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Intensive use

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

Substance misuse and abuse

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

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

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

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

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

Information and terminology: dual diagnosis

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

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

Terms used to describe dual diagnosis:

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

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

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

Long-term goals

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

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

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

Interpreting this information can help you determine whether to:

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

History

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

Assessment information pertaining to a person's history include:

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

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

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

Legal status

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

Psychological status

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

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

General questions include:

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

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

- ▶ physical presentation
- ▶ emotional presentation
- ▶ cognitive state.

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

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

Individuals affected by drugs and alcohol issues:

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

Family involvement

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

Legal and ethical considerations

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

Older people

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

For more information on working with older people with AOD issues, read Preventing and reducing alcohol- and other drug-related harm among older people: a practical guide for health and welfare professionals. You can access this via the NCETA website at: <http://nceta.flinders.edu.au/files/4614/4892/9660/EN605.pdf>.

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

Attitudes and misconceptions

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

Medical conditions

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

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

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

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



Issues beyond the scope of AOD services

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

Issues that may be beyond the scope of your service

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

Referrals: emergency and high-risk situations

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

1D Identify and consult with other professionals or specialists

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



Specialist AOD information

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

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

- ▶ The Australian Drug Information Network (ADIN) at: www.adin.com.au provides a central point of access to quality Internet-based alcohol and drug information provided by prominent organisations in Australia and internationally.
- ▶ DrugInfo Clearinghouse at: www.druginfoclearinghouse.org.au provides newsletters, fact sheets, research reports and other evidence-based information to keep workers in the field informed.
- ▶ National Centre for Education and Training on Addiction (NCETA) at: www.nceta.flinders.edu.au is an internationally recognised research centre and workforce development resources for the alcohol and other drug field.

Professionals or specialists

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

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

Health professionals involved in the person's care

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

Treatment plan information

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

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

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

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

Valuable information contained in the treatment plan

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

Roles of people in the process

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

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

Commonwealth legislation relevant to AOD work

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

Federal versus state legislation

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

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

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

Each state and/or territory has laws governing:

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

Policy frameworks

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



Privacy, confidentiality and disclosure, including limitations

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

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

Confidentiality refers to both written and verbal information.

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

Protect the person's privacy and confidentiality

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

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

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

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

For further information on your mandatory reporting requirements, visit the Child Family Community Australia website at: <https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect>.

Records management

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

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

Accuracy and clarity

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

Objectivity

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

Language

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

Completeness

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

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

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

Objectives of pharmacotherapy treatment

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

Detoxification or withdrawal programs

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

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

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

Detoxification program locations

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

Medication aims

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

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

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



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

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

Determine desired outcomes and priorities

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

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

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

Principles of effective communication

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

Here are some core concepts of communication.

Congruence

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

Unconditional positive regard

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

Empathy

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

Negotiate

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

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

Key negotiating tips

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

Other community settings

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

Example

Inform the person about different services and support options

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



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

Practice task 9

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

2J Record goals and strategies in the individual treatment plan

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

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



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

Use appropriate language

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

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

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

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



Topic 3

In this topic you will learn how to:

- 3A Regularly review the person's progress against goals and action plans**
- 3B Monitor, record and report the person's progress**
- 3C Negotiate and record revised action plans and timelines in the treatment plan**
- 3D Accurately record revisions in the individual treatment plan**
- 3E Negotiate the person's exit from the program and provide support**
- 3F Review the outcomes of interventions with your supervisor and/or colleagues**

Review the person's progress

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

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

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

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

A person may have initially sought AOD treatment to:

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

Changes to the treatment plan

Changes to treatment plans may vary from small tweaks to significant modifications. There are a number of reasons why revisions may need to be made to the action plan and timeline. Some individuals may be progressing well but have not yet reached their treatment goals. They may wish to make alterations and additions to the treatment plan or extend a certain strategy (for example, relapse prevention counselling) until they are more confident they can manage the changes they have made. It may be that individuals wish to change the goals or outcomes they want to achieve as their treatment progresses.



For example, they may start out wanting to quit AOD use altogether and then decide they will be happy if they can cut down AOD use to a reasonable level and minimise harm to themselves. Alternatively, they may start out wanting to cut back and then decide to stop altogether. In each case, you should report the change of goals to your supervisor and other parties in the person's care, and make necessary changes to the treatment plan.

Identify and address additional concerns

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

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

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

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

How to conclude interventions

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

Negotiate post-treatment support

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



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

Summary

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