2022

NADA Practice Guide

PROVIDING ALCOHOL AND OTHER DRUG TREATMENT IN A RESIDENTIAL SETTING

NADA
network of alcohol and other drugs agencies

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While every reasonable effort has been made to ensure that the contents of this resource are correct, NADA does not accept responsibility for the accuracy or completeness of the contents and is not liable to any person in respect of anything done or omitted in reliance upon the content of this resource.

Acknowledgement of Country
NADA proudly acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the lands and waters throughout Australia. Our office stands on the land of the Gadigal people of the Eora Nation.

We recognise, respect and value the deep and continuing connection of Aboriginal and Torres Strait Islander people to land, water, community and culture.

We look to celebrate Aboriginal and Torres Strait Islander people for their cultural guidance, leadership and expertise.

We pay our respects to Elders past, present and future.

A note on language used in this Practice Guide
Language is a powerful tool. As a peak body, NADA understands that its work presents both an opportunity and a responsibility to shape how we, as a sector, discuss alcohol and other drugs and the people and communities affected by their use. NADA is committed to using language and imagery that aligns with the needs and preferences of the people and communities we work with and for, and that demonstrates respect for the agency, dignity and worth of all people. To this end, in this Practice Guide we prioritise using the terms 'person' and 'people' where possible, as opposed to clients, consumers or service users. For further information and tips on inclusive language, see the *Language matters guide*, which NADA developed in partnership with the NSW Users and AIDS Association (NUAA).

Acknowledgements
NADA would like to acknowledge the people with lived experience of accessing alcohol and other drug treatment in a residential setting who provided insights, advice and feedback on this Practice Guide. This resource was developed by Dr Suzie Hudson, Clinical Director at NADA, with considerable contribution from NADA members, who were consulted and provided feedback to the guide. We also acknowledge the contribution of members of the NADA Practice Leadership Group (NPLG), Women's Network, Youth Network and the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN), without whom this guide would not have been possible. NADA also thanks staff from the NSW Ministry of Health, Centre for Alcohol and Other Drugs (CAOD), for their advice and input.

NADA would like to acknowledge the thorough and extensive work conducted by the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney, in the research and consultation conducted as part of the evidence check for this Practice Guide. The evidence and consultations with members and consumers that were conducted by the Matilda Centre provide the foundation for this Practice Guide.
Best practice approaches for alcohol and other drug treatment in residential rehabilitation

NADA would also like to acknowledge that this piece of work was supported by funding from the Australian Government Department of Health and the NSW Ministry of Health.

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NADA Practice Guide

PROVIDING ALCOHOL AND OTHER DRUG TREATMENT IN A RESIDENTIAL SETTING

ABOUT THIS PRACTICE GUIDE

The *NADA Practice Guide: Providing Alcohol and Other Drug Treatment in a Residential Setting* was informed by evidence-based practices documented in peer-reviewed literature (Madden et al. 2021), the previous NSW Health Drug and Alcohol Treatment Guidelines for Residential Settings (NSW Health 2007), and extensive consultation with NADA member organisations that provide specialist alcohol and other drug treatment in residential treatment and with people who have accessed this treatment. In addition, key resources that have been drawn on for principles of good practice include:

- Non-Government Organisation Alcohol and other Drugs Treatment Service Specifications (NSW Health 2017)
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 (Department of Health 2019)
- Non-Government Alcohol and Other Drugs Treatment Services Specifications (NSW Health 2021)
- NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment (NSW Health 2020)
- Non-Government Alcohol and Other Drugs Treatment Services Specifications (NSW Health 2021)

This Practice Guide was developed in response to a need for workers who provide AOD treatment to people in residential settings to have the most up-to-date evidenced-based practice approaches at their fingertips. While this Practice Guide was developed for use by the non-government AOD sector in NSW, the information in it is also relevant for, and could be used by, organisations that provide specialist AOD treatment in residential settings anywhere in Australia.

How this Practice Guide relates to the NADA Workforce Capability Framework

Preventing and reducing alcohol and other drug (AOD)-related harm in Australia requires a skilled, effective and adaptable workforce. The NSW non-government AOD sector's **Workforce Capability Framework** (NADA 2020) establishes a common language and shared understanding of the knowledge, skills and attributes that workers in the sector are expected to have in order to carry out their work efficiently and appropriately. The Framework plays an important role in promoting many of the core capabilities expected of the AOD sector to work effectively and meaningfully with diverse populations. It is organised into six areas of professional responsibility, referred to as domains. Each domain requires specific capabilities – or the knowledge, skills and attributes that a worker in the sector is expected to have to carry out their work effectively, efficiently and appropriately within that domain. This Practice Guide is aligned with, promotes and addresses the NADA Workforce Capability Framework core capabilities.NADA Workforce Capability Framework core capabilities.

ABOUT NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for non government AOD services in NSW. We advocate for, strengthen and support the sector. Our decisions and actions are informed by the experiences, knowledge and concerns of our members.

We represent 80 organisational members that provide services in over 100 locations across NSW and the ACT. They provide a broad range of AOD services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Our members are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery.

We provide a range of programs and services that focus on sector and workforce development, data management, governance and management support, research and evaluation, sector representation and advocacy, as well as actively contributing to public health policy.

Together, we improve the health and wellbeing of people who use, or have used, AOD across the NSW community.

NADA has award level accreditation under the Australian Services Excellence Standards (ASES), a quality framework certified by Quality Innovation and Performance (QIP).

GLOSSARY

AOD	alcohol and other drugs
ASSERTIVE FOLLOW UP	a process of checking in with clients by SMS, phone call, email, social media platform or letter as a means of providing support, reminding them of upcoming appointments or following up on missed appointments
CLINICAL CARE STANDARDS FOR ALCOHOL AND OTHER DRUG TREATMENT (NSW MINISTRY OF HEALTH)	a set of statements about the treatment a client should be able to expect when they seek treatment for a specific condition or health problem; devised by the Centre for Alcohol and Other Drugs (CAOD) in collaboration with the NSW AOD sector, they are applicable to all services and agencies providing AOD treatment in NSW
COMPLEX NEEDS	refers to the interaction of the multiple areas of need that people accessing AOD treatment may experience, including mental health issues, experiences of trauma, domestic and family violence, experiences with the criminal justice system, physical and cognitive health needs and factors associated with marginalisation
CONTINUING CARE	can refer to the provision of support and/or services (such as support groups, supported accommodation, case management) that occurs after a more intensive initial period of AOD treatment, such as a residential program; however, it can also include services and support that assist a person to connect and maintain engagement with AOD treatment, which may be delivered through community-based programs and primary care
FAMILY-SENSITIVE OR FAMILY-INCLUSIVE PRACTICE	family-sensitive or family-inclusive practice an approach that recognises that interventions are more effective when they include family members, including any/all relevant personal supports and significant others; supports the view that individuals influence other members in their environment, especially family, and that family members in turn affect the individual outcomes
HOLISTIC PRACTICE	an approach that recognises that interventions are more effective when they include family members, including any/all relevant personal supports and significant others; supports the view that individuals influence other members in their environment, especially family, and that family members in turn affect the individual outcomes
NADABASE	the online data platform provided by NADA to all members that is the repository for national and state alcohol and other drugs treatment (AODTS) minimum data sets, outcomes measures and screeners for domestic and family violence (DFV), bloodborne viruses and sexual health, suicidal ideation and tobacco use
RESIDENTIAL TREATMENT SERVICE	any 24-hour, staffed residential treatment program that offers intensive, structured interventions after withdrawal from drugs of dependence
STRENGTHS-BASED APPROACH	an approach to treatment that recognises the resilience of individuals and focuses on their strengths and potential rather than their deficits
TAKE HOME NALOXONE	a harm-reduction program delivered by NSW Health that makes naloxone available to use at home through treatment and health services and pharmacies as a way of reducing the harms associated with opioid overdose
TRAUMA-INFORMED CARE OR PRACTICE	describes a way of working with people that acknowledges the lasting effects of trauma, emphasises physical, psychological and emotional safety for both consumers and providers, and supports survivors to regain a sense of control and empowerment over their lives

ACRONYMS

AOD	alcohol and other drugs
ACT	Acceptance and Commitment Therapy
ADARRN	Aboriginal Drug and Alcohol Residential Rehabilitation Network
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
ATCA	Australasian Therapeutic Community Association
BBV	bloodborne virus
CALD	culturally and linguistically diverse
CAOD	Centre for Alcohol and Other Drugs, NSW Ministry of Health
CBT	Cognitive Behavioural Therapy
CRA(FT)	Community Reinforcement Approaches (and Family Training)
CTO	Community Treatment Order
DAMEC	Drug and Alcohol Multicultural Education Centre
DCJ	Department of Communities and Justice
DFV	Domestic and family violence
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer and other sexuality and gender identities
MOH	NSW Ministry of Health
NADA	Network of Alcohol and other Drugs Agencies
NSW	New South Wales
NCETA	National Centre for Education and Training on Addiction
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NGO	non-government organisation
NRT	nicotine replacement therapy
PARVAN	Prevention and Response to Violence, Abuse and Neglect

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Do you work in the AOD sector?

Chances are you bring some essential qualities to your work, including:

- a non-judgemental attitude
- empathy and compassion
- a willingness to work with clients 'where they are at'
- the ability to listen and support clients and those who support them
- a commitment to challenge discrimination and stigmatising language and behaviour
- skills and professionalism
- an optimistic approach that creates an environment to foster hope or a positive regard for change on the part of the person accessing treatment
- holistic practice that considers all of the factors that contribute to improved wellbeing
- a passion for social justice and equality
- a curiosity that drives you to engage with innovative, best-practice interventions.

The great news is that these are exactly the kinds of qualities that are essential when providing AOD treatment in a residential setting.

What is unique about residential rehabilitation?

Providing AOD treatment in a residential setting offers a unique set of opportunities for holistic and intensive treatment. Throughout the client journey in residential treatment there are many and varied occasions when therapeutic support can be provided in response to daily tasks and activities. Furthermore, it provides for holistic care where a variety of physical, social and emotional health needs can be attended to as a result of the person being an active participant in treatment during their residential stay.

Treatment in a residential setting provides small opportunities to make big personal gains

An argument has started in the kitchen between two residents over the lid not being put back on the butter. A small issue, you might think, but an opportunity for growth and therapeutic learning in the moment.

- *What does it say about someone that they would like the lid to be put back on the butter?*
- *How can these small gestures of respect be grown and emphasised?*
- *What might supporting two people to work through this apparently minor conflict provide for each of them with regard to their other significant relationships?*

PURPOSE OF THE RESOURCE

Designed as a Practice Guide, this resource replaces the previously developed *Drug and alcohol treatment guidelines for residential settings* (2007), produced by the Ministry of Health in collaboration with NADA members and providers of residential treatment in New South Wales. It was developed in response to a need for workers who provide AOD treatment to people in residential settings to have the most up-to-date and evidenced-based practice approaches at their fingertips.

The purpose of this Practice Guide is to support you in the work that you and your organisation engage in every day. In this resource you will find frontline worker experiences from organisations that provide specialist AOD services in residential settings; best-practice approaches that you and your organisation can implement; and a range of templates and resources that you can use in your practice. While it covers a wide range of topic areas, it is by no means exhaustive.

A considerable variety of written documents was reviewed for the purposes of informing this Practice Guide, including treatment guidelines, policy documents, grey literature, technical reports, quality standards and strategy documents. Sources were most commonly state or federal government health departments or peak bodies such as NADA and the Australasian Therapeutic Community Association (ATCA) (Madden et al. 2021). In addition, current providers of AOD treatment and people who have been engaged by these services were consulted for their views on best-practice approaches to AOD treatment in residential settings, practical application of research evidence and essential elements for sustainable outcomes.

In this Practice Guide, the term 'residential treatment service' is used to mean any 24-hour, staffed residential treatment program that offers intensive, structured interventions after withdrawal from drugs of dependence. This Practice Guide does not address residential stays in withdrawal management (or detoxification) programs; however, it does make reference to withdrawal management models.

The evidence check and consultations commissioned by NADA (Madden et el. 2021) have significantly informed the development of this Practice Guide in order that it:

- be current and evidence-informed
- reflect the broader Australian context and frameworks for service provision and treatment delivery
- review the effectiveness of AOD treatment modalities within the residential treatment setting, as well as the implementation of these modalities for particular client groups
- consider the perspectives of people with lived experience of AOD use and residential treatment.

For more information about the methods used to undertake the evidence check and member consultation please refer to ***Best practice approaches for alcohol and other drug treatment in residential rehabilitation*** (Madden et al. 2021).

HOW TO NAVIGATE THIS PRACTICE RESOURCE

This Practice Guide is designed to be a quick reference guide. It is separated into seven sections that each cover a specific topic. The concluding section provides important additional guidelines, templates and recommendations for further reading, grouped according to the topics they relate to.

Sections have been structured to promote thought, reflection and discussion about practice approaches in residential settings based on the evidence and feedback from treatment providers and people who have experienced residential treatment. Each section addresses a key area of knowledge that contributes to improved ways of working. Concise summaries of research and practice literature relevant to each topic area are presented throughout the resource, as well as a number of regular features including:

Key points and principles – appear at the beginning of each section for quick reference on the takeaway points and principles explored in the section.

From the frontline – provides a snapshot of real-life worker experiences and practice wisdom sourced from AOD workers and managers who provide AOD treatment in residential settings and who were consulted as part of the development of this Practice Guide.

Case studies – present lived experiences and insights into the journeys of people accessing AOD treatment in a residential setting.

Find out more – provides references and links to original source literature, published research, guidelines and clinical guides that have been reviewed in the development of this Practice Guide; recommended resources can be used as a catalyst for further reading and exploration into material that will support improved treatment provision.

Partnerships & links – provides suggested partner services and links to providers/stakeholders, including those from other sectors, that can support the care you provide.

1 ALCOHOL AND OTHER DRUGS TREATMENT IN RESIDENTIAL SETTINGS

KEY POINTS AND PRINCIPLES

- All people seeking AOD treatment are able to access high-quality treatment appropriate to their needs, when and where they need it.
- Specialist AOD treatment is provided along a continuum of intensity, and treatment provided in a residential setting is among the most intensive treatment available.
- AOD treatment in a residential setting provides a unique opportunity to provide 24-hour, structured care in a safe, alcohol and illicit drug–free environment.
- As with all specialist AOD treatment, treatment provided in a residential setting is person-centred, holistic, collaborative and trauma-informed.
- Awareness and respect for Aboriginal, Torres Strait Islander and all First Nations peoples' knowing informs the way AOD treatment is provided.
- AOD treatment provided in a residential setting is inclusive and respectful of diversity.
- Specific attention should be paid to the experience and effects of stigma and discrimination against those accessing treatment and those who support them.
- AOD treatment provided in a residential setting is subject to accreditation standards that ensure quality improvement processes are part of quality service delivery.
- AOD treatment provided in a residential setting is shaped by client demographic, outcomes and experience data.

1.1 AOD treatment in residential settings: service standards

In this Practice Guide, the term 'residential treatment service' is used to refer to any 24-hour, staffed residential treatment service that offers intensive, structured interventions after withdrawal from drugs of dependence. While the model of care for treatment, program elements and length of residential stay may vary across services, there are key principles and practice approaches that are common across all. There are also clear service standards relating to what is expected from AOD treatment provided in a residential setting with respect to quality of care, and the defined performance deliverables by a service in line with funding agreements.

The National Quality Framework for Alcohol and Other Drug Treatment Services "provides a national agreement on a quality benchmark for the delivery of AOD treatment services" (Commonwealth of Australia, Department of Health 2018). In practice the Framework articulates an expected nationally consistent set of quality service principles regarding accreditation and quality improvement processes. The Framework applies to all AOD treatment providers regardless of their funding source and asserts that "providers of drug and alcohol treatment services are required to obtain accreditation with at least one of the accreditation standards to be compliant with the National Quality Framework (Commonwealth of Australia, Department of Health 2018, 12).

The companion document to the National Quality Framework for Alcohol and Other Drug Treatment Services is the National Framework for Alcohol, Tobacco and other Drug Treatment 2019–2029 (Commonwealth of Australia, Department of Health 2019). This Framework, also endorsed at national level, provides clear guidance to the workforce and all treatment providers on the key principles of quality AOD treatment and ensures a common understanding among providers, funders, policy makers, people accessing treatment and members of the community. Treatment provided in a residential setting is outlined as an intensive intervention according to the Framework, and described as:

> An intensive treatment program that integrates a range of services and therapeutic activities, including counselling, behavioural treatment approaches, social and community living skills, relapse prevention and recreational activities (Commonwealth of Australia, Department of Health 2019).

In NSW the **Clinical Care Standards for Alcohol and Other Drug Treatment**, outline the core elements of care that underpin treatment in the AOD sector and apply to all service types, including treatment provided in a residential setting. This Practice Guide refers to the Clinical Care standards throughout with the intention that they complement the guidance provided here in delivering high-quality and safe treatment.

In Australia, residential treatment accounts for approximately one in six (or 16% of) closed treatment episodes, and recent Australian Institute of Health and Welfare (AIHW) figures show that closed treatment episodes delivered in Australian AOD treatment settings increased by approximately 45% from 143,672 in 2008–09 to 208,935 in 2017–18 (2019). Residential treatment takes place in a 24-hour, staffed facility that offers intensive interventions for people with moderate to severe AOD conditions. These interventions usually take place following withdrawal, with the aim of delivering treatment in an AOD free environment (NSW Health 2007).

Residential treatment (excluding withdrawal treatment) is often best suited for those seeking intensive, structured 24 hour support and those with complex support needs. It delivers holistic, client-centred treatment to address substance use disorders, and provides psychosocial interventions to address issues behind the substance dependence. Some specialist services also provide withdrawal management on site, which may be tailored to include pregnant women, women with babies and young people. Some residential treatments also provide skills-development programs including education, accredited training, sport, and recreation activities. In a therapeutic community (one approach of residential treatment), the 'community' is thought of as both the context and the method of the treatment model, where both staff and those seeking treatment and support, often referred to as 'residents' are responsible to an extent for the functioning of the service as an element of their treatment program (NSW Health 2007, ATCA 2019).

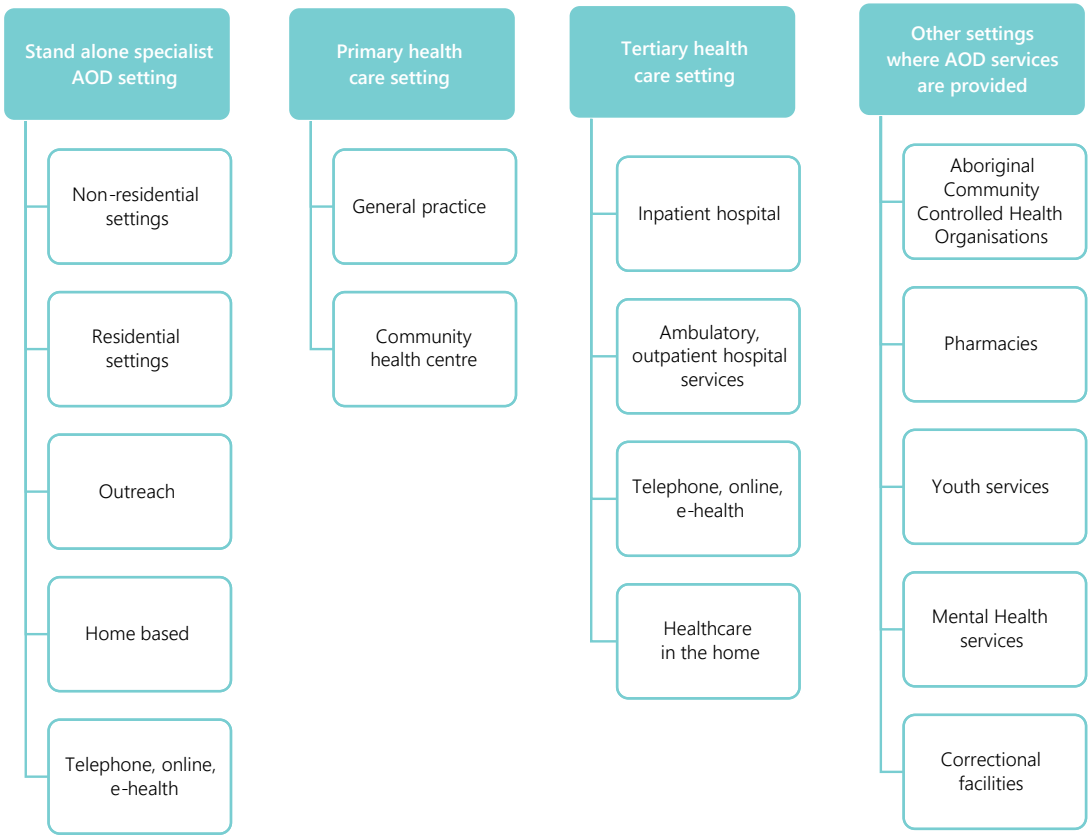
Some services offer supported accommodation programs where clients live semi-independently with support. Continuing care support may be provided as part of a transition process in the community, with the length of stay in this part of care shaped by client need and organisational capacity.

The length, intensity and type of residential care provided is driven by client need. However, there can be variation of stay length depending on the program offered. According to the Non-Government Organisation Alcohol and Other Drugs Treatment Service Specifications (Ritter & Sotade 2017), the goals of residential treatment are to:

- provide an environment free of alcohol, other drugs and non-prescribed pharmaceuticals
- deliver a structured and person-centred treatment program
- reduce the harmful use of alcohol or other drugs
- facilitate the achievement of health, wellbeing and quality of life
- provide care in the context of harm reduction.

The history of AOD treatment in residential settings in NSW is lengthy and was originally shaped by '12 step' approaches, supported by other intervention types and health/medical service support, influenced by US and UK models. Approaches from the 1970s were influenced by the principal drugs of concern identified by people accessing treatment, such as heroin and alcohol, this was in response to the absence of any regular state wide data identifying principal drugs of concern and the emphasis was on longer-stay programs. Throughout the 1980s and 1990s programs began to be structured into modules or phases of treatment, which affected their length, and the availability of short (around one month) and medium (up to six months) programs emerged. Currently, program length is more flexible, with services adopting a person-centred approach and program length being shaped to suit the needs of the person accessing treatment. However, many residential programs continue to offer programs designed around specific lengths of stay.

Different alcohol and other drug treatment settings



The variety of services available to people in NSW now includes:

- specialist residential programs for Aboriginal and Torres Strait Islander people, delivered by Aboriginal community–controlled organisations
- specialist residential programs for women, pregnant women, women and their children, and families
- specialist residential programs for young people
- specialist residential programs for men, and mixed-gender programs
- specialist residential treatment programs for people on opioid substitution treatment
- specialist residential treatment programs for people who have co-occurring mental health concerns
- specialist residential programs that focus on faith-based or spiritual approaches
- specialist treatment programs for people diverted from the criminal justice system through the Magistrates Early Referral Into Treatment (MERIT) program and Drug Court – residential programs

For more information about these services, explore the Network of Alcohol and Drug Agencies (NADA) website at www.nada.org.au

In addition, there are involuntary drug and alcohol treatment services provided by local health districts, for people who have been placed under a legal order by the government to reside in treatment.

1.2 Accreditation and quality standards

In NSW, as in most other states and territories across Australia, AOD treatment provided in residential settings that is funded by the government is subject to specific quality standards and an accreditation process. Under the National Quality Framework (Commonwealth of Australia, Department of Health 2018), all providers of AOD treatment across Australia are required to hold accreditation by November 2022.

Accreditation is based on recognition by an independent third party that a service or program meets the requirements of defined criteria or standards. Accreditation provides quality and performance assurance for owners, managers, staff, funding bodies and consumers (Ritter & Sotade 2017). The key providers of healthcare accreditation programs recognised by the NSW Ministry of Health are registered on the MoH website and at the time of publication includes the following. However, the National Quality Framework includes some additional standards.

Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) Evaluation and Quality Improvement Program 6th edition (EQuIP6) is a quality assessment and improvement accreditation program for healthcare organisations that supports excellence in consumer or patient care and services. It aims to assists healthcare organisations and services with quality improvement efforts.
www.achs.org.au/publications-resources/equip6

Quality Improvement Council Health and Community Services Standards
The Quality Improvement Council's (QIC) Health and Community Services Standards 7th edition are used by a wide range of health and community services and involve a continuous quality improvement approach. QIC recognises strengths and areas for improvement, helping organisations to identify quality improvement priorities.
www.qip.com.au

Australian Service Excellence Standards
The Australian Service Excellence Standards (ASES) are managed by the Government of South Australia and support community and non-government organisations (NGOs) in the community services sector, particularly small and medium-sized community service organisations, to effectively manage resources, gain a better understanding of consumer needs, and improve accountability and reporting.
www.dhs.sa.gov.au/services/community-services/australian-service-excellence-standards

Australasian Therapeutic Communities Associated Standard for Therapeutic Communities and Residential Rehabilitation Services
The Australasian Therapeutic Communities Associated (ATCA) Standard for Therapeutic Communities and Residential Rehabilitation Services was approved by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) in 2012, and has subsequently been updated twice, with a third edition released in 2019.
www.atca.com.au

Alcohol and other Drug and Human Services Standard
Evidence Informed, Culturally Responsive
The Alcohol and other Drug and Human Services Standard was developed by the Western Australian Network of Alcohol and other Drug Agencies (WANDA) in 2019 in consultation with the WA alcohol and other drug sector and other human service sector representatives.
www.wanada.org.au/sector-quality/the-standard

Centre for Alcohol and Other Drugs, NSW Ministry of Health
In 2018 the NSW Ministry of Health introduced a new set of key performance indicators for services funded by the NSW State Government. They include:

- AOD-Core 1 NSW Minimum Data Set for Drug and Alcohol Treatment Services
- AOD-Core 2 Organisation Accreditation and Clinical Governance
- AOD-Core 3 Client Reported Experience
- AOD-Core 4 Clinical Incident Management
- AOD-Core 5 Client Discharge and Transfer of Care.

CLINICAL GOVERNANCE

Membership of peak organisations such as the Network of Alcohol and other Drugs Agencies (NADA) is another indication that a service provides a standard of quality care. NADA membership is dependent on identifying as a specialist AOD service, providing evidence-based services, and being accredited. Organisations that are not accredited, but have a formal quality improvement program are eligible to be an associate member, without voting rights.

Good clinical governance ensures that a comprehensive system of relationships and clearly articulated responsibilities is in place to ensure the delivery of safe and high-quality care and quality improvement. Organisations that deliver AOD treatment in residential settings require a documented clinical governance framework that everyone, including frontline workers, management and board members, is informed and educated about. Roles and responsibilities need to be clearly articulated and accountability to each person accessing treatment, their supports and the wider community needs to be transparent. The development of a clinical governance framework is one element of an accreditation process.

More specific information about developing a clinical governance framework is available through the Australian Commission on Safety and Quality in Health Care's National Model Clinical Governance Framework (2017), which emphasises the importance of people accessing treatment being central to informing good clinical governance through feedback mechanisms, consultation and involvement in quality improvement processes. The case study below provides a snapshot of clinical governance in action, and is followed by a closer exploration of some specific elements of a clinical governance framework.

Case study

Journey, a specialist AOD residential treatment facility, put in place a new incident management system, conducted a training and implementation program, and had the project overseen by an advisory committee that included staff, consumer representatives and senior managers. Six months later it conducted a review to gather feedback on the implementation process, to identify any gaps in knowledge or support, and to assess whether the new system had affected service delivery. The review found that the way in which the new incident management system published alerts and how they were discussed in clinical meetings left staff feeling blamed for incidents and disempowered regarding potential ways to mitigate incident risks. A need was also identified for improved pathways to escalate incidents. In response, the organisation facilitated some small-group discussions to explore better ways of understanding incident management and enhanced the clinical governance pathways regarding escalation of identified risks. It also modified the way incidents were reported and discussed, based on staff and consumer input. A further review was scheduled for six months' time.

CLINICAL INCIDENT MANAGEMENT

A clinical incident management system ensures that clinical incidents are identified, appropriately responded to and reported, and that this information is used to improve the safety and quality of care. AOD treatment in residential settings requires a clearly articulated system for clinical incident management, and services and programs funded by NSW Health are required to provide evidence of current clinical incident policy and protocols, and a regularly reported analysis of recent clinical incident data, trends and improvement plans.

Find out more ...

- Safety and Quality and the National Model Clinical Governance Framework www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf

- National Treatment Framework https://www.health.gov.au/sites/default/files/documents/2019/12/national-quality-framework-for-drug-and-alcohol-treatment-services_0.pdf

NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment

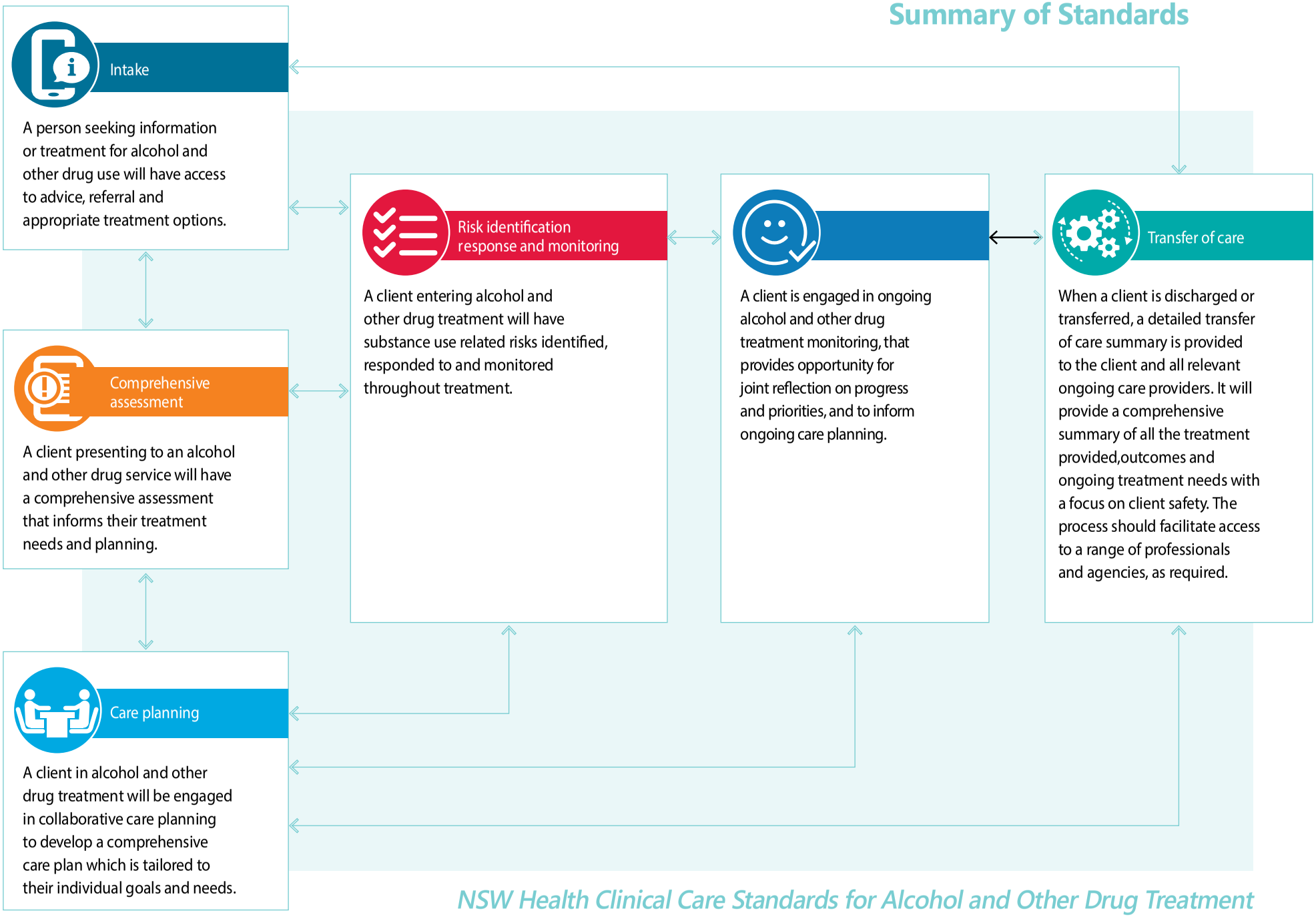
The NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment outline the key elements of care that people accessing AOD treatment in NSW can expect to receive. Consistent with the principles of value-based health care, the standards underpin the delivery of outcomes and experience that matter to people and the communities in which they participate (NSW Health 2020).

People with alcohol and other drug-related harms experience person-centred, safe high-quality intervention and care

PRINCIPLE	PRACTICE
Principle 1 Services are person-centred	Services are provided within a trusted, inclusive and respectful culture that values and promotes a beneficial partnership between clients, their significant others and staff. The service respects diversity and is responsive to clients' needs and values. The experience of clients and their families is reflected in the service system.
Principle 2 Services are safe	Services are continuously improving outcomes by giving regard to the physical, psychosocial and cultural wellbeing of all clients, and minimising the risk of harm.
Principle 3 Services are accessible and timely	The service system is visible, accessible from multiple points of entry, equitable and timely. Clients experience care as welcoming, accepting, non-judgemental and responsive to their needs.
Principle 4 Services are effective	Services are holistic, evidence-based and supported by NSW Health endorsed standards, policies and guidelines. The service system attends to the diverse medical, psychological and social needs of clients. The continuum of care is integrated across NSW Health, primary care and non-government organisations to reduce fragmentation and optimise outcomes.
Principle 5 Services are appropriate	The service system provides a range of approaches to meet the diverse needs of clients. The experience of clients and their significant others is reflected in the service system. Clients are informed about and engaged in influencing, services, treatment and options in a clear and open way. The right evidence-based care is provided by the right providers to the right person, in the right place and at the right time, resulting in optimal quality care.
Principle 6 Services use their resources efficiently	Services maximise the use of available resources to deliver sustainable, high-quality care. Services ensure close alignment and integration across services and sectors to avoid duplication or omission of service.
Principle 7 Services are delivered by a qualified workforce	The workforce has the requisite skills, knowledge, values and attitudes to respond to clients' needs, and a capability and willingness to work across disciplines and sectors.

The principles of practice underpin all levels of AOD care and service delivery.

Summary of Standards



1.3 Residential treatment principles of care

STIGMA AND DISCRIMINATION

Experience of stigma and discrimination is common among people who use alcohol and other drugs, including those who may be trying to access health care. Awareness of this fact is important to the provision of safe, quality care. In practice, this means engaging in training opportunities designed to assist workers to understand the experience of stigma and discrimination and how their own approach to supporting people in treatment needs to be conducted. It is also useful to be aware that some groups have multiple layers of stigma as a result of their gender, sexual orientation, cultural background, age or disability. Language is powerful, especially when talking about alcohol and other drugs and people who use them. Being mindful about the language we use is not about being 'politically correct': language is an important practice tool that can empower clients and fight stigma, and is a useful focus for behaviour change in an AOD treatment context.

'Person-centred language' is language that focuses on the person and not on their alcohol or drug use. Using person-centred language is an effective way to show respect for a person's agency, dignity and worth. These considerations extend to the people who support those accessing treatment, including families, carers, significant others and children. For more information about person-centred language designed to reduce the stigma and discrimination experienced by people who use alcohol and other drugs and/or who engage in treatment, see the Language matters guide, which NADA developed in partnership with the NSW Users and AIDS Association (NUAA).

STRENGTHS-BASED AND PERSON-CENTRED APPROACH

Working from a strengths-based approach means identifying the positives in a person's life and putting energy into growing them. There is a focus on wellness, and acknowledgement that despite facing adversity, people often do well and thrive. To achieve the goal of reducing substance use harms, this might mean focusing on growing alternative activities and connections, and reducing the significant space and time that the substance use occupies.

A strengths-based approach is a way of working, rather than a set of rules or tools. In

From the frontline

'Aboriginal people are incredibly resilient! And strengths-based approaches build upon this. By using clients' strengths in AOD work, you take away the shame. Strengths-based approaches also encourage high levels of self-esteem – clients see achievements quickly and then reach their goals.'
Lee Lawrence, Nana Muru Project, Lives Lived Well

'Working from a strengths-based approach provides an opportunity to see young people differently and give them a different experience of themselves. This creates space and opportunity to tune into things they are passionate about, identify what they are good at, and tune into what their values are for themselves in the future.'
Mardi Diles and Dylan Clay, Speak Out Program, Weave

'Many of the women we work alongside have experienced significant adversity throughout their lives, particularly trauma. Working within a strengths-based model allows us to collaborate with our clients, who are ultimately the experts in their own recovery.'
Lara Newstead, Eloura Women's Program, Lives Lived Well

practice, it looks like this:

- **Be goal oriented**
  'What is one thing you would like to work towards while you're here?'
- **Assess the person's strengths**
  'What did it take to get you here today?'
- **Make links to resources**
  'Are there people or activities that you've connected with before?'
- **Apply the right methods**
  'Let's focus on your story of courage – how can we grow that?'
- **Emphasise positive relationships**
  'Did you know there's a great neighbourhood centre that does some cultural programs you might be interested in – shall we give them a call?'
- **Provide opportunities for meaningful choice**
  'Are you aware there are a couple of different kinds of programs we offer – can I take you through them so we can explore what might suit your situation best?'

Find out more ...

Strengths-based practice framework UK Department of health & Social Care 2019

Youth AOD Toolbox: Strengths-based approach YSAS and The Centre for Youth AOD Practice Development

NADA Advocate: Strengths-based approaches NADA 2021

TRAUMA-INFORMED CARE

Trauma is often considered as resulting from a one-off event, yet repeated extreme interpersonal trauma resulting from adverse childhood events (known as `complex trauma') is not only more common but far more prevalent than currently acknowledged, even within the mental health sector. The effects of complex (cumulative, underlying) trauma are pervasive and, if left unresolved, can negatively affect mental and physical health across a person's lifespan.

Research shows that the effects of even severe early trauma can be resolved, and its negative intergenerational effects can be intercepted. People can and do recover, and their children can do well. For this to occur, mental health and human service delivery needs to reflect current research insights (Kezelman & Stavropoulos 2012).

AOD treatment services and workers wanting to become trauma informed and engage in trauma-informed care need first to connect with the following five core principles.

- **Safety** How can workers/AOD services be modified to more effectively and consistently ensure physical and emotional safety?
- **Trustworthiness** How might a service modify its practices to engender trustworthiness through task clarity, consistency, transparency and interpersonal boundaries?
- **Choice** How can services be modified to ensure that consumer experiences of choice and control are maximised?
- **Collaboration** How can services be modified to ensure that collaboration and power sharing are maximised?
- **Empowerment** How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximised?

(Adapted from Complex Needs Capable, NADA 2013, based on ASCA practice guidelines for trauma-informed care)

AOD use disorders, mental health and trauma are now recognised as critical and interrelated issues, requiring comprehensive treatment responses (NIDA 2009). According to the Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework that guides all NSW Health services to provide a coordinated response for people accessing AOD treatment with their experiences of violence, abuse and neglect. And that service provision be person-centred, family-focussed, provide seamless care across multiple services, and use a multidisciplinary and trauma-informed approach designed around the holistic needs of the person and their family throughout their life course (PARVAN 2020)

Find out more ...

- IPARVAN Framework
- PARVAN Information

SAFETY AND AMENITY

Safety and physical space considerations are important to providing person-centred and trauma-informed AOD treatment in residential settings. We can learn a lot from Aboriginal and Torres Strait Islander people regarding healing spaces and the integration of trauma-informed care into the physical amenity of a residential facility where AOD treatment is provided. You can read more about Aboriginal community–controlled organisations that provide residential care and how they create a healing space on the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN) website. Additional consideration needs to be extended to safety with regard to visits from children, family and friends, where an opportunity to connect is supported. Clear policies around Work Health and Safety (WHS) need to be in place and clear to people accessing treatment and those who may be visiting. Attention to the physical environment, cleaning and hygiene (hand, food and amenities) is essential for keeping everyone safe and healthy.

Safety considerations in terms of the physical capabilities and needs of people accessing treatment are also paramount if access and equity are to be achieved. Ramps, handrails and lifts facilitate ease of access, and this should be extended to lighting, green spaces and modified materials that can be accessed by people who have a vision, hearing or cognitive impairment.

Safety also includes consideration of the potential harms associated with substance use, such as accidental overdose A period of time in residential treatment will have an impact on a person's tolerance for different substances, making the time just after exiting important regarding the potential for overdose. It is for this reason that all organisations and workers should be aware of the availability of the Take Home Naloxone program and either have registered to supply naloxone or know where it can be accessed.

Services should be familiar with the requirements of the NSW Occupational Health and Safety Act 2000 and use them as a guide in developing policies on duty of care. Under the Act and the associated Regulations, service providers must:

- provide or maintain equipment and systems of work that are safe and without risks to health
- ensure that equipment and substances are used, stored and transported safely and without risks to health
- provide information, instruction, training and supervision that ensures the health and safety of employees and others
- maintain the workplace(s) in a safe condition, including entrances and exits n ensure the health and safety of visitors to the workplace.

The principle of **duty of care** is that you have an obligation to avoid acts or omissions that could reasonably be foreseen to injure or harm other people. This means that you must anticipate risks for your clients and take care to prevent them coming to harm. Remember that harm encompasses both physical and emotional harm.

See *Clinical Governance* above for information on clinical incident management system.

Find out more ...

- **Duty of care**
  www.safework.nsw.gov.au/legal-obligations/employer-business-obligations/primary-duty-of-care

- **Clinical incident management**
  https://www.health.nsw.gov.au/aod/Pages/core4-cim.aspx

1.4 Who is residential AOD treatment for?

The provision of AOD treatment in a residential setting is an indication that the support required by the person accessing the service is intensive. It is implied that, as a result of complex social, physical and emotional factors, the person would benefit from 24-hour support in a more controlled environment than they currently have access to. AOD treatment in a residential setting should be seen as one of the most intensive treatment options on a continuum of AOD treatment that may include brief interventions and education, community-based counselling (individual or group), outreach, group day programs and peer-support or self-help groups.

The demand for AOD treatment in a residential setting is high, and waitlists are often long. It is for this reason that consideration should be given to the range of AOD treatment services available and, as far as is practical, treatment matched to individual needs.

Given the quality of the range of AOD treatments available in Australia careful consideration should be given to whether treatment in a residential setting is the best option. Particularly where no other treatment has been explored, such as counselling (group or individual), day programs or self-help groups. Furthermore, support and interventions provided by good case management that address other physical, social and/or welfare needs may be better provided in the community.

There are several factors that might make a residential setting the desired option for a person, including:

- Severity of current AOD dependence / Patterns of use
- Previous treatment attempts with other AOD treatment providers and their outcome(s)
- lack of safe or stable accommodation conducive to major lifestyle change
- family/support network fatigue, and desire to have someone they care about who is experiencing harms from AOD use in a safe place
- challenges with reducing or abstaining from harmful AOD use in the community
- impending sanction/action by a relevant authority, such as the criminal justice or child protection system
- current experience or potential risk of homelessness.

With respect to who residential treatment is most effective for, some groups have been studied more extensively than others, and thus more evidence has been accrued on the effectiveness of residential treatment in these groups than in others. The most frequently studied groups included people with co-occurring mental health conditions, women with co-occurring trauma-related conditions, young people, Indigenous people, and veterans. Fewer studies have focused on men, or on people in criminal justice settings. For more detailed findings on the outcomes of individual studies refer to the evidence check commissioned to inform this Practice Guide.

The **evidence check** conducted for this Practice Guide also revealed a dearth of literature examining the effectiveness of residential AOD treatment among sexuality and gender-diverse people, people experiencing homelessness, people from culturally and linguistically diverse backgrounds, rural and remote populations and people with low socioeconomic status Additionally, evaluations of effectiveness of certain interventions within residential treatment was concentrated within particular groups (e.g. treatment induction readiness programs were exclusively examined among young people; trauma-informed interventions were almost exclusively examined among women). Lastly, the studies varied in their outcome measures and follow-up periods across groups (Madden et al. 2020).

1.5 Workforce capabilities

All frameworks, standards and guidelines that inform this Practice Guide identify the importance of established workforce capabilities and the need to invest in workforce development. There is no current minimum qualification for the specialist AOD workforce in NSW. However, most workers providing AOD treatment in residential settings have, or are working towards, qualifications ranging from the equivalent to a Certificate IV in Alcohol and Other Drugs Work, Community Services or Mental Health to a tertiary qualification in health, social or behavioural sciences, social work, psychology or nursing. Professional registration is required for some positions, and professional development and clinical supervision should be a provision of all specialist AOD worker employment to ensure quality care.

It is usual practice in residential services to have a multidisciplinary team with a range of professional backgrounds including nursing, social work, AOD workers and counsellors, peer support, mental health, psychology, children and family services. In situations where access to workers from different disciplines is not possible, partnerships and linkages to GPs, psychologists or other health specialists should be considered. Feedback from people who have accessed AOD treatment in residential settings clearly indicates the importance of workers who have lived experience of alcohol and other use and/or treatment for substance use issues.

The NADA **Workforce Capability Framework: Core capabilities for the NSW non-government alcohol and other drugs sector** (NADA 2020) describes the knowledge, skills and attributes that workers must demonstrate to perform their roles effectively. Developed for, and with input from, those who work in the AOD sector, the Framework describes the core capabilities and associated behaviours expected of all NSW non-government AOD workers. It was developed to identify specific and measurable capabilities, while remaining broad enough to encompass the diversity of roles, occupations and areas of speciality that make up the NSW non-government AOD sector. It provides a common foundation for the full range of workforce development activities: workforce planning; role design and description; recruitment and selection; performance management; professional development; and career planning.

Continuing professional development is an important way of both engaging staff as well as ensuring best practice approaches to AOD treatment are applied in residential settings. Attention to specific workforce needs may include and are not limited to:

- WHS and First Aid Training
- specific training courses regarding evidence-based practice in AOD treatment
- professional development planning
- clinical supervision
- being up to date with specific professional requirements such as registration
- having any and all required vaccinations – where appropriate

Of particular significance in AOD treatment provided in residential settings is the role of peers, or people who have lived experience of alcohol and other drugs use, coupled with AOD treatment experience. The role of people with lived experience is clearly articulated by people who have been in residential treatment as one of guidance, support and advocacy in navigating the treatment experience. Key to quality treatment provision is embedding the consumer or lived experience voice in all layers of treatment provision, including:

- in recruitment of staff
- at board level
- in informing service delivery
- in supporting people in treatment to access, orient and be retained
- in supporting feedback mechanisms and quality improvement activities.

From the frontline

NADA members who provide specialist AOD treatment in residential settings suggested a range of ways in which 'important' approaches, models and activities could be better implemented into AOD treatment in residential settings. These included:

- employing trained and qualified staff with a diverse skill set
- providing ongoing training and education to existing staff through access to multimodal training packages (face-to-face workshops and online modules)
- developing a common repository of resources to support good practice (e.g. NADA Resource Finder).

Other key strategies included greater collaboration and sharing of knowledge across treatment agencies, including opportunities for shared training and the formation of frontline worker networks. In addition to professional development opportunities, treatment providers acknowledged the need for both top-down (policy and procedures, awareness building among treatment funders) and bottom-up (input from clients into decision making about treatment provision) approaches to implementation.

SUPERVISION

Regular supervision can help support the AOD workforce and provide structured opportunities for reflecting on clinical practice. It is important to be clear about what kind of supervision is being provided, and to articulate this clearly to the person being supervised (known as the supervisee).

Professional supervision focuses on the development of the supervisee's skills, understanding, abilities and ethical practice, through a process of self-reflection. The focus is on the development of the supervisee within their chosen role or profession.

Clinical supervision focuses on the development of the supervisee's clinical role and practice, including quality control and assessment of knowledge, role performance, attitudes, beliefs and skills.

The focus is on clinical practice and competency to work within the sector, rather than within a chosen profession. Clinical supervision can be provided individually or as part of a group.

Both types of supervision should involve:

- **regular, diarised check-ins** and ensuring that everyone involved is comfortable with the functions of the relevant technology
- **clear structuring** of the supervision sessions, and the setting of achievable goals for each session as part of a supervision plan or contract
- **familiarity with each employee's individual skills, strengths and challenges**, including any specific challenges faced as a result of working remotely, such as competing pressures
- **collaborative case review** when either in an individual or group session, review of cases can be conducted in a collaborative fashion
- **time for focused wrap-up and review** of the session to ensure goals have been reached and the outcomes of the session have been documented.

Find out more ...

- **NSW Drug and Alcohol Clinical Supervision Guidelines**
  www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2006_009.pdf

- **Feeling Deadly, Working Deadly**
  nceta.flinders.edu.au/application/files/7615/0646/7794/S6.pdf

WORKER WELLBEING

Taking care of one's own health is important, no matter what one does for a living. For people working in the AOD sector, this is especially important. While AOD work can be very rewarding, the passion and dedication that drives this work can also lead to burnout, compassion fatigue and secondary trauma if not accompanied by solid self-care strategies. It is important for AOD workers to remember that one 'can't pour from an empty cup', and to make meeting their own needs a priority.

NADA's ABC's of self-care resource recommends that workers:

- build **awareness** of how they react to stress (as everyone is different), and check in and monitor for signs that work is taking a toll so they can intervene and seek help early
- strive for **balance** in their work and in other areas of their life; this survey helps to assess current self-care practice and identify any imbalances
- nurture **connection** to self, to others and to something larger, whatever that means for the individual, as intentionally engaging in practices that reconnect us to our beliefs, values and ethics is an important part of cultivating meaning and purpose and feeling sustained in our work.

NADA has also developed a suite of online worker wellbeing resources, which include a module on Coping with stress and uncertainty during COVID-19 and Well Beings, a short animation series featuring practical, evidence-based ways to reduce stress and enhance health and wellbeing during the COVID-19 pandemic and beyond. Access to Employee Assistance Programs (EAP) is also standard practice should people working in AOD treatment need additional support outside of the organisation.

1.6 Consumer engagement and feedback

The engagement and integration of consumer involvement in service provision has clear benefits that have been widely reported. Inclusion of consumer voices has an established effect on improving outcomes for individuals, staff, organisations and the broader community in health-related, socially beneficial and organisationally supportive ways (Bryant et al. 2020). Consumer representatives, peer workers and people with lived experience provide valuable knowledge, skills and expertise across all areas of AOD service delivery. It is also important to note that while the terms 'consumer representative', 'peer worker' and 'person with lived experience' are often used interchangeably, they can have different meanings across service sectors (e.g. mental health, housing) and within peer-based drug user organisations.

Consumer participation is beneficial on a variety of levels, and for a range of stakeholders, including in ensuring:

- inclusion in decisions that affect an individual's health and wellbeing, which is both an ethical and a human right
- improvements in quality of the services available, which leads to increases in service users' satisfaction with, subsequent retention in, and adherence to treatment programs
- improvements in relationships between consumers and staff, which leads to greater trust, satisfaction and morale.

NADA, in partnership with consumer representatives, has developed specific training and audit tools to assist workers who provide AOD treatment in residential settings to gauge their current level of consumer participation in service delivery, policy and program development, access and equity, and capacity building.

In addition to the crucial role of consumer engagement, there is a need for routine collection of consumer and carer/supporter experience of treatments and services provided. Patient-reported experience measures (PREMs; see below), which are collected to inform practice and service provision, have a specific role to play in quality improvement and service delivery.

For consumer participation projects to be both feasible and successfully maintained, a number of factors must be put into practice early. Management support is crucial, as without it other staff cannot be expected to support the project. Training and education for staff and clients alike should also be implemented early, as this will help to challenge any myths or misunderstandings, identify any barriers and provide strategies to address any obstacles. Identifying a key staff contact person and keeping staff informed with updates is also essential, as is ensuring equality of consumer engagement within the project is.

Find out more ...

- The NADA Consumer participation audit tool was developed to support service providers to gauge their current levels of consumer participation in service delivery, policy and program development, access and equity, and capacity building.
- Patient-reported experience measures (PREMs; also referred to as person-reported experience measures, or as client reported experience measures, or CREMs) are standardised tools that enable people who have accessed a service to provide feedback on their experience of the service provided. PREMs are one indicator of the quality of care provided, with the information gathered used to drive service improvements. Implementing PREMs supports NSW Health's vision that people with alcohol and other drug-related harms consistently experience person-centred, safe, high-quality intervention and care.
- A NADA panel discussion between members and consumers about consumer engagement in non-government AOD services is available online, as is a recorded webinar featuring consumers discussing their experiences of engagement, the role of language,
- The NADA resource Access and equity: Working with diversity in the alcohol and other drugs settings provides practical ways to improve consumer access to services; the development of this resource was guided by consumer input and engagement.

WHY IS CONSUMER ENGAGEMENT SO IMPORTANT IN AOD TREATMENT?

In 2020, NADA commissioned research into the barriers and enablers associated with access and equity in AOD treatment in NSW. One of the key findings was that accessing to and retention in treatment services was improved where supportive peer relationships were actively encouraged and seen to be part of the therapeutic journey, especially if peer support was offered to the range of people enrolled in treatment (Bryant et al 2020)

Consumers actively participating in an organisation can assist with:

- providing advice and input into organisational policies, service delivery and staff recruitment
- supporting consumers to find information about the service
- delivering the service in a way that is helpful to consumers
- improving relationships between consumers and staff, leading to greater trust, satisfaction and morale
- an organisations commitment to consumer engagement also builds a person engaged in treatments own self-determination and capacity to feel empowered to be active participants in their own treatment
- facilitating higher rates of consumers choosing to complete the program.

From the frontline

NADA's consumer engagement project works with member services to increase and improve the quality of their consumer representation. The consumer engagement audit tool is designed to help member assess their current level of consumer participation and set goals on how they would like to build their engagement with consumers.

As members have begun using the audit tool, some staff have discovered that consumer participation is already happening in an organic way. They tell us they're excited that they can be involved in the process, alongside consumers, of making consumer participation a regular part of how they work and ensuring it is embedded in the way their services operate.

On completion of their audit, some staff have noted that they hadn't previously considered having consumers actively participate at all levels of their service operations, particularly at higher levels such as on staff interview panels, in service planning days, in writing policy and in creating resources. Once the idea of consumers engaging in these activities is raised, most staff involved can see how valuable it is.

1.7 Client data collection and evaluation

DATA COLLECTION

Alcohol and other drug treatment services data and outcomes measurement data help services to paint the picture they provide to clients of their services and the impact they can have. Data collection is a key part of treatment provision, and should constantly be informing the care of clients, in real time, at every step of their treatment journey. In order to carry out this in practice, outcomes measures and personal experience feedback needs to be collected at regular intervals throughout treatment and the results presented back to the person in treatment for exploration. Sharing outcomes measurement and treatment feedback as part of a therapeutic interaction with a person in treatment enhances the therapeutic alliance and ensures the treatment is person-centred.

The data we collect can:

- identify who is accessing a service
  'Our data tells us that there has been an increase in people who identify as Vietnamese accessing our service – perhaps we should link in with the Vietnamese community in a new way.'
- identify who might be missing from a service
  'We are a mixed-gender service and yet we don't appear to be seeing many women – I wonder why that is? How can we encourage women to attend our service?'
- help a service to respond to patterns and trends by bringing the data to case review, staff and board meetings
  'Most of our clients are entering the service with high levels of mental health distress – can we improve orientation to our service so that it might respond better?'
- help a service to evaluate whether the treatment it is providing is effective
  'Looking at our outcomes data, we can see some improvements in general health and wellbeing. It would be good to increase our follow-up data collection with the clients in the continuing care program.'

How do I ask sensitive questions?
We know that being able to articulate who is reaching out for a service is vital to ensuring that the service is inclusive and responsive to the needs in the community. If your service does not routinely ask whether a person identifies as Aboriginal and/or Torres Strait Islander, or as gender diverse, or whether they have injected any substance within the past four weeks, then it loses an opportunity to adequately plan their care. Preface a conversation about sensitive questions with a person accessing treatment with some lead in about how these questions are of a sensitive nature, they are asked of everyone who attends the service for the purposes of ensuring person-centred care planning and that the person is welcome not to answer the question should they wish not to. This recorded webinar explains how to ask such questions effectively.

EVALUATION OF TREATMENT

As the effectiveness of residential treatment cannot be determined solely on the basis of achieving abstinence, factors such as time in treatment, client retention and continuing care services are useful measures of effectiveness. In NSW, specialist NGO AOD treatment providers have access to a suite of data collection, collation, reporting and analysis resources including NADAbase – a data collection online platform. NADA has engaged in a large body of work to embed routine outcomes and client demographic data collection into treatment. With respect to outcomes measurement the engagement of the NGO AOD sector with outcomes measurement has mean that there is a repository of outcomes data collected for over 10 years that provides an important tool for evaluating the treatment provided in residential settings. Each year data snapshots are published on the NADA website detailing the demographic and outcomes data for the previous financial year – that can be utilised for evaluation and benchmarking purposes.

Residential treatment services can also be evaluated for their effectiveness in reaching these essential objectives:

- providing a safe, alcohol-and-other-drug–free environment
- providing a time and place for people to withdraw from high-risk lifestyles or situations
- providing peer support and encouragement to withdraw from alcohol or other drug use
- educating people about strategies for maintaining an alcohol-and-other-drug–free lifestyle and harm reduction strategies
- providing additional networks and supports, particularly among others recovering from alcohol or drug dependency
- encouraging open reflection and discussion of personal issues related to alcohol or other drug use
- providing a healthy lifestyle and balanced diet during the residential program
- assisting people with other issues associated with community living.
- providing client satisfaction surveys and other feedback informed treatment tools (Outcomes Rating Scales/Session Rating Scales) to evaluate effectiveness

Find out more ...

- NADAbase Outcomes Measurement
- **NADA videos and recorded webinars on asking sensitive questions, the Australian Treatment Outcomes Profile (ATOP) and other data-related information**
  www.nada.org.au/about/what-we-do/nadabase/
  short animated video

2 EFFECTIVENESS OF RESIDENTIAL TREATMENT FOR ALCOHOL AND OTHER DRUG USE ISSUES

KEY POINTS AND PRINCIPLES

- Treatment approaches and models within Australian AOD residential treatment and therapeutic community services are highly variable due to diversity of client needs, service-level factors and available funding.
- There is strong evidence to suggest that providing AOD treatment in a residential setting is as effective or more effective than providing treatment in other settings.
- Interventions provided within the residential treatment service should be evidence-based and should focus on person-centred and holistic care.
- Residential programs are more effective when a broad range of treatments and interventions are involved (such as individual and group counselling, life skills training, employment or training options and recreation options).
- There has been a positive shift towards person-centred care, with more services tailoring their program offering to suit the needs of the people accessing treatment, recognising that there is not 'one size that fits all'.
- Trauma-informed and person-centred approaches have been identified as essential in the research literature, both by providers and by people accessing treatment.
- Most studies have found that higher treatment retention and engagement are associated with better outcomes, but none has been able to determine optimal length of treatment.
- As abstinence is a requirement for entry into residential treatment and therapeutic communities, AOD use outcomes were frequently measured indirectly.

Treatment and specific AOD interventions provided within a residential treatment service should be evidence-based and should focus on person-centred and holistic care. Residential programs are more effective when a broad range of treatments and interventions are involved, such as individual and group counselling as well as life skills training, employment or training options and recreation options (Moore 1998). The evidence check conducted to inform the development of this Practice Guide included a systematic search of key databases in public health, medicine and psychology (Medline, PsycINFO, EMBASE and Scopus).

To supplement the empirical research, the review team also performed searches of the grey literature and consulted with field experts for their suggestions on additional literature to include. Returned articles were screened for relevance according to an a priori set of eligibility criteria (Madden et al. 2021). Overall, residential treatment was associated with significant reductions in AOD use, symptoms of mental ill health, criminal activity, and other psychosocial outcomes.

2.1 Research literature outlining effectiveness

Residential services differ with respect to the diversity of needs addressed (e.g. AOD use severity, co-occurring issues, treatment history, whether the person belongs to a specific population group with unique needs); length of treatment program (e.g. brief intervention, short stay, long stay); pathways through care (e.g. intake or assessment procedures, case management approach, coordinated care, aftercare programs); program content and format (e.g. 12-step, CBT, community as treatment, individual or group counselling, educational and vocational, parenting support, life skills, peer support, programs for specific population groups); and outcome measures assessed (e.g. AOD use, mental, physical or emotional health outcomes, homelessness, unemployment, treatment duration and completion, client satisfaction, other health service use post-discharge) (Madden et al. 2020; Turning Point 2017). Variability in the availability of federal, state and local funding also affects the capacity of services to provide consistent models or approaches across and within residential treatment services (Health Policy Analysis 2005; Gowing et al. 2002).

In recent years there has been increased focus by government and peak bodies on quality improvement, resulting in the publication of the first two national quality frameworks for the AOD sector (the National Quality Framework and the National Treatment Framework). When evaluating treatment models or approaches for AOD residential treatment, important aspects to consider include client needs, length of stay, pathways through care, treatment program content, and outcome measures. Broader treatment philosophies such as person-centred, holistic and coordinated care approaches and harm reduction were consistently endorsed in reports, quality standards and strategy documents (Commonwealth Government, Department of Health 2018 and 2019).

The most frequently studied groups in AOD residential treatment settings include people with co-occurring mental health conditions, women with co-occurring trauma-related conditions, young people, Indigenous people (US, Canada and Australia), and veterans. Fewer studies have focused on men or on people in criminal justice settings. Scant literature has examined the effectiveness of residential treatment among sexuality and gender diverse people, people experiencing homelessness, people from culturally or linguistically diverse backgrounds, rural or remote populations, or people with low socioeconomic status.

When comparing residential treatment to other treatment settings, most reviews, large Australian naturalistic studies and grey literature reports have found residential treatment to be equally or slightly more effective than that provided in other settings. Australia's longest naturalistic study of heroin dependence (the Australian Treatment Outcome Study) found that over a follow-up period of eleven years, people who had accessed residential treatment showed greater reductions in heroin and other drug use, severity of dependence, injection-related health problems, involvement in criminal activity, and physical health problems than people who had not accessed residential treatment (Teeson et al. 2015).

Optimal length of treatment stay is often queried, and the majority of studies have found that treatment retention and engagement are associated with better outcomes; however, studies have been unable to determine an optimal length of stay in residential treatment. A 2017 AOD service planning report by Turning Point recommended a minimum stay of eight to 26 weeks, depending on individual needs. Similarly, a 2014 report by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recommended a minimum three-month stay for positive treatment outcomes. The vast majority of studies recommend aftercare programs, a view shared by grey literature reports (Turning Point 2017; Shakeshaft et al. 2018; Deady et al. 2014; Williams et al. 2017; NIDA 2014; Taylor et al. 2010). For specific populations with complex needs (such as Indigenous people, or people with co-occurring mental health conditions) aftercare/continuing care programs that include assertive follow-up may lead to lower rates of relapse and reduced AOD use post-discharge (de Andrade et al. 2019; Reif et al. 2014; Taylor et al 2010).

2.2 Modern models of residential treatment provision

Modern approaches to AOD treatment in residential settings have evolved over the past 10 years. However, specific principles seen in residential treatment from previous decades have been retained, including ensuring safe environments that reduce alcohol and other drug harms, and providing opportunities for improvements in general health and wellbeing.

It is rare in the research literature to see direct comparisons between one intervention in a residential setting over another, which makes it difficult to determine which approach works better over another. Furthermore, there is a shift towards person-centred care, with more services tailoring their program offerings to suit the needs of the people accessing treatment or services providing a larger suite of treatment interventions for clients to choose from, recognising that there is not 'one size that fits all'.

The evidence check conducted to inform this Practice Guide examined the interventions that were most evaluated and yielded the best outcomes (Madden et al. 2021). The kinds of psychological therapies included were:

- cognitive behavioural therapy (CBT)
- relapse prevention
- motivational interviewing techniques
- counselling (a variety of approaches)
- mindfulness and relaxation techniques
- acceptance and commitment therapy (ACT)
- dialectical and behavioural therapy (DBT)
- self-help programs (12-step and SMART)
- smoking cessation programs

In addition to specific psychological therapies, certain complementary interventions were assessed as being effective for people accessing AOD treatment in residential settings, including:

- physical activities such as walking, yoga and sports
- life skills programs (cooking, budgeting/financial management and planning)
- relationship and parenting programs
- complementary therapies such as acupuncture, music or art therapies, and animal-assisted therapies.

INCLUSIVITY

Modern approaches to AOD treatment in residential settings have an increased awareness of what it means to be inclusive and proactively consider issues of access and equity for people seeking specialist AOD treatment. To this end, there is better recognition of the need for programs to be flexible and to respond to the needs of Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds with respect to their cultural, spiritual and community needs. Much can be learned from Aboriginal and Torres Strait Islander people about the provision of quality care with an emphasis on:

- creating safe, inclusive and healing environments that are trauma-informed
- taking the time and making space for people to tell their story and inform their treatment journey
- being inclusive of families, significant others, and communities as part of the treatment journey
- attending to the whole person and having them take the lead in their treatment.

From the frontline

'For me it's really important, because I generally feel really unsafe due to being judged as a First Nations woman. It's important for me to have a culturally appropriate space. I feel more comfortable amongst Aboriginal communities – it's like a family, a sense of belonging.'

Gail, identifies as a Gumbaynggirr and Wiradjuri woman

'We need representation…to be able to understand our [AOD] use, to have language for it, to have a way to self-support and support other people, because that will trickle through to the community. When diversity isn't visible, it just reignites shame, it reignites otherism.'

Basem, identifies as a Queer Lebanese man

A review of 19 studies of residential treatment approaches for Indigenous people in North America, including culture-based trauma approaches (Rowan et al. 2014), found that AOD use was reduced or eliminated among 74 per cent of people engaged in these studies. Improved psychosocial outcomes such as spiritual, mental, emotional and physical wellness were also observed. Importantly, all studies involved integrative treatment programs that offered participants and their families a mix of Western-based approaches (such as assessment, education, counselling, treatment and/or aftercare services) as well as cultural and traditional services, with an average of six cultural interventions per study.

2.3 Trauma-informed environments

The residential setting is one of the key differences that makes this treatment type unique. Consideration of the physical environment in which the treatment takes place is important, given the intensity of the AOD intervention, and it is for this reason that creating a safe space for people is a foundational treatment element. A trauma-informed environment describes a whole-of-organisation approach that is embedded at every level of governance and extends to the physical setting where the treatment is provided. In a residential setting there is particular opportunity for thought to be given to how the physical environment might be experienced by a person accessing treatment, and the role it might play in their treatment journey. How a person is welcomed and oriented into the service is part of what assists with ensuring that the physical space is trauma-informed.

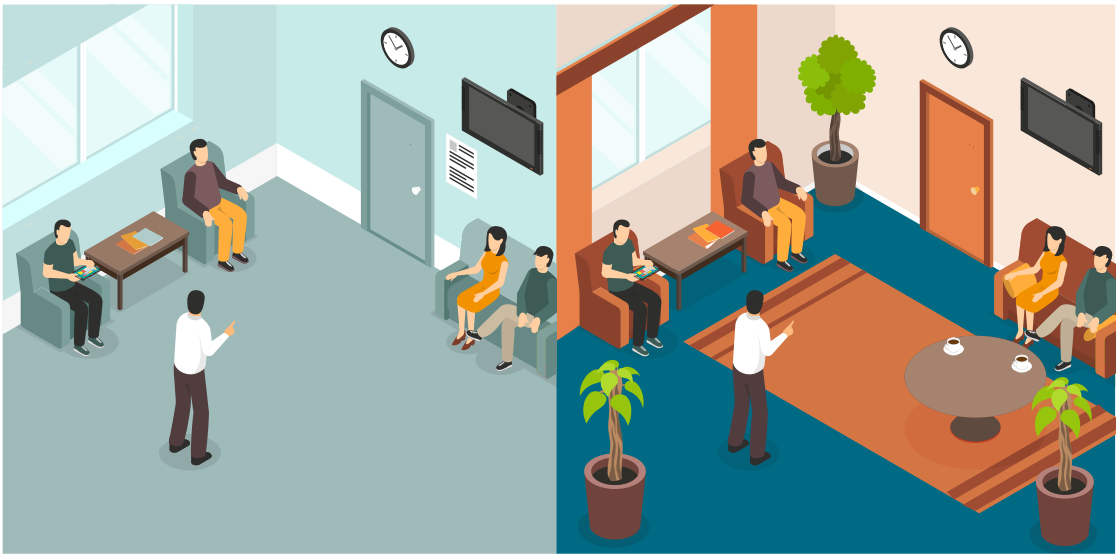
Some useful questions to ask yourself about the environment in which you provide treatment

- **How does the physical environment promote a sense of safety, calm and de-escalation for both people receiving services and staff?**
- **In what ways do staff members recognise and address aspects of the physical environment that may be re-traumatising for people receiving services, and work with them on developing strategies to deal with this?**
- **How has the organisation provided space that both staff and people receiving services can use to practise self-care?**
- **How has the organisation developed mechanisms to address gender-related physical and emotional safety concerns (e.g. gender-specific spaces and activities)?**

(SAMHSA 2014)

In terms of unique benefits, AOD treatment in residential settings creates a safe environment for clients, removed from usual environmental triggers for AOD use/relapse, as well as greater access to staff and support. Given that residential treatment is ongoing and sustained over a period of weeks or months, treatment providers have scope to offer more intensive interventions and gain more comprehensive and holistic insights into client behaviours and reactions over time, and in response to a variety of situations and potential stressors.

Which feels safer and more welcoming to you?



A key function of trauma-informed care is providing spaces where emotional regulation can be practised, and therefore choices relating to green spaces, natural light, colours and spaces should be made with this in mind.

The physical layout and structure of residential facilities should also consider the safety of staff, people accessing treatment, visitors and children. Audits should be regularly conducted by staff and people who are accessing treatment to identify any potential risks and how to mitigate them.

Safe spaces for children, family members and significant others are important considerations in the design of residential settings. All clients of residential treatment programs that accommodate parents with children have a responsibility for the safety and care of the children, regardless of whether they have children themselves. However, sensitivity regarding people who may not have regular contact with their children is a further consideration when onsite visits are arranged.

From the frontline

NADA members providing AOD treatment in residential settings have told us that trauma-informed and person-centred approaches were needed, because many clients presenting to AOD treatment have a history of trauma and some client groups have diverse needs.

Providing a trauma-informed environment includes creating a physical and sensory space that is accessible, welcoming, inclusive and healing, and attends to potential trauma reminders. It means giving thought to creating a cultural environment that is responsive to the people and communities being welcomed, with attention to respect, empowerment and transparency. Providers should create emotional safety and an environment that is flexible and responsive to individual, family and support community needs.

Find out more ...

- Trauma-informed care: Healthcare environments
- Tools for transformation: Becoming accessible, culturally responsive and trauma-informed
- Trauma-informed environments: Basic principles for creating safe, support environments

3 THE TREATMENT JOURNEY

KEY POINTS AND PRINCIPLES

- AOD treatment in a residential setting is part of a continuum of treatment options and should be considered one of the most intensive treatment options.
- A comprehensive intake process that can assess suitability for AOD treatment in a residential setting should include supporting pathways to other treatment options.
- While withdrawal management may be necessary to prepare a person for AOD treatment in a residential setting, there are a variety of ways to achieve this that may not necessitate an in-patient stay in hospital.
- A treatment journey that includes AOD treatment provided in a residential setting requires assessment, planning and continuing support in the community.
- Planning for exiting treatment and returning to the community should occur at the start of a person's journey, and then be reviewed regularly throughout their treatment journey.
- Harm reduction is part of the treatment journey and should be explored regularly.
- People who are supporting someone in treatment – such as family, partners and friends – have a role in the person's treatment journey and should be engaged early.
- A residential setting provides regular opportunities for learning and growth, even when these may be perceived as challenges.
- Measurement of treatment progress should coincide with and inform care plan review.
- Urine screening for drug use and breath analysis for alcohol use are only useful therapeutic tools in combination with other assessment information and in partnership with the person accessing treatment.
- Suicide prevention is part of AOD treatment and suicidal ideation concerns should be explored with people accompanied by prevention strategies at regular intervals

3.1 Pathways to residential treatment

Pathways to AOD treatment provided in a residential setting are varied, but the most common is via self-referral, meaning that a person who is concerned about their own alcohol or drug use, or someone else is concerned and has prompted them to reach out for support. As with other personal challenges in life, there are frequently other pressures on a person, such as family/relationships, financial or work/study issues, mental health concerns and/or general wellbeing concerns that may be exacerbated by problematic alcohol and/or other drug use or dependence. Frequently these kinds of pressures are the catalyst for a person reaching out for assistance.

In Australia there are a number of options for people who may be concerned about their own or another person's substance use. Treatment provided in a residential setting is one of those options – and it is one of the most intensive conditions, young people, Indigenous people (US, Canada and Australia), and veterans. Fewer studies have focused on men or on people in criminal justice settings. Scant literature has examined the effectiveness of residential treatment among sexuality and gender diverse people, people experiencing homelessness, people from culturally or linguistically diverse backgrounds, rural or remote populations, or people with low socioeconomic status.

People may also be referred to AOD treatment in a residential setting by GPs, external health or social services, or diversion programs such as the Magistrates Early Referral Into Treatment (MERIT) program or Drug Court. MERIT is a voluntary program for people who are involved in matters at participating local courts. The program targets people who are experiencing problems with substance use and who are eligible for release on bail and are willing to engage in treatment and rehabilitation.

WITHDRAWAL MANAGEMENT

A residential treatment setting is defined as being free of alcohol and illicit drug use. Therefore, it is a routine requirement that a person entering AOD treatment in a residential setting have undertaken a safe withdrawal process from their drugs of concern, excluding medications that may be part of their treatment (eg. Opioid treatment or mental health medications) in order that they might participate in the treatment being provided. It is acknowledged that some services providing AOD treatment in a residential setting also provide withdrawal management services, and that there are specialty withdrawal services for pregnant women, women with babies and young people.

According to the NSW Management of Withdrawal from Alcohol and other Drugs Guidelines (2022, 8), withdrawal occurs for substance-dependent people who stop or reduce their substance use. While withdrawal can usually be managed with symptomatic relief, in some cases there may be risk of physical or psychological harm (e.g. seizures, delirium, acute discomfort). It is for this reason that the first step in the process is a comprehensive assessment to determine what level of care is needed.

Withdrawal management is not a standalone treatment; rather, it is one part of the treatment journey. A person who has been medically assessed as having completed a period of detoxification or withdrawal is no longer at risk of serious physical or psychological harm in the absence of the substance. However, they may still experience psychological dependence and cravings for the substances they were using, which may also trigger physical sensations.

A medical assessment of detoxification completed as part of an inpatient stay or in the community indicates that a person is physically able to engage in a program of activities and interventions provided in a residential setting to improve their psychological, physical and emotional wellbeing.

Models of withdrawal are varied, and again can be considered on a continuum of intensity that responds to the level of physical dependence a person may have on the substance(s) they use.

Models of withdrawal management include:

- ambulatory withdrawal with virtual care
- ambulatory withdrawal with face-to-face in-community contact
- inpatient withdrawal during short stay (for moderate to high acuity)
- inpatient withdrawal during long stay (for high acuity).

	INPATIENT HOSPITAL	RESIDENTIAL/COMMUNITY RESIDENTIAL	AMBULATORY
Predicted withdrawal severity	Moderate – Severe	Moderate – Severe	Mild - Moderate
Likelihood of severe withdrawal complications	Moderate – High (Prior/ current withdrawal delirium, seizures of unclear cause)	Moderate – High (Prior/current withdrawal delirium, seizures of unclear cause)	Minor
Medical or psychiatric comorbidity	Significant comorbidity	Significant comorbidity Minor or no comorbidity	Minor or no comorbidity
Other substance use		Heavy or unstable use of other drugs	No heavy/regular other drug use
Social environment		Unsupportive home environment or not conducive to ambulatory withdrawal	Alcohol/drug free 'home' Regular monitoring by reliable support people Emergency plans in place
Previous attempts		Repeated failure with ambulatory withdrawal	Limited or no previous failure with ambulatory withdrawal

A period of abstinence managed in the community, whether at home or in another suitable safe place, coupled with a medical assessment, is sufficient for admission into treatment in a residential setting and can mitigate the need for delays in getting treatment started. While there may be some residual withdrawal symptoms, such as interrupted sleep patterns or cravings, these may be easily managed within the treatment program provided in a residential setting.

From the frontline

Treatment providers reported benefits in being able to work with clients during a period of abstinence, and felt that having their clients 'in residence' facilitated rapport-building and provided greater therapeutic and social support.

WAITING LIST MANAGEMENT

There is no denying the current under-resourcing of the AOD treatment sector, which affects the timeliness of people's entry into treatment and their resultant placement on waiting lists. NADA members that provide treatment in residential settings have indicated that under-resourcing and underfunding of AOD residential treatment services has resulted in a host of logistical challenges including long waiting lists for entry into treatment, lack of appropriately qualified and trained staff, and use of non–purpose-built facilities for accommodating and treating clients. This means that services often have to come up with creative ways to support people who are on their waiting lists.

In the past it was common for people seeking treatment to have to ring a residential service regularly, even daily, to demonstrate their motivation to engage with treatment. However, it is widely understood that this approach does not take into account the myriad factors that may make someone unable to maintain daily phone contact with a service, including homelessness, lack of access to a phone, competing family and childcare issues and financial hardship.

Models of supportive waiting list management include:

- regular virtual-care check-ins by the service to ensure the person's safety
- engagement in online or in-person group sessions while still in the community
- referral to a waiting list support or continuing care service.

The term 'continuing care' was previously used to refer to a period of support following treatment, also referred to as 'aftercare' (McKay 2021, 2). However, as the AOD treatment system has evolved, the term 'continuing care' has expanded to also include supports and services that assist a person to connect and maintain engagement with AOD treatment. A continuing care program may assist a person seeking treatment with referral and entry into residential treatment and/or provide support to them while on a waiting list. If a residential program is unable to provide support to people who are on its waiting list for treatment, staff of the program may need to be aware of what other continuing care services are available to support these clients. These may include complementary services such as Continuing Coordinated Care Programs and Assertive Community Management Programs, which are located across NSW.

From the frontline

'Extending support to people while they're still in the community helps to create rapport, so they follow through to the service, overcoming one less barrier to entry. Often when potential clients are ambiguous in their state of change, a support person can help them maintain momentum and put things in perspective.'

Latha Nithyanandam, CEO Kathleen York House

3.2 Promotion and intake

PROMOTION

Most people find out about available treatment options either online or by word of mouth. For this reason it is important for providers to invite and encourage people to seek support by providing comprehensive information, making their decision making as easy as possible. They can do this by:

- maintaining an up-to-date website with visibility on search engine results
- providing clear, detailed information about specific services offered
- using everyday language, not clinical language or unexplained abbreviations
- being connected to networks where prospective clients are likely to ask for help, such as GPs, peer workers, community leaders, and other health and welfare services.

The information provided should show what the service looks like, using pictures and videos (including pictures of green spaces), whether people stay in private or shared rooms, and what options are available for cultural needs such as specific foods, support for different faiths and so on. Displaying the Aboriginal and Torres Strait Islander flags, an acknowledgement of country is important on a website. Displaying the rainbow flag can also signal to a person that you are inclusive. People also need to know whether smoking is permitted and, if not, whether nicotine-replacement therapy and accompanying smoking cessation support are available.

Weighing up the different entry criteria can be challenging for people seeking treatment, so services should provide reassurance in this regard on their website.

Virtual tours are an effective way for people seeking treatment to 'get a feel for' a particular service and its facilities. Such a tour should:

- clearly show the physical environment and setting
- show positive service encounters, such as of frontline staff interacting with clients
- show signs or symbols of safety, such as the Aboriginal flag, the pride flag
- communicate the benefits of the service
- provide information about its programs and treatments
- clearly explain any specific entry criteria and/or intake procedures
- include maps to indicate geographic location
- state any costs involved, and how payment can be made
- outline how diverse client needs and cultural safety requirements are met, such as facilities for clients' children
- show or promote any Aboriginal and/or multilingual staff
- disclose any religious or spiritual affiliations.

INTAKE

Intake is often the first experience a person has of a service, so emphasis should be on engagement, support and information giving. Intake is also an important opportunity to identify any immediate risk of harm that might affect the person, whether from themselves or from others.

According to the NSW Health **Clinical Care Standards for Alcohol and Other Drug Treatment**, intake is the part of the treatment journey at which:

"A person seeking information or treatment for alcohol and other drug use will have access to advice, referral and appropriate treatment options."

Since intake is often the first point of contact with a treatment service, building rapport is important. An intake interview should be conducted to elicit key clinical information and facilitate access to the most appropriate service(s). The intake process also identifies any urgent issues requiring immediate action. Implementing harm reduction and brief intervention strategies may also be appropriate as part of the intake process, such as ensuring the person is aware of the availability of the **Take Home Naloxone** program. It is important to note, however, that the intake interview is not equivalent to a comprehensive AOD assessment.

A person's first contact with a treatment service is a sensitive time for them, and it has generally taken considerable courage for them to seek assistance. For this reason, if your intake process reveals that there is a preferred treatment match with a program other than the one your service offers, then a clear explanation needs to be provided to the person as to why there is another preferred option, along with comprehensive information about that option. Ideally, a guided or warm referral to the other service should be made in order to make the most of the opportunity, and the outcome clearly recorded.

SUICIDE PREVENTION

Suicide warning signs and suicidal ideation needs to be explored with any person reaching out for AOD treatment, and should be checked in with regularly throughout contact. Asking about previous suicide attempts, and using a suicide screener can assist in exploring prevention strategies while a person waits to enter residential treatment. Providing the number for 24 hour support services is key as well as places a person might find tools to support their mental health.

Find out more...

- Lifeline Australia: 13 11 14
- Beyond Blue: Suicide prevention resources
- NADAbase Suicide Screener
- NSW safe haven: a place you can go if you're feeling distressed or having suicidal thoughts

Partnerships and linkages

All staff at your service should have a good working knowledge of the different specialist AOD service providers in your area. Find out about the different kinds of services available along the continuum of care, from support groups and counselling to day programs and continuing care, and arrange site visits or coffee mornings to help build solid partnerships and support warm referrals.

Online resources for identifying AOD service providers in your area include:

- NADA members
- Alcohol and Drug Information Service (ADIS)
- Your Room

Keep in mind the importance of diversity, and link people to services that have a specific focus where appropriate, such as on:

- LGBTIQ+ communities (Pivot Point)
- Aboriginal communities (ADARRN)
- Culturally and linguistically diverse communities (DAMEC).

3.3 Comprehensive assessment for residential treatment

A comprehensive biopsychosocial assessment focuses attention on a person's physical, psychological, emotional and social needs in order to inform a clear case plan. Cultural considerations are also paramount to understanding the preferred supports a person has, as well as those that may be strengthened during the treatment journey. According to the NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment:

The assessment seeks to gain a thorough understanding of the client's presentation. It explores what outcome(s) the client is seeking, their substance use, and related physical, psychological, social, and cultural considerations. It is also an opportunity to explore with the client, their strengths and any requirements that they may have to support engagement in treatment. Comprehensive assessment identifies what needs to be considered and included in the care plan.

A comprehensive assessment is a considerable undertaking and may be an overwhelming experience for a person. The courage it has taken for them to get to this point should be acknowledged, and water and breaks offered if needed. Your service's assessment forms and processes should be reviewed against the **trauma-informed practice** ideals. The assessment process is also an opportunity to explore with the person their catalyst for seeking support and presenting for treatment, and to identify any supports that might assist in the treatment process and personal strengths that might be developed further on their treatment journey. The assessment process may occur across multiple meetings/sessions. However, urgent or immediate risks and potential risks need to be identified as a mater of priority, with a detailed response or plan that will mitigate these risks identified and documented.

Details that should be recorded in order to assist with care planning include:

- reason for presenting at the service
- identification and personal details
- socioeconomic background
- general physical health background, and any relevant medical needs
- cultural, sexuality, sex, gender, other personal or spiritual identity elements
- all psychoactive substances used in the past 28 days, and how they would describe the particulars of their alcohol and drug use
- history and results of any previous treatments accessed
- other relevant personal history
- any mental health issues
- any physical health issues
- any legal circumstances
- any specific concerns or risks regarding physical or mental health, suicidal ideation or emotional state, domestic and family violence risk – using screening tools.
- expectations about the program and personal treatment goals
- learning or cognitive challenges
- current community supports

NADA members have indicated that AOD-related intake and assessment processes for treatment in residential settings are often more comprehensive than those for other treatment settings. The opportunity to conduct such a comprehensive assessment that may be added to along the treatment journey and inform a dynamic care plan is a benefit of this treatment type, as is the opportunity to collect outcomes data that can easily be followed up while the person is in treatment. Written or electronic records of all assessments should be made and kept in a secure location. Clinical documents need to be reviewed and audited in line with policy around case notes and case files, all staff need to be aware of the potential for subpoena's and/or access to records via freedom of information.

People entering AOD treatment provided in a residential setting are highly likely to be experiencing financial disadvantage, low employment opportunities, and homelessness or risk of homelessness. Engagement in AOD treatment is an opportunity to explore further education and vocational training options, which benefits from partnership building with organisations that specialise in this area. This issue is further explored in Section 5: Models of Care and Treatment Approaches.

An assessment is also an opportunity to use tools and outcome measures that can inform care planning and record a baseline of the person's general health and wellbeing, mental health symptoms, substance use or dependence, and resilience.

From the frontline

Homelessness or risk of homelessness is of great concern to people accessing AOD treatment, particularly given that prolonged problematic substance use is a significant contributing factor to financial difficulties and accommodation instability. Homelessness (along with criminal justice involvement) has been found to be one of the main issues affecting people's access to AOD treatment in NSW, according to research recently commissioned by NADA (NADA, 2021).

The overlap between people experiencing insecure housing and people experiencing AOD issues is well documented. However, it is important to note that a common myth about homelessness is that people who are experiencing homelessness are "addicted to drugs or alcohol". Instead, research suggests that around 60 per cent of people experiencing homeliness had no problematic drug use issues before they became homeless.

Artificially correlating AOD use with homelessness diverts attention from the real causes of homelessness and plays into the stigma of drug use, as well as the idea that people who use drugs are somehow less deserving of housing, or that it is their fault that they are homeless. These assumptions are incorrect. Homelessness in NSW is most commonly associated with domestic and family violence, accommodation issues (the housing crisis, inadequate or inappropriate dwellings) and financial difficulties (housing stress, unemployment). Therefore, it is important not only to focus on a person's alcohol and/or drug use but also explore and support them with any housing, education, income and other co-occurring issues.

Find out more ...

Trauma-Informed Care and Practice Organisational Toolkit: (MHCC)

Trauma-Informed Organizational Toolkit for homelessness services (Guarino et al. 2009)

3.4 Orientation to residential treatment

As with many experiences, first impressions are important for a person entering AOD treatment in a residential setting. Welcoming and orienting a person to the service so that they feel safe is important, as is checking in regarding anything significant that may have arisen at intake stage, in order to revisit any cultural, spiritual, dietary or other particular support needs.

It is preferable that a person entering treatment have a medical clearance relating to withdrawal from alcohol and all non-prescribed drugs. In some cases this will come in the form of a discharge summary or transfer of care from an inpatient or community-based withdrawal management or detoxification episode. Connection with a local GP or Aboriginal Medical Service may assist with, among other things, potential support for any residual withdrawal symptoms, and therefore a strong partnership approach is very helpful. Good connections with a specialist withdrawal unit may also assist if there is an escalation of symptoms or if advice is needed. The Drug and Alcohol Specialist Advisory Service (DASAS) is a 24-hour support line for services that can provide advice and support from an Addiction Medicine Specialist and may alleviate any specific concerns about any specific symptoms a person may be experiencing.

Efforts should be made to understand and connect with all community-based supports a person may have had contact with prior to their admission to treatment, which may include:

- the justice system
- child protection services
- homelessness services
- community-based AOD counsellors or other counselling supports.
- Financial support and Centrelink
- Psychiatrists and Community Mental Health
- Primary heath care supports
- Legal Aid if there are ongoing legal issues that may benefit from action such as applying for a Work and development Order (WDO)

Where other service providers are identified, access to appropriate shared information with client consent, is important such as medical summaries or other care plans.

At orientation, potential residents should be provided with information that would have been outlined as part of an intake process, and potentially sent to the person accessing treatment about:

- the roles of program staff and how the staff work (shifts, groupwork, case management)
- safety mechanisms in place for residents and staff
- program approach and treatment options provided
- expectations of residents regarding participation, groups, exercise, etc.
- rights of residents
- process for making a complaint
- available facilities and amenities
- visiting arrangements and contact arrangements with family/community supports
- income support arrangements
- (if applicable) fees for the program and payment methods
- privacy and record-keeping policies.

Evidence suggests that the first 72 hours in treatment is very important for setting the experience and engagement in ongoing treatment. For this reason, emphasis should be placed on safety, communication and client engagement. Feedback from people who have experienced residential AOD treatment in NSW indicates that the involvement of peers or people with lived experience has been extremely beneficial in assisting their navigation of and gaining access to the treatment system, as well as supporting their retention in treatment. More intense support to clients during these first 72 hours in treatment are encouraged, through methods such as closer observation, increased general interaction and/or the use of a 'buddy system', whereby a new resident is paired with an established resident for support. Consideration may also be given to providing information sessions on how the treatment program runs, what it is like to participate in a group session, and the strengths and challenges of the residential setting.

From the frontline

Focus on the immediate concerns of the client rather than the program and support them to understand that everyone's treatment journey is different. Intervene early in order to get clarification of any specific issues of concern for the person as well as providing clarity about roles and responsibilities.

URINE SCREENING AND BREATH ANALYSIS

People entering residential AOD treatment may be asked to provide a urine or breath sample to test for recent substance use. These tests are best used as part of a comprehensive assessment, and as a therapeutic tool to engage the person in their treatment. Tests of this kind are not diagnostic in isolation, and unless strictly adhering to a chain of custody would not be admissible in court. Therefore, caution should be taken when using urine or breath analysis in making a decision to withhold or withdraw treatment. As a therapeutic tool, UDS may be employed as a method of monitoring a person's progress, an opportunity to explore specific additions or enhancements to a person's treatment program. Where an external body such as a child protection service from DCJ make UDS a requirement, formal conversations need to be had about the intended purpose and implications of a positive detection to ensure these are clear for the person engaged in treatment. It may also be an opportunity to explore whether this approach is useful for supporting the treatment process. Consideration should be given to any prescribed medications and how they might be detected in a screen, assistance from someone who has expertise in interpreting a urine screen may be required.

Furthermore, where a service includes day or weekend leave from the residential setting and applies UDS on return to the residence, there should be clear information and plans around how a positive test may be treated. Any positive drug screen on return from the community is a therapeutic opportunity to explore relapse prevention, intensify treatment where suitable and provide active support rather than be the catalyst for discharge.

3.5 Primary health needs and medication management

For the majority of people accessing AOD treatment in a residential setting it may be an opportunity to attend to a number of primary health needs that have been unable to have examined including, but not limited to:

- family planning and reproductive health checks
- women or men's specific health checks
- dental health checks
- general physical check ups
- pain conditions or unaddressed injuries
- eye care
- mental health medication reviews
- podiatry and or other mobility-related issues

Some residential services may have a GP or other medical practitioners that attend their service for specific clinics. Otherwise, a standing arrangement or partnership with a Primary Health clinic is an important element of service provision.

Partnerships and linkages

Make contact with a variety of Primary Health services via your local NSW Primary Health Network (PHN). Each PHN has a website with some of the specific primary health services in their region, they may even be able to assist with building links and partnerships.

Local Aboriginal Medical Services (AMS) are important primary health providers to Aboriginal and Torres Strait Islander people and their families. The map of Aboriginal and Torres Strait Islander health and medical services across Australia is a helpful place to start, to find a service in the local region.

Women's Health NSW is a useful place to find resources and services in the local area for women's heath needs.

SEXUAL HEALTH

It can be useful for the AOD sector to have a good working knowledge of how different substances shape sexual drive and function, and how to provide a safe space for clients to explore the possible effects substance use may have had on their sexual experiences. Healthy sexual relationships can have a profound effect on an individual's emotional, physical and psychological wellbeing, and assisting clients to reconnect with their sexual selves should be considered part of holistic person-centred care. While people accessing treatment may have experienced trauma in relation to sexual experiences, AOD treatment can be a useful entry point into sexual, reproductive health and family planning health check-ups, so linking clients into getting STI and HIV testing and knowing their options for contraception is a good start. Using clinical judgement and ensuring that discussion regarding sexual health is appropriate may require some staff education, recognising that it can be sensitive area of health.

Pharmaceutical drugs can also affect sexual activity, more specifically libido or sex drive. A significant proportion of people accessing AOD treatment are also experiencing poor mental health or chronic pain conditions that can have a detrimental effect on libido, even before they are prescribed medications that further affect sex drive. Having a working knowledge of the potential effects of various pharmaceutical drugs on sexual drive and function, sharing this information with clients and, most importantly, exploring clients' own experiences are important aspects of providing holistic care.

- Routinely and non-judgementally ask about sexual and reproductive health as part of your therapeutic conversations.
- Routinely and non-judgementally ask about sexual orientation
- Where appropriate and after review of significant trauma, explore the role substance use might play in sexual intimacy for your client.
- Provide free access to contraception and guidance on where to find further information.
- Know where to refer people for testing or support, or where to get more information with your client.
- Form a partnership or create some links with a sexual health service.

HEPATITIS C

Hepatitis C screening is part of the work we do in the AOD sector, and treatment provided in a residential setting provides a unique opportunity to support a person through testing and treatment so that they exit hepatitis C free. Facilitate access to hepatitis C testing and treatment by linking to your local HIV And Related Program (HARP) units. **HARP units** oversee sexual health and bloodborne virus screening and treatment, and can help your clients to live hepatitis C free. **The bloodborne virus and sexual health screener** included in NADAbase (the online repository for NADA members' client demographic and outcomes data) is designed to identify whether clients attending AOD services have had access to testing and/or treatment for hepatitis C, and prompts workers to consider testing and treatment as part of a client's care plan. The screener is accompanied by links to support testing services and more information about bloodborne viruses and sexually transmitted infections.

The NSW Hepatitis C Strategy 2021–2025 has a key focus on improving access to testing and treatment for people engaged in AOD treatment services settings. It identifies NADA and NGO specialist AOD treatment services as key partners in improving pathways for testing and treatment in the NSW strategy, noting that:

"AOD settings will follow best practice hepatitis C care in line with Clinical Guidelines and Policies (AOD Clinical Care guidelines) such as completing audits of medical records, care plan reviews and intake screening" (p. 11).

Asking your clients sensitive questions, including whether they have been tested or are receiving treatment for hepatitis C, helps to ensure they receive the best care planning possible. **Be supported by watching this video** of people sharing their experiences and advice on how to broach difficult topics with clients.

DRIED BLOOD SPOT TESTING

Dried blood spot (DBS) testing is a helpful approach to reducing the barriers people may experience in getting a blood test for hepatitis C, and it only requires a finger-prick test. AOD services are a key setting for increased availability of these simple tests and there are some excellent examples of AOD treatment providers in residential settings partnering with peer organisations such as Hepatitis NSW to offer this service. In some residential services Hepatitis C testing may be available and a preferred option and it is worth exploring what approach is best according to the service itself.

Find out more ...

- Hepatitis NSW provides a range of resources and information that you can watch or download, and they can also connect you with peers. They also provide a range of training options, including workshops and events, eLearning, and hearing from people with lived experience.

To increase access to hepatitis C treatment in regional NSW, ASHM (a peak organisation of health professionals working in bloodborne viruses and sexually transmissible infections) is coordinating a program that facilitates links between nurses who perform patient assessment and medical/nurse practitioners experienced in prescribing hepatitis C treatment.

- The program's remote prescribing pathway summarises the roles of participating nurses (referrers) and medical/nurse practitioners (prescribers).
- The program also provides a remote consultation request for initiation of hepatitis C treatment form.

PRESCRIBED MEDIATIONS

If a person has a prescribed medication, they are taking to manage a health condition it is helpful to make contact with the person's prescribing doctor and include them in the care plan, if the person provides written consent for this to occur. In some rare instances where there is a concern for a person's safety', then contact may be initiated without consent, as outlined in the Privacy Act. It is preferable that the current prescriber be involved in the continuing management of the person's medication where possible. If reducing or exploring a review of any medication is an objective of treatment, the involvement of the prescribing doctor is important. However, where this is not possible having specific links with a GP practice near to the residential service is essential to facilitate health care for all people accessing residential treatment.

- The Assist Clients with Medication Skill Set course is suitable for people working in a care or support role in the community services sector.

According to the **NSW Health Clinical Care Standards**, for clients who are prescribed or dispensed medication by the service, the following should be included, as a minimum:

- a list of the medications prescribed or dispensed by the AOD service, that are current at discharge
- changes made to medications by the AOD service
- the ongoing plan for these medications
- a statement noting that the client may be on other medications.

3.6 Care planning and case management

CARE PLANNING

Care planning and case management are collaborative processes that happen between the AOD worker at the service, the person accessing treatment, and any people they feel might support their treatment journey, such as family, medical providers, cultural supports, peers, gender and sexuality diverse communities and social or welfare support providers. Reassuring a person that there is a team working alongside them to help them reach their goals and improve their wellbeing can be empowering, particularly in understanding that they are not on their own. Good communication is essential in the development of a care plan, and regular review based on outcomes and the person's feedback is part of the process.

According to the **NSW Health Clinical Care Standards**, a care plan is a document in which the client's short- to medium-term goals regarding substance use, health and welfare are identified and recorded. A care plan should assist in improving the quality of treatment through enhanced communication by those involved in the delivery of care. It is used as a tool to engage clients in decision making related to their substance use, health and welfare needs. The care plan can also be used to improve communication with the range of service providers and carers involved in client care. It outlines treatment goals, actions to achieve the goals, the person(s) responsible for completing the planned actions and review dates.

The development of a care plan is a collaborative and dynamic process that supports a person to identify achievable goals, their strengths and strategies for reaching their goals. It is also assists in identifying potential challenges and specific areas that may require support. A care plan needs to be brief and concise so that a person can easily refer to it during their treatment journey. Some useful elements of a care plan include:

- SMART goals
- actions or strategies to achieve the goals
- who is responsible/who is going to support
- timeframes for review and the process
- space for the person engaged in treatment to make comments.

A copy of their care plan is held by the person who has helped create it, and the service. In the spirit of coordinated care, and with the permission of the person you are working with, a copy may be provided to other support people or service providers. The dynamic part of the care plan is that it needs to be regularly reviewed, again in collaboration with the person who owns it, and can be informed by:

- regular communication with the person about how they feel they are going in relation to the plan
- involvement in interpersonal groups and individual sessions
- involvement from other support people
- exploring outcome measures that examine different aspect of a person's experiences.

TRAUMA-INFORMED PRACTICE AND EMOTION

In line with a trauma-informed approach, a care plan should routinely outline specific strategies that support effective emotion regulation, which are supported by program content. This recognises the unique opportunities and challenges treatment in a residential setting presents. Engaging in a treatment journey alongside other people can be an intense experience and so a focus on strategies for emotion regulation should be part of the residential program and be outlined in a care plan to reinforce its significance. Incorporating emotion regulation as part of each care plan will support the development of effective communication and healthy relationships – another common area people are looking to focus on as part of their treatment experience. Embedding a trauma informed approach in a service is supported by the effective modelling by staff of emotion regulation strategies in their own daily lives.

CASE MANAGEMENT

Case management is the process that oversees or directs the administration, planning, coordination and delivery of services to a person by the case worker or case manager and/or by other workers (Dale & Marsh 2000). It usually involves one primary case manager who personally establishes a series of relationships with other professionals or services as required. The approach to case management is person-centred and client-led, meaning that the person accessing treatment is at the centre of the planning, care and it is responsive to the needs they have identified.

Elements that contribute to effective case management include:

- clear and open communication between the professionals involved
- knowledge of the other professionals involved and the nature of their involvement in the case
- clarification of the requirements and boundaries of each specialist, which includes what information will be communicated to and from the case manager
- having a contract that outlines expectations and boundaries of service provision, methods for ensuring continuity of care during staff turnover and a formal record of agency agreements and responsibilities
- keeping clients informed of their case management plan.

DOCUMENTATION AND CASE NOTES

Clear, concise and respectful documentation is essential to providing person-centred and trauma informed care. Documentation on a person's file should include:

- a contract for participation with your service, which clearly articulates the rights and responsibilities of both parties
- regular, timely and concise case notes
- care plans and review timelines
- progress against goals, including outcomes data, which is shared with the person throughout their treatment journey
- contact details of key support people and other services involved in the person's case.

A case note is a chronological record of interactions, observations and actions relating to a particular client. Case notes are an integral part of practice for AOD practitioners providing frontline services and are one of the most important sources of information available to clinicians. Research has shown that record-keeping practices can affect client outcomes. Good case noting can help you to provide better, more consistent and more accountable interventions and treatment. Information recorded about a client should be objective, correct and complete.

The guiding principle for deciding what information to include in a case note is whether it is relevant to the service or support being provided. Always write your case notes as soon as possible after you have seen or spoken with a client. Clients have the right to access their case notes and other clinical records, so all documentation should be made with this in mind. Various methods may be used for writing case notes. Using a standardised format can assist you to structure information about a contact you have with a client in a logical and sequential format.

One way to organise your case notes is the S**OAP** method, which stands for **S**ubjective data, **O**bjective data, **A**ssessment, **P**lan. This guide from Insight explains more about this method.

Case note audits are conducted to ensure the organisation is meeting its legal, clinical, professional and in some cases contractual obligations with regard to case notes. The following practical templates can assist in conducting case note audits.

- Case notes audit
- Case notes audit schedule
- Case notes audit evaluation

WHAT DOES IT MEAN TO HAVE CASE FILES SUBPOENAED?

A subpoena is a court-ordered legal document that requires a person to provide documentation or give evidence in a hearing or trial. The courts can subpoena your case notes and other clinical records. When your case files are subpoenaed by the court, you need to explain and justify your case notes and every entry in your client's file. Therefore, you need to write your case notes clearly, and only write what you have observed and relevant statements.

Find out more ...

- Legal Aid NSW: **Subpoena survival guide**
- Department of Communities and Justice Law Access NSW: **Subpoenas**
- Department of Communities and Justice Children's Court: **Being subpoenaed** (child protection proceedings, or 'care cases', are civil proceedings brought by Department of Communities and Justice in the Children's Court, usually to remove a child from their family where there are serious allegations of abuse or neglect)
- NSW Health: **Clinical care standards for AOD treatment**, which outline the core elements of care that underpin treatment within NSW
- Department of Health: **advice on writing case notes**
- Insight: **Writing and formulating case notes**
- Turning Point: **Take Note**! (a resource that outlines the principles for writing effective, standardised case notes and illustrates how these written records represent a critical component of delivering quality clinical care)

3.7 Risk and clinical incident management

The residential treatment service should have a comprehensive operational policy document containing clear policies aimed at acknowledging risks and ensuring the health and safety of all staff and residents. Services must manage risks within their treatment facilities. This should involve providing regular reports on risks and incidents to learn from them and to provide a safer environment. Accreditation services refer to their standards for risk management requirements.

Assessing risk is an important part of AOD treatment. Identifying and responding to risk commences at intake and continues throughout treatment. There is a range of risk factors to be considered, including personal characteristics and circumstances, behaviours and risks associated with the substances being used. Core risks are risks that should be considered routinely for all clients in AOD treatment, regardless of the substances used or the treatment they are receiving. There is also a broad range of other risks and harms that should be considered depending on the individual presentation.

CORE RISKS To be considered for all clients	NON-CORE RISKS Non-core risks to be considered based on individual presentation
Domestic and family violence	Deteriorating physical health
Child wellbeing	Significant cognitive impairment
Overdose, including poly sedative use	Injecting drug use risks (e.g. blood-borne virus transmission)
Complicated withdrawal history including withdrawal seizures and alcohol withdrawal delirium	Perinatal risks including during pregnancy and breastfeeding
Recent release from hospital or residential health setting (including residential rehabilitation) or a custodial facility (e.g. prison, remand, police cells)	Unstable or deteriorating mental health, psychosis delirium
Risk of harm to self or others	Sexual health
Risk of homelessness or eviction	Fitness to drive

Monitoring risks alone won't avoid risks. A clinical incident management system ensures that clinical incidents are identified, appropriately responded to and reported, and that information used to improve the safety and quality of care. As part of an accreditation process, and good clinical governance, there needs to be a clear understanding of the clinical incident management system by all staff. It is also essential that clinical incidents are reviewed, and where appropriate, reported to the appropriate funding body or governance body.

Find out more ...

- NADA Policy Toolkit: Risk Management
- NSW Health Centre for Alcohol and Other Drugs: Reporting Incident Form and Practice Tips
- www.ourcommunity.com.au
- www.ncoss.org.au

3.8 Ongoing monitoring and review

MONITORING OF TREATMENT PROGRESS AND OUTCOMES

Monitoring of treatment progress and outcomes is an ongoing process and brings together the information collected in continuous assessment, care planning, identifying, responding to and monitoring risk, implementing the treatment plan, reviewing treatment progress, and discharge planning. It is an opportunity to partner with clients for joint reflection on progress and priorities and informs the ongoing care planning. Coupled with outcomes and a person's experience of service data a clear picture of treatment can be gained to assist at the person-level through to service delivery and policy change. The forms and tools noted in the Find out more... noted above are useful in this process.

WHAT DOES IT MEAN TO HAVE CASE FILES SUBPOENAED?

Monitoring of treatment progress and outcomes is conducted in collaboration with the person who is accessing treatment. Exxploring it together is key to sustainable outcomes and structured, validated outcomes measures that are AOD-specific and that attend to mental health and general health and wellbeing are essential. Structured measurements of AOD-specific Measurement of treatment progress should coincide with and inform care plan review. The frequency of review should be determined by treatment type, risk factors and clinical presentation, and reviews should occur at least every three months. There should be regular clinical reviews to assess ongoing risks and suitability of the treatment plan. The type, frequency and membership of clinical reviews should be in accordance with the client's clinical needs, care plan and risk issues.

Feedback Informed Treatment should be routine, where outcomes, the quality of the therapeutic relationship and experience of service is examined in real time in collaboration with each person - and adjustments to treatment made in response if needed. Tools such as the Outcome and Session Rating Scales (ORS and SRS) designed to enhance the therapeutic relationship, which evidence tells us is key to better treatment outcomes.

From the frontline

Monitoring, reviewing and exploring a person's outcomes data and experience of service data can lead to increased communication between consumers, clinicians and service providers. It is a process for consumers to see where they have been, and where they are going. Consumers can provide real-time feedback on the lived experiences and health outcomes which are important to them. Their insights can illustrate how the experience of health care impacts not only on their own physical and mental wellbeing, but when collated with others, it forms a big picture.

People accessing treatment should be encouraged to give feedback and raise any matters of concern regarding their treatment at any time. A structured treatment review provides one opportunity for this.

What might it be like to ask people we are working alongside whether the therapy we are providing is helpful, while they are still with us in treatment?

We know that in AOD treatment one of our key areas for improvement relates to retention in treatment. One way to address this is to engage people early on in conversations about the importance of the therapeutic relationship or alliance. This means letting people know that we will be regularly asking them about how they are finding the services we provide, and whether they feel their quality of life is improving. Currently, across the specialist AOD treatment sector we are asking about treatment outcomes and client satisfaction, but usually outside the therapeutic interaction with the person in front of us. If we were to ask for feedback, throughout treatment, it would enable us to modify what we were providing and the way it was being delivered to suit the person that was in front of us.

Find out more ...

- NADAbase: resources and tools for client outcomes measurement
- ATOP: resources for using the Australian Treatment Outcomes Profile
- AIHW: Patient-reported outcomes

CASE REVIEW

The review of a person's treatment while in a residential setting is usually referred to as a case review. It is scheduled to occur on a regular timeframe such as every month if a person is in a short term program, three months for longer programs, or in response to specific experienced by the person accessing treatment. A review needs again to be person-centred, engaging them in the process and finding out how the treatment is being experienced and whether it is supporting them in the goals they have set for themselves. Individual choice and control underpin all decisions made with and for the person, which is aligned with a trauma-informed approach to AOD treatment.

3.9 Exit planning, transfer of care and relapse prevention

Exit planning is folded into each part of the treatment journey, which ensures that if a person decides to exit treatment in either a planned or unplanned manner there are clear options in place that will support them in the community. Providing AOD treatment in a residential setting provides unique opportunities and challenges regarding exit, because of the intensity of the treatment and the fact that it is in an environment that is substance-free and away from people's usual context and community.

Before treatment at a service is ceased, an AOD worker will discuss with the person accessing treatment and any support people identified by them their ongoing management plans and the supports that they will need. The plan will set out the person's goals for maintaining their wellbeing and prevent complications from any health, social and wellbeing matters that they may have developed. It will include ways that they can continue to work towards or maintain goals regarding their substance use, including to reduce the risk of relapse.

The plan will describe any ongoing counselling, support and or medical intervention that may be required. The AOD worker will provide the person accessing treatment with information on community resources and other avenues for community support. The person is to be involved in the development of this plan, in a format that is easily understood, and be offered a copy. If relevant and with the person's permission a copy of the plan may be provided to other support people. If the person chooses to discontinue treatment early, they are to be given information that will support them in any ongoing support that they may require.

Whether planned or not, relapse prevention (or recovery planning) is part of treatment provided in a residential setting. Relapse prevention provides a framework for a person to understand circumstances that could affect their capacity to maintain change or their recovery process. Relapse prevention helps a person become aware of how to avoid or work through specific triggers for drug use. A 'trigger' is a situation or stimulus that causes a pattern of thoughts, feelings and behaviours that increase a person's risk of using alcohol or other drugs. Relapse prevention involves supporting people to develop coping skills to handle triggers and high-risk situations. Carefully identifying triggers and developing appropriate strategies and interventions to lessen their effects are a key part of relapse prevention. Furthermore, risk assessments need to be completed as part of any exit, particularly if unplanned, with strategies for support regarding suicidal ideation, risk for domestic and family violence and potential homelessness.

Find out more ...

- Relapse Prevention: Youth AOD Toolbox YSAS 2019
- Lifeline Australia: 13 11 14
- NSW safe haven: a place you can go if you're feeling distressed or having suicidal thoughts

TRANSFER OF CARE

Transfer of care is Standard 6 in the Clinical Care Standards and is defined as:

Transfer of care, including discharge, is a process of identifying and documenting a client's needs which includes information regarding engagement in treatment, relapse prevention and harm reduction information, as appropriate.

Before leaving residential treatment, decisions should be made about the client's continuing needs. When clients are referred back to local services for further treatment these services need to be included in treatment planning as part of a combined case management approach. When a client transfers to other mental health or social care services a joint review should, where practical, be undertaken to ensure that effective handover takes place. Discharge summaries will assist these services to tailor ongoing treatment plans to the needs of clients.

Exit planning and transfer of care planning start at the assessment stage of treatment, with identifying:

- current supports and needs that are not yet addressed that will need time to be worked through, such as housing stability, networks of support relating to ongoing assistance with substance use and mental health needs and financial/welfare needs
- ongoing physical health needs and where the person will receive that support
- medication needs relating to hepatitis C and long-acting reversible contraception
- physical exercise needs
- relevant support groups and services in the community, and making connections with them.

Find out more ...

- NSW AOD Treatment Clinical Care Standards: Standard 6 Transfer of Care
- Clinical Care Standards Readiness Toolkits

UNPLANNED EXITS

There are many reasons why people may discontinue treatment before completing their treatment journey. Under these circumstances, the aim is to maintain engagement with the person as appropriate and ensure that they are aware of:

- opportunities to re-engage with services, as required
- strategies to manage and reduce health risks or harms with any continued substance use
- information to access alternative treatment services, community support and resources.

When discharges are unplanned, the person should be given appropriate information and advice to maintain their wellbeing.

Partnerships and linkages

Partnerships and links with community-based services are vital for effective transfers of care. These might include, among others:

- the local health district in your region for other AOD, physical and mental health needs
- Aboriginal community–controlled services
- housing services
- financial services
- education and vocational education services.

3.10 Continuing care

Continuing care approaches can have a positive effect on treatment outcomes across a range of AOD treatment settings (Kelly et al. 2021). The important functions of continuing care include maintaining abstinence/initial treatment goals, addressing relapse/relapse prevention, providing referrals/connections to other sources of support, and addressing other co-occurring issues, including employment, housing, physical and/or mental health issues (McKay 2021, 2).

Continuing care should be prioritised for all people leaving residential treatment and is equally appropriate for people who complete treatment and for those who do not, including those who leave the program early and those who are discharged due to issues while at the service. As a minimum standard, all clients leaving treatment should be given a basic exit package or safety kit, containing updated support information harm reduction information, safe injecting equipment where appropriate and resources, such as free-call telephone numbers, details of online services and naloxone resources.

Engaging people in continuing care can be challenging, with some research finding that just 21–36 per cent of participants commence continuing care following residential or outpatient AOD treatment (Kelly et al. 2021). This low uptake of continuing care indicates that many people who could benefit from these supports and interventions are not accessing them. Unfortunately, there is limited research available that looks at why people do or do not engage in continuing care programs, and this is something that needs to be better understood so that programs can be modified and adapted to increase uptake (Kelly et al. 2021).

One factor that has been found to potentially influence engagement in continuing care is community-affiliated social support (Kelly et al. 2021). Social support and feelings of acceptance and belonging are important factors in supporting recovery and improving outcomes for people who have experienced problematic drug use (Ingram et al. 2020). Connectedness, active engagement in the community and supportive social networks are key to changing problematic alcohol and other drug use issues (Best & Lubham 2012). Continuing care that provides these elements as part of the intervention can therefore be more effective at supporting people to maintain their goals achieved during residential treatment.

Continuing care that includes more assertive approaches and rapid initiation can be even more helpful (Passetti et al. 2016). Continuing care of longer duration that includes more active efforts to keep clients engaged has been found to produce more consistently positive results, particularly for people at higher risk for relapse (McKay 2021, 1). Regardless of the types of interventions provided as part of continuing care, people's needs and situations will change over time, so continuing care needs to include regular reviews to be able to change or adapt the supports and services when required (McKay 2021).

It may be the case that the residential treatment service is unable to provide a program of continuing care, and/or a person is exiting treatment to another location. In these cases, strong links with a continuing care program of support that is local and accessible for the person is important.

Effective continuing care needs to be:

- assertive and started as early as possible
- tailored to reach a broad range of people, include Aboriginal and Torres Strait Islander people and people who exit treatment services early, to ensure that all people who might benefit from this support can access it
- of significant duration and include active efforts to keep people engaged
- an integrated care approach that is adaptable and responsive to the person and includes regular review of their situation.

Examples of continuing care offerings include:

- providing a drop-in facility
- telephone-delivered check-ins and counselling
- outreach workers who meet with the person in the community to provide support
- coordinated recreational activities
- support for people in voluntary work and training courses
- encouraging people to return to participate in occasional sessions and activities at the service
- living skills and peer support groups
- referral and case management support
- where possible the option for rapid re-access to a residential service for someone who has recently exited program and needs further assistance
- tailoring support to suit the person such as phonecalls scheduled to check in around school/ study or work commitments

Case study

Sally was referred to a community-based continuing care program for support with her problematic polysubstance use, housing and mental health issues. Sally needed support with building social connections and with her housing, as she was about to be evicted from her Housing NSW property due to rental arrears. Sally's continuing care case worker supported Sally at her housing tribunal hearing and was able to help her to obtain some assistance with her rental arrears from a non-government organisation. The continuing care case worker supported Sally to contact different AOD detox and residential programs and organised an admission to detox and then rehab. While Sally was in residential rehab, her continuing care case worker maintained contact with Sally and participated in Sally's discharge plan, to support her when she exited the program.

4 HOLISTIC CARE

KEY POINTS AND PRINCIPLES

- AOD treatment in a residential setting is holistic, in that it accommodates the variety of needs a person accessing treatment may present with.
- Providing holistic care requires links and strong partnerships with communities, services and other specialist providers.
- As part of person-centred care, treatment needs to be individually tailored to suit the person.
- Holistic care works when you take a universal approach, apply trauma-informed principles and are sensitive to learning and memory issues.
- AOD treatment in a residential setting responds to the whole person's health and wellbeing needs.
- Evidence-based approaches applied in AOD treatment in a residential setting are effective in the treatment of co-occurring mental health issues.
- Celebrating and harnessing diversity as part of AOD treatment contributes to sustainable treatment outcomes.
- Aboriginal and Torres Strait Islander approaches to connecting people to land, culture and community can provide useful insights relevant to effective AOD treatment.
- Pharmacotherapies can be an effective option for people and can complement AOD treatment provided in a residential setting
- Involvement of family, significant others and/or community supports where appropriate to support and sustain treatment outcomes.

4.1 Holistic care

People accessing AOD treatment in residential settings have complex sets of needs that have shaped and been shaped by their experiences. Engaging in this intensive treatment is a significant commitment by a person, and an opportunity to be provided care in a holistic and integrated way. As described in the NADA Capability Framework, services need to work closely with general health, mental health and social care services to promote a holistic approach to treatment and support. This may include integrated care within a single setting, close ongoing working relationships between systems of care and/or supported referral during and after treatment.

What assists holistic care?

- Holistic care requires a universal approach. Evidenced-based practices for working with people who are experiencing issues with their AOD use will be effective for mental health issues and cognitive impairment issues and vice versa.
- Providing holistic care requires strong community partnerships with other service providers and community groups. It can't be done alone.
- Everyone can benefit from strategies to improve memory and information retention, which are part of cognitive impairment programs (e.g. ACE).
- Psychoeducation and strategies for maintaining good mental health should be part of all AOD treatment programs delivered in residential settings.
- Holistic care means attending to the unique experiences of each person accessing treatment, and seeing diversity as a strength that can be harnessed for sustaining positive treatment outcomes (e.g. connection to culture, celebrating of sexuality and gender diversity).

Partnerships and linkages

Make links and form partnerships with these and other services.

- Local Aboriginal communities: Elders and specialist Aboriginal providers (e.g. AMS)
- Child protection services: local DCJ communities of practice
- Mental health providers: community mental health providers
- LGBTIQ+ community groups: ACON and other LGBTIQ+ providers
- culturally and linguistically diverse communities: neighbourhood centres, cultural groups and community Elders/leaders
- criminal justice services: establish contact with DCJ service providers or specialist criminal justice workers (e.g. CRC)
- domestic and family violence services: victim/survivor services and men's behaviour change services
- childcare providers: local services who may be able to provide specific training or support for parents or for children who may be onsite

4.1 Diversity: Enhancing inclusion

AOD services provided in residential settings are as diverse as the people who access them. Person-centred approaches mean that we get to know the person seeking support, assess their needs and treatment goals and tailor our approach to suit. Having flexibility in programs is key, including identifying what your service may not be able to provide and how you might fill that gap. It means celebrating diversity and tapping into your local community groups to ensure you are providing each person the supports and connections they need, to sustain their treatment journey long after they have left the residential setting.

In each domain of the NADA Capability Framework there are indicators that align specifically with the provision of holistic care and the enhancement of inclusive practices. Domain 3 outlines indicators that are designed to promote cultural safety, access and equity for people accessing treatment.

Find out more ...

- Access and equity: Working with diversity in the alcohol and other drugs setting (second edition), NADA 2021
- NADA Capability Framework: Domain 3 Access and Equity, NADA 2020
- Human rights and health rights, NSW Health

4.2 Mental health care

The specialist AOD treatment services sector is well aware of the significant prevalence of co-occurring mental health and alcohol and other drug use issues for people seeking support. The good news is that AOD treatment approaches are well aligned with effective interventions for improving people's mental health. It is also true that some people find relief, at least initially, from their poor mental health symptoms in the absence of substance use. Symptoms associated with PTSD may in fact worsen in the absence of alcohol and other drug use, making a trauma informed approach all the more vital. However, applying a universal approach through psychoeducation, therapeutic support and strategy building designed to improve mental health will encourage retention and engagement in treatment. It can frequently be a challenge for people with a diagnosed mental health condition to access treatment, particularly when they are on medication. Consideration needs to be given to the clear evidence that addressing both AOD use issues and co-occurring mental health conditions at the same time is best practice.

From the frontline

NADAbase (the online repository for NADA members' client demographic and outcomes data) now contains 10 years' worth of client outcomes data, and that data indicates that people entering treatment in a residential setting routinely show evidence of high psychological distress at intake, year on year. People entering AOD treatment provided in residential settings will require support regarding experiences of poor mental health – this is the rule rather than the exception.

Suzie Hudson, Clinical Director, NADA

IS YOUR SERVICE AOD–MENTAL HEALTH CAPABLE?

- Do you screen and assess for mental health issues and symptoms?
- Are all staff confident about evidence-based practices that are effective for people with co-occurring mental health and alcohol and other drug use issues?
- Have you developed strong links to local mental health services?
- Do you have the capacity to welcome someone into your service who may need to take medication to support their mental health?
- Are there contingencies in place if a person's mental health symptoms escalate or require specific support?
- Do your care plan templates pay specific attention to goals and strategies that might support good mental health outcomes?

Staff need to have sound knowledge of mental health diagnoses, psychological distress and how these can affect wellbeing, and to work with tools and program materials that support this knowledge. Outlined in the NADA Workforce Capability Framework, under Domain 1: Foundational knowledge and practice, is the need for the AOD workforce to:

"recognise and respond appropriately to potential medical and mental health conditions that may co-exist with AOD-related health conditions" (NADA Workforce Capability Framework in Domain 1: Foundational knowledge).

For people with co-occurring mental health conditions (including trauma), an integrated, coordinated-care approach with assertive follow-up may lead to better treatment outcomes. If possible, having a variety of psychological treatment programs for specific disorders (including trauma-informed approaches) may also be beneficial. If there is no dedicated mental health clinician who can deliver such programs within the service, additional staff training and supervision is essential.

There is strong evidence that AOD treatment in residential settings is effective for people with co-occurring mental health conditions (including trauma-related conditions). Relevant studies indicate reductions in both AOD use and mental health symptoms. Upon treatment entry, it is recommended that screening and risk assessment include screening for co-occurring mental health conditions.

Find out more ...

- Comorbidity Guidelines: Guidelines, eLearning and training for co-occurring mental health and alcohol and other drug use issues
- **Building on personal strengths**: Check out these stories on the Flourish website that explore how people have connected with their strengths such as music, art, community groups and support networks
- Implementing evidenced-based practice: What AOD managers and workers need to know
- Audit your service: Dual Diagnosis Capability in Addiction Treatment (DDCAT Toolkit)

4.3 Cognitive impairment care

All the activities provided in AOD treatment in a residential setting has the potential to improve cognition. People engaged in AOD treatment may experience challenges that are the result of cognitive impairment. In daily life this can be an experience of difficulties with planning, problem solving, recalling information and emotional regulation – many of the tasks we ask of people during treatment. Recent research has shed light on how common this experience can be, and has led to the development of supportive tools you can use in your practice to better support people accessing treatment.

Find out more ...

The ACE screening tool is a brief set of questions that was developed to be administered by frontline AOD clinicians to clients. You can download the screening tool and user guide here. It will take you through how to administer it, score, and explore pathways for additional support you may need to consider. If a person screens for possible cognitive impairment, you can then you can use the Brief Executive Function Assessment Tool (BEAT) that was developed specifically for people accessing AOD treatment.

Screening and assessment for cognitive impairment will inform a person's care planning and has the potential to inform program content. When you explore the kinds of questions that are asked as part of a screener for cognitive impairment it assists in understanding why people accessing AOD treatment in residential settings may have difficulties with memory, impulse control and planning. You may also notice that the following strategies for supporting someone who has cognitive impairment are perfectly aligned with a trauma-informed approach.

Turning Point has also produced a resource: Managing Cognitive Impairment in AOD Treatment. Designed to provide practice-based strategies for AOD workers to support people who may have a cognitive impairment.

From the frontline

- Avoid noisy, distracting environments when trying to concentrate on something important.
- Complete one task, activity or conversation at a time.
- Summarise what you have been told to make sure you have correctly understood what has been discussed.
- Set up daily/weekly routines that are written down or represented visually.

AOD treatment in a residential setting is the perfect environment for conducting a specialist cognitive impairment program: the Alcohol and Drug Cognitive Enhancement (ACE) program. Trialled in NSW specialist residential AOD treatment services, the ACE Cognitive Remediation Program consists of 12 one-hour group sessions. Each session is dedicated to strategy training, which includes traditional instructional teaching approaches, group discussion and reflection, and exercises to demonstrate the concepts that are learned in the program.

Find out more ...

- **ACE Cognitive Remediation Program** Manuals
- **ACE Cognitive Remediation Program** Module Videos
- Clinical treatment guidelines for alcohol and drug clinicians (Turning Point)
- **Looking Forward: Acquired Brain Injury** (arbias)

FOETAL ALCOHOL SPECTRUM DISORDER

Foetal alcohol spectrum disorder (FASD) is a term that describes the neurodevelopmental impairments that can result from alcohol exposure before birth. FASD is the leading cause of non-genetic developmental disabilit y in Australia. People with FASD experience challenges in their daily living, and need support with motor skills, physical health, learning, memory, attention, communication, emotional regulation and social skills. For people accessing AOD treatment in a residential setting who may have FASD, applying an approach in line with supporting people with a cognitive impairment outlined above is effective. Providing tools and strategies that may assist with memory, goal setting and emotion regulation will support a person with FASD to engage in a specialist AOD treatment program.

Knowledge about FASD provides opportunities for the AOD workforce in both the prevention and treatment space to:

- provide information to people accessing treatment who may become pregnant or are supporting someone who may become pregnant
- provide treatment to people who may have FASD.

Find out more ...

- nofasd: information, resources and support services
- Every Moment Matters (FARE): information for health professionals

4.4 Care for people with criminal justice involvement

People involved in the criminal justice system are understood to generally experience high levels of social disadvantage. Among police detainees in Australia, women were found to be substantially more socially and occupationally disadvantaged than women in the general community, and more disadvantaged than male detainees (Loxley & Adams 2009). For people who have convictions or who have spent time in custody, the experience of stigma and discrimination is compounded. People frequently get caught in the grey area between trying to access support to address their complex needs and the perceived need to manage risk by an AOD treatment organisation.

Some treatment services have strict policies about accepting people with a criminal history into their service, and this may be informed by concerns about potential safety risk. However, there may be constructive ways to support people with a criminal history that avoids excluding them from treatment. There are specialist residential programs designed to support people who are engaged with the criminal justice system, for both adults and young people. It is often the case that these specialist programs have links or conduct specific therapeutic programs designed to address offending behaviour. However, many of the themes and topics covered in these programs are aligned with principles of trauma-informed practices, exploring emotion regulation, problem solving, building social networks and developing resilience. Evidence indicates that working with people pre-release is more effective to ensure a smooth transition back into the community (Sotiri et al. 2021).

Improving access for people involved in the criminal justice system requires:

- connecting with a specialist service that provides support to people exiting custody or engaged by the criminal justice system to discuss any concerns the organisation may have and identifying potential solutions
- reviewing your staff mix and considering recruiting someone who has experience working with people exiting custody
- examine your policies and inclusion criteria regarding accepting a person with a criminal history and get some advice. Consider reviewing each case on its individual merits as opposed to having a blanket exclusion approach
- exploring a case management model that involves your service and specialist workers from juvenile justice or adult justice programs who can provide additional support
- linking people with support groups while they are waiting for treatment
- providing an environment that is sensitive to the experiences of institutionalisation by providing space, time and emotional safety, to facilitate engagement.

From the frontline

Community agencies are sometimes reluctant to engage with people in custody because of the assumptions that people on release from prison are significantly different from or more dangerous than other vulnerable people with complex needs, and that people are already linked with services because they are incarcerated. Neither assumption is true.

Paul Hardy, Community Restorative Centre

Find out more ...

- Community Restorative Centre language guide
- Your Guide to Surviving on the Outside: CRC
- Health Justice Australia
- www.healthjustice.org.au/resources-home
- The Miranda Project

A number of specialist AOD services that provide residential treatment across NSW have priority places for people engaged in the MERIT program or Drug Court New South Wales. The service requirements of these programs align with the key aims of specialist AOD treatment in residential settings outlined in this Practice Guide, including:

- the provision of a safe, alcohol and other drug–free environment
- engagement in each element of the NSW Health Clinical Care Standards
- a focus on improvements in physical, emotional and social wellbeing outcomes.

Of particular importance is the relationship between the residential service and the MERIT or Drug Court teams for the benefit of the person engaged in treatment. Good communication for the duration of the program regarding administration, planning and coordination is key, as is clarity with respect to primary responsibility, which shifts from the MERIT or Drug Court team to the residential service for the duration of the person's stay. However, contact is maintained with the MERIT or Drug Court teams regarding progress and any alterations to the care arrangement. Attendance in court may also be required throughout the program. If this is not practicable then a progress report or discussion with each respective team is required for collaborative continued management of the persons treatment and legal obligations.

MAGISTRATES EARLY REFERRAL INTO TREATMENT (MERIT) PROGRAM

The Magistrates Early Referral Into Treatment (MERIT) program is a voluntary, pre-plea program for adults in the Local Court system who have issues relating to their alcohol and other drug use. MERIT provides access to a wide range of alcohol and other drug treatment services for 12 weeks while court matters are adjourned. The program aims to aims to improve health and wellbeing and reduce offending for adults who have issues related to their alcohol and other drug use and are in contact with the criminal justice system. The program provides access and support to the spectrum of specialist AOD services, including in residential settings.

Specific MERIT residential treatment Guidelines published by NSW Health emphasise the importance of collaborative relationships across the health and justice sectors.

Find out more ...

- Magistrates Early Referral Into Treatment (MERIT) program: NSW Health
- MERIT Residential Treatment Guidelines: NSW Health
- The MERIT Program: Aims, referrals and procedures

DRUG COURT OF NEW SOUTH WALES

The Drug Court of NSW is a specialist court that sits in three locations, Parramatta, Toronto, and Sydney in New South Wales, Australia. It takes referrals from the Local and District Courts of offenders who are dependent on drugs and who are considered to be eligible for a Drug Court program. The Drug Court of NSW attempts to address underlying drug dependency which has resulted in criminal offending.

The Drug Court program is a long-term treatment option, aiming for participants to be engaged for approximately a year. This includes three distinct phases: Phase 1 – Initiation and stabilisation, Phase 2 – Consolidation, and Phase 3 – Re – Integration. Each phase has distinct goals that must be achieved before the participant graduates to the next phase. Often residential treatment is accessed by the Drug Court Program and their participants in Phase 1.

Find out more ...

- Drug Court of New South Wales (nsw.gov.au)

Principal drug of concern and medications to support treatment

This table is a starting point to investigate medications available, there are many more to explore.

	Medication	Example brand	Route of administration	Who might it be useful for
Alcohol	**Acamprosate**	Campral	Oral	Taken daily, this is for people who are wanting to manage cravings and may already be experiencing cirrhosis of the liver.
	Disulfiram	Antabuse	Oral	Prevents alcohol use due to extremely unpleasant side effects that occur when alcohol is ingested e.g., vomiting and headaches.
	Naltrexone	ReVia, APO-Naltrexone	Oral or injection	People who are wanting to block the pleasurable effects of alcohol use, those who may have a binge pattern of alcohol use.
Opioids (e.g., heroin, codeine, morphine, etc.)	**Methadone**	Methadose, Biodone	Oral	Prevents opioid withdrawal symptoms, for those able to attend a clinic on a daily basis, or are able to access take aways for use at home
	Buprenorphine	Subutex	Oral	People who want to avoid opioid withdrawal symptoms and discontinue the use of all other opioids—blocking the effect of additional opioids if taken.
	Buprenorphine and Naloxone	Suboxone	Oral	People who want to avoid opioid withdrawal symptoms and discontinue the use of all other opioids—blocking the effect of additional opioids if taken. In addition to an additive of Naloxone which is activated in the case of injection of the medication.
	Buprenorphine depot	Buvidal, Sublocade	Depot injection	Taken weekly or monthly, this is for people who would like to avoid regular dosing of alternative opioid pharmacotherapy.
	Naltrexone		Oral or depot injection	People who have abstinence as their goal. However, the evidence for the effectiveness of this pharmacotherapy for opioid dependence is weak.
Nicotine	**Nicotine Replacement Therapies**	Nicorette, Nicabate, QuitX	Patches, gum, nasal and mouth spray, inhalers	Provides a similar effect of tobacco use without having to smoke. Reduces cravings and withdrawal and can be purchased without a prescription.
	Varenicline	Champix	Oral	People who wish to cease smoking. It reduces cravings and withdrawal and interrupts the enjoyable effects of smoking.
	Buproprion	Zyban	Oral	A sustained release medication suitable for people who have had multiple quit attempts. The medication is often used in conjunction with NRT and if the person is not suitable for Varenicline. Also functions as an anti-depressant.
Methamphetamine	**Dexamphetamine**		Oral	A short-acting stimulant medication used in the treatment of ADHD, currently prescribed as part of clinical trials as a potential agonist pharmacotherapy for people who are dependent on methamphetamine.
	Lisdexamfetamine		Oral	A long-acting stimulant medication used in the treatment of ADHD, currently prescribed as part of clinical trials as a potential agonist pharmacotherapy for people who are dependent on methamphetamine.
	Modafinil		Oral	Sporadically prescribed off-label for methamphetamine or cocaine dependence as an agonist treatment. The research evidence for its effectiveness is weak.

4.5 People receiving pharmacotherapy

Pharmacotherapy is the use of prescribed medications in the treatment of a disorder, such as a substance use disorder. In the context of specialist AOD treatment provided in residential settings it is the use of medications for managing cravings, reducing the risk of relapse or maintaining the stability of a person, such as the use of methadone while the person addresses concerns about a different substance such as methamphetamine. Pharmacotherapy is most effective when it is provided alongside additional therapeutic interventions such as individual and group counselling, social and physical activities.

Medications can be provided to support abstinence from a range of substances, and while there is varying research evidence across the different medications it is important that people working in the specialist AOD service sector have a good working knowledge of these medications. Some pharmacotherapies may work better in outpatient or community settings and therefore may be a preferred option for people as they exit residential treatment or where an alternate treatment option is being considered.

Some residential settings provide specialist pharmacotherapy programs for opioid use, such as Methadone to abstinence (MTAR) programs, or provide longer acting buprenorphine depot options for people who wish to maintain their pharmacotherapy while in residential treatment. The provision of nicotine-replacement therapy (NRT) should be an option for all people accessing AOD treatment in a residential setting. The table below outlines some of the common pharmacotherapies available. Consultation and support from an addiction medicine specialist is advised when establishing pharmacotherapy as part of AOD Treatment in a Residential Setting. Models for opioid pharmacotherapy.

Models for opioid pharmacotherapy

- Residential treatment of people undergoing methadone or buprenorphine maintenance treatment, where remaining on the treatment while seeking to cease use or reduce the harm associated with alcohol or other drugs of concern
- Residential treatment of people seeking to discontinue methadone or buprenorphine maintenance
- Residential treatment with the use of antagonist pharmacotherapy (e.g. naltrexone) as an aid to abstinence

Some people on methadone or buprenorphine maintenance have social or health-related difficulties that compromise their ability to engage with therapy, and they may be helped by combining residential treatment with maintenance pharmacotherapy. In some cases, mental health comorbidity or poly-drug use may mean that residential programs can assist people achieve sufficient life stability to commence engagement with methadone or buprenorphine maintenance treatment that can be continued in the community. Close collaborative case management needs to be maintained with the pharmacotherapy prescriber.

Methadone or buprenorphine to abstinence programs are designed to assist people to reduce maintenance doses, usually at the person's request. The safety, security and support provided by a residential treatment program enables people to withdraw from the pharmacotherapy in a timely, planned and systematic way. Clear agreements are developed between pharmacotherapy providers and the treatment program for the ongoing shared care of the person accessing treatment. These arrangements include an agreement on scripting the withdrawal regimen, shared case confidentiality (with the person's consent and in line with Privacy Legislation) on issues related to pharmacotherapy prescription and a capacity for the person to return to maintenance pharmacotherapy for reasons of personal choice or good clinical practice.

Clear partnerships should be developed with the dispensing pharmacy to ensure that consistent dosing times, good dosing practice and transparent shared care partnerships (with the person's consent) are in place. It is recommended that the residential program develop partnerships with a prescriber and a pharmacy. Apart from the economy of these arrangements, it leads to consistent practice and information exchange across the providers. However, there might be some benefit from a person remaining with their existing maintenance prescribers if the therapeutic relationship is significant.

DEPOT BUPRENORPHINE

Empathy for the prolonged, moderate withdrawal symptoms experienced by some people is essential. These may include insomnia, excessive perspiration, restlessness, and daytime lethargy. There are marked performance differences between people in drug-free residential treatment and those undergoing slow withdrawal, and these may need to be taken into account regarding involvement in program activities.

In situations where women accessing treatment are pregnant, induction to methadone maintenance as part of comprehensive treatment programs is considered best practice (Keegan 2010, Minozzi et al. 2008). Commencement of methadone should ideally take place in an outpatient setting, with maternal and obstetric supervision, as is common practice in Australia and supported by the American College of Obstetricians and Gynaecologists (ACOG). Continued buprenorphine treatment is safe for women who become pregnant while already using this type of treatment. It achieves similar outcomes to methadone in reducing maternal drug use and promotes positive neonatal outcomes, and appears to result in a less severe neonatal abstinence syndrome (Young & Martin, Jones et al. 2012). However, as buprenorphine induction may place the foetus at risk from precipitated maternal withdrawal and potentially trigger relapse in mothers, methadone is recommended for active opioid users who need to be inducted to pharmacotherapy during pregnancy (Young & Martin 2012).

A depot injection is a term for an injection formulation of a medication that is released slowly over time, which allows a person to reduce the number of times they need to have the medication administered. The introduction of depot preparations of buprenorphine has meant that the frequency of people having to attend for dosing has reduce to weekly or even monthly. Specialist AOD services that provide residential treatment but do not have medical staff or the capacity to provide pharmacotherapy now have an opportunity to have people reside in their service who may be currently receiving opioid pharmacotherapy.

Find out more ...

- NSW Clinical Guidelines for use of depot buprenorphine
- Depot Buprenorphine: NSW Health
- Depot Buprenorphine Fact Sheet: NSW Health
- Depot Buprenorphine Webinar: RACGP
- **Drug and Alcohol Specialist Advisory Service** (DASAS)

4.6 Smoking cessation

Smoking rates for people accessing AOD treatment in residential settings remain high, even after they exit treatment (Kelly et al. 2020). Since this is the substance use that is most likely cause the most harm and even premature death, support with smoking cessation is a key element of treatment, and to this end many services have decided to go **smoke-free**. However, this decision is not consistent across the state and with that in mind it is worthwhile have specific education options for both staff and people accessing treatment to ensure that people have access to support and to onsite nicotine-replacement therapy (NRT).

Continuing to support smoking has implications for both those who are smoking and other people residing in the program, through second-hand smoke. Providing a smoke-free environment can support a person's intention to quit, and there are specific resources and consultation opportunities available through the NSW Cancer Council and **iCanQuit** to assist both staff and people accessing treatment who smoke.

More recently nicotine vaping products have become available to people on prescription, particularly targeting those who have had difficulty quitting and are at risk of significant harm. It is important that the AOD sector seek out the most up to date information to inform any policy regarding the use of caping products.

Find out more ...

- NSW Cancer Council **tackling tobacco programs** – grants for NRT
- **Medication interactions** with smoking cessation products
- **Vaping: the facts**: A New Zealand resource with a presentation by Professor Hayden McRobbie, NDARC
- *The Lancet*: Information about e-cigarettes and **smoking cessation**
- Alcohol and Drug Foundation: **Information and statistics** regarding vaping across Australia
- **The vape debate**: The ABC's *Nightlife* debate exploring the range of opinions about vaping and electronic cigarettes

5 MODELS OF CARE AND TREATMENT APPROACHES

- A model of care clearly articulates the approach, interventions and outcomes your service intends to provide to each and every person.
- A trauma-informed approach is essential to service provision. It is a whole-of-organisation approach that permeates all elements of service delivery.
- AOD treatments provided in residential settings are evidence-based and usually involve a number of modalities of individual, group and peer support.
- Treatment is person-centred and holistic, and attends to the key principles of respect, equity of care and appreciation for diversity.
- Strengths-based approaches that empower people to lead their own care with consistent support produce sustainable outcomes.
- AOD treatment provided in residential settings present unique opportunities for holistic care and growth in emotional, physical and cultural wellbeing.

MODEL OF CARE

A model of care, in the context of this Practice Guide, clearly encapsulates the key elements and processes of a therapeutic program, describing the best practice approaches and the intended outcomes. The NADA Enhanced Performance Guide provides step-by-step guidance on all the important steps that inform the development of a model of care including:

- clinical governance
- developing a program logic
- constructing a theoretical framework
- articulating a model of care
- measuring performance and identifying outcome domains.

A model of care needs to be underpinned by the philosophy, culture and theoretical approach the organisation has to treatment provision. Exploring what this philosophy is with people who have attended the service, staff, board and relevant community members is helpful. Various modalities or treatment approaches for residential treatment are available in NSW, reflecting the range of philosophies and interventions available and the range of populations served by different programs. However, AOD treatment provided in a residential setting generally conduct a program including therapeutic counselling (individual and group) using a range of modalities (Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Acceptance and Commitment Therapy and Motivational Interviewing), living skills training, parenting skills, case management, physical exercise, relapse prevention, education and vocational training.

NSW specialist AOD treatment provided in residential settings has a rich history and was originally shaped by the Alcoholics Anonymous '12 step' approach influenced by the US and UK. The other key influence was the Therapeutic Community model of treatment. Approaches from the 1970s were influenced by the principal drugs of concern identified by people accessing treatment such as heroin and alcohol, and the emphasis was on longer-stay programs. Throughout the 1980s and 1990s programs became more structured around modules or phases of treatment, which in turn affected program length, and the availability of short (around one month) and medium (up to six months) programs emerged. Currently, program length is more flexible, with services in the sector adopting an increasingly person-centred approach and program length being shaped to suit the individual needs of the person accessing treatment.

THERAPEUTIC COMMUNITY MODEL

The therapeutic community (TC) model harnesses self-help and the mutual support of the treatment community (those participating in the residential program) as the method and means of personal change. Whether or not a service makes explicit that it applies a TC model, all services use the support of the people in the treatment service (clients and workers) as a community of support and growth. However, a TC model enlists those participating in the program to play a specific role in the treatment delivery and operation of the service.

Find out more ...

- Australasian Therapeutic Communities Association: ATCA
- Community as method: principles and practice of therapeutic community treatment

5.1 Aboriginal community–controlled models of care

Aboriginal and Torres Strait Islander ownership of solutions was overwhelmingly identified as being an important principle in the consultations held by the National Indigenous Drug and Alcohol Committee (NIDAC) to inform the development of the National Aboriginal and Torres Strait Islander Peoples' Drug Strategy. An added dimension was the importance of this ownership being community focused and led (commonly referred to as community-controlled) rather than just being left to individuals. Indigenous ownership of solutions was identified as needing to occur from inception and planning, through implementation and provision, to monitoring and evaluation of any solutions. This understanding is consistent with international research (Marmot 2011) and the United Nations Declaration on the Rights of Indigenous Peoples (United Nations 2007).

The Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN) is a network of representatives of Aboriginal residential rehabilitation services across Australia, who meet to advocate for issues and to share and develop culturally sound best-practice principles, knowledge and experience. It aims to be the key consultative group at both state and national levels with regards to Aboriginal residential rehabilitation services.

ADARRN MODEL OF CARE

Aboriginal governance and Aboriginal people's involvement in program delivery is critical to ADARRN members. At local level, ADARRN services consult with and are governed by the local Aboriginal community, including Elders and local Aboriginal community leaders

Adaptations of evidence-based mainstream interventions that integrate culturally specific practices, including traditional values, spirituality and activities, have been shown to be more effective among Aboriginal and Torres Strait Islander communities than mainstream services, as these elements increase credibility and relevance to Aboriginal and Torres Strait Islander people (Terrell 1993; Anderson 1992; McCormick 2000; Brady 1995b; Gray et al. 2014). The ADARRN model of care has been specifically designed for Aboriginal and Torres Strait Islander people, with a specific focus on culture and healing. However, according to non-Aboriginal consumers can be effective for any person reaching out for treatment support.

The literature (Brady 2002) indicates that to develop effective cultural adaptations of mainstream interventions:

- workers and services need to be flexible, open and culturally sensitive to the needs of people seeking treatment
- interventions need to be delivered in culturally meaningful ways
- traditional healing practices need to be used
- cultural differences need to be respected
- a focus on learning about Aboriginal and/or Torres Strait Islander culture and identity needs to be included
- the unique family structures of Aboriginal and Torres Strait Islander communities needs to be acknowledged, by allowing for close contact with family members (such as phone contact with family members throughout treatment, and regular family visits).

From the frontline

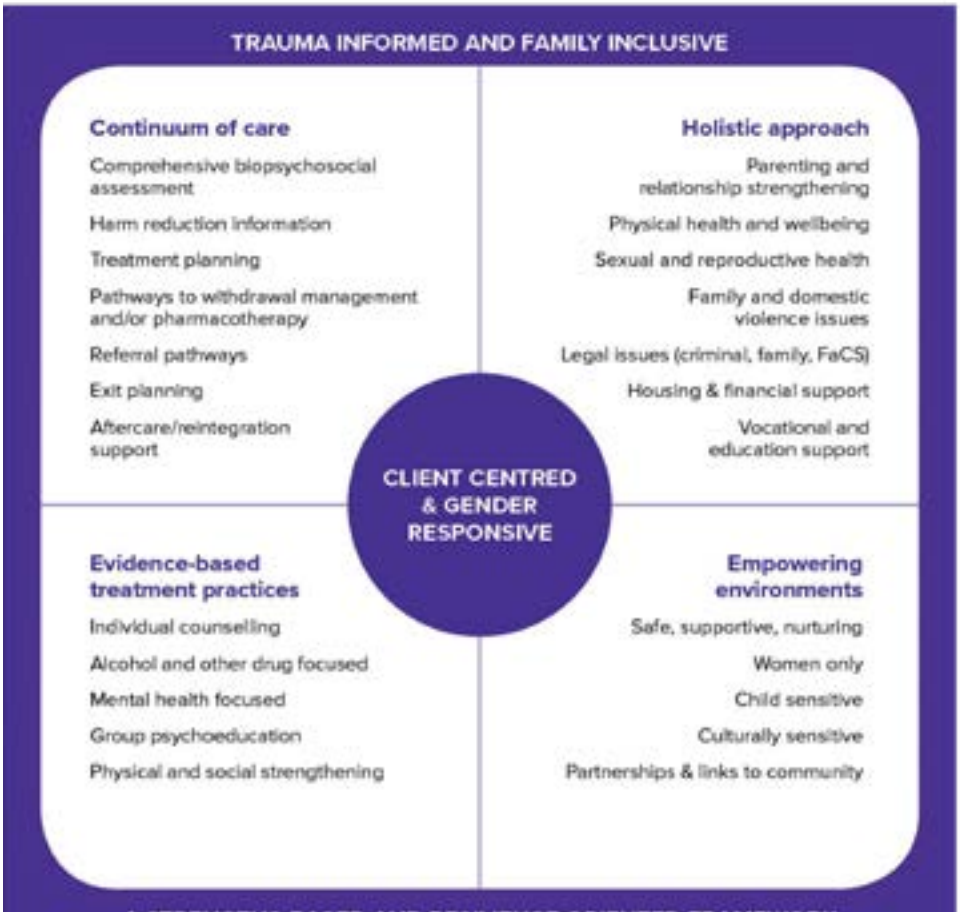
Effective Aboriginal-focused residential AOD services use and adapt evidence-based mainstream practice and integrate culturally specific values, ceremonies, history, connection to land, family (kinship) and spiritual and healing techniques within the program. These adaptations make treatment in Aboriginal services more effective for Aboriginal and Torres Strait Islander people than treatment in mainstream services. A trauma-informed, client-centred approach encompassing a flexible care plan that addresses individual needs is important, as is the involvement of family and community.
Alan Bennett, CEO Orana Haven

Find out more ...

- Our Healing Ways resources support the healing of people with both mental health and drug and alcohol issues from an Aboriginal perspective.
- Resource book for Aboriginal workers includes background information and sections on holistic assessment, setting up a recovery plan together, stages of change, interventions, resources and services.
- Supervision: A culturally appropriate model for Aboriginal workers has been developed to help meet the need for culturally appropriate supervision models.

5.2 Working with women: Gender-responsive models of care

The Women's Alcohol and other Drug (AOD) Services Network was established to improve pathways and connections for services working with women. Comprising representatives from women's specialist non-government services in NSW that provide services to women seeking AOD treatment, including those providing services to pregnant women and to women with children. This model of care was developed to articulate the evidence-based practices common to all these services.



The review of research evidence indicated that trauma-informed, gender-sensitive and family-inclusive approaches to treatment (including providing childcare so that children can stay with their mothers) may result in higher levels of engagement and retention as well as better treatment outcomes for women. Women have a significant experience of stigma with regard to alcohol and other drug use and coupled with likely experiences of trauma and program approaches need to take this into account. These findings are also consistent with recommendations made in the NADA Practice Guide: Working with Women Engaged in Alcohol and Other Drug Treatment (NADA 2021). Other specific approaches recommended by specialist women' services who are working with women and their children include attachment-based therapies, Dialectical Behavioural Therapies (DBT) and approaches that are sensitive to trauma experiences and emotion regulation. With regard to gender-sensitive treatment models, this current evidence check found that women-only treatment may lead to better treatment outcomes for women; however, individual preferences should be taken into account before referral.

Find out more ...

NADA Practice Guide: Working with Women Engaged in Alcohol and Other Drug Treatment (NADA 2021)
NADA Women's clinical care network

5.3 Working with young people

Young people accessing AOD treatment in residential settings in NSW generally range in age from 13 to 18 years, although youth-focused services may accommodate young people up to 25 years of age. Young people seeking help for AOD issues represent arguably one of the most disadvantaged and vulnerable groups in society. These young people have multiple and interrelated mental health, substance use and psychosocial difficulties that go beyond the normal developmental challenges of adolescence and young adulthood, and which pose significant risks to healthy development. They also display resilience, creativity and a multitude of strengths that can be harnessed for positive change.

Stages of development are an important consideration when providing AOD treatment to young people in a residential setting, and it is important to understand that trauma can have a considerable effect on development. Workers might require specific training to work with people across these stages of development, and consideration needs to be given to the mix of young people in the residence at any given time.

There is a vast amount of research showing the high rates of trauma experienced by young people and adults reaching out for AOD treatment. For some young people, this trauma can be very recent; in some cases it may also be current. They might be leaving an environment where they were experiencing physical, sexual or emotional abuse. This constant exposure to trauma can make treatment difficult, and can mean that the focus of treatment needs to shift away from their substance use and onto the immediate risks they may face and strategies that will keep them safe.

Key practice elements that are evident in the models of care for young people accessing specialist AOD treatment in residential settings include:

- trauma-informed practices
- appreciation for developmental stages of young people
- person-centred and person-led care provision
- treatment that is holistic, culturally appropriate and inclusive of diversity
- family or support community involvement
- behavioural, experiential and skill-focused treatment
- strengths-based approaches.

(Drawn from a review of NADA member Models of Care and YSAS 2012)

In the few available controlled trials of AOD treatments provided to young people, positive outcomes were found for cognitive–behavioural, skills training and residential treatments. For residential treatment, three months appeared to be the optimal period, with longer stays appearing to produce little additional benefit. However, providing continuing care after the residential period appeared to improve outcomes.

The immediate aim when treating young people may be cessation of use, controlled use, or withdrawal management. There are usually also broader objectives, such as reducing criminal activity, increasing involvement in education, employment or training, improving family functioning, improving interpersonal skills and improving physical and mental health. Treatment includes prevention, in that it aims at preventing further harm.

From the frontline

Tips for connecting therapeutically with young people

- **Be present**: young people can tell when you are not 'in the moment'.
- **Take their issues and position seriously**: respect is key.
- **Recognise normal adolescent behaviour**: be aware that there will be a lot of normal adolescent developmental behaviour going on and that may not be clinically problematic.
- **Consider young people's diet and sleep patterns**: these can affect their mood.

Dimitri Poulos, Salvation Army OASIS.

Interventions need to be developmental (sub)stage–specific and take into account the needs and capacities of the young person and their stage of development, particularly cognitive capacity, developmental/maturational lags, and the need for recreation and fun. Much adult treatment is very serious business, and young people tend to react to such approaches by acting out and/or acting up. Unfortunately, this sometimes means that they are discharged from treatment for their 'unsatisfactory' behaviour or apparent lack of motivation. Improving the friendliness of programs to young people increases accessibility. Accessibility involves more than location: it also relates to the perception of a non-discriminatory, non-judgmental, non-marginalising, welcoming program.

Key features of an environment created for young people

- The environment looks and feels youth-friendly (e.g. posters, music, magazines, colour).
- Young people are kept safe in the waiting room and in areas around the service.
- The service has a clear confidentiality policy, which is explained to all young people in simple, easy-to-understand terms.
- Staff have access to ongoing training and professional development in working effectively with young people.
- There are effective feedback mechanisms in place that seek out the opinions of young people and takes this on board (e.g. a youth consumer advisory group).
- The service has clear policies and procedures relating to family/support person involvement in treatment.
- Clear policies related to child protection issues and responsibilities

The Youth AOD Services Network profile Supporting young people with AOD issues: A profile of non-government AOD services for young people in NSW outlines the specialist AOD services designed for young people in NSW.

Everyone comes from a family of some kind, but for young people their family is often – but not always – still central to their lives, and needs to be addressed in treatment. Evidence suggests that young people do better in AOD treatment when there is family involvement. This can be difficult to negotiate, especially if a young person really doesn't want their parents involved. Perhaps even more difficult to navigate is the scenario where a young person's parents have significant AOD problems themselves, and in some cases may have introduced the young person to substance use. Services need to be prepared to manage these kinds of family dynamics sensitively and supportively.

The objective of building life skills is part of a comprehensive holistic approach to treating people with drug dependency. While it is not suggested that all young people who use drugs and develop drug-use–related difficulties lack intelligence, education or interpersonal skills or are psychologically disturbed, residential treatment interventions do need to build on their individual strengths and identify and address any deficits.

Find out more ...

- The Centre for Youth AOD Research and Practice
- Love Bites: Respectful and healthy relationship programs
- Reachout.com: Social media
- Regulator: Modified DBT program for young people

5.4 Working with people with diverse gender/sex and/or sexuality identities

Being inclusive requires action as well as words. An LGBTIQ+ inclusive service is one that meets the specific needs of each client, taking into account their lived experience of gender identity, sexual orientation and intersex status. It challenges assumptions and stereotypes about gender and sexuality diverse minorities. LGBTIQ+ people are welcomed and encouraged to seek support in an environment where they will never experience judgement, discrimination, harassment or violence because of their gender identity, sexuality or intersex status.

Key treatment principles and approaches that are relevant to working with people of diverse genders and sexualities include:

- trauma-informed care and practice
- intersectional approaches
- recovery-orientated practice
- community consultation and co-design
- person-led and family-inclusive approaches.

Services must invest in organisational and staff development to ensure that knowledge about LGBTIQ+ people is evidence-based, and that policies and practices meet the needs of the individuals and communities it serves. An Inclusive Client Journey Checklist provides some tips and resources support your workers and your service.

Throughout their lives, many people of diverse genders and sexualities have experienced stigma, discrimination, violence and abuse driven by homophobia, biphobia, transphobia and/or cisgenderism. Ongoing public debates about the rights of LGBTIQ+ people – such as the marriage equality debate in 2017, and debates relating to the Anti-Discrimination Amendment (Religious Freedoms and Equality) Bill 2020 and the Education Legislation Amendment (Parental Rights) Bill 2020 – continue to place strain on LGBTIQ+ people and their families and allies. Being trauma-informed with respect to LGBTIQ+ people means understanding the relevant historical and current contexts and being open and transparent about the effects of the individual and collective experiences of this diverse community.

Ensuring inclusivity throughout a service may be enhanced by considering the following questions.

- Are all levels of the organisation committed to LGBTIQ+ inclusive practice? If so, how do all staff know this?
- Are all levels of the organisation provided with the resources to make LGBTIQ+ inclusive practice a reality?
- Does the organisation rely on employing out LGBTIQ+ workers as evidence of inclusive practice, or does the organisation ensure that the responsibility is on all workers?
- Does professional development focus on building cultural knowledge and competency as well as skills?
- Access and equity: Welcoming people who are gender and/or sexuality diverse

ACCESS AND EQUITY: WELCOMING PEOPLE WHO ARE GENDER AND/OR SEXUALITY DIVERSE

Historically, AOD treatment provided in a residential setting has been shaped by the person's sex at birth. There are services for women, services for men, and mixed services where men and women are separated for sleep and bathroom amenities and brought together for the program. However, increased acknowledgement that a person's gender may differ from the sex that was presumed for them at birth means that services need to become more inclusive of diversity. A person may also identify as non-binary, and may feel more comfortable accessing bathroom amenities that are gender-neutral. Asking a person how they identify, and where they would feel most comfortable for sleep and bathroom use (shower and toilet) is one way to support inclusivity.

Specific tools to support inclusivity include:

- websites and other online presence that indicate that the service is inclusive, including by featuring symbols, flags and statements
- registration forms, both online and in-house, that include questions about gender, sexuality and pronoun preference, and provide space for people to articulate diverse sex, gender and sexuality
- partnerships with specialist services and consumer groups can visit a service and provide advice on the environment, such as on gender-neutral bathrooms and sleeping areas that are well signposted.
- Clear policies are important (see below policy example) that emphasise that people accessing treatment should be treated with dignity and respect for the gender they identify with

Partnerships and linkages

Explore partnerships and links with specialist services that support people who identify as gender diverse.

- The Gender Centre provides services, support and activities that enhance the ability of transgender, gender-diverse and gender-exploring people to make informed choices.
- ACON provides health, support and advocacy services for LGBTIQ+ people.

Find out more ...

- TransHub: information for trans and gender-diverse people
- Policy and Practice Recommendations: for AOD services supporting trans and gender-diverse communities
- Health and Wellbeing Equality Index: Pride in Diversity: tools

FAMILY-INCLUSIVE PRACTICE

To be truly family-inclusive, services need to be welcoming and inclusive of chosen family (or family of choice) in any support service planning. People of diverse genders and sexualities come from diverse backgrounds, have had diverse experiences, and create diverse families. For these reasons, the support needs of LGBTIQ+ people are varied and distinct, and care planning needs to be led by the individual and tailored accordingly.

- Have you included the person's family, family of choice and partner(s) in their recovery plan?
- Have they been invited to participate in counselling and/or other sessions with your LGBTIQ+ client?

Find out more ...

- Rainbow Cultures: LGBTQIA+ multicultural directory
- Trauma-informed Care and Practice Organisational Toolkit (TICPOT) - MHCC
- Rainbow Tick
- Say it out loud (an online resource focusing on healthy LGBTIQ+ relationships and tackling intimate partner violence)

5.5 Involuntary drug and alcohol treatment

The Involuntary Drug and Alcohol Treatment (IDAT) program provides involuntary treatment as an option of last resort to people with severe substance dependence. The NSW Drug and Alcohol Treatment Act 2007 provides the legislative basis for assessment, detention, stabilisation and treatment. The intention of the program is to protect the health and safety of people with severe substance dependence who are at risk of serious harm, while also safeguarding human rights. The program provides medically supervised withdrawal management and short-term rehabilitation in a specialised inpatient unit, followed by community care on a voluntary basis.

The IDAT program is delivered by multidisciplinary care teams that include medical practitioners, nurses, social workers, psychologists and occupational therapists. The Involuntary Treatment Liaison Officers (ITLO) in local health districts coordinates the referral process and an AMP from one of IDAT units conducts an assessment for a Dependency Certificate. If the relevant criteria are met, the AMP will issue the person with a Dependency Certificate, and if bed is available the person can be admitted for treatment. Within seven days of admission the Dependency Certificate is reviewed by a magistrate at an informal hearing, usually at the treatment unit.

Treatment admission is the first stage of the program. The typical length of stay is 28 days from when the Dependency Certificate is issued, unless otherwise decided by an AMP or magistrate.

The treatment includes:

- comprehensive medical and psychiatric assessment
- medically supervised withdrawal management
- psychoeducation and therapeutic program
- aftercare and discharge planning.

At the end of the treatment, the patient is discharged and transitioned to community care. The continuing care stage of the program provides community-based support and intervention for up to six months, with the aim of relapse prevention. Aftercare support in the community may include a residential rehabilitation program, ongoing case management, other medical or health care, housing assistance and vocational and education supports (NSW Health 2019).

Find out more ...

Involuntary Drug and Alcohol Treatment Program information sheet (NSW Health 2019)
NSW Drug and Alcohol Treatment Act 2007

5.6 Working with people from diverse cultural backgrounds

Cultural inclusion in health service provision involves awareness of, and respect for, people from culturally and linguistically diverse (CALD) backgrounds. In the context of AOD treatment provision, cultural inclusion also recognises the importance of responding to specific cultural needs to ensure that the care provided is safe, equitable and of a high standard.

From the frontline

What sometimes gets missed, or at least minimised, is that seeking and receiving help can be more difficult for CALD communities (both men and women), in our service system. Our system is distinctly Anglo, and its significant cultural difference means that it can be unfamiliar and confusing [to people from non-Anglo backgrounds]. In addition, CALD communities across Australia are diverse, and this can further complicate the provision of culturally appropriate support and treatment. What is culturally appropriate service provision for one community may be inappropriate for another.
Margherita Basile, Manager, Sydney Women's Counselling Centre

CALD communities, particularly newly arrived groups, may be unfamiliar with health services in Australia. Services should take time to patiently explain treatment options, rationales and processes, more than once if required. In some cases, using metaphors or stories may be useful. While access to interpreters may not always be easy, and may require more resources, using trained interpreters is particularly important when explaining confidential or sensitive issues, when clients and/or caregivers are distressed, at discharge, when providing referral information, and when working with children and young people. Use cultural and family support systems as desired by clients.

In some cultures, talking about certain subjects with a member of another gender or with a younger person might be inappropriate. Let your clients know that you understand if they have concerns about appropriate gender and age relations, and try to offer some options. Be flexible about how intake and assessment are done. Prioritise addressing your client's concerns and earning trust. Explain what intake and assessment processes involve, what information will be recorded, and what duty of care means. Your client might be particularly concerned about confidentiality. Assure them that their information will be kept safe, by clearly explaining the service's protocols for securely storing information. Make your service more welcoming for CALD clients by recruiting a diverse workforce and using signage that reflects cultural diversity.

Dale and Marsh (2000) recommend the following principles when working with CALD people.

- CALD clients should be given the option (where possible) of being referred to an appropriate culturally specific service.
- When referral is not possible and the client has a poor understanding of English, services should seek the permission of the client to enlist the help of an interpreter (e.g. through the Telephone Interpreter Service).
- Staff and counsellors should use clear and unambiguous language.
- Where appropriate, staff should consult clients about relevant cultural norms and expectations.

The term 'culture' broadly refers to systems or patterns of beliefs and behaviours that influence the worldview of a member of society. We acknowledge that culture informs our own and our clients' worldviews, including gender roles, family and community relationships and sense of self. As AOD workers we need to be aware of and responsive to how our own culture, education, training and lived experience influence our own beliefs and attitudes, and how these play out within our practice.

Unpacking culturally relevant factors allows us to better understand our clients and identify their cultural strengths and challenges. Taking into consideration the importance of feeling safe, belonging and being proud in one's bicultural or multicultural identity is an integral component of strengths-based modalities designed to enhance connection, resilience and identity formation.

Services need to recognise the diversity within communities and seek to respond to the AOD issues of people seeking treatment from a cultural perspective that resonates with that person's understanding about their presenting issues within their cultural context. While many AOD services provide a holistic treatment approach, including improving the physical and psychological health of the individual, services should also strive to incorporate cultural factors into their AOD assessment and treatment planning.

Find our more.....

- Drug and Alcohol Multicultural Education Centre (DAMEC)
- NADA Access and Equity Resource
- Transcultural Mental Health Centre: Tools
- Agency for Clinical Innovation CALD Tools

5.7 Counselling

Counselling is provided routinely as part of AOD treatment in a residential setting, and may be provided individually or in a group context. As a central part of AOD treatment, counselling provides an opportunity for a person to explore in depth the role a substance may play in their life, the barriers and enablers for them reaching their treatment goals, and how they might sustain their treatment outcomes beyond the treatment setting.

Key elements of effective counselling include:

- developing a strong therapeutic alliance
- unearthing and growing aspects of a person's life that may support their change goals, such as culture, relationships, activities and self-worth
- attending to the goals and hopes that the person has identified
- exploring and developing strategies for emotion regulation
- attending to and repairing therapeutic ruptures, as attending to the therapeutic relationship provides opportunities for growth.

There is no evidence to suggest that any particular theoretical approach to counselling is better than others (see, for example, Andrews 2001). Some approaches, such as cognitive behaviour therapy and interpersonal therapy, however, have been more researched and therefore have a better evidence base. All theoretical orientations to counselling advocate the use of certain techniques, and these techniques play a limited, but important, role in successful intervention. Counselling techniques strengthen the person's expectations of change by heightening the credibility of counselling, provide a rationale and strategies for change, and diminish the person's sense of hopelessness and despair (Marsh et al. 2013).

Find out more ...

- NSW Health Drug and Alcohol Psychosocial interventions: Professional practice guidelines (NSW Health 2008)
- Counselling guidelines: Alcohol and other drug issues (4th edition) (WA Alcohol and Drug Office 2019)
- Talking therapies for people with problematic substance use (Te Pou o Te Whakaaro Nui 2010)

5.8 Group work

NADA members who provide AOD treatment in residential settings reported that activities need to be group-based, culturally informed and/or involve consultation with the client's community, and involve a range of evidence-based interventions (including psychoeducation and psychosocial support). NADA members noted that it was important for activities to be structured and routine-based, and bolstered by effective case management that incorporates pre-treatment supports and AOD/mental health aftercare.

Both group-based and culturally informed/in-community activities were seen to be important because they provide connection to others and help to establish social supports while in treatment as well as on exiting treatment to return to the community. In addition, group-based activities allow clients to open up … as they realise they are not alone in their struggles, provide validation and an opportunity to practise pro-social attitudes and behaviours, and hold people more accountable to their goals.

GROUP WORK FACILITATION

Group work is an approach to therapeutic work based on the idea that people are social beings who learn, develop and grow from our interactions with each other. Therapeutic group work is applied in the AOD treatment setting because of the belief that there is strength in a sense of collectiveness and shared experience. There is also an opportunity to normalise experiences and provide opportunities to practise new skills and behaviours.

Groups are also perceived by many practitioners to be empowering to those participating. There is evidence to suggest that therapy provided in groups can provide:

- a space where people can feel they are not along in their experiences
- strength gained from a sense of belonging and acceptance
- opportunities for personal growth through participating in group processes
- augmentation of individual therapy and extension of learning.

Which group format will work best for the people I work with?
There are a number of different formats for therapeutic group work.

- **Open groups** allow participants to join at any time, and each session is effectively stand-alone, so that a person attending a session does not need to have attended the session before to engage with the content.
- **Closed groups** involve a consistent group of participants, and usually have a particular number of sessions, each of which may build on the session before. A closed group can provide more opportunity for the group to facilitate the process, and there is usually a specific growth process that occurs, summarised as 'forming, storming, norming, performing, adjourning'.
- **Psychoeducational groups** are often stand-alone and targeted, providing specific information and education to participants on a specific topic, such as the effects of cannabis or how to deal with cravings. They are designed to provide information rather than therapy.
- **Support groups** or 'check-in' groups are brief intervention groups that are frequently used as a support mechanism for people who are waiting for more intensive treatment (such as residential rehabilitation or counselling) or who have exited more intensive treatment and are attending the group as a relapse-prevention strategy and for community-based support, often as part of continuing care.
- **Self-help groups** are traditionally facilitated by peers or people with a lived experience, and may be part of the 12-step mutual movement which has people come together and share their experiences, working through 12 defined steps of recovery. Another approach to self-help groups is SMART Recovery.
- **Families and friends groups** are usually a form of support groups. They may either be consumer/peer led or facilitated with the focus on normalising, supporting and providing information and/or skills and strategies to participants. For more information about family and friends support groups, see Family Drug Support.

When designing a group, the key outcomes or objectives of the group for the participants needs to be taken into account, as well as where and who will facilitate the group, and how the service might evaluate whether it has been effective for those attending. **Speaking with some of the potential participants can help to identify what they would find most useful from a group program.**

PREPARING CONTENT FOR A FACILITATED GROUP SESSION

A group work facilitator attends to both **purpose** and **process**, meaning that they are clear about both the objectives of the group and the techniques needed to get the group there. Planning of the goals and intended outcomes of the group session is key, and articulating this as part of a standardised group work plan or schedule is helpful. A group work plan should include:

- **session aims**
- **goals or objectives of each section (these will fulfil the aims)**
- **facilitator tasks**
- **participant tasks**
- **materials needed to support the activity or discussion.**
- **Orientating group members to group process**

To ensure group cohesion, participants need clear information and instruction about the group program and their role in it. There is often an expectation that participants will instinctively know how to participate in a group session, but this is rarely the case. Providing accessible information about how the group will be facilitated, the expectations of members and what to do if a person feels uncomfortable or distressed is essential before the group sessions begin.

EVALUATING A GROUP WORK PROGRAM

Identifying and describing an evaluation framework for the group is important before beginning, as this will ensure that participants are benefit from group sessions. There are a number of tools designed to assess group processes and outcomes, one of which is the Group session rating scale, which looks specifically at the group–therapy alliance. Outcomes tools for group therapy need to consider both the aims of the group and the process. In terms of the current availability of approaches, models and activities in residential treatment of AOD, treatment providers agreed that group-based activities were widely available and came in a variety of forms including therapeutic, educational, support and peer-led.

5.9 Therapeutic communities and mutual aid

The defining characteristic of the therapeutic community is its emphasis on the community created by the staff and residents as both the forum and catalyst for individual behaviour change. In therapeutic communities, the social environment, peer support and staff guide residents through the recovery process (DeLeon 1995).

The 2002 Australasian Therapeutic Communities Association report 'Towards better practice in therapeutic communities' (Gowing et al 2002) outlines the essential elements of therapeutic community programs in Australia. These elements were identified in a "modified essential elements questionnaire" derived from the US "survey of essential elements questionnaire" (Melnick and De Leon 1999). The essential elements of therapeutic communities identified in the report are not unique to therapeutic communities but are considered to be important in defining the therapeutic community approach.

A useful source of information regarding the Therapeutic Communities approach is the Australasian Therapeutic Communities Association (ATCA). ATCA members have diverse approaches aligned with the client groups they serve; however, there are common principles they all share. In general, programs aim to have enough structure to ensure a degree of order, security and clarity, while allowing room for participants to learn, make mistakes and learn from experience. Therefore, some adopt a more traditional hierarchical model, with graded levels of responsibility for participants, while smaller programs often adopt a 'flatter' structure, known within the literature as a 'democratic' model (ATCA website 2019).

The therapeutic community approach:

- focuses on the social, psychological and behavioural dimensions that precede and arise from substance abuse
- provides a safe, supportive environment for people to experience and respond to emotions and gain understanding of issues relating to their drug use
- provides therapeutic involvements between residents and staff and among residents (especially senior and junior residents), combined with the experience of living in a caring and challenging community, as the principal mediums to encourage change and personal development.

Treatment is multidimensional, involving therapy, education, values and skills development. According to the evidence check overall, therapeutic communities are associated with significant reductions in AOD use, symptoms of mental ill-health, criminal activity and other psychosocial outcomes.

5.10 Harm reduction

Harm minimisation is the key AOD use policy in Australia, and has been in place since 1985, and is made up of the three key approaches of harm reduction, demand reduction and supply reduction. What this means for all Australians is that we aim to address AOD use issues by reducing the harmful effects of AOD use at individual and community levels. This approach shapes our service provision and ensures that our primary focus is on reducing harm for individuals and communities. More information is available on the NCETA harm minimisation website.

HARM REDUCTION

Given the experience of relapse and the different treatment goals people may have, all treatment programs should incorporate harm reduction strategies (Dale & Marsh 2000). Harm reduction strategies can be incorporated into abstinence-based programs, and should aim to reduce the harms associated with continuing use, such as:

- overdose (avoid mixing drugs, avoid using alone)
- family and domestic violence (avoid using when feeling angry, have an escape plan)
- driving under the influence of alcohol and/or other drugs (have alternative forms of transport)
- bloodborne viruses (use clean injecting equipment, have routine medical check-ups that include screening for HCV and HBV)
- providing training on first aid and CPR
- tobacco-related illness and dependence (use quit kits or nicotine patches).

The literature recommends an approach that goes beyond the simple dissemination of information and involves working with people to find strategies that are acceptable to them and that they are willing to put into practice.

TAKE HOME NALOXONE PROGRAM

Naloxone quickly reverses the effects of an overdose and gets people breathing again. It can be competently administered by community members with only basic training. By providing education and naloxone, the NSW Health Take Home Naloxone program empowers people to keep themselves and those around them safer. The program trains AOD workers free of charge, and enables AOD services to provide naloxone to clients free of charge, increasing the number and range of workers and volunteers who can safely provide naloxone to clients.

Data from the Pennington Institute has shown that unintentional drug-induced deaths from opioids have almost tripled in the past 14 years. This means many more people in the NSW community are at risk of experiencing or witnessing an opioid overdose, and so could benefit from having access to naloxone.

People are more likely to trust AOD service providers that they are already familiar with. Services are therefore encouraged to discuss naloxone and the Take Home Naloxone program with all clients. This can help to destigmatise opioid-related conversations and remind both workers and clients that preventing opioid overdose harms is a community issue. Many people would benefit from having naloxone on hand.

5.11 Physical exercise and healthy diet

Following a regular exercise routine and consuming a healthy diet is often underestimated as a means of helping to maintain treatment goals. AOD treatment provided in a residential setting provides a perfect opportunity to engage people in understanding the role of exercise and diet in supporting mental health and general wellbeing. When paired with other types of treatment, exercise can prevent relapse by providing a reliable routine, filling spare time, managing mental health and inspiring higher self-esteem. Physical and mental health are more connected than we realise, and exercising gives us an valuable opportunity to improve both at the same time.

Purposeful and meaningful activities based on the person's needs, goals and capabilities (both related to and beyond their AOD use to other life domains) were critical for improving client engagement and outcomes, according to NADA members who provide residential treatment. One specific program that has been trialled alongside a residential AOD treatment program is Healthy Recovery (Kelly et al. 2019).

Healthy Recovery is an eight-session group-based program that aims to help people reduce smoking, increase physical activity, and increase fruit and vegetable intake. It incorporates six central components:

- education for participants about the benefits of a healthy lifestyle, using the Australian national guidelines for smoking, physical activity and diet
- group-based motivational interviewing
- goal setting
- self-monitoring of health behaviours
- contingency management
- use of nicotine-replacement therapy.

From the frontline

Our studies of Healthy Recovery have demonstrated that people attending residential AOD treatment are willing and able to engage in healthy lifestyle programs. Even people who report low motivation or low confidence to address their smoking were often willing to participate in the program to help improve their other health behaviours.
Professor Peter Kelly, University of Wollongong

All specialist AOD residential services in NSW provide access to fitness equipment and engage participants in regular exercise such as walking, gym-based activities, yoga and meditation classes, as well as sporting competitions, to support their treatment goals. Other areas of physical health worth exploring include sleep hygiene, nutrition and gut health.

Residential AOD treatment also provides an opportunity to learn skills regarding healthy diet and meal planning. Engaging people in meal planning and cooking can provide them with valuable skills to support any treatment goals being sustained in the community.

Find out more ...

Healthy eating during treatment for AOD: This factsheet explores nutrition, healthy eating and the effects of withdrawal on appetite.

Healthy eating for wellbeing: A nutrition guide for AOD workers: There is a significant overlap between AOD use and physical and mental health, and nutrition can play a major role in improving these. This guide from WANADA provides basic information about the overlap between nutrition and AOD use and rehabilitation.

Treating sleep problems of people in recovery: SAMHSA developed this guide to inform healthcare providers of the relationship between sleep disturbances and substance use disorders and provide guidance on how to assess for and treat sleep problems in people in recovery.

5.12 Living skills, vocation and educational development

People accessing AOD treatment need to be supported by AOD workers to gain insight into and address issues that may be hampering progress towards their goals. Consumer representatives who were consulted noted that some clients may lack the skills necessary to achieve their goals, such as general living skills and financial management skills, and therefore may need extra support or guidance in these areas in order to achieve their goals. Consumer representatives also highlighted the importance of teaching people that it is okay not to reach goals, that goals need to be flexible and revisited and revised as necessary, and that setbacks are part of the recovery process.

Offering living skills activities and courses such as cooking, hand and food hygiene and budgeting are a useful way to engage people accessing treatment. Growing the mastery of living skills has strong links to positive therapeutic outcomes and will sustain people as they transition back into the community. Specialist AOD treatment in a residential setting has the unique opportunity of linking people with further education and vocational courses that they can maintain throughout treatment and further as they transition to community supports. For many people, time spent in residential treatment may be the first safe, focused and supported time they have had, making engaging in learning a much more realistic goal. Building in living skills, vocation and educational training as part of care planning are useful in supporting a person's other treatment goals, particularly towards the end of their treatment journey.

Developing partnerships with education and training providers such as local TAFE providers, other training organisations and job-ready course providers is an essential element of residential treatment programs.

Partnerships and linkages

- Education NSW
- TAFE NSW
- Open Universities Australia

6 INCLUSIVE PRACTICES FOR FAMILIES, SIGNIFICANT OTHERS AND CHILDREN

KEY POINTS AND PRINCIPLES

- Family-inclusive practice supports and sustains the outcomes of AOD treatment
- Families are as diverse as the people who seek treatment, and developing family member, significant other and community supports is an essential part of the treatment journey.
- Establishing partnerships with other specialist services that work with or provide support to families, significant others and children is the foundation of family-inclusive practice.
- Working with Aboriginal and/or Torres Strait Islander people intrinsically involves family and extended kinship groups. Flexibility and person-led inclusion of family is essential for Aboriginal and Torres Strait Islander people.
- Families and other people supporting a person accessing treatment need their own support and self-care resources.
- A key program focus for AOD treatment provided in residential settings is healthy relationships.
- Domestic and family violence is a common experience for people accessing treatment and should be assessed and planned for as part of treatment.
- Consideration of children, whether they are in the care of the person accessing treatment or not, needs to be explored as part of treatment.

6.1 Family-inclusive practices

A family-inclusive or family-sensitive approach recognises the possibility of harnessing constructive support from family members, significant others, friends and community. This approach acknowledges that the meaning of 'family' is defined by the person seeking treatment, and can include family of origin, chosen family, significant others and/or carers. Accommodating contact with family and other supports is woven into the treatment experience, acknowledging that for some people their interpersonal relationships may have encountered challenges along the way. Sensitivity regarding the involvement of family, partners and children is vital and reinforces the need for treatment to be person-centred and person-led.

A family-inclusive practice approach recognises that interventions are more effective when they include family members. It supports the view that people influence others in their environment, especially family, and that family members, in turn, have an effect on the individual (Kina Family and Addictions Trust 2005, in NADA 2009). A toolkit designed to inform AOD workers about working better with family members and carers of problematic substance users was produced by NADA (2009), and provides practical tips, interventions, resources and examples of AOD organisations that have implemented a family-inclusive practice approach. This is a good place to start when considering how family-inclusive practice might be applied to the work you do with clients.

The NADA toolkit (2005) provides interventions that address three broad categories as identified by Copello, Vellman and Templeton:

- working with family members to promote the engagement of people with services
- involving families and others in treatment plans
- providing services directly for family members.

Family-inclusive practice is part of the whole treatment journey, and family members can be a catalyst for a person reaching out for AOD treatment. Family of origin, significant others and current community supports are all explored as part of a comprehensive assessment. Information gathered from a person accessing treatment about who might be a support and the way they might be engaged as part of treatment can inform care planning. Individual and group sessions explore healthy relationships, ways of communicating, setting boundaries and respectful relationships and may be an opportunity for reconciling challenging family dynamics.

Find out more ...

- Tools for Change: A new way of working with families and carers (NADA 2009)
- Working with Families and Significant Others: Youth guide (Dovetail 2016)
- Say It Out Loud: Family-inclusive practices and healthy relationships for the LGBTIQ+ community
- A checklist for Family Sensitive Practice for the Alcohol and Other Drug Field (NCETA 2010)
- Aboriginal-specific Community Reinforcement and Family Training (NDARC)

eLearning modules and in-service tools

As noted above, when we talk about family-inclusive practice in the AOD treatment sector we mean the broadest definition of family, which may include significant others, children and chosen family. The resources below provide more information:

- Engaging with families and significant others eLearning module
- Tools for facilitating an online in-service.
- Organisational audit to explore how family-inclusive your service is.

HEALTHY RELATIONSHIPS

Providing AOD treatment in a residential setting provides a specific opportunity to explore healthy relationships. Group and individual counselling are good spaces to explore the intersection of personal relationships and substance use, including whether there were experiences of problematic AOD use in the home when growing up, the role substance use may have played in peer groups and/or sexual or intimate relationships, and what using or not using might mean for these relationships.

Providing AOD treatment in a residential setting also presents unique opportunities to explore and practise key elements of healthy relationships, such as:

- respect
- trust
- communication styles
- power and positioning
- fairness and equality.

Find out more ...

- Relationships Australia
- Family Drug Support
- Say It Out Loud
- 1800RESPECT
- Families and friends affected by the drug and alcohol use of someone close (NSW Health)

DOMESTIC AND FAMILY VIOLENCE

AOD treatment in a residential setting may provide an opportunity for respite from a situation involving domestic or family violence, and specialist AOD treatment providers play an important role in identifying and responding to this issue. It is vital to screen for the experience of domestic and family violence and to have the results inform the care planning for a person accessing treatment. Also essential is ensuring a person's safety with regard to contact and visits by a person who may have exerted power or control or been violent with them.

NSW Health's IPARVAN Framework (NSW Health 2019b) requires integrated responses to working with people with experiences of violence, abuse and neglect to be person-centred, to be family-focused, to provide seamless care across multiple services, and to use a multidisciplinary and trauma-informed approach designed around the holistic needs of the person and their family throughout their life course. To help achieve this, Phase 2 of IPARVAN Framework implementation includes NSW Health workers having access to education, training, professional development and workplace resources to build the skills, knowledge, attitudes and values to provide holistic and integrated services. Providing integrated and collaborative care for AOD clients with experiences of violence, abuse and neglect requires the development of further guidance and referral pathways including shared clinical assessments, integrated models of care of care and other resources to support AOD and VAN services to work better together.

Partnerships and linkages

Partnerships with specialist domestic and family violence services will improve the confidence of AOD staff in responding effectively to victim-survivors and perpetrators of violence.

- 1800RESPECT service finder
- Safer Pathway Safety Action Meetings are fortnightly meetings attended by government agencies and local service providers to coordinate service responses for victims assessed as being at serious risk
- NSW Domestic Violence Line provides advice and support on a range of community services

MEN WHO PERPETRATE DOMESTIC AND FAMILY VIOLENCE

- Men's Referral Service

Given that a considerable proportion of people accessing AOD treatment are men, there is potential for some of them to have been perpetrators of domestic and family violence. This presents an opportunity within the context of AOD treatment to explore domestic and family violence as standard practice. It is also important to be aware that it is not just women who have been victims of domestic and family violence. The NADA Practice Resource **Engaging men who perpetrate domestic and family violence in the AOD treatment context** (NADA 2020) provides starting points on how to have safe and non-collusive conversations with men who perpetrate DFV, minimise collusion with the attitudes, belief systems and narratives that perpetrators adopt to justify and give themselves permission to use violence, and discuss referrals to appropriate, specialised domestic and family violence services.

6.2 Involving children and working with Child Protection Services

CHILD AND FAMILY PROGRAMS

A number of specialist AOD services that provide treatment in residential settings have designated family programs that can accommodate children. These specialist programs may provide opportunities for family therapy alongside AOD treatment, have childcare or early childhood programs onsite and support older children to attend school. There may be differences in the age ranges of children who may be accepted, and the way they are accommodated within the program. Children accompanying their parents in AOD treatment in a residential setting with their parents need more than childcare on site. Many children accompanying their parents may present with attachment and behavioural challenges. Their parent(s) frequently come from a trauma background, or have mental health conditions, as well as having substance use problems. The children may have lived with traumatic experiences such as domestic violence, neglect and abuse. Supporting both the parent and child with attachment and attachment-based activities can support the overall treatment outcomes.

Attachment issues can often present in children as having behavioural difficulties, being withdrawn, having emotional regulation problems, having sensory integration problems, being hyperactive, or having post-traumatic stress disorder or another diagnosis such as attention deficit hyperactivity disorder. Therefore, interventions designed to regulate emotions and support attached-parenting practices can improve outcomes for both the parent and child. Residential programs that include children should have child and family workers and strong relationships with early childhood and education partners.

The Australian Institute for Family Studies (**AIFS**) and Emerging Minds have developed the following webinars and tools for supporting families and children whose parents may be using AOD.

- Working together to support families where a parent uses AOD **recorded webinar**
- Free online courses and resources to support **child-aware practice**
- Culturally aware practice: **Podcast with Judy Atkinson** on supporting Aboriginal children and families

A child development program provides activities for children such as dexterity and motor skills activities, games requiring coordination, visual and auditory memory and recognition skills, interactive games with other children, fun educative sessions for those preparing for school, exploring the environment we live in, art and craft, and so on. The program may use local playgroups, kids' gyms, libraries and Child Health Services. Assessments of the child–parent relationship should be conducted on admission and worked on in individual counselling sessions with the childcare worker.

The development of the parent–child relationship is also improved by involving parents in the child development program. This may mean that at some times during the week, parents may be excused from other activities of their residential treatment program to attend the child development program with their children. Young children should be in the care of their parents except for the time that parents attend groups or counselling, at which time they are in the supervision of the childcare worker. School-aged children may attend school in the local area.

PARENTS SEPARATED FROM THEIR CHILDREN

Where a service may not have the option for children to stay or the capacity to run dedicated parenting programs, there are alternative strategies they can use to be family inclusive, including:

- setting up specific times and appropriate spaces for family/children to visit, or safe spaces for phone or video calls
- having particular environments that are welcoming to children, such as waiting areas or gardens
- involving specialist parenting services to provide workshops to clients as part of their regular program
- using parenting examples in the context of therapeutic groups as appropriate; many parenting skills are relevant to 'coping skills rehearsals' and identifying the stressors that might be a precursor to relapse
- engaging clients in developing information brochures that target family members, providing details about the experience of AOD treatment as a way of demystifying the process
- having open days, art exhibitions, picnics and other activities that family members can attend
- offering single-session therapy, an effective and efficient therapeutic approach that addresses family needs without requiring a long-term commitment to therapy.

Emerging Minds: Keeping in touch with your children
These practical resources, workshops and tools have been designed to support parents who are accessing treatment in a residential setting. **Keeping in Touch (KIT)** includes:

- a **poster** featuring supportive strategies that a parent can use to stay connected with their children while in treatment
- a **workshop presentation** to support you to run an online session with your team
- an **action plan** designed to implement Keeping in Touch with parents who are in treatment.

WORKING WITH CHILD PROTECTION SERVICES

AOD services and statutory child protection agencies have traditionally experienced difficult working relationships. Historically the sectors have worked independently due to different organisational cultures, views, policies and language. Many clients of AOD services, particularly Aboriginal and Torres Strait Islander clients, who are grossly overrepresented in the child protection system, have experienced the trauma of being removed from their parents' care and/or have had their children removed from their care, causing devastating effects on the individual, their families and communities across generations.

For AOD services working with clients who have current or past child protection involvement, it can be difficult to comprehend the system and how and why decisions are made that may involve the removal of children from their family. However, it is important to work collaboratively with child protection services and avoid an adversarial stance when advocating for your client. Research and practice advice suggest that bringing down the barriers between child protection and alcohol and other drug services requires a greater understanding of each other's roles, regular communication and a shared language.

Where a child or young person is at risk of significant harm, AOD workers must respond. This includes making a report to the NSW Child Protection Helpline under the Children and Young Persons (Care and Protection) Act 1998. The duty to report possible harm through abuse or neglect overrides the duty to maintain the confidentiality of a person who is accessing treatment. Use the online **Mandatory Reporter Guide (MRG)** to inform initial decision making.

Note that a parent or carer of children seeking to engage in AOD treatment in a residential setting is not in itself a reason to make a child protection report.

It is common for **Child Protection Services: Department of Communities and Justice (DCJ)** to be involved with parents and families who are accessing AOD treatment. Collaborative practice with DCJ will support treatment goals.

TIPS TO ENCOURAGE COLLABORATIVE PRACTICE WITH DCJ

- Ask the DCJ caseworker if you can attend group supervision about that family. Group supervision is where DCJ staff meet to discuss families, reflect on practice and draw on multiple viewpoints. DCJ can invite partner agencies to group supervision sessions. For more information, visit the **DCJ website**.
- Invite your DCJ colleagues to your service for a site visit, or ask them if you can present about your organisation at their office.
- Learn about DCJ's **Child Protection Practice Framework** and **Practice Framework Standards**, which are being rolled out across NSW.
- If you are concerned about a decision or response by DCJ, or would like to gain a better understanding about a decision, you can escalate the issue, using the DCJ's **escalation pathway**.

ABORIGINAL AND TORRES STRAIT ISLANDER PERSPECTIVES

The removal of Aboriginal children from their families and the experiences of the Stolen Generations are not things of the past – the grief and trauma experienced by Aboriginal people remains today. There needs to be acceptance by non-Aboriginal people of the effects of intergenerational trauma and its hold in the present. Anyone working alongside Aboriginal people (workers or clients) needs to be mindful of this fact. Sometimes child protection orders or treatment goals don't appear to match with clinical AOD experience, best practice or what is best for an Aboriginal person. Consult with communities, families and Aboriginal workers. Appreciate that if a removal has occurred then the parent and wider family will be grieving the loss of that child, regularly bringing up experiences of intergenerational trauma, Under such circumstances, expecting a person to respond quickly to treatment is unrealistic and sets the person up for failure.

Case reviews that involve the whole family as well as other workers who may have something to offer in terms of support are helpful. Children also need to be represented. Conduct these case conferences respectfully and with consistency, in order to foster trust. Appreciate the challenges for Aboriginal workers, such as their own experiences of intergenerational trauma, mistrust, lateral violence and the potential for cultural overload. Family group conferencing is one method of bringing family members together in a positive way with an impartial facilitator to make a plan for their child or young person.

Find out more ...

- **Department of Community Services factsheet:** Working together
- **Working with** Child Protection
- AOD treatment guidelines for working with Aboriginal and Torres Strait Islander people in a non-Aboriginal setting
- Roles and responsibilities of DCJ
- DCJ's practice framework, approaches and systems
- Understand FACS practice framework, approaches and system
- **NSW Women's Legal Service's advice for** parents whose children have been removed

6.3 Parenting

PREGNANCY

Women accessing AOD treatment may be pregnant or may become pregnant, presenting a unique opportunity to link them with a wide range of supports to enhance outcomes for themselves and their babies. While there is clear evidence that AOD use is harmful for both mother and unborn child, pregnancy can be the catalyst for change. The key message should be that there is '**no wrong door**': if a service does not have capacity to respond to a woman who is pregnant then they need to make every effort to link her with services that can.

If a woman presents to an AOD treatment service that may not have the capacity to respond to all the issues relating to pregnancy and parenting, then all effort should be made to engage with her while additional or specialist services can be sought. Access to childcare, prenatal care, mental health services, women-only programs, psychoeducation sessions focused on women-specific topics and comprehensive services that offer multiple components have all been associated with improved outcomes for women. Pregnancy and care of children can be significant motivating factors for AOD treatment engagement and retention. However, child safety should always be paramount.

Find out more ...

- Clinical Guidelines for the Management of Substance Use During Pregnancy, Birth and the Postnatal Period (NSW Ministry of Health 2014)
- "It's time to have the conversation": Understanding the Treatment Needs of Women Who Are Pregnant and Alcohol Dependent (FARE 2013; Burns & Breen)

SUPPORTING PARENTS

Providing AOD treatment in a residential setting provides some fantastic opportunities to support people with the care of their children. Problematic substance use can be a source of shame for people, particularly if they have children, or if they have had the experience of having children removed where substance use has been a contributing factor. Implementing a child development program within a residential treatment program enables the treatment approach to be all-encompassing in its approach to providing opportunities to learn parenting skills. In a situation where a stay in a residential treatment service may mean a period of separation from a child(ren), creative ideas for ongoing contact (where appropriate) should be encouraged.

There are many opportunities in the context of residential treatment to explore what it means to be a parent and be inclusive of all experiences related to caring for children and young people. There are few options, particularly for fathers and their children to enter residential treatment together, so a focus on parenting can be helpful for many people accessing treatment.

Some useful topics to explore within individual or group sessions around parenting include:

- what it means to be a parent
- connecting with children
- understanding developmental stages
- strategies for responding to challenging behaviour
- emotional regulation strategies
- being a role model for respectful relationships with young people
- working in partnership with other family members (partner, grandparent, other carers)
- managing experiences of childhood trauma when connecting with your own children.

Find out more ...

- Responding to the Needs of Children and Parents in Families Experiencing Alcohol and Other Drug Problems (ADF 2012; Gruenert & Tsantefski)
- Being a Dad (DCJ Parenting Resources)
- Always Mum (Lou's Place)
- My Kids and Me CatholicCare and Interrelate
- Rainbow Families: Section 5.3 Working with Families (Dovetail)

6.4 Visits and creating a culture of inclusion

Consultations with NSW providers of AOD treatment in residential settings emphasised the importance of visits and opportunities for people in treatment to have contact with family members, children and community supports. Establishing safe and inviting spaces for visits to occur, conducting barbecue or picnic days where people can invite a support person, can be a way to empower a person in treatment and strengthen the connections they will need when exiting treatment. Acknowledgement needs to be made that spaces for visits need to take into account the privacy of both those engaged in a visit and other residents of the service.

Time and care should be taken in organising appropriate visits, particularly with regard to children and carers who are not residing in treatment. At times this may require supervision or support by a staff member. Identifying safe spaces for access visits close the residential setting is important and connecting with services that may provide support for access visits is also useful. Acknowledging the variety of families that may intend visiting a person in treatment is important, to ensure there is adequate space and privacy. Aboriginal people may want to see extended family and so adequate planning is recommended. Expectations about visits should be well articulated to people in treatment and provided to those who may visit. Questions to be answered may include the following.

- Where the visits will occur?
- What level of privacy will the visit be provided?
- Will there be access to refreshments that a person in treatment can provide to their visitor?
- Does the person in treatment need to register the visitor and how much time is required for that process?
- Can gifts or food be brought along to the visit?
- Are visitors allowed to smoke on site during the visit?

7 RESOURCES AND GUIDELINES

7.1 Information and support

This section provides a selection of information and support services, resources and toolkits for workers, and government-produced guidelines and strategies, which relate to working in the AOD sector. It is by no means an exhaustive list; however, many of the websites listed here provide further useful links to an expansive array of support documents and other resources.

ALCOHOL AND OTHER DRUG SUPPORT

Alcohol and Drug Information Service (ADIS)
ADIS is a 24-hour helpline that provides alcohol and drug related information, support, crisis counselling and referral to NSW services.
Website: www.yourroom.com.au
Phone: 02 9361 800 or 1800 422 599

Drug and Alcohol Specialist Advisory Service (DASAS)
DASAS is a free alcohol and drug–related advisory telephone service for doctors, nurses and other health professionals. Specialist medical consultants are on call 24 hours to provide advice on diagnosis and management. DASAS is especially designed to support regional and rural areas in NSW, but is available to all health professionals.
Phone: 02 9361 8006 or 1800 023 687

Drug and Alcohol Multicultural Education Centre (DAMEC)
DAMEC was established to promote access by culturally and linguistically diverse (CALD) people to alcohol and other drug services. It provides counselling and support for CALD people and has a research and information focus. DAMEC works within a harm minimisation framework, and uses the term alcohol and other drugs to describe both licit and illicit drugs, including alcohol, tobacco and prescription medicines that are used outside medical advice.
Website: www.damec.org.au
Phone: 02 9699 3552

Family Drug Support (FDS)
FDS was formed in 1997 after its founder, Tony Trimingham, lost his son to a heroin overdose. FDS is a caring, non-religious and non-judgemental organisation, primarily made up of volunteers who have experienced firsthand the trauma and chaos of having family members with drug dependency. FDS provides a 24-hour telephone support line, a website, support groups and courses for family members and significant others.
Website: www.fds.org.au
Phone: 1300 368 136

Alcohol, Tobacco and other Drugs Association of ACT (ATODA)
ATODA is the peak body representing the non-government and government alcohol, tobacco and other drug (ATOD) sector in the ACT. ATODA seeks to promote health through the prevention and reduction of the harms associated with ATOD.
Website: www.atoda.org.au

Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC)
The ATDC is the peak body representing the interests of the community service organisations that provide services to people with substance misuse issues in Tasmania.
Website: www.atdc.org.au

Association of Alcohol and other Drugs Agencies in Northern Territory (AADANT)
AADANT is the peak body for alcohol and other drug service providers in the NT. It is currently under the auspices of the Northern Territory Council of Social Service.
Website: www.ntcoss.org.au

NSW Users and AIDS Association (NUAA)
NUAA is the peak drug user organisation in NSW. It is a not-for-profit organisation advocating for people who use drugs, particularly those who inject drugs. NUAA provides education, practical support, information and advocacy to users of illicit drugs and their friends and allies.
Website: www.nuaa.org.au

Queensland Network of Alcohol and Drug Agencies (QNADA)
QNADA is the peak organisation representing the views of the non-government alcohol and other drug sector in Queensland. QNADA's purpose is to support member services to deliver high-quality, evidence-based services.
Website: www.qnada.org.au

South Australian Network of Drug and Alcohol Agencies (SANDAS)
SANDAS is the peak body providing independent, state wide representation, advocacy and support for non-government organisations working in the South Australian alcohol and other drug sector, through networking and policy development.
Website: www.sandas.org.au

Victorian Alcohol and Drug Association (VAADA)
VAADA is the peak body representing drug and alcohol services in Victoria; it provides leadership, representation, advocacy and information to both drug-and-alcohol and non-drug-and-alcohol-related sectors.
Website: www.vaada.org.au

Western Australian Network of Alcohol and other Drug Agencies (WANADA)
WANADA is the peak body for the drug and alcohol education, prevention, treatment and support sector in Western Australia. WANADA's vision is to lead and support development of the alcohol and other drug sector to deliver best possible outcomes for the community of Western Australia.
Website: www.wanada.org.au

COMPLEX NEEDS

Acquired Brain Injury Services
This is a not–for-profit specialist service for people with an acquired brain injury. Its aim is to enhance people's lifestyle by maintaining and promoting independence and providing opportunities for socialisation and community integration with appropriate and quality service provision.
Website: www.abis.org.au

Ageing Disability and Home Care and Acquired Brain Injury
This webpage dedicated to acquired brain injury on the Family and Community Services Ageing Disability and Home Care website provides information on care and support pathways for people with an acquired brain injury, as well as information on the new Ageing Disability and Home Care training resource.
Website: ABIS Training

Alcohol and Drug Cognitive Enhancement (ACE) Program
The Alcohol and Drug Cognitive Enhancement (ACE) program has been in the making since 2010. It began as a single research project at WHOS Residential Rehabilitation with involvement from Advanced Neuropsychological Treatment Services (ANTS) and the University of Wollongong. This led to multiple research projects involving hundreds of clients across government and non-government residential and non-residential AOD treatment services.
Website: www.aci.health.nsw.gov.au/projects/ace-program

arbias
arbias provides support to people with an acquired brain injury, specialising in AOD-related brain injury, in NSW and Victoria. arbias is a case management, specialist assessment and intervention service targeted at people living with an alcohol-related acquired brain injury aged 16 to 65. It also offers a comprehensive range of training package options, which offer practical strategies for working with people with acquired brain impairment and associated complex support needs.
Website: www.arbias.org.au

Brain Injury Australia (BIA)
BIA is the peak acquired brain injury advocacy body representing, through its state and territory member organisations, the needs of people with an acquired brain injury, their families and carers. It works at national level to make sure all people living with acquired brain injury have access to the supports and resources they need to optimise their social and economic participation in the community.
Website: www.braininjuryaustralia.org.au

Community Restorative Centre (CRC) NSW
CRC is a NSW community organisation dedicated to supporting people affected by the criminal justice system, particularly prisoners, ex-prisoners, and their families and friends. Staff offer personal and practical assistance such as counselling, accommodation, a subsidised transport service, a court support service, outreach to prisons, information, advice and referrals.
Website: www.crcnsw.org.au

National Organisation for Fetal Alcohol Spectrum Disorder: NOFASD
NOFASD Australia is an independent not-for-profit charitable organisation. NOFASD are the national peak organisation representing the interests of individuals and families living with foetal alcohol spectrum disorders (FASD). The website provides information, training and support related to FASD.
Website: www.nofasd.org.au

Fetal Alcohol Spectrum Disorder and Justice (Canada)
This site is designed for justice system professionals and others who want to understand more about FASD. It provides information and resources about FASD, including background information, case law, legal resources and strategies for effective intervention.
Website: www.fasdjustice.on.ca

FAMILY AND DOMESTIC VIOLENCE

The Domestic Violence Line provides telephone counselling, information and referrals for women and same-sex partners who are experiencing or have experienced domestic violence. Trained female caseworkers are sensitive to the needs of people who have experienced domestic violence, and staff are aware of the special needs of Aboriginal women and women from other cultures, as well as those living in rural and remote areas. Interpreters and TTY can be arranged where necessary to ensure that all people, regardless of language or disability, can use the service. The service has an extensive list of contacts, people and services across NSW who can help.
Phone: 1800 656 463

Domestic Violence Website
Includes information regarding domestic and family violence DFV, including telephone referral lines, tips and apps that can be downloaded, providing information for those experiencing DFV. For information, support and referrals, contact the Domestic Violence 24 Hour Hotline.
Website: www.domesticviolence.nsw.gov.au

Full Stop Australia
Full Stop Australia is here to put a full stop to sexual, domestic to family violence through support, education and advocacy.
Website: www.fullstop.org.au

Walking a Tightrope
Walking a Tightrope is a comprehensive resource for people who have a family member who uses both alcohol and other drugs (AOD) and violence in their relationships. The resource has been produced through a partnership between Family Drug Support (FDS) and the National Centre for Education and Training on Addiction (NCETA) and was funded by the Department of Social Security.
Walking a Tightrope

MENTAL HEALTH

Beyond Blue
Beyond Blue is an independent, not-for-profit organisation working to increase awareness and understanding of anxiety and depression in Australia and to reduce the associated stigma. It offers support through a 24-hour helpline as well as a web chat service.
Phone: 1300 22 4636
Website: beyondblue.com.au

WayAhead Mental Health Association
The WayAhead Mental Health Association runs both the Mental Health Information Service and the Anxiety Disorders Information Line. These lines provide information, telephone support and referral for issues relating to mental health.
Mental Health Information Service phone: 1300 794 991
Website: www.mentalhealth.asn.au

Mental Health Coordinating Council (MHCC)
MHCC is the peak body for community mental health organisations in NSW. It provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services for the community. MHCC provides a range of training and education through its Learning and Development Unit.
Website: www.mhcc.org.au

Dual Diagnosis Australia and New Zealand
Dual Diagnosis Australia and New Zealand is a resource repository created to contribute to better outcomes for persons with co-existing substance use and mental health disorders.
Website: www.dualdiagnosis.org.au/home

WOMEN'S HEALTH

Women's Health NSW
Women's Health NSW (WHNSW) is an association of statewide women's health centres and specialist women's centres. All centres are non-government, community-based, feminist services that provide choices for women to determine their individual health needs. WHNSW centres aim to improve the health status of women by providing a unique, holistic, woman-centred approach to primary health care. The centres aim to blend medical and clinical services and a range of counselling, health promotion, education, self-help and consumer advocacy services. They also aim to provide women with the knowledge, skills and resources to enable us to take more responsibility over factors the adversely affect our health.
Website: www.whnsw.asn.au

Australian Women's Health Network
The Australian Women's Health Network is a health promotion advocacy organisation that provides a national voice on women's health, based on informed consultation with members. Through the application of a social view of health, it provides a woman-centred analysis of all models of health and medical care and research. It maintains that women's health is a key social and political issue and must be allocated adequate resources to make a real difference. It aims to foster the development not only of women's health services but of stronger community-based primary health care services generally, which it sees as essential to improve population health outcomes. It advocates collaboration and partnership between relevant agencies on all issues affecting health.
Website: www.awhn.org.au

ACON
ACON provides specific support services that relate to the health and wellbeing of lesbian, bisexual and transgender women. In addition, through partnerships with academic institutions, ACON have engaged with significant research projects aimed at improving health outcomes for the LGBTIQ+ community as a whole.
Website: www.acon.org.au

7.2 Practice resources and toolkits

NADA RESOURCES

Access and Equity: Working with Diversity in Alcohol and other Drug Settings **(2022)**
This resource was developed to support non-government alcohol and other drug services work with the diversity of clients that access our services and represent the NSW population. It contains examples of best practice approaches to working with different clients, as well as a range of useful resources for services providers. The following populations have been included:

- Aboriginal and Torres Strait Islander people
- culturally and linguistically diverse communities
- lesbian, gay, bisexual, transgender and intersex people
- older people.

NADA recognises that there are other populations that have not been included, such as young people, women, children, and those with a disability, and hopes to update the guide as more information is developed. For best practice examples in working with young people, see the Dovetail Youth Alcohol and Drug Good Practice Guide.
Website: www.nada.org.au

Tools for Change: A New Way of Working with Families and Carers **(NADA 2009)**
Tools for Change provides a range of interventions, practice tips, service models, resources and training organisations to assist services in working with families.
Website: www.nada.org.au

From Individuals to Families: Single Session Consultations (DVD) 2012
This DVD, developed in partnership with NADA and The Bouverie Centre, provides a practical case example from an alcohol and other drug service. It also included interviews with staff from three NADA members discussing the implementation of the single session approach to working with families in alcohol and other drug settings.

ABORIGINAL RESOURCES

The Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN)
This network comprises representatives of Aboriginal residential rehabilitation services across Australia. They meet quarterly to support each other and advocate for issues, to share and develop culturally sound best practice principles, knowledge and experience, as well as aiming to be the key consultative group at both a state and national level in regards to Aboriginal residential rehabilitation services.

Aboriginal Corporation Drug and Alcohol Network of NSW (ACDAN)
ACDAN (formerly known as ADAN) provides Aboriginal AOD workers support, opportunities to network and share information. Working together, the network can influence policy, represent Aboriginal cultural values and inform program development. To join the network or learn more, email ACDAN.

National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA)
NATSIWA was established in 2009 to empower Aboriginal and Torres Strait Islander Women to have a strong and effective voice in the domestic and international policy advocacy process.
Website: www.natsiwa.org.au

Australian Indigenous Health Infonet
This comprehensive web resource for working effectively and supportively with Indigenous Australians provides information, training resources, projects, news and links. It's a 'one-stop info shop' for people interested in improving the health of Indigenous Australians.
Website: www.healthinfonet.ecu.edu.au

Aboriginal-specific Community Reinforcement Approach (CRA) Training Manual
NDARC (Rose et al. 2014).
The Community Reinforcement Approach (CRA) as it is described in this manual has been adapted from a comprehensive explanation as published in Meyers and Smith (1995) Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach. This adapted CRA manual is designed for Indigenous Health and Family Workers and other Workers within Australian Indigenous community settings to support people who are at risk for alcohol related harm.

Strengthening Aboriginal Family Functioning: What works and why?
This resource is a paper that explores and discusses the contemporary evidence base, including case studies of programs that work, to provide insights into the protective effects and risks that influence forms of functioning among Aboriginal families. It also has a section on specific resources.

NIDAC AOD Treatment Report (NIDAC 2014)
This paper was developed by the National Indigenous Drug and Alcohol Committee (NIDAC) in response to a misperception that effective AOD treatment is not available for Aboriginal and Torres Strait Islander peoples. The paper aims to allay these misperceptions by outlining who can benefit from receiving treatment; what treatment is known to work; key principles that should guide the application of treatment; and what constitutes effective treatment for Aboriginal and Torres Strait Islander people.

Aboriginal Mental Health Resources
Menzies School of Health Research has compiled a suite of resources developed under the

DOMESTIC AND FAMILY VIOLENCE

Australian Integrated Mental Health Initiative.
Website: www.menzies.edu.au

Aboriginal Mental Health Resources
Menzies School of Health Research has compiled a suite of resources developed under the Australian Integrated Mental Health Initiative.
Website: www.menzies.edu.au

FAMILY INCLUSIVE PRACTICE

Can I ask ...? An alcohol and drug clinician's guide to addressing family and domestic violence
White, M., Roche, A., Nicholas, R., Long,C., Gruenert, S., Battams, S. (2013). Adelaide, National Centre for Education and Training on Addiction. Flinders University. This resource explores the relationship between AOD and domestic and family violence, with a focus on identifying how the AOD sector can better support clients who have co-existing AOD and domestic and family violence issues, and minimise associated harms experienced by their children.

For Kids' Sake: A Workforce Development Resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs Sector
Battams, S., A. M. Roche, A. Duvnjak, A. Trifonoff and P. Bywood (2010).Adelaide, National Centre for Education and Training on Addiction. Flinders University.
This resource aims to minimise cases of child abuse or neglect by increasing collaboration between child and adult service agencies. It is a new initiative developed by NCETA to improve the safety and welfare of children with parents who misuse alcohol or drugs. The toolkit builds a bridge between the alcohol and other drugs (AOD) treatment and child protection sectors to improve cooperation and collaboration.

The signs of safety: Child protection practice framework
This is a policy document that seeks to create a more constructive culture around child protection organisation and practice. Central to this is the use of specific practice tools and processes where professionals and family members can engage with each other in partnership to address situations of child abuse and maltreatment.

Children of Parents with a Mental Illness Website
There are a number of eLearning and other resources available to access online, the COPMI (Children of Parents with a Mental Illness) national initiative develops information for parents, their partners, carers, family and friends in support of these children. This information complements online training courses developed by COPMI for professionals to support families either individually or through community services and programs.

Family Focus Project Toolkit
Eastern Drug and Alcohol Service (2010). Canberra, Department of Health and Ageing.
The Family Focus Toolkit is a collection of selected resources including screening tools, questionnaires, worksheets, and utility practice tools gathered from the sector, research and professional bodies.

Single Session Therapy (The Bouverie Centre)
Single Session Therapy (SST) or Single Session Work (SSW) is best conceptualised as a process rather than an event that assists workers to make the most of the first, and what may be the only, session for clients. The process includes: initial phone contact between counsellor/intake worker and client/s, and/or the completion of a pre-session questionnaire; one longer than normal face-to-face session; a follow-up phone call booked in by the counsellor at the end of the session, which functions both as a clinical contact and a means to determine future treatment or referral options (Talmon 1993).

From Individuals to Families: Single Session Consultations (DVD) 2012
This DVD, developed in partnership with NADA and The Bouverie Centre, provides a practical case example from an alcohol and other drug service. It also included interviews with staff from three NADA members discussing the implementation of the single session approach to working with families in alcohol and other drug settings.

CALD COMMUNITIES

Legal Aid Care and protection factsheets
This is translated information that helps people to navigate the Children's Court and children's services. The five factsheets in the series cover the process of going to the Children's Court and the role of Family and Community Services. The Kids in Care fact sheets have been translated into 10 community languages: Arabic, Bengali, Dari/Farsi, Dinka, Kirundi, Chinese (Sim), Swahili, Tamil, Thai and Vietnamese. They can be ordered and are also available online.

Immigrant Women's Speakout Association NSW
Immigrant Women's Speakout Association is the peak advocacy, information/referral and research body representing the ideas and issues of immigrant and refugee women in NSW. The Association also undertakes community development projects and provides direct services including in the areas of domestic violence and employment, education and training. Speakout is a community-based organisation, managed by women of non-English speaking background. There are a number of resources available via the website, including training opportunities.
Website: www.speakout.org.au

Drug and Alcohol Multicultural Education Centre (DAMEC)
DAMEC was established in 1989 as an access and equity initiative designed to promote access by culturally & linguistically diverse (CALD) clients to alcohol and other drug services. DAMEC provide counselling and support for CALD people and have a research and information focus. DAMEC works within a harm minimisation framework, and uses the term alcohol and other drugs to describe both licit and illicit drugs, including alcohol, tobacco and prescription medicines that are used outside medical advice.

Respect: Best practice approaches for working with culturally diverse clients in AOD treatment settings. DAMEC

LGBTIQ+ COMMUNITIES

CALD Early Intervention and Perinatal Program
The CALD Early Intervention and Perinatal Program (EIPP) services aims to provide children from CALD communities with the best start in life. The program follows an evidence-based, strength-based and child-centred approach.

AOD LGBTIQ inclusive guidelines for treatment providers
This guide aims to increase the understanding of AOD workers about the needs of LGBTI people and communities, their needs and how to provide an inclusive service response. LGBTI inclusive practice, and LGBTI inclusive practice policies and guidelines provide AOD clinicians, workers and services with the tools and resources with which they can meet the specific needs of each client, taking into account their lived experience of gender identity, sexual orientation, body diversity and intersex status, as well as the varied and multiple minorities existing within these diverse communities (people living with disability, culturally and linguistically diverse people, and Aboriginal and Torres Strait Islander people).

Say It Out Loud
Say It Out Loud encourages LGBTQ+ communities to have healthy relationships, get help for

MENTAL HEALTH

Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings (2009)
Available from: www.ndarc.med.unsw.edu.au

Mental Health Reference resource for Drug and Alcohol Workers (2007)
Available from: www.health.nsw.gov.au

MHCC Trauma Informed Care and Practice webpage
This website contains a range of resources and events listings and a network on trauma-informed care and practice.
Website: www.mhcc.org.au/TICP

NSW Clinical Guidelines for the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings (2009)
Available from: www.health.nsw.gov.au

PREGNANCY AND PARENTING

Supporting Pregnant Women who use Alcohol or other Drugs: A guide for primary health professionals (NDARC 2014)
Healthcare professionals can make a substantial difference to the health of women and their babies by identifying and supporting women who use alcohol or other drugs during pregnancy. This guide is intended for a range of health professionals, in a variety of settings to help support and provide information to pregnant women who use alcohol and other drugs. It also contains a detailed resource list of additional support services and resources.

Family Centred Practice in the Alcohol and Other Drug Field
Family sensitive policy and practice involves raising awareness of the impact on substance use upon families, addressing the needs of families and seeing the family as the unit of intervention. NCETA have developed programs and resources to support the workforce in this area of work.

Adults Surviving Child Abuse (ASCA)
ASCA is a national organisation that works to improve the lives of adult survivors of child abuse throughout Australia. ASCA offers a number of training courses and has resources suitable for professionals working with adult survivors of child abuse.

TRAUMA-INFORMED CARE

Blue Knot Foundation
Blue Knot Foundation are the national centre of excellence for complex trauma. That means that they advocate for and provide support to people who have experiences of complex trauma, and those who support them, personally and professionally.

Practice Guidelines for Clinical Treatment of Complex Trauma
These 2019 updated Clinical Practice Guidelines from the Blue Knot Foundation present evolving research and clinical insights around complex trauma. It includes substantial additions around the nature of complex trauma, dissociation and the related clinical challenges, phased therapy, 'new' and emerging treatment approaches and issues relating to `evidence-based' treatment.

Education Centre Against Violence (ECAV)
ECAV is a statewide unit responsible for training programs in the specialised areas of adult and child sexual assault, domestic and Aboriginal family violence and physical and emotional abuse and neglect of children across NSW. ECAV provides the mandated training for specialist child protection, sexual assault and Aboriginal family health workers, as well as targeted training for mental health and drug and alcohol workers in government and non-government organisations.
Website: www.ecav.health.nsw.gov.au

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
STARTTS supports refugees to recover from their experiences and build a new life in Australia. STARTTS is committed to assisting and resourcing people and organisations to provide appropriate and culturally sensitive services to refugee survivors of torture and trauma. Additionally, STARTTS provides a range of counselling and therapeutic services.
Website: www.startts.org.au

Guidelines for Trauma-Informed Practices in Women's Substance Use Services
A Canadian resource produced via the Jean Tweed Centre for Women and their Families, these guidelines set out to specifically focus on the intersections of trauma and substance use issues among adult women. It provides background information and best practice approaches to working with women engaged in substance use services from a trauma-informed approach to practice.

7.3 Government guidelines and strategies

New South Wales Opioid Treatment Program: clinical guidelines for methadone and buprenorphine treatment of opioid dependence
These guidelines represent a significant revision of two previous documents: the methadone maintenance treatment clinical practice guidelines, released in 1999, and New South Wales policy for the use of buprenorphine in the treatment of opioid dependence, released in 2001. The new guidelines take account of the release of a buprenorphine plus naloxone combination, which has been designed to reduce risk of diversion of this product from patient use to street use. The guidelines are based on current literature, which indicates the cost efficiency of this approach to the treatment of opioid dependence. Both methadone and buprenorphine can lead to significant reductions in the adverse health, social and criminal consequences of opioid dependence and the guidelines seek to provide detail on the optimal use of these agents in the treatment of our patient population.

Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants
Published by NSW Department of Health in 2009, Safe Start is one of a suite of three documents aimed at integrating care for women, infants and families in the perinatal period. This document provides guidance on conducting psychosocial assessment, risk prevention and early intervention. Strategies to coordinate clinical responses to issues identified during assessment are also suggested, including effective responses to parental mental health problems and perinatal psychosocial issues, as well as advice on assisting mothers that have problems with substance use.

Keep Them Safe: A shared approach to child wellbeing
In response to findings from the Wood Special Commission of Inquiry into Child Protection Services in NSW, the NSW government enacted a five year plan entitled Keep Them Safe, which spans the years 2009-2014. Keep Them Safe was designed to enhance the broader service system in NSW to improve prevention and early intervention services; protect children at risk; support Aboriginal children and families; and to strengthen partnerships with non-government agencies to improve service delivery to vulnerable families. As a result of Keep Them Safe, a number of guidelines and legislative changes have taken place in the child protection arena in NSW, which are described briefly below.

Child Wellbeing and Child Protection – NSW Interagency Guidelines
Published in 2006, these guidelines were produced by Family and Community Services to support collaborative efforts to improve child wellbeing and child protection in NSW. They cover inter-agency collaboration initiatives; roles and responsibilities of agencies in child protection matters; making a child protection report voluntarily or through mandatory reporting requirements; exchange of information with Family and Community Services; criminal proceedings; and best practice in working with children and families.

NSW Mandatory Reporter Guide
All non-government drug and alcohol service providers in NSW are mandatory reporters under child protection legislation. To assist workers to navigate the 'grey areas' and make confident decisions when considering making a child protection report to Family and Community Services, a Mandatory Reporter Guide is available online.

Counselling guidelines: Alcohol and other drug issues 3rd Edition (Marsh et al. 2013)
These materials are evidence-based consistent with evidence-based medicine (EBM), in which best existing research evidence is integrated with clinical wisdom and expertise, as well as client circumstances and expectations (Gambrill 1999). A cognitive behavioural approach in the counselling strategies described has been adopted because it has a good evidence base. However, other approaches to counselling may be just as effective but are less researched. The strategies described in this guide can also be integrated into other counselling approaches. These guidelines should be used in addition to agency policies and procedures.

NSW Health Drug and Alcohol Psychosocial Interventions: Professional Practice Guidelines
(NSW Department of Health 2008)
The Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines are the first generic professional guidelines for psychosocial interventions to be developed in NSW for drug and alcohol practice. The Guidelines take a stepped care approach to drug and alcohol treatment, which focuses on the adoption of best practice models for people with drug and alcohol issues, and reflects current best evidence and practice in the drug and alcohol counselling field.

Pathways of recovery (Rickwood 2005)
This monograph raises the vital issue of the role of relapse prevention in the recovery process for people who have been seriously affected by mental illness. While preventing further episodes of mental illness should be a routine component of treatment and continuing care for people with mental illness, feedback from consumers and carers shows that frequently this is not the case. Too often the experience of consumers, and their families and carers, is of a crisis-focused mental health system that doesn't respond early enough to avert further episodes, nor prioritise rehabilitation and relapse prevention as essential components of ongoing continuing care to facilitate recovery. Although relapse prevention has traditionally been viewed as an illness focused approach, it is reconceptualised here as one of the essential components of a recovery-oriented mental health system.

7.4 Training and workforce development centres

Blue Knot Foundation: **https://blueknot.org.au**

Centre for Community Welfare Training (CCWT): **www.acwa.asn.au/CCWT**

Education Centre Against Violence (ECAV): **www.ecav.health.nsw.gov.au**

Insight: **https://insight.qld.edu.au/training**

Intellectual Disability Rights Service (IDRS): **www.idrs.org.au**

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