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Model for the delivery for community-based alcohol and other drug (AOD) interventions for young people

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April 2019

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Introduction

Coordinare commissioned Lives Lived Well (LLW) to describe a model for the implementation and delivery of alcohol and other drug (AOD) interventions for young people that is suitable for community settings. The model was developed from an extensive review of recent research, a current study on headspace AOD services and service delivery information based on LLW expertise in this area. This document includes information about staff roles, links to other services, necessary referral pathways, suitable client load for full time equivalent positions (FTE) and for the type of complex needs that are likely to be encountered in young people presenting to an AOD service.

This document is complemented and draws on the information from an earlier report by the same authors, '*A Review of Evidence-Based Alcohol and Other Drug (AOD) Interventions Suitable for Young People in A Community Setting*' and will refer to this report throughout.

Principles

There are three key principles[1] that guide this Model and the delivery of AOD interventions for young people:

- Flexibility – Flexibility is a key approach when working with young people and within AOD treatment generally. The ability to adapt, change, and innovate when responding to young people, their different circumstances and how these change over time is critical. Flexibility should apply to approaches, client goals, service policies and protocols, and engagement, e.g. allowing for activities, outreach or drop-in as opposed to traditional appointments (Bruun & Mitchell 2012; Crane, Francis & Buckley 2013; Crane, Buckley, & Francis 2012). However, flexibility and innovation does not negate the importance of skills in counselling, therapeutic approaches and AOD impacts.
- Accessibility – Accessibility refers to services that are physically accessible, affordable, and non-discriminatory. This includes being located centrally, close to public transport, providing services at no cost, being able to make appointments outside of work hours, and providing services in non-traditional settings (Ware 2013)[2].
- Inclusiveness – Inclusive services are where "clients, staff and communities will feel respected and welcomed" (Office for Youth n.d.). The service should particularly ensure that young people don't feel different from their peers. They should ensure that they are inclusive of young people, including Aboriginal and Torres Strait

[1] See key characteristics of youth AOD services covered in *treatment approach* on page 11 – 12 of *A Review of Evidence-Based Alcohol and Other Drug (AOD) Interventions Suitable for Young People In A Community Setting* (Meumann, Allan, & Snowdon 2018)

[2] See *Youth friendly service delivery* in the literature review, page. 16 – 17.

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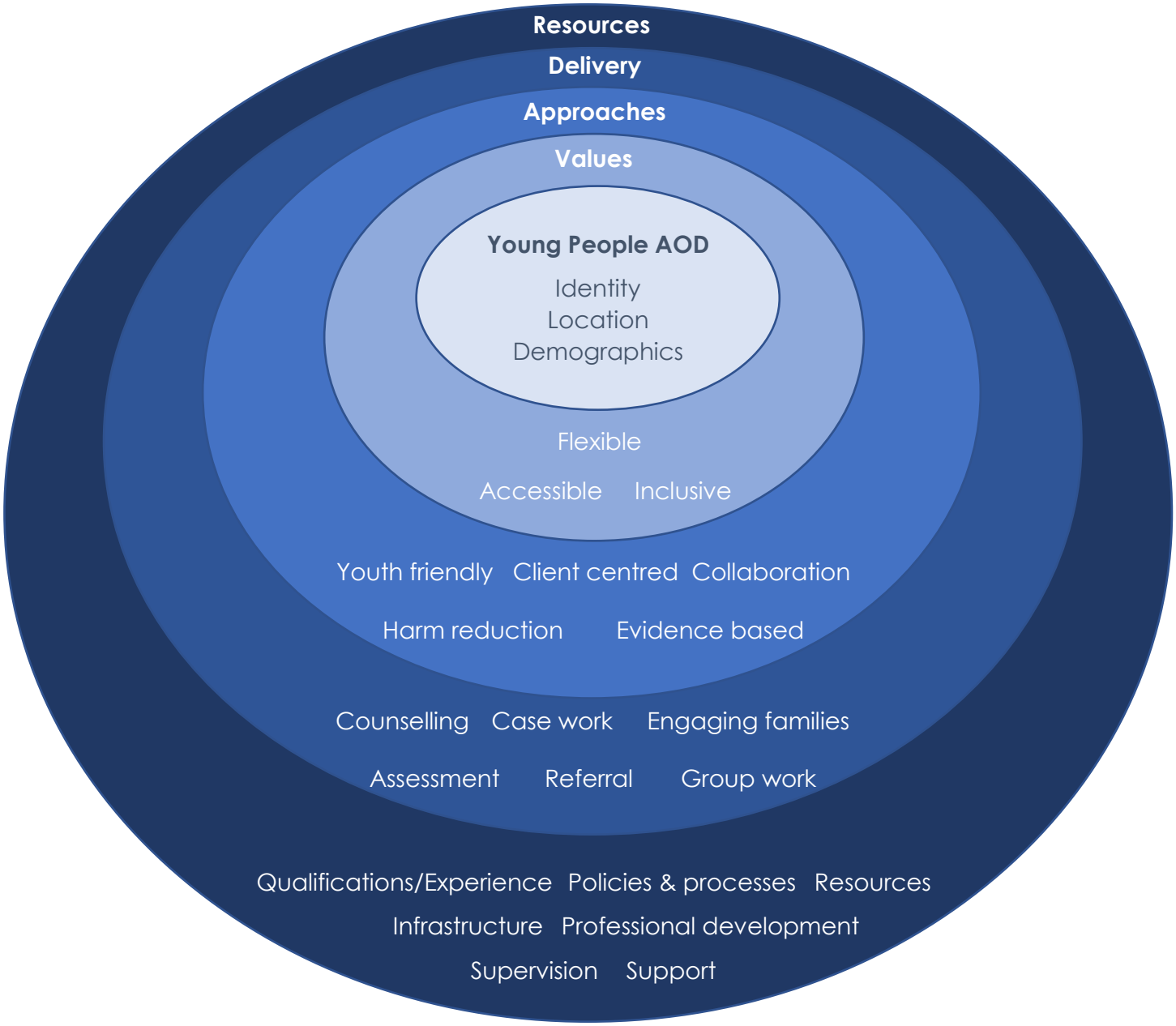
Islanders, Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI), and Cultural and Linguistically Diverse (CALD)[3].

Figure 1 - Model for the delivery for community-based alcohol and other drug (AOD) interventions for young people



[3] Details of these groups in the context of AOD are in the literature review, page. 18 - 19.

Service Delivery

A community based AOD service for young people should deliver psychosocial counselling. Psychosocial counselling should be inclusive of case work, assessment, referral, and care coordination. The service should also be inclusive of families and be able to provide groups. Services are provided face-to-face in outpatient or outreach settings, e.g. schools and other services or community locations (Bruun 2012). The service and the workers should be flexible in the treatment approaches, length, intensity, mode of engagement, and outcomes for the young people who engage with the service[4].

There are aspects of service delivery that assist young people engaging in AOD services, particularly those with complex needs. It's important that the space creates physical and emotional safety, which will assist young people to address their substance use without feeling judged. Some may have basic needs that need to be met in order for AOD counselling to be effective. These needs could include, clothing, food, practical help, and accommodation. The service should be able support the young person to meet these needs (Bruun 2012). However, case management tasks should not replace AOD interventions but complement them.

Staff roles, qualifications, and supports

When delivering AOD services to young people it is important that staff have appropriate qualifications, that the roles are flexible to provide the range of services that may be required to support young people, and that staff are properly supported to fulfil their job requirements.

Staff qualifications

As there is no accreditation for alcohol and other drugs workers, the focus should be on recruiting staff who are suitably qualified and experienced to perform counselling, including assessments, case work, family inclusive practice, and groupwork.

Recruitment should focus on workers with social work, psychology, youth work, allied health, and AOD work qualifications and backgrounds. Rural and regional based services often have challenges in recruiting and retaining qualified staff (Roche & Pidd 2010). Therefore, a focus on training and professional development is required. For example, if a candidate has enough qualifications and community service experience, but lacks AOD knowledge, then training and professional development will assist them in upskilling. However, candidates without skills and qualifications in interpersonal communication, counselling approaches and clinical interventions will require so much upskilling they are most likely unsuitable for a youth AOD treatment position.

The NSW Ministry of Health *Non-Government Organisation Alcohol and Other Drugs Treatment Service Specifications* does not include peer support workers in the

[4] See Treatment Approaches in literature review, pages 10 – 13; and Outcomes, page. 9.

psychosocial counselling services but does acknowledge peer support workers in residential treatment and day programs. It does acknowledge other forms of peer support, e.g. in aftercare groups (Ministry of Health 2017).

Peer support has not been covered here because peer support programs are different to AOD treatment programs. A successful peer support program requires significant support, time, and resources from the organisation[5].

Alcohol and Other Drugs (AOD) Clinician

An AOD Clinician will deliver individual counselling, assessment, referral, and group programs for clients. AOD Clinicians should also be able to meet the other non-service delivery requirements of the role, including safe and competent practice, administration, case notes, reporting, and maintaining key relationships.

The number and FTE workers will depend on the on the number of treatment places that are available. Additionally, the grading and seniority of workers would depend upon the service size (Ministry of Health 2017). Junior or inexperienced workers will require team support and practice supervision. Therefore, small teams or sole workers will need to be experienced.

Manager/team leader

The requirements for management and/or team leader roles will depend on the structure of the services, whether it is stand alone or part of a larger existing organisation. It is essential for the manager, team leader, or clinical lead to have "sufficient seniority and experience" (Ministry of Health 2017, p. 14).

Depending on the service size and the team leader/manager's other responsibilities, they may be required to provide some direct service, e.g. provide individual counselling, assessments or waitlist management. The manager/team leader would also be required to provide service management, non-clinical supervision of staff, reporting, quality improvement, and maintaining stakeholder relationships.

Resources and support

There are several key processes, systems, and supports that need to be in place to support staff in the delivery of AOD treatment[6].

- Supervision – It is necessary for new and experienced staff to receive supervision from a professional of the same discipline (NSW Ministry of Health 2017, p. 14). Supervision assists with quality assurance and risk management. Supervision assists to identity challenges and potential client risks are identified and responded to (Bruun 2012). There is evidence to suggest that supervision

[5] See *implementation of a peer support role*, *challenges and issues for peer workers in a service delivery context*, and *peer support in action* on pages 12 – 17 in *Peer Workforce Models in Alcohol and Other Drug Treatment* (Meumann & Allan 2019)

[6] See *What supports, policy and infrastructure are required to deliver youth AOD services* in literature review pages. 16 – 18

can improve a worker's connection to the organisation and AOD sector and lowers emotional stress and worker turnover (Nicholas et al. 2017).

- Professional development and training – Opportunities to access professional development and training to upskill and enhance knowledge to assist with emerging issues are required (Roche & Pidd 2010).
- Case review – There are two types of case reviews that can be utilised, either reviewing a specific case with the team or service unit fortnightly or monthly or the worker reviewing all their cases with their supervisor. Case reviews can assist to create consistent and coherent practice across all team members (Bruun & Mitchell 2012).
- Policies and procedures – There are several key policies that need to be taken into account, particularly in regard to working with young people and working within AOD. These key policies include duty of care, confidentiality, and child protection (NSW Ministry of Health 2014, p. 15).

Links to other services

A critical aspect for ensuring effective youth AOD services is to develop and maintain "collaborative links among gateway service systems…[and] help to identify and refer young people to AOD services" (Bruun 2012, p. 58). Services should have strong links to:

- Juvenile Justice and Corrections
- Mental health services
- Vocational services
- Schools
- Aboriginal and Torres Strait Islanders services
- CALD support services
- Homelessness services

The service should also engage with relevant bodies and services. This may include local or issue based inter-agencies or peak bodies.

Case conferences

Case conferences are also a significant component of working collaboratively with other services. Case conferences are arranged when there are several agencies involved with a client, particularly when they have complex needs. These assist to get the key services who are working with a specific client on an "as needs" basis (QCOSS 2013). Case conferences may assist (QCOSS 2013):

- Avoid duplicating services, effectively utilizing services and resources
- Create an interface for key stakeholders
- Improve communication between service providers
- Give clarity on the needs and goals of the clients and create collaborative case plans

It's important when services are seeking to cooperate or share information that they have clear service-level agreements (SLA) or memorandum of understanding (MOU) to outline the work they are undertaking. These are higher level agreements that establish a framework for how organisations will work together and set out common goals (Justice Connect 2018).

Necessary referral pathways

A youth AOD service should accept a range of referral pathways, including but not limited to:

- Self-referral – in making a self-referral, there should be flexibility in how a young person makes contact, e.g. telephone, social media, email, in person etc.
- Referrals from other services, including schools
- Referrals from other parts of the service
- Referrals from a young person, parents, family, significant other etc.

(Crane, Francis & Buckley 2013; Rickwood et al. 2018; Ministry of Health 2017)

Assessment

In order to be able to ensure that the service can meet the client's needs and develop a treatment/care plan "a comprehensive assessment, inclusive of mental health and physical health status, is essential" (NSW Ministry of Health 2017, p. 12). Assessments should be ongoing and ensure that treatment continues to be able to meet the needs of the clients (NSW Ministry of Health 2017). Services should have uniform assessments that are used with all young people. These could include:

- Global Assessment of Functioning (GAF) Scale
- Client Complexity Rating Scale
- K-10 The Kessler-10 (K-10)
- SACS (Substances and Choices Scale)
- HEADSS (Home, Education, Activities, Drugs, Sexuality, Suicide)

There should be clear policies and procedures that guide the assessment, particularly to assist in identifying risks. It can also be important in identifying protective factors and actions that should be taken to respond to the risks. It is important that any risks and the decision-making responses are documented (Crane et al. 2013). Some of the potential risks include (Crane et al. 2013):

- Threatening violence or risk of being a victim of violence
- Suicide/self-harm
- Risk associated with substance use, e.g. overdose, sharing injecting equipment
- Risk associated with intoxication, e.g. unsafe sex, driving whilst intoxicated

Prioritisation for assessment

In the intake of the service there should be a prioritisation system in place. Those in most need of treatment should be prioritised to receive comprehensive assessment and treatment as soon as possible. In assessing how urgently a client needs to receive an assessment, a number of factors have to be taken into account, these include (Victorian Department of Health and Human Services 2018):

- AOD dependency, such as frequency and amount used
- Risk of family violence
- Homelessness

Waitlist management

AOD services support people from the first point of contact with the service and young people should be able to receive some level of support tailored to their needs prior to treatment entry (NSW Ministry of Health 2017).

Levels of support provided prior to treatment entry can be referred to as waitlist management. This could incorporate a range of different strategies, including (Ministry of Health 2017; Lubman et al. 2017):

- Providing information and self-help material.
- Providing brief intervention, such as Quik Fix (see Complex Needs).
- Telephone support initiated by the service.
- Face-to-face support groups.
- Other forms of client contact.

Research has identified that a single session of brief and empowering counselling and self-help material is significantly more effective than no intervention or only being placed on a waiting list (Lubman et al. 2017).

Suitable client load for FTE

In identifying a suitable caseload for FTE there are a number of factors that need to be considered. These include the complexity of cases, size of the team, and needs and functions of other available services (Queensland Health 2016). Other responsibilities of staff members should also be considered, such as groupwork.

Approximately 20 active cases are a suitable client load per FTE. This number includes clients who require regular contact and support and those that require infrequent 'check in's'.

Complex Needs

Young people who access AOD services often have "multiple and interrelated mental health, substance use, and psychosocial difficulties that go beyond the

normal development challenges of adolescence and young people" (Sloan et al. 2018, p. 427). This can include histories of trauma, child protection involvement, family conflict, and involvement with youth justice (Sloan 2018, p. 428). As a result of these factors young people engaging with a youth AOD service are likely to be highly vulnerable.

Young people with complex needs will frequently engage with services "intermittently and in brief bursts" (Bruun 2012, p. 56). A service should be geared to be able to engage and support young people who attend in crises and require brief intervention in additional to longer term intervention. A service model that is geared only towards long-term interventions will waste many opportunities (Bruun 2012).

As a result of the way that young people are likely to engage with AOD services, it is vital for an AOD service for young people to be able to provide brief intervention with suitably trained staff. Brief interventions can vary considerably with their structure, target, underpinning theory and philosophy. The defining characteristic of a brief intervention involves relatively brief contact time or approximately 1 to 5 sessions for 5 minutes to an hour. Brief interventions are not intended to replace comprehensive treatment, but rather provide resources and motivate people to access treatment (Tanner-Smith & Lipsey 2015; Tait & Hulse 2003). This could also act as a key part of waitlist management.

Quik Fix is a good example of an effective brief intervention designed specifically for young people. Quik Fix involves two 30-minute telephone sessions using motivational interviewing to target mental health and substance use issues (Hides, Wilson, Quinn & Sanders 2016. P. 55)[7].

Stepped care

Young people may need different levels of support across time. This is recognised in a stepped care approach. "Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs" (Australian Government n.d.). Progressively more intrusive and costly approaches may be utilised when the first or subsequent did not obtain a positive outcome (Lubman et al. 2017).

A stepped care approach would provide a variety of options for young people requiring support including brief intervention, specialist services, groups, longer-term psychotherapy counselling and referral to residential programs if required.

Case management for complex needs

AOD Clinicians can engage in case management to support young people with complex needs, however case management tasks should complement, not replace

[7] For more information on brief intervention see pages 7 – 8 in Meumann, Allan & Snowdon (2018).

AOD intervention. The key tasks of case management should involve developing a reliable and respectful relationship building, particularly in assisting the people to navigate the service system (Moore 2016). This task is vital when working with young people and keeping them engaged in the service (Bruun & Mitchell 2012). The AOD Clinician would will also undertake comprehensive assessment and ensure that young people are referred to the relevant services.

Evaluation

The delivery model would require an integrated evaluation. Generally, it would involve a:

- Process evaluation, "Examines whether program activities have been undertaken as planned and helps to identify where improvements can be made" (NADA 2016, p. 3).
- Outcome evaluation, "Examines the effectiveness of a program in facilitating change for the client group, as indicated by changes in client outcome measures" (NADA 2016, p. 3).

The process evaluation would feed into and inform the outcome evaluation.

Conclusion

This model takes into account existing evidence and has been developed to be flexible to adapt to the local circumstances, demands, and needs, as well as being inclusive of the stepped care model; and providing greater support for young people with complex needs. The model also allows for services to play a key role in supporting young people with problematic AOD use in a region through outreaching to other services, such as headspace. A significant element of the model is ensuring that there is sufficiently qualified and supported staff who are able to implement evidence-based AOD interventions.

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