been completed.

Counselling

Counselling is usually focused on empowering the person to make decisions about their drug-using behaviour and to understand the harm associated with their AOD use. Counselling can take place in a clinic or out-patient setting, as part of a residential treatment program or in other settings including over the phone, online and in an outreach setting.

Here are several methods of counselling that you may recommend to a person.

Motivational interviewing

- Motivational interviewing focuses on increasing the person's motivation to change, even if they have not yet made a decision to change, or are not sure that they can or want to change their drug use. The technique uses open questions, affirmations, reflections and summaries to encourage the individual to explore their reasons for drug use and reasons for changing it. It accepts that ambivalence is a normal part of changing any entrenched behaviour and works with the person at their current stage to explore their impediments to change.

Intensive counselling

- The aim of intensive counselling is to support and assist the person to achieve their goals, often of changing behaviour. In these types of sessions, the therapist will work with the person to improve awareness of their thinking, feelings and behaviour, and to develop alternate coping strategies for difficult situations.
- Cognitive behaviour therapy is an example of intensive counselling and is provided by professionals such as psychologists, counsellors and AOD workers with training. For example, a person identifies a behaviour they want to change, such as managing their anger or reducing drinking. The counsellor will ask them to identify what they were thinking about the last time they got angry or were drinking too much. They will explore the person's beliefs, values and thought processes. Then, they will ask the person how they were feeling during this episode and identify those emotions. Next, they will detail the actions taken in a step-by-step way, so the incident is broken down into components and the ones that showed some dysfunction are isolated and focused on. Strategies are then developed on how to handle the unhelpful thoughts, feelings and behaviours. The person is encouraged to monitor these and report on their implementation of alternate coping strategies.
- Other examples such as intensive counselling programs Acceptance and Commitment Therapy, mindfulness-based therapies, narrative therapy and solution-focused therapy are used. Single session family work or family therapy may also be utilised to focus on the person's relationships and family, with the understanding that empowering and involving other significant people in the person's life can have an effect on the person's drug use.

Relapse prevention

- Relapse prevention counselling involves developing strategies to help maintain abstinence or reduce drug-using behaviours following the withdrawal period. Individuals are provided with instruction and rehearsal of strategies for coping with relapse, for dealing with cravings and thoughts about the drug, and managing lapses and relapses.
- Relapse prevention encourages the person to recognise high-risk situations and provide strategies for coping in these situations. High-risk situations may include:
  - participating in events or attending parties where people are likely to drink heavily
  - being with friends in familiar drug-using environments
  - times of stress, such as arguments with family members
  - payday or the payment of pensions or allowances (when the person has money to spend)
  - worsening symptoms of health issues or recognising early warning signs of exacerbations in mental illness.
- Individuals might be assisted to develop relapse prevention plans, identifying the behaviours they intend to use when faced with situations that could trigger relapse. Back-up support, such as phone calls or visits from AOD workers, is important.

Self-help programs

Self-help approaches vary in structure, but usually focus on the person taking responsibility for their own treatment. Other self-help options also include books, videos, telephone counselling and online support. Self-help options are commonly included in a treatment plan alongside other forms of treatment but may also be used as a stand-alone option for people who are highly motivated or don't require more intensive treatment.

Self-help groups are managed and run by peers with lived experience of the issues being discussed in the group; either as a person with AOD issues or as family members and loved ones of people with AOD issues. They encourage members to understand and support each other. Self-help meetings are free and held in public venues in metropolitan and rural areas.

Self-help or peer support programs available in Australia include the following:

- Alcoholics Anonymous
- Narcotics Anonymous
- Crystal Meth Anonymous
- Family Drug Support
- Gamblers Anonymous
- SMART – Self Management and Recovery Training

Pharmacotherapies

Pharmacotherapies are a treatment option for drug-dependent individuals, particularly those dependent on opioids or alcohol. They use a range of prescription drugs to assist people in withdrawal programs to obtain some control over their drug use, and are usually recommended in combination with counselling and other support services.

The prescription drugs used for this purpose include methadone, buprenorphine and naltrexone for opioid dependence, and acamprosate (a medicine believed to help restore chemical balance in the brain) for alcohol dependence. Another example of a pharmacotherapy more widely used is nicotine patches for smokers wishing to quit.

There are no pharmacotherapies for other types of drugs, but research is being carried out to support individuals aiming to control dependence on other drug types. The main objectives of pharmacotherapy treatment are listed below.

Objectives of pharmacotherapy treatment

- Bring to an end or significantly reduce an individual's illicit opioid use.
- Reduce the risk of overdose.
- Reduce the transmission of bloodborne diseases.
- Improve general health and social functioning, including a reduction in crime.

Detoxification or withdrawal programs

The goal of withdrawal programs is to address the biopsychosocial elements of withdrawal. These may include pharmacotherapy reduction or maintenance, and management of concurrent illnesses and psychological, social and emotional issues.

Individuals in withdrawal programs are offered support and counselling to encourage them through the difficult symptoms, and to motivate them to continue changing their drug-using behaviour. They should also be given a clear plan for the provision of further support or intervention once the withdrawal program is finished.

Medications provided to individuals on different types of withdrawal programs can have a number of aims. Some common locations for detoxification or withdrawal programs include the following.

Detoxification program locations

- Residential or in-patient withdrawal, where the person is cared for within the service for the duration of the program
- Out-patient withdrawal, where the person attends a clinic each day, collects medication and is counselled about their progress
- Home-based withdrawal, where a nurse or counsellor attends the person's home each day

Medication aims

- Helping them to relax and sleep
- Reducing the risk of seizures and other serious effects of withdrawal
- Reducing other symptoms, such as diarrhoea and nausea
- Mimicking the drug so that withdrawal is slower and less severe
- Provoking a more severe but faster withdrawal

Residential and supported accommodation

Residential rehabilitation and supported accommodation services provide support to people withdrawing from alcohol and other drug dependence in a supervised but 'home-like' residential or hospital facility within the community. This may be a short-term or long-term stay depending on the person's needs.

Residential rehabilitation

- Residential rehabilitation usually occurs in a community setting with supervised medical care. This type of service is most useful for people who have tried other drug or alcohol programs without success. Programs may last for several months and provide a range of interventions, such as group and peer therapy, counselling and other behaviour- change strategies designed to promote lasting change.

Supported accommodation

- This type of program aims to provide individuals who have completed withdrawal or a rehabilitation program with safe accommodation in the community. Often residents are required to take part in self-help groups and maintain links with support workers from the service providing accommodation or their AOD workers. This allows them the opportunity to maintain stable accommodation while accessing employment, educational, recreational and other support services to enable a change in lifestyle. These programs require abstinence and will have different policies on how to handle relapse.

Example

Consult the person about readiness to develop treatment plan

James is a 44-year-old man with a 15-year history of daily alcohol use (a six pack of beer every day). Up until recently his alcohol use had not been of great concern; however, he was admitted to hospital three weeks ago with acute pancreatitis. After his stay in hospital for four days, he was advised not to drink anymore. After two days back at home, James found he experienced strong cravings and started drinking again. James has realised that his alcohol use is more of an issue than he first thought.

James attends an appointment at his local drug and alcohol agency. A comprehensive assessment is completed by Heather, who gives James some initial feedback about his pattern of alcohol use and how this may have affected his body over many years. James admits the idea of abstinence feels 'too hard' at the moment due to alcohol playing a large role in his social life at the football club, where his family and friends all drink heavily. James also uses alcohol as a way to wind down after a stressful day at work. James is becoming more aware of the implications that drinking will have on his health.

Heather suggests that drug and alcohol treatment is not just for people who want to abstain altogether and there might be some goals they could set around reducing his use and minimising the risks. Together, James and Heather start developing his treatment plan. James says he has found it helpful speaking with Heather as a way to 'get things off his chest'. He would like to see a counsellor to explore his alcohol use further and clarify his decision to cut down or stop completely. Heather suggests counselling with a focus on motivational interviewing as well as stress management/relaxation. James also thinks that attending a peer support group would be helpful, although he does not feel Alcoholic Anonymous will be a good fit for him. A SMART Recovery group is suggested and James plans to attend next Tuesday evening.

Practice task 6

1. In what circumstances might a brief intervention be completed with a person before they complete a drug and alcohol assessment? List two examples.

2. In your own words, describe the principles of person-centred communication.

3. Research online where your closest Alcoholics Anonymous (AA) meeting is held. How many kilometres is it from your house?

Click to complete Practice task 6

Summary

1. Information about a person forms the basis of assessment. The interpretation of the assessment helps with the treatment planning process.
2. Treatment plans need to be developed in accordance with a person's presenting issue, goals and readiness to change.
3. Appropriate and person-centred language should be used throughout your work with the person.
4. Feedback needs to be provided to the person after an assessment. Feedback involves talking to the person about the types of options and considerations arising from your assessment interpretation with specific focus on identifying relationships between the person's substance misuse and the impacts their health, relationships, psychosocial status and mental health.
5. Special considerations need to be made when working with people from specific populations, groups and workers must ensure that they are working with people from all backgrounds in a respectful way. Referring to specialist services is at times appropriate.
6. Identify a person's needs and services that are outside of your organisations or the AOD sector's scope and ensure they receive adequate support. By consulting with colleagues, your supervisor and seeking specialist information, you will be able to make appropriate decisions and referrals within and outside of your organisation.
7. You must be able to explain developing the treatment plan, and the roles of different people to the person.
8. Workers need to take into consideration legal and ethical obligations of their role, including legislation and policy that provide standards and frameworks from which to work within. Workers must also have a working knowledge of policies and procedures that are in place within their organisation regarding privacy and confidentiality, duty of care, dignity of risk and work health and safety. Any documentation regarding a person must be clear, objective, timely, and filed appropriately.
9. Gain an understanding of the individual's readiness to develop a treatment plan through a variety of means; active listening, person-centred communication and interpreting information from their assessment.
10. Individuals may require or be more suited to brief interventions while others will identify a need for longer-term treatments such as detox/withdrawal services, residential rehabilitation, and counselling and self-help groups. For people with multiple or complex needs, case management may be required.

Learning checkpoint 1
Consider the types of treatment and services to be provided

This learning checkpoint allows you to review your skills and knowledge in considering the types of treatment and services to be provided to the person.

Part A

1. List two key considerations you may need to make when supporting a young person and two reasons why they may be more suited to brief interventions. Explain how and where you may access specialist alcohol and other drugs (AOD) information specific to young people.

2. List two ways that AOD codes of conduct align with human rights.

3. List two ways in which AOD codes of practice may contribute to your consideration of a long-term intervention with a person receiving support services.

4. List two examples of potential workplace safety risks when working with people with AOD issues.

Part B

Read the case study, then answer the questions that follow.

Case study

Cassandra has recently completed an assessment for Nousha, a 32-year-old woman whose general practitioner (GP) has referred her for services to address her alcohol misuse. She is attending without her husband's knowledge.

Nousha began drinking three years ago shortly after moving to Australia, and says that she drinks to numb herself of traumatic memories and manage her 'panicky feelings'. She drinks a one-litre cask of wine every 2–3 days while her husband is at work. Nousha is fearful of what will happen if her husband finds out about her alcohol use, but she is unsure if she wants to abstain from alcohol completely.

She discloses that she has recently had thoughts of throwing herself in front of a train.

1. What does the information provided tell you about Nousha's pattern of use, stage of change and dual diagnosis issues?

2. What cultural- and gender-specific considerations need to be taken into account when working with Nousha? List two of each.

3. Nousha discloses that she has recently had thoughts of throwing herself in front of a train. What considerations should Cassandra take when considering Nousha's privacy and Cassandra's duty of care?

4. List two other services that may be potential referrals for issues beyond the scope of AOD service.

5. How might an organisation's policies and procedures determine how Cassandra proceeds when completing Nousha's treatment plan?

Topic 2

In this topic you will learn how to:

- **2A** **Discuss desired outcomes, priorities and long-term goals**
- **2B** **Identify barriers and/or cultural factors that may impact goals**
- **2C** **Inform the person about different services and support options**
- **2D** **Help the person evaluate and select strategies to achieve goals**
- **2E** **Determine and prioritise preferred actions**
- **2F** **Confirm the person's ability to meet the logistical demands of strategies**
- **2G** **Establish timelines for goals and consider overlap by different services and support**
- **2H** **Agree on the type and frequency of interactions**
- **2I** **Consult with the person to identify informal support network and role in treatment plan**
- **2J** **Record goals and strategies in the individual treatment plan**

Determine treatment goals and strategies

Every person receiving alcohol and other drugs (AOD) support services has some form of individualised treatment plan. The plan should contain agreed options and set tasks regarding the type of treatment and intervention to be offered to the person. These agreed options, particularly the intervention strategies that may be contained in the treatment plan, are designed to meet agreed outcomes or goals. The treatment plan may include relevant information about the intervention from other community services via referral, doctors or other professional reports, or from the person's family or support network.

Treatment plans contain a range of treatment goals, all of which are devised in conjunction with the person. Plans use a biopsychosocial model, which aims to prevent and reduce health and wellbeing complications by providing the person with support from a team of appropriate specialists.

Treatment plans are negotiated with each person and their involvement and decision-making is actively encouraged; however, the person's level of ambivalence is not often reflected in the treatment plan. At certain stages, the person may have an awareness of the need for change, as reflected in the treatment plan, but the person may not yet be ready to invest time, money or energy into the process.

2A Discuss desired outcomes, priorities and long-term goals

A treatment plan is generally developed throughout or at the completion of a comprehensive drug and alcohol assessment. An assessment is the collation of information by the worker from the individual with the substance misuse as well as, with consent, relevant information from other workers or specialists involved in the person's care and significant others in the person's life.

There is always a reason why a person presents to a drug and alcohol service (whether voluntarily or mandated through court requirements) and there is often a goal or hope they have in regards to the change they want to make. Throughout the assessment process, desired outcomes are often referred to. The assessment worker will get a picture of the person's circumstances and motivation to make changes. Subsequently, the individual may have a chance to reflect on their situation, consider what changes they wish to make, and how they think drug and alcohol treatment may be beneficial to them.

The process of developing a treatment plan can help a person turn their desires and hopes into tangible goals and achievable tasks.

Determine desired outcomes and priorities

Treatment planning is underpinned by the idea that a person with a substance use issues has a hope for something different in their life. They have a desire of what they want their life to look like and a picture of what the consequences of making a change might be. The end result that we are seeking to clarify is the 'outcome'. What does this person what to change in their life, and what do they want their life to look like?

By broadly asking what the desired outcome is and using the information you already know about the person from their assessment, you can start to prioritise their needs. For some, the substance use issue may be the presenting issue but not the highest priority. For example, a person may be seeking to stop or reduce their substance use but may have more pressing complexities that require addressing before any drug and alcohol treatment can take place (for example, unmanaged mental health, significant medical concerns, insecure housing). These can be added to the treatment plan and goals can be set to address these needs.

Priorities may also need to be clarified regarding the use of multiple substances. If a person is using a number of drugs, addressing one substance may take priority over another. For example, tobacco is not always seen as a high priority for many individuals when other substances are also being used. Commonly, when asked about a person's tobacco use in the context of a drug use history, people may answer, 'I just want to focus on my alcohol/methamphetamine use first, then look at addressing my smoking down the track'.

Stages of change

As discussed in Topic 1, the Transtheoretical (or the Stages of change) model was developed by James Prochaska and Carlo DiClemente in 1982 as a guide to determine a person's readiness to change their behaviour. The model also proposes strategies that can be adopted to guide the individual through the different stages. Use the Stages of change model to underpin your understanding of the person and in turn feed the development of treatment planning. This ensures that goals and tasks written into the plan are matched to suit the person's readiness and motivation.

Pre-contemplation

If at the time of assessment a person is pre-contemplative about making a change, it may not be suitable to develop a treatment plan. The worker may provide a brief intervention, inform the person about the harms associated with their current substance use, and discuss with the person ways of reducing harm or adopting healthier behaviours.

Contemplation

At this stage, ambivalence is still a major factor. Therefore, effort is put into increasing the person's awareness of the negative aspects of their current behaviour and the possibilities of a new life if the change does occur. Being ready to change requires two things:

1. The goal must be important to the person so discussion needs to be about what they want out of life, relationships that they want and values they hold.
2. The person must have confidence in their ability to achieve the goal; if they don't, they are less likely to try, so focus discussion on the supports that will help improve the person's confidence.

Treatment planning may be suitable at this stage, but with a focus on counseling to increase motivation or attending self-help groups to seek out peer support.

Preparation

During this phase, individuals make decisions and actively plan for the change. Support and encouragement are vital here and this can be a time where the development of a treatment plan is most important; the treatment plan provides the individual with a structure to address their substance use and prepare to make changes. Tasks on the treatment plan may include making doctors' appointments or completing a referral to a withdrawal services.

Action

Individuals who are at this stage have sustained their new behaviour for some time, and require support to keep going. A treatment plan may have already been developed or may be part of the action stage. Tasks for this stage may include relapse prevention counselling, residential rehabilitation or supported accommodation, attending peer support or self-help groups.

Maintenance

People move into this stage when they have sustained the new behaviour for more than six months. They are moving through their treatment plan that may have been developed some time ago, and benefit from continued review of the plan to ensure continued change and low risk of relapse. This may including ongoing counseling, self-help or peer support groups, or linking in with social activities, employment and other positive behaviours.

Effective treatment goals for AOD issues

Depending on a person's presenting issue, the information provided and interpreted thorough their assessment and discussing goals with the individual, treatment goals will generally fall into three categories.

Treatment goal categories

Abstinence-based goals
The aim of the person is to abstain or cease their substance use all together.

Controlled AOD use goals
The aim of the individual is to reduce their use and therefore their risks of their substance use.

Harm reduction goals
The individual may have little motivation to change and may not wish to consider reducing the levels or frequency of their substance use, but through brief intervention or counselling, may set goals around reducing the risks of their current use.

SMART goal setting

One way of developing effective treatment goals is to ensure they follow the SMART criteria. SMART goal setting is a widely used goal-setting framework for a range of different clinical and non-clinical fields.

SMART principles ensure that goals are clear and specific, which makes monitoring and adjusting these easier in the review and discharge/exit process.

SMART GUIDE
An easy to remember guide for setting objectives:

S	**Specific** Target and clearly define a specific area that you want to improve.
M	**Measurable** Suggest an indicator of progress; quantify if possible. Determine how you will know the goal has been achieved
A	**Attainable** Agree what the goals should be and keep them achievable in the time frame.
R	**Realistic** Identify what results can realistically be achieved given the available resources, knowledge and time.
T	**Time framed** Specify when the result can be achieved; make sure there is enough time to achieve the goal, but not too much time.

Example

Discuss desired outcomes, priorities and long-term goals

Different therapeutic approaches and skills will explore a person's desired outcome in varying ways. Those with training in Solution Focused Therapy may ask the Miracle Question, 'If you woke up tomorrow and your biggest issue was gone, how would you know? What would you see and do differently?'

For those who have a background in Acceptance and Commitment Therapy, a question around what values the person has and what a values-driven life looks like to them.

For AOD workers and others, three simple ways of clarifying a person's desired outcome and goal are as follows:

- 'What does change look like for you?'
- 'What is the biggest hope you have for your life at the moment?'
- 'If you had successfully made this change, what would life look like?'

Practice task 7

1. Briefly explain why is it important to distinguish between a person's presenting issue and their desired outcome or goal for treatment.

2. If a person was pre-contemplative about their substance use but was required to attend treatment for court purposes, what type of goals would you likely focus on?

3. A person comes in with a long-term goal of reducing her alcohol intake. What might a SMART goal look like for this person?

Click to complete Practice task 7

2B Identify barriers and/or cultural factors that may impact goals

Barriers need to be considered and addressed when setting goals for treatment. Barriers will look different for each person but have the potential to impact on the success of any goals and tasks that are set. Barriers may be as a result of the person's circumstances and motivation, the worker or the service system. Cultural barriers can also reduce the likelihood of people from Aboriginal, Torres Strait Islander and culturally and linguistically diverse (CALD) communities achieving their goals. By being aware of barriers, openly discussing them and reducing their potential impact, individuals have the best chance to meet their goals and tasks set out in their treatment plan.

Barriers that may impact on reaching goals

System and worker-created barriers can impact a person reaching their goals. Service systems may not meet the demands of the person due to difficult referral processes, strict eligibility criteria or waiting lists. Some services have specific eligibility criteria, which can exclude individuals from accessing them. Waiting lists for services can be extremely lengthy and, at times, closed due to the demand. In this case other services may need to be considered or negotiated. Be aware of the referral process and eligibility criteria for any service being considered, and have an estimate of the waiting time. This gives you enough information to discuss potential barriers with the person and offer them alternative options.

At times, barriers that impact a person reaching their goals may be as a result of the worker. A worker may use forceful or directive language to try and make a person see that they 'need to change'. This can be off-putting for a person who may not be ready and, in turn, may cause them to disengage with the worker and treatment all together. Alternatively, a person may simply agree with the worker to please them without being committed to following through on their goals. Use person-centred principles and communication to ensure individuals take ownership of their goals. Barriers that may impact goals are usually identified at the point of assessment.

The following issues may need to be considered when setting goals and planning interventions.

Issues to consider
▶ Complex medical conditions
▶ Complex or untreated mental health conditions
▶ Poor cognition or cognitive impairment
▶ Poor levels of literacy
▶ Poor support and unstable living arrangements

Ways to address ambivalence

Ambivalence can also be a barrier that may impact goals. The person's involvement and decision-making is actively encouraged when setting goals; however, ambivalence can always fluctuate. At certain stages, the person may have an awareness of the need for change, as reflected in their assessment, but may not yet be ready to begin the process. Continually assess a person's readiness, motivation and level of ambivalence, which will help you to discuss and set goals that are suited to the person's needs.

Ambivalence is more likely to be slowly redirected towards motivation to change if you acknowledge the benefits of drug use in the person's life, even if those benefits are merely the person's perception. Once you acknowledge the positives of drug use, discussing the more negative aspects allows the person to see how the positive perception may be flawed.

It can be useful to encourage the person to create a list of the good and not so good aspects and effects of their substance. This can allow the person to compare and consider their reasons for wanting to continue using drugs and wanting to change their behaviours.

Motivation for change usually grows when a person recognises a discrepancy between where they are and where they want to be. This recognition usually needs to be driven by the person's own thought processes, rather than the support worker.

Cultural factors that may impact reaching goals

A person's culture is a filter through which they experience life. People from the same cultural background share language, knowledge and traditions that are common to everyone within their group. Culture provides the group with rules for living and this is reflected in the values, attitudes and beliefs of each member of that group. Cultural differences should not provide a barrier to service delivery.

Individuals from other cultures may be less able to achieve their goals due to difficulty in speaking and reading English. Many organisations have access to written information in other languages. If you work for a smaller organisation you may not have the resources to have large amounts of information translated.

There are links and free resources available in a number of languages on the Alcohol and Drug Foundation's website at: http://aspirelr.link/adf-resources.

Culturally-specific services

Individuals from CALD background and Aboriginal and Torres Strait Islander people may wish to access culturally-specific services. Most states in Australia have AOD services that cater specifically for Aboriginal and Torres Strait Islander people. Such services are designed to consider the range of personal and cultural needs of the person and provide a range of community interventions including education and information. Services that cater for the needs of other cultural groups are also available. In some cases, these services provide education and information about people's cultural needs to other mainstream AOD services.

If there are no culturally-specific services available, it may be helpful to organise an interpreter or support person present who can speak both languages. If a language barrier is present, the person's English skills may deteriorate when they are stressed or anxious.

Cultural barriers may create feelings of shame, fear or distrust, causing distress and affecting the person's ability to achieve their goals. Certain cultural beliefs, such as the belief that saying 'no' could be considered rude or offensive, may also cause barriers for a person achieving their goals. AOD workers must take care to research, recognise and respond appropriately to individual and cultural differences in communication.

Example

Identify barriers and/or cultural factors that may impact on goals

Jackson sees Binh to develop a treatment plan for Binh's heroin use. Binh is a 32-year-old male originally from Vietnam who moved to Australia with his family at the age of 12. He reports a 10-year history of dependent heroin use (smoking). Binh has been directed to attend drug and alcohol treatment as part of a court order. Binh would like to cease smoking heroin and commence opiate replacement therapy but says that he finds the $35 per week dispensing fee expensive. He is also concerned that if his parents become aware of his daily trip to the pharmacy they will realise he has been using heroin again and may kick him out of the house, as they had threatened previously. Binh reports that his parents are extremely strict when it comes to drug use.

Jackson reflects that there were a number of barriers that need to be worked through for Binh to achieve his goal. These barriers are impacting on Binh's ambivalence about making changes to his heroin use. Jackson and Binh discuss the good and not so good things about continuing to use heroin as he currently does. Binh states that using helps him to 'disappear' from his issues, but he acknowledges that his issues only get worse each time he uses due to increasing debts and the risk of further legal issues, including incarceration.

Jackson and Binh agree that his parents would be more disappointed if Binh went to jail than if they found out he had been using heroin again. Jackson finds some Vietnamese-specific family brochures that Binh can give to his parents. Binh is also reminded that $35 a week is affordable if he reduces and ultimately abstains from using heroin.

Jackson and Binh continue with the development of the treatment plan.

Practice task 8

1. One barrier for change may be lengthy waiting times to access a service. What is one thing you could do to plan for and manage this?

2. How might you work with someone who is displaying signs of ambivalence? List two examples.

3. Last week you completed a treatment plan with a man who has recently moved from Cambodia. Goals and strategies were set; however, after the initial appointment you never see the man again. What are two potential barriers that may have impacted this man completing his treatment?

Click to complete Practice task 8

2C Inform the person about different services and support options

It is the role of the AOD worker to ensure that the person is aware of the range of services and support options available to them. Individuals have the right to be informed of all the options and together these services and treatments can be determined and planned out within the person's treatment plan. This process requires a balance between person-centred principles and skills in negotiation. A person's treatment journey is largely based on their own decision but it is also important that the tasks being set are based on your assessment of the person's stage of change, current capacity and any barriers to treatment you foresee.

Models of service planning and case management

The case management model is practised in Australia when a person has multiple issues. A case manager might be an AOD worker, a social worker or a nurse involved in community AOD support.

Service planning and case management are often based on the principles of holistic person-centred care and require effective communication and negotiation techniques. The case manager has an important role. Here are some of their responsibilities.

The role of a case manager

- Acts as advocate for the person, liaises with appropriate support services and ensures the person has a smooth and effective transition between agencies
- Forms a point of contact for all services; for example, a social worker employed by a community AOD service might assess an individual and then suggest the types of services that could benefit them
- Makes referrals and liaises with different services and professionals (doctors, mental health workers, AOD withdrawal clinics and housing providers)

A holistic and person-centred approach

A holistic and person-centred approach means looking at all of a person's needs and issues and not just one particular issue. Alcohol or drug misuse cannot be treated in isolation.

The aim of a holistic and person-centred approach is to address these needs by providing individuals with, or referring them to, appropriate services. Education and health promotion strategies and a holistic and person-centred approach helps in the early identification of health issues and in empowering individuals to take greater control over their own health needs.

The person-centred approach places the person at the centre of service delivery. The person's opinions and preferences are taken into account and the focus is on meeting their individual needs. A person-centred approach seeks to uphold the rights, dignity, privacy and personal choice of individuals.

Individuals may have a range of issues that require attention.

Issues that may require attention:

- Other health issues or mental health issues
- Unsuitable living arrangements or homelessness
- Difficult family or interpersonal relationships
- Social or geographical isolation and lack of a support network
- Little idea of how to access appropriate services
- Little knowledge of what services are available

Principles of a person/client approach

A person-centred approach is used in conjunction with two other principles associated with community services work. These are holistic and strengths-based approaches to service provision.

A holistic approach means taking into account all of a person's needs and not just focusing on one issue such as drug addiction. Workers who adopt a holistic approach also consider a person's environment, their social connectedness, their physical and mental wellbeing and whether or not their basic needs for housing and financial security are being met.

A strengths-based approach identifies a person's strong points, advantages and assets and helps the person use these to build confidence and self-efficacy in other areas of their life. For example, if a person is interested in creativity and art, they may benefit from the opportunity to explore this area of their life. Not only might this provide an interesting hobby and diversion from AOD abuse, but it may also foster personal growth and understanding.

Key aspects of a person-centred approach to work practice are as follows.

Person-centred approach
Respects and values each individual as they are
Provides individualised services that match an individual's needs
Provides a safe and supportive environment
Includes people in decision-making regarding decisions that involve them
Listens to and addresses complaints.

Principles of effective communication

Person-centred interpersonal communication is based on core concepts, which apply to communication with colleagues as well as people accessing support services.

Here are some core concepts of communication.

Congruence

- Congruence means the communicator is genuine in their interest in the other person and their actions match their words. They do not have to fake this or adopt the position of an expert dispensing information.

Unconditional positive regard

- Unconditional positive regard means the communicator respects the other person by showing them unconditional positive regard. This means accepting the other person unconditionally, without judgment, disapproval or approval. This helps the other person to feel increased self-regard and to value their own experiences and actions.

Empathy

- Empathetic understanding means that the communicator seeks to understand the other person's internal frame of reference instead of imposing their own views on them.

Negotiate

Negotiations require a willingness to state your position and be open to exploring, opposing or differing positions to reach a mutually acceptable outcome. When it comes to negotiating goals and tasks within the treatment plan with the person, it is more than a case of simply trying to get your way. You may need to negotiate with a person when they are having difficulty with, or do not want to participate in, some part of the treatment plan that you believe is important to a successful outcome for them. On the other hand, individuals at times wish to engage with every form of treatment and set the bar high in terms of their goals versus what is realistically achievable for them currently. Negotiation in this instance may involve encouraging them to start small, take their time and be aware of any potential barriers that they may need to work around.

It is important that you understand the basic skills involved in negotiation. Here are some tips.

Key negotiating tips

- Avoid trying to get your own way or win at all costs.
- Understand the other person's perspective – ask questions to encourage them to speak about their concerns; for example, 'What are your concerns about what I am suggesting?'
- Use reflective listening skills to understand and clarify the other person's point of view; for example, 'So you would rather focus on just a few basic strategies. Is that right?

- Try to uncover points or issues that you can agree on and then build on.
- Avoid becoming angry or emotional as this may cloud your judgment and your ability to behave in a rational manner.
- Focus on issues, not personalities.
- State your position clearly so that the other party knows exactly what you mean or what you want.
- Explain reasons for your position to help the other person see things from your frame of reference.
- Don't argue, as negotiation is about finding solutions, not about trying to prove the other person wrong.
- If you disagree with something the other person is saying, you need to tell them in a calm yet assertive way – don't demean the other person or get into a power struggle.
- Be prepared to accept a workable compromise so that all parties feel that they have gained something.

AOD service delivery models and treatment settings

Treatments are not mutually exclusive. Depending on the severity of their issue and the type of drug they have been using, individuals may be offered all the treatments at the same time or at different stages of the treatment process.

Generally, AOD service delivery models and treatments fall into three main types, which are described below.

AOD service delivery model/treatment types
Withdrawal Withdrawal treatments help the person manage the difficult period of stopping drug use and allowing their system to detoxify itself of drugs.
Behavioural interventions Behavioural interventions include counselling and other behaviour change strategies.
Pharmacotherapies Pharmacotherapies use medication to ease symptoms of detoxification and support individuals through difficult withdrawals; for example, use of methadone to help people withdrawing from heroin use.

Treatment settings

Treatment settings range from home-based withdrawal to hospitalisation and detoxification units. Here are some typical treatment settings.

In-patient treatment

In-patient treatment may take place in a hospital or private clinic. The person usually stays in the service until they have completed withdrawal. In-patient treatment is often followed by out-patient programs to support the person in their own environment.

Issues associated with in-patient care include the person having to live away from their home and community environment for a time and difficulty maintaining changes in their own environment when they return.

In-patient programs may be the most suitable choice if:

- the person has not been successful in out-patient programs
- the person has other medical issues that require careful monitoring
- the person's home environment is not conducive to change
- the person does not have access to out-patient programs.

Out-patient programs

Out-patient or day programs are suitable for individuals who are less likely to experience severe withdrawal or who have already almost completed withdrawal from alcohol or drug use in another facility. Day programs usually offer a range of services including behaviour-change interventions, counselling, group work, relapse prevention, life skills training and self-help groups.

Residential options

Residential rehabilitation usually occurs in a community setting with supervised medical care or psychosocial support. This type of service is most useful for people who have tried other drug or alcohol programs without success. Programs may last for several months and provide a range of interventions, such as group and peer therapy, counselling and other behaviour-change strategies designed to promote lasting change.

Detoxification is an important first step in severe cases of alcohol or drug addiction. A residential detoxification unit allows a person to rid themselves of toxins associated with AOD dependency under medical supervision and in a supportive environment. Detoxification is most effective when it is followed by additional drug treatment and interventions to address other psychological, social or behavioural issues that accompany addiction.

A detoxification unit should be considered when a person:

- is likely to experience severe withdrawal symptoms
- does not have a supportive home environment
- is homeless
- has failed other treatments

Home-based withdrawal

The purpose of services designed to withdraw individuals from drug or alcohol dependence is to enable the person to quit the drug in a safe way that alleviates or reduces unpleasant withdrawal symptoms.

Individuals who do not need ongoing supervision and support while they withdraw can safely withdraw in their own homes with the support of medication and access to telephone support and limited medical care.

Home-based withdrawal works best when a person has a home environment that is drug free and with a supportive family or others who can help them through the process.

Outreach

Outreach services are mobile services that provide support to people within the community; for example, people who are homeless and have AOD issues or people who are intoxicated and need to be taken to a shelter. Outreach services also provide referrals, and information about AOD misuse and treatment options.

Outreach services are often used in youth services to engage young people who may be reluctant to attend community AOD centres.

Telephone/email settings

Telephone and email services may act as a referral and/or counselling service to support people who are in the rehabilitation or continuing care stage of treatment. These services may also be helpful for people who are unsure about making changes and as part of a brief intervention or feedback session. These technology based settings may be especially helpful for individuals that live in rural and remote areas.

Each state and territory has an AOD information telephone service. Many operate 24 hours and offer a free-call number for people living in regional areas. Workers should be aware of other AOD and community services that operate in their area but most AOD service organisations will have a resource folder or brochures containing contact details that workers or individuals may access.

Online-based services

In recent years technology or online-based services and settings are being encouraged as part of a person's goal setting and treatment options.

A variety of mobile apps are also available for goals around controlled use and abstinence; alcohol diaries and smoking cessation support apps are extremely popular, and the Australian Drug Information Network (http://aspirelr.link/adin) provide reviews for many that are available currently.

Counselling Online: a service run by Turning Point Alcohol and Drug Centre in Victoria with flexibility of involvement; individuals can seek support anonymously or register their details so they are saved for continuity of support – http://aspirelr.link/counselling-online

BDZ eHealth: an online and mobile-based psychoeducation program consisting of six modules to assist people to reduce and cease their benzodiazepine use. Supplementary telephone and email support is offered throughout the duration of the program (http://aspirelr.link/bdz-ehealth).

Other community settings

Not all individuals will need specialised AOD treatment services. Some may manage with the support of their doctor and other community support services, which monitor their wellbeing and provide support and referral when necessary. Self-help groups also offer community-based support for people attempting to rehabilitate themselves in the community.

Example

Inform the person about different services and support options

Vivienne is an AOD case manager and is meeting with Megan for the first time. Megan is a 43-year-old woman with a 15-year history of dependent alcohol use and harmful misuse of benzodiazepines. She is currently drinking up to half a bottle of spirits a day. Megan lives with a diagnosis of anxiety and has been unemployed for over 3 years. Megan has a goal of abstaining from alcohol and benzodiazepine use and has attended the service with no knowledge of the treatment options available and initially asks about any medications that can assist with her alcohol use.

Vivienne advises Megan that the safest way to withdraw from her current level of alcohol use would be in an in-patient setting. Megan is unsure if this is necessary; however, Vivien provides further feedback to Megan on her level of dependence and the complications that could arise from an unsupported withdrawal from alcohol and benzodiazepines. Megan takes this feedback on board and agrees to a referral to an in-patient withdrawal unit attached to the regional hospital. Vivienne advises that Megan would be offered an anti-craving medication, Campral, during her in-patient admission, which can be helpful to maintain abstinence after her discharge. Vivienne discusses options for behavioural interventions and Megan agrees to weekly relapse prevention counselling with Vivienne. Vivienne also suggests a support group for women with anxiety called Grow, which Megan states she has attended before and found quite helpful in the past.

Practice task 9

1. Besides people who live in remote areas, what type of individuals may benefit from the use of online (email, internet) treatment services?

2. In your own words, describe two key components of negotiation.

3. List two community settings in which a person may be asked about their drug and alcohol use and supported in making changes or accessing specialist services.

Click to complete Practice task 9

2D Help the person evaluate and select strategies to achieve goals

The person's drug and alcohol assessment and their long-term goals or desired outcomes are both essential to consider when evaluating and selecting strategies. Assessment information will help you to determine variables and needs when selecting strategies. An understanding of the person's long-term goal and desired outcome helps you to match treatment goals with interventions.

One part of this process if full disclosure of the options available that fit with the person's treatment goal and provide feedback on why some strategies may be more suitable for them than others. Allowing the person to consider and decide each strategy is the aim. Person-centred communication and negotiation remain key clinical skills in this part of the treatment planning process.

Revisit the person's goal for treatment and discuss possible interventions accordingly. Strategies will range from those aimed at abstinence, those aimed at controlled substance use and those that are specific to reducing risks and harms associated with substance use. If strategies are not aligned with the person's treatment goal, the chance of them completing the interventions is extremely low.

Evaluate and select strategies to meet goals

When evaluating and selecting strategies, consider the information that has been collected and interpreted at the person's initial drug and alcohol assessment.

Referring to the assessment and your discussions with the person will provide a clear picture of what their individual needs and circumstances are. The person's own preferences should always be taken into account.

The assessment will have information that reveals individual variables amongst individuals. Some possible variables are listed below.

Possible individual variables
▶ Their history, pattern and circumstances related to their drug use, including types of substances used and level of dependence
▶ AOD treatment history and attempts to make changes in the past
▶ What interventions have previously worked best for the person and what interventions were least successful
▶ The person's level of motivation and potential barriers that may impact successful treatment
▶ Their level of complexity including co-occurring mental health conditions, medical complications and housing, financial and legal issues
▶ Their family and social support network

Discuss the most suitable strategies

Providing clear feedback about the assessment information and the strategies you think would be most effective for the person is important. This must not be done in a forceful or judgmental way, but you have a part to play by advising what you think may work best for the person in an unambiguous way.

People accessing support services are sometimes unsure of what strategies are going to work best and may require a bit more direction than someone who has a clear plan on how they are going to implement the changes they want to make. Using your observation skills and listening to a person's language can be helpful in determining how much guidance they need. For those who are less sure about which strategies would be best for them, it may be helpful to narrow down the range of options down to two or three as a starting point. This way, the person can still have ownership over the choice between these options rather than feel overwhelmed by all of them. This can also be a helpful strategy when a person wants to put their hand up for any and every treatment type. In this instance, the treatment plan can quickly become uncontained and individuals can be left feeling confused if referrals are made to an unnecessary amount of services. If you have this experience, negotiate with the person to start with two or three different strategies on their treatment, and agree to review it down the track.

Match treatment goals to interventions

Some types of interventions may be appropriate for more than one treatment goal; for example, counselling may be appropriate regardless of whether a person is seeking to control their use or whether they wish to cease their substance use all together. The focus of counselling may shift, however, and strategies and tasks within counselling may vary slightly.

Some types of interventions are described below.

Strategies aimed at abstinence

A person with the aim of abstinence has a number of options they can consider. For some, a referral to specialist in-patient, out-patient or home based withdrawal services may be deemed necessary depending of the initial level of dependence and any complicating factors. The person may also complete a withdrawal with little support from specialist services or with the support of a GP. Then a broad range of interventions may be offered to maintain abstinence and reduce the risk of relapse.

Example

A person may have a goal of withdrawing and maintaining abstinence from cannabis. Their treatment plan may include:

- referral to in-patient, out-patient or home-based withdrawal
- relapse prevention counselling with a focus on cravings and high-risk situations
- abstinence-based self-help groups
- pharmacotherapy to maintain abstinence from the drug of concern (for example, acamprosate for alcohol dependence, nicotine replacement therapy for tobacco cessation).

Strategies aimed at controlled AOD use

Controlled AOD-use strategies are usually completed within an out-patient setting with the aim of moderating or reducing the amount or frequency of substance use using behaviour change and modification treatment types.

Example

A person may have a goal of monitoring and reducing their alcohol intake from one bottle of wine to half a bottle of wine per evening and introducing alcohol-free days a week. Their treatment plan may include:

- counselling (motivational interviewing, intensive counselling and relapse prevention)
- completing a drug use record and setting goals and limits contract
- attending a therapeutic group
- self-help groups such as AA, SMART and peer support groups
- online, home-based and app-based programs may also be of benefit to someone who is aiming to control their substance use

Harm reduction strategies could also be discussed to address the risks associated with their continued (albeit reduced) substance use.

Strategies aimed at harm reduction

Interventions and tasks under this category aim to reduce the broad range of risks and harm for someone who chooses to continue using drugs or alcohol without any desire to reduce or stop all together.

Example

A person who is injecting heroin may not wish to stop but is open to harm reduction strategies such as:

- learning skills on recognising and responding to overdose
- working on a plan to ensure they have clean injecting equipment each time they use
- carrying condoms at all times to reduce the risk of unplanned pregnancy and STIs when intoxicated
- attending a GP and getting tested for bloodborne viruses

Example

Help the person evaluate and select strategies to achieve goals

Drug use records can be a helpful intervention at any stage of a person's motivation and, regardless of whether the goal is abstinence, controlled use or harm reduction only.

People accessing support services can repurpose a diary or notebook to record their use, or you may find drug use record template on the internet. You can create a template document yourself or ask colleagues if they use something similar.

A drug use record assists individuals to monitor and increase their drug use of a set period of time (for example, one week). Individuals are encouraged to record each time they use a substance through the day and answer the following questions:

- What time is it, where am I and who am I with?
- How much did I use and what did it cost me?
- What feelings did you experience:
  - before using
  - while using
  - after using?

Practice task 10

Read the scenario, then answer the questions that follow.

Scenario

You are working with Jim who wants to abstain from his daily and dependent alcohol use but does not wish to make any changes to his cannabis use, which he smokes 4–5 nights a week.

1. Given the different goals Jim has for cannabis and alcohol, how might you proceed?

2. What are two strategies you may discuss with Jim when setting goals to prevent his alcohol use?

3. What are two strategies you may discuss with Jim when setting harm-reduction goals for his cannabis use?

Click to complete Practice task 10

2E Determine and prioritise preferred actions

Person-centred principles emphasise the importance of individuals to choose their own course of treatment. Together, you and the person are responsible for considering and evaluating all the options and choosing the strategies that are going to work best for the person and their circumstances.

Through the process of selecting strategies and taking into account other services that may be required as part of the treatment plan, the list of tasks to undertake can become quite lengthy. Individuals must have the opportunity to choose their preferred treatment strategies and start to action them. The tasks and strategies selected may all complement each other but it is still important to prioritise the first tasks they wish to action. This will help increase self-efficacy and motivation to continue completing tasks and achieving their long-term goal.

A person may identify one strategy as the highest priority. For example, they may determine that accessing an in-patient withdrawal is their highest priority. If they do not wish to follow through on any other tasks until this has been set up, you may consider discussing with the person whether they would like to be referred to more than one withdrawal service. The person may have a preference for one service over the other, but due to their determination to access an admission, the may be happy to attend their second preference if a place becomes available earlier.

Be flexible to meet the person's needs

Work at the person's pace and respond to the person's capacity to take on more than one task at once. If a person is able to complete multiple tasks within the first week of their treatment, such as link in with a pharmacotherapy prescriber, call the housing service to check their place on the public housing waiting list, attend their first NA group and commence drug and alcohol counselling, this is great. Others will find it difficult to complete more than one task at any given time. In this instance, ask what is most important for them to focus on this week, and what steps can be taken to achieve this.

There are some parts of the treatment plan that may be added due to a need rather than motivation. Priority of need also must be taken into consideration – if there are complex issues that need addressing as a matter of urgency, negotiate that these take precedence over other actions that could wait.

This is also the time when responsibilities are discussed within the collaborative partnership; it may be the person's job to book a GP appointment and get a referral letter for an Addiction Medicine Specialist, and it might be the worker's job to complete a referral for residential rehabilitation and contact the person's corrections officer.

Example

Determine and prioritise preferred actions

Trevor and Tim are working to develop Tim's treatment plan. Tim is 20 years old and has dependence on over-the-counter codeine tablets and co-occurring depression. Tim reports that he started to use codeine after sustaining a back injury at work. He has since quit his job due to ongoing pain and recently stopped taking his anti-depressants. Tim attended the drug and alcohol service after an accidental overdose on codeine and alcohol. Tim's goal is to gradually reduce his use of over-the-counter codeine medication and commence Suboxone. Tim discusses the options available to him and together they decide on a number of strategies and actions to include in Tim's treatment plan. They come up with the following:

- Link in with a GP and pharmacy to manage his reduction and commence Suboxone.
- Attend a youth drug and alcohol service to discuss harm reduction and relapse prevention strategies.
- Link with a psychologist at a community health service to manage his depression.
- Recommence taking his anti-depressants.
- Attend a youth employment agency to look at retail jobs that don't require heavy lifting.

When discussing priorities, Tim states that his first priority is to start taking his anti-depressants again and speak with his GP about commencing a reduction plan for the codeine. He feels that he will have more motivation to take on the other tasks once he is back on anti-depressants.

Trevor advises that there is a 3–4 week wait for the youth drug and alcohol program. They agree that Trevor will send the referral for this service through in the next week so by the time Tim is ready to attend, they will be available to see him. Tim feels that it will be better to hold off on the psychologist and employment agency until after he stabilises on Suboxone and his anti-depressants.

Practice task 11

1. List two steps you might take if the priorities you determine for the person are not the same as the priorities they determine for themselves?

2. What are two examples of small actions on a treatment plan that can be completed within the first week while waiting for bigger strategies to start?

Click to complete Practice task 11

2F Confirm the person's ability to meet the logistical demands of strategies

Goal setting requires a certain amount of planning. Not only does a person require high motivation to complete a task, details and logistics also need to be discussed and addressed so the person has the best chance of success.

Logistical demands of drug and alcohol strategies may include the location and transport to and from interventions, timing and cost concerns, and resources available to complete the strategies.

Location and transport

- Most services that are part of a person's treatment plan will require that the person attend the service. Drug and alcohol services are located throughout metropolitan and regional areas of Australia; however, for some people – particularly in rural and remote settings – they may be required to travel some distance to access the appropriate service.
- While many metropolitan services may be relatively close to individuals, not all people have access to cars and public transport can be costly and difficult to access. Some programs may assist with the payment of public transport costs. Individuals who are physically frail or who have a disability may find it difficult to travel by public transport. Discuss transport options with the person so that this barrier is overcome. Transport may be available with the help of case managers or an outreach worker, family members, friends or volunteer services.
- Some people who have a disability or difficulty accessing other locations may prefer strategies that can take place within their home. Organisations will have specific guidelines for visiting people in their homes and conducting interventions in that environment. These guidelines will cover areas such as worker safety, respecting the person's privacy and confidentiality, and making a suitable time to visit. Make sure you speak with the service to see if home visits are available.

Timing and costs

- There are many reasons why certain times may be better for some individuals than others. When determining strategies, always ask a person what times will be most convenient for them. If individuals need plenty of notice for them to attend a residential or in-patient service, ensure that you make note of this and inform the service when you make the referral. It is also an opportunity to discuss peer support and group options that may be more accessible after hours or on weekends if this suits the person.
- Most publicly-funded drug and alcohol agencies do not cost the person any money. However, some in-patient and residential services will require payment to cover basic expenses throughout the person's stay. Additionally, if a person is seeking to commence opiate replacement therapy (methadone, Suboxone), a dispensing fee of approximately $35 a week is payable to the pharmacist. These considerations must be taken into account when discussing and choosing strategies for a person.

Other logistical considerations

- To ensure all issues are considered, ask the person if they can foresee any logistic demands. For example, many individuals may not always have credit on their phone to make or receive calls or they may not have access to the internet to look up support groups or access online counselling. By considering and working through any potential issues, or tweaking the strategies so that they work better for the person, you are giving the person the best chance of being able to achieve the tasks and goals they have set for themselves.

Example

Confirm the person's ability to meet the logistical demands of strategies

Tanja is developing a treatment plan with Dale, who is seeking an in-patient withdrawal from methamphetamines. Dale was advised that he needs to call the service the day before to confirm he will be attending. Dale has no credit on his phone, so Tanja applied for a small amount of emergency assistance funding ($20) to top up his credit for this purpose. Dale will need to make his own way to the service on his admission date; however, the service is not accessible by public transport. In the session, Tanja and Dale call his older brother who advises he can take the morning off work to drive Dale to the service and will pick him up at the completion of the program.

Practice task 12

1. Provide two examples of groups of people who may require appointments on certain days, at certain times of the day or after-hours appointments.

2. What are two ways a service might ensure the safety of their workers when conducting home visits?

3. What are two ways you can address the logistics of a person not having a phone for a period of time?

Click to complete Practice task 12

2G Establish timelines for goals and consider overlap by different services and support

As discussed previously, one principle of the SMART goal-setting method is that goals are set against a timeline. Simply setting a non-specific long-term goal of 'cease my benzodiazepine use' has no context if there is no time frame attached to it. A person could decide they are quitting tomorrow or quitting in 25 years. Having timelines attached to a goal helps to give it context, structure and a starting point to review at a later date. Establishing a timeline also helps to maintain momentum for individuals who are ready to make a change by helping them plan out their treatment and intervention.

Identify realistic timelines

The nature of the service system is that due to different referral processes, lengths of treatment and waiting times, some services and supports will create gaps. For example, because a residential withdrawal service accepts people for 7–14 days, the throughput of individuals is a lot higher than residential rehabilitation, where the length of treatment can be anywhere from 3–12 months. An individual may only need to wait 2–4 weeks to be admitted to a residential detox, but may need to wait 6–12 months for an admission to a long-term rehabilitation program. This is where out-patient services like case management or counselling may overlap with other treatment to maintain a person's momentum for change. They can achieve this by supporting their continued motivation prior to an admission to a residential rehabilitation and linking them with other supports (such as group programs).

Help establish timelines with a person and break their treatment down in into smaller goals and tasks. The aim is to reduce their sense of frustration and helplessness at the prospect of not being able to access residential services for some weeks and months.

Prioritising the needs and goals for a person will help determine a rough timeline for their treatment plan. For example, if a person is hoping to reduce their heroin use by attending a peer support group but they are also being evicted from their rental property in two weeks, it would seem that the priority is to find secure housing before linking in with a group.

Identify service overlap

Timelines are also likely to overlap due to the complexity and co-occurring conditions of individuals. For example, multiple tasks may be actioned at the same time for a person with co-occurring alcohol dependence and bipolar disorder who has just found out they have been diagnosed with hepatitis C.

Continued attendance to drug and alcohol care coordination appointments may occur as well as monthly care team meetings with the drug and alcohol case manager and mental health worker. A referral to a liver clinic may also happen concurrently with the support of the case manager. All these tasks may be overlapping but can be coordinated and monitored through the treatment plan.

Example

Establish timelines for goals and consider overlap by different services and support

Frank and Yolanda are discussing a number of goals that Yolanda wishes to add onto her treatment plan. Yolanda has a goal of abstaining from her current poly-drug use and as part of her treatment plan would like to attend the Glenferry House residential rehabilitation. Frank contacts Glenferry House to find out their current waiting time for admission. He is advised that Yolanda could expect an admission in approximately three months.

Frank advises Yolanda of the waiting time, and informs her that he will send a referral to the service. They agree to add residential rehabilitation to her treatment plan knowing that it will be some months before this task can be achieved. Together they discuss some shorter terms goals that Yolanda can work on, such as having her current medication reviewed by a psychiatrist, accessing family counselling for her partner and sister to attend and attending a four-week harm reduction group. Frank encourages Yolanda to see him on a weekly basis and also advises that when a place becomes available at Glenferry House, they will need to complete a referral for an in-patient withdrawal service, with the dates lining up so that Yolanda can be transported straight from detox into Glenferry House.

Practice task 13

1. List two examples of issues that may take priority over addressing substance use and require a shorter timeline to implement.

2. List two ways you can assist individuals who are feeling overwhelmed with overlapping treatment tasks and appointments.

Click to complete Practice task 13

2H Agree on the type and frequency of interactions

The role that you play within the individual's care will determine if and when your involvement continues. Your role in the development of the treatment plan may be as part of the assessment, with no ongoing involvement assumed. In some states the intake and assessment function may be completed by one agency while other agencies complete any treatment or intervention. This is currently the case for Victoria, where intake and assessment are centralised, and the assessment worker completes referrals to all AOD treatment agencies, including residential services. Therefore the assessment worker's involvement may end once the assessment is completed and the treatment plan is developed.

Negotiate the type and frequency of interactions

A number of factors will impact the type and frequency of interactions you and the person have over the course of their treatment plan.

It may be that the service or worker completing the assessment will be an ongoing part of the treatment plan; providing counselling, case management etc. Your organisation and scope of practice will determine whether you remain involved throughout the course of the treatment plan or just at the development and commencement of it. If your scope of practice determines that you can remain engaged with the person in a case management or counselling capacity, more frequent appointments in the beginning stages of treatment may be ideal, with appointments being spaced out after other goals have been achieved (for example, completing a withdrawal or engaging with a peer support group). Alternatively, you may encourage the person to see you more frequently in the lead-up to and immediately after their withdrawal/detox to ensure they receive intensive preparation and relapse prevention support.

Negotiate shared care arrangements

The type and frequency of interactions between the individual and the worker will also be determined based on how many other services and supports the person already has in place or is being linked with. It may be that as part of a shared care arrangement, it's appropriate for you to see the person less frequently than their case manager, or mental health worker. This can be negotiated when developing the treatment plan by discussing with the person and communicating with other workers in their care team.

The type of interaction is important to negotiate and agree on; it may be that you maintain contact with the person in person through clinic-based appointments or in an outreach capacity. Alternatively, regular phone contact may be appropriate, or a combination of the two.

Example

Agree on the type and frequency of interactions

Geraldine is developing and coordinating the implementation of a treatment plan with Jack who has set a goal of abstinence from dependent cannabis use. As part of Jack's treatment plan, he has been referred to an in-patient withdrawal unit.

Geraldine and Jack agree to meet weekly prior to his admission to the withdrawal service. Geraldine advises Jack she will call him on the day of admission at the withdrawal unit and also contact him four days into his stay. During the second phone call, Geraldine books an appointment with Jack for the day after his discharge to review the discharge plan and set a relapse prevention plan for continued abstinence. It is agreed that weekly appointments will continue for the next four weeks, giving Jack an opportunity to work on relapse prevention strategies and link in with a local weekly peer support group. At this point, Geraldine and Jack agree that fortnightly appointments will be appropriate.

Practice task 14

1. List two occasions when phone interactions may be more appropriate than face-to-face interactions.

2. Based on your knowledge, list two skills you have, considerations to make or principles to draw on if the person you are working with wants to see you twice a week while you think that fortnightly appointments are more appropriate.

Click to complete Practice task 14

21 Consult with the person to identify informal support network and role in treatment plan

Evidence suggests that working collaboratively and involving family members and other informal supports in an individual's treatment plan significantly increases their chance of achieving the goals they set.

Family inclusive practice guidelines outline a tiered system of family involvement in a person's engagement and treatment with drug and alcohol services. This may range from providing information about the services that are on offer for the individual and the family as well as providing psychoeducation on the impact of substance use for the individual and the family members/loved ones. It can be helpful to have family members attend a single session or care team meeting to discuss their role in supporting the individual to achieve the goals set in the treatment plan. Further to this, family therapy or counselling may be recommended as part of an individual's treatment plan, where family relationships and dynamics are discussed as triggers or unhelpful patterns. In family therapy, families are encouraged to confront and resolve conflict within the relationship which in turn may break the pattern of the individual using substances as a way of coping.

The role of support network members

Other ways family and informal supports may be involved are helping to provide a safe physical and emotional environment for an individual to implement their treatment plan. They may assist in the contribution and implementation of a safety plan in the case of the complexity or the person's issues and the need for a crisis response. Family members and informal supports may also transport individuals to appointments and residential services if this is a barrier for individuals in accessing appropriate treatment.

It must be acknowledged that involving families can be complex and not all adult individuals will consent to family members or significant others being involved in their treatment. Family and informal support networks are always explored to complement any formal or professional treatment that is being added to the treatment plan.

Example

Consult with the person to identify informal support network and role in treatment plan

Here are some questions to demonstrate how you may introduce and explore the inclusion of family and informal supports into the treatment plan:

- Who out of your family and friends would you say is your biggest support/knows the most about your current circumstances?
- How do you think this person may support this plan or assist you to achieve these tasks?
- Have you got any friends who don't use substances or have had a good experience of drug and alcohol treatment?
- Have you thought about becoming involved in a peer support group such as AA, NA, SMART?
- What sort of support do you need from your family and friends at the moment? Perhaps we could invite one or two of them to a session so we can ensure they know how to best support you.

Practice task 15

1. Apart from immediate family members, who may the person identify as an informal support?

2. List two potential benefits of identifying family and informal supports.

3. List two concerns and considerations when identifying family and informal supports.

Click to complete Practice task 15

2J Record goals and strategies in the individual treatment plan

Policies and procedures for maintaining accurate and up-to-date documents are based on legislative requirements that are directed at community organisations to be accountable for the services they provide.

You have a responsibility to document information regarding a treatment plan in an accurate manner and ensure all records adhere to organisational procedures and guidelines. Take care to complete the treatment plan in clear and accurate language based on fact rather than opinion.

Case notes and records are used as a reference for organisations to take responsibility for their actions and provide appropriate services to individuals. At various times, courts may request certain documentation to resolve legal matters related to service provision.

Use appropriate language

Ensure you use respectful, objective and appropriate terminology when writing up a treatment plan. This means using non-judgmental and strengths-based language that avoids jargon or labelling.

If AOD terminology is required, be aware that terminology changes over time and can vary between treatment approaches and organisations. For example, the term 'alcoholic' is rarely used these days because it has many negative associations that can be labelling and stigmatising to the individual. Suitable terminology may include 'alcohol dependency' or 'issues with alcohol'. Other terms that have negative connotations include 'drug addict' or 'junkie'. These terms label people in a negative way and imply that the individual may be dangerous and out of control. Note also that 'drug abuse' is commonly accepted terminology, but some organisations may suggest you avoid using the word 'abuse' as they prefer other terms such as 'drug misuse,', to describe the harmful or inappropriate use of drugs.

Always check the preferred use of terms in the organisation you work for before making reports or discussing a person. Use the same terminology that everyone else in the organisation uses so that everyone understands what you mean and you do not confuse or offend others. Always take care to use terminology that is respectful and unbiased.

The treatment plan is a document that the person will usually keep a copy of and that may be shared with other agencies as well as informal supports so simple, factual and non-judgmental language and terminology is used in the documenting of a treatment plan. It can often be helpful to use the person's word when relating to the presenting issue, goals being set and tasks to be undertaken.

Example

Record goals and strategies in the individual treatment plan

An AOD worker, Leah, records Sandra's presenting issues, goals and strategies using appropriate terminology and non-judgment language. Here is the record.

Presenting issues and goals:

Sandra states she is having difficulty keeping her drinking under control. She started drinking heavily several years ago when she was going through a difficult divorce.

She does not want to have to stop drinking completely, but would like to cut back to a moderate level; for example, having a wine with the evening meal and one or two drinks when she goes out on the weekend.

She has tried to cut back on her own but without success. She says that one of her main issues is that she feels very isolated. She would like to get a job and meet more people but lacks confidence.

Drug use/reduction strategies:

- Short term: Conduct brief intervention to raise awareness/provide information about controlled drinking strategies.
- Medium term: Prepare and use relapse prevention plan.
- Long term: Join AOD support group.

Social/recreational strategies:

- Discuss social support/recreational needs and consider options.
- Identify appropriate activities and groups and take steps to participate.

Employment/education training strategies:

Refer to the career counsellor/employment service.

Practice task 16

1. Using person-centred language, reword the following three labels that have previously been used for people experiencing AOD issues.
   a. Alcoholic

b. A borderline client

c. Addict

2. List two reasons why it is important to document goals and strategies in a person's treatment plan.

Click to complete Practice task 16

Summary

1. Establish the person's desired outcome by asking them questions about what change would look like for them, or what kind of life they hope for. Acknowledge any priorities regarding non-AOD issues or within a poly-drug use presentation.
2. Determining a person's stage of change in relation to their substance use will be helpful in clarifying the desired outcomes, goals and treatment strategies that are chosen. Effective treatment goals for AOD issues are broadly abstinence-based goals and controlled AOD use goals. Goals can also be set to reduce harm and risks if a person continues to use substances.
3. Effective goals adhere to SMART principles, which are specific, measureable, achievable, realistic and time framed.
4. There are a number of barriers that can impact a person achieving their goals, which can be a result of the person's circumstances, the worker's intentions or the service system itself. Barriers relating to culture may also impact a person's success in treatment.
5. A case management approach may be helpful when a person presenting with complex or multiple needs. Person-centred principles and negotiation are clinical skills that are required when developing an individual's treatment plan.
6. AOD workers are required to have a solid understanding of the treatment types and settings that are available to the person, including residential settings, in-patient and out-patient settings, home-based and technology-based treatment types.
7. Evaluating and selecting strategies that are appropriate for the person will take collaboration and negotiation. Take previous treatment attempts into consideration when considering particular strategies. Strategies are chosen based on the overarching treatment goal of abstinence or controlled AOD use. Harm reduction strategies may also fit with a person's goal of controlled substance use or as a stand-alone goal.
8. Once goals and strategies are chosen, prioritise tasks and preferred actions, and ensure the person has the ability to meet the logistical demands of the strategies, such as location, transport, timing of interventions and costs.
9. Timelines can be established in implementation of the treatment plan. Communicate potential overlapping strategies as well as potential gaps in goals and how the person may get support during these times. Timelines should also be determined based on priorities and need.
10. Clarify with the person what future interactions they will have with you as the worker.
11. Evidence suggests that working collaboratively and involving family members and other informal supports in an individual's treatment plan significantly increases their chance of achieving the goals they set. Informal supports should always be identified to complement and strengthen any formal or professional treatment that is taking place.
12. Treatment plans should be appropriately documented according to your organisation's policy using appropriate and non-judgmental language. The treatment plan should be freely shared with the person, so clear and simple language is important.

Learning checkpoint 2
Determine treatment goals and strategies

This learning checkpoint allows you to review your skills and knowledge in determining treatment goals and strategies.

Part A

1. Evidence suggested two main effective treatment goals for AOD issues: abstinence-based goals and controlled use goals. In your own words, describe both and provide one example of a strategy that may be matched to these goals.

2. Provide two examples of questions you might ask to help identify the role of others who may be involved in the treatment plan.

3. In your own words, describe outreach-based models of treatment.

4. Suggest two ways that you could help a person receiving support services to evaluate and select appropriate strategies that match the change they want to make.

5. List two reasons why it may be important to prioritise a person's preferred actions.

Part B

Read the case study, then answer the questions that follow.

Case study

Harold, an AOD worker, is working with Sophie who has recently completed an assessment. Sophie lives with her husband Omar and her mother, for whom Sophie is a primary carer. Sophie works part-time in a florist and has been able to hold down a job despite her carer role.

Sophie has presented to the service with dependent use of benzodiazepines, which she took originally for back spasms. She has been taking up to 10 Valium a day and reports experiencing withdrawal symptoms when she tries to stop. Sophie lives with anxiety. Sophie was recently in a minor car accident and, while the police did not question her, Sophie is worried that the medication she had taken may have played a role in her lapse in concentration. She has told her husband and he has encouraged her to attend the service to explore her options. Sophie advises that she needs to find better ways to cope with the everyday anxieties and stresses. She wishes for a better balance between caring for her mother and tending to her own needs.

Sophie advises that she drinks two large glasses of wine most evenings and sometimes takes one of her mother's Endone to help sleep. She has little knowledge of the impacts this may be having on the effects of Valium.

Sophie and Harold set a goal for Sophie to reduce and cease her Valium use over the course of one week. Harold makes a referral to a home-based withdrawal nurse so Sophie can be assisted with her reduction at home. Sophie is reluctant at first to agree to ceasing alcohol but, using person-centred communication and negotiation, Sophie agrees to make this part of her withdrawal plan. Harold is aware that the home-based withdrawal service has a four-week wait.

Other strategies that Sophie and Harold have added to her plan include completing an online course that provides psychoeducation and harm reduction strategies, and enrolling in a six-week mindfulness-based stress reduction course being held by a partner AOD agency. Sophie is required to be abstinent from all substances of concern to attend this group.

Sophie will remain linked in with Harold for support before, during and immediately after the withdrawal.

1. How may Harold have explored and determined Sophie's desired outcomes, priorities and long-term goals?

2. List two ways Harold may have used stages of change to identify appropriate treatment goals, strategies and referral options for Sophie.

3. List two potential barriers that may impact Sophie achieving all the tasks in her treatment plan and how she and Harold may address these. What are two examples of logistical demands that Sophie and Harold may need to address to ensure she is able to follow through on all the tasks set?

4. Why might Sophie be well suited to a home-based withdrawal program? Provide two other examples of out-patient programs Harold may have informed Sophie about regarding withdrawal.

5. What are two considerations Harold needs to make when establishing the time frame for different strategies? What impact may these time frames and other factors have on the frequency and type of meetings Harold and Sophie have?

6. List two examples of how Sophie's husband Omar can be involved in the success of her treatment plan.

7. Provide two examples of considerations Harold needs to make when recording the goals and selected strategies in Sophie's treatment plan.

8. Name two principles of person-centred care and negotiation that Harold may have used when developing Sophie's treatment plan.

9. List two ways in which Harold's work may reflect a case management or holistic model of care.

Topic 3

In this topic you will learn how to:

3A **Regularly review the person's progress against goals and action plans**

3B **Monitor, record and report the person's progress**

3C **Negotiate and record revised action plans and timelines in the treatment plan**

3D **Accurately record revisions in the individual treatment plan**

3E **Negotiate the person's exit from the program and provide support**

3F **Review the outcomes of interventions with your supervisor and/or colleagues**

Review the person's progress

The nature of substance use issues are that plans and goals may need to change. Treatment plans ensure that a review and monitoring mechanism is standard practice for the person's journey through the service system. Regular review of goals and tasks set in a treatment plan help ensure the person is getting the most appropriate care and ultimately leads them to be discharged from the service system. Reviewing the person's progress should always be a collaborative process between worker, supervisors/colleagues, other services and the person and their supports. Documenting an individual's progress in treatment and exit is a crucial part of the process in treatment planning.

3A Regularly review the person's progress against goals and action plans

Organisational policies and procedures will generally include guidelines on when and how to complete progress reviews. Reviews may take place at regular intervals throughout a person's treatment or at the completion of particular tasks set within the treatment plan. Reviewing a person's progress can occur both informally through conversations with the person or through a formal review appointment. When developing a treatment plan, advise the person of the review process and timeline and clarify any questions they have.

Seek advice during the review process

When preparing for a review appointment, you may find it helpful to discuss the person's progress with your supervisor for advice. A formal review can be completed with a person by yourself or with other parties in the care team, including other services as well as chosen family members or informal supports. If it is appropriate to have other workers and supports attend the review appointment, ensure that all parties are available to attend on a set date and time and that there is a large enough room to accommodate everyone. Have a copy of the treatment plan available for all attendees so that goals and action plans can be referred to specifically. This can be extremely helpful to remind the person of the goals that were initially set, rather than have them feel like there were goals or tasks that were added without their knowledge or consent.

Seek feedback during the review process

Listen to the person about how they feel they are progressing against the goals and actions plans initially set during the treatment plan development. This can provide an opportunity to highlight aspects of their progress they are feeling proud of and difficulties they may be experiencing in certain areas of the treatment plan. If there are other parties at the review, each person should be given an opportunity to speak about their experience and how they perceive the treatment plan is progressing. Ensure you prepare some positive feedback for the person regardless of their progress. Celebrate small achievements and try and reframe any difficulties or setbacks as opportunities to learn and make changes rather than an example of failure. Notes can be made against goals that have been met, partially met or have yet to be completed. There may also be a need to reconsider some tasks or discuss alternative or additional supports based on the person's progress.

The next steps in a person's treatment can be set and clarified at the point of review, as well as a date for the next review. Reviews are also a way of continuing to clarify roles of all the services and who is responsible for each task in the treatment plan.

Example

Regularly review the person's progress against goals and action plans

Patrick is Grace's AOD case manager. He has set up a review appointment with Grace, her mother, her mental health outreach worker and himself. Before the appointment, Patrick discusses with his supervisor Grace's progress against the goals she has set to abstain from ecstasy and cannabis. He has printed out a copy of the treatment plan for everyone who is attending and has prepared some positive feedback for Grace, highlighting her ability to attend all scheduled appointments and her abstinence from ecstasy for almost two months. He is aware that the team will want to discuss Grace's lapse on cannabis last week, and plans to ask Grace if she would consider four sessions of relapse prevention counselling with a colleague to address further risks of relapse. The session will also be a chance to clarify if Grace feels ready to enrol in the art course she had planned to do this month and clarify that Grace and her mental health worker are still meeting weekly.

Practice task 17

1. Why do you think it is important to provide positive feedback even if the person has made little progress?

2. Give two examples of when you might review a person's progress in an informal way.

3. How might an organisation's policies, procedures and guidelines inform how and when you review?

Click to complete Practice task 17

3B Monitor, record and report person's progress

Depending on the service you work for, there will be different organisational guidelines on what is required to monitor, record and report a person's progress. This may be dependent on whether a person receiving treatment is doing so voluntarily or at the request of the police or child protection. The setting in which the intervention takes place will also determine how progress is monitored and reported.

Here is some more information

Monitoring

- Depending on the nature of the person's goal and the treatment strategy being employed, monitoring may look very different in varied settings. For in-patient units and residential services, urine screens or blood tests may be used to monitor any drug use and a reduction of drugs in a person's body. Breathalysers may also be used in abstinence-based in-patient, residential and out-patient settings. For other services, monitoring occurs through the person's reporting of their progress, and can be subjectively observed and interpreted through a person's presentation at each appointment. Changes in a person's appearance and mental state from week to week may tell you a lot about their progress or deterioration. Individuals can also assist by self-monitoring, using tools such as a drug use record, which tracks their use and any steps they made to reduce or abstain from their substance use. Further information about a person's progress may be provided by others involved in the person's care such as a loved one or another worker.

Recording

- However you monitor, it is important to record progress whenever you can. Most organisations have guidelines on reporting and these are in line with practice standards in healthcare settings. The person's progress will generally be recorded in their file or against their treatment plan, either of which can be paper or electronic. Write case notes as soon as possible after the appointment or event to ensure accurate recollection of progress. In out-patient settings, a worker may take notes throughout their session with a person to prompt their memory after the appointment. Workers should make an effort to use person-centred and strengths-based language such as, 'Mr Bragg expressed difficulty in completing the task' rather than, 'Mr Bragg failed to comply with the goal'.

Reporting

- You may be required to report a person's progress throughout their treatment to a number of people. These may include:
  - your supervisor
  - colleagues
  - a person's family member
  - other workers involved in the person's care
  - corrections officer
  - child protection worker.
- It is crucial that the person provide consent and advises you of anything that do not wish to disclose to certain parties. Not all of a person's information should be shared, even if they have given consent to release all information. Only that which is relevant to the person's progress is required when sharing information with others. You must advise the person of what you may need to report to court or child protection services.

Example

Monitor, record and report person's progress

AOD worker Oliver is working with Alan, who is seeking to reduce his benzodiazepine use due to child protection requirements. Oliver calls his GP to gain results of three urine screens that Alan has completed in the past three weeks. The GP advises Oliver that results show a drop in Alan's levels of benzodiazepines in his system. Oliver calls Alan's child protection worker and advises them that Alan has been attending appointments regularly and is observed to be more alert and engaged at each session. He also feeds back the GP's results and advises he will call again when he has further information regarding Alan's progress. Oliver records all phone calls into Alan's file.

Practice task 18

1. Name two reasons why breathalysers may be used in out-patient settings such as counselling and group programs.

2. Stuart is accessing AOD support services. He has set a goal to only smoke half a gram of cannabis per evening for a week but at the follow-up appointment advises that he has smoked over 1g each night. How might you record this in an objective and person-centred way?

3. What are two examples of personal information that the individual may not want reported to their family?

Click to complete Practice task 18

3C Negotiate and record revised action plans and timelines in the treatment plan

As a result of the review process, it may be decided that actions and timelines need to be revised.

Here are some reasons that a person may have initially sought AOD treatment.

A person may have initially sought AOD treatment to:

- reduce or eliminate their AOD use
- learn about safer AOD practices
- reduce high-risk behaviour
- improve their overall health through reducing or eliminating AOD use
- improve their relationships with others through reducing or eliminating AOD use
- achieve improved emotional and psychological wellbeing through reducing or eliminating drug use.

Changes to the treatment plan

Changes to treatment plans may vary from small tweaks to significant modifications. There are a number of reasons why revisions may need to be made to the action plan and timeline. Some individuals may be progressing well but have not yet reached their treatment goals. They may wish to make alterations and additions to the treatment plan or extend a certain strategy (for example, relapse prevention counselling) until they are more confident they can manage the changes they have made. It may be that individuals wish to change the goals or outcomes they want to achieve as their treatment progresses. For example, they may start out wanting to quit AOD use altogether and then decide they will be happy if they can cut down AOD use to a reasonable level and minimise harm to themselves. Alternatively, they may start out wanting to cut back and then decide to stop altogether. In each case, you should report the change of goals to your supervisor and other parties in the person's care, and make necessary changes to the treatment plan.

Identify and address additional concerns

As part of the process of reviewing their treatment plan, some individuals may reveal additional unanticipated concerns or difficulties. Revisiting difficulties and barriers in completing set tasks can be helpful when considering changes and new goals. We do not wish for the person to continually fail to meet the goals they set for themselves, so negotiating more achievable tasks is important.

Individuals may have difficulty completing interventions that were initially selected due to a number of factors including:

- not properly understanding what is expected of them
- ambivalence about receiving treatment and lack of motivation
- preoccupation with other concerns such as financial issues
- not thinking the intervention meets their needs
- a lack of rapport with their AOD worker
- existing conditions, such as mental illness, acquired brain injury or disabilities, that make it difficult for them to carry out the intervention.

Reflect on the person's past treatments

Individuals may require additional support and the treatment goals and strategies set may have to be negotiated and revised. When discussing new actions and timelines with the person, consider why the changes are required in the context of the person's presentation as well as past interventions and their level of success. During the initial assessment, you would have asked the person about past attempts to seek help for their AOD use.

If they have made past attempts, it is a good idea to reflect on:

- factors that have motivated the person to reduce their use in the past
- what has been learnt from previous attempts about drug use, relapse, vulnerabilities and coping strategies
- symptoms and complications that have occurred during withdrawal
- medications used during withdrawal
- complementary or alternative treatments
- attendance at counselling, self-help groups, methadone or other substitution therapy
- the person's own efforts at cutting down or abstaining.

Example

Negotiate and record revised action plans and timelines in the treatment plan

Shelley is Zack's AOD care coordinator. She has booked a treatment plan review appointment with Zack, his disability worker and his psychologist. Zack sets a treatment goal of stopping ecstasy and has set tasks of weekly psychologist appointments, spending weekends with friends who don't use and exploring alternative ways of relaxing and feeling good. Shelley is concerned that Zack has not been able to attend two of the past three appointments scheduled with his psychologist, although he reports that he has managed two weekends in a row without using ecstasy.

When discussed further, it becomes clear that Zack only thinks he needs to attend his psychologist appointment if he has used ecstasy over the weekend. The psychologist clarifies that it can be helpful to attend regularly to build on the work they are completing together and to discuss relapse prevention and alternative ways to relax. They agree to meet for four weeks in a row and review at this point. Zack has decided he would like to attend a neighbourhood house to look at courses. This is added to his treatment plan but Zack doesn't have access to public transport. A support worker agrees to drive him to his local centre. They agree to meet in four weeks for another review. After the appointment, Shelley makes copies of the revised treatment plans and sends them to Zack, the support worker and psychologist.

Practice task 19

1. Name two barriers that could exist when trying to achieve tasks that have been set.

2. List two ways you might revisit a person's stage of change to consider revised plans and timelines.

3. A person has identified they would like to change their treatment goal from controlled speed use to abstinence from speed. Name two strategies that may be added to the person's treatment plan

Click to complete Practice task 19

3D Accurately record revisions in the individual treatment plan

Accurately record any revisions to the treatment plan to ensure all parties are aware of the changes and revisions. Revisions to the treatment plan must be recorded in accordance with organisational protocols because they are based on legislative requirements.

Recording revisions accurately caters for any instance that you are away for a period of time. If a person makes contact with the service or a colleague is able to easily review the treatment plan and check the progress of the new tasks or continue to work with the person. If the revisions of the plan are not recorded, the colleague may refer to goals set in the initial plan that was developed, causing confusion to both the worker and the person seeking support.

Recording revisions is also important when including the treatment plan in a person's referral documentation to send to another service. If a worker from the service receiving your referral only has a copy of the initial treatment plan without a record of the changes made, they may see that the treatment plan doesn't include them and decline or disregard the referral. The goals and tasks that were initially added may be outdated and exclude a person from being able to access that service.

Record amendments

Depending on your organisational procedures, changes in the treatment plan tasks and timelines may be added or a new treatment plan may be completed all together. Ensure you accurately record revisions by documenting them as soon as possible after meeting with the person. If you keep a hard copy of the individual treatment plan, be sure to initial and date any additions or changes that you have made to the plan or if you are recording changes on a computer system, ensure you have a record of all treatment plans that have been completed with the person to refer back to. It is also important to send a new and revised treatment plan to everyone involved in the person's care.

Example

Accurately record revisions in the individual treatment plan

Verity and her support worker developed some possible strategies for reducing alcohol use in her treatment plan. The strategies are below.

Drug use/reduction strategies:

- Short term: Conduct brief intervention to raise awareness/ provide information about controlled drinking strategies.
- Medium term: Prepare and use relapse prevention plan.
- Long term: Join AOD support group.

Social/recreational strategies:

- Discuss social support/recreational needs and consider options.
- Identify activities and groups and take steps to participate.

Employment/education training strategies:

- Refer to career counsellor/employment service .

Verity has maintained her controlled alcohol behaviour for three months. She has decided she no longer wants to join an AOD support group and has decided instead to join the gym as she feels this will be more beneficial for her. Verity would like to wait another three months before looking for work.

A revised strategy is below.

Drug use/reduction strategies:

- Short term: Conduct brief intervention to raise awareness/ provide information about controlled drinking strategies – COMPLETED
- Medium term: Prepare and use relapse prevention plan – CONTINUED
- Long term: Join AOD support group – TAKEN OFF TREATMENT PLAN 08/09/16

Social/recreational strategies:

- Discuss social support/recreational needs and consider options. – COMPLETED
- Identify activities and groups and take steps to participate – COMPLETED
- Join the gym. – TO BE ACTIONED BY 30/09/2016

Employment/education training strategies:

- Refer to career counsellor/employment service – ON HOLD, R/V DEC 2016

Practice task 20

1. List two reasons why timely recording of treatment plan revisions is important.

2. Why is it important to keep all previous copies of the treatment plan (or not delete tasks if they have been changed)?

Click to complete Practice task 20

3E Negotiate the person's exit from the program and provide support

Individuals will generally exit the drug and alcohol system for two reasons: they have completed the treatment goals that were set and are feeling confident to maintain the changes they have made, or they will cease before achieving all the goals set in their treatment plan. These can be very different experiences for both the person and the worker and you should consider how to manage both possibilities.

Just as there are protocols in place for the development of a treatment plan, there are also accepted practices involved in concluding interventions. These are listed here.

How to conclude interventions

- Consult with the person to review treatment status and whether or not they have reached their treatment goals.
- Ask individuals about any ongoing concerns they have.
- Discuss how the person will move forward after they are discharged.
- Record all relevant actions and ensure everyone in the treatment plan is aware of the discharge from treatment.

Negotiate post-treatment support

Sometimes individuals will remain engaged with other services or peer support or self-help groups even after the formal treatment planning process. For example, a person may continue to be linked with a mental health worker, their general practitioner (GP) and regular Alcoholics Anonymous (AA) attendance. One important step in a person's discharge process is informing other services who will remain involved that the person has completed their drug and alcohol treatment. This ensures all services are aware of the closure and can continue to support the person, monitor any changes to the person's substance use and determine whether drug and alcohol support is required again in the future.

Advise the person of the process should they require further support or need to re-engage with drug and alcohol services at a later date. Your organisation's policy will dictate whether a person can call you directly or whether they need to complete an assessment with another worker or service. This may be determined based on the scope of your role, your availability and how long it has been since the person has received services. It is a good idea to provide individuals with contact details and clear steps outlining the referral process should they need to access support again. Depending on your organisation, you may have protocols for assertive follow-up over agreed points in time (for example, three and six months after exit) to check in with the person.

Compliance issues

People with drug and alcohol issues can be highly complex and, at times, the work can be very challenging. The reality is that individuals will not always complete the goals and tasks that they initially set or changed as part of the review process. For a range of reasons, individuals do not always comply with intervention strategies that they may have previously agreed to. For example, the person may find it consistently difficult to turn up to appointments, may state that they are adhering to agreed intervention strategies when they are not or they may fail to follow all aspects of agreed intervention strategies.

Apart from obvious signs of relapse or continued drug use, there are a number of ways that you may identify compliance issues. One way is through subjective reporting; for example, a person tells you they have not been following intervention strategies. Another way is through objective reports obtained from test data; for example, breathalysers or blood tests, or reports from AOD professionals.

You may also use your own observation skills; for example, a person may tell you they have not been using alcohol or other drugs, but you can smell alcohol on their breath or observe other signs that indicate they are using.

Monitor compliance

Check a person's compliance on a regular basis. You can do this by simply asking them if they are having any difficulties carrying out the intervention strategies that they have agreed to follow. If a person tells you they are not complying or you hear this from someone else, you should ask permission from the person to discuss the situation and find reasons why this is happening.

Check if there are barriers that are impacting a person's compliance to the treatment plan and work on how these can be addressed. If compliance is still difficult for a person despite discussing and addressing these barriers, review the treatment plan with your supervisor.

Monitor and report eligibility status

In some cases, individuals who are consistently unable to comply with treatment or intervention strategies may no longer be eligible to receive services. While they may have treatment goals it may be that they are not treatment ready. In these circumstances, discuss with your supervisor and follow your organisation's policies and procedures regarding reporting of compliance issues. Advise the person in a sensitive and respectful manner of the need to exit them from the program for now, and offer them options for support. If the person is able to access the service again at a later date when they are ready to address their substance use, let them know of the option to re-engage in the future. Ensure you advise others who are part of the treatment plan (both professional and informal supports) of the person's exit from the program and their options for re-engagement.

Disengagement

An issue that can be common in the drug and alcohol field is a person disengaging without notice. They may simply stop attending appointments and attempts to contact them may be unsuccessful. Most organisations will have guidelines regarding assertive follow-up. This means that a number of attempts should be made to contact the person through phone, text, emergency contact or letter as appropriate prior to closing the person's case file. If the person was referred by another service or has other services that you have consent to share information with, it is good practice to advise those involved that the person has disengaged from the service.

Example

Negotiate the person's exit from the program and provide support

Tina is an AOD worker who is working with Aidan, a teenager who is part of a diversionary program aimed at redirecting young people involved in drug-related offences to AOD services rather than having to go through the legal system. He has been referred to a community AOD service to participate in interventions aimed at raising his awareness of issues associated with drug abuse. When Aidan misses an appointment with her, Tina attempts to call him to reschedule with no success. Despite making two further attempts over the next fortnight, Tina does not get through to Aidan. As per the organisational guidelines regarding noncompliance and disengagement, Tina sends Aidan a letter at the address provided asking him to contact her within one week. Aidan does not make any contact with Tina. Tina calls the diversion worker and advises that she has had no contact with Aidan since he missed an appointment one month ago. Tina informs her supervisor that she has closed Aidan's current treatment and documents each step taken in his file.

Practice task 21

1. List two ways you may know that a person is ready to be discharged from the service.

2. List two potential reasons a person may disengage without notice.

3. If you have been advised to close a person's case file due to their continued inability to attend appointments and difficulty complying with goals they have set, what are two alternative support options you may be able to provide them?

Click to complete Practice task 21

3F Review the outcomes of interventions with your supervisor and/or colleagues

Organisations have a range of processes in place for treatment plans and outcomes to be reviewed. You will be advised of the practices in place for your organisation as part of your orientation to the role.

Supervisors require regular progress feedback so they know how you and the person are proceeding with the treatment plan. Giving supervisors regular feedback helps keep them informed and engaged in what you and the person are trying to achieve. The supervisor's role is to monitor the treatment plan and intervention process. Regular feedback from you allows them to provide suggestions and advice about the strategies and interventions that are being implemented. Providing information about the person's progress is part of your role and is not a breach of the person's confidentiality or privacy.

Here are two ways you can review outcomes of interventions.

Clinical supervision

There is growing interest in clinical supervision for the AOD field. Clinical supervision is now incorporated into most AOD services throughout Australia. The aim of clinical supervision is to develop less-experienced AOD workers' clinical practice skills through the provision of support and guidance from a more-experienced practitioner.

The process of clinical supervision is primarily through collaboration between an experienced practitioner and less-experienced practitioners. Clinical supervision may be individual between a worker and their supervisor or senior clinician, or may be in a group setting with other members of the team for case review and discussion. Clinical supervision is not designed to be a punitive process. Rather, it is an opportunity for workers to learn from others, reflect on their work, and recognise good clinical practice and personal outcomes.

Consult with colleagues

It can also be helpful to review outcomes of interventions with colleagues in a more informal setting, through collegial support and debriefing. This may occur in a spontaneous manner or arise due to an issue that is on your mind immediately after meeting with a person accessing support services. Colleagues are a great source of collective knowledge and will often provide you with an idea or suggestion that you had not considered. If you wish, seek assistance from a colleague about a person's progress and outcomes, be aware of who is around and ensure you find a private area of the office to talk to respect the person's privacy.

Example

Review outcomes of interventions with supervisor and/or colleagues

Connor has been working with Richard for the past 6 months, implementing his treatment plan to abstain from methamphetamine and GHB use. Richard has completed a number of tasks including a course in forklift driving and a course to get his license back. He has reduced his use of both substances significantly with the support of counselling. Richard has recently secured a place at a 6-month residential rehabilitation service and after this will be moving interstate to live with his sister. Connor completes the treatment plan and takes it to his supervisor to review the outcomes. Connor's supervisor suggests that he contact Richard in one week and after one month in the program to ensure he has settled. He advises both the rehabilitation service and Richard's sister that Connor's role has ended.

Connor completes these tasks and one month later closes Richard's file.

Practice task 22

1. Look up the NCETA Guidelines webpage on clinical supervision and read through the section marked Benefits of Clinical Supervision at:
   - http://aspirelr.link/nceta-clinical-supervision.

   What are the top three benefits you think clinical supervision would provide you?

2. Why might it be important to let your supervisor know if you are unsure how to proceed with a person's treatment plan or intervention?

Click to complete Practice task 22

Summary

1. Effective treatment planning involves regular informal and formal reviewing with the individual and other parties involved in the plan.
2. Positive feedback is important for the person regardless of the progress they have made. Reviews can also help clarify roles and next steps.
3. You are required to monitor, record and report a person's progress according to your organisation's guidelines. Monitoring may be through observation, medical tests, and gathering information from the person, family members and workers.
4. Reporting should only be as required and to those that the person has consent for you to share information with.
5. From the review, individuals may identify the need to revise and make changes to their actions or timelines. It can be helpful to revisit difficulties and barriers when added or revising the treatment actions.
6. All revisions in the treatment plan must be recorded according to organisational protocols.
7. Individuals will exit by completing the tasks set in the treatment plan, not complying with the treatment plan or disengaging from the service. Be aware of the organisation's capacity to continue providing support and advise the person of other support options to help maintain the changes they have made.
8. Individual outcomes and difficulties should be reviewed with your supervisor at regular stages throughout a person's care. Colleagues can also provide a wealth of knowledge and experience to contribute to your work with the individual.

Learning checkpoint 3
Review the person's progress

This learning checkpoint allows you to review your skills and knowledge in reviewing the person's progress.

Part A

1. List two examples of how you may monitor a person's progress according to various organisational guidelines.

2. Provide two examples of key tasks that the worker must complete when discharging a person receiving support services at the completion of treatment.

3. Your colleague Meredith has a review appointment with Luther, where she negotiates new action plans and timelines for his goals. Two days after the appointment Meredith breaks her foot and will unable to work for four weeks. Provide two potential consequences of Meredith not recording the revisions in the treatment plan according to organisational protocols.

Part B

Read the case study, then answer the questions that follow.

Case study

AOD worker Bianca has been working with Elsie to coordinate the implementation of her treatment plan. Elsie is 20 years old and has been court ordered to attend drug treatment. She is required to attend six appointments with Bianca. Today is Elsie and Bianca's fourth appointment, which also marks a review of Elsie's treatment goals and strategies.

Elsie originally sets a treatment goal of controlled use of methamphetamines, which she was smoking on a daily basis. Elsie had set the task of only smoking on the weekends (Friday, Saturday and Sunday) and not smoking throughout the week. Elsie has been keeping a drug use record and has attended three sessions of counselling with Bianca. Elsie also attended a three-hour methamphetamine education session called 'Breaking the ice'. Elsie has been unable to abstain from methamphetamines throughout the week, and has only managed two days in a row of not using in the past month.

Elsie decides she would like to change her treatment goal to a period of abstinence, with a desire to have a break from methamphetamines for three months starting at the beginning of next month. She decides to complete a 14-day youth residential stay and continues to see Bianca in a voluntary capacity after her required sessions are finished.

1. Based on the information that you have about Elsie, list two areas where you could provide positive feedback in her review appointment.

2. Why is it important for Bianca to provide positive feedback if she perceives that Elsie has not been able to achieve all the set tasks according to the initial plan?

3. Outline two changes that Bianca and Elsie have negotiated to Elsie's treatment and that Bianca will be documenting in the treatment plan.

4. Bianca meets with her supervisor Anthony to advise him of the outcomes of Elsie's treatment to date and the changes that have been made to the treatment goal and strategies. List two reasons why it is important for Bianca to consult with Anthony about Elsie's treatment.