Coming Down the High Road: Doing Residential Drug Rehabilitation

Volume 2: Model of Residential Drug Rehabilitation

Hannah Graham & Rob White

School of Sociology & Social Work
University of Tasmania
Coming Down the High Road:
Doing Residential Drug Rehabilitation

Volume 2:
A Model of Residential Drug Rehabilitation

Hannah Graham & Rob White
School of Sociology & Social Work
University of Tasmania

April 2008
A Model of Residential Drug Rehabilitation

Introduction

This project reflects The Salvation Army’s desire to provide the ‘best drug and alcohol treatment service in Tasmania’ and develop policy, procedures, and practices that will assist residents. The Salvation Army required a user friendly Final Report to identify and describe best practice models and examples of alcohol and drug residential rehabilitation. The Final Report is meant to inform future Salvation Army planning regarding the provision of residential rehabilitation services in Tasmania.

This project has comprised of a literature review with reference to a service delivery context that includes:

1. Court mandated provision of services
2. Involuntary clients and practice
3. Innovative models and examples

The literature review was based on, but not limited to:

1. The continuum of care concept, and existing evaluation practices
2. Relevant international and national comparisons
3. Information on treatment reporting and evaluation systems

In preparation of the report we were aware that residential rehabilitation must address issues related to:

- Capacity and approach adopted by service agencies
- Client profile and receptivity to diverse types of rehabilitative services
- Policy context of licit and illicit substance use, such as implementation of drug diversion programs and harm minimisation strategies
• Collaboration and partnerships across agencies and client services
• Concepts of rehabilitation and restorative processes
• Language(s) of communication, professional practice and service mission

The report is provided in two volumes. The information provided in Volume 1 of the report is largely based upon publicly available documents and documentation, as reflected in the reference list and the list of websites at the end of the report. This information was supplemented by participation at a few drug and alcohol forums and workshops ‘National consultation forum on amphetamine-type stimulants’ and the ‘Court mandated diversion drug offenders in Tasmania symposium’, and informal discussions with stakeholders from a variety of different agencies within the Hobart precinct.

Our key task was to provide an overview of existing practices, to discuss prevalent principles and practices within the residential drug rehabilitation sector, and to synthesise ‘the best of the best’ in terms of constructing an ideal type model for the doing of residential drug rehabilitation. This is the second volume of the report. It provides ‘A Model of Residential Drug Rehabilitation’. Based upon the literature review in Volume 1, this volume provides a step-by-step approach towards innovative practice, and gives strategic direction towards organisational change. Volume 2 has been designed to be practitioner-friendly and a manual of service provision.

In the model, differentiation is made between the linear and processual nature of clients transitioning through the programme, and the more complex and multi-faceted nature of agency infrastructure development. However, there are important interconnections between the two. The topical areas covered in the model are a compilation of the key elements outlined in the literature review, and are designed for practitioners to be accessible and applied. All practice must be driven by principle and, while not all areas of practice are covered in the model, key guiding principles are outlined. In addition, question boxes have been provided in order to aid reflexive examination of current practice.

The first part of Volume 2 deals with client services; the second part with agency considerations.

We wish to acknowledge the commitment of the Salvation Army’s Ronda McIntyre, Peter Fraser and Jed Donoghue to the development of this project.
Figure 1: Client Rehabilitation Pathway Flowchart

**Stage 1: Stabilisation**

- Person indicates substance use/abuse issues, is seeking entry to residential rehab.
- Eligibility criteria addressed?
  - No
    - Denied entry to program at present time
  - Yes
    - Assessment Conducted
      - Program entry, orientation
      - Medical assessment by GP
      - Assigned a case worker
      - Personal needs considered, individual treatment plan and goals devised

**Stage 2: Personal Development**

- Ongoing rehabilitation program participation: individual & group counselling, capacity development, problem solving, recreation, get information & education, relapse prevention training, refining coping skills
- After specified period of time, allowed to take leave off campus
  - On return, possible random testing/urinalysis/breathalyser
    - Positive test, relapse
      - Exit program
    - Negative test, staying clean
      - Stay in program
- Is the client a CMD drug court offender?
  - No
  - Yes
    - Review hearings(?)
    - Update reports to: the court, prob. officer
    - Mandatory testing

**Stage 3: Transition**

- Outreach support in the community
- Program graduation/completion hand-over to outreach worker
- Referral to and engagement in external programs / groups
- Preparation and planning for leaving and full independence, goal-setting, extended leave in outside accommodation
- Ongoing data collection; seek client feedback and evaluation
- Individual needs re-assessed, treatment plan, goals, and progress regularly monitored
- Referral to and service provision from any external professionals or agencies as required during program participation – integrated care and service provision
The Client: Service Provision Processes and Protocols

Client Services

Six stages of rehabilitation and client progression through the programme are examined, starting from before they enter the programme through to six months post-programme completion.

<table>
<thead>
<tr>
<th>Pre-Entry</th>
<th>Entry &amp; Orientation</th>
<th>Assessment &amp; Case Planning</th>
<th>Service Engagement</th>
<th>Exit Preparation &amp; Transition</th>
<th>Exit &amp; Post-Care</th>
</tr>
</thead>
</table>

In addition to the stages, there are six accompanying continuums that can be assessed and implemented for each individual stage. These continuums represent important elements of client rehabilitation and service provision good practice. The aim of each continuum is to maximise service interventions, client capacity and wellbeing within each stage.

Continuums – these refer to something that consists of a series of variations or sequence of things in regular order. For example, the concept of ‘continuum of care’ involves stages, milestones and indicators that demonstrate progress in relation to identified needs. A continuum implies forward and backward movement, as well as defined benchmarks along the way.

<--->

Overall, strengths-based principles have been built in to promote practitioner assistance of clients with the aim of active empowerment and long-term change. Positive strengths based practice facilitates the client to engage in a holistic reconstruction of self, which takes into examination what the person was like pre-substance use, mid-substance use, and post-substance use – individual agency is the key in planning and enacting a new possible self. Practitioners play a key role in helping the client to accomplish their goals and aspirations as a part of their rehabilitation and recovery.
Figure 2: Six Stages of Rehabilitation

- **Pre-Entry**
  - Stage 1: Weeks/days prior to entry

- **Entry & Orientation**
  - Stage 2: First 48 hours

- **Assessment & Case Planning**
  - Stage 3: First week

- **Service Engagement**
  - Stage 4: Programme duration

- **Exit Preparation & Transition**
  - Stage 5: Last 4-6 weeks

- **Exit & Post-Care**
  - Stage 6: Exit and 6 month outreach period

---

**Continuum of Assessment**
- Continuum of Therapeutic Support
- Continuum of Individual Agency
- Continuum of Competency Development
- Continuum of Social Connection
- Continuum of Community Contribution
Stage 1 – Pre-Entry:
weeks/days prior to entry

Pre-Entry Continuums

- **Continuum of Assessment**: Eligibility pre-assessment is conducted at this stage. This involves a preliminary establishment of personal details and background involving information that ascertains the person’s suitability and readiness for the residential programme, and awareness of anything that will impact on service engagement.

- **Continuum of Therapeutic Support**: Little or no therapeutic support (from programme practitioners) takes place in this stage. The prospective client is simply engaging with outreach workers to be assessed, and not undertaking (as of yet) any assistance or intervention. Instead, prior to programme entry, the prospective client may be receiving therapeutic support from other practitioners, for example, their GP, psychologist, or other case worker (e.g. housing, family services).

- **Continuum of Individual Agency**: Pre-entry involves the prospective client exerting relatively high levels of initiative and decision-making because they are in the process of applying for entry, voluntarily undergoing assessment and meeting eligibility criteria such as undergoing detoxification.

- **Continuum of Competency Development**: The pre-entry stage comprises no focus on competency development.

- **Continuum of Social Connection**: The pre-entry stage involves the prospective client commencing a process of reduction in social connection, due to the aim of moving into a residential campus and especially if they have to spend 4-10 days in inpatient detoxification (where little social contact is likely).

- **Continuum of Community Contribution**: At the stage of the client preparing to enter rehabilitation, most people are not likely to be participating in any contribution to the wider community. The main focus is on their problems, and getting into rehab.
## Pre-Entry

<table>
<thead>
<tr>
<th>Knowledge of the programme and application for entry:</th>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is important that examination take place of existing documentation and information available in the public domain for prospective clients, potential referral sources, and professional in the field. Information about the rehabilitation programme should be extensively distributed.</td>
<td>- What is the main source of information external to the campus in which people are informed about the programme and organisation?</td>
</tr>
<tr>
<td>- This information should be in a relevant and easily accessible format, and should contain details of the following: admission/eligibility criteria, goals and aims, campus life, and treatment/therapeutic activities.</td>
<td>- Is there a waiting list to enter the programme? If so, what is being done to reduce the waiting time for prospective clients?</td>
</tr>
<tr>
<td>- Prospective clients who may experience barriers to application should receive support in this regard, e.g. literacy considerations and forms.</td>
<td>- What referral or support is available to client applicants in the intermediate time between initial application and programme entry?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-entry eligibility assessment:</th>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach workers conduct the pre-entry eligibility assessment to determine appropriateness of referral into the residential programme. Also, it is important that the prospective client is able to have any questions or concerns about entering the residential programme addressed.</td>
<td>- Is there anything further that can be done to enhance the pre-entry eligibility assessment?</td>
</tr>
<tr>
<td>In cases where the person is not accepted entry into the residential programme, clear protocols and referrals should be in place. The aim of this is so the person is still able to access support in handling issues stemming from their substance use, but more appropriate services providers or methods of intervention are offered and used as alternatives to residential rehabilitation.</td>
<td>- Are there any areas/parts of the assessment that are not useful that could be removed?</td>
</tr>
<tr>
<td>- Are there any areas of information that are not currently being assessed during this stage that perhaps should be?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Detoxification:</th>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioners involved pre-entry assist the client in choosing the most appropriate option for detox prior to programme entry:</td>
<td>- Has the client properly detoxed yet?</td>
</tr>
<tr>
<td>- Inpatient: see Alcohol and Drug Service for nearest facility.</td>
<td>- What is their level of toxicity and/or dependency?</td>
</tr>
<tr>
<td>- Outpatient: receive guidance from a medical practitioner.</td>
<td>- What period of time are they facing to be able to access inpatient detox?</td>
</tr>
<tr>
<td>- Home: the client is able to personally manage their withdrawal and detoxification at home.</td>
<td>- What period of time is recommended for the client’s detoxification?</td>
</tr>
</tbody>
</table>
Stage 2 – Entry and Orientation:
first 48 hours

- **Continuum of Assessment:** Assessment in this stage takes on a very practical nature and is not required to be extensive (that type of assessment occurs in the next stage). For example, the person may require an assessment of detoxification, and a breathalyser or drug screening test may be administered to ensure the person has properly detoxed. Within the first 48 hours, the client should undergo a medical health assessment by a general practitioner. Also, the person needs to be assessed for suitability for different parts of campus life (i.e. whether there are any personal characteristics that might impact on their capability or involvement in a certain aspects of daily routine). They need to be assigned accommodation and move into their new room, with practitioners having established that any prospective room mates are well matched and appropriate.

- **Continuum of Therapeutic Support:** Little or no therapeutic support (from programme practitioners) takes place in this stage. These 48 hours are like a hand-over transitional stage between having been outside to moving into the residential programme. Therapeutic support is available if the client feels overwhelmed or upset about the process of change, but no interventions take place in this stage.

- **Continuum of Individual Agency:** The entry and orientation stage involves little exertion of individual agency. The client is, with their permission, subject to the procedures and protocols of entering the residential campus. Most activities in this period of 48 hours are lead by practitioners, and the client is required to comply and adjust to the changes.

- **Continuum of Competency Development:** The entry and orientation stage comprises no focus on competency development.

- **Continuum of Social Connection:** The entry and orientation stage involves little social connection on a deep level. However, in the first 48 hours, the client is introduced to a variety of new support people and fellow residents, so brand new social connections are made as the client moves onto the campus.

- **Continuum of Community Contribution:** At the stage of the client entering rehabilitation, there is no focus yet on community contribution. To avoid overwhelming the individual in the process of change, this 48 hour window is used to simply orientate the person to campus life. They are not required to do any duties or attend therapeutic activities during this time.
## Entry and Orientation

### Arrival at residential campus:
- Admission ‘days’ where new clients enter the residential programme occur on two specific week days.
- Upon arrival, security assessment and check for contraband, e.g. bag search and body search, hand over mobile phone etc.
- Where required, breathalyser or drug screening tests conducted.
- Introduction and formal agreement to rules and regulations governing campus life, as signified by the written or verbal agreement.
- Room allocation in same-gender accommodation, meet room-mates.

### Questions:
- What can be done to make the client comfortable in their new surroundings?
- How respectful can we make the security procedures, especially given the vulnerability of many clients to things such as searches?
- How are the key principles of therapeutic communities to be conveyed at this stage?

### Entry procedures for first 24-48 hours on campus:
- Medical assessment by a General Practitioner.
- Allocation of and introduction to case worker.
- Campus tour and orientation.
- Negotiation of administrative financial details, payment of board, and Centrelink arrangements.
- Organisation of pharmacotherapy and medication arrangements.
- Formal introduction to rehabilitation structure: arrangement of daily schedule and timetable, including details of when and where therapeutic activities, duties and rosters, and work therapy occurs.
- Communication and agreement on confidentiality protocols and signing of release of information forms.

### Questions:
- How are the guidelines that underpin client and staff, client and client, and staff and staff relationships to be conveyed?
- What media will be used to explain the rehabilitation site and structure (e.g., maps, pamphlets, cartoons)?
- Is there adequate signage and notice boards that can guide clients and staff (especially volunteers) to various areas on campus?
Stage 3 – Assessment and Case Planning:
first week

- **Continuum of Assessment:** Stage 3 is the most significant period of client assessment, where a series of appointments should ascertain the past history, current condition, and future capacity of the client. Thorough assessment is necessary in the following areas: biopsychosocial assessment, assessment of risk and vulnerability, and assessment of strengths, skills, and potential. Detail is crucial because this assessment stage influences each of the following stages. Accredited and evidence-based diagnostic tools or tests should be used for a comprehensive biopsychosocial assessment and also risk and vulnerability assessment. Qualitative open-ended questions and motivational interviewing may be more beneficial in terms of gaining information not covered by tests and for ascertaining qualitative information such as the client’s strengths, future aspirations and goals. Assessment for vocational suitability and personal development and skills training may also be beneficial to conduct, where required, during this stage.

- **Continuum of Therapeutic Support:** Practitioner input is focused around assisting the client to reflect on their past (where they have come from), the present (where they are now), and their desired future (where they want to go). Establishment of rapport and a safe and trusted environment for open and realistic reflection is imperative. In the process of goal-setting and planning for a desired positive future, the practitioner should assist the client to set realistic and achievable goals. The first therapeutic session is likely to be conducted during the time period of stage 3, and case planning is a key task within appointments during this week. It is important to discover the client’s level and nature of motivation and readiness for change. Therapeutic practitioners need to undertake role clarification and communicate the nature of their professional assistance and therapeutic relationship with the client.

- **Continuum of Individual Agency:** The client is able to exert moderate individual agency during this stage. A high level of voluntary client participation is required for detailed assessment and case planning to occur. The client is encouraged to communicate in detail regarding their aspirations and goals, and they should be encouraged to be active in decision-making about what they want to do with their future.

- **Continuum of Competency Development:** During this stage, existing client competencies and strengths are assessed and personal insight is promoted in preparation for development in this area.

- **Continuum of Social Connection:** During the first week, the client is adjusting to life in the residential campus, and should be encouraged to foster positive social ties with fellow clients and staff.

- **Continuum of Community Contribution:** During the first week, the client will be commencing contribution to the therapeutic community and campus life, but is not yet at the stage to widen this to the outside community.
### Assessment and Case Planning

#### Formal comprehensive assessment:
Conduct a formal assessment using evidence-based assessment tools.
- Biopsychosocial assessment conducted using appropriate tests.
- Medical assessment by general practitioner may be able to inform assessment of specialist health considerations and physical wellbeing. Establish whether there are any health considerations that will impact on the client’s engagement in campus activities and life, e.g. arthritis or chronic fatigue and participation in sport or work therapy.
- Qualitative interviewing may be beneficial in order to ascertain the client’s background and life history, and any factors within this that may be influential or key in their rehabilitation and programme engagement.

#### Assessment of risk, vulnerability and support needs:
There is evidence-based assessment tools that can be utilised to ascertain the risks and vulnerabilities associated with an individual client.
- If appropriate, assess the client’s level of criminogenic need and associated risk factors.
- Establish whether the client is currently or is likely to be a multiple service user. Link them into services as appropriate to their complexity of need.

Risk factors could include things that are directly and obviously related to substance use and relapse, and they could also include other areas or facets of life that indirectly relate to substance use. For example, diverse things such as responses to personal dissatisfaction and depression; social connection, popularity and personal identity derived communal participation in drug taking; or pain, conflict and trauma triggering relapse as an avoidant coping mechanism could be risks associated with substance use.

When conducting this assessment, practitioners should be mindful that the elements of risk and vulnerability only form *some* pieces to the puzzle. It is a form of knowledge that is necessary as a means to an end – achieving a positive fulfilling life (i.e. one that is not dominated by vulnerability, deficit and relapse). Therefore, the assessment of risk is one part of understanding the person holistically, and it is important to seamlessly move to the next part of assessment (strengths and capacity) because they go hand in hand and are more beneficial when understood together.

#### Questions:
- What information is already known from the eligibility pre-assessment?
- What level of training has been provided to practitioners conducting assessments?
- What quality assurance is in place to ensure thorough and effective assessment is occurring for a diversity of clients?
- Is there adequate expertise to match the assessed needs?
- How does the client make sense of their areas of risk and vulnerability? What are their thoughts pertaining to this? What changes need to take place to promote progress and thus successful risk management?
- What amount of focus emphasis is being placed upon risk and vulnerability? Is this stage viewed as an exercise in problem solving and overcoming barriers?
- What can be learned from past behaviour that can contribute to an estimate of risk?
- How can knowledge of risk and barriers contribute to planning for positive lifestyle choices free from these things?
- Is there anything that suggests there may be safety and security issues associated with the client and/or their interaction with others on campus (both staff and clients)?
### Strengths assessment: skills, capabilities, capacity and potential

For individuals who lack personal insight and future orientation, and are not used to engaging in self-analysis and planning, this may be a difficult exercise.

To encourage the pursuit of a fulfilling life of goal achievement, it is important for the client and practitioner to, together, examine the following:

- Personal strengths, talents, interests, capabilities [individual strengths]
- Available resources and capacity [external practical resources]
- Context of client’s life and networks [social network, external supports]
- Motivation, hopefulness, future orientation [positive reasoning]
- Goals for development and self-realisation [planning for change]
- Decision-making and autonomy [preparation for independence]
- Changed sense of self [internal and external realisation]

Furthermore, there are basic elements of strengths development:

- Identifying strengths and interests (to enable the lifestyle desired)
- Developing personal skills, competencies and capacity
- Analysing and bolstering motivation and self-esteem
- Identifying and increasing available practical resources
- Building social networks (networks of care, meaningful relationships)
- Achieving the positive goals through the use of appropriate methods

### Questions:

- What key strengths and capabilities does the client have?
- What positive achievements is the client seeking?
- What have they achieved in the past?
- How do they plan to achieve these goals?
- What are the most significant areas of opportunity and potential? Where in the client’s life are these evident? How can growth and self-realisation in these areas be fostered during the course of their rehabilitation?
- Where appropriate, are wider community and familial supports engaged as a regular part of case planning and empowering the client for positive change?

### Case planning and goal formulation:

As this is the assessment stage, it should be known if the client is a multiple service user. Connection and integration of care with existing and new services is important. The practitioner will need to find out the extent of collaboration and partnership that may be necessary. This will involve sorting out what other agencies and workers they will work with, and how any collaboration is to be managed at a day-to-day level.

Client involvement and self-advocacy is important in case planning, and should be an integral part of the planning process. Negotiation and discussion is central to this.

- Base case planning around information gained from assessment.
- Discover what goals the client seeks to achieve in life.
- Are these goals appropriate, realistic and achievable for the client?

### Questions:

- How many other services is the client already connected with? What implications does this have for case planning if other case workers are involved?
- What knowledge of and contacts with external agencies and other practitioners does the service have, and is this regularly shared among staff?
- How is the active involvement of the client encouraged in case planning and goal formulation?
- Establish how they plan on attaining these goals. Help them to plan the trajectory they wish their life to take during their rehabilitation.
Figure 3: Essential Knowledge

**Detoxification**
- Has the client properly detoxed yet? What is their level of toxicity and/or dependency?
  - No
    - Choose most appropriate option for detox, make referral.
    - Inpatient: see Alcohol and Drug Service for nearest facility.
    - Outpatient: receive guidance from medical practitioner.
    - Home: able to personally manage withdrawal at home.
  - Yes

**Drug History**
- What is the client’s alcohol and other drug history?
  - What type of substance use? Licit and illicit categories.
  - Single or polydrug use? What is the principal drug of concern?
  - What is their dependency and frequency of use?
  - What period of time has elapsed since uptake?
  - What symptoms or side effects does the individual experience?
  - What is the social context of their substance use?
  - How many prior attempts have been made at cessation or reduction? What happened?

**Pharmacotherapy**
- Do they want it? Is it an appropriate substitution option?
  - No
  - Is there a place available in the pharmacotherapy program?
    - No
    - What primary health care partnerships are in place to oversee the dispensation of it?
    - What are the protocols for the medication regime for the individual client?
    - What monitoring occurs to prevent/detect any misuse or non-compliance?
    - What dosage is the client receiving? What strategies or options are available should the client wish to decrease their use of or dependence on it?
  - Yes

**Co-morbidity**
- Are there any psychiatric issues? What is the client’s dual or multiple diagnoses?
  - Personality Disorder
  - Mental Illness
  - Intellectual Disability or ABI
  - What treatment partnership supports are in place with which practitioners and agencies?
  - What level of awareness does the client’s AOD case worker have of his/her symptoms?
  - What is the nexus or relationship between the co-occurring disorders? What complexities does this raise for treatment in both areas?
  - What specific tailoring made considerations or interventions are required to maximise progress and recovery?
  - How is the individual with dual or multiple diagnoses being seen and treated holistically? (integrated care and overall wellbeing)
Figure 3 (continued)

**Gender & Sexuality**
- Are there any gender specific or sexual orientation/preference considerations?
  - No
  - Yes
  - What is the current gender balance of the residents?
  - Are there any considerations relating to sexual orientation?
  - Is there anything about the residential context that will affect the individual client?
  - What is the code of conduct relating to sexual activity? What are the protocols for addressing non-compliance?
  - Are there any issues relating to gender identification (e.g. transgender)? How will their identity be supported within the context of same-gender accommodation?

**Parental Status & Family**
- Are there any parental or family needs or considerations requiring support or planning?
  - What is their parental status? What level of child custody?
  - What type of family unit is the client a part of?
  - Are they a victim or perpetrator of domestic violence?
  - Which family members play what role in supporting the client at this present time?
  - How many family members also engage in substance use? Is it something that they took up because a partner or other family member was doing it? Was it a communal activity?

**Age**
- Life stage and development across the lifespan.
  - What age specific considerations are there?
  - What are the individual’s developmental needs?
  - What educational or learning history do they have?
  - What were their life experiences prior and leading up to substance use?

**Minority Groups & Special Populations**
- Individual differences and characteristics, affinity with / membership of specific groups
  - Examples: ethnicity, migration and refugee status, indigenous, and culturally and linguistically diverse groups (CALD); faith and spirituality; offenders and victims of crime; varying socio-economic backgrounds; specific sub-cultural groups e.g. Emo’s or goths.
  - What differences or characteristics does the individual client possess?
  - Are there any specialist health considerations? Examples: hepatitis C & AIDS status, diabetes, pregnancy, disability or chronic health issues.
  - In light of the organisation and programme being faith-based/Christian, what spiritual supports can be put in place for the client? (i.e. accommodating all religions and beliefs)
  - How are the following demonstrated and developed? Acceptance, tolerance, respect, openness, celebration of diversity
Stage 4 – Service Engagement:

programme duration

- **Continuum of Assessment:** Stage 4 involves ongoing informal and formal assessment or re-assessment to coincide with programme participation and client progress. This should be a fluid and reflexive process.

- **Continuum of Therapeutic Support:** This is the most intensive and important stage of therapeutic support. Therapeutic interventions should be adapted to the individual needs of the client. During the programme duration, the practitioner assists the client in achieving the progress and goals set out in their case plan.

- **Continuum of Individual Agency:** The client is able to exert moderate individual agency during this stage. A high level of voluntary client participation is required for service engagement in the programme. The client should be encouraged to participate and guide individual decision making and problem solving wherever possible. Stage 4 is an active process of embarking on personal change to aid the achievement of goals and their desired future. Self-realisation should be aided through therapeutic interventions.

- **Continuum of Competency Development:** During this stage, existing client competencies and strengths are developed through programme activities such as work therapy, the various types of skills training, and strengths discovery and empowerment. Service engagement is one of the most significant stages for enhancing the personal capacity and skills of the client, and this should be done in a multi-faceted way.

- **Continuum of Social Connection:** During this period, the client is continuing to deepen and develop social connection with fellow clients and staff. However, positive social connections and relationships should be encouraged as the client is allowed leave of the campus and participation in the external community.

- **Continuum of Community Contribution:** Stage 4 should involve contribution to the therapeutic community as well as the wider community. Both individual clients and teams of clients should be encouraged to engage in voluntary work and meaningful community contribution. This should foster the client’s self-esteem, use their skills and accentuate their strengths, and heighten positive perceptions of value of programme clients amongst the wider community. If appropriate, positive publicity and recognition should be sought when individual clients or teams of clients undertaking a significant contribution to the wider community.
## Service Engagement

### Therapeutic interventions and programme activities:
It is important to establish the most appropriate and effective therapeutic intervention methods in relation to the client’s specific drug use (see Appendix 1). What works for a young party drug user will be different to what effectively rehabsilites an older alcoholic. However, there are some therapeutic activities that are generally beneficial and can be tailored to individual need or context. Practitioner discretion is imperative.
- Individual and group counselling
- Cognitive behavioural therapy
- Anger management, conflict resolution and coping skills training
- Relapse prevention training
- Psychosocial education and drug and alcohol information
- Life skills training
- Active problem solving, goal setting and decision-making
- Strengths discovery and personal capacity development

### Balance of harm minimisation with abstinence:
Attempts should be made to balance the requirement of abstinence with the concept of ‘abstinence eventually’, the reality of relapse and adoption of harm minimisation principles. In other words, it is important to balance rules (drug free campus) with responsibility (duty of care to client wellbeing until achieving sustained abstinence).
- The client should be able to regularly access to specialist health support services such as TasCAHRD so they are able to receive professional support for their substance use and health related issues.
- Each client should engage in relapse prevention training and, in the case of relapse, be supported to maintain sustained abstinence as part of their rehabilitation.
- However, it is important to ensure that the harm minimisation information is targeted in terms of relevance. It is not beneficial to adopt a one-size-fits-all approach. For example, if a young person is not yet familiar with all of the methods and harms associated with different drug use (i.e. types other than the ones they’ve used), it may not help to show them how to do it if they have not considered this type of use before.

### Questions:
- Do the therapeutic interventions chosen match the evidence base for effectiveness for type of drug user?
- In relation to therapeutic interventions and activities, how much focus is placed upon substance use and associated personal problems of the past? How are these problems conceptualised?
- How is capacity development and skills enhancement encompassed within the daily workings in this period? How are the client’s strengths maximised?
- How well trained in therapeutic interventions are practitioners?
### Court mandated diversion clients:

This group of clients have additional specific considerations and protocols that accompany their service engagement in residential rehabilitation.

- Establish the conditions and stipulations of the client’s bail or drug treatment order reporting requirements.
- Clarify with the client the role and obligations of the practitioner in regards to knowledge of non-compliance and reporting, i.e., “if you tell me about any criminal offending or transgression of court orders, I am required to report you to your probation officer and/or the drug court.”

Practitioner assistance or input may be required in the form of getting the client to review/update hearings of their case in the drug court, or writing court reports or submissions about the client.

### Questions:

- What are the communication and liaison protocols for each CMD client with external practitioners (probation officer) and agencies and bodies (e.g. Drug Court)?
- How is confidentiality to be defined or interpreted in the case of CMD clients?
- What obligations does the service provider have to the Court? The client? The service?

### Recreation, leisure and sport:

Recreation, sport and leisure activities provide a relaxing outlet and can be differentiated from the intensity of therapeutic engagement. They have therapeutic value within themselves. A variety of options reflecting different areas of interest should be present on campus, and time should be scheduled into the routine of each week for participation in these types of activities. Options that involve both individual and team participation are valuable.

### Questions:

- In the case of clients that may not have previously engaged in healthy recreational or leisure activities, what is done to encourage engagement with recreational activities on campus?
- What skill development and training can be offered in relation to recreational and sporting activities?

### Work therapy and duties

Work therapy that is highly beneficial to the community (residential campus and the outside community) will promote increased levels of self-esteem and citizenship-like contribution. Roles should instil a sense of usefulness and capability, as well as be a practical demonstration of functional productive behaviour.

Where appropriate within the area of work and duties, group experiences and team work may enhance cohesion amongst the client group. Team work also raises the opportunity for specific clients to take leadership roles, while facilitating the team to engage in decision making and cooperation.

### Questions:

- How is work allocated in light of client skill sets and interests?
- Are there any facets of work that clients may find menial or uninteresting?
- How are clients within the programme encouraged to participate in work that is meaningful to them and also contributes to others?
<table>
<thead>
<tr>
<th>Avenues of communication (i.e. telephone, internet access):</th>
<th>Questions:</th>
</tr>
</thead>
</table>
| Access to communication with the outside community can become complex when there are general rules for all clients, but also client specific circumstances that may arise. Generally speaking, the crescendo approach may work best, with the moderate limitation of communication upon entry and adjustment to residential life and increasing privileges and external contact throughout the rehabilitation programme. | • Are there clear protocols or sanctions in place for client abuses of avenues of communication? How is this monitored or known? What implications does this have for client privacy?  
• Where do family considerations fit into the communications protocols? |
Stage 5 – Exit Preparation and Transition:
last four to six weeks

- **Continuum of Assessment:** Stage 5 is an important stage of re-assessment. Case plans, expectations, goals and targets should be examined in light of client progress made during the programme and realistic ability to meet these expectations in the future.

- **Continuum of Therapeutic Support:** In stage 5, the intensity and level of therapeutic support is lessening, in line with increased independence and preparation for leaving. Future orientation and realisation of potential should be encouraged to empower the client to engage in positive change once outside the therapeutic community. Transitional handover of the client’s case should take place with outreach workers, and the practitioner should also identify any referrals necessary to continue support of the client in the community.

- **Continuum of Individual Agency:** The client’s level of independence and individual agency markedly increases during this stage, in preparation for a transitional exit of the programme. The practitioner should assist the client to actively take hold of their own rehabilitation (i.e. have a low level of dependency on practitioners).

- **Continuum of Competency Development:** During this stage, existing client competencies and strengths are re-assessed and personal insight is promoted in preparation for further development in this area.

- **Continuum of Social Connection:** Fostering positive social connections external to the residential community and identifying networks of care and support in the wider community is an important task in stage 5. The client should be actively re-establishing contact with people who they have a positive relationship with, as well as making new friendships through involvement in social and recreational groups that match the client’s interests. The client is decreasing their connection with members of the residential community as they prepare to leave; however, it is likely friendships will be maintained.

- **Continuum of Community Contribution:** In exit preparation, the client should be encouraged to identify areas where they could make a positive contribution to the lives of others. Voluntary work and active citizenship and community participation should be encouraged as part of a positive lifestyle.
## Exit Preparation and Transition

### Exit planning and preparation for independence:

All those involved with the client’s preparation and transition (multiple staff and the client themselves) should be actively collaborating in the exit planning process. Independence should increase during this stage.

- Reassess client goals in light of progress made thus far and, where necessary, readjust any expectations, goals or plans.
- Assist the client in the logistics of exit planning, e.g., housing, employment.
- Promote client agency in decision-making and planning. Design a support plan, including specific goals and targets.

### Fostering positive external social connections and ‘networks’ of care:

The practitioner should assist the client in assessing their past social connections and external context and environment in which they live. The client should be encouraged to recognise any social connections or contexts that could be a source of relapse vulnerability or negative outcome in their life. After this is done, the main focus is upon fostering positive social connections and networks of care and support for the client to transition into when exiting the residential component of the programme. Support people who are trustworthy and likely to encourage ongoing personal growth should be identified and connected with. Connecting with recreational and social groups may provide both a forum for positive social connection as well as further development of strengths upon re-entry to the wider community.

### Referrals and hand-over to external support:

The client should be actively involved in recognising areas where they may need further support in the community, and they should agree to any referrals made to external services. Practitioners need to engage in a thorough process of hand-over of each client case to ensure the continuum of care is maintained. Organisational policy and protocols should be in place to guide this process, and individualised and adapted in the case of each client.

### Programme completion and graduation celebration:

Celebration of progress and programme completion is an important element of life in a drug and alcohol therapeutic community. Meaningful ceremonies add joy and commendation of success. Family and friends should be involved, and recognition should be formalised (certificates, awards etc.).

### Questions:

- What protocols are in place to address situations in which a client misuses or abuses increased independence (e.g., during longer stays off campus and reconnection into the community, they relapse, or there is non-compliance with rules)?
- Who is the client likely to interact with upon return to the wider community?
- Does the client have any interest in joining any social and recreational groups? Are there any they could be referred to that would form positive social networks and skills development?
- What monitoring of this occurs?
- What information is relayed in the process of referral and hand-over to external support?
- What rituals and protocols ought to guide the hand-over process?
- How could the existing processes and events marking programme completion/graduation be enhanced?
Stage 6 – Exit and Post-Care:
exit and six month outreach period

- **Continuum of Assessment:** Little assessment is required during this stage. Outreach workers should informally assess the ongoing wellbeing and progress of the client, but the level of practitioner intervention is reduced upon programme exit.

- **Continuum of Therapeutic Support:** Little practitioner intervention occurs during this stage. Outreach workers are available to help if the client is experiencing difficulty or needs support in overcoming challenges in the community. Post-care should involve identification of and referral to any necessary services to ensure the continuum of care is consistent across the six month outreach period. However, the majority of therapeutic support ceases upon exit of the residential programme.

- **Continuum of Individual Agency:** Stage 6 signifies the highest level of individual agency and independence because the client is embarking on life after the programme in the community. Self-determination and self-control should be promoted to ensure maintenance of progress gained from rehabilitation and lasting change. Outreach workers should monitor client progress.

- **Continuum of Competency Development:** Ongoing competency development and utilisation of personal strengths and skills should be encouraged. Competency development is particularly important in the area of employment/unemployment. If the client is interested in education or vocational and professional development, they should be assisted to pursue positive educational and career paths. Referral to employment consultancy agencies may be of assistance to the client.

- **Continuum of Social Connection:** Positive social relationships are the main goal of stage 6. Participation in networks of care and social and recreational groups should foster meaningful social connection in the client’s life.

- **Continuum of Community Contribution:** In tandem with the continuum of competency development, community contribution should be encouraged as a positive outlet. Personal strengths, interests and capabilities may be utilised in a diversity of roles or projects – it is up to the client to determine the nature and extent to which this occurs. Community contribution as a lifestyle choice will foster self-esteem and positive social recognition in the wider community.
### Exit and Post-Care

**Outreach support in the community:**

The six months after leaving the residential programme present a positive opportunity for outreach workers to maximise the integration of the client into the community. A relationship of trust, openness and accountability is required. This is a time where the client transitions from low dependency to no dependency because they have been assisted achieve self-realisation and live a healthy and functional life.

- Monitor the client’s progress and achievement of goals and targets upon re-entry into the community.
- It is the task of outreach workers to regularly reassess the client’s support plan. If progress is not made, it is the task of the outreach worker to assist the client in effectively using available resources and support networks to work past any barriers or obstacles.
- Where there are still multiple areas of support need, the outreach worker should seek to actively engage the appropriate type and level of services to best support the client in the community.
- Examine ongoing competency development and where possible, meaningful community contribution. Encourage the client to take on roles that contribute to the lives of others as well as enriching their own.

**Questions:**

- Upon achieving long-term sustained abstinence, is there any opportunity for the person (if desired) to return to the campus to participate in peer mentoring initiatives?
- Did the outreach worker have a connection with the client before leaving the site?

---

<table>
<thead>
<tr>
<th>Client Evaluation and Feedback:</th>
</tr>
</thead>
</table>

An exit survey evaluating the client’s perceptions of the programme and its value should be conducted to incorporate client feedback into overall evaluation. The exit survey should cover topics that are key areas of agency operation and are benchmarked. The feedback should be incorporated into service development and planning.

**Questions:**

- What type and how much client feedback is sought?
- Can the client be confident that their views will be heard, and that they will have some impact?
Clients and Agencies:

Clusters of Need and Clusters of Expertise

Figure 3 provides a basic illustration of client clusters of need. The clusters of need represent areas where the individual client may require support. Accompanying this are the representative clusters of expertise present in various community and government services and agencies.

Examples stemming from the outer parts of the circle signify issues that are stand alone and simply apply to that area. For example, an older client may have arthritis, which falls within the health and wellbeing cluster of need. This is a medical condition, and the suggested solution is referral to a general practitioner who can monitor and help the person with that condition. However, there is no need for the client’s case worker from the rehabilitation programme to be involved in this or participate in collaboration. This only one example of a basic issue; different circumstances or characteristics will arise from each cluster of need.

However, examples stemming from the inner parts of the circle signify issues that are intertwined with other clusters of need (see examples in the Figure). If the client needs to engage with multiple services, then integration of care of clusters of expertise need to match the clusters of need, i.e. if there is a cross-over or relationship between the issues, then collaboration is required between the services/practitioners involved. This form of collaboration avoids duplication between services, and is oriented towards the needs of the client (i.e. not agency driven factors). Thus, the illustration implies prioritisation of high risk or complex cases, and matching of resources and intervention to level of need.
Figure 4: Clusters of Need and Clusters of Expertise
The Agency: Service Provision Processes and Protocols

Agency Issues

At the agency operational level, five areas of service provision are discussed:

1. Agency Mission and Service Culture
2. The Physical Setting
3. Personnel and Resources
4. Agency Processes and Protocols
5. Benchmarks and Evaluation

As demonstrated by the diagram below, the agency mission and service culture is central to all aspects of the operations of the programme.
Figure 5: A Dynamic Community Model of Interaction

**Clients**
Client Profile - Diversity

- Individual Differences:
  - Personality
  - Age and Developmental Life Stage
  - Gender and Sexuality
  - Family Unit and Parental Status
  - Health Status and Wellbeing
  - Ethnicity and Cultural Heritage
  - Offender and Criminogenic History
  - Employment and Education
  - Financial and Socio-Economic Status
  - Spirituality and Worldview
  - Recreation and Creative Interests
  - Personal Life Experiences

**Substance Use History:**
- Single or Polydrug Use (Legal / Illicit)
- Principal Drug of Concern
- Drug Type and Side Effects, Harm
- Period of Use, Nature of Use
- Toxicity, Dependency and Addiction
- Social Context of Substance Use
- Readiness for Rehabilitation

**Therapeutic Community Principles of Practice**
Dynamic Engagement in Diversity

- Dignity & Respect
- Fairness
- Difference
- Empowerment
- Safety & Wellbeing
- Confidentiality
- Multi-tasking
- Collaboration
- Accountability
- Integrity

**Staff**
Staff Profile - Diversity

- Individual Differences:
  - Personality
  - Age and Developmental Life Stage
  - Gender and Sexuality
  - Health Status and Wellbeing
  - Personal Life Experiences

**Job Related Characteristics:**
- TAFE or University Qualifications
- Professional Development
- On the Job Training
- Length and Nature of Experience
- Skill Set and Professional Discipline
- Work Role and Job Description
- Nature of Contact with Clients
- Available Job-related Resources
- Level of Supervision and Support
- Positional Context within Staff Team
- Work Environment / Work Space
- Policy and Legal Obligations
- Level of Independence and Flexibility
- Salary and Remuneration
Agency Mission and Service Culture

Key principles

There are ten areas represented in the key principles of practice that guide the model:

- Dignity and Respect
- Fairness
- Difference
- Empowerment
- Safety and Wellbeing
- Confidentiality
- Multi-tasking
- Collaboration
- Accountability
- Integrity

These principles apply to both clients and staff, and should influence all areas of service provision and practice within the residential rehabilitation programme. The ten principles above embody the five mission values of the Salvation Army: human dignity, justice, hope, compassion, and community. The way in which these principles promote diversity and apply to client-to-client relationships, staff-to-staff relationships, and client-staff relationships is illustrated in Figure 4. Also, the application of these principles can be extended further to encompass the way in which liaison and collaboration is conducted with external professionals, agencies, families, and community members and groups. There is a diversity of application of the principles to circumstances that may arise in the operation of the residential programme.

Client Scenario 1: Client with complex and multiple needs

The client is a 28 year old male who has been referred to the residential rehabilitation programme through the Court Mandated Diversion and the drug court. The current charges are all in the category of theft – stealing that was done to support his drug habit. He has a significant criminal background, mainly minor crimes but a few of which are assault charges. For one assault of a more significant nature, the man spent six months in prison. As a teenager, he started out on ‘softer’ drugs like alcohol and marijuana, but has been an injecting drug user since uptake in his early twenties. Due to occasional use of contaminated needles, he contracted the hepatitis C virus. He is the father of two young children, but his ex-girlfriend has custody of them. He is allowed to see the children through fortnightly arranged visits with child protection services. The man is unemployed and receives a Centrelink allowance. He has a probation officer who is involved in his case in the drug court. He is a current client of a non-government agency in two areas: (1) as a
client of their financial service to try and reduce debt incurred from past drug-related financial mismanagement, and (2) as a client of their men’s support service. The client has several complex issues, and will be required to multi-task during their service engagement to overcome barriers to progress in the different areas of need.

- What is the role of the client’s probation officer during his participation in the residential programme? What information sharing protocols and reporting requirements are involved?
- What liaison and collaboration is required between the residential rehab drug service and the other non-government agency to support this client in an integrated way? How is the principle of confidentiality best utilised to ensure information sharing that is beneficial for all parties involved, but does not overstep client or agency privacy boundaries?
- How can this client be empowered to multi-task on working on the issues at hand? How can their strengths and positive abilities be developed and better utilised from this point on?

Client Scenario 2: Client with specific individual characteristics

The client is 19 year old female who has entered residential rehabilitation to address issues stemming from her use of methamphetamines (specifically party drugs). She has a six month old baby boy in her care. The young woman has little knowledge or understanding of being a good parent because her life has been marked by disruption and unhealthy lifestyle habits. However, she loves her baby and does not want to release him into the care of others at the present time. She has not undertaken any vocational or educational training post-high school, and is not really sure what she would like to do with her life.

- What considerations need to be made for both the mother and baby in regards to rehabilitation?
- Is there a youth health service available that could provide relevant support in light of her age and developmental life stage?
- How does the client, as a methamphetamine user, differ from people who use other drug types? What therapeutic interventions have proven to be most effective with this specific population of users (especially in light of the fact that she is young)? Are there any elements of the programme that are not likely to be effective for this specific type of user?
- How can practitioners assist this client be empowered to engage in strengths discovery and skills training?
## Agency Mission and Service Culture

<table>
<thead>
<tr>
<th><strong>Principles and philosophy of care:</strong></th>
<th><strong>Questions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be a set of principles and values that represent the agency’s philosophy of care, and these should be clearly communicated to all staff and clients. A list of these should be visible in a client-accessible space on campus. The principles of care should be inclusive and community oriented as well as promote diversity.</td>
<td><strong>• What are the core values of the programme? How are these reflected in practice?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dynamics of community engagement</strong></th>
<th><strong>Questions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating each person with respect and dignity is part of the guiding principles for social interaction. This is regardless of circumstance or context, and applies to all staff as well as all clients.</td>
<td><strong>• Does everyone know and understand the guidelines for social interaction?</strong>&lt;br&gt;<strong>• What policies are in place to deal with issues such as bullying?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Collaboration and integration of service:</strong></th>
<th><strong>Questions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To enhance effective collaboration, the following elements should be enacted and developed in the partnership process:</td>
<td><strong>• Which agencies does the programme have partnership agreements with? How are these formalised and communicated to practitioners in both agencies?</strong></td>
</tr>
<tr>
<td>• partnership agreement detailing mutually beneficial desired outcomes</td>
<td><strong>• How are the partner agencies different (e.g. goals, perspective, approach to case management, organisational framework)? How will this affect the partnership?</strong></td>
</tr>
<tr>
<td>• role clarification (who does what, and how) and joint commitment</td>
<td><strong>• What are the mutually agreed upon goals and aims of the partnership?</strong></td>
</tr>
<tr>
<td>• integration of assessment protocols that are relevant to both partners</td>
<td><strong>• Are there any areas of fragmentation or communication breakdown? How can these deficits in collaboration be overcome?</strong></td>
</tr>
<tr>
<td>• delineation of clear information sharing and confidentiality protocols</td>
<td><strong>• What is the agency’s working relationship and level of collaboration with the ATDC?</strong></td>
</tr>
<tr>
<td>• coordination of planning and integrated case management and conferencing, agreement on role of ‘lead’ worker and/or agency</td>
<td></td>
</tr>
<tr>
<td>• definition of legal and policy frameworks from both partners</td>
<td></td>
</tr>
<tr>
<td>• identification and allocation of resources and possible joint budgets</td>
<td></td>
</tr>
<tr>
<td>• establishment of power-sharing and accountability measures</td>
<td></td>
</tr>
<tr>
<td>• regularity of liaison, communication and discussion forums</td>
<td></td>
</tr>
<tr>
<td>• agreed methods for handling conflict resolution and difference of perspective, willingness to negotiate, mutual trust and flexibility</td>
<td></td>
</tr>
<tr>
<td>• implementation of modes of evaluation and monitoring</td>
<td></td>
</tr>
</tbody>
</table>

In addition to inter-agency collaboration, there needs to be a strong working relationship in place with the NGO representative body the Alcohol, Tobacco and other Drugs Council of Tasmania (ATDC).
<table>
<thead>
<tr>
<th>Effective approaches to case management:</th>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Role clarification</td>
<td>• Is reflexive research and development conducted regarding case management? With what regularity and level of consultation is this area of practice being developed?</td>
</tr>
<tr>
<td>• Flexibility and individualisation</td>
<td></td>
</tr>
<tr>
<td>• Modelling and affirming pro-social values and actions, optimism that promotes hope and positive expectation</td>
<td></td>
</tr>
<tr>
<td>• Collaborative problem-solving</td>
<td></td>
</tr>
<tr>
<td>• Empathy and reflective listening</td>
<td></td>
</tr>
<tr>
<td>The Physical Setting</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Architecture, design and layout:</strong></td>
<td></td>
</tr>
<tr>
<td>The architecture, design and layout form key elements of the physical setting and overall atmosphere of the therapeutic community. The physical setting should balance functionality and purpose with aesthetic and visually pleasing design. Atmosphere and feeling arising from the layout of the campus (internally and externally) is an important consideration. The campus should avoid looking like a hospital or prison and, where possible, should aim for the appearance of a normal living space. Obviously resources and finances are a consideration in achieving optimal design and aesthetic.</td>
<td></td>
</tr>
<tr>
<td><strong>Questions:</strong></td>
<td></td>
</tr>
<tr>
<td>• What paint colours are used?</td>
<td></td>
</tr>
<tr>
<td>• What atmosphere does the physical campus environment have as both a living and a working space?</td>
<td></td>
</tr>
<tr>
<td>• How disability friendly is the campus for wheelchairs, crutches?</td>
<td></td>
</tr>
<tr>
<td>• What plants are used inside and outside to brighten up the facility?</td>
<td></td>
</tr>
<tr>
<td><strong>Security and safety:</strong></td>
<td></td>
</tr>
<tr>
<td>There is a complex balance to be maintained between the security imperative of protecting the safety of all on campus and having a therapeutic imperative of having a warm embracing community with space and freedom (i.e. not feeling like a prison). However, the two goals are not mutually exclusive. Strict security and safety procedures need to be in place, communicated to all staff and clients, and tested or practiced with regularity. Occupational health and safety considerations should be part of the induction of all clients and staff. Specific strategies should be in place to deal with crimes on campus, e.g. theft or assault. Duress buttons and security measures may be required for situations or areas on campus with moderate to high risk clients.</td>
<td></td>
</tr>
<tr>
<td><strong>Questions:</strong></td>
<td></td>
</tr>
<tr>
<td>• Where do breaches of security of safety occur most commonly?</td>
<td></td>
</tr>
<tr>
<td>• What situational crime prevention initiatives or design changes to the physical setting need to occur?</td>
<td></td>
</tr>
<tr>
<td>• When and why do searches (person, room) occur for security purposes?</td>
<td></td>
</tr>
<tr>
<td>• In an incident, who calls the police?</td>
<td></td>
</tr>
<tr>
<td><strong>Living accommodation:</strong></td>
<td></td>
</tr>
<tr>
<td>The following are all considerations to be made dependent on the context of the individual client and the mix of clients living on campus at the time:</td>
<td></td>
</tr>
<tr>
<td>• Room size, toilet and bathroom facilities – capacity and crowding</td>
<td></td>
</tr>
<tr>
<td>• Communal living rooms and dining areas – design and atmosphere</td>
<td></td>
</tr>
<tr>
<td>• Ventilation, heating and cooling – temperature control and comfort</td>
<td></td>
</tr>
<tr>
<td>• Furniture and design – aesthetics, beauty, style and decoration</td>
<td></td>
</tr>
<tr>
<td><strong>Questions:</strong></td>
<td></td>
</tr>
<tr>
<td>• What is done in specific cases of clients who are unable to live in shared accommodation with ease? (e.g. social phobia, anti-social tendencies in the context of a shared room) What impact do these cases have on overall capacity?</td>
<td></td>
</tr>
<tr>
<td>• What criteria are to be used to determine whether or not a client occupies a 1-person or a shared room?</td>
<td></td>
</tr>
</tbody>
</table>
**Campus facilities:**

Campus facilities should be adequately functional in providing for all the needs associated with campus life and residential rehabilitation for both staff and clients. Clear protocols should be in place guiding the use of shared facilities such as lounge rooms, laundry facilities, games rooms etc. Active and non-active recreational and entertainment facilities are required. The capacity of facilities should match demand and client numbers on campus.

**Questions:**

- Are there any key areas of demand for new campus facilities? What facilities do the clients and staff want? Can any funding or resources be secured or allocated to allow this go ahead?
- What scope is there for staff and clients to share meals together, including preparation of food?
## Personnel and Resources

### The staff team:

The staff team should consist of multi-disciplinary areas of expertise and skills to reflect the complexity of need of the client group and different professions and disciplines required to adequately support different clients.

Another consideration is that a culture of care and nurture should be established to support the wellbeing of all staff. Practitioners should be guided in methods of self-care to be able be able to effectively handle what is a complex and demanding area of work.

### Professional development, education and training:

Opportunities for career development and for the systematic transfer of skills and knowledge is vital to the future development of residential rehabilitation.

Each staff member needs to learn basic occupational health and safety protocols. As part of this, they need to know ‘first response’ protocols and be familiar with suitable chains of command.

Each staff member ought to be provided with opportunities to gain further skills in their particular area of expertise, whether this is related directly to drug therapy or to financial accounting. Importantly, training needs to be seen in terms of ‘total system’ needs – that incorporate direct service provision, support work, garden and facility maintenance, volunteer workers and other members of the overall enterprise.

### Questions:

- How many different areas of expertise/skills are represented in the current staff team?
- How is a culture of care developed to support the staff? Is self-care actively promoted?
- Are support staff such as cleaners and receptionists made to feel that they are part of the staff team?

- What time and resources are allocated for in-service training, external education (such as university courses) and conferences, for practitioner staff?
- How is training and education valued by the agency, and how is this demonstrated to staff?
- What professional development, education and training do support staff (such as reception, gardening, building maintenance) receive?
- What career structure(s) are available?
Staff recruitment:
A total system approach demands that staff recruitment involve employment of a mix of practitioners and support staff, united by common mission and purpose. Recruitment needs to take into account the needs for established and demonstrated expertise, as well as the need to develop expertise in the case of early career practitioners. In other words, the long term efficacy of any facility depends upon an appropriate selection of ‘older’ and ‘newer’ workers.

Staff shortages need to be analysed from the point of view of issues such as what is needed to complement an existing team; staff burnout and stress-related matters; lack of adequate remuneration, training and career development opportunities; workplace culture and general staff morale. Recruitment to problematic workplaces will ensure high turnover and persistent staffing problems.

Volunteer resources:
The volunteer work force presents a valuable resource to the organisation in complementing professional staff in the daily administration and running of the programme and campus life. Expansion of volunteer roles may ease pressure on workloads for other staff.

Regardless of role, all new volunteers should receive an orientation and supported introduction to campus life and their role as a volunteer. Training and support should occur to enhance the skill sets of volunteers. There should be clearly articulated job descriptions, hierarchies of accountability and supervision, as well as forums or formats for volunteers to give feedback in contribution to service development and programme evaluation.

<table>
<thead>
<tr>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What recruitment strategy is needed now and into the future to guarantee adequate diversity amongst staff?</td>
</tr>
<tr>
<td>• How can experienced staff be retained, and staff new to the field encouraged to gain experience and stay in the field?</td>
</tr>
<tr>
<td>• What is the policy on hiring former clients to join the staff?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How many volunteers are there?</td>
</tr>
<tr>
<td>• Are there additional roles or duties that could be assigned to voluntary work? In which areas could more volunteers be recruited?</td>
</tr>
<tr>
<td>• What volunteer training occurs, and who provides it?</td>
</tr>
<tr>
<td>• What conflicts are there between volunteer and paid workers, and how might these best be resolved?</td>
</tr>
</tbody>
</table>

*Staff Scenario 1: Experienced practitioner*

The staff member is a 45 year old male who has worked as a professional practitioner in the area of alcohol and drug services for years. He originally undertook undergraduate and postgraduate study at University in counselling, with a special interest in addiction and substance abuse. Since then, he has participated in multiple professional development courses. Previous work experience includes; six years of work in a different sector of crisis accommodation; years of employment as a case manager in a government alcohol and drug service; and a management position in an alcohol and other drug community service agency on the mainland. The practitioner often contributes to applications and tenders made by the agency for state and federal funding, makes contributions to sectoral newsletters and journals, and is highly competent at report writing. This practitioner is highly experienced, engages in multi-tasking, and has various roles and
requirements under their current job description. However, this person (like many members of staff) experiences occasional periods of stress. He is frustrated at the lack of sectoral development and change in the alcohol and other drug area in Tasmania. On a personal level, this practitioner fears potential burnout due to job related pressures and increasing workload and overtime, but is not open to discussion of this at all in the workplace. Nevertheless, his work–life balance is an issue of concern for his family.

- What can be done to further harness the wealth of experience that this practitioner has?
- How can this experienced practitioner be stimulated and challenged to learn new things and engage in innovative service provision?
- In regards to the principle of wellbeing, what measures can be put in place to protect the practitioner against serious job-related stress and burnout?

*Staff Scenario 2: Graduate practitioner recently recruited to the programme*

The practitioner is a 22 year old female who has recently graduated from the University of Tasmania with a Diploma in Rehabilitation Counselling, and has also completed an undergraduate degree in Psychology and Sociology. She undertook two different placements as a component of her study, one of which was a student placement at this programme. She was hired because she demonstrated competency equivalent to her level of knowledge, but comparatively she is still relatively inexperienced. In order to gain membership of one of the professional associations for rehabilitation counsellors, it is a requirement that supervision be undertaken by a senior and accredited staff member. The practitioner is open to ongoing learning and professional development and on-the-job training. She has excellent knowledge of policy and procedures, but is still learning the ropes in practical application to complex situations. With the clients, she conducts herself with respect and professional rapport. The clients like her, but are rather amused that she is young and attractive. In the first few weeks of her employment, some clients were known to test the boundaries because they perceived her to be naïve and inexperienced and thought they could ‘take her for a ride’.

- Who is responsible for the provision of clinical supervision for this psychology graduate? Are her requirements for professional recognition and accreditation based on supervision and post-University experience being fulfilled?
- Are there any staff members providing a peer mentoring support to assist her in this new job?
- What professional development and on-the-job training opportunities can be used to develop her skills as a practitioner? How is experiential learning incorporated into everyday professional practice for this practitioner?
Staff Scenario 3: Receptionist/Administrative Officer

The member of staff is a female in her mid-thirties. She studied at TAFE and undertook a few certificates and a diploma in business administration. This woman has a warm and friendly nature when dealing with clients and staff, she treats them with dignity and respect. She is knowledgeable about nearly all areas of the programme, and is quite competent at her office duties and multi-tasking. She has also done some training in occupational work health and safety. In the case of an emergency, this member of staff is key in the orchestration of emergency procedures (e.g. ringing the police in the case of a violent incident, activating the alarm and helping with the evacuation of all clients and staff). As the first point of contact when entering the campus as well as the general liaison point for clients and staff, her daily work routine involves contact with a variety of people and situations. Recently, there have been a few incidences where a client threatened her because she would not do what he wanted (she was obeying agency policy).

- How is this member of staff treated in comparison to the professional client support practitioners? Is this staff member invited to participate in any forums for staff feedback and discussion? How often is she consulted and what input is she allowed to have?
- What professional development and training does this member of staff receive?
- What is the confidentiality and information reporting obligations if this staff member overhears clients speaking about illegal or harmful activities? What hierarchy of reporting exists?
- In relation to the principle of safety and wellbeing, what support and care has she received after the incidences in which she was threatened? What measures have been put in place to ensure that she is protected?
<table>
<thead>
<tr>
<th>Agency Processes and Protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entry and orientation:</strong></td>
</tr>
<tr>
<td>Entry processes require efficiency and effectiveness to aid the smooth transition of clients into the rehabilitation programme. The orientation and induction process should be informative and detailed, while avoiding overwhelming the client in their introduction to campus life. New clients should be monitored and supported in the first few weeks, this role may be undertaken by staff and, where appropriate, peer supports. New clients should be clearly informed of their rights and responsibilities when entering the programme, with rules and potential consequences for non-compliance clearly articulated. The guiding principles of social interaction within the facility need to be carefully and comprehensively explained. It needs to be emphasised that these principles guide all interactions, and cover staff as well as clients in their scope.</td>
</tr>
<tr>
<td><strong>Questions:</strong></td>
</tr>
<tr>
<td>• What barriers or challenges to accessibility exist for prospective clients? Do these relate to the service or specific client groups?</td>
</tr>
<tr>
<td>• What supports are in place for supporting new clients in their first few weeks of the programme?</td>
</tr>
<tr>
<td>• Is there a mentoring or peer support initiative in place? How can this be further developed and enhanced?</td>
</tr>
<tr>
<td><strong>Exit and post-care:</strong></td>
</tr>
<tr>
<td>The distinction should be made in processes and protocols for those that leave the programme upon graduation and natural transition into the community, and those who have unplanned exits entailing programme non-completion. It is necessary that clear protocols are in place in the case of premature exit. Information should be provided to the client who is leaving in a format that is relevant, e.g., an information pack or booklet. As a client transitions from residential rehabilitation to outreach support, the continuum of care should continue to be evaluated and benchmarked. Clients may be transitioned into activity and service engagement externally that might involve personal development, skills training, recreation, social connection, and skill/competency building. Referrals and post-care outcomes for each client should be monitored and, where necessary, followed up.</td>
</tr>
<tr>
<td><strong>Questions:</strong></td>
</tr>
<tr>
<td>• What information is given to clients who choose to exit the programme prematurely?</td>
</tr>
<tr>
<td>• What is the referral process for those unplanned exits?</td>
</tr>
<tr>
<td>• How are referrals and post-care outcomes monitored and followed up?</td>
</tr>
</tbody>
</table>
**Occupational health and safety and emergency/crisis management:**

It is imperative that clearly articulated policy and protocols of practice are established in this area. All relevant procedures pertaining to occupational health and safety and crisis management in an emergency should be communicated to all members of the residential community – staff and clients – and, where appropriate, to visitors who frequent the campus. It is important that health and safety considerations be built in to induction and campus orientation. Procedures and protocols should be tested regularly. Evacuation plans and emergency exits should be plainly identified. Members of staff should receive training for the skilful handling of emergencies and protocols for crisis management and conflict resolution.

<table>
<thead>
<tr>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Who is in charge of what and whom in different types of emergencies?</td>
</tr>
<tr>
<td>• If a duress button is set off by a staff member in danger, who is</td>
</tr>
<tr>
<td>responsible for doing what? How often is this tested?</td>
</tr>
<tr>
<td>• If one of the emergency services is required, who is responsible for</td>
</tr>
<tr>
<td>phoning them?</td>
</tr>
</tbody>
</table>
## Benchmarks and Evaluation

<table>
<thead>
<tr>
<th>Information management:</th>
<th>Questions:</th>
</tr>
</thead>
</table>
| Information systems and organisational data management strategies should be well maintained and upgraded whenever necessary. Organisational development of service delivery should be matched by efficient methods of data collection and management. Information management includes such areas as client profiles and case management details, staff profiles and performance reviews, financial statements and recurrent budgeting processes, facility maps and event promotions (see Appendix 2). | - What information systems, technology and data management are used? Do these need to be developed or replaced?  
- How are client and staff privacy and confidentiality protected in the collection of data? |

<table>
<thead>
<tr>
<th>Good practice benchmarks and performance indicators:</th>
<th>Questions:</th>
</tr>
</thead>
</table>
| Benchmarks and performance indicators ought to reflect the agency mission, specific agency goals and the guiding principles that shape everyday interactions. They should be determined and monitored for different staff roles and aspects of service provision. Benchmarks and standards should be designed and developed with input from relevant members of the residential community (staff and clients). | - How do the benchmarks reflect the strategic goals of the agency and the rehabilitation programme? How are the principles of care measured?  
- How are diverse perspectives incorporated into strategies and goals? Who has input on what?  
- Within a collaborative inter-agency partnership, how are goals and outcomes measured and monitored?  
- To what extent are the tools, interventions and programmes based on evidence-based practice?  
- What standards and priorities govern the sector as a whole? How do the benchmarks and performance indicators of the programme relate more widely to sectoral development and strategic goals?  
- How are new ideas and innovative approaches to practice encouraged?  
- How is infrastructure (physical and social) developed? |
| - Design evaluation methodology. This should be relatively simple and straightforward, and incorporate a range of measures including quantitative (e.g., number of clients over period of time) and qualitative (e.g., client exit comments, staff interviews). | |
| - Define desired outcomes and goals, and formally integrate these into benchmarks and standards. Establish performance indicators at both the operational (staff) and strategic management (agency) levels. | |
| - Monitor and reassess progress and outcomes with regularity. | |
| - Gather and compile evaluation and research data on an ongoing basis. | |
| - Review areas of success and failure, analyse contributing factors. Enact any necessary structural adjustment. | |
| - Monitor and review resource allocation and prioritisation. | |
| - Design and enact strategies for organisational change, including specification of what positive change would look like for each area. | |

Regular assessment of the management and leadership capacity of the agency is necessary. Leadership style and agency vision should be assessed, and measurable agency targets and strategic goals should be developed as general benchmarks of progress.

Benchmarks and standards should be designed and developed with input.
Overall programme and agency quality assurance, audits and accreditation form the ‘bigger picture’ level of good practice.

<table>
<thead>
<tr>
<th><strong>Openness to research and building an evaluation culture:</strong></th>
<th><strong>Questions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and good practice benchmarks should be thoroughly integrated into the workings of the agency at an organisational level, as well as service delivery at the operational level of daily client contact. Evaluation should not be a threatening issue in the workplace. An evaluation culture can contribute to continuous improvement and/or acknowledgement of problems before they become too serious.</td>
<td>• Who is to organise the evaluation process and what report-back mechanisms are in place regarding evaluation assessments?</td>
</tr>
<tr>
<td>The agency should seek to, where possible, involve students (TAFE or university) from a variety of disciplines to undertake relevant research and set up research agreements that encourage participation in both directions to better understand the problems at hand and enhance practice.</td>
<td>• How many research projects take place each year relating to the agency? What type of research is it?</td>
</tr>
<tr>
<td>Student placements can provide an important entry point into the field and constitute a useful recruitment ground.</td>
<td>• What are staff attitudes to active research participation?</td>
</tr>
<tr>
<td></td>
<td>• What is the policy on student field placements and what resources are there to ensure adequate mentoring of students on placement?</td>
</tr>
</tbody>
</table>
Policy development and change

Figure 5 illustrates a cycle of policy development and implementation that is inclusive of all involved and is imbued with research and evaluative measures. The step that is of particular importance in policy development is that of consultation. Policy interventions should reflect the best interests of those that will be affected by any changes. All people and groups that are involved in relation to a particular issue should be consulted and given the opportunity for input into suggested changes. This means that from the stakeholder and management level of the agency, to staff and clients, consultation is necessary. Consumer advocacy and client input is imperative and an important voice to be heard when undertaking service delivery planning. Organisational change should involve a team approach comprising representation and active participation and leadership from all areas of the programme and organisation. Also, the impact of government policy changes and strategic directions for the sector need to be carefully and regularly considered.
Figure 6: Policy development and cycle of change
A Model of Residential Drug Rehabilitation

Conclusion

This report has provided an outline of key ingredients for best practice in residential drug rehabilitation. It is based upon an extensive literature review, presented in Volume 1 of *Coming Down the High Road: Doing Residential Drug Rehabilitation*. Our intention in presenting the model is to provide practitioners with ideas, practical questions and useful strategies that can inform and facilitate their work in the area of residential drug rehabilitation. The model is intended to guide rather than impose, to be a practical toolkit rather than blueprint. It is our belief that basic principles are at the heart of good practice. Hence, we have devised the model as a principles-driven model, one that may vary in immediate circumstances but that nonetheless expresses important ideals with regard to client-staff and client-institution relationships.

Agency mission and service culture will obviously have a significant influence on actual residential drug rehabilitation practices. One way in which to assess current practice is to use models such as that presented here as a means to gauge existing methods of work and relating. As stated above, the emphasis of this model is on principle-driven practice for staff and also for clients, especially given that it is not possible to prescribe all the potential issues that may be encountered in the daily workings of a residential rehabilitation community. Client complexity of need should be supported by practitioner complexity of expertise, as well as a focus on achieving integrated practice where the client is an active driver of their rehabilitation. This demands a high degree of collaboration between many different people and agencies, as well as sustained application of the principles which underpin a dynamic engagement with diversity.

Future work that is similar to that mapped out in this volume is planned on issues such as co-morbidity and service provision. This will have applied components as well as involve further discussion of principles and perspectives. What to do in practice, and how to do it, will be crucial to this project.

The implementation of residential drug rehabilitation always throws up issues that are persistent and complicated. As such, it requires ongoing evaluation and reflection, as well as principled intervention. We hope this report assists these processes.
Appendix 1

Two separate national reports, ‘Evidence supporting treatment: the effectiveness of interventions for illicit drug use’ and ‘Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals’, have examined the research and evidence base regarding the appropriate use of certain interventions for specific types of clients. There is a raft of options that can be used in therapeutic practice, but it is important to prioritise and specify which should be used and which interventions should be avoided in certain contexts. Thus, the tables below contain informative guidance for clinicians with heavy workloads and a lack of time to survey the literature and regularly be updated.

Table 1.1: Effectiveness of Psychosocial Therapeutic Interventions for Opioid Users

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Users</td>
<td>• Psychosocial therapy adds to the effectiveness of methadone maintenance treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contingency management interventions in conjunction with methadone maintenance treatment are effective in reducing illicit drug use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Therapists with high-level skills – the competency and approach of the therapist are important factors in the context of methadone maintenance treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Available evidence suggests that, in the years following treatment, ex-residents of therapeutic communities show lower levels of heroin use and criminal behaviour, and higher levels of legal employment than in the years prior to treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychotherapy may be useful for treatment of heroin addicts on methadone maintenance who have comorbid psychiatric disorders, but otherwise cannot be justified on present evidence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Abstinence-based treatment without pharmacotherapy - psychosocial therapy as a stand alone treatment only works with 5-30% of long-term heroin addicts.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intensive day program treatment is not necessary with opiate users because it is no more effective than weekly counselling as an adjunct to methadone maintenance treatment, and thus is taxing on time and resources.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• There is no evidence that specific techniques such as relaxation training impact on client outcomes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• There is no evidence that ex-addicts are more effective than other therapists or educators.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coercively mandated counselling may be counterproductive for some.</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.1 highlights the importance of pharmacotherapy with opioid users, emphasising that psychosocial interventions are designed to be supportive and complimentary not stand-alone as a treatment for opioid addiction. Also, it contains a warning by suggesting that the coercion of involuntary clients into counselling may be counterproductive for some.

**Table 1.2: Effectiveness of Psychosocial Therapeutic Interventions for Alcohol Users**

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Users</td>
<td>• Counselling using psychological interventions such as those listed below is helpful. Clinicians should have a warm supportive relationship with the client.</td>
<td>• Except for those types of drinkers listed in the previous column, most clients do as well in a non-residential treatment as they do in residential programmes.</td>
</tr>
<tr>
<td></td>
<td>• Cognitive behavioural therapy is more effective than just general counselling alone. It gives the client a set of thinking and behaving strategies that can be used to assist change. Cognitive restructuring and skills training are both useful.</td>
<td>• Unstructured counselling alone is not usually sufficient to change drinking behaviours and should be supported by more specific techniques.</td>
</tr>
<tr>
<td></td>
<td>• Behavioural self-management training is helpful to clients who wish to cut down rather than abstain from drinking. This procedure is especially useful for drinkers whose lives are enmeshed in a drinking culture, where non-drinking is extremely unlikely.</td>
<td>• Clinicians who use confrontational methods will do more harm than good, so to speak. Confrontation is associated with increased client resistance and higher levels of drinking.</td>
</tr>
<tr>
<td></td>
<td>• Couples therapy involves the partner of the drinker. It can produce better drinking and relationship outcomes compared to approaches that do not include the partner. However, this therapy should only be used if all three agree about it.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cue exposure is seen to be effective in changing a person’s associations to do with drinking and the context in which they do so.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Residential treatments are better for clients with a history of chronic drinking and relapse, clients who are homeless, clients who live within an enmeshed drinking culture, and clients with comorbid disorders.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Shand & Gates (2003: 17-19)
Table 1.2 makes the interesting point of non-residential treatment options being as effective as residential treatment options for alcohol users. This raises interesting considerations in relation to efficacy and use of resources, leading to the conclusion that residential treatments are best suited to those in the categories outlined in the ‘what works’ column.

**Table 1.3: Effectiveness of Psychosocial Therapeutic Interventions for Psycho-stimulant Users**

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-stimulant Users</td>
<td>• Best outcomes are associated with treatment duration of three months of more, psychological treatment and monitoring at least once a week.</td>
<td>• Group drug counselling alone (without other counselling) is not very effective with this type of user.</td>
</tr>
<tr>
<td></td>
<td>• Individual counselling in addition to group drug counselling has significantly better outcomes in comparison to just group drug counselling.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Attendance of and participation in self-help groups (generally based on 12-step model) may improve long-term outcomes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cognitive behavioural therapy (CBT) is more effective at moderating cocaine use than equivalent time spent in non-therapeutic activities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The effects of cognitive behavioural interventions may be more durable than other psychotherapies, and hence be more protective against relapse.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Positive reinforcement for abstinence, in combination with a community reinforcement approach, can reduce cocaine use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• For cocaine users, participation in long-term residential programmes (with at least 3 months in treatment) is associated lower relapse to weekly cocaine use one year following discharge.</td>
<td></td>
</tr>
</tbody>
</table>


Table 1.3, and the associated research it was developed from, does not demonstrate extensive knowledge of interventions that do not work. It is possible that further research into the
effectiveness of psychosocial interventions with psycho-stimulant users may be warranted in order
to establish or seek out any treatments that may not work.

<table>
<thead>
<tr>
<th>Substance</th>
<th>What works</th>
<th>What doesn’t work</th>
</tr>
</thead>
</table>
| Cannabis Users| • Adult cannabis users (not polydrug users) are interested in treatment and respond well to several types of intervention.  
• Comprehensive relapse prevention or brief intervention is more effective than no treatment in reducing cannabis use.  
• A community reinforcement approach, relapse prevention, cannabis-focused supportive social interaction groups, and brief motivational interventions, or combinations of these, are likely to be effective in clinical treatment.  
• Long-term residential and outpatient drug-free treatment may reduce cannabis use by polydrug users, with the degree of reduction dependent on length of stay in treatment. | • Non-behavioural supportive treatment was found to be significantly less effective than treatment involving behavioural components. |


Table 1.4 highlights considerations of use of a single substance, and polysubstance use and cannabis as a principal drug of concern. The evidence is supportive of long-term residential drug-free treatment of cannabis use for polysubstance users.

The above variations of what works and what doesn’t demonstrate the need for the clinician to consider therapeutic interventions in light of a client’s principal drug of concern. Also, polysubstance use needs to be considered in relation to any interactions or clashes that might potentially occur between the appropriateness of different therapeutic interventions. Clinical judgment and insight is needed in addition to the evidence base presented in the tables above.


Appendix 2

Information systems and data management

As mentioned in the Benchmarks and Evaluation section, the design and use of databases is a significant factor in ensuring effective information management and service provision.

<table>
<thead>
<tr>
<th>Organisational Data Management Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Types of Databases and Data Sources</strong></td>
</tr>
<tr>
<td>• Client-related data – information relating to client profiles and case management.</td>
</tr>
<tr>
<td>• Staff-related and human resources data</td>
</tr>
<tr>
<td>• Financial and resource data – information relating to money, budgets, funding and resources necessary for each area of service delivery.</td>
</tr>
<tr>
<td>• Evaluation and research data – depending on the methodology of the evaluation and research being conducted, this information may be collected by internal and/or external people or bodies.</td>
</tr>
<tr>
<td>• Policy and legislative data – information relating to policy (internal and external) and legislative requirements.</td>
</tr>
<tr>
<td>• Intra-organisational data – information that arises from partnerships and collaboration within the organisation between programmes and professionals. Information sharing protocols may allow for extensive data flow.</td>
</tr>
<tr>
<td>• Inter-organisational data – information that arises from partnerships and collaboration with external agencies. It is important that information sharing and confidentiality procedures are adhered to closely (in both directions).</td>
</tr>
</tbody>
</table>

Secure data storage, both physical and electronic, is highly important in ensuring confidentiality and protection of information pertaining to clients, staff, and the organisation.