

NON-GOVERNMENT ORGANISATION ALCOHOL AND OTHER DRUGS TREATMENT SERVICE SPECIFICATIONS



Health

Purpose:

Treatment Service Specifications (TSS) aim to provide guidance to both purchasers and providers of NGO services regarding the principles and key elements of different types of Alcohol and Other Drug (AOD) treatment. They aim to facilitate state-wide consistency of contemporary and high quality, evidence-based service delivery by NGOs. The intention of treatment service specifications is to give the provider sufficient guidance that they can plan the organisational structures, conditions and resources needed to deliver the service; and to give purchasers clarity about what they are purchasing. TSS are not the same as clinical guidelines – clinical guidelines provide direction to clinicians in working with an individual client. The TSS are also not a planning document.

These treatment service specifications are specific to NGO alcohol and other drug treatment in NSW.

There are four treatment types covered:

- Withdrawal management
- Psychosocial counselling
- Residential treatment
- Day programs.

Development:

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These TSS have been developed through an iterative process. Literature reviews, followed by focus groups with NGO managers of services informed the first drafts, which were then followed by significant input from the Expert Advisory Group, and further input from NGO service providers. Delphi surveys were conducted with clinicians as well as an online survey of clients which informed the essential elements specified for each service type. Feedback from LHDs/LHN and the Ministry of Health was incorporated.

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1 CONTEXT

These Treatment Service Specifications have been prepared for Non-Government Organisation (NGO) service providers. Yet the NGO alcohol and other drug treatment services are only one component of the NSW treatment service system. People receive alcohol and other drug treatment from multiple agencies and services in NSW, notably government providers (LHDs/LHN), primary care providers (GPs), and through private facilities.

Most people will interact with multiple services over time, and some people will simultaneously seek treatment from multiple providers. For any one client, this may entail referral to another provider prior to the commencement of treatment but after a comprehensive assessment; or shared care arrangements (simultaneous treatment by more than one provider); or transfer during the course of treatment due to the development of new symptoms or problems; or referral at the end of treatment.

This ongoing interaction between multiple providers requires:

- formal organisational agreements between NGO and LHD providers that detail the governance and clinical governance arrangements, including processes for dispute resolution
- ongoing assessment during the course of treatment to ensure that the client's needs are met by the current service provider; and
- procedures for transfer of care including documented transfer of care/discharge plans communicated between service providers.

2 KEY TREATMENT PRINCIPLES

These treatment principles inform all AOD care received in NSW from NGOs.

For the client receiving care

- Treatment is client-centred care and with client-agreed treatment goals
- Treatment provides the best possible care to achieve the desired outcomes
- Treatment involves integrated and holistic care responses and provides for continuity of care
- Individuals seeking treatment and their families, partners and friends, are treated with respect and dignity
- Treatment is tailored and culturally appropriate to the needs of the individual and is responsive to diversity
- Individuals receive support during the process of entering treatment, during treatment and after treatment.

For the NGO providing care

- Treatment is based on evidence from the best available research
- Treatment is provided in a safe, supportive environment
- Treatment is delivered by a suitably qualified and experienced workforce
- Harm reduction principles are incorporated into post-care treatment planning for all clients
- Treatment providers engage in culturally sensitive practice
- Treatment providers engage in family/partner sensitive and inclusive practices
- Treatment is provided in collaboration with other service providers, to support clients

- Services are responsive to short and longer term client goals
- Informed consent is obtained for treatment
- Each NGO has documented Quality Improvement processes and procedures
- Each NGO has a documented governance process
- Each NGO has a documented clinical governance process that includes all service providers (including external providers such as general practitioners)
- Each NGO commits to a process of clinical audit/case review
- Consumers and/or carers are involved in organisational governance and quality improvement processes.

For the treatment service system

- Clients receive timely and high quality, evidence based treatment regardless of service setting or provider (state government, primary care and NGO services)
- Treatment quality and outcomes are measured consistently across the service system
- Treatment is readily available, affordable and accessible for clients
- The treatment service system meets an individual's treatment and support needs
- There is coordination and communication across and between NSW alcohol and other drug treatment providers and systems of care
- Approaches to address drivers of disadvantage are considered
- The treatment service system engages in continuous improvement.

3 PRIORITY GROUPS

NGO AOD treatment services in NSW are targeted at those with significant alcohol or other drug problems, including those who experience harms, have complex needs, are dependent on alcohol or other drugs, and have a high risk of future harm for themselves or others.

These are some of the more vulnerable and disadvantaged in our community as listed in the NSW Health Alcohol & Other Drugs Strategy 2017-2021 (draft):

- Aboriginal people
- People living in rural and remote NSW
- People with mental health issues
- Pregnant women
- Individuals who are at risk of domestic and family violence
- Children of parents who have alcohol and other drug use issues
- Young people
- Older people
- People in contact with the criminal justice system
- Culturally and linguistically diverse populations
- Lesbian, gay, bisexual, transgender or intersex (LGBTI) people.

For Aboriginal and Torres Strait Islander people there are two possible service delivery models: Aboriginal-specific services, staffed and run by Aboriginal people in community controlled organisations; or mainstream AOD services that have staff trained in cultural awareness. These Treatment Service Specifications refer only to the latter – that is mainstream services. There will be alternate and/or additional requirements for Aboriginal-specific services. Aboriginal clients require access to culturally safe and secure treatment services.



4 ACCREDITATION

Consistent with the key treatment principles, NSW NGO AOD treatment services are required to meet standards of care through accreditation. Accreditation has two aspects: organisation accreditation and worker accreditation. In addition, there is professional registration of NGO workers.

Accreditation is based on recognition from an independent third-party that a service or program meets the requirements of defined criteria or standards. Accreditation provides quality and performance assurance for owners, managers, staff, funding bodies and consumers. Accreditation:

- independently verifies competence and credibility
- builds a service with more efficiency and quality and performance assurance
- confirms Quality Improvement policies and procedures and their effective ongoing implementation (including incident management, complaints procedures, audits and reviews)
- provides international recognition
- enables benchmarking against relevant standards
- informs clients that the highest level of assessment of professionalism has been met
- flags a service's ability to meet mandatory regulatory requirements
- strengthens a service's ability to compete overall.

Accreditation for an NGO AOD service can be obtained through generic accreditation and quality frameworks by a certified entity or through more specialised accreditation schemes.

ORGANISATION ACCREDITATION

An accredited NGO meets acceptable standards of service delivery, management, staffing and organisational development. The AOD sector does not have a formal, national agency accreditation process, but a number of organisational accreditation systems are available to be used for NGO AOD treatment services. These include:

The Australian Council on Healthcare Standards (ACHS)

EQUIP5 (5th edition of the ACHS Evaluation and Quality Improvement Program) is a quality assessment and improvement accreditation program for health care organisations which supports excellence in consumer or patient care and services. It aims to assist health care organisations and services with quality improvement efforts.

www.achs.org.au/publications-resources/equip5/

Quality Innovation Performance (QIP) or QICSA

The QIC Health and Community Services Standards 6th edition were developed by the Quality Improvement Council (QIC). The QIC accreditation is used by a wide range of health and community services and involves a continuous quality improvement approach. QIC recognises strengths and areas for improvement, helping organisations to identify quality improvement priorities. The three main areas of focus include:

- Building quality organisations
- Providing quality services and programs, and
- Sustaining quality external relationships.

www.qip.com.au/

The Institute for Healthy Communities Australia (IHCA)

The IHCA is a non-profit organisation, which works collaboratively with organisations within the Health and Community Service sectors across Australia and provides accreditation services. IHCA Certification fosters and promotes the tradition and culture underpinning the quality principles, directed at enhancing the effectiveness of the human services sector through continuous quality improvement, transparency, democracy and accountability. IHCA Certification offers expertise in undertaking quality reviews and certification against a range of national and government standards.

www.ihcac.com.au/about-us/

In addition to organisations that provide accreditation, a number of organisations specify the standards by which accreditation occurs. These include:

The International Organization for Standardization (ISO) which does not provide accreditation, rather ISO develops and publishes International standards. The ISO 9001 is a widely recognised Quality Management System (QMS), belonging to the ISO 9000 family of quality management system standards. It sets out the requirements of a quality management system based on a number of principles.

www.iso.org/iso/home.html

While the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) does not certify or inspect organisations, products or people, it accredits the bodies that do. This is done by development of the assessment criteria which certifiers and inspectors must meet to become accredited <http://www.jas-anz.org/>. The Australasian Therapeutic Communities Association (ATCA) has a standard certified with JAS-ANZ for therapeutic communities.

www.atca.com.au/wp-content/uploads/2013/12/ATCA-Standard.pdf

The NSW quality improvement resource tool for non-government drug and alcohol organisations is a useful resource:

http://www.nada.org.au/media/41192/nada_achs_equip5_resourceool_april2013.pdf

WORKER ACCREDITATION

Worker accreditation is the formal recognition that a person is competent to carry out specific tasks. This can involve the requirement of workers to hold a minimum qualification level to be employed in a particular job or role, or the registration of a qualified worker with a professional body. To-date there is no national minimum qualification strategy for AOD specialist workers. Some jurisdictions currently have a minimum qualification strategy for AOD specialist workers. Both the Victorian and ACT minimum qualification standards require AOD workers to hold either:

- an AOD-specific qualification equivalent to (or above) CHC40408 Certificate IV in Alcohol and Other Drugs Work, or
- a tertiary qualification in health, social, or behavioural science, and a minimum of four AOD core competencies from the CHC40408 Certificate IV in Alcohol and Other Drugs Work. (The CHC40408 Certificate IV in Alcohol and Other Drugs Work consists of 16 units of competency, 9 of which are compulsory and 7 are elective).

PROFESSIONAL REGISTRATION

Professional disciplines that work in the AOD sector require registration with a relevant professional body. These individual professional registration bodies include:

- The Australian Psychological Society
- The Royal Australian College of General Practitioners
- Pharmacy Board of Australia
- The Australian College of Nursing
- The Royal Australasian College of Physicians
- Australian Association of Social Workers (AASW)

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia.

5 WITHDRAWAL

5.1 SERVICE DEFINITION; AIMS AND OBJECTIVES

Withdrawal management (detoxification) refers to the safe discontinuation of use of a substance of dependence. Withdrawal management services aid in the cessation or reduction of heavy and prolonged drug use in a safe, supportive environment. Treatment is acute and provides short-term outcomes

“The rationale of withdrawal management is to provide the appropriate level of support for withdrawal to be completed safely, which then allows the individual to determine his or her optimal ongoing management strategy” (NSW Health, 2007).

The main aims of withdrawal management services are:

- The alleviation of distress - the treatment of discomfort caused by withdrawal symptoms
- The prevention of severe withdrawal complications, such as medical or psychiatric conditions and the risk of overdose following withdrawal
- The provision of linkages to services required post-withdrawal (e.g. services for medical, psychological or social factors).

There are two roles for NGOs in withdrawal management in NSW:

1. support clients who are receiving withdrawal in LHDs and primary care settings (for example with case management or post-withdrawal psychosocial counselling programs);
2. provide withdrawal management services.

These treatment service specifications are only concerned with the second of these two functions, that is, the direct provision of withdrawal management services by an NGO.

These treatment service specifications do not cover withdrawal from opioid maintenance programs (such as methadone or buprenorphine), nor do they cover management of a neonatal abstinence syndrome. There are separate specific regulations and guidelines for withdrawal from OST and NAS management.

5.2 SERVICE SETTINGS

Withdrawal can be provided in a number of different settings:

- home-based
- outpatient
- community residential
- inpatient hospital
- primary care (by a GP)

For NGO services, the settings for withdrawal are limited to:

- Residential withdrawal in the community (non LHD patients)
- Ambulatory, outpatient withdrawal
- Home-based withdrawal (support provided through daily home visits)

Matching the service setting with client level of need/severity is important. “Always consider ambulatory withdrawal management (patient at home, supported by visits to the clinic or visits from the clinician and telephone) as the first option” where clinically appropriate (NSW Health, 2008).

5.3 ESSENTIAL TREATMENT ELEMENTS

Pre-treatment support

It is important that NGOs support people from the point of first contact with the withdrawal management service. Providing support to people as they go through the process of treatment seeking forms part of the care to be provided under this service specification. This support should be tailored to the client needs, and may take the form of harm reduction information, access to primary health care, telephone support (where the service calls the client), or other forms of regular contact initiated by the NGO pending treatment entry, and as required while the client prepares to enter treatment.

Comprehensive assessment

A comprehensive assessment, inclusive of mental health and physical health status, must be conducted by the NGO. A comprehensive assessment ensures that the NGO services to be provided will be matched to and meet the client's needs at that time and this level of intervention is clinically appropriate. Assessment may occur with other providers with adequate skills in drug and alcohol assessment and treatment (eg GP, LHD). An individual care plan will be developed in collaboration with the client including agreed treatment goals for the episode.

Withdrawal management

The essential services to be provided as part of withdrawal management are:

- Ongoing assessment and monitoring
- Access to medication to assist with withdrawal where clinically indicated by comprehensive assessment and review
- Counselling during withdrawal (whether individual and/or group-based), appropriately tailored to client needs
- Harm reduction and overdose prevention information
- Exercise (for example yoga, and/or relaxation training).

These essential elements must be provided by every NGO withdrawal program. Other services provided as part of withdrawal may include tobacco interventions for those seeking to cease/reduce tobacco consumption, and other health care interventions.

Ongoing assessment and transfer of care

Throughout treatment, clients should be monitored and have ongoing assessment to ensure that the current treatment is meeting his/her needs. Organisational links between the NGO and other service providers are required to fulfil duty of care, and exercise appropriate risk management. Transfer of care includes written communication from the NGO (including a patient summary, details of the care provided, the current treatment plan, and reason for transfer) for each transfer.

Referral at end of treatment

A concrete plan for further treatment for those clients seeking treatment post-withdrawal is essential. This may include medication-assisted treatment where clinically indicated such as methadone and buprenorphine for opioids, naltrexone or acamprosate for alcohol, and opioid overdose prevention (naloxone treatment). In addition, facilitation of access to appropriate support services after withdrawal (this may include legal services, primary health care, housing, etc) is also essential. Development of the post-withdrawal treatment plan entails a documented plan for each client including identifying the person/agency responsible for providing the care, and communication of the treatment plan to other service providers engaged in it. Referral planning should occur at the commencement of the withdrawal episode. The planning must include overdose prevention in vulnerable clients.

Assertive follow-up

It is expected that every client who has received an NGO withdrawal management will be contacted within 1 month of leaving withdrawal: in order to check in with the client, provide advice and support as required, and ensure that the treatment plan post-withdrawal has been effective. This may include facilitating and following up on a referral to another treatment service. For example, if transport between services is an issue for the client, it may be that the NGO provides assistance to ensure that this does not become a barrier to accessing further care.

5.4 ELIGIBILITY CRITERIA/TARGET GROUP

Withdrawal management is suitable for people who are drug-dependent and want to stop or reduce their drug use.

A moderate to severe substance use disorder is generally required prior to undergoing withdrawal. Eligibility for withdrawal is unrestricted within this.

There must be an appropriate match between the intervention being delivered by the NGO and the client need. Comprehensive assessment and treatment matching (the right level of treatment intensity for the client presentation) is essential.

Any inclusion or exclusion criteria adopted by an NGO must be flexible, adapted to each individual circumstance and be non-discriminatory. Equity of access for all client groups is essential. For example, services may not exclude people based on past criminal charges, or client characteristics (such as GLBTI or mental health issues) or client circumstances (such as homelessness). The target group for NGO specialist AOD treatment is those most vulnerable and marginalised. Individuals with specific needs or complex conditions may require further assessment and additional support.

There are some specialised withdrawal management services that are targeted to particular population groups (eg women with children, Aboriginal people) which therefore apply exclusion criteria for those outside these target populations. Any exclusion criteria must be employed flexibly, without discrimination and ensure equity of access within the target client group.

5.5 REFERRAL PATHWAYS INTO AND OUT OF THE SERVICE

Referral into withdrawal is not limited by a defined intake pathway and may include: self-referral, through a doctor, a mental health service, correctional services, and/or non-government or government agency.

An individual assessment at intake (or triage) will determine whether the client is suitable for the withdrawal service, ensuring that the NGO service can meet the needs of that individual.

Withdrawal management is a short-term intervention. The duration of a withdrawal management episode can vary depending on the type of substance(s) that an individual uses. For those clients seeking further behaviour change there is a need for clear, client-centred and

facilitated referral to post-withdrawal treatment. Connecting individuals with post-treatment services is crucial if long-term behaviour change is sought. This may take the form of counselling, residential rehabilitation, day programs or pharmacotherapy maintenance. Active referral to these services at the conclusion of the withdrawal episode is essential.

Harm reduction information should be provided throughout the period of withdrawal management. Neuroadaptation reversal results in a reduction in tolerance, and the risks of overdose (due to reduced tolerance) are very high for people who have undergone withdrawal. Information regarding the effects of reduced tolerance, plus information about access to harm reduction services, is essential.

5.6 ACCREDITATION, SERVICE STANDARDS / AND CLINICAL GUIDELINES

NGO withdrawal services must have organisational accreditation (see Section 3 above). The NGO can choose the most appropriate organisational accreditation scheme.

Worker accreditation and professional registration is required for some positions, for example a visiting medical officer, registered nurse, psychologist, social worker or other allied health worker.

The NGO is responsible for ensuring that each staff member maintains her/his qualifications and registration.

Clinical Guidelines and best practice standards for withdrawal management include (see also appendix):

- Drug and Alcohol Withdrawal Clinical Practice Guidelines - NSW. Mental Health and Drug and Alcohol Office. (2008). Sydney: NSW Department of Health. http://www0.health.nsw.gov.au/policies/gl/2008/pdf/gl2008_011.pdf
- Alcohol and Other Drug Withdrawal: Practice Guidelines, 2nd ed. Frei M, Berends L, Kenny P, Swan A, Jenner L, Hunter B, et al. (2012). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre. <http://www.turningpoint.org.au/media-centre/centrepubs/getfile.axd?oid=22d5bd3f-876a-4ba2-acb1-ba94c4f4a5b4>

5.7 WORKFORCE CHARACTERISTICS

Each withdrawal service should have access to medical and nursing staff experienced in the management of drug and alcohol problems. This may include nursing staff accredited by DANA or a GP who is part of the GP Specific Interest group (GPSI).

At a minimum, each NGO withdrawal service requires:

- A registered nurse per shift
- A solid working relationship with a doctor – this may occur through a visiting GP attending the service, or through arrangements for clinic hours for the withdrawal service at the surgery.
- After hours emergency medical coverage (eg in association with a local hospital, medical practitioner or nurse consultant/nurse practitioner)
- An AOD case manager
- An AOD support worker (minimum Certificate IV)
- Access to an Addiction Medical Specialist as required

The number and grading/experience/seniority levels of the FTE will depend on the setting (residential or ambulatory) and the number of beds/treatment places available. A clinical manager of sufficient seniority and experience is essential.

All staff should receive supervision (from a professional from the same discipline) and ongoing professional development opportunities.

5.8 OUTCOMES

The outcomes for withdrawal should include:

- Reduction in withdrawal symptoms and management of physical and psychological distress
- Successful neuroadaptation reversal
- Achievement of the client's treatment goals
- Improvement in physical health
- Provision of pathways to further treatment and client-supported active referral into further treatment.

References

¹ The ISBAR framework is a useful tool to structure a transfer of care communication (<https://safetyandquality.gov.au/implementation-toolkit-resource-portal/resources/organisational-leadership/ISBAR%20revisited%20Identifying%20and%20solving%20barriers%20to%20effective%20handover%20in%20inter-hospital%20transfer%20-%20Project%20Toolkit.pdf>).

² DSM 5 criteria for Substance Use Disorder (n=11), where 2 or 3 symptoms indicate a mild substance use disorder, 4 or 5 symptoms indicate a moderate substance use disorder, and 6 or more symptoms indicate a severe substance use disorder.

¹ Taking the substance in larger amounts or for longer than you meant to

² Wanting to cut down or stop using the substance but not managing to

³ Spending a lot of time getting, using, or recovering from use of the substance

⁴ Cravings and urges to use the substance

⁵ Not managing to do what you should at work, home or school, because of substance use

⁶ Continuing to use, even when it causes problems in relationships

⁷ Giving up important social, occupational or recreational activities because of substance use

⁸ Using substances again and again, even when it puts you in danger

⁹ Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance

¹⁰ Needing more of the substance to get the effect you want (tolerance)

¹¹ Development of withdrawal symptoms, which can be relieved by taking more of the substance.

6 PSYCHOSOCIAL COUNSELLING

6.1 SERVICE DEFINITION; AIMS AND OBJECTIVES

Psychosocial counselling programs for the treatment of alcohol and other drug use cover a wide range of therapeutic interventions. It is a program of care that includes at its core psychological therapeutic interventions but also includes case management, care coordination, and wraparound services. This TSS refers to psychosocial counselling that is not provided within a residential treatment setting, nor within a day program, but is rather a stand-alone, outpatient program of care.

The nature of the psychosocial therapeutic interventions may vary depending on the client need and the practitioner expertise but must be an evidence-based therapeutic intervention. A client's care should be stepped up or stepped down in intensity as their needs change, with a range of interventions available along a continuum from prevention to specialist inpatient care.

Interventions include:

- Cognitive behaviour therapy (CBT)
- Dialectical behaviour therapy (DBT)
- Acceptance and commitment therapy (ACT)
- Contingency management (CM)
- Community reinforcement approach
- Couples and family treatments
- Relapse prevention (RP)
- Motivational Enhancement Therapy (MET)
- Social skills training

The primary goals of psychosocial counselling are to:

- reduce or cease the harmful use of alcohol and/or other drugs
- support positive behavioural and psychological change
- minimise the harms associated with alcohol or other drug use.

Psychosocial interventions should provide individuals with an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of wellbeing. They encompass the physical, psychological, spiritual, environmental, family and cultural aspects of wellbeing.

Psychosocial counselling programs can be group-based programs, individual programs or a combination of the two.

This treatment type does not include community education and community awareness programs. The provision of community education requires a different workforce, skill set and service specifications and guidelines that are not specified here.

This treatment type also excludes screening and brief interventions. Screening and brief intervention occurs in a different clinical context (usually general health and welfare settings), requires a different skill set from that specified here for psychosocial counselling, and has significantly different resource implications.

6.2 SERVICE SETTINGS

For NGO services, by definition, counselling (in this TSS) is outpatient/ambulatory care that is face-to-face.

Online and/or telephone counselling tailored to client needs can be provided in addition to face-to-face care. (An online or e-health counselling service alone would not qualify within this TSS).

6.3 ESSENTIAL TREATMENT ELEMENTS

Pre-treatment support

NGOs support people from the point of first contact with the psycho-social counselling service. Providing support to people as they go through the process of treatment seeking forms part of the care to be provided under this service specification. This support should be tailored to the client needs, and may take the form of telephone support (where the service calls the client), face-to-face pre-treatment support groups, or other forms of regular contact initiated by the NGO pending treatment entry, and as required while the client prepares to enter treatment.

Comprehensive assessment

A comprehensive assessment, inclusive of mental health and physical health status, is essential. A comprehensive assessment ensures that the NGO services to be provided will be matched to and meet the client's needs at that time. An individual care plan will be developed in collaboration with the client including agreed treatment goals for the episode.

Psychosocial counselling

The essential services to be provided as part of a psychosocial counselling program are:

- Assessment (comprehensive and inclusive of mental health assessment)
- Case management and coordinated care for each client
- Counselling/therapeutic interventions (individual and/or group-based; focussed on alcohol and other drug issues as well as mental health issues)
- Counselling/therapeutic interventions with families/partners/children where appropriate for the individual client
- Harm reduction and overdose prevention information
- Facilitation of access to appropriate support services (this may include legal services, primary health care, housing, etc). These essential elements must be provided by every NGO psychosocial counselling program.

Some psychosocial counselling programs may include other interventions such as interventions to cease tobacco use, exercise programs, relaxation training, and for some clients, assistance with accessing appropriate medication. Support from peers is valued by clients.

Ongoing assessment and transfer of care

Throughout treatment, clients should be monitored and have ongoing assessment to ensure that the current treatment is meeting his/her needs. Organisational links between the NGO and other service providers are required to fulfil duty of care. Appropriate transfer of care includes written communication from the NGO (including a patient summary, details of the care provided, the current treatment plan, and reason for transfer) for each transfer.

Aftercare

Aftercare commences once treatment has finished. For psychosocial counselling this can be difficult to determine, but if counselling for ongoing issues is being provided, this is part of the treatment, not aftercare. Aftercare is a lower level of intensity, and commences once the client has achieved her/his treatment goals. It is the responsibility of the psychosocial program staff to develop an aftercare plan in collaboration with each client, and communicate that plan to other service providers. The intensity of the aftercare will vary depending on client needs, but may include:

- Booster sessions and/or follow up meetings
- Support to attend self-help groups (eg. AA/NA)
- Information about community engagement opportunities (e.g. interest groups, social networks)
- Participation in regular sessions with other aftercare peers
- Support for access to a range of health, welfare and ongoing support services (such as housing, legal, vocational, mental health services, primary health care)

Assertive follow-up

It is expected that every client who has received psychosocial counselling will be contacted between 1 and 3 months post-treatment: in order to check in with the client, provide advice and support as required, and ensure that the aftercare plan has been effective.

6.4 ELIGIBILITY CRITERIA/TARGET GROUP

The most important consideration regarding client eligibility is that there is an appropriate match between the intervention being delivered by the NGO and the client need. Comprehensive assessment and treatment matching is essential.

Eligibility for an NGO psychosocial counselling program is unrestricted, but the target group for NGO specialist AOD treatment is those most vulnerable and marginalised. Individuals with specific needs or complex conditions may require further assessment and additional support.

Any inclusion or exclusion criteria adopted by an NGO must be flexible, adapted to each individual circumstance and be non-discriminatory. Equity of access for all client groups is essential. For example, services may not exclude people based on past criminal charges, or client characteristics (such as GLBTI or mental health issues) or client circumstances (such as homelessness).

There are some specialised psycho-social counselling services that are targeted to particular population groups (eg women with children, Aboriginal people, young people) which therefore apply exclusion criteria for those outside these target populations. Any exclusion criteria must be employed flexibly, without discrimination and ensure equity of access within the target client group.

6.5 REFERRAL PATHWAYS INTO AND OUT OF THE SERVICE

For this TSS, the referral pathways into the program include:

- Self-referred
- Court ordered
- Health provider referral
- AOD service referral
- From other health care services (e.g. MH)

- From hospital services
- From prison, post-release.

For psychosocial counselling provided in the context of other AOD treatment, such as OST, the referral pathway is via the treating clinician (e.g. prescriber of OST or case manager).

Every client should be involved in the development of a post-treatment plan, which commences at entry to the treatment.

6.6 ACCREDITATION, SERVICE STANDARDS AND CLINICAL GUIDELINES

NGO psycho-social counselling services must have organisational accreditation (see Section 3 above). The NGO can choose the most appropriate organisational accreditation scheme.

Worker accreditation and professional registration is required for some positions, for example a registered nurse, psychologist, social worker or other allied health worker.

The NGO is responsible for ensuring that each staff member maintains her/his qualifications and registration.

Clinical Guidelines and best practice standards for psycho-social counselling include (see also appendix):

Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines. Mental Health and Drug and Alcohol Office. (2008). Sydney, NSW: NSW Department of Health.

http://www0.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf

Clinical Guidelines for the care of persons with comorbid mental illness NSW Health (2009) <http://www.health.nsw.gov.au/mentalhealth/programs/mh/Publications/comorbidity-report.pdf>

Drug misuse in over 16s: psychosocial interventions. National Institute for Health and Care Excellence.(2007). London: National Institute for Health and Care Excellence.

<https://www.nice.org.uk/guidance/CG51/chapter/Introduction>

6.7 WORKFORCE CHARACTERISTICS

At a minimum, each NGO psychosocial counselling service requires:

- A qualified therapist (psychologist, social worker, etc) with experience and seniority in delivering psychosocial psychotherapeutic interventions
- An AOD case manager
- An AOD support worker (minimum Certificate IV).

Access to medical (primary health care) and mental health practitioners needs to be demonstrated by the NGO.

The number and grading/experience/seniority levels of the FTE will depend on the number of treatment places available. A clinical manager of sufficient seniority and experience is essential.

All staff should receive supervision (from a professional from the same discipline) and ongoing professional development opportunities.

6.8 OUTCOMES

The primary outcomes from a psychosocial counselling program are:

- Client achievement of treatment goals
- Reduction or cessation of harmful alcohol or other drug use
- Improvements in psychological wellbeing and/or quality of life
- Access to health, welfare, legal and social services that a client may need.

Secondary outcomes from psychosocial counselling include:

- Improvements in physical health
- Improvement in social circumstances.

7 RESIDENTIAL TREATMENT

7.1 SERVICE DEFINITION; AIMS AND OBJECTIVES

Residential treatment provides structured, residential care after physical withdrawal from alcohol or other drugs that enables a focus on intensive recovery activities. It aims to help people with substance use disorders and a high level of psychosocial needs become stable in their recovery.

The aims of residential treatment are to:

- effect change in alcohol or other drug using patterns
- assist clients with integration into the community post treatment.

Residential treatment (excluding withdrawal) is a program of care for people with intense, complex needs. It delivers holistic, client centred treatment to address substance use disorders, and provides psychosocial interventions to address issues behind the substance dependence. Some residential treatments also provide programs to enable skills training including education, accredited training, sport and recreation activities. In a Therapeutic community, one type of residential treatment, the “community” is thought of as both the context and method of the treatment model, where both staff and other residents assist the resident to deal with his or her substance dependence. Supported accommodation programs provide care in which clients live semi-independently with support. The length, intensity and type of residential care model is driven by client need.

The goals of residential treatment are to:

- Provide an environment free of alcohol, other drugs and non-prescribed pharmaceuticals
- Deliver a structured and often personalised treatment program
- Reduce the harmful use of alcohol or other drugs
- Facilitate the achievement of health, wellbeing and quality of life
- Provide care in the context of harm reduction.

7.2 SERVICE SETTINGS

Residential treatment is by definition a residential service.

7.3 ESSENTIAL TREATMENT ELEMENTS

Pre-treatment support: providing support to people as they go through the process of treatment seeking forms part of the care to be provided by NGOs under this service specification. This support should be tailored to the client needs, and may take the form of telephone support (where the service calls the client), face-to-face pre-treatment support groups, or other forms of regular contact initiated by the NGO pending treatment entry, and as required while the client prepares to enter treatment.

Comprehensive assessment

A comprehensive assessment, inclusive of mental health and physical health status, is essential. A comprehensive assessment ensures that the NGO services to be provided will be matched to and meet the client’s needs at that time. An individual care plan will be developed in collaboration with the client including agreed treatment goals for the episode.

Residential rehabilitation

The essential services to be provided as part of an NGO residential rehabilitation program are:

- Ongoing assessment and treatment monitoring
- Case management and coordinated care for each client
- Counselling/therapeutic interventions (individual and/or group-based; focussed on alcohol and other drug issues as well as mental health issues)
- Counselling/therapeutic interventions with families/partners/children where appropriate for the individual client
- Harm reduction and overdose prevention information
- Facilitation of access to appropriate support services (this may include legal services, primary health care, vocational training, etc).

These essential elements must be provided by every NGO residential rehabilitation program.

Some residential rehabilitation programs may include other interventions such as interventions to cease tobacco use, exercise programs, practical living skills, and for some clients, assistance with accessing appropriate medication. Support from peers is valued by clients.

Ongoing assessment and transfer of care

Throughout treatment, clients should be monitored and have ongoing assessment to ensure that the current treatment is meeting his/her needs. Organisational links between the NGO and other service providers are required to fulfil duty of care. Appropriate transfer of care includes written communication from the NGO (including a patient summary, details of the care provided, the current treatment plan, and reason for transfer) for each transfer.

Aftercare

Aftercare commences once treatment has finished. For residential rehabilitation it commences once the client has achieved her/his treatment goals and concluded the residential rehabilitation program. It is the responsibility of the NGO residential treatment staff to develop an aftercare plan in collaboration with each client, and communicate that plan to other service providers. The intensity of the aftercare will vary depending on client needs, but may include:

- Support to attend self-help groups (eg. AA/NA)
- Booster sessions and/or follow up meetings
- Participation in regular sessions with other aftercare peers
- Assistance with recreational/social activities/community engagement
- Support for access to services (such as housing, legal, vocational, mental health services)

Assertive follow-up

It is expected that every client who has received residential treatment will be contacted between 1 and 3 months post-treatment: in order to check in with the client, provide advice and support as required, and ensure that the aftercare plan has been effective.

Opioid substitution treatment (OST)

Some NGO residential treatment services provide pharmacotherapy maintenance (methadone/buprenorphine) and/or opioid maintenance withdrawal programs. There are different models for these OST services: 1. On-site prescribing and on-site dispensing; 2. Off-site prescribing with on-site dispensing; 3. Off-site prescribing and off-site dispensing to current residents (with the residential service providing transport). These treatment service specifications do not include coverage of these various OST programs and service models. The appropriate clinical and regulatory guidelines cover these practices.

7.4 ELIGIBILITY CRITERIA/TARGET GROUP

The most important consideration regarding client eligibility is that there is an appropriate match between the intervention being delivered by the NGO and the client need. A comprehensive assessment, ensuring that the client's needs are matched to the program is necessary before admission.

The target group for NGO specialist AOD treatment is those who have not succeeded or are not likely to succeed in less intensive treatment settings such as outpatient counselling or day programs. Individuals with specific needs or complex conditions may require further assessment and additional support.

Any inclusion or exclusion criteria adopted by an NGO must be flexible, adapted to each individual circumstance and be non-discriminatory. Equity of access for all client groups is essential. For example services may not exclude people based on past criminal charges, or client characteristics (such as GLBTI or mental health issues) or client circumstances (such as homelessness).

There are some specialised residential services that are targeted to particular population groups (eg women with children, Aboriginal people, young people) which therefore apply exclusion criteria for those outside these target populations. Any exclusion criteria must be employed flexibly, without discrimination and ensure equity of access within the target client group.

7.5 REFERRAL PATHWAYS INTO AND OUT OF THE SERVICE

Residential treatment is preceded by withdrawal, hence entry into residential treatment comes from either an inpatient or community based/ outpatient withdrawal service. This does not preclude referrals that are:

- Self-referred
- Court ordered
- Health provider referral
- AOD service referral
- From other health care services (eg MH)
- From hospital services
- From prison, post-release

Every client should be involved in the development of a post-treatment plan, which commences at entry to the treatment and is revisited throughout the duration of treatment.

7.6 ACCREDITATION, SERVICE STANDARDS AND CLINICAL GUIDELINES

Residential treatment services must have organisational accreditation (see Section 3 above). The NGO can choose the most appropriate organisational accreditation scheme.

Worker accreditation and professional registration is required for some positions, for example a registered nurse, psychologist, social worker.

The NGO is responsible for ensuring that each staff member maintains her/his qualifications and registration.

Clinical Guidelines and best practice standards for residential treatment include (see also appendix):

Drug & Alcohol Treatment Guidelines for Residential Settings. Mental Health and Drug and Alcohol Office. (2007). Sydney, New South Wales: NSW Department of Health.

<http://www.health.nsw.gov.au/mentalhealth/programs/da/Publications/drug-a-guidelines.pdf>

Service Standards for Addiction Therapeutic Communities. The Community for Addiction Therapeutic Communities. (2006). London, U.K: The Royal College of Psychiatrists.

http://www.emcdda.europa.eu/attachements.cfm/att_231083_EN_INT05_Service%20Standards%20for%20Addiction%20Therapeutic%20Communities%201st%20edition%202006.pdf

7.7 WORKFORCE CHARACTERISTICS

For residential treatment, the minimum staffing profile is 24 hour coverage (and minimum one overnight staff member).

The staffing profile should include:

- AOD case managers
- AOD clinicians

The different disciplinary backgrounds in a residential treatment program will reflect the program requirements and the client needs. These disciplines may include:

- Psychotherapist
- Psychologist
- Social worker
- Nurse
- Peer support worker
- Mental health clinician
- Staff appropriately qualified to work with children and families

Access to medical and mental health practitioners needs to be demonstrated by the NGO.

The number and grading/experience/seniority levels of the FTE will depend on the number of beds/treatment places available. A clinical manager of sufficient seniority and experience is essential.

All staff should receive supervision (from a professional from the same discipline) and ongoing professional development opportunities.

7.8 OUTCOMES

The outcomes from residential treatment include:

- Achievement of the client's treatment goals
- Cessation or reduction in harmful patterns of alcohol/drug consumption
- Improvement in physical health
- Improvement in psychological wellbeing
- Improvement in social circumstances, quality of life and social connectedness
- Living independently in the community
- Successful referral to appropriate ongoing support systems.

8 DAY PROGRAMS

8.1 SERVICE DEFINITION; AIMS AND OBJECTIVES

Day programs provide intensive, non-residential support for people seeking to change their alcohol or other drug use patterns.

Day programs may entail:

- structured therapeutic groups, with daily attendance; or
- support programs, with daily attendance.

As with all the treatment types, day programs include comprehensive assessment, treatment planning, case management and care coordination for the duration of the day program.

The nature of the interventions provided through the day program may vary depending on the client need, and the practitioner expertise, but must be an evidence-based therapeutic intervention. These include:

- Cognitive behaviour therapy (CBT)
- Dialectical behaviour therapy (DBT)
- Acceptance and commitment therapy (ACT)
- Contingency management (CM)
- Community reinforcement approach
- Couples and family treatments
- Relapse prevention (RP)
- Motivational Enhancement Therapy (MET)
- Social skills training

Day programs may be offered weekdays, in working hours, but also in the evenings or weekends (times of potential high risk for some clients).

Day programs can take a number of different forms, such as a fixed intake program (closed groups which commence on a four-six week cycle), or programs with rolling admissions. Daily attendance and a high therapeutic structure are essential features of the day programs considered under this TSS.

Outreach services, which are here defined as locating clients where-ever they are, and engaging in flexible, non-appointments based work that may include brief interventions,

education and information, advocacy and support, and assistance with referral to an AOD treatment service, is not covered by these TSS.

8.2 SERVICE SETTINGS

Day programs are by definition outpatient. While in some cases, a stand-alone location is preferable, day programs may also be offered on the same site as other NGO AOD treatment services or allied community services.

8.3 ESSENTIAL TREATMENT ELEMENTS

Pre-treatment support

It is important for NGOs to support people from the point of first contact with the day program service. Providing support to people as they go through the process of treatment seeking forms part of the care to be provided under this service specification. This support should be tailored to the client needs, and may take the form of telephone support (where the service calls the client), face-to-face pre-treatment support groups, or other forms of regular contact initiated by the NGO pending treatment entry, and as required while the client prepares to enter treatment.

Comprehensive assessment

A comprehensive assessment, inclusive of mental health and physical health status, is essential. A comprehensive assessment ensures that the NGO services to be provided will be matched to and meet the client's needs at that time. An individual care plan will be developed in collaboration with the client including agreed treatment goals for the episode.

Day program

The essential services to be provided as part of a day program are:

- Assessment (comprehensive and inclusive of mental health assessment)
- Case management and coordinated care for each client
- Counselling/therapeutic interventions

(individual and/or group-based; focussed on alcohol and other drug issues as well as mental health issues)

- Counselling/therapeutic interventions with families/partners/children where appropriate for the individual client
- Harm reduction and overdose prevention information
- Facilitation of access to appropriate support services (this may include legal services, primary health care, housing, etc)

These essential elements must be provided by every NGO psychosocial counselling program.

Some day programs may include other interventions such as interventions to cease tobacco use, practical living skills, exercise programs, relaxation training, and for some clients, assistance with accessing appropriate medication. Support from peers is valued by clients.

Ongoing assessment and transfer of care

Throughout treatment, clients should be monitored and have ongoing assessment to ensure that the current treatment is meeting his/her needs. Organisational links between the NGO and other service providers are required to fulfil duty of care. Appropriate transfer of care includes written communication from the NGO (including a patient summary, details of the care provided, the current treatment plan, and reason for transfer) for each transfer.

Aftercare

Aftercare commences once formal treatment has concluded (eg if a client requires ongoing counselling, this would be regarded as part of the treatment, not aftercare). It is the responsibility of the day program staff to develop an aftercare plan in collaboration with each client, and communicate that plan to other service providers. The intensity of the aftercare will vary depending on client needs, but may include:

- Booster sessions and/or follow up meetings
- Participation in regular sessions with other aftercare peers

- Assistance with recreational/social activities/ community engagement
- Support to attend self-help groups (eg. AA/ NA)
- Support for access to services (such as housing, legal, vocational, mental health services)

Assertive follow-up

It is expected that every client who has received a day program will be contacted between 1 and 3 months post-treatment: in order to check in with the client, provide advice and support as required, and ensure that the aftercare plan has been effective.

8.4 ELIGIBILITY CRITERIA / TARGET GROUP

The most important consideration regarding client eligibility is that there is an appropriate match between the intervention being delivered by the NGO and the client need. A comprehensive assessment, ensuring that the client's needs are matched to the program is necessary before admission.

Eligibility for day programs is unrestricted, but the target group for NGO specialist AOD treatment is those most vulnerable and marginalised. Individuals with specific needs or complex conditions may require further assessment and additional support.

Any inclusion or exclusion criteria adopted by an NGO must be flexible, adapted to each individual circumstance and be non-discriminatory. Equity of access for all client groups is essential. For example services may not exclude people based on past criminal charges, or client characteristics (such as GLBTI or mental health issues) or client circumstances (such as homelessness).

There are some specialised day programs that are targeted to particular population groups (eg women with children, Aboriginal people, young people) which therefore apply exclusion criteria for those outside these target populations. Any exclusion criteria must be employed flexibly, without discrimination and ensure equity of access within the target client group.

8.5 REFERRAL PATHWAYS INTO AND OUT OF THE SERVICE

Referral into a day program may come from a number of different sources, including:

- Self-referred
- Court ordered
- Health provider referral
- AOD service referral
- From other health care services (eg MH)
- From hospital services
- From prison, post-release

Every client should be involved in the development of a post-treatment plan, which commences at entry to the treatment.

8.6 ACCREDITATION, SERVICE STANDARDS AND CLINICAL GUIDELINES

Day programs must have organisational accreditation (see Section 3 above). The NGO can choose the most appropriate organisational accreditation scheme.

Worker accreditation and professional registration is required for some positions, for example a registered nurse, psychologist, social worker.

The NGO is responsible for ensuring that each staff member maintains her/his qualifications and registration.

There are no specific clinical guidelines and best practice standards for day programs. The following Best Practice Guidelines may be useful (see also appendix):

Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines.

Mental Health and Drug and Alcohol Office. (2008). Sydney, NSW: NSW Department of Health.

http://www0.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf

Counselling guidelines: Alcohol and other drug issues (3rd ed). Marsh, A. O'Toole, S., Dale, A., Willis, L., Helfgott, S. (2013). Mount Lawley, WA: Government of Western Australia Drug and Alcohol Office.

http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=844&PortalId=0&TabId=211

8.7 WORKFORCE CHARACTERISTICS

At a minimum, a Day Program requires:

- A qualified therapist (psychologist, social worker, etc) with experience and seniority in delivering psychosocial psychotherapeutic interventions
- An AOD case manager
- An AOD support worker (minimum Certificate IV)

Access to medical (primary health care) and mental health practitioners needs to be demonstrated by the NGO.

The number and grading/experience/seniority levels of the FTE will depend on the number of treatment places available. A clinical manager of sufficient seniority and experience is essential.

The different disciplinary backgrounds in a day program will reflect the program requirements and the client needs. These disciplines may include:

- Psychotherapist
- Psychologist
- Social worker
- Nurse
- Peer support worker
- Mental health clinician
- Staff appropriately qualified to work with children and families

All staff should receive supervision (from a professional from the same discipline) and ongoing professional development opportunities.

8.8 OUTCOMES

The outcomes from a day program should be:

- Achievement of the client's treatment goals
- Cessation or reduction in harmful patterns of alcohol/drug consumption
- Improvement in psychological wellbeing and quality of life
- Improvement in social circumstances
- Improvement in physical health
- Successful referral to appropriate ongoing support systems

APPENDIX: BEST PRACTICE GUIDELINES AND RESOURCES

Withdrawal

- Queensland Alcohol and Drug Withdrawal: Clinical Practice Guidelines. Mental Health Alcohol and Other Drugs Directorate. (2012). Fortitude Valley: Queensland Health.
<https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/medicines/drugs-of-dependence/detox-guidelines.pdf>
- Alcohol and Other Drug Withdrawal Practice Guidelines: Acute inpatient and residential services. Cementon, E. (2011). Victoria: NorthWestern Mental Health.
http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=doc_download&gid=69
- Effective weed control working with people to reduce or stop cannabis use. Clinical treatment guidelines for alcohol and drug clinicians. No 6: Engelder, M. (2002). Fitzroy, VIC: Turning Point Alcohol and Drug Centre.
- Substance Withdrawal Management: Guidelines for medical and nursing practitioners in primary health, specialist addiction, custodial and general hospital settings. Matua Raki. (2011). Wellington: Matua Raki.
<http://www.matuaraki.org.nz/resources/substance-withdrawal-management-guidelines-for-medical-and-nursing-practitioners-in-primary-health-specialist-addiction-custodial-and-general-hospital-settings/374>

Psychosocial counselling

- Psychological Therapy and Psychosocial Interventions in the Treatment of Substance Misuse. European Monitoring Centre for Drugs and Drug Addiction. Luxembourg: European Union
http://www.emcdda.europa.eu/attachements.cfm/att_231378_EN_UK22_psychosocial.pdf
- Counselling guidelines: Alcohol and other drug issues, 3rd ed. Marsh, A. O'Toole, S., Dale, A., Willis, L., Helfgott, S. (2013). Mount Lawley, WA: Government of Western Australia Drug and Alcohol Office.
<http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=CoreDownload&EntryId=844&PortalId=0&TabId=211>

- Clinical treatment guidelines for alcohol and drug clinicians. No 10: Managing difficult and complex behaviours. Lee N, Hocking S, Smith H & Richards J. (2003). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Clinical Treatment Guidelines for alcohol and drug clinicians. No 7: Working with polydrug users. Swan, A., & Ritter, A. (2000). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Clinical treatment guidelines for alcohol and drug clinicians. No 5: Controlled drug use interventions. Addy, D. & Ritter, A. (2000). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Clinical treatment guidelines for alcohol and drug clinicians. No 4: Reducing harm for clients who continue to use drugs. Addy, D. & Ritter, A. (2000). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Clinical treatment guidelines for alcohol and drug clinicians. No 3: Relapse prevention. Addy, D. & Ritter, A. (2000). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Clinical treatment guidelines for alcohol and drug clinicians. No 2: Motivational interviewing. Addy, D. & Ritter, A. (2000). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Clinical treatment guidelines for alcohol and drug clinicians. No 1: Key principles and practices. Addy, D. & Ritter, A. (2000). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- Routes To Recovery: Psychosocial Interventions For Drug Misuse. Pilling, S., Hesketh, K., Mitcheson, L. (2010). London: British Psychological Society, Centre for Outcomes, Research and Effectiveness (CORE).
http://www.emcdda.europa.eu/attachements.cfm/att_231394_EN_UK38_Residential%20drug%20treatment%20service_a%20summary%20of%20good%20practice.pdf
- Youth Alcohol and Drug Outreach Guidelines. Petroulias, D., Bruun, A., Papadontas, M. & Ipsita, R. (2005). Victoria: Turning Point Alcohol and Drug Centre.

Residential rehabilitation

- Models of residential rehabilitation for drug and alcohol misusers. National Treatment Agency for Substance Misuse. (2006). London: NHS: National Treatment Agency.
http://www.emcdda.europa.eu/attachements.cfm/att_231364_EN_UK07_residential_rehab.pdf
- Residential drug treatment services: good practice in the field. Murray, T. (2009). London: NTA.
www.nta.nhs.uk

Pregnancy

- Supporting pregnant women who use alcohol or other drugs: A guide for primary health care professionals. Breen, C., Awbery, E., Burns, L. . Sydney: National Drug and Alcohol Research Centre 2014.
<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Supporting%20Pregnant%20Women%20who%20use%20Alcohol%20or%20Other%20Drugs%20Resource.pdf>
- Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period. Mental Health and Drug and Alcohol Office. Sydney: NSW Health 2014.
http://www0.health.nsw.gov.au/policies/gl/2014/pdf/GL2014_022.pdf
- National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn. New South Wales Department of Health. Sydney: 2006.
http://www.drugsandalcohol.ie/6297/1/3795_National_clinical_guidelines.pdf

Methamphetamine

- Psychotherapy for methamphetamine dependence: Treatment Manual South Australia Smout, M., Longo, M. KS., Wickes, W., Mitchell, A., Cahill, S., Williamson, P., White, J. DASSA 2008.
https://www.sahealth.sa.gov.au/wps/wcm/connect/ac8a8e0041783f539037ff67a94f09f9/Psychotherapy+for+Methamphetamine+Treatment+Manual_2008-DASSA-Oct2013.pdf?MOD=AJPERES&CACHEID=ac8a8e0041783f539037ff67a94f09f9
- Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine dependence and treatment. Lee, N., Johns, L., Jenkinson, R., Johnston, J., Connolly, K., Hall, K. & Cash, R. (2007). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

- Guidelines for the medical management of patients with methamphetamine-induced psychosis. Mclver, C., McGregor, C., Baigent, M., Spain, D., Newcombe, D., Ali, R. Adelaide: Government of South Australia, Southern Adelaide Health Service, 2006.
<https://www.sahealth.sa.gov.au/wps/wcm/connect/cbad29804178755b94d1ff67a94f09f9/Guidelines+methamphetamine-induced+psychosis-DASSA-Oct2013.pdf?MOD=AJPERES&CACHEID=cbad29804178755b94d1ff67a94f09f9>
- Psychostimulant Users - Clinical Guidelines for Assessment and Management. Mental Health and Drug and Alcohol Office. Sydney: Department of Health NSW 2006.
http://www0.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_001.pdf

Family work

- Clinical treatment guidelines for alcohol and drug clinicians. No 11: Working with families. Patterson J & Clapp C. (2004). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.
- For Kids' Sake: A workforce development resource for Family Sensitive Policy and Practice in the Alcohol and other drugs sector. Battams, S., Roche, S. M., Duvnjak, A., Trifonoff, A., Bywood, P. (2010). Adelaide: National Centre for Education and Training on Addiction.
<http://nceta.flinders.edu.au/files/3913/0915/8536/EN435%20Battams%20et%20al%202010%20.pdf>

Comorbidity

- Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings. Mills, KL., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R., et al. . Sydney: National Drug and Alcohol Research Centre 2009.
http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Comorbidity%2BGuidelines_0.pdf
- Te Ariari o te Oranga: the Assessment and Management of People with Co-existing Mental Health and Substance Use Problems. Todd, FC. . Wellington: Ministry of Health, 2010.
<https://www.health.govt.nz/system/files/documents/publications/te-ariari-o-te-orang-te-ariari-13-04-10.pdf>

Tobacco

- Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 12: Smoking cessation - working with clients to quit. Lee, N., Coonan, D., Dunlop, A., Stephens, R., & Ritter, A. (2005). Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

Generic

- Guidelines for the Treatment of Alcohol Problems. Haber, P., Lintzeris, N., Proude, E., Lopatko, O. Canberra: Australian Government Department of Health and Ageing 2009.
[https://www.health.gov.au/internet/main/publishing.nsfContent/OFD6C7C289CD31C9CA257BF0001F96BD/\\$File/AustAlctreatguidelines%202009.pdf](https://www.health.gov.au/internet/main/publishing.nsfContent/OFD6C7C289CD31C9CA257BF0001F96BD/$File/AustAlctreatguidelines%202009.pdf)
- Guideline for the treatment of drug dependence: A European perspective. European Monitoring Centre for Drugs and Drug Addiction. Luxembourg: European Union 2011.
http://www.emcdda.europa.eu/attachements.cfm/att_144638_EN_SI_treatment-guidelines-p3.pdf
- Clinical governance in drug treatment: A good practice guide for providers and commissioners. Harris, S., Taylor, S. & National Treatment Agency. London, NTA 2009
<http://www.nta.nhs.uk/uploads/clinicalgovernance0709.pdf>
- Treatnet: International Network of Drug Dependence Treatment and Rehabilitation Resource Centres. Good practice document. United Nations Office on Drugs and Crime. Vienna, Austria: United Nations Office on Drugs and Crime 2008.
https://www.unodc.org/docs/treatment/CBTS_AB_24_01_09_accepted.pdf
- A Counsellor's Guide to Working with Alcohol and Drug Users. Marsh, A., Dale, A., Willis, L. Perth, WA: Drug and Alcohol office, Government of Western Australia 2007.
http://www.dao.health.wa.gov.au/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=172&PortalId=0&TabId=211
- Treatment of patients with substance use disorders, second edition. Kleber, HD., Weiss, RD., Anton, RF., George, TP., Greenfield, SF., Kosten, TR., et al. American Psychiatric Association. The American journal of psychiatry. 2007;164(4 Suppl):5-123.
- Practice Guideline for the Treatment of Patients With Substance Use Disorders. Kleber, HD., Weiss, RD., Anton, RF., George, TP., Greenfield, SF., Kosten, TR., et al. Arlington, U.S.A: American Psychiatric Association, 2006.
http://psychiatryonline.org/pb/assets/raw/site-wide/practice_guidelines/guidelines/substanceuse.pdf
- Models of care for treatment of adult drug misusers: Update 2006. National Treatment Agency for Substance Misuse. London: National Treatment Agency for Substance Misuse 2006.
http://www.nta.nhs.uk/uploads/nta_modelsof-care_update_2006_moc3.pdf

