NSW Health

Alcohol and Other Drugs Psychosocial Interventions

Practice Guide

NSW GOVERNMENT

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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Acknowledgement of Country

The Centre for Alcohol and Other Drugs (CAOD) acknowledges that Aboriginal and Torres Strait Islander peoples are the First Peoples and Traditional Custodians of Australia, and the oldest continuing culture in human history.

We pay respect to Elders past and present and commit to respecting the lands we walk on, and the communities we walk with.

We celebrate the deep and enduring connection of Aboriginal and Torres Strait Islander peoples to Country and acknowledge their continuing custodianship of the land, seas, and sky.

We acknowledge the ongoing stewardship of Aboriginal and Torres Strait Islander peoples, and the important contribution they make to our communities and economies.

We reflect on the continuing impact of government policies and practices and recognise our responsibility to work together with and for Aboriginal and Torres Strait Islander peoples, families, and communities, towards improved health, economic, social and cultural outcomes.

Acknowledgements

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We acknowledge the significant contribution of all stakeholders in the NSW Alcohol and Other Drug Treatment Sector, our colleagues in the Primary Health Networks (PHNs) and consumers in the development of this Practice Guide.

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Key organisations

The MoH would like to acknowledge the following organisations for their contribution to the Practice Guide:

- NADA Practice Leadership Group
- Aboriginal Corporation Drug and Alcohol Network (ACDAN)
- Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN)
- Aboriginal Health and Medical Research Centre (AHMRC)

Ministry of Health

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Consumers

We wish to acknowledge the significant contribution of peer workers and consumers who engaged in consultation to ensure this work is person-centred.

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Language

Language is a powerful tool and needs to be used in ways that demonstrate respect for the agency, dignity and worth of all people. To this end, the terms person and people are used throughout this publication, alongside the term clients – denoting when a person becomes engaged by a treatment service that then has a duty of care to them.

Acronyms	
ACT	Acceptance and Commitment Therapy
ACDAN	Aboriginal Corporation for the Drug and Alcohol Network
ADARRN	Aboriginal Drug and Alcohol Residential Rehabilitation Network
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
BBV	Bloodborne virus
CALD	Culturally and linguistically diverse
CAOD	Centre for Alcohol and Other Drugs, NSW MoH
CBT	Cognitive Behavioural Therapy
CM	Contingency Management
CRA(FT)	Community Reinforcement Approaches (and Family Training)
DBT	Dialectical Behaviour Therapy
DCJ	Department of Communities and Justice
DFV	Domestic and family violence
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer and other sexual and gender identities
MBI	Mindfulness Based Interventions
MBSR	Mindfulness Based Stress Reduction
MI/MET	Motivational Interviewing/Motivational Enhancement Therapy
MoH	NSW Ministry of Health
NADA	Network of Alcohol and other Drugs Agencies
NCETA	National Centre for Education and Training on Addiction
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NGO	Non-government organisation
NRT	Nicotine replacement therapy
NUAA	NSW Users and AIDS Association
PARVAN	Prevention And Response to Violence, Abuse and Neglect
RCT	Randomised control trial
TAU	Treatment as usual
TBI	Technology-based Intervention

Psychosocial Interventions for Alcohol and Other Drug (AOD) Use Treatment

01

1.1 Who is this Practice Guide for?

This Practice Guide has been developed to support the AOD workforce. This includes all people who work in an AOD treatment setting (public and private), such as AOD workers, Aboriginal AOD workers, counsellors, psychologists, social workers, nurses, occupational therapists and medical practitioners who provide AOD psychosocial interventions for people accessing specialist AOD treatment in NSW. It explores the key principles, clinical care standards and evidence based intervention types recommended for the provision of high quality care. This Practice Guide is also applicable in shaping how psychosocial interventions are incorporated into Models of Care at the service level.

All workers who provide psychosocial interventions in the AOD sector, regardless of their professional background, should apply the principles set out in this Practice Guide to ensure consistency of care across the sector. It complements other guides and guidelines from the specialist AOD treatment sector, including but not limited to:

- **NADA Practice Guide: Providing Alcohol and Other Drug Treatment in a Residential Setting** [1]
- **NSW Health Management of Withdrawal from Alcohol and other Drugs** [2]
- **NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment** [3]

For the purposes of this Practice Guide, psychosocial interventions are defined as interventions designed to illicit improvements in psychological, emotional and overall wellbeing, applied as part of specialist AOD treatment through counselling. The information outlined in this Practice Guide can be applied in outreach, community-based and residential settings as well as through psychosocial interventions provided via virtual means (telephone, video conferencing, and instant messaging). The Practice Guide should be used in conjunction with relevant standards and competencies associated with specific professions.

To maximise outcomes, psychosocial interventions should focus both on *process* and *content* throughout treatment [4]. *Process* refers to the interaction between the AOD treatment provider and the person engaged in therapy, both in terms of the therapeutic relationship generally and the interpersonal processes that occur during the therapy session. These strategies are discussed in **Section 3**. *Content* refers to the skills, strategies and theoretical orientations of the treatment itself, such as those interventions described in **Section 4**.

1.2 Development of this Practice Guide

An Expert Advisory Group (EAG) was established with senior member representatives from across the AOD treatment sector in NSW who have demonstrated expertise in the design, delivery and evaluation of evidence based psychosocial interventions. A number of members from this group had been involved in the development of the original *Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines* published in 2008. The 2008 Guidelines synthesised and evaluated the available evidence on a range of psychosocial interventions for treating AOD use issues and provided evidence based recommendations for health professionals responsible for treatment. In 2013, they were reviewed for currency and found to be current.

In December 2019, the Centre for Alcohol and Other Drugs (CAOD), NSW Heath commissioned the University of Sydney's Matilda Centre for Research in Mental Health and Substance Use to undertake a rapid review and evidence check of the recent literature (from 2008 onwards) on AOD psychosocial treatments [5]. The EAG extensively reviewed each chapter of the original guidelines, provided edits and in some instances developed new content based on current psychosocial approaches. The Clinical Advisor to the CAOD then reviewed and developed new content based on the evidence check and current clinical expertise.

In addition to the evidence check and review by the EAG, key resources developed since the original guidelines were also drawn upon for principles of good practice. These include:

- NSW Health NGO Alcohol and Other Drugs Service Specification Guideline –**www.health.nsw.gov.au/aod/resources/Pages/treatment-service-specifications.aspx**

- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29 - **www.health.gov.au/resources/publications/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29**
- NSW Health Clinical Care Standards for Alcohol and Other Drug Treatment - **www.health.nsw.gov.au/aod/Pages/clinical-care-standards-AOD.aspx**
- **NSW Ministry of Health NGO Service Specifications Guidelines**

Others consulted on the content of this Practice Guide include AOD treatment providers not involved in the EAG, such as those clinicians who regularly attend The Quality in Treatment (QIT) Subcommittee, the Aboriginal Corporation for Drug and Alcohol Network (ACDAN), the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN) and consumer advisors.

Some chapters from the previous edition have not been included in this edition. The decision not to include specific drug-related chapters or a chapter on prevention was based on the current plethora of up to date and being-updated resources on specific substances in use in Australia and overseas. Some types of drugs, such as emerging psychoactive substances, are changing rapidly, with current information at risk of becoming quickly out of date.

While prevention may be part of the delivery of psychosocial interventions, there is a wide variety of excellent evidence based, accessible resources available on drugs and prevention:

- Your Room – **www.yourroom.health.nsw.gov.au**
- Alcohol and Drug Foundation – **www.adf.org.au/drug-facts/**
- Alcohol and Drug Foundation – Indigenous resources – **www.adf.org.au/programs/indigenous-resources/**
- Positive Choices – Drug and Alcohol Information – **www.positivechoices.org.au/teachers/drug-facts-for-young-people/**

1.3 How to Navigate this Practice Guide

Each section of this Practice Guide builds on the information from the previous section, starting with (**Section 1**), which outlines how to use the Practice Guide and its intended audience, the NSW AOD treatment sector.

Guiding Principles and Professional Practice (**Section 2**) explores essential principles that guide person centred, safe and quality care and outlines key elements of professional practice including core competencies, confidentiality and privacy and clinical supervision.

Core Psychosocial Processes and Treatment Settings (**Section 3**) presents key principles of practice and the **NSW AOD Treatment Clinical Care Standards** [3] for core processes of care, delivery models and the various settings in which psychosocial interventions may be delivered. These foundational principles for the person providing evidence based psychosocial interventions are then enhanced by the exploration of the documented evidence base for the psychosocial interventions routinely provided in AOD treatment.

Psychosocial Interventions (**Section 4**). Each intervention type described is accompanied by a brief example of how it might be applied in practice and where to find additional resources for further education, such as eLearning platforms, webinars and other relevant guidelines or practice manuals.

Integrated Care: Considerations for co-occurring needs (**Section 5**), highlighting the importance of holistic and integrated care which takes into account the co-occurring needs people may present with, such as mental health conditions, cognitive impairment and physical health conditions.

Supporting Diverse Needs: Equity for Priority Populations (**Section 6**) highlights the specific needs of priority populations and looks at the available evidence for psychosocial interventions that are effective for different groups, such as young people, people who may be coerced into treatment or have involvement with the criminal justice system, and older people.

This Practice Guide is not intended to replace accredited courses, practice-based learning, clinical supervision or ongoing professional development. Instead, the Practice Guide will support good practice in the delivery of psychosocial interventions and provide a starting point from which to grow, develop and improve capacity. Throughout the Practice Guide additional resources are featured to encourage further exploration into the topics covered, and a reference list provides a useful guide to the literature that has been consulted in its development.

1.4 Understanding AOD use and the Treatment available in NSW

Substance use is a normal part of people's lives, and although many people drink alcohol or use drugs, not everyone suffers harm to their physical or mental health. Understanding substance use means identifying the reasons a person may be drinking alcohol or using drugs and the role these play in their life rather than just focusing on the substance they use in isolation. When people come into contact with an AOD treatment service they are either experiencing their own concerns regarding their substance use, or someone external to them has expressed concerns. There are a number of different pathways to people accessing AOD treatment psychosocial interventions and these may specifically relate to the harms they have experienced, ranging from financial issues and impacts on relationships or their physical or mental health (potential or actual), to negative impacts on activities such as work, study or leisure [6].

The key focus for any treatment intervention should be to reduce the harms experienced by substance use, whether or not a person has decided they wish to continue using substances. As indicated above, most people will not experience harms for their alcohol and other drugs use, or the harm may be related to a specific situation. It is useful to think of substance use ranging across a spectrum from experimental, occasional and regular through to dependent use.

According to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), dependence is defined as 'a cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences' [7]. The World Health Organisation (WHO) lexicon of alcohol and drug terms [8] identifies dependence syndrome as 'a cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated substance use'. These phenomena include:

- A strong desire to take the drug
- Impaired control over its use
- Persistent use despite harmful consequences
- A higher priority given to drug use than to other activities and obligations
- Increased tolerance
- Experience of physical withdrawal reaction when drug use is discontinued [9]

Harms associated with substance use will vary depending on the drug used and the amount consumed, and for this reason a comprehensive intake and biopsychosocial assessment is undertaken as part of every psychosocial intervention – see **Section 3**. A key focus for any psychosocial intervention is to explore with a person their social and emotional supports (friends, family and community) and how these might be impacted by the substance use, and at the same time how these supports may be a potential area of strength to support any positive change a person may decide to make.

AOD Treatment Modalities

Psychosocial interventions can be provided in a variety of settings by a variety of clinicians, often in conjunction with other AOD treatment modalities. In NSW, AOD treatment services are provided in Local Health Districts (LHDs) by the NSW Health workforce, by Non-Government Organisations (NGOs) and in private practice. Psychosocial interventions may be provided in residential and community-based settings as part of withdrawal management, alongside

pharmacotherapy programs and as part of AOD treatment provided in residential settings. They can be provided via individual, couple, family or group sessions – both in person and via virtual care (telephone, video link, messaging).

Regardless of setting or modality, psychosocial interventions should focus on *process* and *content* – explored in **Section 3** and **Section 4**. AOD psychosocial services aim to give equal regard to the physical, psychosocial and cultural wellbeing of all people receiving care. All practice should therefore include a comprehensive substance use assessment and offer suitable interventions and harm reduction strategies to all clients identified at risk of or experiencing problems associated with substance use. These may include intoxication, regular/harmful use, withdrawal and/or dependence, and related health and social issues. AOD professionals have an important advocacy role to play in improving clients' access to these services in a timely and equitable manner.

Guiding Principles and Professional Practice

02

This Section outlines the professional practice standards for clinicians delivering psychosocial interventions in AOD services in NSW. Each person involved in providing AOD treatment in NSW should strive to deliver value-based healthcare that improves:

- health outcomes that matter to patients
- experiences of receiving care
- experiences of providing care
- effectiveness and efficiency of care.

These are known as the four essentials of value. In practice, providing value-based healthcare (VBHC) means AOD workers are expected to seek feedback on clients' experiences of treatment. They are also asked to engage clients to reflect on the progress they are making towards their goals, and to shape treatment in response to this and the ongoing needs of the client. Application of VBHC means that services will apply psychosocial interventions that have been demonstrated to be effective in achieving outcomes that matter to people accessing AOD treatment – such as the psychosocial interventions outlined in **Section 4** of this practice guide.

Aligned with the aims of value-based healthcare in NSW are the **National Quality Framework** and **National Framework for Alcohol, Tobacco and Other Drug Treatment**. These guidance documents outline treatment principles [10] that align with the NSW Clinical Care Standards (CCS) for Alcohol and Other Drug (AOD) Treatment [3]. Psychosocial interventions by their nature attend to both the psychological and social experiences of a person attending for AOD treatment and are person centred, strengths based, trauma informed and shaped by feedback sought throughout the treatment journey.

Elevating the Voice and Approaches of Aboriginal and Torres Strait Islander peoples

In Australia elevating the voice and approaches of First Nations people is essential to positive outcomes for both Indigenous and non-Indigenous people – this is a key goal of Closing the Gap. Respecting the culture and contribution of Aboriginal and Torres Strait Islander people to healthcare and self-determination involves genuine relationship building, the acknowledgement of intergenerational trauma of colonisation, the significant role family, kinship and community play as part of a healing process, and the need to work holistically. Working towards acknowledgment, respect and reconciliation is vital in the provision of quality healthcare and should underpin all psychosocial interventions.

2.1 Guiding Principles for AOD Psychosocial Interventions

2.1.1 Person Centred and Feedback Informed

Person centred care is the delivery of healthcare that is respectful of and responsive to the preferences, needs and values of all clients. In practice this means attending to the role of culture for Aboriginal people, ensuring equity of access to people who may speak another language at home through offering an interpreter or counsellor that can speak in a person's first language, and ensuring we provide spaces that are safe and inclusive for people who may identify as sexually or gender diverse. Being person centred includes:

- Treating each person with dignity and respect
- Encouraging and supporting client participation in decision making
- Communicating and sharing information with clients about clinical conditions and treatment options
- Providing clients with information in a format they understand so they can participate in decision making

Engaging in person centred psychosocial practice necessitates asking questions about a person's identity, the things they identify as needing specific support or assistance with, and engaging them in providing regular feedback on their own progress and experience of treatment. By not regularly checking in with clients about how their treatment is progressing, we miss an opportunity to provide person centred and responsive care. Outcomes measurement and personal experience feedback needs to be collected at regular intervals

throughout treatment, and the results presented back to the client for exploration. Sharing this information enhances the therapeutic alliance, ensures treatment is person centred and is linked with a higher quality of care.

Feedback Informed Treatment should be routine. This is where outcomes, quality of the therapeutic relationship and experience of service are examined in real time in collaboration with each client – with adjustments to treatment made in response as needed. There are a range of outcomes and experience measures which should be used on a regular or routine basis to enhance the therapeutic relationship. Tools such as the Outcome and Session Rating Scales (ORS and SRS) [11] are designed to be used at the commencement and conclusion of each counselling session and allow for responsive, person-centred practice. These are designed to assist in monitoring treatment progress while providing opportunities to review, reflect and respond to changing needs throughout the treatment journey.

Providing regular feedback to people on their treatment outcomes ensures that the intervention being provided can be stepped up or down according to need. A focus on brief interventions or psycho education may be sufficient in some cases, while others may required more intensive psychosocial interventions. There may also be a situation where additional treatment approaches, such as inpatient withdrawal, may be of benefit to complement psychosocial interventions.

2.1.2 Trauma Informed

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

Research shows that even the effects of severe early trauma can be resolved and its negative intergenerational effects intercepted. [12] People can and do recover, and their children can do well. For this to occur, mental health and human service delivery need to reflect current research insights [12].

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

- **Safety:** How can workers/AOD services be modified to more effectively and consistently ensure physical and psychological safety?
- **Trustworthiness:** How might a service modify its practices to engender trustworthiness through task clarity, consistency, transparency and respect for interpersonal boundaries?
- **Choice:** How can services be modified to maximise client experiences of choice and control?
- Collaboration How can services be modified to maximise collaboration and power sharing?
- **Empowerment:** How can services be modified to maximise experiences of empowerment and the development or enhancement of client skills?
- **Respect for Diversity – Culture, gender, history and identity:** We will regard diversity as a strength and respond with a person centred approach that acknowledges the experience of stigma and discrimination [12]

AOD use disorders, mental health and trauma are now recognised as critical and interrelated issues requiring comprehensive treatment responses [12]. According to the **Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework** that guides all NSW Health services to provide a coordinated response for people accessing AOD treatment who have experiences of violence, abuse and neglect, service provision must be ***person-centred*** and ***family-focused***, *provide* ***seamless care*** across multiple services, and use a ***multidisciplinary and trauma-informed approach*** designed around the ***holistic needs*** of the person and their family throughout ***their life course*** [13].

The **NSW Health Integrated Trauma-Informed Care Framework: My story, my health, my future** brings together elements of trauma-informed care and integrated care to enhance the experiences of clients and their families and carers accessing NSW Health services. It provides guidance to staff, as well as a platform for the changes required to implement this type of care.

2.1.3 Holistic

The principle of holistic care within psychosocial practice acknowledges that people accessing AOD treatment may present with a variety of needs including physical, psychological, social welfare, employment, criminal justice and relationship. Improvement in overall wellbeing for people accessing AOD psychosocial treatment interventions requires attending to their needs holistically, and may require collaborative work with other parts of health and social services. Providing holistic care requires links and strong partnerships with communities, services and other specialist providers.

A holistic approach also considers the variety of developmental stages, potential experience of cognitive impairment, learning styles and social determinants that may act as barriers to being able to adequately engage in psychosocial interventions. Assessing and tailoring psychosocial interventions to this variety of needs contributes to positive and sustainable outcomes.

2.1.4 Reducing Harms

A 'harm reduction' approach is recommended for all psychosocial interventions with people seeking AOD treatment. Harm reduction approaches take a realistic and practical approach to the potential issues associated with problematic AOD use and focus on reducing the harms (negative effects) associated with a person's use, reinforcing any positive changes a client can make [14]. It is important to note that while harm reduction approaches acknowledge there are harms associated with all AOD use and that abstinence may be the goal of some people, it also recognises that for others abstinence may not be their goal or not always realistic. In practice, a harm reduction approach in the context of psychosocial interventions involves exploring practical, targeted strategies that a person can put in place to actively reduce both direct and indirect harms from their substance use.

Harm reduction strategies include but are not limited to:

- If a person is injecting, always sourcing sterile injecting equipment and having it on hand
- If a person is unsure of the potency of a drug that has been purchased, using a small amount first and having naloxone on hand should there be a potential risk of overdose
- Consuming alcohol and/or drugs in a safe place and avoid driving if intoxicated

2.1.5 Addressing the Experience of Stigma and Discrimination

All AOD clinicians who work alongside people seeking treatment for AOD use have a responsibility to provide care that acknowledges the experience of stigma and discrimination and takes active steps to address these experiences. People who use alcohol and other drugs are often stigmatised as having made unhealthy or immoral choices, stereotyped as being dangerous or untrustworthy, and may be treated in a way that suggests they have less right to access health services. The experience of discrimination with regard to access, treatment and quality care is a common experience for people who have a lived or living experience of AOD use.

Stigma is a significant cause of health inequality: it can be a barrier to help-seeking and can lead to poor quality care and premature cessation of treatment. It does not lead to reduced substance use. The impact of stigma and discrimination experienced by people who have a lived or living experience of alcohol and other drug use can adversely impact upon their reaching out for support and ability to speak openly about their substance use.

It is also useful to be aware that some groups have multiple layers of stigma as a result of gender, sexual orientation, cultural background, age or disability. Language is powerful, especially when talking about alcohol and other drugs and people who use them. Being mindful about the language we use is not about being 'politically correct': language is an important practice tool that can empower clients and fight stigma, and a useful focus for behaviour change in an AOD treatment context.

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

2.1.6 The NSW Clinical Care Standards

In NSW the development of the Clinical Care Standards (CCS) for Alcohol and Other Drug (AOD) Treatment [3] is intended to provide a set of statements about the treatment a person can expect from the range of treatment settings they can access across the sector – both government and non-government. The principles that underpin all treatment types are included in Table 1.

It is recommended that AOD clinicians familiarise themselves with the operational protocols and professional standard documents relevant to their profession and AOD treatment setting.

Table 1: NSW Clinical Care Standards [3]

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

2.1.7 Responding to Violence, Abuse and Neglect in AOD services

Everyone deserves a life free from violence, abuse and neglect (VAN) and their adverse effects, yet these are very common in Australia, and rarely experienced as a single incident. Within NSW Health VAN is used as an umbrella term to refer to domestic and family violence, sexual assault, all forms of child abuse and neglect, and children and young people displaying problematic sexual behaviour or engaging in harmful sexual behaviour, who often have their own experiences as victims of abuse and neglect. Responding to violence, abuse and neglect is the responsibility of all people working in the provision of AOD treatment – whether employed directly by NSW Health, as part of the NGO sector and in private practice. Extensive research indicates violence, abuse and neglect have serious health and wellbeing outcomes for women's, children's and men's health. The serious long term negative health outcomes of violence, abuse and neglect make them key social determinants of health, and thus core concerns for NSW Health.

The **Integrated Prevention and Response to Violence, Abuse and Neglect (IPARVAN) Framework** is guiding and improving NSW Health's efforts to provide 24 hour integrated psychosocial, medical and forensic responses to violence, abuse and neglect. Phase 2 of the IPARVAN Framework is currently underway, which focuses on broadening integration of violence, abuse and neglect responses across the whole NSW Health system and interagency partners – including NGO Providers; with AOD services as a priority. The health sector plays a crucial role in efforts to prevent, respond to and minimise the impacts of violence, abuse and neglect [15]. The provision of high quality care and support services to victims of violence contributes to 'reducing trauma, helping victims heal and preventing repeat victimisation and perpetration' [16]. High quality interventions with children and young people displaying problematic or harmful sexual behaviour also maximise safety and reduce risk of harm to that child or young person as well as to others, minimising longer term health and social impacts.

NSW Health and NGOs funded by NSW Health are committed to providing consistent, high quality, comprehensive and integrated services for people who have experienced violence, abuse and neglect and for their families [14]. The available evidence suggests violence, abuse and neglect are significant mainstream issues for AOD services and the relationships between these issues are complex. For example, alcohol or drugs can be used as a coping strategy for trauma, yet clients accessing AOD services may not have their experiences of violence, abuse or neglect considered in treatment. Alcohol and other drugs can also be a factor in vulnerability to and risk of experiencing violence, abuse or neglect as well as severity of injury. Further, perpetrators may deliberately use substances to create or exploit vulnerabilities in their victim/s or use their own substance use to excuse or trivialise violence and harm they have caused. These will be included as part of Phase 2 of the IPARVAN Framework and informed by programs in development such as the integrated, specialist service for adult survivors of child sexual abuse with complex needs; which includes an integrated therapeutic treatment and case management model between sexual assault, mental health, Aboriginal Health, and AOD services.

Phase 2 implementation of the IPARVAN Framework previously referred to in **Section 2.1.2** will also include NSW Health workers having access to education, training, professional development and workplace resources to build the skills, knowledge, attitudes and values to provide holistic and integrated services. Providing integrated and collaborative care for AOD clients with experiences of violence, abuse and neglect requires the development of further guidance and referral pathways including shared clinical assessments, integrated models of care and other resources to support AOD and VAN services working better together.

AOD services will adopt a trauma informed system that uses trauma informed care as a 'universal precaution'. The '4Rs' underpinning trauma-informed care are:

1. **R**ealise – All people at all levels of the organisation or system realise how trauma can affect families, groups, organisations and communities as well as individuals. This includes understanding that both clients and staff may have their own experiences of trauma

2. **R**ecognise – People in the organisation or system recognise the signs of trauma, that relationships can be the basis for healing, and that the service delivery setting plays a role in establishing the foundation for integrated trauma-informed care
3. **R**espond – The organisation or system responds by applying the principles of trauma informed care to all areas of functioning and organisation.
4. Prevent **R**e-traumatisation – of clients as well as staff

More detailed guidance, including practice guidance on clinical interventions in these areas, is available from the NSW Health policy directives:

- Responding to Sexual Assault (adult and child) Policy and Procedures – **www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_006**
- Identifying and responding to domestic and family violence Policy and Procedures – **www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2006_084**
- Child Wellbeing and Child Protection Policies and Procedures for NSW Health – **www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2013_007**
- NADA Policy Toolkit – **www.nada.org.au/resources/policy-toolkit/**

The service models for NSW Health Violence, Abuse and Neglect (VAN) services require that they provide a professional consultation, informal training and support role including information and advice on violence, abuse and neglect for health professionals and other service providers. AOD workers are therefore encouraged to contact their local VAN services to seek information and advice, and to collaborate with them when working with people affected by violence, abuse and neglect.

Further information regarding how AOD clinicians respond to child protection issues, domestic and family violence (DFV) and sexual assault can be found in **Section 3** and **Section 6**.

2.2 Clinical Governance

Excellence in clinical care involves integration between individual AOD professionals, the team within which they are operating and the wider service in which their team sits. Individuals working at each of these levels will have differing roles and responsibilities in ensuring that high quality clinical care is being consistently delivered to clients engaged with AOD services.

Clinical governance processes allow AOD clinicians to identify, analyse, contain and manage risks while providing clinical treatment and client care [17]. As outlined in the NSW Health Clinical Care Standards – Alcohol and Other Drug Treatment [3], ongoing risk assessment is an integral part of AOD treatment. Examples of relevant processes include incident reporting systems, clinical and operational escalation pathways, and clinical review and supervision forums as well as line management.

Clients are also important partners in the clinical governance process, most often as active participants in all stages of the treatment process (ie. assessment, treatment planning and review). This is part of good clinical practice, with strategies for client collaboration and the engagement of significant others, communities and other support people.

2.3 Workforce

A range of health professionals, often working within multidisciplinary teams, provide treatment services in the AOD sector, and may include:

- Aboriginal health workers
- Addiction medicine specialists
- Alcohol and other drug workers
- Community support workers
- Counsellors
- General practitioners
- Nurses
- Nurse practitioners
- Occupational Therapists
- Peer workers
- Pharmacists

- Psychiatrists
- Psychologists
- Social workers
- Youth workers

The type and focus of treatment interventions depends on the skills, training and scope of practice of the individual clinician. *Service context* is the other key element that informs the clinical scope of practice of the AOD clinician. To ensure effective and appropriate care, AOD clinicians need to be aware of their professional scope of practice, core capabilities and the clinical environment and operational context in which care is delivered [18].

A specialist AOD treatment or clinical team may encompass a range of disciplines, with each clinician having a defined role to play or contribution to make in supporting clients to address their AOD use and reach any other goals they have set for themselves. AOD clinicians working in a team environment need to respect these different roles and in particular to acknowledge differences in professional backgrounds, lived experience and alternative training.

AOD clinicians working within multidisciplinary teams also need to be aware of and function within their own clinical scope of practice. In practice, all team members have input into the consultation, supervision and management process, alongside the person seeking treatment. Strong communication and clearly stated clinical governance and processes of care will assist with the coordination of safe treatment and positive outcomes.

2.4 Scope of Practice

A scope of practice outlines the professional boundaries for a clinician and describes the requirements of the role. These requirements are informed by the AOD clinician's professional background, level of training, knowledge and experience. Scope of practice includes the outlining of specific competencies expected for the role, as well as professional development activities required for skills maintenance and development .

These competencies will reflect the clinical services context and clinical operational capabilities in which the AOD clinician provides services, as AOD services differ in level of consumer need and complexity of care provided. Specialist AOD clinicians need to also comply with individual professional practice guidelines appropriate to their specialty area of practice.

AOD clinicians and services are required to be familiar with and adhere to the relevant codes of conduct and ethical standards applicable to their clinical role (both organisation and profession based). This includes an understanding of the requirements around privacy, confidentiality and mandatory reporting and application in practice.

2.5 Core Capabilities

There are several core capabilities and areas of knowledge required for clinicians working in the specialised AOD field. The Clinical Care Standards identify the competencies AOD clinicians should demonstrate to deliver the core components of AOD treatment (intake, comprehensive assessment etc). The core processes outlined in the Standards are complementary to the clinical accountability processes in services and the treatment interventions that are provided, as shown here:

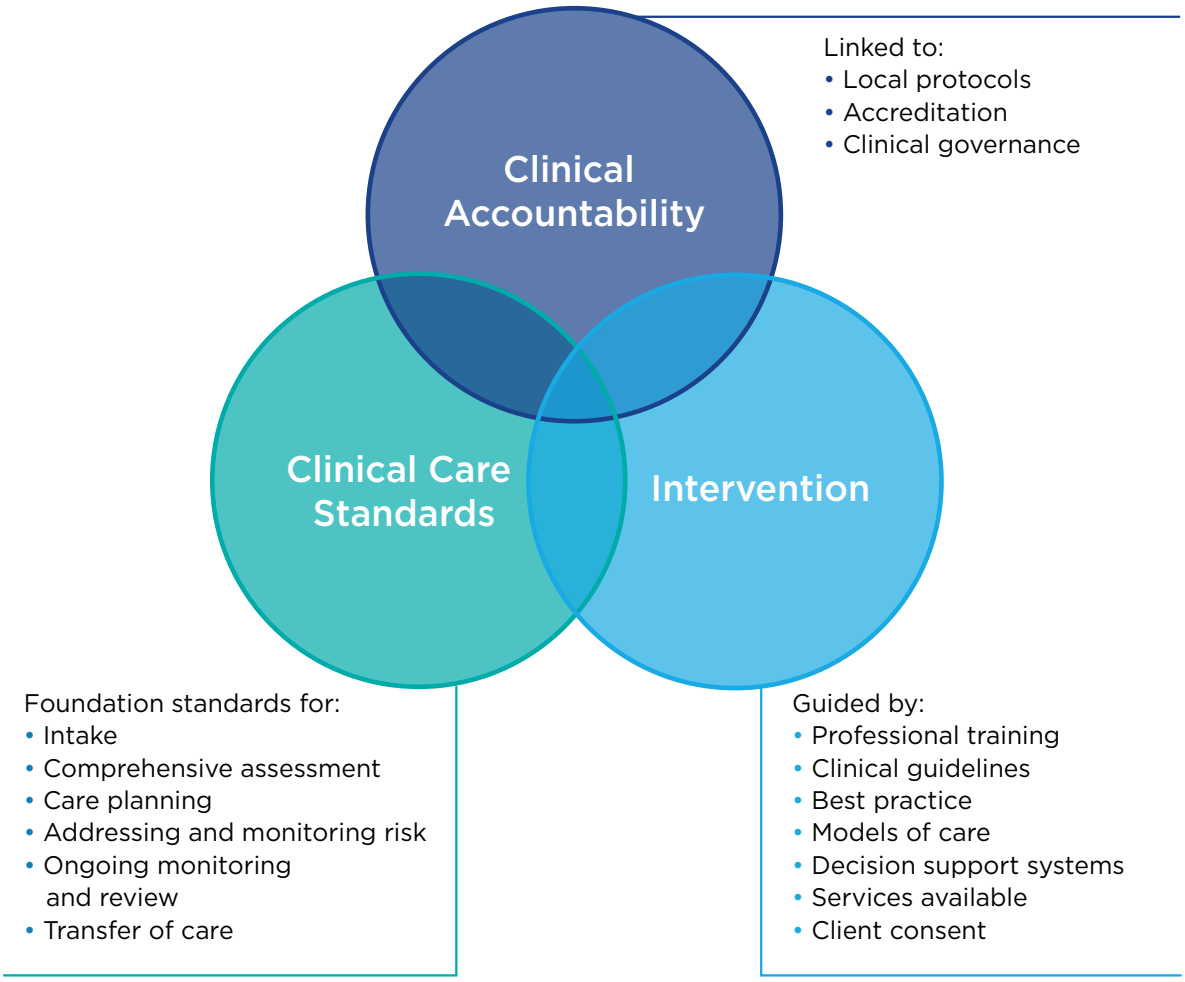


Figure 1: Core Capabilities [4]

People employed within the specialist AOD sector come from different backgrounds and have different skills and experience. It is important that these skills are matched to the specific requirements of clinicians specialising in the provision of care to AOD clients, as well as aligning with the clinical context of the organisation and client requirements.

Clinicians need to be supported and trained, and this includes an assessment of existing skills and areas for training and development from commencement of their role. When AOD clinicians commence a role they need to be provided with orientation, support and, where appropriate, mentoring and supervision for a period of time to ensure core AOD competencies are being met. The **NADA workforce capability framework** and CCS competency based assessment package are available to services to assist them in operationalising this. Key knowledge in an AOD setting includes but is not limited to being able to identify and manage clients presenting with signs of intoxication and withdrawal and linking them with the most appropriate AOD treatment service type.

AOD clinicians provide a range of assessments and evidence based treatments to assist people presenting with substance use issues and associated biopsychosocial concerns. Psychosocial treatment requires a broad range of skills, and an individual clinician may have expertise in one or more treatment intervention types. Skills development and continuing professional development contributes to enhancing knowledge and practice. However, it is also a professional responsibility to be cognisant of scope of practice, and seek support from supervisors where additional support is required.

2.6 Confidentiality, Privacy and Release of Information

Privacy and confidentiality differ: *privacy* focuses on the client and relates to a client's 'control over the use, disclosure and sharing of information that is collected about them' [19], while *confidentiality* concerns the 'management of the information and the processes put in place to handle information once it has been disclosed' and involves how this information is stored, what access protocols are in place and how this information is released [19].

AOD clinicians are required to ensure the privacy and confidentiality of individual psychosocial sessions. This ensures a safe and constructive environment for clients and helps encourage a sufficient level of disclosure and participation. Information can also be shared, subject to the informed consent of the client, with other clinical service providers under shared care planning arrangements.

AOD clinicians need to ensure that any serious issues related to clinical practice are dealt with appropriately and transparently. AOD clinicians must refrain from disclosing information received in confidence unless there is an immediate, sufficient and compelling reason to do so and/or mandatory/legislative requirements dictate a disclosure is required. Sufficient and compelling reasons include but are not limited to:

- Having the written consent of the client to disclose confidential information, eg. about the client during the course of supervision, when referred by other agencies for treatment, or as part of integrated and shared care treatment arrangements
- Some agencies (eg. Department of Communities and Justice, the Courts) may provide legal authority to require access to clinical information
- If the client threatens to self harm or harm someone else
- If a child is currently 'at risk' of abuse or neglect as per mandatory reporting requirements under the Children and Young Persons Care and Protection Act – see the **Mandatory Reporter's Guide**. For more information see **Child Wellbeing and Child Protection Policies and Procedures for NSW Health**
- Reporting risk of prenatal harm is not obligatory, establishing connection with the Substance Use in Pregnancy and Parenting Programs (SUPPS) can be useful for the purpose of providing comprehensive support
- If the AOD clinician or their clinical documentation are subpoenaed to court or requested via other legislative processes
- AOD clinicians may also be required to disclose information about clients who are mandated to attend treatment or clients who are minors. For more information see Chapter 16A of the **Children and Young Persons (Care and Protection) Act 1998**
- To reduce serious domestic violence threat in accordance with **Part 13A of the Crimes (Domestic and Personal Violence) Act 2007**. While victim-survivor consent to share information should always be sought, Health services are permitted to share information under Part 13A if victim-survivor consent is not provided or it is unreasonable or impractical to gain consent when: there is a valid threat assessment indicating the victim is at serious threat; and the service provider believes on reasonable grounds that the use or disclosure of personal and health information is necessary to prevent or lessen the threat to the victim or other people's life, health and safety; and the serious threat is related to the commission or possible commission of a domestic violence offence.

Further guidance and requirements on information sharing to reduce domestic violence threat is set out within the **NSW Government Domestic Violence Information Sharing Protocol** and the Information Bulletin: Use of Exchange of **Information Part 13A Crimes (Domestic and Family Violence) Act 2007 Form**

When responding to all subpoenas capturing information related to the identification and response to violence, abuse and neglect, consideration is to be given to whether the records are protected by sexual assault communications privilege (SACP) or other privileges. The likelihood of harm to the patient or others if the records are produced is also to be considered, including identifying any potential increased risks and possible action to mitigate these risks.

Sexual Assault Communications Privilege (SACP) protects counselling communications to or about a victim or alleged victim of a sexual assault offence from being used as evidence in criminal proceedings, including those related to Apprehended Violence Orders (AVOs), regardless of when that counselling may have occurred. This applies to when there is a counselling communication about sexual assault within an AOD Service.

When responding to subpoenas NSW Health workers are to refer to the NSW Health Subpoenas Policy Directive (PD2019_001).

Confidentiality and privacy limits need to be discussed with the client where appropriate, and clearly articulated by the AOD clinician in the case of mandatory reporting requirements [4]. This is an essential component of informed consent to treatment. AOD clinicians should consult the guidelines outlined in the **NSW Health Privacy Manual** (Version 2) and if unclear at any stage about the appropriateness of disclosing information they should seek advice from a manager, supervisor or clinical supervisor prior to release. It should also be noted that informed consent may need to be revisited after an initial appointment or assessment, where substance use or distress may impair a person's ability to provide informed consent.

2.7 Clinical Review

Clinical review meetings allow treatment services to review the quality of care being provided and identify any opportunities for improvement. This process ensures the assessment of ongoing risks and suitability of the treatment plan [3]. Clinical review meetings are safe collaborative space for clinicians to learn from one another and bring together clinical knowledge and experience often from different disciplines and walks of life.

All clients should be regularly presented within a clinical review framework. The type and frequency of the review should be in accordance with the client's clinical needs, care plan and identified risk issues [3]. An AOD case formulation incorporates a holistic and biopsychosocial lens and at a minimum covers nature and duration of substance use, severity of use, stage of change, co-occurring needs (either confirmed or potential), personal strengths, assessment of risks and current care plan and supports.

Review of client progress through treatment, including the core activities of regular consultation, supervision, clinical review and the measurement of clinical and operational outcomes, is central to the provision of good clinical care [3]. The ways in which these activities are routinely incorporated into a team or service context should be determined at a service level in line with protocols and the requisite needs of the clinical team.

2.8 Clinical Supervision

Clinical supervision is a component of professional support and learning which empowers individual clinicians to develop knowledge and competence, maintain responsibility for their own practice and optimise safety and quality of care in clinical situations [20]. It is generally (but not always) between a more experienced clinician (who may come from a variety of clinical backgrounds) with knowledge of the treatment setting, and a less experienced clinician. Supervision requires clinical cases to be reviewed and reflected upon, a process which helps ensure client welfare, supports the clinician's work with clients and facilitates the clinician's professional development [22, 23].

Clinical supervision helps an organisation meet its quality client service objectives and has been associated with increasing the proficiency of service delivery [24]. Therefore it is regarded as an important part of clinical governance [25]. AOD clinicians should ensure they engage in regular supervision to 'support quality, safety and productivity and improve competence and confidence in clinical practice' [25]. Clinical supervision supports the acquirement of skills and knowledge, promotes reflective practice and encourages the development of professionalism, confidence and competence in clinical practice as well as fostering professional growth and development [25].

Clinical supervision also plays a role in staff development and satisfaction, perceived support, professional confidence and workforce retention [20]. More detail relating to clinical supervision can be found at:

- NSW Drug and Alcohol Clinical Supervision Guidelines (NSW Health) – **https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2006_009.pdf**
- Clinical Supervision Resource Kit for the Alcohol and Other Drugs (NCETA) – **www.nceta.flinders.edu.au/resources/nceta-workforce-development-resources/csk**
- The Superguide: a handbook for supervising allied health professionals (HETI) – **https://www.heti.nsw.gov.au/__data/assets/pdf_file/0005/424859/HETI_Superguide_Txt_WARAHETI_OCT_19.pdf**
- Remote Supervision (NADA) – **www.nada.org.au/resources/remote-supervision/**

2.9 Clinical Line Management

All AOD clinicians will report to a senior person or clinical line manager. Just as the knowledge base and competencies for an AOD clinician vary and take many years to learn, so too the management of psychosocial services requires learning. At a minimum, the management of a psychosocial team needs to be conducted by managers who are themselves knowledgeable about the range of psychosocial treatments and the often complex issues involved in their delivery. In contrast to clinical supervisors (who are only responsible for addressing matters raised within clinical supervision sessions), clinical line managers carry the overall clinical accountability on behalf of the service, ensuring compliance with clinical care standards [20, 25].

2.10 Professional Development

Continuing professional development is the means by which members of a profession maintain, develop and expand their knowledge, expertise and competence required in care delivery. All AOD clinicians should participate in regular professional development activities aligned to their scope of practice. Clinical supervision is one important forum that allows for review of clinical practice and professional development to occur.

The content of professional development activities should be directed towards 'enhancing professional competencies (both skills and knowledge) including keeping up to date with advances in research evidence, theoretical developments, clinical practices and relevant trends' [25]. These competencies relate to both the clinical context/treatment setting in which services are provided and the AOD clinician's professional background.

2.11 Worker Wellbeing

Taking care of AOD worker health is important no matter what role people are providing. When it comes to psychosocial interventions it is even more important. Working in the AOD sector can be very rewarding but the passion and dedication that drives many in this field can also potentially lead to stress, burnout and even 'compassion fatigue' if not accompanied by solid self-care strategies.

There is increasing recognition that workers in the health and human services fields often experience high levels of work-related demands and stressors and are particularly vulnerable to stress, burnout or vicarious trauma [26]. However, there are several strategies that are protective factors for reducing stress and hopefully avoiding burnout, including:

- Worker role clarity and workload review
- Regular clinical supervision and supportive management
- Social supports and community connection
- Cultural mentoring and support

- Time out, breaks and leave from work
- Involvement in decision making
- Support for self care

More detail relating to worker wellbeing can be found at:

- NADA Worker Wellbeing Resources – **www.nada.org.au/resources/worker-wellbeing/**
- WellMob – Healing Our Way – **www.wellmob.org.au**
- NSW Health Employee Assistance: **www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2022_048.pdf**

Core Psychosocial Processes and Treatment Settings

03

In NSW the development of the Clinical Care Standards (CCS) for Alcohol and Other Drug (AOD) Treatment [3] is intended to provide a set of statements about the treatment a person can expect from the range of treatment settings they can access across the sector – both government and non-government. This section describes the core processes of psychosocial interventions and the nature of the settings where they may take place, independent of the specific type of psychosocial intervention or modality applied by the AOD clinician. The guiding practice principles outlined in **Section 2** ensure that psychosocial interventions are:

- Elevating the voice and approaches of Aboriginal and Torres Strait Islander people
- Person centred and feedback informed
- Trauma informed
- Holistic
- Reducing harms
- Addressing the experience of stigma and discrimination

These guiding principles emphasise the importance of tailoring the AOD treatment to the person and the outcomes that matter to them, through regular assessment and review of their care via feedback. In practice, the application of standardised core processes as outlined in the NSW Clinical Care Standards for AOD Treatment [3] ensures that the treatment provided can be intensified or reduced as needed – in alignment with a stepped-care approach [27]. It further outlines clear standards of practice for people providing AOD treatment and expectations of the care that all people accessing AOD treatment should receive.

An essential component in the provision of care is to seek and provide feedback with each person engaged in treatment, and use that feedback to shape the delivery of psychosocial interventions.

The NSW Clinical Care Standards for AOD Treatment describe six Practice Standards that all people accessing AOD treatment should expect to receive as part of safe, quality care, including:

1. Intake
2. Comprehensive assessment
3. Care planning
4. Identifying, responding to and ongoing monitoring of risk
5. Monitoring treatment progress and outcomes
6. Transfer of care

One of the most important ingredients of a successful psychosocial intervention is the effectiveness of the rapport building and therapeutic alliance between the person seeking treatment and the AOD clinician or worker [4]. General counselling such as supportive, non-judgmental discussions about the support a person is seeking and their experience of alcohol and drugs use, good interpersonal skills, empathy and the ability to provide clients with a warm, supportive environment in which to discuss their problematic AOD use – while not sufficient on their own to produce long term change – are associated with improved treatment effects and better outcomes for clients. It is generally accepted that, regardless of the treatment applied, therapeutic alliance and environment are likely to have a significant impact on client outcomes [28].

3.1 Clinical Care Standards

The Clinical Care Standards (CCS) for AOD treatment outline standards or core processes that each AOD clinician providing psychosocial interventions engages in as part of quality care. Every person who undergoes AOD treatment can expect to be engaged in these processes, regardless of the setting [3]. As depicted in Figure 5, each standard is informed by the others and some are revisited throughout the treatment journey – not always in a linear fashion.

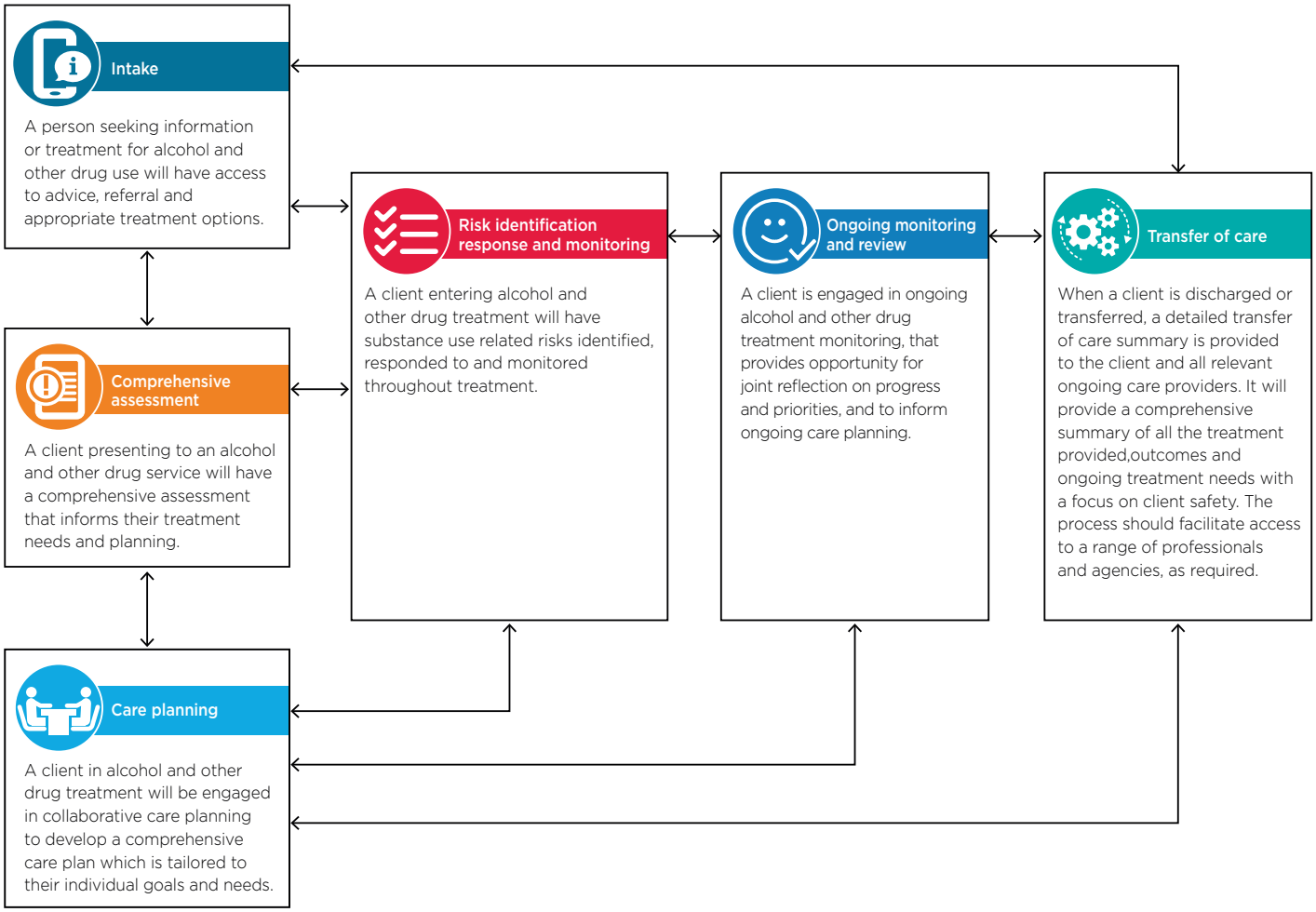


Figure 2. Summary of Standards [4]

3.1.1 Intake and Screening: Standard 1

Intake is the initial contact between a person or referrer and the AOD treatment system. As it is often the first point of contact with treatment services, building rapport is important. The intake interview is conducted to elicit key clinical information and facilitate access to the most appropriate service, and at the same time identify any urgent or crisis issues requiring immediate action. It is not equivalent to a comprehensive AOD assessment. [3]

Intake provides an opportunity to understand what may have prompted a person to reach out for AOD treatment and what they hope to achieve by engaging in treatment. Exploration of a person's AOD use, type(s) of substance used, in what quantities, how often and for what duration assists with assessment and treatment matching. Specific detail that may provide information about acute presentations, such as intoxication and withdrawal, is important in establishing whether additional services may be needed. It is also useful to explore any experiences the person may have had with AOD treatment and whether they have a current connection with other services.

Screening for current risks, crisis issues and co-occurring health and social needs e.g., mental health conditions, suicidal ideation and pain, is important to ensure a person is provided with information and additional referrals as appropriate. For specific detail on risk screening see **Section 3.1.4** Risk identification, response and monitoring. It is crucial to ensure a person remains safe during the period between the intake process and when they may engage in any psychosocial intervention; this may involve engagement with an alternate service or the provision of information to ensure their safety.

Key considerations for intake

- Engaging with the person reaching out for assistance is central to intake, as is appreciating that this may not be the first time they have tried to access assistance; so patience and warmth are key
- Intake is an opportunity to explore with a person what they need and what they may have tried before, and to identify any immediate needs or risks
- Where possible, treatment matching appropriate to the identified needs and goals of the person reaching out needs to occur
- Intake, assessments and treatment may all be unfamiliar, so it is an opportunity to provide information about treatment and what a person can expect from the treatment type you are offering
- Concrete information about next steps, including harm reduction and other strategies or supports to mitigate any identified risks, should be explored (For more on risk identification and monitoring such as violence, overdose etc, see 3.1.4)
- Ask about whether the person has parenting/ caregiving responsibilities and consider any impact their experiences may have on parenting and care giving – with consideration for any supports that might be explored
- Feedback from the person about whether they felt heard and are clear about next steps is critical, as is ensuring they have supports in place in the interim before they attend for AOD treatment

Managing intoxicated clients

Responding supportively to a person who may be intoxicated while attending for treatment is part of person centred care. Intoxication occurs when a person's intake of a substance exceeds their tolerance and is a transient state that may vary in severity. A risk assessment to ensure appropriate care is provided is part of any psychosocial intervention and includes gathering information on:

- What substances have been used and when, route of administration and how much
- A person's AOD use history and level of dependence
- Relevant medical history (other chronic conditions such as diabetes can mimic intoxication)
- Specific risk factors (suicidal ideation, previous overdose etc)

How a person presents when intoxicated will be shaped by the factors outlined above and may contribute to the types of behaviour exhibited. Safety is key for the person who is intoxicated and where there is evidence of distress, de-escalation techniques should be applied – such as being in a safe, quiet place, speaking calmly, respecting personal space and monitoring for any signs of overdose. It may be useful to keep the session brief while acknowledging the effort made to attend, and to reschedule for a time in the near future. Making contact with a support person, with permission, may assist in ensuring the person is safe when leaving or completing the contact. There may be a scenario where notifying additional supports as part of duty of care is assessed as appropriate such as where a person who presents as intoxicated is assessed as having additional risks [28].

3.1.2 Comprehensive Assessment: Standard 2

It is essential for clients attending AOD treatment services to have a comprehensive assessment conducted at the start of treatment in order to attain a thorough understanding of the client's presentation. It explores what outcome(s) the client is seeking, their substance use and related physical, psychological, social and cultural considerations. It is also an opportunity to explore with the client their strengths and any requirements that they may have, to support engagement in treatment. Comprehensive assessment identifies what needs to be considered and included in the care plan. [3]

A comprehensive assessment will explore in detail the presenting issues of the client, their background and personal history, AOD use history (including current use), what goals they may have for treatment and whether they are engaged in any other AOD or related interventions. Exploring information about the full range of other mental health, physical health and social needs they may want support with, and what positive areas of their life are currently in place as supports, is part of gathering a holistic picture. During the assessment the need to raise sensitive issues will arise and therefore empathy, warmth and genuineness are essential [4].

Key considerations for comprehensive assessment:

- Maintain engagement and ensure a therapeutic approach: a good general method is to ask open-ended questions, to listen reflectively, affirm the client and summarise throughout
- Unearth strengths and supports the client feels that they already have or that may be nurtured
- Document current and future needs, and work alongside a client to determine their priorities
- Ensure the client understands confidentiality, privacy and their rights, as well as the nature of psychosocial interventions and what that entails
- Identify any areas of risk and specific plans to mitigate those risks (more detail can be found in **3.1.4** Risk identification)

At the conclusion of a comprehensive assessment, a case formulation or summary is completed that identifies the '5 Ps':

- Presenting problem or area of concern – what has brought the person here today?
- Predisposing factors – aspects of a person's life that may have contributed or made them susceptible to their current circumstances, such as mental health history, trauma experiences
- Precipitating factors – recent events that may have contributed/caused the current situation such as a breakdown in relationship(s), stressful life situation
- Perpetuating factors – the things that may keep a person feeling stuck, such as how they see themselves, homelessness, DFV situation
- Protective or positive factors that may play a role in supporting treatment outcomes

Feedback from the client about whether they felt heard and safe, and if there is anything else they wish to talk about, is key in commencing the therapeutic relationship based on openness and the understanding that you will request feedback from them throughout their treatment journey.

3.1.3 Care Planning: Standard 3

A care plan is a document in which the client's short to medium term goals regarding substance use, health and welfare are identified and recorded. It is used as a tool to engage clients in decision making related to their substance use, health and welfare needs and designed to assist in improving quality of treatment through enhanced communication with the range of service providers and carers involved in client care. It outlines treatment goals, actions to achieve these goals, the person(s) responsible for completing the planned actions and review dates. [3]

Devised in collaboration with a client, a care plan explores key issues they wish to focus on, what kinds of supports/interventions may have been useful in the past and what might be useful now. Identifying areas of engagement and support such as friends, support groups and activities, and who or what else might assist or sustain improved outcomes, are all part of this process. Identifying realistic goals and reviewing regularly assists with motivation, and it is also useful to identify the outcomes a client might expect to see, such as an improvement in wellbeing, reduction of substance use and improved connection with supports – these can be captured via outcomes measures (see more in 3.1.5) and feedback from the client.

Offer a copy of the care plan to the client so they can refer to it or share with external supports should that be helpful. Where appropriate, have specific conversations around relapse prevention and harm reduction strategies. Psychoeducation about the effects of various substances, their withdrawal symptoms and how to manage them safely (where possible) may also be useful to provide as part of the care plan that they can take away with them.

Clients should feel that goals and treatment plans target their wants and needs, and decisions may need to be made about whether their major goal needs to be broken down into smaller, short term goals, as this approach will allow for positive reinforcement of any changes made in the direction of the ultimate goal. Taking a strengths based approach to treatment planning and implementation will help counter the messages clients receive and internalise about their problematic drug and alcohol use and encourage self-efficacy for change.

Key considerations for care planning

- Care plan development is a collaboration with the client, and any support people they feel might be helpful to involve
- Review with the client their situation, including strengths, on a regular basis
- The care plan should encapsulate stated client goals and current support needs
- Outline in detail the strategies for achieving goals, breaking these down into achievable parts
- Describe the way progress and outcomes will be measured and engage the client in the plan's collection and exploration of these, seeking feedback in relation to the goals they have in mind for themselves
- Feedback should also be sought from each client on a routine basis after each session to ensure you have heard them, they have felt safe and they are getting their needs met (for more information see 3.1.5 on Outcomes monitoring)
- Offer a copy of the care plan to the client for their reference

3.1.4 Identifying, Responding to, and Ongoing Monitoring of Risk: Standard 4

Assessing risk is an important part of AOD treatment. Identifying and responding to risk commences at intake and continues throughout treatment. There is a range of risk factors to be considered, including personal characteristics and circumstances, behaviours the client or external people may be engaging in, and risks associated with the substances being used. Core risks are risks that should be considered routinely for all clients in AOD treatment, regardless of the substances used or the treatment they are receiving. There is also a broad range of other risks and harms that should be considered depending on the clinical presentation. [3]

CORE RISKS To be considered for all clients	NON-CORE RISKS Non-core risks to be considered based on individual presentation
• domestic and family violence	• deteriorating physical health
• child wellbeing	• significant cognitive impairment
• overdose, including poly sedative use	• injecting drug use risks (e.g. blood-borne virus transmission)
• complicated withdrawal history including withdrawal seizures and alcohol withdrawal delirium	• perinatal risks including during pregnancy and breastfeeding
• recent release from hospital or residential health setting (including residential rehabilitation) or a custodial facility (e.g. prison, remand, police cells)	• unstable or deteriorating mental health; psychosis/delirium
• risk of harm to self or others	• sexual health
• risk of homelessness or eviction	• fitness to drive

Table 2: Core and non-core risks [4]

Responding to violence, abuse and neglect

The following is a summary of some of the key legal and policy responsibilities relevant for AOD Services and workers when responding to clients with experiences of violence, abuse and neglect, and should be read in conjunction with the information presented earlier in **Section 2.1.7**. More detailed guidance, including practice guidance on clinical interventions in these areas, is available from the NSW Health policy directives:

- **Responding to Sexual Assault (adult and child) Policy and Procedures**
- **Identifying and responding to domestic and family violence Policy and Procedures**
- **Child Wellbeing and Child Protection Policies and Procedures for NSW**

Domestic and family violence

Upon suspecting any client (irrespective of gender) of experiencing DFV, NSW Health policy requires NSW Health workers to ask direct questions about the possibility of violence and provide responses to disclosures. NSW Health Workers should be guided by the **Identifying and responding to domestic and family violence Policy and Procedures**.

The AOD workforce must engage new clients in questions relating to potential experiences of violence in the following manner:

- Ask about DFV only when the client is alone (or with an accredited interpreter); workers should never ask questions about suspected violence and abuse when the possible perpetrator or others are present
- Provide time for the client to disclose, and listen carefully to their concerns
- Respect the client's choice not to disclose and do not pressure them to talk
- Ensure a safe, calm and private environment

AOD clinicians where appropriate should also use a DFV screener tool and apply a 'structured professional judgement' approach that combines the use of a structured risk assessment tool, professional judgement and the victim's own assessment of risk.

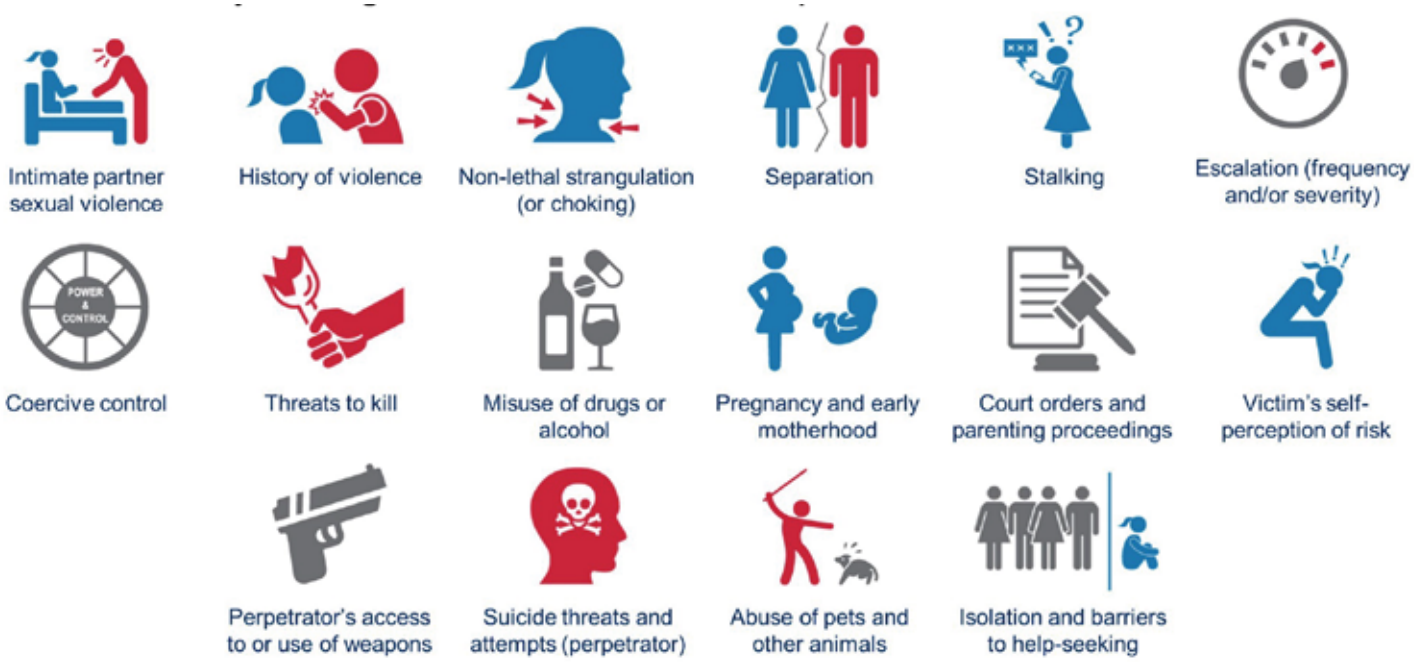
Where a client is identified as being at serious threat, health workers should advise the client (where it is safe to do so) of their serious concerns for their safety and work collaboratively with them on safety planning strategies to reduce threat. Responses may include:

- Referral to a **Safer Pathway Safety Action Meeting** (SAM). All clients assessed as being at 'serious threat' should be offered a referral to a SAM. SAMs are fortnightly meetings attended by government agencies and local service providers to coordinate service responses for clients assessed at serious threat
- Urgent referral(s) to NSW Health Violence, Abuse and Neglect services and/or specialist DFV services for ongoing risk assessment, safety planning and support. Where a referral is not immediately available, the health worker will actively support the client to access crisis services such as **NSW Domestic Violence Line** (women only – 1800 65 64 63) or **1800RESPECT** (1800 737 732) and support further safety planning and action to reduce the threat prior to the appointment ending
- Reporting to NSW Police. The decision to report to NSW Police or share information must be considered on a case by case basis, taking into consideration DFV risk assessment (assessed threat level); views of the client; seriousness of the injury/injuries and the offence; the context of the therapeutic relationship and risk of damage to it; and whether or not an offence has been committed on health premises or a health worker has been threatened in their role.

While working with perpetrators of violence is a specialised area of intervention, engaging in safe and non-collusive conversations with clients who use violence is important. Understanding patterns of coercive and controlling behaviour, seeking out clinical supervision support and engaging in training are all part of providing AOD psychosocial interventions. *"As practitioners and community members, we can be empathic to some of the difficult situations that some perpetrators have experienced in their lives, while still expecting them to make non-violent choices"* [29]

Resources

- NADA Practice Resource: Engaging men who perpetrate domestic and family violence in the alcohol and other drugs treatment context
- **https://nada.org.au/resources/engaging-men-who-perpetrate-domestic-and-family-violence-in-the-alcohol-and-other-drugs-treatment-context/**
- Say It Out Loud: a resource for healthy LGBTIQ+ relationships – **https://sayitoutloud.org.au/?state=NSW**



[30]

Figure 3: High risk-factors for domestic and family violence

Responding to suicidal ideation

Suicide prevention is a focus for all health staff including the AOD workforce and it is therefore vital to screen, respond and take action once suicide risk is identified. Self-harm and suicidal ideation needs to be screened and discussed with each new client as part of intake and comprehensive assessment; it then needs to be part of regular risk monitoring and checking in. Standardised tools can be used and it is important to employ plain/direct language and avoid euphemisms. In 2020 NSW Health instituted the **Zero Suicides in Care Initiative**, informed by the Zero Suicide Healthcare Framework which identified that evidence based practices can be applied across the elements of suicide care, supported by leadership, training and ongoing improvement.

Compassionate care of people who may be suicidal is also culturally responsive, inclusive, non-judgmental, person centred, recovery oriented, trauma informed (including recognising the potential of mental health service environments and interventions to cause or compound trauma), and evidence based. As suicide risk is dynamic and subject to change, a risk assessment should be part of a process rather than an isolated event. Therefore, it is important that all clients are assessed for suicide risk regularly as need presents and at different change points during treatment, such as intake, transition from one phase of treatment to another and at discharge.

Key considerations for risk monitoring

- Monitoring and responding to risks is an ongoing process throughout treatment
- Frequency of monitoring should be planned and not less than every three months
- Standardised processes for recording risks and their responses should be in place, including documentation, assessment and response
- Ensure the identification of risks and planned responses are devised in collaboration with clients so that they have specific strategies in place
- Engage with other professional specialists where risks are identified that may fall outside the scope of practice for AOD treatment
- Ensure pathways for escalation are in place and all staff are aware of their accountability

3.1.5 Monitoring Treatment Progress and Outcomes: Standard 5

Monitoring treatment progress and outcomes is an ongoing process and brings together the information collected in continuous assessment (including comprehensive assessment in Standard 2), care planning (Standard 3), identifying, responding to and monitoring risk (Standard 4), implementing the treatment plan, reviewing treatment progress and discharge planning (Standard 6). It is an opportunity to partner with clients for joint reflection on progress and priorities and informs ongoing care planning. [3]

Validated tools are essential in monitoring treatment progress, and feedback should be sought from each client throughout the treatment process. Frequency of review is determined by treatment type, risk factors and clinical presentation, and should occur at least every three months. Clients should be encouraged to provide feedback on their psychosocial interventions.

Key considerations for monitoring treatment progress and outcomes

- Monitoring treatment progress and outcomes is an ongoing part of treatment and should shape how treatment is delivered to each individual in real time
- Validated measurements that are associated with the outcomes people expect from AOD treatment are useful as they provide an opportunity for benchmarking – the key is to use validated tools that explore specific areas such as AOD health, mental health and wellbeing outcomes
- Frequency of review needs to be determined by treatment type, risk factors and clinical presentation and occur at least every three months
- Review treatment progress and provide feedback to clients, reflecting on what is working and what needs to change
- Use outcomes to shape care planning, as a dynamic tool within therapeutic sessions and as a useful discussion point on how treatment is progressing
- Ensure the interpretation of a tool is within your scope of practice/expertise, some tools require specialist training to administer and interpret results

3.1.6 Transfer of Care

When a client is discharged or transferred, a detailed transfer of care summary is provided to the client and all relevant ongoing care providers. It will provide a comprehensive summary of all the treatment provided, outcomes and ongoing treatment needs with a focus on client safety. The process should facilitate access to a range of professionals and agencies as required.

Transfer of care, including discharge, is a process of identifying and documenting a client's needs which includes information regarding engagement in treatment, relapse prevention and harm reduction information as appropriate. Transfer of care may be required at any time throughout the client journey in the AOD health system and may occur:

- between treating clinicians or service providers
- to other AOD community-based services and agencies
- on completion of the agreed treatment plan
- to a client's own care [3]

Transfer of care may occur both within an episode of care and at the completion of an episode of care. In the case of a transfer of care occurring within an episode of care, eg. at a treatment handover meeting, a useful approach is ISBAR (see below) which provides a means of handover with all relevant information to maintain safe, quality care.

- ✓ **Introduction**
- ✓ **Situation**
- ✓ **Background**
- ✓ **Assessment**
- ✓ **Recommendation** [31]

Key considerations for transfer of care

- Completing or ceasing treatment is a significant change in a client's experience – it may be either planned or unplanned, and in both situations it is important to prepare for completion at the commencement of the treatment journey
- Planning for treatment completion needs to include a thorough exploration of the ongoing supports currently in place for the client, and those that they might want to cultivate for themselves
- Reviewing the treatment experience – what was useful and not so useful – assists with relapse prevention and harm reduction. Strategies for both need to be discussed and where appropriate documented for a client's later reference
- Linking clients formally with the services with which they will be connecting after they have ceased treatment with your service is important, as is ensuring that a contact person is aware of any referral, and that appointments and/or meeting times have been communicated to all relevant people
- A written discharge summary or transfer of care plan needs to be provided to the client, to service(s) that may be providing ongoing support, and placed on file as a record
- A discharge summary or transfer of care plan should contain the following elements:
  - A description of the reason for presentation to the AOD service
  - The treatment provided by the AOD service during the treatment encounter including key timeframes if appropriate
  - For clients who are prescribed or dispensed medication by the service during the encounter, the following should be included as a minimum:
    - A list of the medications prescribed or dispensed by the AOD service that are current at discharge
    - Changes made to medications by the AOD service
    - The ongoing plan for these medications
    - A statement noting that the client may be on other medications

- How the client responded to treatment, including progress on goals, new skills or understandings developed, and a description of quantitative outcome scores if relevant
- A summary of current and ongoing concerns, risks, strengths and protective factors; and plans to monitor and address these, including who is responsible
- Recommendations for ongoing care needs, including the option to return to the AOD service in the future

3.2 Waitlist Management and Assertive Follow Up

Due to the high volume of people seeking treatment a waitlist system is frequently instituted. It should be noted, however, that people usually reach out for support for AOD treatment when they are in crisis and therefore strategies to support people assertively while they wait for an appointment is crucial. Assertive follow up is an important element of evidence based practice, providing useful information about treatment efficacy, effective components of treatment and relapse rates [4].

Waitlist management is dependent on the needs of priority groups, a client's level of risk and existing supports, and the capacity of the service or program. Specific groups such as pregnant women need to be prioritised and the waitlist should be reviewed frequently. Where possible, offers of support group sessions, phone or text check-ins or alternate supports should be explored. Follow up with clients on a waiting list as well as those who miss an appointment assists with motivation and connection. Potential barriers such as childcare responsibilities or work commitments need to be identified to ensure the treatment being offered is appropriate. It is recommended that clients who have been in treatment are followed up between one and three months after treatment, irrespective of whether or not they have relapsed.

3.3 Integrating AOD treatment Modalities

The full range of AOD treatment options should be presented to people reaching out for support, including pharmacological and/or psychosocial options and inpatient/outpatient programs, as well as the scope of providers – public, private and non-government sector. A range of modalities is available for the delivery of psychosocial interventions including face to face approaches, virtual care and other forms of self-help solutions. AOD clinicians need to be aware of and able to discuss the range of available treatment options with clients, provide advice around these issues and integrate the most appropriate options into the AOD treatment plan developed for each client. The addition of complementary AOD treatments, such as pharmacotherapy that can be supported by psychosocial interventions, need to be explored with each client.

Table 3 provides an outline of the various pharmacotherapies available for different substances – the AOD clinician can then work alongside medical practitioners to ensure holistic care is provided. In assessing a person's suitability for a particular pharmacotherapy, it is essential in all cases to work alongside addiction medicine and nurse practitioner colleagues and specialist GPs in this area. You, and any health worker, can also reach out to the Drug and Alcohol Specialist Advisory Service (DASAS) for more information on any of these medications.

Drug and Alcohol Specialist Advisory Service (DASAS)

- **Sydney metropolitan (02) 8382 1006**
- **NSW regional, rural and remote 1800 023 687**

Table 3: Pharmacotherapy options for substances

Principal drug of concern	Medication*	Brand name example	Route of administration	Who might it be useful for
Alcohol				
	Acamprosate	Campral	Oral	Helps maintain abstinence from alcohol in persons with moderate to severe alcohol use disorder whose goal is abstinence
	Disulfiram	Antabuse	Oral	Helps maintain abstinence from alcohol by deterrent effect in persons whose goal is abstinence – unpleasant physical side effects result if drinking occurs while taking disulfiram. Not suitable for persons with significant co-morbid cardiovascular, respiratory or hepatic disease.
	Naltrexone	APO-Naltrexone	Oral	Helps reduce relapse to heavy drinking – not suitable for persons with opioid dependence or chronic pain conditions requiring opioid analgesia.
Opioids (heroin, codeine, morphine etc..)				
	Methadone	Methadone syrup, Biodone Forte	Oral	An opioid agonist, it supports people to reduce or cease opioid use by suppressing opioid withdrawal symptoms and reducing cravings. Initially requires daily attendance to optimise dose. Some people prefer the more sedating effects of methadone compared with buprenorphine.
	Buprenorphine	Subutex	Sublingual	A partial agonist which means it is a safer opioid than methadone in relation to risk of over sedation and overdose. Supports people to reduce or cease opioid use by suppressing opioid withdrawal symptoms and reducing cravings. Optimal dose usually reached more quickly than with methadone.
	Buprenorphine and Naloxone	Suboxone	Sublingual	A partial agonist which means it is a safer opioid than methadone in relation to risk of over sedation and overdose. Supports people to reduce or cease opioid use by suppressing opioid
	Buprenorphine depot	Buvidal and Sublocade	Weekly or monthly depot injection	Useful option for people who would like or need greater flexibility with dosing due to work, travel or family commitments.
	Naltrexone		Oral	For people who have abstinence as their goal. Evidence for the effectiveness of this pharmacotherapy in maintaining abstinence from opioids is weak, although has been helpful in some highly selected patients
Nicotine				
	Nicotine Replacement Therapies	Nicorette, Nicabate, QuitX	Patches, gum, lozenges, nasal and mouth spray, inhalers	Assists a person by providing nicotine in a safer formulation and without having to smoke. Reduces cravings and withdrawal and can be purchased without a prescription.
	Varenicline	Champix	Oral	Reduces cravings, withdrawal and the enjoyable effects of smoking.
	Bupropion	Zyban	Oral	Suitable for people who have made multiple quit attempts. Can be used in conjunction with NRT and if the person is not suitable for varenicline. Also has antidepressant properties.
Methamphetamine				
	Dexamphetamine		Oral	A short-acting stimulant medication used in the treatment of ADHD, currently prescribed as part of clinical trials as a potential agonist pharmacotherapy for people who are dependent on methamphetamine.
	Lisdexamfetamine		Oral	A long-acting stimulant medication used in the treatment of ADHD, currently prescribed as part of clinical trials as a potential agonist pharmacotherapy for people who are dependent on methamphetamine.
	Modafinil		Oral	Sporadically prescribed off-label for methamphetamine or cocaine dependence. Research evidence for its effectiveness is weak.

*Some of these medications are contraindicated in pregnancy and should be considered at assessment

3.4 Community Links and Partnerships

To facilitate an integrated treatment program for each client, AOD clinicians need to develop and maintain strong clinical partnerships with professionals working with other treatment modalities and in other treatment settings. The formalisation of these partnerships, particularly between government and non-government sectors, can enhance treatment provision and ensure a coordinated, consistent approach to the client's care is maintained [32].

If the service within which the AOD clinician is operating does not have links with particular relevant services, the AOD clinician can create and foster these partnerships with individual workers within other clinical settings. This way, arrangements can be formalised for the responsibility of service provision to the client, and the release/sharing of client information (with client consent). The most effective and useful response in this situation is to establish strong respectful partnerships with other services that can fill the gaps that may not be covered by AOD treatment, such as childcare support, specialised mental health support, practical welfare interventions and healthcare.

Key elements of building good partnerships

- Clear goals and purpose
- Clearly defined roles and responsibilities
- Documentation that explains the nature of the partnership
- Robust monitoring and evaluation
- Sharing of information with clear protocols
- Use of 'local champions' within partner organisations
- For long term partnerships, a clear purpose and governance structure is recommended [32]

3.5 Continuing Care

Continuing care is the provision of support and/or services (such as support groups, supported accommodation and case management) that occurs after a more intensive initial period of AOD treatment, such as intensive counselling. It can also include services and support that assist a person to connect and maintain engagement with AOD treatment which may be delivered through community-based programs and primary care. A standard program of continuing care may include regular contact (usually monthly) with a range of providers, including psychiatrist/medical professional for medication monitoring, along with access to a case manager for service coordination, and/or outreach. Continuing care allows for ongoing contact that triggers 'step up' or 'step down' treatment for the client, depending on their needs.

As there are very few methodologically strong studies focused on continuing care, data is limited. However, existing evidence indicates a trend of better outcomes from continuing care interventions which involve the client more actively, when compared to 'usual continuing care'. There is also specific evidence for the benefit of continuing care with young people [6].

3.6 Service Delivery in Regional and Rural Areas

People living in rural/remote communities report particular difficulties accessing psychosocial treatments because of limited available services and geographic isolation. In addition, attitudinal or cultural barriers to treatment for substance misuse may be more prevalent, reducing the likelihood of rural clients engaging in self-help meetings or treatment more generally. The benefit of self-guided approaches, such as bibliotherapy or computerised treatments, in these settings cannot be overstated, along with the potential for psychosocial treatments to be offered via virtual means. However, 'on the ground' support between counselling sessions is critical for the provision of holistic care. The need to adequately assess access (appropriate devices, data and IT support) is also important [33].

As in other communities, AOD professionals working in rural/remote areas need to spend time networking with local health providers and fostering trust, non judgmental acceptance and confidentiality in their engagement with rural clients. In small rural communities, anonymity is very difficult to maintain, presenting a range of additional challenges for the AOD professional in maintaining professional boundaries with the client group. However, supportive supervision and networking with other services can assist in the integration of working and living in smaller communities.

3.7 Virtual Care

Providing psychosocial Interventions using technology (telephone or via video link) is now commonplace. The provision of such services to people who may not otherwise be able to access them as a result of remote location and disability, or who prefer to receive them via these means, is an important option to be able to provide. There are, however, a number of important considerations in setting up and facilitating access to safe, high quality psychosocial care. According to current literature, virtual care or technology-based interventions (TBIs) were effective in general, yet there were no reviews of studies on the implementation of these interventions in real world clinical practice [6]. Furthermore, most of the virtual care or TBIs identified used digital adaptation of existing treatments (eg. Cognitive Behavioural Therapy). However, most of these were blended interventions (eg. Motivational Interviewing (MI) + CBT) or interventions not adhering to a specific therapeutic orientation (often described only as counselling or psychotherapy). Common elements to these interventions included assessment and personalised normative feedback, psychoeducation and goal setting. One review identified factors related to the success of internet based interventions, specifically that they should be intensive (requiring engagement and assignment completion), include educational material, only be used as an adjunctive rather than mainstay approach, and apply a progressive approach through a course of treatment [33].

Key elements of providing virtual care

- Consider how you set up your space for delivering virtual care
- Ensure the person to whom you are providing virtual care has adequate equipment and data, and is able to engage in a safe environment
- Record the person's location and who may also be present for reasons of safety and if an emergency response is required at any time
- Prepare your client by letting them know what to expect and what to do if the connection is lost, and ensure you have their contact details (or those of a safe support person) for risk management
- Check your positioning on the screen and use eye contact with the camera to ensure there is a connection with the person to whom you are providing therapy; active listening skills are vital, and you should use affirming nonverbal cues
- Become familiar with the video platform you are using and support your client in navigating its use
- Ensure you are in a quiet and confidential space

For further information, refer to the NSW Health AOD Virtual Care guide

Psychosocial Interventions

04

Psychosocial interventions are the mainstay of AOD treatment and the most common treatment type provided in NSW year on year. They are therapeutic and interpersonal in nature, attending to the needs of the whole person within their unique social context. Provided on an individual or group basis, psychosocial interventions seek to enhance psychological, emotional, physical and social wellbeing. They may be conducted in a number of settings including face to face, via telephone and virtually (ie. via videoconferencing).

This section explores those psychosocial interventions that are evidence based for application in the AOD treatment sector and/or are frequently applied in AOD treatment by clinicians with specific training and expertise. As indicated in **Section 1** the interventions explored here are informed by a summary of the current evidence, published between 1 January 2008 (2013 for guidelines) and 31 January 2020, and are inclusive of people aged 12 years and over. In addition, Expert Advisory Groups who informed the original Psychosocial Guidelines and the group formed for the development of this current edition, provided guidance based on their experience.

To explore a summary of the levels of evidence and quality of evidence assessment on specific features such as clinical impact and generalisability, please refer to **Appendix A**. Evidence based interventions explored here are based on the previous edition of the Guidelines, the updated Evidence Check [6] and advice from an AOD Clinical Expert Advisory Group.

Trauma informed

A trauma informed approach is applicable for all people accessing AOD treatment regardless of the psychosocial intervention applied, based on the understanding that a significant number of people who may access AOD treatment have experienced trauma in their lives [34]. Trauma informed care emphasises physical, psychological and emotional safety for both clients and providers, and helps survivors regain a sense of control and empowerment over their lives.

Core trauma informed principles are:

- **Safety:** In what way can I/an AOD treatment service create a space that is physically and emotionally safe for each person who reaches out for support?
- **Trust:** We will shape practices in AOD treatment that engender trust through providing clarity, being consistent and transparent, and having clear boundaries
- **Choice:** We will provide opportunities for people accessing AOD treatment to have choice and a sense of autonomy over how treatment is provided
- **Collaboration:** We will engage in collaborative practice that maximises power sharing and allows for AOD treatment to be person-led
- **Empowerment:** We will create opportunities for people accessing AOD treatment to experience empowerment through skills building and self determined decision making, and we will value their strength and expertise
- **Respect for Diversity – Culture, gender, history and identity:** We will regard diversity as a strength and respond with a person centred approach that acknowledges the experience of stigma and discrimination [12, 35]

As part of a trauma informed approach, choice about how and where treatment is provided is essential; a person may prefer to engage in individual or group treatment, and/or to participate face to face or via a virtual setting. The provision of clear, concise information describing available treatment options is also essential to good practice. This information may be provided electronically, on a website or as an information sheet that can be physically provided to the person seeking treatment, giving them the option to explore the information later or share with others. Basic information can include the rights and responsibilities of the person accessing treatment, and for the AOD clinician a brief description of the treatment, a summary of what the client can expect during treatment and tips for addressing any potential barriers to access and participation.

Person centred

Person centred care is the delivery of AOD treatment that is respectful of and responsive to the preferences, needs and values of all patients; as such it includes an appreciation for the significance and strengths of First Nations culture, and consideration of cultural, gender and sexual orientation. Person centred care ensures a flexible and responsive approach to AOD treatment delivery that emphasises the quality of the therapeutic relationship and allows for honest feedback on a person's experience of the treatment being provided.

Feedback informed

Providing person centred care is dependent upon seeking regular feedback from the client about their experience of treatment and whether the outcomes that matter to them are being achieved. Routine outcomes measurement and client feedback help strengthen the psychosocial intervention being provided while allowing for review and the making of subsequent adjustments as needed. Regular review of treatment goals alongside outcomes data and the client experience ensures that psychosocial interventions are appropriately matched with the needs of the person seeking treatment.

Holistic

Psychosocial interventions for AOD use issues are clearly defined as different from pharmacological or medication based interventions. However, it is common for psychological interventions to be complemented by additional supports or interventions and the prescribing of medications to support treatment goals and assist with preventing relapse [1, 3, 4]. AOD clinicians need a comprehensive understanding of the range of pharmacological options available to people seeking treatment and links with potential prescribers who may become part of care planning. The variety of pharmacological interventions available in NSW that may complement psychosocial interventions is outlined in **Section 3.3** Integrated AOD Treatment Modalities.

4.1 Evidence-based Interventions and Practice Essentials

The key principles of person centred, trauma informed, safe and high quality care apply to the provision of all psychosocial intervention types. Evidence-based practice refers to the combination of research evidence, clinical expertise and feedback provided by the person in treatment, it is also shaped by the clinical context. The psychosocial interventions presented in this section are those that have an evidence base for use in AOD treatment and are endorsed by the clinicians who provide it. Current approaches to evidence building favour highly structured interventions, eg. Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI), that can be replicated in different conditions and conform to traditional research and evaluation approaches such as randomised controlled trials (the gold standard in determining the scientific quality of treatments provided). However, there is recognised evidence from research, in combination with clinical experience and self-reported outcomes from people attending treatment, that supports a broader range of psychosocial interventions, and those are also described. Some of the psychosocial interventions presented here have been evaluated in related sectors such as mental health treatment.

Effectiveness outcomes were broadly defined across the domains of general health, wellbeing and reduction of AOD use-related harms, again with reference to the domains focused on in the 2008 Professional Practice Guidelines. In keeping with the broad usage of these guidelines, the evidence was collated for both adolescents (aged 12 years and older) and adults, in diverse treatment settings located in countries similar to Australia (eg. UK, US, Canada, Western Europe) [5]. To assess the quality of the evidence relating to the use of psychosocial interventions in treating people with AOD use issues, a hierarchy of evidence was used, based on publications by the National Health and Medical Research Council (NHMRC), the Oxford Centre for Evidence-based Medicine Levels of Evidence, and the Melnyk and Fineout-Overholt – Level 1-7 [5]. In addition, the NHMRC body of evidence matrix with adapted wording was used to summarise

the evidence within the reviews. This matrix considered five components including evidence base, consistency, clinical impact, generalisability and applicability, and graded each from A to D (with A being excellent and D being poor) – see **Appendix A**.

Therapeutic alliance

The quality of the therapeutic relationship or alliance with the client – ensuring they have choice and are empowered through a strengths-based approach – is the foundation upon which any evidence based psychosocial intervention must sit. Treatment processes as explored in **Section 3** provide steps for the assessment, treatment planning and continued monitoring and review of a client's situation. Seeking regular feedback on a client's outcomes and experiences of treatment allows the approach to be adjusted as necessary, stepping up or down in intensity as required, and ensures that the care provided is truly person centred.

Emotion regulation

Contemporary understanding of the impact of trauma on a person's life course and overall wellbeing needs to inform the whole of the client journey throughout treatment. Empathy and the development of strategies for emotion regulation need to be part of AOD treatment for all who seek support. Several evidence based psychosocial interventions described in this section focus on emotion regulation. Supporting people to develop practical strategies in regulating their emotions assists with engaging in treatment (which itself has the potential to be stressful), improves coping in the community, and helps in sustaining treatment goals when faced with life challenges that may occur during the course of AOD treatment.

Harm reduction

Harm reduction strategies and AOD psychoeducation can be woven into all AOD psychosocial interventions and are an important part of AOD treatment. Harm reduction information is relevant for all people accessing treatment and recognises the need for information and strategies to reduce the harm that may be associated with AOD use. A comprehensive knowledge of the different substances in relation to which people may present to treatment, their effects, possible interactions with prescribed medications, and strategies for reducing the harm associated with their use, is essential for all workers providing treatment in the AOD sector. Harm reduction and psychoeducation interventions can be provided in both individual and group settings, whether face to face or virtual.

All AOD clinicians providing psychosocial treatments should be able to provide CBT and be competent in the use of one additional intensive psychosocial treatment with a strong evidence base for application to people experiencing problematic AOD use. It is incumbent on those who provide psychosocial treatment to contribute to the evidence through research and evaluation on the range of therapeutic tools and approaches that assist people in managing problematic AOD use, as different people will be better suited to different therapeutic models or approaches.

In this section, psychosocial interventions relevant for AOD treatment are outlined with:

- A brief description of the intervention and its key elements
- Relevant evidence of its application in AOD treatment
- Resources that provide more information, training and support for application

Decisions about which evidence based psychosocial intervention is most suitable for use need to consider the individual circumstances and preferences of the person seeking treatment and be guided by clinical expertise. Seeking regular client feedback coupled with routine outcomes measurement will ensure the treatment provided is person centred and responsive.

4.1.1 Brief Interventions

Brief interventions are generally between 5 – 90 minutes in duration, delivered in single or multiple sessions across a range of health settings and in some cases accompanied by written health information [36,37]. Brief interventions can be an effective first level of treatment and because they are brief they can be delivered opportunistically in both inpatient and outpatient settings by a range of specialist and generalist professionals trained in the use of these approaches [37].

Typically, brief interventions involve the provision of formal feedback from the comprehensive assessment (see **Section 3** for more detail), and brief advice regarding how best to reduce the harms that may have been identified through the assessment. Delivered in a sensitive, nonconfrontational manner, they are intended to raise awareness and invite a person to reflect on their use of alcohol and other drugs as they may not have previously considered it to be problematic.

The most effective brief interventions combine good general counselling skills with motivational interviewing techniques [36]. One example of how a brief intervention may be structured uses the FRAMES approach [36,37]:

Examples of how to structure a brief intervention using the FRAMES approach

- F: Feedback (risks, indicators, health status)
- R: Responsibility (communicate choice to change)
- A: Advice (importance of change, with permission)
- M: Menu (variety of change options – harm reduction)
- E: Empathy (warm, non judgmental, nonconfrontational)
- S: Self-efficacy (optimism to attain chosen goals)

Based on recent Cochrane systematic review of randomised control trials (RCTs) [38], brief interventions are rated with Level 1 evidence supporting the benefits of use, particularly with alcohol. There is also evidence of the benefit of generalist health professionals or those with specific drug and alcohol training delivering the intervention, in both generalist and specialist settings [39]. Brief, opportunistic interventions should be used routinely in all clients with problematic drug and alcohol use across a range of settings by specialist and generalist drug and alcohol professionals.

Resources and Training

- More detailed information on the provision of brief interventions can be found in Shand [38], Miller [36] and Hulse [40].
- Brief intervention tools are useful to work through with people – a number of examples can be found on the following websites:
  - Insight (**https://www.dovetail.org.au/news/2019/january/insight-s-brief-intervention-toolkit**)
  - AOD Knowledge Centre: Yarning Tools (**https://aodknowledgecentre.ecu.edu.au/key-resources/resources/25868/?title=Yarning+about+alcohol**)
  - DACAS: FRAMES brief intervention tool (**https://www.dacas.org.au/clinical-resources/screening-assessment/frames**)

4.1.2 Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET).

Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) are person centred methods or approaches to treatment for strengthening an individual's motivation for and commitment to change. MI/MET challenges a deficit-based approach by evoking a person's own strengths, motivations and resources and leveraging them for change. It is a collaborative, goal oriented style of communication with particular attention to the language of change [36]. Core skills familiar to psychosocial therapeutic interventions utilised as part of MI/MET are described by the acronym OARS:

- **O**pen-ended questioning
- **A**ffirmation, using affirming language
- **R**eflective listening
- **S**ummarising of the key points outlined by the person and feeding them back

Based on the stages of change model developed by Prochaska and Diclemente [41], it suggests that people will progress through a series of five stages in deciding and acting upon a plan to change a particular behaviour. These stages include: (i) precontemplation, (ii) contemplation, (iii) preparation, (iv) action and (v) maintenance, each characterised by the balance between the benefits/losses of maintaining current behaviour versus the benefits/losses of changing that behaviour.

MI/MET seeks to promote engagement, minimise resistance and defensiveness, and encourage behaviour change. It should be noted, however, that while the client's stage of change is a useful tool in assessing how they currently regard AOD use, care should be taken not to overemphasise the importance of stage of change in deciding on an appropriate treatment strategy. Clients will often be at different stages of change for different drugs, and this also needs to be taken into account in providing treatment. Importantly, the emphasis is on the client's ambivalence about their substance use and evoking their own arguments for change.

The main features of Motivational Interviewing are:

- **Engaging:** establishing a connection and strong therapeutic alliance with the person seeking treatment, and maintaining it as a continual process ***"It takes a lot of courage to reach out for support and be here, I just wanted to acknowledge that"***
- **Focusing:** a process of developing and maintaining a specific direction in the conversation about change; supporting a client to not feel overwhelmed by too many goals and options, and exploring the good and less good things about AOD use and what it might mean to change ***"You talked before about things not going well when you drink, can you describe to me what happened the last time you felt things didn't go well?"***
- **Evoking:** eliciting the client's own motivation for change ***"Can you describe to me the key reasons for making change now?"***
- **Planning:** developing a commitment to change and formulating a concrete plan of action – when your client is ready to take that step ***"Can we talk about how to put a plan together for making change – do you feel ready for that now?"***

Motivational Interviewing can be used in all phases of assessing and treating AOD clients to increase treatment engagement and adherence. Although it can be used as a standalone treatment, in general Motivational Interviewing is combined with other psychosocial techniques as a means of encouraging a reduction in problematic AOD use [5].

Resources and Training

- **Insight:** Motivational Interviewing eLearning – **www.insight.qld.edu.au/search?q=motivational+interviewing**
- **Headspace Clinical Toolkit:** Motivational Interviewing **www.headspace.org.au/assets/download-cards/CT-Motivational-Interviewing.pdf**
- **RACGP:** Motivational Interviewing for Adolescents and AOD use – **www.racgp.org.au/education/professional-development/online-learning/resources-and-webinar-series/clinical-support-resources**

4.1.3 Contingency Management

Contingency Management (CM) is based on the behavioural principles of reinforcing healthy behaviours that the client wishes to continue into the future [4, 6, 42]. For example, clients receive positive reinforcement, vouchers or other incentives to encourage the maintenance of their treatment goals, whether they be abstinence, medication compliance or attendance at treatment sessions [42]. CM is well documented in the research literature (Level 1 evidence) and often provided within the context of a research protocol – eg. reimbursement or vouchers for participation. In practice, the use of financial incentives is less often applied routinely, and may be more likely to be applied for early support and encouragement to transition from receiving pharmacotherapy in a public clinic to attending a private pharmacy for dosing. Another example is small rewards for reaching treatment milestones [42].

CM is based on the principle of positive reinforcement through incentives for desired behaviours and may include:

- Financial reward for a drug-free urine screen or alcohol-free breath test
- Opportunity to enter a prize draw for consistent attendance to counselling appointments
- Toys or vouchers for child activities where parents positively engage with AOD programs
- Subsidising treatment program costs to transition from public to community pharmacotherapy dosing

In practice, these strategies need to be embedded within a range of other treatment approaches to encourage clients to take ownership of their goals and the treatment process, following withdrawal of the reinforcement strategy. Contingency Management can be combined with other psychosocial approaches by suitably trained drug and alcohol professionals to reduce problematic AOD use.

4.1.4 Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy (CBT) is a structured psychological approach to AOD treatment aimed at identifying and challenging unhelpful thoughts, learning how these thoughts shape mood and how together they impact on behaviour. Designed to develop strategies to bring about positive change, CBT is based on the premise that events or situations are not the cause of feelings or behaviour; rather interpretations (thoughts/cognitions) of those events are what lead to actions and emotions [4, 6, 43]. The overall objective of CBT is to identify and challenge unhelpful beliefs that maintain problematic patterns of thought and behaviour, and replace them with more adaptive beliefs and behaviours.

Common CBT techniques include:

- Cravings monitoring and coping strategies development
- Cue exposure
- Contingency management – rewarding positive behaviour change
- Functional analysis – breaking down the factors (precipitating factors, thoughts, emotions/mood) that lead to an occasion of substance use
- Thought monitoring
- Mindfulness practices
- Relapse prevention strategies development
- Problem solving skills
- Social skills training

Behavioural strategies should be introduced first, with cognitive strategies commenced later in the treatment program when thinking may be clearer, problematic drug and alcohol use may have reduced and negative mood states lifted [43, 44].

CBT has the best-documented efficacy of the psychosocial approaches for the treatment of clients with problematic AOD use. This is because it is the most thoroughly research psychosocial intervention. In the recent literature review [5] reductions in use attributed to CBT interventions were found for alcohol [45] and cannabis [46-49], but less consistently positive results in the treatment of other substance use; CBT was often no superior to control/comparison in improving rates of benzodiazepine discontinuation [50], opioid abstinence [51] and smoking cessation [50]. In addition, combined CBT and other behavioural therapy led to greater improvements in psychosocial functioning for people with cannabis use issues compared to controls/comparisons (including Treatment As Usual (TAU) and waitlist control) [48]. There was also some evidence that higher-intensity CBT led to greater improvements in severity of cannabis use disorder and cannabis related problems compared to lower intensity CBT.

CBT strategies are effective with all AOD clients to improve psychosocial outcomes, reduce problematic AOD use, and reduce risk of relapse.

Resources and Training

- Counselling Guidelines: Alcohol and other drug issues Marsh et al 2013 **www.mhc.wa.gov.au/media/1178/aod-counselling-guidelines.pdf**
- CBT for AOD Workers: Insight – **www.insight.qld.edu.au/toolkits/cbt-4-aod/detail**
- A brief CBT intervention for regular amphetamine users: UNE **www.drugsandalcohol.ie/13632/1/NTA_AMPHETAMINE_cognitive-intervention.pdf**
- CBT for Youth in AOD: Youth AOD Toolbox **www.youthaodtoolbox.org.au/cognitive-behaviour-therapy**

4.1.5 Mindfulness Based Interventions

Mindfulness Based Stress Reduction (MBSR) is a meditative practice which involves intentionally bringing one's attention to a range of physical, emotional and cognitive experiences in the present moment (47). MBSR has been used as a standalone treatment for craving management, stress management, emotion regulation and relapse prevention. It has also been adopted alongside other therapies such as CBT and DBT. It serves as an alternative coping strategy for people who may use alcohol and other drugs as a way to manage stress, anxiety, depression and other life challenges.

Key elements to applying MBSR in practice:

- Create a sense of safety in the environment before guiding a person through a mindfulness exercise – eg. closing their eyes may trigger a trauma response, soft gaze on the floor is adequate
- Emphasise that mindfulness is not about clearing your mind, but rather focusing on the here and now; a focus on the breath can be used as the foundation for mindfulness exercises
- Encourage people to view MBSR as a practice, like exercise or other activities that you engage with routinely
- Providing choices to a person: would they like it to be guided, is there music or visual imagery that may support this practice?
- An emphasis on observing your thoughts as a stream of consciousness without judgement
- Check in with a client after a mindfulness practice to ensure they feel calm and safe before they leave the session

Mindfulness Based Interventions (MBIs) appear to offer clinically significant albeit preliminary advantages over other therapeutic approaches on AOD use-relevant outcomes such as abstinence and reduction in perceived stress [5, 52]. A combination of Level 2 and 3 evidence is available based on a systematic review of RCTs [53]. MBIs were found to be superior to control/comparisons (including other active interventions) on perceived stress and distress, emotion regulation and mindfulness, health related quality of life, pain severity, and functioning interference. [53-55].

Resources and Training

- Counselling Guidelines: Alcohol and other drug issues – **www.mhc.wa.gov.au/media/1178/aod-counselling-guidelines.pdf**
- Comorbidity Guidelines: Mindfulness Training – **www.comorbidityguidelines.org.au/psychological-approaches/psychological-approaches/mindfulness-training**

4.1. 6 Acceptance and Commitment Therapy (ACT)

ACT grew out of Cognitive Behaviour Therapy and mindfulness-based approaches to managing a range of conditions such as pain, chronic illness and stress [56]. Generally ACT aims to retrain clients who have typically been avoiding painful events such as thoughts, memories, feelings and bodily sensations to feel more comfortable experiencing these events [56]. This willingness to 'approach' problems, as opposed to avoiding them and situations that stimulate experience of these problems, is thought to increase the client's capacity for change. Given clients are asked to explore a range of deep emotional issues, a strong therapeutic relationship built solidly on trust is fundamental to the use of ACT. Evidence presented in the current literature review indicates alignment with outcomes for MBIs – Level 2-3 [5].

Key principles of ACT and their application include:

- Acceptance (expansion): supporting someone to make an active choice to allow unpleasant experiences to exist without trying to avoid or change them
- Cognitive defusion: assisting someone to allow thoughts to come through, noticing them as just thoughts and then letting them go, rather than holding on to them as truth
- Being present: being present in the moment without trying to predict or change the experience – supporting a client through a mindfulness exercise to experience being in the present moment
- Observing of self: accepting that we are not only what happens to us but also the experience of what is happening, and doing this with openness and curiosity
- Values clarification: exploring with a person what is meaningful to them, and how we can hold on to our values even when we have negative experiences
- Committed action: supporting a client to set SMART (Specific, Measurable, Assignable, Realistic and Time related) goals that are reasonable and achievable

ACT can be used in the treatment of problematic drug and alcohol use by suitably trained and experienced AOD professionals.

Resources and Training

- **ACT Mindfully:** Worksheets for Clinicians – **https://www.actmindfully.com.au/upimages/2016_Complete_Worksheets_for_Russ_Harris_ACT_Books.pdf**)
- How does ACT work? Positive Psychology– **www.positivepsychology.com/act-acceptance-and-commitment-therapy/**
- **Six Principles of ACT:** Australian Institute of Professional Counsellors – **www.aipc.net.au/articles/six-principles-of-acceptance-and-commitment-therapy/**

4.1.7 Dialectical Behaviour Therapy

DBT draws on CBT, MBSR and acceptance strategies: individual sessions are combined with group based skills training sessions over a 12 month period, with participants also permitted access to a 24 hour telephone line for crisis situations. According to the recent evidence check informing this Practice Guide, Level 1- 2 evidence based on review, it delivers positive outcomes for general health, wellbeing and harm reduction [5]. A review of three RCTs suggested that DBT of 50 weeks duration on average is similarly effective to '12 Step' programs and more effective than TAU in promoting abstinence, better mental health and reduced severity of AOD use at short (up to six months) and long term follow up (up to 16 months) [5,57].

In recognition of the high rates of co-occurring problematic drug and alcohol use among people with borderline personality disorder, DBT was modified to directly target problematic drug and alcohol use, develop coping skills for managing withdrawal and cravings, make increased use of case management and provide options for pharmacotherapy [58].

Key modifications to DBT for application within AOD treatment include:

- Direct discussion of problematic drug and alcohol use
- Skills for coping with cravings and withdrawal
- Increased use of case management
- Options for pharmacotherapy
- Development of a set of attachment strategies to encourage treatment engagement and retention and reduce missed appointments

Modified DBT (for AOD use) can be used in the treatment of problematic drug and alcohol use by suitably trained and experienced drug and alcohol professionals.

Resources and Training

- Youth AOD Toolbox: Dialectical Behaviour Therapy – **https://www.youthaodtoolbox.org.au/dialectical-behaviour-therapy**
- Regulator: Modified DBT – **documents.uow.edu.au/content/groups/public/@web/@project-air/documents/doc/uow251368.pdf**

4.1.8 Systemic Approaches

Systemic approaches examine a client's presenting problem in terms of the 'system' of relationships, activities and parts that make up the client's problem [4, 58]. Joining together the individual parts of the 'system' will lead to a greater understanding of the whole problem, which is more than just the sum of the parts [4, 58].

These approaches are sometimes referred to in the context of family therapy, where clients are typically viewed in terms of their relationships with other key people in their lives, such as family members and/or significant others and extended families where appropriate – all taking active roles in the treatment [58, 60].

During treatment discussions the clinician focuses on how the people within the system communicate with each other, what they communicate, and how these translate into the various roles and expectations the system has for its individual members [59 - 61]. Importantly, what happens in between therapy sessions is regarded as at least as vital to treatment as what happens during the treatment session [4, 59-61].

Systemic approaches are particularly useful for the treatment of young and adolescent clients and could be used in isolation or as an adjunctive approach to other psychosocial treatments [59, 61]. However, currently there are no treatment trials or case studies describing how systemic approaches relate to drug and alcohol use outcomes. Systemic approaches should only be used by suitably trained and experienced AOD clinicians who have supervision that can adequately support their practice.

Key features of systemic approaches include:

- Conducting psychosocial interventions within a systems context – moving beyond the individual and including family and/or significant others in the therapy
- Exploring the nature of a person's relationships with other people and their substance use, and looking at improving ways of communicating and relating
- Supporting the system to make positive changes which will have an impact on the individual
- Recognising it may be close family/friends/significant others who have raised concerns about a person's substance use and how this plays into the treatment goals

4.1.9 Narrative Approaches

Narrative therapy is based on the assumption that people have narratives about themselves in order to make sense of their lives and relationships [4, 62]. As people mature, these stories govern how they see themselves, and their behaviour will be either consistent or incongruent with these stories.

It is of little relevance whether these stories are accurate; rather the emphasis is on the impact these stories have on the person's life. Narrative approaches place an emphasis on the person being the expert in their own life and therefore in possession of the solutions to their personal challenges. There is evidence to suggest that narrative therapeutic approaches are particularly useful when working alongside Aboriginal people [62-63].

The narrative therapist assists the client to re-author their story in a way that might assist a process of change or growth. In addition, narrative approaches see problems as very separate from the people experiencing the problem, which can often make the problems seem more manageable. Narrative approaches can be conducted both individually and as group based practice.

'Key features of narrative approaches include:

- Curious stance – be curious in your interactions with people, with no preconceived assumptions of why they do what they do
- Alternative stories – assist the person to recognize whether there is a negative "dominant" story at play and what alternative stories may be nurtured together in therapy
- Reframe the problem – support the person to reframe their substance use, working on developing effective alternate strategies for responding to moments of distress
- Person as expert – encourage the person to see themselves as the expert in their own life, and therefore the best resource for addressing the issue that may be occurring in their life
- Externalising – assist the person to separate themselves from the problems they are experiencing

There is a scarcity of research evidence on the effectiveness of narrative approaches in AOD treatment and it is therefore recommended that only suitably trained and experienced AOD clinicians use this approach. There is evidence for the use of narrative approaches as a generic therapeutic technique and in combination with other psychosocial interventions.

4.1.10 Emerging Psychosocial Interventions

This Practice Guide is inclusive of all the psychosocial interventions that have a strong evidence base in the research literature and/or have specific utility and are documented as being applied routinely in AOD treatment. However, as in any field, there is an imperative to grow the evidence for new and emerging psychosocial interventions and their specific application for the benefit of people engaging in AOD treatment.

Eye Movement Desensitisation and Reprocessing (EMDR) is an example of a psychosocial intervention that has significant evidence for improving the outcomes for people experiencing PTSD and trauma-related mental health concerns [64, 65]. EMDR, like some other psychosocial interventions, shows promise in the AOD field [66].

It is incumbent on all clinicians to be adequately trained, supervised and to engage in the evaluation of these new therapies to grow the evidence and provide choice for people seeking AOD treatment.

4.2 Modes of Delivery

Psychosocial interventions can be conducted via a variety of modes depending on the skill levels of the clinicians, availability of adequate clinical supervision expertise, and access to appropriate physical space or technology. The variety of modes of engagement available in NSW AOD treatment are described below.

4.2.1 Individual

Individual counselling, as the name suggests, occurs between the individual accessing AOD treatment and the clinician or AOD worker. Usually contained in up to 90 minutes of counselling, as is commonly practiced. However, is more likely to be a 50 – 60 minute face to face session, individual counselling incorporates all the processes of care outlined in **Section 3** of this Practice Guide and is reliant on therapeutic alliance, regular feedback and outcomes measurement based on what is identified as important by the person engaged in

treatment. Physical space is important to the conduct of an individual psychosocial intervention, with awareness of safety for both client and clinician and can be conducted in both residential and community-based settings.

Resources and Training

- Counselling Guidelines: Alcohol and Other Drug Issues – **www.mhc.wa.gov.au/media/2604/mhc_counselling-guidelines-4th-edition.pdf**
- Blue Knot professional community – **https://professionals.blueknot.org.au/**
- Dovetail Youth AOD Practice Guide: **www.dovetail.org.au/media/1188/dovetail_gpg_3_practice-strategies-and-interventions.pdf**
- Let's Get Talking Toolkit, Te Pou – **www.tepou.co.nz/initiatives/talking-therapies/lets-get-talking-toolkit**

4.2.2 Group

Several of the psychosocial interventions explored in this Practice Guide are well suited to a group setting, including CBT, DBT and harm reduction psychoeducation. The group process is designed to engender a sense of belonging and normalising while reinforcing positive behaviour change. Group based interventions have Level 1 evidence based on synthesis of studies in a Cochrane Review [67]. Therapeutic group work is applied in the AOD treatment setting because of the belief that there is strength in a sense of collectiveness and shared experience. There is also an opportunity to normalise experiences and provide opportunities to practise new skills and behaviours [68].

Resources and Training

- Counselling Guidelines: Alcohol and Other Drug Issues – **www.mhc.wa.gov.au/media/2604/mhc_counselling-guidelines-4th-edition.pdf**
- NADA Practice Guide on Alcohol and Other Drug Treatment in Residential Settings – **www.nada.org.au/resources/providing-alcohol-and-other-drug-treatment-in-a-residential-setting/**
- Substance Abuse Treatment: Group Therapy – **www.store.samhsa.gov/sites/default/files/d7/priv/sma15-3991.pdf**

4.2.3 Telephone, Virtual or Technology-based Interventions

The provision of psychosocial interventions in AOD treatment conducted virtually, over the phone or using other technologies is now well established. There is Level 1 evidence from systematic review and meta-analysis of RCTs e.g. Hai et al 2019 [6] indicating that this mode of engagement has both a high level and high quality of evidence. However, research studies described here are conducted under a research protocol and there were no reviews of studies on the implementation of these interventions in real world clinical practice [5]. It is likely that the use of these interventions as an adjunctive intervention to in-person services, or virtual care ie. technology-based interventions (TBIs) guided by a clinician, will be more effective than standalone interventions [5].

Evaluations from clinical practice exist and feedback is largely positive as a choice for people who may be reluctant to attend a service, are living in remote areas or require the convenience of therapy online. Telephone, web-based and video counselling services have continued to grow as a treatment of choice for people and have solid foundations across Australia in services such as Alcohol and Drug Information Services (ADIS) and Quitline for Smoking Cessation. Choice is an important consideration for people seeking AOD treatment, and for a number of community groups face to face treatment provision will remain their preference.

Resources and Training

- ACI Alcohol and Drug Telehealth Service Model: **www.aci.health.nsw.gov.au/__data/assets/pdf_file/0005/671180/Virtual-care-initiative-alcohol-and-drug-telehealth.pdf**
- Mental Health Online: A practice guide to video consultation: **www.mentalhealthonline.org.au/Assets/A%20Practical%20Guide%20to%20Video%20Mental%20Health%20Consultation.pdf**
- Telephone Counselling: Insight QLD – **www.insight.qld.edu.au/toolkits/telephone-counselling/detail**
- Australia's Alcohol and Other Drug Telephone Information, Referral and Counselling Services: A Guide to Quality Service Provision (2012) NCETA – **https://digital.library.adelaide.edu.au/dspace/bitstream/2440/80149/1/hdl_80149.pdf**

4.2.4 Psychosocial Interventions provided in Residential Settings

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

Resources and Training

- NADA Practice Guide on Alcohol and Other Drug Treatment in Residential Settings (2022) – **www.nada.org.au/resources/providing-alcohol-and-other-drug-treatment-in-a-residential-setting/**
- Best Practice Approaches to AOD Treatment in residential rehabilitation – **www.nada.org.au/resources/best-practice-approaches-for-alcohol-and-other-drug-treatment-in-residential-rehabilitation/**

Considerations for Co-occurring Needs: Integrated Care

05

Section 5 explores in more detail the core elements of person centred and holistic care within the AOD treatment context. Responding to co-occurring needs is directly informed by a comprehensive assessment, working alongside the person who has reached out for AOD treatment to identify any and all co-occurring needs that will benefit from intervention and support throughout their treatment journey. Co-occurring needs may include physical health conditions, mental health concerns and cognitive impairment needs, among others. Whether or not a person has a formal diagnosis, the approach should be to work with them, acknowledging where they are at and the potential impact of trauma.

To respond effectively to the potential range of personal experiences identified via a comprehensive assessment in an AOD setting, strong links with other specialist service providers are essential. Providing integrated care relies on strong ongoing working relationships with other systems of care, such as mental health providers, primary healthcare and social welfare supports. Accessing AOD psychosocial intervention may be the catalyst for receiving support in a variety of other areas that will contribute to overall improvements in wellbeing. Assisting a person to address their other needs will also sustain positive changes in regard to their AOD treatment outcomes.

Making links with other specialist services contributes to providing integrated care, such as connecting with:

- **Local Aboriginal communities and Aboriginal Community Controlled Organisations:** Elders and specialist Aboriginal providers (eg. AMS)
- **Child protection services:** local Department of Communities and Justice (DCJ) communities of practice
- **School/education services:** connection with schools to support treatment goals and exploration of adult education
- **Culturally and Linguistically Diverse communities:** neighbourhood centres, cultural groups and community Elders/leaders
- **Mental health providers:** community mental health providers
- **LGBTIQ+ community groups:** ACON, the Gender Centre and other LGBTIQ+ providers
- **Criminal justice services:** establish contact with DCJ service providers or specialist criminal justice workers (eg. Community Restorative Centre (CRC)
- **Domestic and family violence services:** victim/survivor services and men's behaviour change services
- **Parenting/childcare providers:** local services which may be able to provide specific training or support for parents or for children who may be onsite

5.1 Mental Health

The AOD workforce is well positioned to support people who may be experiencing a mental health condition and using alcohol and/or other drugs. The development of the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, now in its third edition [69], has enabled an increase in confidence and capability for AOD workers providing psychosocial interventions to recognise and respond to co-occurring mental health and substance use issues. Having a sound knowledge of mental health diagnoses and psychological distress and how these can affect wellbeing, and working with tools and program materials that support this knowledge, is essential in the provision of holistic and integrated care.

Such an approach means treatment can proceed in absence of formal diagnosis and even when substance use is active, thereby facilitating earlier engagement in treatment and encouraging multidisciplinary input from a range of health professionals. Integration of treatment for co-occurring AOD and mental health conditions can occur at the level of the service or organisation that does not necessarily specify a particular defined clinical approach to treatment, or can refer to treatment offered by the one AOD worker simultaneously targeting co-occurring substance use and mental health conditions, using techniques drawn from evidence based treatment approaches across mental health and substance use domains. According to the guidelines, the most frequently seen mental health conditions in the general population mirror those in people who may be reaching out for AOD treatment, and these are explored in some detail.

Some of the key messages explored in the guidelines include:

- Psychosocial interventions in AOD treatment are useful when responding to mental health concerns (CBT, emotion regulation, relapse prevention etc)
- Focus on the person's reported experiences and distress rather than the diagnosis. Work collaboratively with goals identified by the person seeking treatment
- All AOD workers need a good working knowledge of mental health conditions and their symptoms
- Routine screening for mental health conditions and suicidal ideation is an essential part of AOD treatment provision
- Ongoing assessment and review of mental health conditions and symptoms using validated tools assists with care planning; having referral pathways for additional mental health supports is key to providing safe and effective care
- Involving family, friends and community supports is good practice in responding to both AOD and mental health concerns

It is always important to work within the scope of expertise and capacity, engage in ongoing professional development and consult with mental health specialists. There is a wide range of support materials, including eLearning, written guides and webinars, available for the AOD workforce on the subject of co-occurring mental health and substance use concerns and these can be accessed on the **website**.

Resources and Training:

- Comorbidity Guidelines: Guidelines, eLearning and training for co-occurring mental health and alcohol and other drug use issues – **www.comorbidityguidelines.org.au**
- Aboriginal Mental Health Learning Resource: - Working with Aboriginal People: Enhancing Clinical Practice in Mental Health Care – Professionals – **www.health.nsw.gov.au/mentalhealth/professionals/Pages/Aboriginal-people.aspx**
- Building on personal strengths: Stories that explore how people have connected with their strengths via music, art, community groups and support networks – **https://www.utsc.utoronto.ca/projects/flourish/building-your-strengths/**
- Implementing evidenced-based practice: What AOD managers and workers need to know – **www.comorbidityguidelines.org.au/resources/webinars/implementing-evidencebased-practices-what-aod-managers-and-workers-need-to-know**
- Audit your service: Dual Diagnosis Capability in Addiction Treatment (DDCAT Toolkit) – **www.case.edu/socialwork/centerforebp/resources/dual-diagnosis-capability-addiction-treatment-ddcat-toolkit**

5.1.1 Depression

It is not uncommon for people accessing AOD treatment to experience depressive symptoms that may include but are not limited to low mood, disinterest in activities and interactions they once enjoyed, sleep disturbance, feelings of hopelessness/worthlessness and in some cases suicidal thoughts. Screening for signs of depression should be routinely undertaken, and engaging people in exploring strategies that are appropriate for addressing thoughts and feelings about AOD use as well as depressive symptoms is important. Engaging with mental health clinicians, where more specific assessments regarding diagnosis and the use of medication can be done as complementary to AOD treatment, is useful, as is exploring the relationship between the depressive symptoms and substance use. Providing education about the impact of different substances on low mood can impart useful insights, including informing goals for treatment.

Practice tips:

- Encourage connection with activities that were previously enjoyable, even where there is no desire to do them – provide practical assistance with this connection
- Regularly monitor mood and suicidal ideation, and where necessary explore a safety plan

- Utilise outcomes measurements and provide feedback on treatment goals and progress – sometimes concrete examples of change can be motivating
- Explore realistic goals and provide encouraging feedback and hope
- Warmly connect with mental health clinicians so that if they are needed, introductions have already been established

5.1.2 Anxiety

Feelings of anxiety can be very common for people who engage in psychosocial interventions, whether as the result of a persistent anxiety disorder or merely because of the stress experienced in taking the step to enter treatment. In all cases, focusing on reducing symptoms of anxiety (such as restlessness, inability to relax or sleep, heart palpitations, shallow breathing and sometimes panic) will benefit AOD treatment outcomes such as emotion regulation, responding to cravings and preventing relapse.

Explaining how withdrawal syndromes from some substances such as alcohol, methamphetamine and nicotine mirror anxiety can also assist people engaged in treatment to see the benefit of specific strategies such as mindfulness, breathing exercises and relaxation techniques. All these can reduce anxiety symptoms and have the added benefit of assisting in changing substance use behaviours.

Practice tips:

- Explore a number of techniques that are effective with anxiety and provide people you are supporting with choices, as not all methods feel safe/relaxing for everyone
- Try a few relaxation techniques with the person, explaining as you go and not imposing too many rules on how to do it (eg. “You can close your eyes, or if you feel more comfortable just lower your gaze to the floor”)
- Normalise the experience of anxiety, explaining how fight, flight and freeze is one of the body’s strategies and why at times it works
- Continue to monitor and assess the person for persistent anxiety symptoms that may remain even if they have completed a period of withdrawal, as specific mental health treatment may be required
- Be patient and calm and provide the person with a safe environment – checking in with them throughout the session about whether they are comfortable
- Be explicit with instructions and explain what is happening each step of the way and how long each interaction may take, so that they are reassured

5.1.3 Obsessive Compulsive Disorder (OCD)

Obsessive compulsive disorder (OCD) was previously classed as an anxiety disorder. However, it is now a separate category of disorder in the DSM-5-TR and ICD-11 [69]. OCD is a condition in which people feel distressed regarding recurring and persistent thoughts that actively get in the way of engaging in or enjoying daily activities. They may feel compelled to engage in repetitive or ritualistic behaviours in an attempt to control or calm their anxiety. The preoccupying thoughts and behaviours may be obsessive or compulsive or both and frequently revolve around specific areas of concern such as germs, illness, hoarding things, and repetitive and ruminating thoughts and concerns around order or placement of things to name a few examples. Providing support and specific strategies such as calming thoughts or addressing areas of stress can reduce the compulsion. However, specific mental health support may be required alongside AOD treatment.

Practice tips:

- Avoid being disrupted or deterred by unusual behaviour, if not harmful, and explore with the person to whom you are providing psychosocial interventions what role such behaviour plays in their life
- Be calm and patient when exploring their concerns and situation – allow space for the areas of their life they feel comfortable discussing
- Engage people in alternative methods of calming, soothing or relaxation
- Avoid engaging in restrictive or negative messaging about the behaviour

5.1.4 Trauma, Post-Traumatic Stress Disorder and Stressor Disorders

As explored in previous sections, experiences of trauma are common for people accessing AOD treatment and these can take different forms – all of which may have a lasting impact and the potential to contribute to harmful substance use. Ongoing symptoms related to exposure to trauma can be long lasting and complex [70]. There is evidence to suggest that of those Australians who experience a traumatic event, one in ten go on to develop Post Traumatic Stress Disorder (PTSD) which includes symptoms of intrusive thoughts, reliving the trauma experience as if it is happening for the first time, and hypervigilance that may prevent engagement in daily activities.

Creating safe opportunities for people to engage with their feelings regarding a traumatic event, should they express them, is important, as opposed to instructing them to avoid these, which may exacerbate feelings of shame and being silenced. The experiences of trauma, PTSD and stressor disorder are responsive to treatment alongside AOD treatment, and have good alignment with the principles and practice of psychosocial interventions in AOD treatment.

Practice tips:

- Validate the experiences people share and the feelings they have about them, ensuring they are feeling safe and supported
- Provide space and unconditional positive regard for each person in the context of psychosocial interventions and allow them to lead when it comes to exploring their experience of trauma, should they indicate a desire to do so
- Acknowledge the strength and resilience shown by each person and the ways they have managed their lives to this point
- Apply relaxation techniques where appropriate

5.1.5 Psychosis

Psychosis, whether drug induced or related to an additional mental health condition, can be challenging for AOD clinicians who have not had specific training or skills development. People experiencing psychosis may present with intrusive thoughts, persecutory thoughts that someone is trying to harm them, disorganised thoughts or speech, and cannot be dissuaded that their beliefs are real. In such cases, it is important for the AOD clinician to be calm and respectful, ensuring each person feels as safe as possible – this will assist with agitation, mood swings or irritability.

In the case of AOD treatment, the experience of psychosis may subside in response to the substance losing its effect and leaving the body. However, additional support with a mental health professional will be useful, should the person seeking treatment be amenable. The potential requirement for additional external support means it is important to flag this possibility early as part of engaging with a person seeking treatment.

Practice tips:

- Pay particular attention to the physical environment, ensuring it is calming and safe with ample space and away from noise
- Listen attentively and respectfully
- Focus on the way a person is feeling/responding to the thoughts and experiences they are having rather than actively querying the content of what they are saying
- Be clear with instructions and the reasons for the actions being taken, ensuring you have the confidence of the person – although you may feel confused or anxious yourself
- Ensure your own safety and where possible be aware of exits for yourself and your client

5.1.6 Personality Disorders

People with a personality disorder experience thoughts, feelings and behaviours that make meaningful relationships and engagement with life experiences challenging. As a result of difficulties in relating to others, and frequently being perceived as manipulative or deceitful, there is a significant amount of stigma attached to a personality disorder diagnosis – which can have the potential for excluding people from treatment. The challenges of personality disorder, such as impulsivity and difficulty with emotion

regulation and self-control, can exacerbate AOD harms. However, it also provides clear indications of the kinds of psychosocial interventions that may be effective – such as emotion regulation strategies, interpersonal reflection and behaviour change practice and planning.

As people with personality disorders have higher rates of childhood abuse, trauma or neglect, any treatment for this groups needs to be guided by trauma informed principles. Establishing safety and building trust and rapport should be at forefront of any treatment planning. This is achieved by building a strong engagement with the client, setting clear boundaries, developing clear, achievable treatment goals and avoiding the exploration of childhood experiences. Dialectical Behaviour Therapy (DBT) is a treatment approach for people with personality disorders.

Practice tips:

- Spend time on building therapeutic relationships, with strong boundaries, connection and compassion
- Ensure consistency of approach, and where possible have a consistent approach across the team – sharing care can be a useful way of building confidence in improved relationship building
- Engage in clear goal setting and review, eliciting tasks each client can manage and providing regular opportunities for feedback
- Try to orient sessions to the present, what is happening now – rather than old issues of the past
- Screen and review regularly for suicidal ideation

Resources and Training

- Project Air – **www.uow.edu.au/project-air/**
- Spectrum Personality Disorder and Complex Trauma – **www.spectrumbpd.com.au/about-us**

5.1.7 Eating Disorders

An eating disorder (ED) is a serious mental health condition characterised by eating, exercise and body weight or shape becoming an unhealthy preoccupation of someone's life, and includes anorexia nervosa and bulimia nervosa. People with eating disorders who have co-occurring substance use disorders present with a range of other mental health and physical health issues and psychosocial stressors. This client group is a complex population in an AOD treatment setting, and the risk of mortality is high due to the negative health impacts caused by eating disorders and substance use disorder. This complexity is exacerbated by the similar features of an eating disorder to that of the effects of, and/or withdrawal symptoms from, substance use. A person using stimulants may experience a loss of appetite at the time they are drug affected and they may eat large amounts of food when withdrawing.

Symptoms of eating disorders

- Dramatic weight gain or loss
- Frequently avoiding meals or eating large amounts of food
- Fatigue
- Change in menstrual cycles
- Poor dental health from vomiting
- Constipation

Clients who are malnourished and whose bodies are lacking electrolytes from co-occurring eating disorders and substance use disorders are at risk of refeeding syndrome if food is reintroduced too quickly. Refeeding is a serious health complication that may cause death. AOD clinicians should consult with dietitians and speech pathologists for this client group, then find the balance between encouraging their client to regain their nutrition while being aware of the risks of refeeding syndrome.

Practice tips:

- Encourage the expression of each person's feelings, listen attentively and empathise with their point of view
- Ensure clear boundaries and emphasise the importance of the therapeutic relationship; it may be important to be working alongside specialists in the area of EDs
- Pay attention to the related physical health issues each person may experience and include these as part of care planning and goal setting
- Provide clarity on interventions being provided and the thinking behind them; be honest and clear in the approach to treatment with holistic attention to activity and eating patterns

Resources and Training

- Inside Out – Institute for Eating Disorders – **www.Insideoutinstitute.org.au**
- Butterfly – Let's Talk Eating Disorders – **www.Butterfly.org.au**
- National Eating Disorders Collaboration: **www.nedc.com.au**

5.1.8 Attention Deficit/Hyperactivity Disorder (ADHD)

ADHD is a common co-occurring mental health condition for people who may be using substances and is associated with a pervasive and ongoing inability to concentrate/attend to tasks and information, and hyperactivity that gets in the way of engaging in daily activities. The overall impact of ADHD is usually evidenced through significant life challenges such as learning/work difficulties, significant relationship issues and potential criminal justice involvement. Research indicates that people who have untreated ADHD have a more challenging time engaging in AOD treatment, maintaining abstinence (if that is their goal) and gaining benefits from the treatment provided [71, 72]. Assessment for ADHD can be challenging if the person being assessed is intoxicated or experiencing withdrawal. However, it is not recommended to delay access to assessment on this basis, and involvement of family or supports the person being assessed lives with can provide useful insights for an assessment.

Practice tips

- Providing psychoeducation on the impact of ADHD behaviours and how they may have contributed to the experiences of the person you are supporting can be enormously helpful in breaking down stigma and shame they may have experienced
- Exploring the potential role substance use has played in managing ADHD symptoms and providing information on alternative approaches can be helpful
- Providing information and training on relaxation and grounding techniques is useful – emphasizing that these don't necessarily require the complete "quietening of the mind"
- Exploring specific tools and strategies that assist with concentration, memory recall and goal setting will be complementary to those skills being provided/explored in relation to a person's ADHD treatment

5.1.9 Substance Induced Disorder

Substance induced disorder (SID) is when a mental health condition is triggered by substance use or when a person is withdrawing from a substance. A SID is usually resolved when the effects of the substance have worn off or the withdrawal symptoms have subsided. This may be through the use of medications or when the client has had adequate rest, hydration and nutrition in a safe environment. Some clients may be at a higher risk of developing a SID as they may have co-occurring mental health and physical health conditions, family history of mental illness, lack of support and psychosocial stressors such as homelessness. Other factors that may increase the risk of SID are the type of substance and how it was used, whether the substance was mixed with other chemicals, and whether the client used another substance as well.

In some instances the SID may develop into an ongoing mental illness, such as schizophrenia or schizo affective disorder, and the symptoms will not subside despite the client's abstinence from the substance. When a clinician has assessed a client who is experiencing SID as requiring an emergency response, it is helpful for the clinician to equip themselves with an understanding of the types of treatment delivered in both health and police setting. This enables the clinician to explain the process to the client who may be experiencing an acute level of distress and fear.

Practice tips

- Given that SID is likely to be reduced or cease as a result of abstinence, exploring this as a primary goal may be useful
- Providing a focus on psychoeducation (how different substances impact the brain and the body) can be a useful place to begin with people who may experience SID
- Providing space to explore the impact of SID and the potential for risky situations in the community when intoxicated can be helpful

5.2 Physical Health

5.2.1 Pain

Pain is frequently a precursor to people using a variety of substances and is a complex and subjective experience for each person [73] [74]. Experiences of chronic pain are challenging and can be frequently undiagnosed and untreated. Furthermore, people who experience pain are frequently stigmatised in the health system, particularly if they are assessed as engaging in harmful substance use. People with chronic pain can feel that their experiences are dismissed and that they are exaggerating, which leads to isolation and resisting reaching out for help. The co-occurring experience of pain and substance use may contribute to elevated suicidal ideation and needs to be regularly monitored [74].

Working closely with pain specialists/teams in a coordinated way can improve overall wellbeing outcomes for clients. Instead of deferring treatment for pain, particularly if AOD abstinence is not a realistic goal for clients with chronic pain, treatment programs need to be flexible and assist the client to work toward a goal of moderated drug and alcohol use while the AOD clinician works with other health professionals to better manage the pain. For example, it may be appropriate to treat the client's problematic drug and alcohol use within the drug and alcohol setting and seek agreement to have the client's prescription medications dosed by providers in that setting [75] [76].

Practice tips

- Build knowledge about the experience of chronic pain and pain responses
- Explore strategies outlined by the pain specialist treatment sector that may support a person seeking AOD treatment also being engaged by a pain clinic
- Provide education and support regarding the monitoring of pain medications – assisting people to ensure they are not being stigmatised when receiving healthcare, and that harms are not increased by having multiple prescribers
- Explore with people different ways to manage activities, sleep and movement involving chronic pain

5.2.2 Blood Borne Viruses

Support, screening, testing and referral for treatment of blood borne viruses (HIV, Hepatitis B and C) are part of AOD treatment and holistic care provision. Advances in testing and treatment, particularly for Hepatitis C, have provided important opportunities for awareness raising, screening and referral in the context of AOD psychosocial interventions. AOD services frequently work alongside local HIV And Related Program (HARP) units which can assist with testing and treatment and provide specialist advice and support to AOD clinicians. Dried blood spot (DBS) testing is a helpful approach to reducing the barriers people may experience in getting a blood test for Hepatitis C and only requires a fingerprick test which can be done at the AOD service. AOD services are a key setting for increased availability of these simple tests.

The **NSW Hepatitis C Strategy 2021 – 2025** focuses on improving access to testing and treatment for people engaged in AOD treatment services settings. It identifies specialist AOD treatment services (NGO and LHD) as key partners in improving pathways for testing and treatment, noting: "AOD settings will follow best practice Hepatitis C care in line with Clinical Guidelines and Policies (AOD Clinical Care guidelines) such as completing audits of medical records, care plan reviews and intake screening" (p. 11). Asking your clients sensitive questions, including whether they have been tested or are receiving treatment for Hepatitis C, helps ensure they receive the best care planning possible.

Resources and Training

- Hepatitis NSW – **www.hep.org.au**
- HIV and Related Program (HARP) Units across Local Health Districts
- Dried Blood Spot Testing – **www.dbstest.health.nsw.gov.au/**
- Guidelines and Training – **www.ashm.org.au**

5.2.3 Sleep and Diet

Prolonged or binge use of alcohol and other substances can have a direct effect on sleep patterns, quality of sleep and nutrition. Psychosocial interventions in AOD treatment provide an opportunity to explore sleep and dietary issues with people and support improved habits. Overall improvements in the quality of sleep and nutrition will support AOD treatment goals and wellbeing [77]. Working alongside people on sleep and dietary improvement strategies and goals can assist them in experiencing treatment progress and tangible outcomes to support better health, regardless of the AOD treatment goals. AOD use may often play a role in diet and sleep and should be a key focus as part of comprehensive assessment and care planning (See **Section 3**).

Sleep disturbances are common among people who use alcohol and other drugs and can also be associated with withdrawal. Although sleep problems can be among the most difficult to address, there are various strategies to help clients increase their chances of a reasonable sleep.

Encouraging clients to eat regularly and healthily will help them to resume an active and healthy lifestyle. This will also assist them to better cope with the demands that withdrawal may place on their bodies. Developing a meal plan with clients that focuses on low fat and increased protein, complex carbohydrates and fibre is recommended. Highlighting the importance of hydration is also important.

Practice tips

- Explore meal plans, exercise and diet as part of psychosocial intervention sessions and provide people with resources, tip sheets and information on the links between improved sleep, diet and exercise and their overall wellbeing
- Explore the nuances of sleep hygiene – rituals and routines for sleep, avoiding screens and smoking before bed
- Encourage frequent drinking of water and provide water as part of each session

Resources and Training

- ADF Healthy eating during AOD treatment – **https://adf.org.au/insights/healthy-eating-during-treatment/**
- Healthy Eating for Wellbeing WANADA: **www.wanada.org.au/wp-content/uploads/2022/09/181219-act-wfd-a-nutrition-guide-for-consumers.pdf**
- Sleep Hygiene: **www.cci.health.wa.gov.au/~/media/CCI/Mental-Health-Professionals/Sleep/Sleep---Information-Sheets/Sleep-Information-Sheet---04---Sleep-Hygiene.pdf**

5.2.4 Sexual and Reproductive Health

It can be useful for the AOD sector to have a good working knowledge of how different substances shape sexual drive and function, and how to provide a safe space for clients to explore the possible effects substance use may have had on their sexual experiences. Healthy sexual relationships can have a profound effect on an individual's emotional, physical and psychological wellbeing, and assisting clients to reconnect with their sexual selves should be considered as part of holistic person centred care [68].

While people accessing treatment may have experienced trauma in relation to sexual experiences, AOD treatment can be a useful entry point into sexual, reproductive health and family planning health check-ups, so linking clients into getting STI and HIV testing and knowing their options for contraception is a good start. Using clinical judgement and ensuring that discussion regarding sexual health is appropriate may require some staff education, given that it can be a sensitive subject area.

Pharmaceutical drugs can also affect sexual activity, more specifically libido or sex drive. A significant proportion of people accessing AOD treatment also experience poor mental health or chronic pain conditions that can have a detrimental effect on libido, even before they are prescribed medications that further affect sex drive. Having a working knowledge of the potential effects of various pharmaceutical drugs on sexual drive and function, sharing this information with clients and, most importantly, exploring clients' own experiences are important aspects of providing holistic care [68].

Exploring reproductive health is part of supporting a person engaging in psychosocial interventions in AOD treatment. People who are using alcohol and other drugs and are sexually active have the potential to become pregnant. Providing factual information on the impact of alcohol and drug use on the body and the foetus is part of providing holistic care. Stigma associated with substance use in pregnancy is a common experience, therefore a supportive and non judgmental approach is critical in building rapport. Alcohol use in pregnancy is a specific area to explore with people accessing AOD treatment and the potential risk of foetal alcohol spectrum disorder (FASD), a neurodevelopmental impairment that can result from alcohol exposure before birth.

Practice tips

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

Resources and Training

- Substance Use in Pregnancy and Parenting Service (SUPPS) **https://www.health.nsw.gov.au/aod/professionals/Pages/substance-use-during-pregnancy-guidelines.aspx**
- NSW Sexual Health Infolink: 1800 451 624 **https://www.shil.nsw.gov.au/About-Us**
- Play Safe – sexual health resources for young people: **https://playsafe.health.nsw.gov.au/**
- NSW Health STI and BBV related services: **https://www.health.nsw.gov.au/sexualhealth/Pages/related-services.aspx**
- Nofasd Australia: **https://www.nofasd.org.au/**
- NSW Health Stay Strong and Healthy **https://yourroom.health.nsw.gov.au/resources/publications/Pages/stay-strong-and-healthy-sharing-pregnancy-poster.aspx**

5.4 Cognitive Impairment

Psychosocial interventions provided in AOD treatment have the potential to improve cognition. People engaged in AOD treatment may experience challenges that result specifically from cognitive impairment. In daily life this can be an experience of difficulties with planning, problem solving, recalling information and emotional regulation – many of the tasks we ask of people during treatment [68]. Sometimes cognitive impairment can result in behaviour that is mistakenly interpreted as the result of poor motivation or lack of effort. Impairments in executive functioning and goal directed behaviour is the most commonly observed cognitive impairment in AOD settings [66]. Recent research has shed light on how common this experience can be and has led to the development of tools to better support people accessing treatment [69].

Screening for the risk factors that may suggest cognitive impairment is important and while there are a number of screeners available, one that has been developed for use by AOD clinicians is the Alcohol and Drug Cognitive Enhancement (ACE) screener. The Alcohol and Drug Cognitive Enhancement (ACE) screening tool is a brief set of questions developed to be administered by frontline AOD clinicians to clients [78]. You can download the screening tool and user guide identified in the resource list below. It will take you through how to administer and score it and explore pathways for additional support you may need to consider. If a person screens for possible cognitive impairment, you can then use the Brief Executive Function Assessment Tool (BEAT) developed specifically for people accessing AOD treatment.

Screening tools like the ACE, BEAT and Montreal Cognitive Assessment (MoCA) [79] are not diagnostic, and care should be taken to set the context for why it may be used with the person accessing AOD treatment In addition to exploring potential support strategies and understanding the pathways for additional assessment and input by a Neuropsychologist and/or other referral options in the community where appropriate.

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

Resources and Training

- Alcohol and drug Cognitive Enhancement (ACE) – Agency for Clinical Innovation – **www.aci.health.nsw.gov.au/projects/ace-program**
- Managing Cognitive Impairment in AOD Treatment – Turning Point – **https://s3-ap-southeast-2.amazonaws.com/turning-point-website-prod/drupal/2022-02/TP_Managing_Cognitive%20impairment_AOD_treatment_VS18_DH_edit.pdf**

Supporting Diverse Needs: Equity for Priority Populations

06

Priority populations refers to groups of people who experience health inequities associated with the population group with which they identify. Ensuring access and equity for priority populations may require specific approaches and considerations, applying a person centred approach that is sensitive to social and cultural factors. It may include connecting specialist services which have expertise or knowledge with a particular group of people to work alongside AOD psychosocial interventions. This section describes some additional considerations for important community groups to whom psychosocial interventions are delivered. While many of these principles could be applied to any AOD client, some additional practice tips provided here may assist the AOD clinician to better engage with the target group. A good working knowledge of relevant social and cultural factors ensures not only the application of appropriate approaches to delivering treatment, but that important links are made with sustainable social supports in the community to sustain positive treatment outcomes.

Consideration of intersectionality is also key to the provision of safe, person centred psychosocial interventions in AOD treatment. While specific priority populations are identified and explored separately in this section, it should be noted that various groups with which people may identify often intersect: eg. a person may identify as an African bisexual woman and their experiences would be shaped by the intersection of these identities. The approach for any AOD clinician needs to be one of respectful curiosity, appreciating that the person you are working alongside may identify in many different ways and that these will all contribute to the way they experience their world.

6.1 Aboriginal and Torres Strait Islander People and Communities

Aboriginal people (an inclusive term for Aboriginal and Torres Strait Islander people) are a priority population for NSW Health. Creating a culturally safe and responsive environment is a key focus across NSW Health, and this is why culturally specific awareness training, as one contributing element to creating safe spaces for Aboriginal and Torres Strait Islander people, is a fundamental competency for people engaged in the provision of AOD psychosocial interventions. This Practice Guide promotes the elevation of the Aboriginal and Torres Strait Islander voice to inform practice as part of the guiding principles (**Section 2**) of AOD psychosocial interventions, recognising both the significant trauma for Aboriginal people resulting from colonisation, and the incredible resilience and knowledge associated with Aboriginal and Torres Strait Islander healing practices. It is acknowledged that psychosocial therapeutic interventions should be culturally secure practices that respond to the strengths and needs of Aboriginal peoples and their communities.

Most Aboriginal people in NSW do not use alcohol or other drugs at harmful levels. However, Aboriginal people are over-represented in exposure to risk factors and experience a disproportionate amount of AOD related health effects and social harms [80, 81]. A range of additional psychosocial issues are associated with high levels of problematic drug and alcohol use among Aboriginal people in Australia. These include increased risk of exposure to violence, risk of depression, anxiety, high rates of suicidality, increased risks of poor nutrition and other medical complications [82].

Realistic treatment plans should be developed which can be incorporated into the wider social and cultural context of the client [83], supporting them within the context of a closeknit Community. The AOD clinician must be sensitive to the possibility that the level of respect, rapport, trust and skill with which they treat any client will be evaluated by the larger Community, highlighting the need to manage these encounters appropriately. Given that the experience of many Aboriginal and Torres Strait Islander people with the health and welfare system is unsatisfactory, it is unrealistic for AOD clinicians to expect members of the Community to access their service in the same way that other groups may do. AOD clinicians need to take time to engage with the Community, building a respectful and trusting relationship with them over time, which may then make the service more 'accessible' to members within the Community. Taking a proactive role in engaging Aboriginal Community controlled services in the care of a client and acting as an advocate for them, particularly if they are experiencing system-

level barriers to treatment, is an essential aspect of responsive care. The onus is on the AOD clinician to find out which local Aboriginal services are available, and actively seek out relationships and clinical partnerships with these services [81].

Clear, effective and culturally appropriate communication is an essential component in providing care, such as acknowledging that different drugs have different 'street' names and that Aboriginal and Torres Strait Islander languages have their own words for alcohol and other drugs [84], and avoiding technical and/or medical jargon [83]. Allow time for key messages to be communicated and discussed, source culturally appropriate and sensitive documents that reinforce any advice or treatment plans involving the client, and be aware of and sensitive to social and body language cues [83].

Enhance psychosocial interventions by:

- Being proactive in establishing relationships with Aboriginal and Torres Strait Islander services and taking responsibility for maintaining them
- Being proactive in engaging with the local Community, rather than waiting for them to access the AOD services
- Understanding that a client needs to be treated in the context of their community
- Recognising that Community views of health professionals will likely be judged according to the Community's experience with an individual drug and alcohol professional
- Working with the local language for different substances
- Avoiding the use of technical or medical jargon
- Reinforcing key treatment messages with culturally appropriate documentation/resources
- Understanding that relationships (including therapeutic relationships) will take time to develop and that this is often a necessary precursor to engaging in treatment, as is learning culturally appropriate ways of interacting with clients

Resources and Training

- Cultural Awareness Training through HETI or NADA
- Working with Aboriginal and Torres Strait Islander people in a non-Aboriginal setting (NADA) – **www.nada.org.au/wp-content/uploads/2021/01/NADA-Aboriginal-Guidelines-Web-2.pdf**
- Indigenous worker wellbeing resource kit – **https://nceta.flinders.edu.au/workforce/indigenous-aod-workforce/feeling-deadly-working-deadly-indigenous-worker-wellbeing**
- Our Healing Ways resources – **www.healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=580414&title=Our+Healing+Ways%3A+successful+strategies+for+working+with+dual+diagnosis+issues%3A+Aboriginal+way**
- Centre for Cultural Competence Australia – **www.ccca.com.au**

6.2 Sexual and Gender Diverse Groups

Engaging with people seeking support for AOD treatment requires the provision of a safe environment that is inclusive and respectful of diversity. Providing an opportunity to explicitly affirm a person's sexuality and gender diversity is important in creating a safe space and is part of comprehensive care planning. Sexual and gender diversity encompasses:

- sex – assigned at birth and determined by biological characteristics such as hormones, sexual organs and genes
- gender – a social and cultural construct of what constitutes being a 'man' or 'woman' and how a person knows themselves to be
- gender identity – how a person perceives their gender and expresses themselves
- sexuality – includes sexual feelings, thoughts, attractions, preferences and sometimes behaviour [4]

Specifically asking a person how they identify, as represented by specific questions outlined by the Australian Bureau of Statistics, avoids assumptions being made based on outward appearance. Enquiring about appropriate pronouns is a useful starting point to ensure safety and support is established early.

Not all people who identify as gender or sexuality diverse experience harms associated with their substance use. However, there is research evidence that indicates higher prevalence of AOD drug use by lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people [85, 86], riskier use [87-89], and a higher proportion who have accessed AOD treatment [90]. Given gender and sexuality diversity data is not routinely collected as part of AOD treatment, knowledge gaps remain in relation to effective treatment approaches and the invisibility of some people in the community.

Despite improvements that may have occurred within society in attitudes towards sexuality and gender diverse groups, discrimination and stigma still exists in many situations, communities and workplaces. Clients of sexual and gender diverse backgrounds will often have experienced overt forms of violence and abuse, and also quite subtle forms of abuse and discrimination (microaggressions). This has important consequences for clients, given national and international research indicating a strong relationship between homophobia, transphobia, heterosexism, social exclusion and the health status of individuals. The concept of 'minority stress' is particularly important within this research literature [88]. Sensitivity to client needs and acknowledgement of experiences of discrimination and exclusion are key, coupled with a holistic approach to the AOD treatment being provided.

There are various subcultures within the LGBTIQ+ community which may have particular cultural norms around drug use. The concept of 'chemsex' has been extensively researched in the past few years, with increased understanding of its impacts on health and wellbeing [89]. Workers should be sensitive to the cultural differences that may arise in relation to drug use within some parts of the LGBTIQ+ community.

Lesbian and bisexual women reported higher rates of cannabis and tobacco use than their heterosexual counterparts, and lesbian and bisexual women are reported to have been initiated into alcohol and tobacco use at an earlier age than heterosexual women [87, 90].

Fundamentally, however, drug and alcohol treatment for clients of sexuality and gender diverse backgrounds is the same as for any other client group, with the focus remaining on the client being treated. Inclusive language that recognises diversity in family, partners and community identity is essential. Importantly, the person providing AOD psychosocial interventions should follow the client's lead in discussing the importance of their sexuality and gender identity as part of their treatment needs. Attention should also be paid to the importance of confidentiality and ensuring the person accessing a service has a clear understanding of how their information is used to inform their treatment, and who has access to it.

Best practice is to adopt a universal approach to all clients around the importance of sexual health and the role alcohol and other drug use can play in sexual experiences and harm reduction strategies [91]. For more specific information about inclusive practice with people who identify as sexuality and gender diverse, the resource AOD LGBTIQ Inclusive Guidelines for Treatment Providers is recommended.

Enhance psychosocial interventions by:

- Creating a welcoming environment through visual signals of inclusiveness – rainbow and trans inclusive flags, posters depicting diverse people, gender neutral bathrooms
- Providing your own pronouns and asking how people accessing your service identify
- Ensuring intake and assessment processes ask inclusive questions about gender and sexuality diversity respectfully and sensitively – be clear about confidentiality and privacy
- Creating an LGBTIQ+ affirmative therapeutic relationship by ensuring a person accessing treatment feels safe and supported in ways that are best suited to them, inclusive of sexual intimacy where it is relevant [88]
- Connecting with specialist LGBTIQ+ service providers where appropriate [92]

- Presenting choices about the gender of the counselling staff
- Being aware of potential high rates of trauma, discrimination and suicide

Resources and Training

- ACON Pride Training – **www.pridetraining.org.au**
- AOD LGBTIQ inclusive guidelines for treatment providers – **www.nada.org.au/resources/aod-lgbtiq-inclusive-guidelines-for-treatment-providers/**
- Pivot Point – **www.pivotpoint.org.au**
- Trans-affirming language guide – **https://www.transhub.org.au/s/Trans-Affirming-Language-Guide_2020.pdf**
- LGBTIQ Clients in Therapy – Joe Kort (2018)

6.3 Older People

Older people in Australia are defined as being aged over 65 (or 'over 50', for First Nations Australians to reflect the life expectancy gap, and for people with long histories of using substances due to premature aging). By 2050 it is estimated that the number of 65 – 84-year olds will double and over 85s will quadruple [93]. With a longer life expectancy, changing patterns of use and age related considerations, adaptations to existing service provisions may need to be considered. It should be acknowledged that older people are not a homogenous group and there is much diversity across and among people who may be engaged in AOD psychosocial interventions.

Older people are more vulnerable to the effects of AOD use and the deleterious side effects and illness associated with prolonged or problematic drug and alcohol use [94]. They will be more susceptible to complications in withdrawal phases of treatment, and more likely to experience falls and associated injuries [39, 94]. Data from the Australian Institute of Health and Welfare indicates there has been a significant increase in older people with drug induced deaths and in the proportion of clients accessing drug and alcohol treatment over the past decade [95].

People born between 1946 – 1964 ('baby boomers') have used substances at higher rates than previous generations and many will continue to do so into older age [96]. This will dramatically increase the number of older people with substance use problems. Those who do not reduce their intake as they age are at particular risk of more harm. Furthermore, the improved health status of older people and advances in healthcare may reduce the incentive to address problematic use until accumulated harms become more severe in older age.

Recent data has indicated tobacco smoking is highest among older people and the leading risk factor contributing to the burden of disease for females (aged 64 – 84) and males (aged 45 – 64). The 2019 National Drug Strategy Household Survey (NDSHS) showed the proportion of daily smokers aged 60 and over was not declining at the same rate as younger age groups, and it has increased for people aged 50 and over [95]. Older people are also the least likely age group to have intentions to quit smoking. Older people who consume alcohol are more likely to drink quantities that exceed the lifetime risk guidelines and/or drink daily, significantly contributing to fatal burden. People aged 60 and over are the most likely age group to drink daily [95]. In addition, a greater proportion of older people reported illicit drug use than ever before, with cannabis and pharmaceutical drugs (used for non-medical purposes) the most commonly used substances [95].

Enhance psychosocial interventions by:

- Understanding different experiences depending on stage of life in older people:
  - 50-70 years– preparing for their 'golden years' (age between retirement and beginning of age-imposed limitations); working, retraining or retiring; caring for others (parents and grandchildren)
  - 70-85 years – facing new independence, challenges with mobility and health, pain, caring for partners and friends
  - Over 85 years – significant health challenges, era of wisdom and gratitude, grief and bereavement and chronic pain
- Being mindful of other co-occurring health issues – liver health, sleep, pain, nutrition, mobility, cognitive impairment and other relevant health screens

- Attending to experiences of loss and grief (retirement, loss of partner/friends, loss of mobility), and by association exploring ways to build and strengthen community supports
- Emphasising a comprehensive assessment that includes any prescribed medications and harm reduction advice focusing specifically on drug interactions

Resources and Training

- Alcohol and Drug Use in Ageing Populations - Resource and Fact Sheets (NCETA) – **www.nceta.flinders.edu.au/society/alcohol-and-drug-use-ageing-populations**
- Supporting older people from culturally and linguistically diverse backgrounds – **www.fecca.org.au/wp-content/uploads/2015/06/Review-of-Australian-Research-on-Older-People-from-Culturally-and-Linguistically-Diverse-Backgrounds-March-20151.pdf**
- LOVE Project—Living older visibly and engaged - LGBTIQ+ support – **www.loveproject.org.au**
- Getting Older – Beyond Blue – **www.beyondblue.org.au/who-does-it-affect/older-people**
- Talking therapies for older adults – Te Pou: **www.health.nsw.gov.au/aod/professionals/Publications/opdap-fullreport.pdf**

6.4 Coerced Treatment and Diversion

Coerced treatment encompasses a wide variety of presentations, including people referred via courts (criminal offences, family law, child protection); legislative recommendations; requirements of employment or educational facilities; and/or perceived pressure from family and/or friends. This category encompasses mandated treatment orders, ie. people presenting for treatment because of a court directive or legally binding arrangement as part of a diversion program

Coerced treatment commonly has compulsory goals of reduced/abstinence from substance use and reduced recidivism – with an overall aim of improved health and wellbeing. There are varied programs and levels of coercion, from diversion into optional treatment through to sentencing orders in which treatment is imposed. From a client's perspective, compulsory treatment can be perceived as a loss of freedom and independence in the short term, for the long term outcome of avoiding incarceration and improving health and wellbeing. Reduction in substance use and recidivism, and improved health and psychosocial outcomes, are most successful when programs target social and environmental factors and treatment programs are completed [97].

Mandated clients who encounter the criminal justice system make up a large portion of coerced clients accessing AOD treatment in our hospitals, community based services and targeted court diversion programs such as Magistrates Early Referral into Treatment (MERIT) or Drug Court. The Australian Institute of Health and Welfare (2020) reports that one in three people detained by police indicated illicit substances contributed to their offending, and 32 per cent had used alcohol in the 48 hours prior to arrest [98]. There is good evidence that drug court and court diversion programs, with their associated psychosocial elements, can produce beneficial treatment outcomes including reduced substance use, better psychological functioning and reduced criminal activity. There is also evidence that programs which address social and environmental factors in addition to focusing on substance use will be more successful. Evidence further exists that outcomes are better when people complete programs [97]. Good outcomes from these types of programs occur when there is a partnership between healthcare professionals, legal professionals and the offender client ('therapeutic jurisprudence', [97]).

Approaches to working alongside people who are coerced due to court/justice mandate, and/or those who perceive their involvement in a psychosocial intervention as coerced, should align with the way people are generally engaged in AOD psychosocial interventions. However, it is particularly important to be explicit about the bounds of confidentiality, where shared information regarding progress (with courts, criminal justice system or child protection) is mandated as part of the treatment process. In addition, it is important to provide clear guidance on agreed treatment goals, such as abstinence as evidenced by urine drug screens (UDS), while also attending to relevant harm reduction information to ensure the safety of the person.

MERIT

The Magistrates Early Referral Into Treatment (MERIT) is a voluntary pre-plea program in the NSW Local Court for adults with issues related to their AOD use. MERIT provides access to a range of AOD treatment services for 12 weeks while court matters are adjourned. MERIT is an interagency partnership between NSW Health, the NSW Department of Communities and Justice (DCJ) and NSW Police. **MERIT Model of Care**

Drug Court

The Drug Court Program (DCP) is a collaborative program between the justice system and health service providers that oversees the voluntary rehabilitation of adults with a substance use disorder who would otherwise be incarcerated. This specialist court takes referrals from Local and District Courts for adults within the catchment areas who plead guilty to non-violent and other eligible offences and provides an intensive, highly structured program of supervision and treatment. **NSW Drug Court**

Enhance psychosocial interventions by:

- Transparency around the bounds of confidentiality, shared documentation and the conditions/goals and monitoring of treatment (eg. UDS, reporting, collaboration with external agencies)
- Rolling with resistance and applying MI to support any psychosocial intervention
- Acknowledging the challenges people experience when criminal justice/child protection or other criminal justice agencies are involved, and endeavouring to work collaboratively and consistently with other involved services to ensure the best outcomes for the person
- Building awareness of the experience of being incarcerated and the impact it can have on engaging in services, living independently, reintegrating into community and building connections
- Exploring MERIT and Drug Court options for people who may become involved in the criminal justice system
- Have an awareness of your own bias regarding coercion into treatment
- Clinicians working with mandated clients may find the dual role of therapy provider and reporting back to the legally binding agreement provider or court challenging. Grappling with the differences between standard drug and alcohol treatment and working with coerced or mandated clients – especially with regard to confidentiality, managing risk and readiness to change, building rapport and trust, and legal implications – can be difficult for some clinicians. It is recommended to explore this in clinical supervision
- Focusing on the person's strengths and their hopes/goals for their future
- Eliciting and selectively reinforcing the client's self-motivated statements of problem recognition, concern, and desire, intention and ability to change
- Awareness of the impact of court, jail, bail conditions and impending court dates and/or appointments can be very stressful for clients and may influence their behaviour and self-reporting
- Feedback informed treatment is a useful tool for empowering people who may feel coerced in their treatment – focusing on the therapeutic alliance is critical
- Clinical documentation should be factual and verified (seek congruence with information provided, clinical observation and client report/assessments)

Resources and Training

- MERIT Model of Care Drug Court Practice Guide – **www.health.nsw.gov.au/aod/programs/Pages/merit-model-of-care.aspx**
- NSW Drug Court – Clinical and Operational Guide for Health – **www.health.nsw.gov.au/aod/programs/Pages/nsw-drug-court-guide.aspx**
- Working with involuntary clients: A guide to practice 3rd Edition

6.5 People from Diverse Cultural and Linguistic Backgrounds

Culture is integral to a person's thoughts, feelings, perspectives, preferences and behaviour. Cultural background, migration, settlement experiences and expectations of family and community will have impacted the way in which a client views the world, and life in Australia. There is limited data available on the proportion of people from culturally and linguistically diverse (CALD) backgrounds using and seeking treatment for problematic substance use. However, 2019 data does indicate people from CALD backgrounds, when compared with primary English speakers, were non-smokers (82% versus 61%), alcohol abstainers (53% versus 19.2%) and less likely to have recently used illicit substances (6.4% versus 18.7%), respectively, when compared to primary English speakers. Cannabis was the most commonly used substance among people from CALD backgrounds (3.6%) [95].

In the context of the provision of psychosocial interventions, cultural background can be harnessed as a strength, and connecting with culture can be woven into AOD treatment. However, it is also the case that people who speak a language other than English, or who are unfamiliar with Western approaches to AOD treatment, may find services difficult to navigate. There is a lack of culturally accessible AOD services in NSW, and for this reason partnerships with specialist organisations which work alongside different cultural groups are essential.

Supporting people to access psychosocial interventions provided in their preferred language or via interpreter should be considered where possible. However, there are additional cultural barriers such as stigma and shame that may be experienced by people who use alcohol and drugs and have a cultural identity that is not accepting of AOD use. Talking therapies with a health professional may not be a common or accepted approach in some cultures, such as those which hold a preference for support/guidance from cultural or spiritual leaders [100]. As a specialist AOD provider it is helpful to connect with local cultural community services to find out more about how and from whom people from CALD backgrounds may want to access support.

Enhance psychosocial interventions by:

- Engaging in cultural competency courses delivered by specialist services [100]
- Being aware of the experience of trauma that may have been experienced, associated with experiences of war, dispossession and people having to leave their country of birth due to persecution
- Connecting with local cultural and refugee services and CALD counselling services
- Taking time to understand the different cultures that your service may be working alongside and their perceptions about AOD and mental health services
- Providing service materials in a variety of languages and signalling through imagery of diverse cultural groups that you offer a safe place for people from a CALD background, such as by recruiting bilingual counsellors
- Taking the approach of a curious or 'naïve' enquirer and exploring a person's culture with them, if they feel comfortable
- Checking in and asking for feedback regarding your understanding of a person's situation, given that they or you may interpret what is being said differently
- Being aware of the impact of family and culture on accessing AOD treatment, and what the implications may be
- Recognising that being of a younger age or particular gender may render you inappropriate to provide treatment in the eyes of some clients from diverse cultural backgrounds. Offer your client options, wherever possible, to demonstrate that you understand that there may be concerns or discomfort
- Understanding that immersion into the Australian culture may play a role in the initiation and maintenance of problematic drug and alcohol use among people from diverse cultural backgrounds, as they try to adapt to life in Australia
- Being sure that the client is giving informed consent and understands the limits to confidentiality and duty of care. Patiently and regularly explain treatment options, rationale and processes and use the 'teach back' method as needed to ensure communication is comprehended. Using metaphors or stories may assist with communication

- Understanding that while cultural specific services may exist, there may be reasons that the client has not or will not engage with that service (eg. privacy and confidentiality, shame)

Resources and Training

- NSW Multicultural Health Communication Service – **www.mhcs.health.nsw.gov.au**
- NSW Transcultural Mental Health Centre – **www.dhi.health.nsw.gov.au/transcultural-mental-health-centre**
- Service for the Treatment and Rehabilitation of Torture and Trauma Survivors – **www.startts.org.au**
- NADA Access and Equity: Working with diversity in the AOD setting – **https://nada.org.au/wp-content/uploads/2021/10/NADA-access-equity-2021.pdf**
- Helping Asylum Seeker and Refugee Background People with Problematic Alcohol and Other Drug Use – QNADA – **www.insight.qld.edu.au/shop/helping-asylum-seeker-and-refugee-background-people-with-problematic-alcohol-and-other-drug-use**

6.6 Rural and Remote Communities

Over 25 per cent of the NSW population lives outside of the major cities of Sydney, Newcastle and Wollongong. Rural NSW is characterised by its diversity and is made up of major regional centres and coastal cities, small towns and remote communities. Australians living in remote areas often have higher levels of disease and injury, poorer health outcomes and shorter lives than people living in metropolitan areas [95]. They also have poorer access to and use of health services. Contributing factors may be lifestyle differences, significant disadvantage in relation to education and employment, lack of recreation, and stoic attitudes, compared to those living in metropolitan areas.

Recent data highlighted that people living outside of major cities had significantly higher rates of daily smoking and were more likely to consume alcohol at levels that put them at risk of lifetime harm [101, 102] . After adjusting for age, the proportion of people who smoked daily and drank at risky levels increased with remoteness [101, 102]. Illicit substance use rates are similar to major cities, However, the type and frequency varies considerably. For example, methamphetamine use is 2.5 times higher in rural areas and cannabis use is also more widespread and more frequent.

Drug induced deaths are increasing rapidly in rural and remote areas, compared to cities. These areas are frequently characterised by limited access to transport, medical, general and specialised care (such as withdrawal management facilities, pharmacotherapy services, rehabilitation providers, needle syringe programs, psychosocial services, GPs and AOD clinicians), and lower treatment rates and hospital presentations for problematic substance use and its health impacts.

Enhance psychosocial interventions by:

- Addressing any confidentiality concerns and dual relationships. Anonymity is often difficult to maintain in small communities, presenting a range of additional challenges in maintaining typical therapeutic boundaries. If the client is known to the clinician in some capacity, it is important to be transparent and discuss any current or future challenges that this may bring. Clinical supervision is recommended to assist in reducing the impact of such breaches
- Being mindful of lower health literacy and reduced ability to afford health related expenses
- Collaborating with other health providers and including family members where possible
- Supporting clients to access your service by knowing the local transport options
- Being flexible regarding appointment times and alternative methods (eg. telephone, video, computer based treatments). Telecommunications and the use of technology in service delivery have a significantly positive impact in making services accessible to these populations. However, it remains important to give a client the option of their preferred method where possible
- Challenging cultural attitudes that normalise frequent or heavy alcohol consumption. However, this must be done in a gentle and genuine manner
- Being aware of what is happening in the local community you are servicing

- Recognising that working in rural settings often requires a broader set of skills in more areas. Be mindful of working within your scope of practice and training

Resources and Training

- Rural Health: **https://www.ruralhealth.org.au/**
- Centre for Rural and remote Mental Health: **www.crrmh.com.au**
- Department of Health - Rural Health Resources – **www1.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-overview**
- Rural & remote Australians Links & other information – Australian Institute of Health and Welfare – **www.aihw.gov.au**

6.7 Working alongside young people

According to recent data, the majority (93%) of young people (14-24 years) have not smoked tobacco, only 10.5% have consumed 11 or more drinks on a single occasion at least once a month and 76% had reported not having recently used an illicit drug [95]. However, young people are identified as a priority population in the National Drug Strategy 2017-2026 [95], because they are vulnerable to AOD use harms.

Because experimentation is a normal part of a young person's experience, and this can often include AOD use, psychoeducation should be provided by way of written, interactive, and group-based interventions about the effects of AOD on the body and potential impacts on social and emotional wellbeing. Supporting parents and care givers to engage in conversations and provide young people with information about substance use can also be a part of psychosocial interventions and resources such as **Your Room** can provide support in this regard.

Experiences of AOD use by young people can be shaped by their stage of life including exploration of identity, testing boundaries and building independence [104]. The term "young people" includes multiple stages of development and related considerations as the age range spans from 12- 24 years [104, 105]. Approaching the support of young people with developmental stages in mind, accepting that pushing boundaries and potential risk taking may be a part of their experience and actively illuminating their strengths and potential resources are a critical part of any psychosocial intervention.

Young people who come into contact with AOD treatment services because of concerns about substance use are more likely to have experienced childhood trauma, poor attachment, experience learning difficulties, have mental health concerns, experience family relationship challenges and have few community supports [105, 106]. Furthermore, it is common for young people to be attending AOD treatment as a result of external pressures, which has implications for engagement [107].

For young people who develop harmful patterns of drug use and may engage in binge use, there is the potential for developing dependence. Developmental experiences attached to adolescence and early adulthood are potential risk factors for problematic substance use such as impulsivity, a desire for instant gratification, experiences of hormone-related mood shifts, difficulty with emotion regulation and a desire for peer acceptance and belonging [108]. Consideration for these potential experiences can assist in the respectful exploration of the role alcohol and other drug use may play in a young person's life.

The key principles of practice in the provision of psychosocial interventions in AOD treatment outlined in **Section 2** apply in relation to working alongside young people. Psychosocial interventions explored in **Section 4**, are equally effective with young people, such as CBT, motivational approaches (BI, MI and MET), contingency management and assertive continuing care [5]. There is evidence that family based interventions with young people are more effective when compared with CBT individual or group-based interventions alone [5]. The importance of family inclusive practices (involving carers and chosen family) are a unique feature of working with young people, which includes family conferencing where appropriate. Where possible clinicians with expertise in the provision of family therapy is desirable as part of a therapeutic team.

Taking time to build rapport and trust is essential, and for young people this may take some time. Having a 'youth-friendly' environment is important and may include simple strategies such as setting up a welcoming waiting room that signals to young people that this is a safe place for them, displaying images of relevant youth activities, providing youth-specific reading material or areas they can engage in creative activities. Other strategies include being proactive and meeting a young person where they feel comfortable, including via outreach, with considerations for safety and confidentiality [4].

It's essential that principles of trauma informed practice are applied through a young person's treatment journey, specifically in relation to safety, choice and empowerment. These principles can be extended to support people and networks engaged in the treatment process. Acknowledgement of diversity, whether cultural or as part of a young person's gender or sexuality identity is important for establishing safety and a feeling of inclusion. Exploring a young person's strengths, and current and potential protective factors, should be part of all psychosocial interventions and woven into assessment and care planning. Encouraging the development of peer-related activities outside of therapy, such as playing sports, joining various social groups, playing music, drawing/artistic expression, should also be the focus of treatment sessions.

Mental health concerns are a common experience for young people who present for AOD treatment. Psychosocial interventions need to accommodate this in order to be effective [4]. As described in **Section 5.1**, there are several strategies for working alongside young people who may have symptoms or a diagnosis of a specific mental health condition. AOD clinicians are well positioned well to provide support for mental health concerns, and a holistic approach that addressed mental health distress and problematic AOD use at the same time is optimum [69]. Body image may be of particular concern for young people and consideration of body dysmorphia and the potential for eating disorders may require collaborative work with specialist programs.

Establishing independence is a key feature of adolescent development where relationships with peers are exceptionally important. A holistic and integrated approach accommodates physical, emotional and psychological development needs and includes exploration of sexuality, sexual experiences and intimate relationships. Providing a safe and open dialogues about sex, intimacy and substance use with a specific focus on contraception and reproductive health may require input from other health professionals and warm referrals.

Alcohol and drug use among children under the age of 12 years is of particular concern and will benefit from the involvement of parents/carers or other family members (where possible), and other services such as child protection services and schools. A child's access to substances will be of particular focus and specialist interventions that include family therapy (where appropriate), and or consideration of mental health, trauma and exposure to physical and sexual abuse and neglect are relevant.

Early foetal exposure to alcohol in pregnancy may also be a consideration for specific support among children and young people who are experiencing harms from alcohol and other drug use. Knowledge of foetal alcohol spectrum disorder (FASD) and it's impact on mental health, challenges in social situations and with schooling [109] can assist when working with children and young people who are engaged in AOD treatment. Collaborative care with specialist support services will support any psychosocial interventions and working with young people who may have a FASD diagnosis will benefit from strategies that support people with cognitive impairment.

Enhance psychosocial interventions by:

- Involving families/carers or other supports in psychosocial interventions
- Providing information and harm reduction strategies that are pitched appropriately
- Applying a holistic approach – inclusive of mental health needs, physical health, emotional health and wellbeing
- Allowing for choice and supporting independence
- Building on strengths and enhancing self determination

- Providing practical coping strategies, structure and consistency
- Being clear about confidentiality
- Paying specific attention to a comprehensive case management approach and flexibility in treatment provision, setting and supports
- Ensuring continuing care and warm referrals where necessary

Resources and Training

- NSW Youth Health Framework (2017) – A resource for strengthening therapeutic practice frameworks in youth AOD services – **www.youthaodtoolbox.org.au/sites/default/files/documents_global/YSAS%20Resource%20for%20Strengthening%20therapeutic%20practice%20frameworks%20in%20youth%20AOD%20services_monograph_0.pdf**
- Dovetail – Youth AOD Service Review Tool – **www.dovetail.org.au/resources/youth-aod-service-review-tool/**
- Your Room – **www.yourroom.health.nsw.gov.au**
- Early Interventions for Adolescents – ASPAD Webinar Presentation – Dr Brownyn Milne – **www.youtube.com/watch?v=5zQ7JqljJhk**
- FASD Hub Australia – **www.fasdhub.org.au**

6.8 Family Inclusive Practice

The term 'family' can mean different things to different people and is used here as inclusive of all support people, significant others and communities. Regardless of the definition, family members can be heavily influenced and affected by the actions of each other, both positively and negatively [110]. Inclusivity of families, significant others and community supports is essential to sustaining AOD treatment outcomes for an individual and should be a focus of holistic care. A range of psychosocial approaches stem from specific family therapy approaches, where treatment is focused on the interactions of the family and individual family members. Where possible and appropriate, care planning is enhanced when others in the community who may support a person seeking treatment can be identified and involved in the treatment process.

6.8.1 Supporting partners, significant others and family members

Given the impact that problematic drug and alcohol use can have on family, partners and children of clients, the importance of couple and family based strategies cannot be overemphasised. Partners, significant others and family members can act as useful supports in assisting clients with goals and strategies for change. Furthermore, engaging these community supports in treatment planning can enhance treatment outcomes for the client.

The priority for the AOD clinician is to ensure the needs of the client are being met with regard to their problematic AOD use and related concerns. A significant other/partner/family member may be engaged in the treatment process, particularly in the context of offering assistance and support. Referral to a clinician who has a speciality in couples or family therapy, and their engagement for any significant additional issues is important when these exist.

In the interests of increasing effective communication, specific information around what to expect from treatment, what the limitations of treatment might be, and the importance of having external supports in place for significant others needs to be provided.

Routine screening of all clients for experiences of family and domestic violence (FDV) is an essential element of AOD treatment. Subsequently, knowledge of pathways for specialist FDV support (in the event they should be needed) is also important – see **Section 3.1.4** for more information.

People receiving AOD treatment may wish to invite a support person to their treatment sessions, but this should only occur with the full consent of both parties. An appropriate support person will be someone who cares about the client, and often will be affected by any changes the client makes. The support person's input will be valuable in setting goals and developing strategies, and they may be of practical help in working towards whatever goal the client chooses. Although change is the client's responsibility, the support person may facilitate the process of change, and help to maintain these changes over the longer term.

Resources and Training

- Family Inclusive Practice eLearning Modules: NADA – **www.nada.org.au/resources/engaging-with-families-and-significant-others/**
- Family Inclusive Practice Training Workshop Facilitation Guide: NADA – **www.nada.org.au/wp-content/uploads/2021/01/Facilitators-Guide-Family-Inclusive-Practice-FINAL.pdf**
- Youth AOD Toolbox – **https://www.youthaodtoolbox.org.au/**
- Your Room – for families – **www.yourroom.health.nsw.gov.au/Families/**

6.8.2 Parents with Drug and Alcohol Concerns

Families NSW is the NSW Government's whole-of-government prevention and early intervention strategy that aims to provide children with the best start in life. The program is delivered by the NSW Ministry of Health, NSW Department of Education, and Department of Communities and Justice (DCJ). The focus is on a child's life from 0 – 8years and the parents who care for them. The AOD treatment sector has a responsibility to support this work through assessments that enquire about any children who may be cared for by someone accessing treatment, mandatory reporting where necessary, and connections made with child protection services to support clients to be the best parents they can be.

Several factors that contribute to problematic substance use, such as poverty, experiences of intergenerational trauma and lack of social supports, are also risk factors for poor parenting and child abuse and neglect. While problematic substance use by a parent can impact how they connect with their child/children, a child can also be the catalyst for change. It is for this reason that integration with/access to parenting programs and support as part of AOD treatment is important.

For clients who already have children, assessment should cover family functioning, child development and safety, even when there are no child protection concerns present for the family.

AOD professionals should be able to provide basic parenting advice to clients with families. However, clinicians should refer to specialist services such as family support in cases where more intervention is required.

Intoxication and withdrawal may present higher risk situations for providing adequate and safe care for children. Specific discussions with parents about the potential for harm and potential alternatives for childcare at those times are crucial. Encourage connection with community supports – family, school or childcare – as these can be helpful protective factors. Services should also explore options for childcare to support attendance in treatment programs if appropriate.

Key areas of knowledge for good practice include:

- Workers are directed to consult the online NSW Mandatory Reporter Guide (MRG) to inform initial decision making about the level of risk to a child or young person, information can be found under the **Child Wellbeing and Child Protection Policies and Procedures for NSW Health**.
- Health workers can call the NSW Health Child Wellbeing Unit (CWU) on 1300 480 420 for advice on reporting requirements and responses to child protection and wellbeing concerns.
- Where a NSW Health or AOD worker suspects that a child or young person is at risk of significant harm, they are required to make a report to the Child Protection Helpline (132 111 or eReport).

Resources and Training

- Emerging Minds – **https://emergingminds.com.au/online-course/parental-substance-use-and-child-aware-practice-principles-and-practices/**
- NSW Human Services: Working with parental substance misuse – **www.community.nsw.gov.au/__data/assets/pdf_file/0019/321634/researchnotes_parental_misuse.pdf**
- Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do? AIFS –**https://aifs.gov.au/resources/policy-and-practice-papers/improving-outcomes-children-living-families-parental-substance**

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Appendix A

	Level of evidence (based on best available evidence)	Quality of evidence assessment – Evidence base (A-D)	Quality of evidence assessment – Consistency (A-D)	Quality of evidence assessment – Clinical impact (A-D)	Quality of evidence assessment – Generalisability (A-D)
Q1: What have been shown to be the most effective psychosocial interventions for treating people with AOD issues					
Brief interventions	**Level I** (Based on recent Cochrane systematic review of RCTs; Kaner et al. 2018	**C** (A systematic review of Level II studies with moderate risk of bias overall)	**B** (Inconsistencies in the evidence can be explained in terms of substantial heterogeneity between RCTs in terms of setting, populations, screening measures used, baseline consumption of alcohol and nature of the Control/ Comparator conditions)	**B** (Mean reductions in AOD use small, equivalent to 2.5 standard drinks, meaning most would still be drinking at harmful/hazardous levels; reductions still determined as meaningful at the individual if not population level)	**A-B** (Overall included RCTs rated as moderately clinically representative or 'real world' trials; RCTs conducted in mostly US and UK-based primary care settings similar to Australia; use of no/minimal intervention Control/ Comparators consistent with 'real world' practice)
CBT	**Level I** (Based on synthesis of studies include in a meta-analytic review of RCTs; Magill et al. 2019)	**A** (Several level I studies with mostly low risk of bias)	**B** (Most studies consistent; inconsistencies may be explained due to differences in outcome measures, Control/Comparator types)	**B-C** (Findings have moderate to substantial implications for clinical practice showing the impact of Control/Comparator on treatment effects; moderate and durable effects over time compared to non/minimal intervention and small, often non-significant effects compared to other non-specific and specific interventions. Efficacy findings would need to be confirmed in 'real world' effectiveness trials)	**A-B** (Included study samples similar to treatment-seeking populations in Australia in terms of AOD use characteristics, age and gender; majority of studies conducted in the USA, which may limit the generalisability of results to a universal healthcare system)
Motivational interviewing/ motivational enhancement therapy	**Level I for MI and - II for BMI** (Based on a synthesis of studies in a systematic review of RCTs; Chatters et al. 2016)	**C-D** (Majority of the included RCTs assessed as being at high risk of bias, with remaining low or unclear risk).	**B-C** (Disparate evidence on primary outcome of AOD use; inconsistencies in study findings may be in part explained by differences in follow-up periods, intensity of the intervention, and nature of the Control/Comparator	**C-D** (Based on the included trials only able to assess the effectiveness of (B)Mis on a heterogeneous mix of individual who may or may not have cannabis use dependence; limited understanding of the longer-term impacts of (B)Mis).	**B-C** (The review was inclusive in scope yet Sub-specific populations at high risk of AOD use issues were excluded. Generalisability of findings to the broader population; and other AOD using populations apart from those that use cannabis may be limited).
Contingency management	**Level I Evidence for CM (+/- CRA)** (Based on a systematic review of RCTs; De Crescenzo et al. 2018)	**C** (Level II studies with overall moderate risk of bias)	**B** (Most studies consistent and inconsistencies may be explained in terms of Control/Comparator, duration of follow-up, and whether CM is combined with another psychosocial intervention, e.g. CRA)	**B-C** (Rigorous synthesis and evaluation of the CM literature, likely to inform clinical guidelines for the treatment of less studied AOD using populations)	**B-C** (Excluded individuals who were not formally diagnosable and those who were not actively treatment seeking, however did include those with another comorbid AOD use disorder, or mental health disorder)
Mindfulness-based interventions incl. Acceptance Commitment Therapy	**Levels II to III** (Based on meta-analytic review of RCTs and Non-Randomised Controlled Trials; Cavicchioli et al. 2018)	**B** (Combination of Level II and III studies, with the largest proportion rated as being of low risk of bias)	**B-C** (Heterogeneity in findings on some outcomes could not be explained due to a paucity of studies)	**C-D** (MBIs appear to offer clinically significant, albeit preliminary advantages over other therapeutic approaches on AOD use-relevant outcomes such abstinence, perceived stress)	**B-C** (Populations included in the reviewed studies appear mostly similar to the target population, further research needed to ascertain the effects for specific populations, e.g. those with co-occurring versus non co-occurring AOD use)

	Level of evidence (based on best available evidence)	Quality of evidence assessment – Evidence base (A-D)	Quality of evidence assessment – Consistency (A-D)	Quality of evidence assessment – Clinical impact (A-D)	Quality of evidence assessment – Generalisability (A-D)
Q1: What have been shown to be the most effective psychosocial interventions for treating people with AOD issues (cont.)					
Other counselling interventions	**Level II-III Evidence** (Based on Cochrane Systematic Review of RCTs and quasi-Randomised Controlled Trials; Lancaster et al. 2017)	**B and C** (Systematic review pooling results from Level II and III studies with mostly low to moderate/unclear risk of bias)	**B** (Most studies consistent and inconsistencies can be explained by whether counselling was used as a standalone therapy or adjunct to pharmacotherapy)	**B and C** (Counselling interventions appear effective across a variety of routine clinical care settings and have moderate to substantial impact on smoking cessation with relative increases of 40-80%)	**B** (Studies included a range of populations, including high-risk special populations, across a range of settings in countries including Australia and others with similar healthcare systems)
Self-help groups	**Level II Evidence** (Based on synthesis of studies in a systematic review of RCTs, De Crescenzo et al. 2018)	**B to C** (Systematic review pooling results from Level I studies with mostly low to moderate/ unclear risk of bias)	**B** (Some inconsistencies which can be explained by the type of Comparator/ Control; TAU versus CBT)	**C-D** (May inform clinical guidelines to some extent, but more research needed)	**C-D** (Unclear whether findings would extend to other AOD use populations aside from individuals with problematic use of psychostimulants; all included studies conducted in the USA, thus uncertain whether generalisable to the Australian healthcare context)
Psychodynamic and psychoanalytic interventions	Could not be determined based on current review of the secondary literature (pooled findings show no intervention-related effects on outcomes)	Could not be determined	Could not be determined	Could not be determined	Could not be determined
Q2: What psychosocial interventions are most effective for treating people and improving outcomes for special population groups					
Pregnancy and postpartum	**Level II–III Evidence for counselling** (CBT, MET, or SS-based) and for incentive-based interventions/CM (based on Cochrane Systematic Review & Meta-analysis; Chamberlain et al. 2017)	**B** (Based on mostly Level II/III studies with overall low risk of bias)	**B** (Inconsistencies able to be explained, e.g., due to differences in the control/ comparison, stage of pregnancy etc.)	**B-C** (Large number of studies providing high-quality evidence to support effectiveness).	**B-C** (Evidence derived from a selective group of women who smoke during pregnancy; low participation rates often reported so findings may not apply more broadly).
Co-occurring alcohol/other drug and mental health conditions	**Level II Evidence for CBT + MI** (Based meta-analysis of RCTs and non-randomised controlled trials; Riper at al. 2014)"	**B** (Combination of level II/II studies with overall low risk of bias)	**B** (Heterogeneity low overall; inconsistencies explained in terms of associations between study characteristics and difference in magnitude in effect size)	**C-D** (Slight impact due to small effect sizes observed on outcomes; but impact may be larger given high prevalence of comorbid conditions)	**C** (Included both RCTs and non-randomised studies and found no difference; all but one included study involved outpatients only which may limit generalisability)

	Level of evidence (based on best available evidence)	Quality of evidence assessment – Evidence base (A-D)	Quality of evidence assessment – Consistency (A-D)	Quality of evidence assessment – Clinical impact (A-D)	Quality of evidence assessment – Generalisability (A-D)
Q2: What psychosocial interventions are most effective for treating people and improving outcomes for special population groups (cont.)					
Older people	**Level II/III Evidence for Psychosocial interventions incl. BI** (based on systematic and meta-analytic review of RCTs and uncontrolled studies; Kelly et al. 2018)."	**C–D** (Includes Level II - IV studies with mostly unclear to high risk of bias)."	**C** (Evidence was mixed with regards to BI; ongoing uncertainty due to limited studies n=3).	**C** (Most of included studies included only a proportion of at-risk drinkers; little evidence on primary intervention of excessive drinking as well as impact on cognitive and dementia outcomes).	**B-C** (Overall, broadly inclusive review i–terms of study participant characteristics; studies recruited limited proportion of at-risk drinkers which may limit generalisability and implementation in practice).
Criminal justice system	**Level II Evidence for MI** (based on 1 RCT identified in a Cochrane Systematic Review; Perry et al. 2019b)	**C** (Level II study with low or unclear risk of bias)	**C** (Inconsistency in findings for MI across studies with different control/comparisons; yet limited number of studies precludes any firm explanations).	**D** (Evidence from a single RCT involving self-report abstinence measures).	**D** (RCT involving adolescent sample only; unable to establish whether finding applicable to an adult population).
Adolescents and young adults	**Level I Evidence for MDFT** (based on a review of 5 RCTs within meta-review; Snowdon et al. 2019)"	**C** (Multiple Level II studies, none of which had a low risk of bias)."	**B** (Mostly consistent findings, which inconsistencies arising over different assessment time-points).	**D** (Scarcity of available data and small effect sizes)	**C–D** (RCT focussed on MDFT in outpatient settings in non-opioid drug use; unable to ascertain the generalisability of findings to other healthcare settings and/or other AOD using-populations)
Indigenous/ First Nations	**Unable to establish Level of Evidence for CBT + pharmacotherapy due to substantial methodological limitations of RCT showing positive effects** (Identified within Cochrane Systematic Review; Carson et al. 2012)	**D** (One Level I study with high risk of bias).	**D** (Evidence is inconsistent)	**D** (Findings of possible clinical significance due to 43% increase in abstinence rates; yet small sample size)	**D** (RCT conducted in Australian indigenous people; yet small sample size and self-selecting sample of study likely to limit generalisability)

	Level of evidence (based on best available evidence)	Quality of evidence assessment – Evidence base (A-D)	Quality of evidence assessment – Consistency (A-D)	Quality of evidence assessment – Clinical impact (A-D)	Quality of evidence assessment – Generalisability (A-D)
Question 3: What are the effective frameworks (i.e. process/care delivery models) that support the delivery of psychosocial interventions					
Technology-based interventions	**Level I Evidence** (systematic review and meta-analysis of RCTs; Hai et al. 2019)	**A** (Most included studies low risk of bias, with some having unclear bias risk)	**B** (Some inconsistencies which are likely explained by methodology and sample size issues)	**B** (Clinical implementation limited by inconsistencies).	**C** (Review focuses on a specific population which may not generalise more broadly)
Other care processes and models					
Group treatments	**Level I Evidence** (Based on synthesis of studies in a Cochrane Review; Stead et al. 2017)"	**B** (Systematic review pooling results from Level I studies with mostly low to moderate/unclear risk of bias)."	**C** (Some inconsistencies which can be explained by the type of Comparator/Control)	**C** (May inform clinical guidelines to some extent, but more research needed).	**C** (Sample quite heterogenous, but largely primary care which may not translate to AOD specific populations)
Intervention intensity	**Level I Evidence** (Based on synthesis of studies in a systematic review of RCTs, Gates et al. 2016)"	**B** (Systematic review pooling results from Level I studies with mostly low to moderate/unclear risk of bias)."	**B** (Some inconsistencies which can be explained by the type of Comparator/Control)"	C (May inform clinical guidelines to some extent, but more research needed)	**C** (Unclear whether findings would generalise to other AOD using groups other than those using cannabis)
Client characteristics	**Level I Evidence** (Based on synthesis of studies in a systematic review and meta-analysis of RCTs; Kock et al. 2019)	C (Systematic review pooling results from Level I studies, however only 14% of studies found to be Low risk of bias).	**B** (Some inconsistencies which can be explained by differences in the interventions used)	C (May inform clinical guidelines to some extent, but more research needed)	**B** (Findings likely to generalise, however not completely reflective of current population of interest)
Integrated care	**C** (Based on synthesis of studies in a systematic review of RCTs, Roberts et al. 2016)	**C** (Systematic review pooling results from Level I studies with mostly low to moderate/ unclear risk of bias)	**C** (Some inconsistencies which reflect uncertainty due to the small number of studies included).	**C** (May inform clinical guidelines to some extent, but more research needed).	**C** (Unclear whether findings would generalise to groups with other mental health disorders aside from PTSD)
Stepped care	Could not be determined based on current review of the secondary literature (pooled findings show no intervention-related effects on outcomes)"	Could not be determined	Could not be determined	Could not be determined	Could not be determined

	Level of evidence (based on best available evidence)	Quality of evidence assessment – Evidence base (A-D)	Quality of evidence assessment – Consistency (A-D)	Quality of evidence assessment – Clinical impact (A-D)	Quality of evidence assessment – Generalisability (A-D)
Question 3: What are the effective frameworks (i.e. process/care delivery models) that support the delivery of psychosocial interventions (cont.)					
Continuing care	**Level I Evidence** (Based on synthesis of studies in a systematic review of RCTs; Lenaerts et al. 2014)	**D** (Systematic review pooling results from Level I studies most of which had unclear risk of bias)	**C** (Some inconsistencies which reflect uncertainty due to the small number of studies included).	**C–D** (May inform clinical guidelines to some extent, but more research needed)	**C** (Unclear whether findings would generalise to other AOD using populations aside from those with alcohol use disorders)
Stage-based interventions	Could not be determined based on current review of the secondary literature (pooled findings show no intervention-related effects on outcomes)	Could not be determined	Could not be determined	Could not be determined	Could not be determined
Stage-based interventions	**Level 1 Evidence** (Based on synthesis of studies in a systematic review of RCTs; Penzenstadler et al. 2017)	Could not be determined	**B** (Some inconsistencies which can be explained by the type of Comparator/ Control and design variations)"	**C** (May inform clinical guidelines to some extent, but more research needed).	**A** (AOD specific populations in Western samples, likely to generalise)
Therapist factors and alliance"	Could not be determined based on current review of the secondary literature	Could not be determined	Could not be determined	Could not be determined	Could not be determined


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