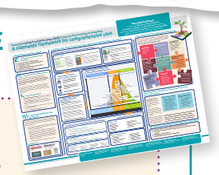
Key features of effective AOD treatment services

The AOD TREATMENT SERVICE DELIVERY FRAMEWORK



The framework provides a state-wide approach to working with AOD clients. Following on from the development of the framework, the Queensland AOD workforce is attempting to build a strong and integrated service sector to ensure continuity of support for the client. The key features of these services are articulated further in this document.

Key features of effective services

Effective AOD treatment services in Queensland are:

- evidence-informed
- targeted to the right clients
- family sensitive
- timely, responsive and comprehensive
- safe, welcoming and non-stigmatising
- accessible and easily contactable in terms of location and opening hours
- accessible in relation to any physical, environmental or procedural barriers
- culturally, religiously, gender, age and developmentally appropriate
- are of adequate standard, staffed by appropriately trained and skilled staff
- Bio-psycho-social in nature

Effective AOD services also:

- promote choice and control by individuals and communities
- monitor progress of all clients to ensure that their service is targeted, coordinated and efficient
- provide continuity of care not only with other AOD services, but also with other health and welfare systems (e.g. mental health, disability, housing, homelessness and statutory services)
- encourage and enable clients and their significant others to provide input and feedback to the service, including opportunities for further engagement where appropriate
- regularly monitor and evaluate their own qualitative and quantitative performance, and use this to inform a process of continuous service quality improvement

Engaging clients and service users

- ✓ The Queensland AOD sector acknowledges the value of meaningful engagement with clients to ensure services meet their needs.
- ✓ Available engagement strategies include a mix of quick, opportunistic tools (such as feedback forms, surveys, questionnaires and suggestion boxes) to deeper engagement options (such as client meetings, focus groups, consumer committees and opportunities to be a member on boards, reference groups and interview panels where appropriate).
- ✓ In order to maximise the benefit of the engagement for both client and agency, the provision of clear, honest communication – including a feedback loop from management – should be maintained.
- ✓ Clients who participate in service development activities should ideally be paid for their contribution and reimbursed for any outlay or expense they incur. Furthermore, clients should be supported to build practical skills wherever possible.

NINE CORE FUNCTIONS OF EFFECTIVE AOD SERVICES

1. Intake, triage, screening and assessment

These should be conducted in a way that enables a service to successfully determine whether further engagement with an individual is appropriate based on the client's needs and the services available. The process should begin with effective engagement and rapport building so that the client feels safe and welcomed. The client's rights and responsibilities must be clearly explained from the outset, including confidentiality and privacy provisions and how to lodge a complaint. The client should be provided with information on all treatment options available (including those offered by other nearby services) to ensure they are able to make an informed choice of service based on appropriate treatment, matched to their needs.

Where the person conducting the assessment believes there is a strong chance the client will not return for further treatment, the session should include a discussion on harm reduction strategies and an exploration of further support options.

2. Counselling and other therapies

AOD services must offer treatment and counselling approaches that match the individual needs and circumstances identified by each client and that are family inclusive. These evidence-informed psychotherapeutic approaches have been endorsed by AOD services and are further discussed in the AOD therapeutic intervention overview A3. 3

3. Outreach

Many AOD services in Queensland use outreach approaches to locate and/or provide treatment to clients. Importantly, outreach is not an intervention in itself. Rather it is a non-agency-based approach to working with clients in order to facilitate interventions.

The Queensland AOD Sector adopts the following definitions to describe the four main outreach modalities offered:

1. Assertive Street Work: Actively looking for individuals who are not currently in AOD treatment in public space locations such as streets, malls, parks, shopping centres etc. Sometimes after hours.
2. Assertive Community Outreach: Actively looking for individuals who are not currently in AOD treatment at other health, social and accommodation service settings, such as hospital emergency departments, Centrelink offices, boarding houses etc.
3. Clinical Outreach: Structured, planned work with clients in another health or support service's venue, such as a hospital, health service, community centre or youth service.
4. Detached/Mobile Outreach: Structured, planned work with clients in their own homes, workplaces or other agreed settings.

4. Waiting list management

Where an AOD treatment service is deemed appropriate but not immediately available, service providers should operate a fair, equitable and clearly explained waiting list. If the service is not deemed suitable, service providers should refer the client to the most appropriate service or option available as soon as possible, and offer assistance to make contact with these services.

5. Case coordination and service integration

Many individuals seeking AOD treatment also experience a range of co-occurring issues or co-morbidities including poor physical and mental health, relationship breakdown, housing stress, financial strain and legal problems. Effective case coordination is required so that clients experience continuity of care.

Case coordination between agencies that have a client in common should be conducted with full client knowledge and consent, unless in exceptional circumstances when there is significant or urgent risk of harm to the client or someone else.

Case coordination is generally more effective when:

- A 'lead agent' is identified who ensures competent case management
- Clear agreements are reached between agencies (e.g. Terms of Reference, MOUs)
- Coordinated treatment plans are regularly monitored and reviewed
- A crisis intervention plan is prepared in advance.

6. Case management and Casework

Case management and casework are common models of support offered to clients across a range of AOD treatment settings.

While it is acknowledged that many practitioners use these terms differently, even interchangeably, the Queensland AOD Sector considers there to be an operational distinction between the practice of case management and casework, as per the following statement:

In the context of AOD treatment, case management comprises the planning, coordinating, brokering and monitoring of a treatment plan, whereas casework is the implementation or actual doing of that plan, and is driven by the client and practitioner.

7. Treatment planning and referral

Treatment plans need to be documented in negotiation with the client and significant others to reflect issues identified during the screening and assessment process. The documented plan should clearly articulate the client's treatment goals, strategies in place to achieve these goals and be regularly reviewed and updated (either triggered by a review timeframe or by the client or clinician).

Post-treatment referral processes should be documented, ensuring the client is not required to re-tell their story unless they request it.

Referrals should only be made once the client has provided informed consent. It is good practice for agencies to follow up their referrals to determine if they were successful and for the receiving agency to provide feedback to the referrer on the process and outcome of the referral.

A successful referral is one that results in the client receiving services from the agency to which they were referred.

8. Harm reduction

Harm minimisation acknowledges that some people will use alcohol and other drugs and, therefore, incorporates polices which aim to prevent or reduce substance-related harms. Harm reduction is a central pillar of the National Drug Strategy's Harm Minimisation approach, along with demand and supply reduction. The defining features of harm reduction are the focus on the prevention of harm, rather than the prevention of substance use itself, and the focus on people who continue to use substances.

Most common harm reduction programs in Australia are needle and syringe programs (primary, secondary and vending machines); a range of peer-based organisations that provide a vital communication link for people who use substances; as well as a range of services that provide intervention into the controlled management of problematic use.

AOD strategies are designed to minimise the harm from substance use and should be coordinated and balanced across the three pillars of demand reduction; supply reduction; and harm reduction.

9. Continuing care and exit of service

The Queensland AOD Sector acknowledges that continuing care is just as important as treatment. Providers are, therefore, committed to high quality post-intervention services where necessary alongside well-executed exit processes when treatment is complete or when a client exits treatment earlier than planned.

The Queensland AOD Sector considers the following practice principles necessary for effective continuing care and/or exit:

- Commence transition planning in the earlier stages of treatment which may include the preparation of a documented exit plan
- Explore and regularly revisit relapse prevention strategies in the lead-up to transition
- Maintain regular communication during transition.

Other activities and support provided within specialist AOD services

Medical Intervention

- Alcohol Pharmacotherapy
- Ambulatory/Out-client/Home-based withdrawal management and support (detoxification)
- Nicotine Replacement/ Smoking Cessation Therapy
- Opioid Treatment Program
- Inpatient/Residential withdrawal management and support (detoxification)
- Blood borne virus screening, vaccination and treatment
- Medical screening, referral and management of co-occurring issues such as pain, mental health, and other chronic conditions

Supportive care

- Assessment only
- Brief intervention
- Consultation and liaison
- Discharge planning, aftercare/ continued care
- Information and education only for clients individually
- Information and education only for clients in groups
- Peer support groups
- Mentoring programs
- Residential Rehabilitation
- Standalone Client Advocacy
- Therapeutic Community
- Therapeutic groups

Court system

- Police Diversion, Illicit Drugs Court Diversion, and Drug and Alcohol Assessment Referral Courses
- Queensland Court Referral
- Queensland Magistrates Early Referral Into Treatment Program

Other

- Preventative activities (e.g. health promotion and population-based measures)

AOD practice with specific populations

The Queensland AOD Sector recognises that specific population groups have particular needs, concerns and barriers that need to be addressed in order to provide fair and accessible AOD treatment. These groups include:

- Family members and significant others
- Intoxicated clients
- People who inject
- People with co-occurring mental health issues
- People who have a physical disability and/or intellectual impairment
- People who are experiencing homelessness
- People who live in rural and remote areas
- Criminal justice clients
- Pregnant women and parents
- Young people
- Culturally and linguistically diverse clients
- Refugees and asylum seekers
- Lesbian, gay, bisexual, transgender and intersex populations

Queensland AOD Services acknowledge the need for ongoing training, workforce and sector development to improve practitioners' and service providers' ability to work effectively with specific populations.

AOD treatment in Aboriginal and Torres Strait Islander communities

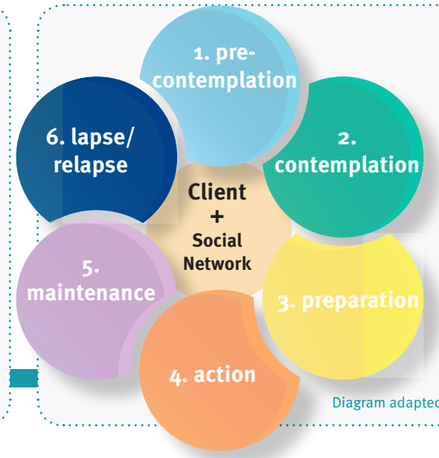
Community-controlled alcohol and other drug services are initiated by local Aboriginal and Torres Strait Islander people and deliver holistic and culturally appropriate care to people within their communities. Aboriginal and Torres Strait Islander issues around AOD use are complex and multi-causal and addressing these issues requires a comprehensive approach that considers social determinants, prevention, culturally safe care and treatment and support to clients, families and communities.

In providing treatment services, Aboriginal Torres Strait Islander community-controlled organisations:

- ✓ Provide appropriate assessment and treatment options for clients
- ✓ Address social and emotional well-being needs of clients which includes connection to culture, family, land and spirituality
- ✓ Consider the role of family and community in treatment
- ✓ Provide holistic treatment services
- ✓ Provide ongoing support post treatment

For non-Indigenous services this includes developing, sustaining and demonstrating cultural competency in service delivery through:

- ✓ Partnering and collaborating with the Aboriginal and Torres Strait Islander AOD sector and communities
- ✓ Participation of Aboriginal and Torres Strait Islander people in governance, management and service delivery levels of the organisation
- ✓ Delivering meaningful outcomes for Aboriginal and Torres Strait Islander people and communities



Putting the client's journey at the centre of our service approach

The Transtheoretical (or 'Stages of Change') Model developed by James Prochaska and Carlo DiClemente in the 1980s is widely used in AOD treatment services as a theoretical tool for guiding psycho-social interventions. It proposes that all individuals move through the following series of stages when attempting to change or modify problematic behaviour.

Identifying the client's 'stage' in relation to their readiness or motivation to change determines what types of interventions may best be applied, as well as the range of possible outcomes that may be achieved.

Diagram adapted from Prochaska and DiClemente (1982)