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Handbook 2.

Clinical and Client management for Drug Services

United Nations Office on Drugs and Crime
AD/VIE/H68 Project
Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level
Hanoi, November 2008

Resources

A number of existing sources of information have been utilised in the development of this resource. Extracts from the following have been incorporated into this resource with minimal adaptation and in text acknowledgement:

Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices prepared by Turning Point (Addy, et al., 2000)

Drugs: How and where to get help? prepared by Victorian government Department of Human Services (Victoria Department of Human Services, 2002a)

Making values and ethics explicit: A new Code of Ethics for the Australian alcohol and other drugs field prepared by Alcohol and other Drugs Council of Australia (ADCA) (Fry, 2007a)

Making values and ethics explicit: The development and application of a revised Code of Ethics for the Australian Alcohol and Other Drug Field. ADCA Discussion paper prepared by ADCA (Fry, 2007b)

Care Planning Practice Guide: national prepared by Treatment agency for substance.(NHS National Treatment Agency for Substance Misuse August 2006)

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Professional practice issues

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Organisational context

Within an organisation, it is recommended a drug worker or drug counsellor is aware of the following depending on the context of the work setting:

- professional conduct guidelines developed by the various professions, for example nursing, psychology, medicine, social work
- job description and job role
- organisational policy and protocols
- interagency protocols
- best practice guidelines
- legal issues
- government regulations and rules

It is also important that you understand the difference between ethics, policy and law.

Ethics - are concerned with the 'correctness' or morality of action and the attitudes or motives for such an action - a matter of conscience.

Policy - 'attitudes or requirements of a government authority, a health institution or a professional body on a particular subject' *(Edginton, 1995; Zweben, et al., 1989)*. Policy is not law but employees may be required to agree to work within organisational policy as part of their contractual obligations. The employee may be subject to disciplinary action for non-adherence to policy.

Law - is concerned with conduct rather than motives - limits of social and moral behaviour. A minimum standard of conduct with external sanctions.

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Ethics

It is essential that you are familiar with, and work within, a structured ethical framework specific to your field. If applicable, you are strongly advised to obtain a copy of the relevant ethical guidelines or code of conduct from your professional body and also to be familiar with the code of ethics produced for Alcohol and Other Drug workers by the Alcohol and other Drugs Council of Australia (ADCA) (Fry, 2007a)

THE ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA ADCA CODE OF ETHICS

The Alcohol and other Drugs Council of Australia (ADCA) approved a new Code of Ethics in 2007 that represents a commitment to the guiding principles above.

The primary goal of the new code of ethics is to provide an explicit statement of core values and guiding ethical principles by way of promoting a 'strengths' approach to ethics: then the emphasis will be upon the things we can and should do in a process of proactive ethical problem solving. The ADCA Code of Ethics is an excellent example of a code that could be adopted by you for use in your clinical workplace.

EXAMPLE -THE CODE OF ETHICS - AN AFFIRMATION ALCOHOL AND OTHER DRUGS COUNCIL OF AUSTRALIA

As an alcohol and other drug worker, I affirm that:

1) I owe a duty of care to my clients: that is, I will take reasonable care in exercising my professional responsibilities and skills when working with and for my clients. This means that I will do what I can to:

(a) do no harm to clients, drug users and other service consumers

(b) achieve and maintain appropriate standards of proficiency in my work for example, through attendance at relevant courses

(c) ensure that my clients have relevant and sufficient information about the programs in which they are participating so that their participation is on the basis of informed consent

(d) maintain appropriate client confidentiality at all times (in accordance with relevant practitioner and professional regulations, the law and when appropriate in accordance with national human research ethics guidelines).

2) I will apply my skills towards assisting with the identification, early intervention, treatment, rehabilitation and social integration of my clients, and I will work towards prevention of drug problems.

3) I will strive towards greater engagement with the ethical challenges that arise in relation to my practice in the AOD field, incorporating:

(a) an awareness of core values that are relevant in particular situations

(b) an alignment with the guiding principles of ethical AOD practice

(c) preparedness to implement formal mechanisms for decision-making on applied ethics dilemmas.

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4) I will commit myself to work, as appropriate, with others who are involved in assisting in my clients' recovery in particular, health and related welfare workers. By doing this, I recognise that I will be able to participate in a holistic approach (involving consideration of diagnostic, clinical, environmental, cultural, service delivery, methodological, and ethical issues) to the care and support of my clients.

5) In keeping with this co-operative approach, I will take steps to ensure that my clients are referred to more appropriate care as soon as it becomes apparent that such referral is necessary in the interests of providing optimum standards of care for them.

6) I will respect the legal, civil and human (including moral) rights of my clients, including their right to make decisions on their own behalf (including decisions relating to personal drug use) and to participate in planning for their treatment or rehabilitation.

7) At all times I will carry my duties and responsibilities without prejudice in regard to the gender, age, ethnicity, religious or political affiliation, disability, sexual preference, or socio-economic and cultural background of my clients.

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8) I will do my utmost to preserve the dignity, respect, health and safety of my clients, and will not enter into a sexual relationship of any kind with any of my clients.

9) I will participate in any reasonable review of my professional standards or skills (including professional ethics) and in any processes that relate to the resolution of conflicts with my clients or the handling of complaints made by or on behalf of my clients.

10) I will endeavour to conduct myself as a positive role model for my clients and colleagues.

11) The research I undertake either directly as a project leader/chief investigator or indirectly as a partner/associate investigator will proceed on the basis of approval from an appropriate ethics committee.

Approved by the ADCA 2007.

Important ethical issues

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IMPORTANT ETHICAL ISSUES YOU NEED TO BE AWARE OF INCLUDE:

- Confidentiality
- Professional boundaries
- Prejudice
- Limitations
- Financial considerations

It is vital to note that this section is designed as an overview only and in no way replaces any existing ethical guidelines for professionals working in the Alcohol and Other Drug field. The remainder of this section is drawn from the *Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices* prepared by Turning Point (Addy, et al., 2000).

CONFIDENTIALITY

The principle of confidentiality exists to ensure that clients confidently and freely disclose information necessary to the therapeutic relationship.

- **Key element of Step 1 of care plan**
- **Your relationship with any client should be private and confidential.**
- **Establishes with a client how information relating to them may be shared and for what purpose.**
- **Underpinned by clear policies and procedures**
- **Statements offering blanket confidentiality are not appropriate**
- **The key worker and client should both be clear about the boundaries of confidentiality and what happens if information has to be shared**
- You should explain the limits of confidentiality at the beginning of each therapeutic relationship.
- The rights and privacy of clients must be respected and safeguarded at all times.
- Client information should not be communicated to any person other than those qualified to help within the case management/managed care program designed specifically for that person and to which that person has consented.
- Information obtained in clinical or consulting/counselling relationships, may be communicated only for professional purposes and only to persons legitimately concerned with the client.
- You must receive consent from the client or guardian before you do this.
- You must maintain the principle of confidentiality at all times
    - except in those exceptional circumstances whereby to do so would result in clear danger to the client or others.
- In these circumstances a decision to breach confidentiality should only be taken after discussion with senior staff as to the most appropriate course of action. In addition, you may also be required by law to disclose client information.
- All decisions relating to the disclosure of personal information must be taken with the law and the best interests of the person (or the person to whom the information relates) as central considerations.

Client confidentiality must be upheld unless the following exceptional circumstances apply:

- **with the consent of the client**, for example, where the client may request the health worker discuss issues with family, friends or other services
- for the client's benefit - disclosure of information to other professionals involved in the client's treatment. **This *must* be only for the purpose of treatment**
- there is clear risk of harm to the client or others (including children)
- your client reports involvement in serious criminal activity The obligation of confidentiality is overridden if in a particular situation it is regarded as being contrary to public policy and would impede the investigation of a serious crime
- client records are requested by the courts
- you are a professional that needs to notify authorities regarding infectious disease diagnosis
- public interest - for example, intervention to prevent the release of a psychiatrically unstable person who may harm the community. (Note that is most likely relevant to mental health workers rather than AOD workers).

Legally the term 'breaching confidentiality' is where a health care worker negligently discloses information about a client and this results in the client suffering damage.

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PROFESSIONAL BOUNDARIES

It is essential that AOD workers receive ongoing regular supervision and support.

- Supervision should enhance a worker's professional development by reviewing their work with clients and ensuring their practice aligns with professional ethics and boundaries, current research and best practice guidelines.

Establishing and maintaining professional boundaries can be a challenging aspect of working in the AOD field.

Some workers come with their own experience of AOD issues and can effectively use this background to inform their practice. The most common trap in counselling for ex-users, and potentially for all workers, is to become over involved or to over-identify with their client. This could lead to the blurring of boundaries between worker and client or even to the development of personal relationships. This is not appropriate and is invariably unhelpful to the client.

In general, it is very important for the worker to consider the appropriateness of self-disclosure. Disclosing a personal history of substance use or any other personal information needs careful consideration. The worker should ask:

- 'Will the client benefit?…
- Do I have any other motives for self-disclosing?…
- Whose needs are being met by the disclosure?
- Am I placing myself at risk, personally or professionally, by self-disclosing?'

Other ethical principles concerned with maintaining appropriate boundaries include:

Personal relationships with ex-clients should be approached with caution.

Serious consideration must be given to factors such as;

- the type of relationship
- potential harm to the client
- the amount of time between the end of the professional relationship and the start of any non-professional liaison.

Many professional codes of conduct specify an appropriate time frame after which a worker could possibly commence a different type of relationship with a client.

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Drug workers should avoid dual relationships that could;

- impair their professional judgment
- increase the risk of exploitation and/or harm the client. Examples include: treatment of employees, students, supervisees, close friends and relatives.

Therapeutic treatment involving physical contact should be approached with considerable caution. Such treatment would require the client's consent in writing regarding the purposes of the procedure and the expected risks and benefits.

Sexual relationships between the worker and clients are highly unethical.

PREJUDICE

As drug workers, you must be aware of your responsibilities to your clients. You must ensure, to the best of your ability, that any prejudices you might have do not lead to discrimination against any individual.

Such prejudices can occur due to the activities in which a client has been involved, something about a client that reminds you of another person, or personality differences between you and the client.

In such cases you should be aware of your potential prejudice or blind spot and your response.

Supervision, consulting with another drug worker or referring the client to a colleague may be an appropriate course of action.

LIMITATIONS

You should accept the limits of your particular training and not operate outside the boundaries of your professional competence. This function is in fact crucial to the provision of holistic client care

- You should have regular access to clinical supervision from senior professionals.
- You should also refer clients to other services when appropriate.

FINANCIAL CONSIDERATIONS

You should not receive private fees, gratuities or other remuneration for professional work with people who are entitled to your services through your service.

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Assessment

Introduction

In many respects, the assessment process is one of the most crucial functions you may have to perform when you work with drug users.

This is the point where, in many cases, the client gets their first introduction to your service. Even if they have had contact with other agencies or other workers, this is their first chance to work with you.

When you are conducting an assessment you will need to draw on a series of complex skills to ensure that the intervention is as effective as possible. You will need to utilise your:

- communication and engagement skills
- knowledge of the assessment process,
- assessment tools and the
- wider range of services that you may need to assist your client to access.

This section of the resource will provide information relating to these areas.

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Organisational parameters

As with all work with drug users you should ensure that you are providing the service in line with organisational policies and procedures and within accepted parameters. For example,

- you need to apply organisational criteria,
- to consider if the client is eligible to use your service in terms of age or gender.
- If so, you will obviously engage the client and assist them with the provision of appropriate services.
- If not, you need to be aware of other services so that you can facilitate the clients' access to those more appropriate services.

Types of assessment

Screening

For many clients the intake and assessment appointment will be their first face to face interaction with a facility. Many facilities treat the screening assessment appointment as a standard clerical process or task, often ignoring clients' needs

This time should be viewed as an opportunity to engage and motivate the client in his or her own treatment. Too often the assessment appointment is a purely administrative function, which can turn off clients and lead to a premature exit from treatment.

Screening assessment can be viewed as a chance to help motivate clients to engage in treatment.

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SCREENING TOOLS

Screening tools such as Questionnaires assist in screening for drug use and related harms. Screening tools

- provide useful information and facilitate further discussion between the client and the drug counsellor or health professional
- are not designed to replace a good history but are complementary and time saving.
- identify co-existing problems.

Examples:

- AUDIT*, FAST (based on the AUDIT) and CAGE for alcohol use.
- SDS for psychological dependence.
- ASSIST for alcohol and other drug use.

*AUDIT - Alcohol Use Disorders Identification Test, a ten item validated questionnaire that takes approximately 2-5 minutes to complete.

Triage

The triage assessment should generally take no more than two to five minutes, obtaining sufficient information to determine the urgency and identify any immediate care needs or risks.

The features used to assess urgency are generally a combination of:

- risk assessment
- the presenting problem
- general appearance of the client,
- physiological observations.

Vital signs should only be measured (by the treatment nurse) at triage if required to estimate urgency.

Triage does not exclude the initiation of an initial drug assessment or referral at this point.

There must be a balance between speed and thoroughness.

The triage assessment is not necessarily intended to make a diagnosis by medical personnel, although this may sometimes be possible.

- Triage can assess the client's motivation to engage in treatment.
- Triage assessment can determine the need for a comprehensive assessment and the development of a care plan.

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Comprehensive Assessment

Conducting an effective and efficient assessment is an essential prerequisite in determining the most appropriate intervention for your clients.

The aims of a drug assessment are to determine:

- the presenting issues
- substance use and treatments (past and present)
- presence of risk and protective factors
- current physical and psychological health
- social functioning
- treatment readiness and motivation
- obtain sufficient relevant information to devise an appropriate individually negotiated treatment plan to address presenting issues and needs

Assessment of drug problems is a complex and dynamic process that occurs 'before, during and following the introduction of treatment processes' (Sobell, et al., 1988).

In some settings, a single initial assessment might be the only intervention at this point in time because the client may not return for further sessions. Some clients may still benefit from that one contact.

In most situations, however, assessment is a continuous process throughout treatment, which identifies problems and changes (such as psychosocial functioning) as they emerge. Ongoing assessment provides valuable information for planning treatment, as well as establishing a baseline to evaluate a client's progress (Mattick, 1993; Skinner, 1988).

Despite this, the general consensus is that the actual assessment does significantly influence whether or not a person enters and/or remains in treatment. Therefore, the therapeutic process is greatly enhanced by an assessment tool that is broad enough to cover all major areas of interest, while also being sensitive enough to specific issues.

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A COMPREHENSIVE DRUG ASSESSMENT SHOULD COMPRISE THE FOLLOWING SECTIONS:

1. Substance Use

Substances used - amounts, duration, frequency, route of administration and patterns of use (continuous/binge).

- Drug related risk taking behaviours such as sharing injecting equipment; poor injecting technique; driving while under the influence; unsafe sex; using alone.
- Severity of dependence.
- History of previous attempts to stop or decrease substance use including: formal treatments or own efforts to change; the client's experience of such treatments.
- Withdrawal assessment where necessary, covering past and present experiences and severity.

2. Medical History

Current medical conditions such as: epilepsy, asthma, diabetes, heart conditions, digestive problems, liver disease and chronic pain.

- Brief screening for brain injury including any loss of consciousness, head injuries sustained via, motor vehicle accidents, violence, falls or overdoses.
- Any testing for blood borne viruses.
- Past medical history including hospital admissions.
- General health issues such as sleep patterns, levels of physical activity, weight gain/loss and appetite.

3. Psychiatric History

- Prior contact if any, with a psychiatric service or professional.
- Prior diagnosis and/ or psychiatric treatment.
- Assessment of Self harm/suicide risk factors such as:

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- co-existing mental illness and substance use
- gender
- recent significant loss, for example bereavement, relationship breakdown
- previous attempts at self harm/suicide
- erious physical illness
- past sexual abuse

- General presentation.
- Other observations regarding thought processes, level of awareness and coherence; level of interaction.
- A mental state exam (conducted by a worker with appropriate training).

4. Psychosocial Assessment

- Spiritual background
- Cultural background information.
- Accommodation.
- Relationships (including any domestic violence).
- Family including children and particularly the impact if any of substance use on the children.
- Social supports.
- Finances and employment.
- Recreation.

5. Legal history

- Charges pending, previous convictions and current orders.
- History of violence.
- Current risk to client and/or risk to others from client to others.

6. Other information

- Other workers or agencies involved.
- Barriers to change.
- Client's understanding of the problems.
- Client's stage of change and coping skills.

IN ORDER TO PERFORM AN EFFECTIVE ASSESSMENT THE WORKER MUST HAVE SOUND COUNSELLING AND INTERVIEW SKILLS, AND A KNOWLEDGE OF:

- drug issues - basic pharmacology;
- risk factors and treatment options (the required level of knowledge will vary according to the profession, role of the worker and the assessment setting)
- related physical health, mental health, social and legal issues
- appropriate interventions
- relevant community services

THE WORKER ALSO NEEDS TO:

- respect the client's right to make decisions and have input into his/her treatment
- respect and uphold confidentiality
- act as the client's advocate
- ensure the physical environment is comfortable and conducive to disclosure
- provide support, information and advocacy to the client and his/her family
- help the client secure the support of family, employer and significant others, where appropriate
- be alert to the client's changing needs and issues, and the possible need for reassessment
- reinforce and continue the treatment process
- model appropriate behaviour and boundaries
- be non-judgmental
- document all relevant information

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Referral

During the assessment or care planning process or at the end of your work with a client, you may be required to assist your client to access other services.

Referral may be considered a form of treatment. It is crucial that you have knowledge of:

- the available services, and their level of appropriateness and accessibility for your client.
- Providing client follow-up is extremely important.

A COMPREHENSIVE ASSESSMENT WILL RESULT IN THE DEVELOPMENT OF AN APPROPRIATE INDIVIDUAL TREATMENT PLAN THAT WILL SPECIFY THE NATURE OF THE TREATMENT TO BE PROVIDED AND THE MOST APPROPRIATE SERVICE PROVIDER.

In some cases, the treatment will be provided by the agency that completed the assessment,

- while at other times it might be more appropriate to refer the client to a different treatment service.

Good referral practice includes:

As part of good referral practice, identify and liaise with relevant drug and support services in your area:

- what is their treatment philosophy?
- what generic or specialist services / treatments do they offer?
    - 12-step
    - harm reduction
    - pharmacotherapies
    - cognitive behaviour therapy (CBT)

- do they cater for specific populations?
  - Young people
  - Women
- what are their admission / entry criteria?
  - what is available
  - how to access it
  - how to maintain contact with both the patient and the service

THERE IS NO SUBSTITUTE FOR LIAISON WHEN IT COMES TO SUCCESSFUL REFERRAL PROCEDURES. MAINTAINING RELATIONSHIPS AND NETWORKS IS IMPORTANT.

HIGH INVOLVEMENT IN REFERRAL IS ASSOCIATED WITH HIGHER UPTAKE AND RETENTION IN TREATMENT.

- where possible **(and with client's consent)** provide a comprehensive assessment (referral letter) to the new provider
- arrange appointments for the client; or if possible assist the client to make the appointment with your support
- give instructions on how to get there, or if possible go as a support person with the client **(with client's consent).**
- provide information to the patient about the service he or she has been referred to
- build expectations of good outcomes
- ask **permission** to call client to ascertain outcome of referral
- follow-up to ensure connection occurred
- ensure referral is coordinated to link other services into care
- establish 'priority of need' with clients to ensure success
  - e.g., 'non-medical' needs (e.g., childcare, housing, food) may be a higher priority for referral than the immediate medical problem / drug issue

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Review

The crucial role of assessment in determining appropriate intervention and referral, ensuring that the client remains engaged in the therapeutic process has been detailed in this section. You have been provided with the key components assessment and have been reminded of the skills and pratice requirements of a drug counsellor.

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Care planning

Introduction

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Care planning is a direct client service for all consumers of health services, and is particularly useful for those with complex needs. A care plan is a formal documents outlining an individualised plan of care for the client.

It involves ongoing and regular contact between the client and the key worker to support and facilitate the accessibility and coordination of appropriate services. Changes in the circumstances for the client can be reflected in the care plan to represent flexibility and changes for the client.

What is care planning?

- The process of goal setting based on the needs identified by an assessment
- Performed with the client/patient across four domains -
  - drug and alcohol,
  - physical and psychological,
  - social
  - criminal justice
- Partnership approach
- Planning how to meet those goals through application of evidence based interventions.
- Planning interventions should be in the context of a harm reduction approach that aims to reduce relative risk.

How does good care planning protect the client?

Information provided by the client which is clearly and professionally documented by the drug worker protects the client in the following ways;

- Guides the assessment process.
- Documents consent and information sharing
- Provides a client guide or "map".
- Charts the effectiveness of treatment
- Used to identify and manage risk.
- Empowers the patient.
- Provides a focus for care.

How does good care planning protect the worker?

A care plan, which is well documented and clearly defined and followed through, protects the worker in the following ways;

- Reduces professional isolation.
- Provides professional boundaries to enable professionals to work within their competencies.
- Provides an audit trail of contacts and care
- An aid to quality improvement and performance monitoring (both service and individual) performance in relation to effective care planning.

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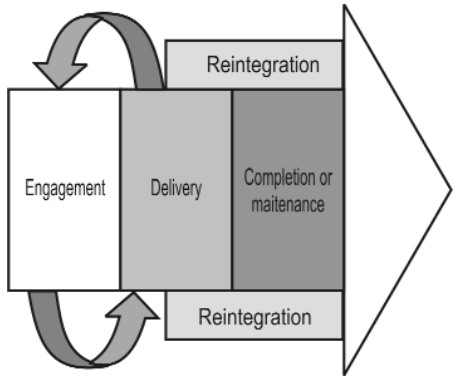
Care plan contents and checklist

- Name
- Date of birth
- Date of care plan
- Key worker and service responsible for the care
- Indication of the main (phase or phases) of the journey
- Needs risks identified in relation to;
- drug and alcohol,
- physical and psychological,
- social
- criminal justice
- Goals
- Interventions (identify who is responsible for what)
- Review date
- Signature of client
- Signature of key worker

The following diagram represents the care plan (The Journey) broad phases taken from the NATIONAL TREATMENT AGENCY (2005) Care Planning Toolkit, Consultation Draft. London, DoH.



- engagement
  - harm reduction and relationship building
- delivery
  - prescribing, psycho-social interventions, social practicalities and offending behaviour
- maintenance or completion
  - training, life skills and employment, NA maintenance prescribing

Figure 1: The client jouney

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Care plan goals

Goals in care plans should be SMART

Specific

Measurable

Achievable

Realistic

Time limited

The central goal of care planning is to ensure;

- that the client has access to the services and resources that they need
- when they are needed.

Care planning is a process that aims, within a specified time period, to;

- work with and for clients
- enhance the client's access to services
- actively involve and empower clients
- assist clients to coordinate access to services

A major focus of care planning includes;

- the identification of the client's needs and goals, and
- helping the client to address them

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STATE WHO IS RESPONSIBLE FOR WHAT

Figure 2 provides the overview of key elements and principles of care planning.

	Elements / tasks	Principles
Entry	• **Identification** of person in potential need • Acquire relevant **contact** details	• Information should ideally be **recorded once** to avoid duplication, and shared as appropriate
Assessment	• **Identification** of **key worker** / single contact • Person and professional agree what the assessment and care planning process is meant to achieve (**outcomes**) Holistic **identification of needs and risks**, including those of carers where appropriate	• Assessment should begin with the **person's "story"**(what's new, what's good, what's tough etc.)issues, evidence, experience) and the **professional's" story"** (issues, evidence and experience). • **Holistic approach** to assessment –eovering all domains (clinical, social, psychological, lifestyle)
Develop care plan	**Prioritisation** of issues by care planner and person • Development of **action plans** for the service and the person • Identification of any **equipment** required	• Care planner / co-ordinator requires adequate training **and** experience (including the capacity to discuss risk) • Care planner / co-ordinator requires access to up to date **evidence and information** including a directory of potential resources • Care plan to be designed **with and for the person** and shared with carers / family if appropriate • Care plan should address how to ***live*** **with the condition** (social as well as medical) • Care plan must be **flexible** to meet a wide range of needs and conditions • Clarity required between **holistic and specific care** to be provided • Care plan to be **held by the individual** and **accessible** by both them and the professionals.
Implement care plan		• Work as a **team** to provide care, not as a series of unconnected individuals • Services and support should **follow the care plan**
Review	• **Review** and update action plans at agreed time periods • Care plan should be **reviewed** and if **necessary continued or modified at agreed intervals, changes documented**	
Exit-re-entry	• **Discharge** to self-care where appropriate, with clear routes back to more intensive professional interventions • **End of life** plan (where appropriate).	
Over-arching elements and principles	• **Process** should be **evaluated** by organisations to identify areas for improvement • Process and decisions taken should be **recorded** and **documented**	**Empowering** professionals • Process led / **endorsed** from the top and **aligned** with wider targets for staff and organisation • Process **joins up** working and **information-sharing** across professional and organisational boundaries • Individual feels like and is seen as a **whole person** not just a patient or service user • Process is **transparent** for all those involved • Process should provide **emotional support** to the individual (and their carer, where appropriate). • Process is **ongoing**, not a one-off event

Figure 2: Key elements and principles of care planning

Care Planning Practice Guide: national prepared by Treatment agency for substance.(NHS National Treatment Agency for Substance Misuse August 2006)

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Regular monitoring of care planning activities and outcomes is an integral component.

Further focus involves;

- coordinating the range of services in which the client may participate, with a view to overcoming the gaps and obstacles that can occur between health and social services delivered by different providers.

The care planning process does not replace the activities of specialist service providers, but represents a central point of coordination for the range of other health professionals involved.

While there is some overlap with counselling and therapy, care planning differs in that it focuses more upon practical needs, gaps in community support, and current obstacles and how they can be overcome.

The key worker is responsible for;

- developing a care plan (also known as and Individual Treatment Plan (ITP)
- meeting goals
- as well as actively liaising with people and services in the client's daily life.

The relationship between the client and key worker differs from that typically found in counselling.

Sessions may be;

- informal and flexible,
- with shorter appointment times
- may vary in frequency.

For example, a key worker may have daily contact with a client starting on a methadone program, or monthly sessions with someone who is relatively stable.

The quality of the relationship established between the client and the key worker is central to effective care planning.

Forging a;

- supportive,
- respectful relationship is vital if the client is to feel capable and hopeful about improving his/her life.

Key worker functions vary according to the setting, but all have common components.

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Comprehensive Individual Treatment Plans

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Introduction

Comprehensive Individual Treatment Plans (ITPs) form a crucial component of effective treatment service provision.

Good service provision involves **a thorough assessment**, including a **collaborative determination** with the client of the most effective treatment plan. This will include:

- the nature of the goals that the client may wish to achieve
- consideration of the type of treatment to be provided (for example withdrawal, substitution pharmacotherapies, counselling, or a combination of treatment types)
- the timelines or length of treatment
- and a review component

Treatment planning is the cornerstone of effective interventions.

Treatment planning is part of reflective and evidence based practice. Workers usually have a plan in their heads of how best to work with an individual and how to proceed.

An ITP is a way of documenting and formalising that plan. (see appendix 1. Individual treatment plan.)

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Effective treatment planning, reflected in the use of ITP's, has significant documented advantages:

- it ensures collaborative decision making between the client and the worker
- it enables progress to be tracked by the client and the worker
- it enables interventions to be focused and effective.

The international literature demonstrates that ITP's enhance practice and treatment outcomes, and are a crucial component in best practice.

Individual Treatment planning is divided into the broad phases of

1. **initiation**
2. **implementation**
3. **transition**

Their specific functions are;

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INITIATION

- Focuses on the process of engaging with the client.

IMPLEMENTATION, which involves the service delivery;

- assessment of client needs and goals
- the development of a comprehensive action plan,
- linkage with necessary services
- advocacy on behalf of clients,
- Monitoring and review of client progress and service delivery.

TRANSITION

- Involves the process of disengaging with the client in preparation for ending an episode of treatment.

Monitoring features of the individual treatment plan

As noted above, the ITP reflects formalised documentation and monitoring of client goals

- actions and timelines following an assessment
- the appropriate treatment goals
- strategies to achieve the goals
- and ongoing review

The process of documenting and monitoring an ITP with an individual client:

1. forges a collaborative approach between client and worker with shared responsibility
2. provides a focus for treatment - clarifying and specifying achievable goals
3. enables evaluation of treatment progress from both the client's and the worker's point of view

The ITP reflects the systematic documentation of these features of the treatment plan.

It may be helpful to provide the client with a copy of the treatment plan.

Clients frequently change their goals or treatment direction during the course of treatment. The treatment plan should reflect a capacity to incorporate such changes as required.

An ITP should be completed after the comprehensive drug assessment and it should be discussed in the first session with the client, although in some instances, the ITP may be completed during the assessment process.

It can be an ongoing, staged process with new goals or new actions arising throughout the course of the intervention.

The ITP is up-dated and reviewed in subsequent contacts.

The most important components of developing an ITP are the formulation of the problem and the specification of treatment goals.

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Content of an individual treatment plan

The core elements of an individual treatment plan are:

- presenting issue or problem
- treatment goals
- actions to be taken
- timeframe
- review

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Treatment goals

There has been much local, national and international discussion and debate about the nature of treatment goals for drug treatment.

The five overarching goals of drug treatment services are:

- reduced substance use
- improved physical health
- improved level of connectedness
- reduced crime
- improved emotional and psychological well-being

All interventions can be described in terms of one or more of the above treatment goals.

GOAL 1. REDUCED SUBSTANCE USE

A change in substance use is clearly an important goal of drug treatment services. However, for some individuals the actual amount of substance use may not change, but a client may become more aware of the negative consequences of use. Examples of indicators for this goal may include:

- completed withdrawal
- achieved abstinence from drug of concern
- linked with substitute pharmacotherapy regime
- reduced level of use of drug of concern
- learnt relapse prevention techniques, or linked successfully to other drug treatment service for further care

GOAL 2. IMPROVED PHYSICAL HEALTH

Improving a client's physical well-being can be an important goal. This may include:

- achieved positive changes in physical health status
- reduced risk-taking behaviours
- linked successfully to GP or other health services

GOAL 3. IMPROVED LEVEL OF CONNECTEDNESS

Improved level of connectedness may include such indicators as:

- improved relationship with family/friends/community
- learnt improved social/communication skills
- linked successfully to workforce training, education or employment
- linked successfully to parenting support services

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GOAL 4. REDUCED CRIME

Reduced crime indicators may include:

- reduced offending
- achieved compliance with legal requirements
- resolved legal issues

GOAL 5. IMPROVED EMOTIONAL AND PSYCHOLOGICAL WELL BEING

Whilst it would be typical for drug counselling to focus on emotional and psychological well-being, other service types such as withdrawal and outreach, can also work towards changes in this area where appropriate and identified by the client. Examples include:

- improved management of problematic emotional states
- resolved self-harming behaviours
- successfully addressed family issues

Most interventions can fit within these five key goal areas.

For example, education aimed towards reducing high-risk behaviour would belong under Goal 2.

An episode of withdrawal will include goals to reduce consumption (Goal 1) and improve physical health (Goal 2).Substitution pharmacotherapy for an individual may be directed primarily towards reducing heroin use and improving psychosocial functioning

(Goals 1 and 3). Youth outreach may concentrate entirely upon engaging the client and reducing high-risk behaviour (Goal 2).

Not all goals need to be addressed in each treatment episode with a client. It is important to ensure that the choice of goals is client-focused (what the client wants) and is achievable.

The five key goal areas provide the worker and client with a structured approach to determining what is appropriate and achievable for the client at that point in time.

Other issues

WORKING WITH SIGNIFICANT OTHERS

Working with significant others (families, partners, friends) may also constitute part of the treatment, and an ITP can be developed to reflect this.

The same principles apply: it is a collaborative endeavour where the worker and the significant other agree to the goals and actions required.

The same form can be used. This enables the worker to word the goals appropriately for the significant other.

For example, a mother of a young heroin user may be particularly concerned with reducing her son's heroin use and improving her own ability to cope. A broad goal of reduced substance use may therefore have specific goals such as 'improving the mother's understanding of patterns of drug use'; and 'communication skills to talk with son about drug use and treatment options'.

A goal of improved emotional well-being could include specific goal to address the mother's coping strategies, and the actions could include referral to a parent support group and counselling regarding coping skills.

It is important to remember that the ITP developed with a family member of a drug user is concerned with goals and actions for the family member (not goals and actions for the drug user - who may or may not be engaged in treatment and have their own ITP).

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COMPLETION OF AN ITP

A client may cease treatment at any stage.

- On completion of treatment, the ITP is reviewed and the number of treatment goals attained is documented.
- The worker must make a judgement as to the degree to which the goals were met. The ITP documentation can then be filed.

SHARED CARE

It is important that drug treatment ITPs make sense in the context of the client's overall engagement with a range of services.

- The ITP needs to provide space for the worker to record the involvement of other agencies.
- Where written informed consent has been obtained, it is extremely useful for the drug treatment worker to forward a copy of the ITP to the other services involved with the client.
- This will enable a greater understanding of the goals, and involvement of various agents in the client's life and ensure more effective, collaborative shared-care.

CLIENT FOLLOW-UP

During the care planning and referral process, it is vital that the following systems are established

- communication,
- review
- evaluation.

It is crucial that you have knowledge of the available services, and their level of appropriateness and accessibility for your client.

It is important to provide any follow up tasks in accordance with organisational policy as this maximises the likelihood of the client achieving the best possible outcomes from their contact with a range of services.

Supervision

Types of Supervision

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There are various types of supervision, which are essential as part of an effective workforce. The following are types of supervision, which benefit both day-to-day work practice and professional development.

- Managerial supervision.
- Personal/pastoral supervision.
- Clinical casework supervision.

Managerial supervision

Managerial supervision provides support, direction and skill development in performing tasks to achieve organisational outcomes. These include;

- Set priorities / objectives
- Monitoring work and work objectives
- Check how objectives are relate to the organisation's objectives
- Identify specific management/administrative tasks e.g. time management, budget skills
- Identify training and development needs

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Personal/Pastoral Supervision

Personal supervision relates to personal issues raised through work or effecting work. This can cover:

- Discussing how issues outside of work are having an effect on work and practice.
- Discussing how issues outside of work are having an effect on work and practice.

Clinical casework supervision

Clinical casework supervision is strongly associated with health professions such as social work or psychology, **and much has been written about its importance for professional development.**

Supervision is an essential component of best practice.

- Casework supervision provides workers with a 'thinking space' about their clinical work, which is vital for them professionally and for their clients.
- For the worker it helps develop skills and competence,
- For the client benefits from having another person thinking about their difficulties and the help required.

WHAT IS CLINICAL CASEWORK SUPERVISION?

Clinical casework supervision is;

- the formal process by which a more experienced counsellor works with a less experienced counsellor to help enhance his/her skills.

Purpose of clinical supervision includes;

- personal growth as part of the supervision and certainly this can be one of the important outcomes.
- reflect and review clinical/treatment practice
- discuss individual cases in depth
- support clinic workers to change/modify their clinical/treatment work
- supports development of clinical/treatment skills in assessment and treatment

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Supervision differs from therapy because the process is focused on;

- the counsellor's work behaviour and environment
- not on the counsellor's personal issues.

Supervision varies depending on the type of clinical work involved. The essential elements are that it;

- is a formal process, where expectations and goals have been set;
- occurs regularly (fortnightly or monthly)
- meets the needs of the counsellor, which may change over time;
- is systematic, focused detailed and written down
- results in improved work practices or increased accountability

Case management meetings and one-off staff training activities do not constitute supervision.

BENEFITS OF SUPERVISION

Supervision has many direct and indirect benefits.

Firstly, for the counsellor, it allows

- ongoing training and skills development and offers a supportive context in which to explore the ways in which he/she is performing.
- Supervision provides increased job satisfaction and self-efficacy.
- It is a method of quality assurance and ensuring worker accountability
- In an organisational context, supervision has been shown to decrease staff turnover, burnout and absenteeism (Valle, 1984).

For the client, the benefits lie in a more competent and accountable counsellor.

It has been noted that an organization that does not involve clinical supervision is not operating within the principles of best practice.

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Glossary

Advocacy	A process that involves the empowerment of people to act in an appropriate way to address the needs, rights or issues of an individual
Analgesic	Medication given for the relief of pain
Axon	Part of a brain cell which sends messages to other brain cells
Central nervous system	Brain and spinal cord
Care planning	Care planning is a direct client service for all con sumers of health and welfare services, and is partic ularly useful for those with complex needs
Dendrite	Part of a brain cell which receives chemical mes sages from adjacent brain cells
Depressants	Drugs which dampen down the actions of the cen tral nervous system
Designer drugs	Synthesized psychoactive drugs, usually stimulant based

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Dual diagnosis	Co existence of DRUG diagnosis and another in same person. Second typically, but not exclusively, psychiatric
Half-life	Amount of time taken for blood levels of a drug to decrease from their peak to 50% of that level. Also known as t2
Hallucinogens	Drugs which alter the way sensory information is perceived via the senses. May effect any of the senses
Harm minimisation	Philosophy which concentrates on the reduction of harm caused by drugs rather than the eradication of the use of drugs
Homeostasis	Biological mechanism that counteracts the effects of a drug on the brain to return it to normal function
MAOIS	Mono Amine Oxidase Inhibitors. A type of anti depressant medication
Neuroadaptation	See tolerance
Neurons	Nerve cells
Neurotransmitter	Chemical responsible for communication between brain cells
Opioid	Any opiate type medication, either derived from the opium poppy or synthesized
Pharmacology	'the knowledge of the history, source, physical and chemical properties, compounding, biochemical and physiological effects, the mechanisms of action, absorption, distribution, biotransformation and excretion, and therapeutic and other uses of drugs.' Goodman & Gillman, 1975

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Psychoactive	As pertains to drugs, those which effect mood, thinking, perception and/ or behaviour
Psychosis	Syndrome where person experiences hallucinations and delusions (fixed ideas not rooted in reality)
Psychotropic	Anti psychotic medication
Receptor site	Place on the dendrite (see above) into which neuro transmitters (see above) fit
SSRI	Selective serotonin re-uptake inhibitors. A form of anti depressant medication
Stimulants	Drugs which stimulate the central nervous system
Substitution therapy	Treatment method for opiate dependence where a longer acting opiate is given with the aim of reduc ing harms associated with drug dependent life style
Synapse	Very small gap between the axon (see above) termi nal of one brain cell and the dendrite (see above) of an adjacent brain cell
Therapeutic purpose	The reason a treatment is instigated
Tolerance	Tolerance develops when the original amount no longer produces the same effect, so greater doses are required in order to obtain the effect
Tricyclics	An older form of anti depressant medication.

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Acronyms

ABI	Acquired Brain Injury
ADCA	Alcohol and other Drugs Council of Australia
DRUG	Alcohol and other drug(s)
APSAD	Australasian Professional Society on Alcohol and Other Drugs
CCCC	Counselling, consultancy and continuing care
CID	Critical Incident Debriefing
CNS	Central Nervous System
ITP	Individual Treatment Plan
NADA	Network of Alcohol and Other Drug Agencies
NDS	National Drug Strategy
VAADA	Victorian Alcohol and Drug Association

Appendix 1. Individual Treatment Plan Tool

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Guidelines

The first part of the form is self-explanatory: client name, UR number, and date ITP developed and by whom. The date the ITP was developed will reflect the first date upon which the worker completed the form. (In the Treatment Plan section there is also a date column to reflect when different treatment goals were established or changed, during the course of the treatment).

The space provided for the presenting problem is where the worker summarises, from the assessment, the current issues and problems facing the client. These are usually what have prompted the person to seek assistance/treatment at this time. Some services have this information summarised in their intake and/or assessment form. Where the ITP is attached to the assessment form, the presenting problem does not need to be repeated (see Appendix 2). It is important that workers work through the 'presenting problem' definition with the client. It is more than just a list of issues - rather it reflects a summary that includes a prioritisation of issues, and identified needs, which has been conducted collaboratively between client and worker.

The most important section of the ITP form is the 'Treatment Plan' table. The first column indicates the date when that individual goal was established. The second column lists the five categories of treatment goals. All five treatment goals have been listed with their own row, with one additional 'other' row.

The first step is for the worker and client to determine whether that goal is relevant (column 2). This will be based upon the presenting issues, and problem definition derived collaboratively with client, resulting in a formulation of the problem to be addressed, expressed as a goal. A box is provided to tick if the goal is relevant. As indicated earlier, not all five goals will be relevant for every client.

If the treatment goal is relevant, and the box ticked, complete column 3. Specific goals that relate to this overarching goal are developed. For example if the first goal (reduce substance use) is relevant, the more specific goal may be to: (i) reduce alcohol consumption to 2 standard drinks per day, and (ii) improve understanding of effect of alcohol on liver. It is important that the client collaborate in determining the specific goals listed in column 3. The list of all five treatment goals, with examples of their indicators is provided on the back of the proforma for cross-reference.

Column 4 is used to indicate the actions required in order to achieve the specific goals. For example a self-monitoring program for reducing alcohol consumption; counselling sessions on high-risk situations and so on. In effect, column 4 (actions) specifies what you and the client will do, what you will focus on in the treatment. Column 5 is used to indicate the timeframe for these actions: days, weeks or months. It also provides a tick-box indicating whether they are short-term or long-term actions.

Columns 6, 7 and 8 are completed as part of the ongoing monitoring and review process, and are not completed in the first session with the client. At the bottom of the form is a place to insert a review date. On or near to this date, the worker and client revisit the ITP, using column 6 to modify any goals or actions. For example, the client may be drinking 4 standard drinks a day rather than two, and feels comfortable with this level of reduction (rather than the one originally specified in column 3). In this instance, you would date and insert the new target. If new goals are established, then columns 1 to 5 are completed for the new goal. In this way, the ITP reflects a staged process, where goals can be built up over the course of treatment. Columns 7 and 8 are generally completed at the end of the treatment. Column 7 indicates the degree to which the goals have been met, and column 8 the date of conclusion of the ITP.

Individual Treatment Plan

Client name:		Date ITP developed:	
UR Number:		ITP completed by:	
Code:			

Presenting issues / problems

Shared Care

Planned date for review	
Date reviewed	

Treatment Plan

Client name:

Date	Treatment Goal Category	Specific goals	Actions required to achieve goals	Timeframe	Modifications to plan	Degree to which achieved	Date completed
	Reduce substance use ❑						
	Improved physical health ❑						
	Improved level of connectedness ❑						
	Reduced crime ❑						
	Improved emotional & psychological wellbeing ❑						

☐ **Copy given to client**

Client signature: _____

Adapted from Alcohol and Drug Information System (ADIS) Guidelines and Definitions(Victorian Government Department of Human Services, 2006)

1. Reduced substance use indicators

- ❑ completed withdrawal
- ❑ stabilised drug withdrawal
- ❑ achieved abstinence from drug of concern
- ❑ achieved abstinence from drug of concern for 3 months or longer
- ❑ completed formal program
- ❑ successfully maintained abstinence from drug of concern
- ❑ linked successfully to community pharmacotherapy
- ❑ achieved stabilisation of substitute pharmacotherapy
- ❑ optimised substitute pharmacotherapy regime outcomes
- ❑ successfully referred to GP/Community pharmacy
- ❑ successfully transferred to alternative pharmacotherapy
- ❑ successfully withdrawn from substitute pharmacotherapy
- ❑ significantly reduced level of use of primary drug of concern
- ❑ significantly reduced level of polydrug use
- ❑ successfully maintained controlled substance use level
- ❑ learnt relapse prevention strategies
- ❑ reduced risks and harms associated with drug use
- ❑ received assistance (re-orientation) after overdose
- ❑ clarified awareness and expectations of the course of treatment
- ❑ linked successfully to other Drug & Alcohol treatment service for further care
- ❑ established care planning relationship with A&D worker
- ❑ other

2. Improved physical health indicator

- ❑ achieved positive changes in physical health status
- ❑ reduced risk-taking behaviours
- ❑ developed regular living patterns (ie sleep, meals, hygiene, etc)
- ❑ linked successfully to GP or other health service
- ❑ received wound care or other health care
- ❑ received information about vein care
- ❑ received safer sexual practice education
- ❑ increased knowledge of effects of drug & alcohol use in pregnancy and breastfeeding
- ❑ successfully engaged in antenatal care
- ❑ successfully engaged in postnatal care
- ❑ linked successfully to maternal and child health services
- ❑ successfully engaged in Childbirth Education
- ❑ other

3. Improved level of connectedness

- ❑ improved relationship with family/friends/community
- ❑ improved social/communication skills
- ❑ engaged in recreational or vocational activity
- ❑ obtained employment
- ❑ linked successfully to workforce training, education or the Centrelink job network
- ❑ linked successfully to (other) meaningful regular activity
- ❑ linked successfully to relevant spiritual or cultural programs
- ❑ improved accommodation status
- ❑ improved social functioning
- ❑ linked successfully to parenting support services
- ❑ family successfully engaged in client's treatment
- ❑ improved physical environment/requirements for baby and children
- ❑ participated in Community Reintegration Program(CRP) electives
- ❑ linked successfully to structured recreational or vocational activity
- ❑ other

4. Reduced crime indicators

- ❑ reduced offending
- ❑ achieved compliance with legal requirements
- ❑ achieved compliance with family court recommendations
- ❑ resolved legal issues
- ❑ acknowledgement of need to meet legal requirements
- ❑ other

5. Improved emotional and psychological well-being indicators

- ❑ improved management of problematic emotional states
- ❑ resolved presenting crisis situation
- ❑ reduced self-harming behaviours
- ❑ successfully addressed family/relationship issues
- ❑ increased self-efficacy
- ❑ linked successfully to mental health service
- ❑ other

Adapted from Alcohol and Drug Information System (ADIS) Guidelines and Definitions (REF #165)