Alcohol and Other Drugs Framework

Version 2.0

Procedure Number	PRO-56
Procedure Name	Alcohol and Other Drugs Framework
Procedure Area	Operations/Clinical
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Contents

Introduction

On average, people with a history of substance misuse problems live between 20-27 years less than the general population. Cardiovascular disease and cancer are the leading causes of mortality for this clinical group.

This Recovery and Wellbeing Framework is intended to guide Richmond Wellbeing (RW) in all its endeavours from reception greeting, engagement of people, front line service delivery, development of training and education, evidence for quality audits, to inform related to projects and tendering.

The framework uses the organisation's principles and values to underpin practice to ensure the quality of people's experiences of service. It is intended to complement existing standards and competency frameworks and create a shared language and understanding.

The framework is informed by contemporary research on recovery practice, as well as relevant policy, standards and frameworks at a national and state level (Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, MHC). Our focus is on the person's life and value rather than on distress and deficit and speak to our commitment to Personal Recovery.

Not all our workforce will provide direct service to individuals however, it is necessary that we all understand that no matter our role, that we are all working to serve the people who use our service (and their families and carers). It is therefore essential that the workforce (as a whole) can operationalise the Richmond Wellbeing Values and Key Principles in our ways of relating, our thinking and our practice sharing a common language regarding AOD and Recovery.

People with co-occurring disorders enter treatment with higher symptom distress compared to those with substance misuse only. Although both groups improve at a similar rate, those with co-occurring disorders started treatment with greater symptom severity and remained significantly more symptomatic at follow-up. This suggests they may benefit from a different treatment approach (e.g., longer, more intense and/or different content) in order to achieve equivalent outcomes to those who have only a substance misuse. Cridland et al International Journal of Mental Health and Addiction, 10(5), 670-683.

Terms and definitions

Alcohol and other drugs	Alcohol, illicit drugs both natural and synthetic and legal tobacco, some synthetic 'herbal' drugs that mimic illicit drugs
Substance or Product	Any of the above
Substance use	The intake to the body of the above listed items and any solvents or other similar chemicals
Equipment	Any specialist or associated equipment that enables the taking of illicit drugs – pipes/bongs needles, syringes, spray paint cans etc.
Person-centered	Shaping the recovery journey and goals for each individual
Recovery program	A person-centered approach that works alongside the consumer, with a joint commitment through a staged process

Medication	Prescribed drugs
Opioids	Compounds extracted from the poppy seed, semisynthetic and synthetic compounds or similar that interact with opioid receptors in the brain. Includes; morphine, fentanyl and tramadol methadone, heroin, codeine.
Opioid overdose signs and symptoms	Pinpoint pupils, unconsciousness and breathing difficulties and death
Opioid overdose risk factors	An opioid disorder, taking by injection, resumption of use after extended abstinence, combination with; alcohol, benzodiazepines, barbiturates and some pain medications
Naloxone	An opioid antagonist, reversing opioid overdose. Nyxiod nasal spray provides up to 45min reversal per spray to allow for transport to treatment, packs contain two sprays = up to 1.5 hrs reversal.

Purpose

This framework is designed to respond to the WA Government's initiative to work with mental health (MH) issues and AOD together and to provide staff with clear operational information. The provision of a clear AOD approach and pathway options is intended to assist the Consumer in the informed decision-making approach and provide clarity and guidance for staff working with consumers who have both MH and AOD issues.

To provide people with co-occurring issues of mental health MH and AOD use to access to the help and support they need to participate in their community. To treat people in a holistic way to enable them to live the life they love.

This will include peer support and group programs, harm reduction programs, and family and carer support, specialist help and counselling services.

The Principles

"Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or… distress,… is a unique and deeply personal process." (Basset & Stickley, 2010, p. 185).

Guided by the National Framework for Recovery-Oriented Mental Health Services, we work toward *Personal Recovery*. The following principles apply:

- AOD is part of the Recovery journey not two separate pathways
- Inclusive practice and no wrong door approach
- Informed decision-making in service entry
- Open communication in referral relationships, documentation and processes
- Shared responsibility and power in decision-making

- All sites are AOD free regarding use, product or associate equipment with the exemption of designated smoking areas
- Partnerships with associated services and clinical streams for person-centred support and co-design of pathways
- Person centred methodologies to assist in distress
- OSH duty of care and dignity of risk apply to entry, while consumers are under the influence of AOD
- Staff have rich skills and knowledge to understand recovery in the AOD space
- Creating a Consumer Service Culture with on-going contact 'check-ins' post service delivery is preferred where possible

Pathways and partnerships

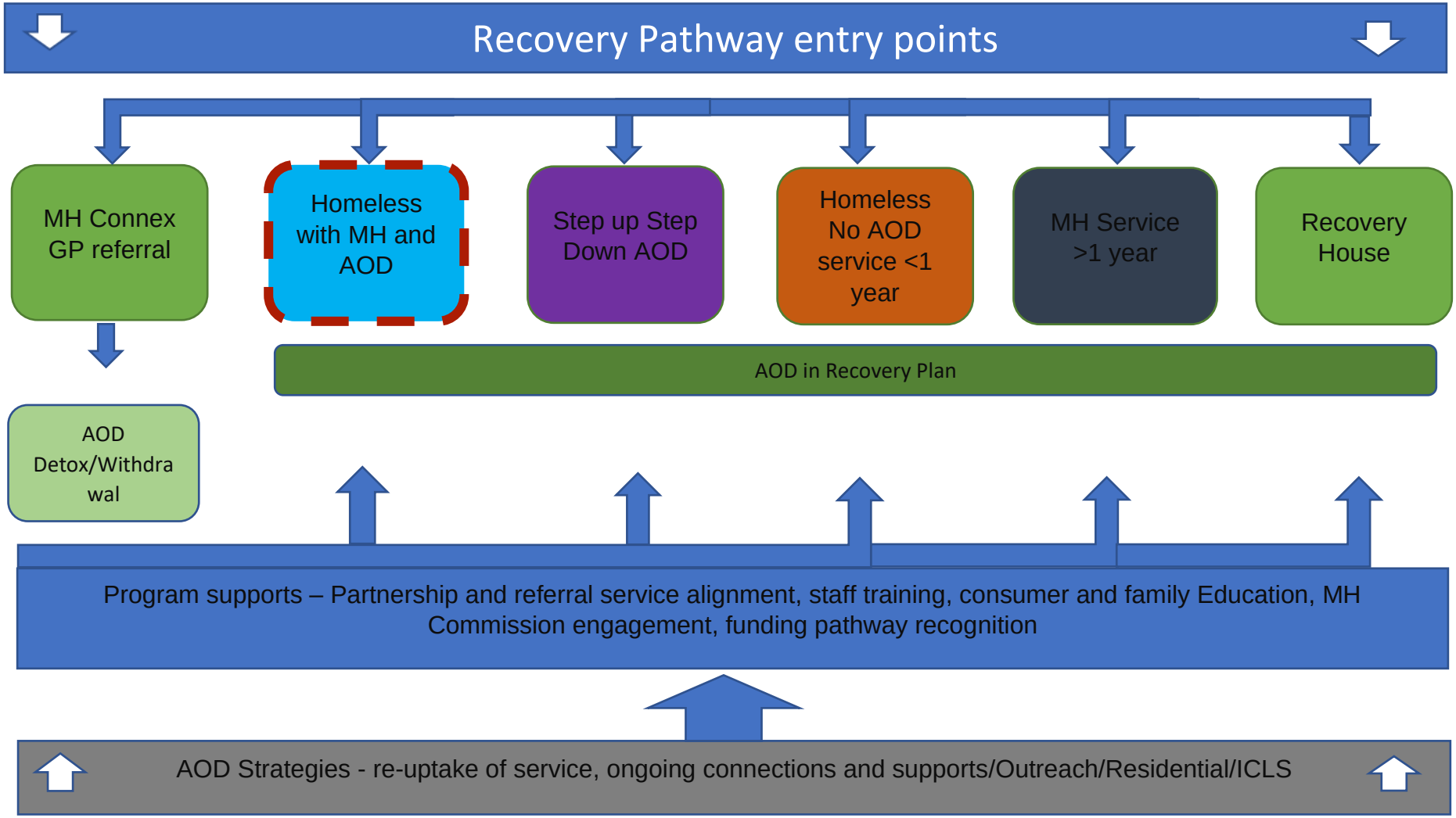
AOD counselling services and relationships currently vary from site to site. To enable partnership agreements to align with the AOD Framework, the following actions are required:

- Review and align MOUs/SLAs to the AOD Framework – availability, response timelines, what the service will look like and how the partnership operates in practicalities, definition of roles, shared information, alerts and feedback – Purpose to incorporate AOD (including smoking) into Recovery Journey and planning.
- Service options for prospective service users are documented and used in intake process (see pathway), known by partners and staff
- Form an initial commitment agreement between consumer and service
- Current partners: Palmerston, Cyrenian House, Holyoake
- At intake, inform Consumers of the options available when out from site and under high influence of AOD (also stated in living agreement) – e.g. Salvation Army, Highgate Sobering up service and conditions of site entry.

Recovery Pathways

A range of options currently exist which can be used individually or in succession as needed. The following diagram shows the pathways into our services to assist the potential consumer make an informed choice at pre-engagement, and for existing consumers to change options as required. While some aspects of the pathway may be linear, there is flexibility for consumers to move into and within the pathways according to their needs.

This diagram shows separate entry points for people experiencing or about to experience Homelessness with MH and AOD issues, and people without AOD issues. Although the current site of referral is Ngulla Mia, it has been recognised that a future option of two sites would improve the likelihood of improved results and would help address the current gap in service provision for co-occurring MH and AOD.


Recovery Pathway entry points
MH Connex GP referral
Homeless with MH and AOD
Step up Step Down AOD
Homeless No AOD service <1 year
MH Service >1 year
Recovery House
AOD in Recovery Plan
AOD Detox/Withdrawal
Program supports – Partnership and referral service alignment, staff training, consumer and family Education, MH Commission engagement, funding pathway recognition
AOD Strategies - re-uptake of service, ongoing connections and supports/Outreach/Residential/ICLS

The AOD Withdrawal/Detox is currently the Serenity Withdrawal Unit (SWU) is a stand-alone unit and can be accessed through self-referrals via GPs. Consumers also enter from Cyrenian House and return to take up the Therapeutic Communities (TC) for long term treatment (LTT). Those who to do detox/withdrawal only also have the opportunity to visit the TC and can be directly referred for LTT. Further services with AOD focus are being established to open in May 2021.

Pre-Engagement and Intake Current situation

The current situation in Western Australia with high demand for AOD service, the low supply of treatment options and the reluctance of treatment centers to accept clients with co-occurring AOD and MH issues, is impacting RW services. The following factors have been identified:

- Clinical referrals are omitting information with the belief that people with AOD will not be placed in residential services
- Potential consumers are coached to gain entry to services
- People with co-occurring AOD and MH may have a longer recovery timeline
- Staff are dealing with high levels of AOD within services
- Further training and consistency of practice is required to support staff and Consumer MH outcomes

Changes to Intake

The pre-engagement and intake process are of vital importance to both choice and control and engagement in the recovery journey. This revised approach is designed to increase the level of AOD and MH outcomes, by improving the matching of services to each individual consumer needs and stage of openness to recovery. The intent is to create an open dialogue and resolve a range of issues in the referral and intake process to improve; Consumer Choice, clinical referral information and relationships, create open dialogue around AOD use and clear understanding about AOD goal setting being inherent in the recovery program for people using AOD.
This will deliver informed decision-making for both the consumer and the intake panels, it will include:

- Investigation, without judgement but with the premise of full disclosure. This enables a good match of expectations and enables people to make an informed decision about what service is best for them at the time, and understand, what may be available in any stages of recovery
- An improved level of communication and information sharing with referring clinicians or teams.

The following change management activities apply:

- High level organisational discussions on the new AOD approach with Senior Managers in referring organisations to outline the change of approach
- Information and education to staff on the purpose, process and guidance on intake decision making
- Information to referring clinicians on the new approach, its purpose and intent, timing and relationship expectations
- The intake process does not proceed without full referral information which is consistent and transparency of the information. Conflicting information is returned to the referrer with

explanation that it does not meet our criteria and suggested actions to resolve in order to re-submit for consideration
- Once the consumer has identified a service entry point, a commitment agreement is to be completed in the intake procedure for all sites
- Formation of a local Advance Health Directive – to ascertain the individual's wishes (overdose response, resuscitation or do not resuscitate) and the crisis management plan (done prior to entry) Appendix 1.

The purpose is for the site service and Recovery Journey to be clearly understood, to enable Consumers to make informed choice of service:

- How the Recovery Journey works
- The different service options available
- The commitment agreement assures transparency to enable informed decisions (done prior to entry) and establish mutual expectations
- The opportunity to trial the service by spend two or three days onsite observing or engaging in activities (9am-5pm).

This framework identifies the need to establish a specialist pre-engagement approach or dedicated team for residential and outreach. The purpose is to establish an accurate picture of each consumer, with the inclusion of the Hospital admission and discharge summaries, 'Psolis' Psychiatric alerts and Psychiatric reports. These are passed to the sites to commence the engagement and service matching process.

Changes in Recovery Practice

Incorporating AOD into the recovery journey means that it is included in the planning documentation through co-design and focusing on the whole person including MH, AOD, Smoking and Physical Health. The following additions to the existing practice are designed to address the identified factors in current service delivery and improve MH outcomes for Consumers.

Staff Training in AOD

The WA Government have ensured that the MHC includes AOD, it is therefore a necessity to provide education to staff to include:

- OSH duties at site, Dignity of Risk, boundaries and responsibilities
- AOD recognition and general terms
- Family inclusive engagement (where possible)
- Intake investigation and decision making
- A suite of training and supported tools to deliver a consistent approach across the organisation in the approach to AOD and co-occurring MH.

The training provision is a mix of face to face, video conference and on-line modules, courses, and presentations including:

- Free training from the MHC delivered at sites and by video conference
- Talks by subject matter experts and people with lived experience

The training delivery schedule will commence with the sites of highest numbers of residents and AOD issues.

Creation of AOD Champions

To support the methodology, integration of practice into core business and provide a consistent and supporting approach AOD Champions will be created. The champions will consist of five subject matter experts to provide support, advice and a debrief process for staff. They will provide coaching, mentoring and promotion of framework integration into recovery practice. The champions and recovery workers will collaborate with AOD partners to ensure a uniform and informed approach for each Consumer. The roles will be filled in an expression of interest approach and appointment will be based on AOD experience. A specific training module will also be designed to establish the AOD Champion roles.

Support and guidance will be provided by AOD Specialists, either through existing partnerships or through a created dedicated in-house role.

Overdose First Aid

Opioids are potent respiratory depressants, and overdose is a leading cause of death among people who use them. Worldwide, an estimated 69 000 people die from opioid overdose each year. The World Health Organisation (WHO) identified that a significant number of accidental deaths are attributed to opioid overdose. A guide to Community Management of opioid overdose was released in 2014.

The number of opioid overdoses has risen in recent years, in part due to the increased use of opioids in the management of chronic pain. The MHC provided a Naloxone product called Nyxiod nasal spray as part of a program to reduce opioid overdose deaths. Free staff training is made available for Nyxiod administration in community Alcohol and Drug Services. An application has been made to the MHC for free supplies, and associated training due to the high number of co-occurring AOD and MH issues. LINK.

Assessment

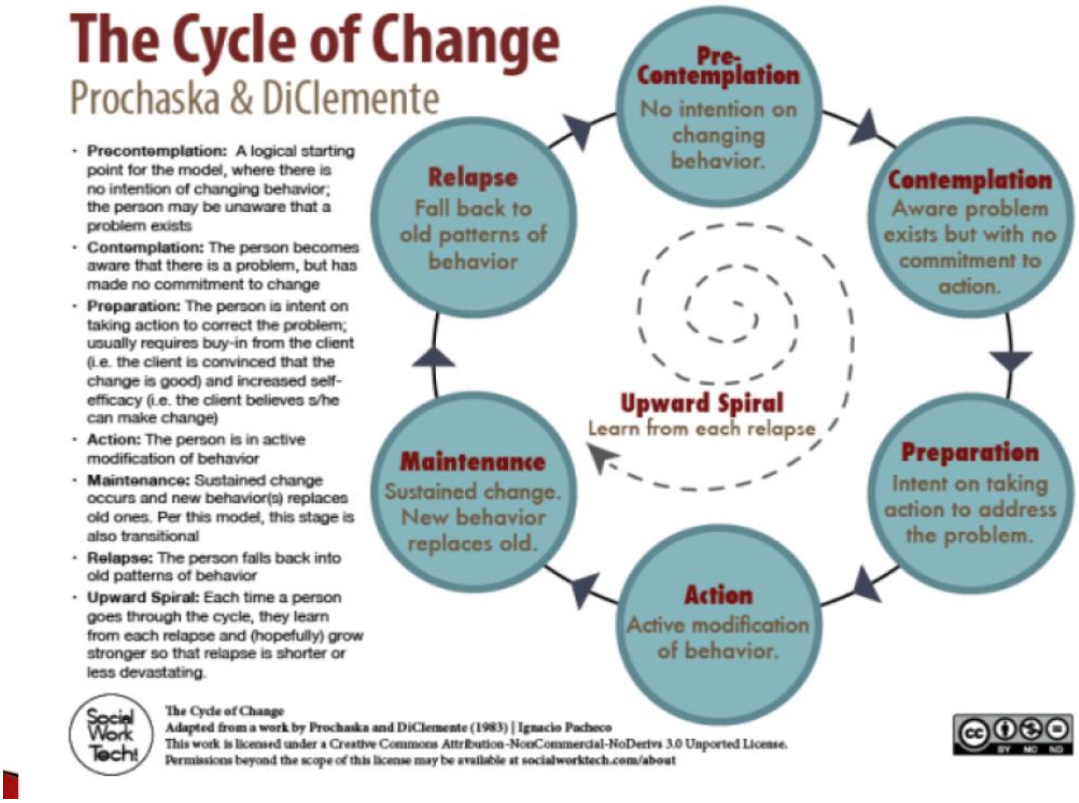
The Framework's assessment tools are designed to inform the recovery journey and provide the foundation for realistic and relevant goal planning. It is a holistic view considering all aspects of the person's life, their family and support networks and the community they live in. The tools promote a person-centered approach, family inclusiveness and trauma informed practice. This assessment process is the foundation of the recovery support provided and will inform the planning process. (Appendix 1). The associate tools are:

- Goal setting – SMART goals
- The Compass of Shame
- Circle of Security
- Self-awareness - Eco map

Planning Process

The tools enable the consumer to recognise their needs, hopes and goals. Staff identify the stages of change to enable the consumer to identify, process and understand the stages of the recovery journey. Each consumer will identify where they currently sit in the stages of change model.

The Stages of Change model



Crisis, Safeguarding and Recovery plans

The crisis, safeguarding and recovery plans ensure that the consumers response needs are identified they will include:

- Planned AOD steps including management, harm minimisation, boundaries at site, and agreed action in the event of pre-defined events
- The requirement for staff to undertake risk assessments and a guide to the steps involved
- Identification of triggers, warning signs, emotions, behaviours and environments that cause sudden increased AOD use (often in relation to increased suicidal thoughts)
- Reference to the option to complete an Advanced Health Directive (to cover express wishes for medical interventions) in consultation with their clinical referrer.

In the event of any resident's wellbeing or the safety of others being jeopardised, due to high level of consumption of AOD or evidence of dangerous items, a room search procedure has been developed Appendix 5. Room searches are a necessary activity to meet the organisation's Policy of AOD free sites and it's duty of care, under the OSH Act 1984.

Family inclusive practice

Living with someone who is using AOD, can be a long and difficult process for those who care about them. While for most family members the goal is to get their loved one 'off' drugs, they often realise that can be a slow, incremental process and many positive steps can be achieved along the road. The information and support will vary in practical support, information and distress response. This can include:

- Improving communication among family members, including the person using drugs
- Providing group support programs with open dialogue both with other families (providing strategies, information) and with the Consumer and recovery worker
- Assisting families to build skills to cope with the various issues
- Effective boundaries
- Family members getting on with their own lives – hobbies/interests and relationships
- Putting harm minimisation strategies in place
- Providing information on drugs, mental health, treatment and other relevant matters

Families may have little understanding of mental health issues, triggers, supports and the recovery journey process. Being open, respectful and collaborative is highly complex and does not always fit well with traditional practices.

- People experiencing mental health and drug and alcohol problems can have a similar effect to major trauma in the sense that trauma puts extreme pressure on clients, families and carers and on their relationships with each other.
- The effect on families is often hidden and not acknowledged, the impacts affect the families and the Consumer directly affecting recovery outcomes
- Blame, guilt, grief, shame and frustration are natural companions of the trauma of mental health issues, drug and alcohol problems and major family difficulties in our culture
- Most of the personal, professional and organisational responses to mental health and drug and alcohol problems are shaped by complex emotional responses. Some of these responses are helpful, others are not
- By and large, family, carers, clients and workers have a personal and social intention mainly directed to personal and social survival rather than malevolence. Put simply, people usually do the best they can, given their situation, history and personal style
- Approaching families in a generous way, empathising with their hardship and acknowledging their strengths, will in return tend to generate good responses to consumers and to workers

Family inclusive practice does not require specialist family therapy training and can result in family members receiving the support in their own right. It can also be beneficial to treatment outcomes for the consumer. (Marsh et al 2007). It is about sharing knowledge and explaining underlying issues to achieving mutual understanding, while creating a supportive relationship. Appendix 6.

Workforce Expectations

It is necessary that all staff in the organisation understand we are all working to enable the people who use our services (and their families and carers) in their recovery journey. Operationalising the Values and Key Principles in how we relate to Consumers and in our thinking and practice.

Ethics, Rights and Safety

Recovery oriented practice is grounded in working toward quality and safety, and ethical, values-based practice. Ethical decision making is central to recovery-oriented practice and that staff are required to work from within an ethical framework.

Staff roles include a mix of responsibilities ranging from their safety, that of other staff and the site as a whole. In accordance with the OSH Act 1984 Duty of Care.

Disposal of illicit substances

WA police will only collect larger amounts of illicit drugs from site, this has given rise to the need of a procedure for smaller amounts of drugs to protect and safeguard staff. Where illegal substances are discovered on site in the room search procedure, a process has been included in Appendix 5.

Related Changes

Consumer and Family Reference Group

To incorporate AOD into Recovery Practice it is proposed that the CAFRG have the following amendment to its Terms of Reference (TOR), to reflect the prevalence of co-occurring AOD and MH issues currently in our society.

Composition

The Group may comprise up to [12] members (with a broad range of backgrounds including Indigenous, LGBTI, and CaLD) with no more than 1/3 of membership taken up by RW staff, with an aim of 50% balance of AOD experience, directly or indirectly.

Documentation

Changes to the following documentation will be required to align with the AOD Framework:

- Entry and Access Policy
- Intake Procedure Manual
- Operational Site Manuals
- Residential Entry Interview form
- Community Living agreements
- Recovery Framework
- New Resident Induction Checklist
- Resident Summary Information
- Sudden Death Procedure
- Recovery Accommodation Service Guide
- Consumer Information Packs
- Selection Panel Checklists
- Physical Health Assessment

References

- 13 Tools for change - The Network of Alcohol and other Drugs Agencies (NADD) – NSW Health
- Richmond Wellbeing Recovery and Wellbeing Framework
- Planning Together - Consumer Involvement in Comorbidity Treatment Planning
- The integration of homelessness, mental health and drug and alcohol services in Australia – Australian Housing and Urban Research Institute WA Research Centre 2010
- Help, not Handcuffs; Evidence-based approaches to reducing harm from illicit drug use – Parliamentary Report, Legislative Council WA, November 2019
- Illicit substance use in acute inpatient Mental Health Services, Office of the Chief Psychiatrist – November 2001.
- Model of Care Overview and Guidelines, WA Health Networks
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029
- Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, MHC
- Counselling guidelines: Alcohol and other drug issues, MHC, Fourth Edition 2019
- WA State Priorities Mental Health, Alcohol and Other Drugs 2020-2024
- The Western Australian Alcohol and Drug Interagency Strategy 2018-2022
- The Cycle of Change, Prochaska and DiClemente
- Integrating Care for People With Co-Occurring Alcohol and Other Drug, Medical, and Mental Health Conditions, Stacy Sterling, Felicia Chi and Agatha Hinman, Alcohol Research and Health - 2011
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- ***Families As Partners in Mental Health Care : A Guidebook for Implementing Family Work*** Paperback – 27 Sept. ***2007***. by Diane Froggatt (Author) et al
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    - Clements, J. (1992) I Can't Explain...Challenging Behaviour: Towards a Shared, Conceptual Framework. *Clinical Psychology Forum 39*, 29–37 (Extract from p. 32).

Appendix 1 – Recovery Tools

Goal Setting

AOD Goal setting is defined in the Counselling guidelines: Alcohol and other drug issues 4th Edition 2019, WA Mental Health Commission. Goals are:

1. Geared towards the consumer's stage of change

A goal of complete abstinence is inappropriate for consumers who are still contemplating whether and to change their AOD use.

2. Negotiated

Goals are client directed to ensure commitment and meaning to the consumer. The Recovery Worker guides consumers to make realistic and achievable goals, this may mean breaking goals down into steps. If the consumer is insistent on the larger goal, suggestions of a trial period may be suitable, with monitoring and then review of the goal's achievability.

3. SMART

All goals need to be Specific, Measurable, Achievable, Realistic and Time-limited, it is important to have short-term and long-term goals. Goal description works best when positively phrased e.g. I will increase my alcohol-free days from three to five per week.

3. Questions to help consumers think through goals

Realistic and achievable goals can be achieved by thinking through the following issues:

- Why they want to achieve the goal?
- What might get in the way?
- Ways to overcome threats.
- Ways in which other people can help.
- How will they start?
- How will they know they have achieved the goal?

4. Problem solving

When people attempt to change their AOD use they often encounter problems that may delay or threaten change and their goals. It is important to encourage clients to deal with one problem at a time. Techniques that can assist consumers:

- Recognise the existence of a problem
- Define the problem
- Brainstorm potential solutions to the problem
- Choose the most effective option and plan how to implement it
- Implement this option and evaluate how effective the approach was

Compass of Shame

Withdrawal (Hide from Others)
Isolating oneself
Running and hiding

Attack Others
Blaming the victim
"Turning the tables"
Lashing out verbally and physically

Attack Self
Self-put-downs
Masochism

Avoidance (Hide from Self)
Denial
Misuse of drugs and alcohol
Distraction through thrill-seeking

Withdrawal* or *Hide from Others - where we isolate ourselves and live-in fear of being exposed. By hiding ourselves we believe that we are protected from feeling small, weak and inferior to others and often place ourselves in passive, submissive relationships.

Attack Self - where we put ourselves down before others can get a chance to reject or hurt us. It can be noticeable as depression. We see ourselves as not deserving of approval or respect.

Avoidance* or *Hide from Self - where we protect ourselves from what is really going on for us. We hide from facing feelings of shame by using drugs or alcohol (or any other compulsive behaviour) to dull the pain. Another way to deny the presence of shame is by doing risky things to make sure that we are seen as 'strong' and in control.

Attack Others - shows as aggressive behaviours such as violence and misuse as well as bullying, sarcasm and blaming. Again, this is to try and be seen as being 'strong' and in control.

Although we can all display some of these behaviours, ***identifying which 'point of the compass' we always go to may indicate a defensive pattern that we use to avoid acknowledging shame***.

When we are able to be at ease with our sense of shame (instead of using some of the above ways to cover it up) we can begin get some positive value out of it. Shame, when recognised for what it is, can help us evaluate our thoughts and actions, show us what is unhelpful and damaging, and point us towards making changes.

Embarrassment is when we feel we have made a mistake.
Guilt is when we know we have made a mistake.
Shame is when we feel we are the mistake.

The difference between guilt and shame is that guilt says, "I made a mistake" whereas shame says, "I am a mistake". Where guilt tells us "You have done something that is not OK", shame tells us "You have done something that is not OK and therefore you are an unworthy, inadequate, bad person".

Circle of Security

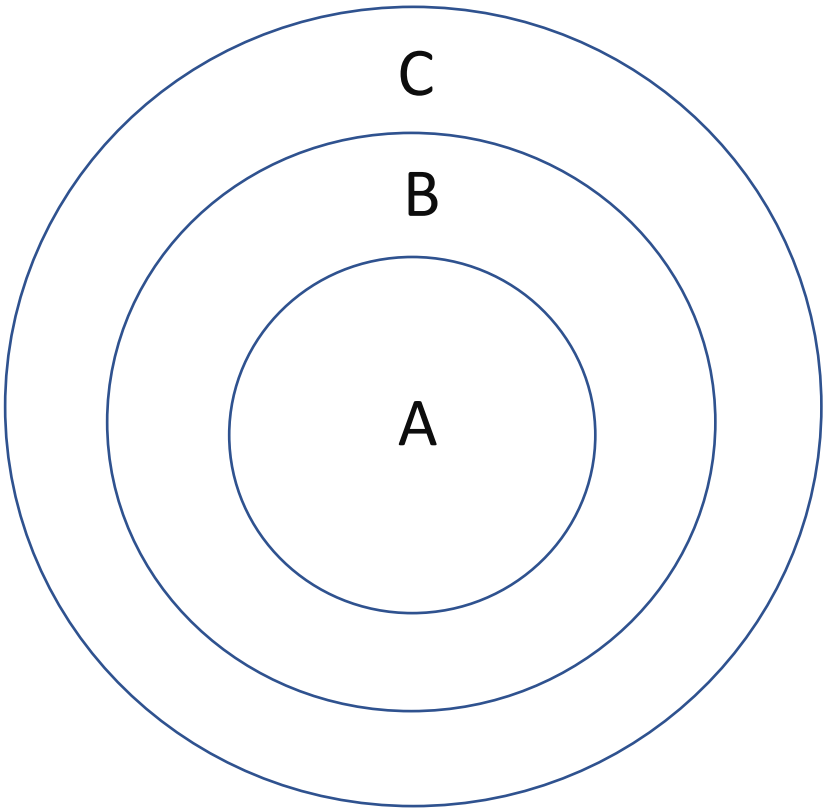
Circle of Security is a program designed to improve the awareness and development of:

1. **Pathways** – movement within and away from the circle
2. **Boundaries** – recognising healthy and unhealthy boundaries
3. **Barriers** – recognising your personal values & how & why values are compromised.

A – The inner circle represents those people closest to you, your parents, family members, caregivers etc

B - Friends, colleagues, ex-partners etc

C – Acquaintances, community members



Trust is perceived to be in the inner circle, however the experience of individuals within the inner circle can be filled with lies, deceit and trauma. The result of this is the individual does not learn healthy boundaries, personal values or trust.

In any of these circles, dramatic histories can be re-lived, playing out more of the learnt behaviours from the inner circle.

In order to make meaning of individual's experiences and to understand their trauma, the circle demonstrates where they were sitting at the time of events. This includes people, places & circumstances that were playing out at that time.

Self-Awareness

An eco-map is a visual tool that many social workers use with families and individuals as a participatory way to involve clients in describing and organising the various elements impacting their lives. Invented by Dr. Ann Hartman in 1975. Eco-maps are a graphic map of a person's inner and outer environment such as the impact of their history, life circumstances, and connections to the external world (or absence of them) and more. They are designed to create awareness, compassion and empathy (self and other). They can enable a 'helicopter view', to ascertain what to work on first and how to respond rather than react as workers.

These are done with the person to support them develop increased self-knowledge. This kind of mapping exercise can assist the person to notice patterns, highlight learning experiences and raise awareness, for example, about how various relationships (and the interactions within them) support or hurt an individual.

This work can bring staff's understanding when they are faced with a *trauma response, distress response* or *coping strategy*. They can also provide a platform with which to connected more deeply to the person's current lived reality and aspirations, as well as remembering the pain of some lived realities.

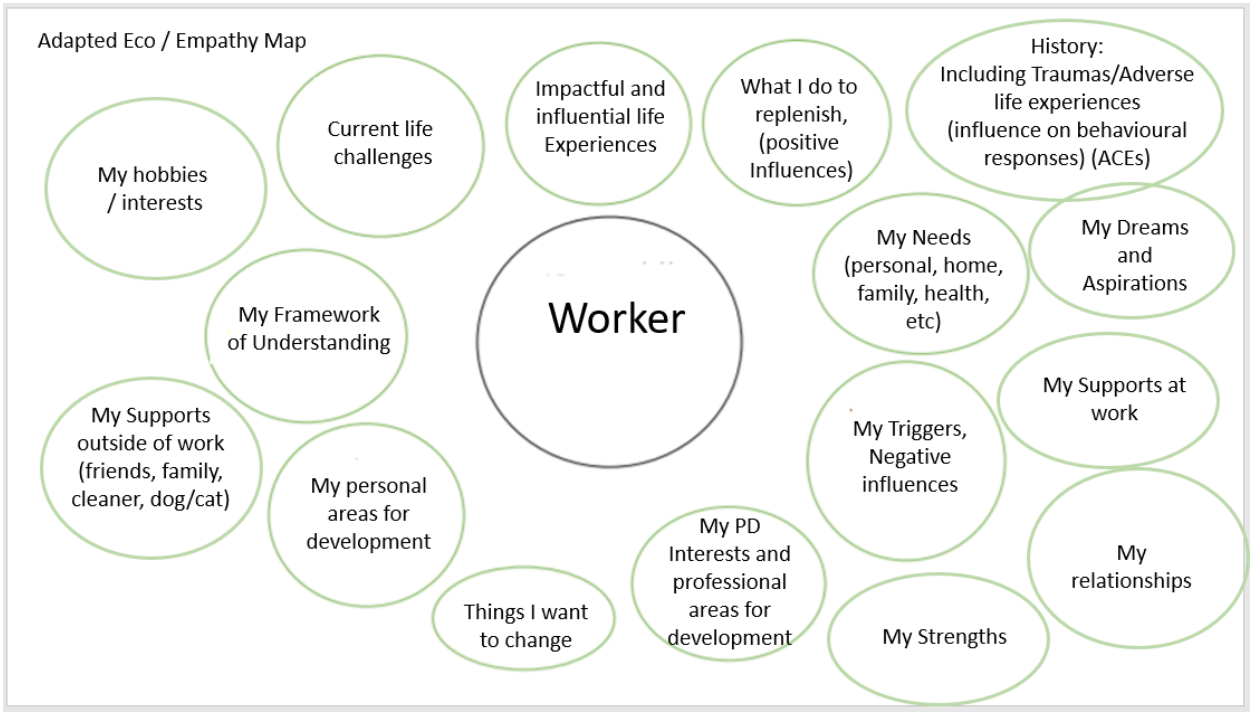
As Dr Pat Deegan (1987) observes, it may not be visible, but we need to believe it is happening even though we may not see it.

'Recovery does not refer to an end product or result. It does not mean that one is "cured" nor does not mean that one is simply stabilised or maintained in the community. Recovery often involves a transformation of the self, wherein one both accepts one's limitation and discovers a new world of possibility'.

Mapping can also provide a comprehensive picture of a range of factors such as:

- Relationship dynamics (nurturing, ambivalent and conflictual relationships) – this can be unpacked to elaborate on which relationships enhance wellbeing and which diminish it, to explore ideas of dependence / co-dependence in a non-labelling way
- Connections to social support systems and resources for living and navigating problems in living (housing support, income support, counselling, justice programs etc and the quality of these connections)
- Connections to community (significant friends, family, neighbours, clubs, spiritual influences - and the quality of these connections)
- Connections to the external world (their interests etc)
- Areas of deprivation where resources may need to be mobilised or strengthened
- Areas of service duplication or gap
- Protective factors, strengths, coping strategies, trauma history, Adverse Childhood Experiences - (ACEs), and the trauma responses / coping strategies that result from them
- Dreams and aspirations
- The person's Recovery Capital:
    - Personal Capital (who am I)
    - Knowledge capital (what I know)
    - Social capital (who I know and who knows me)
    - Resource capital (what I have that assists me in building a good/meaningful life)

Eco-Map



Note: It is helpful for staff to do one for themselves to understand the experience of mapping.

When mapping 'behaviour' it is important to go beyond the usual Antecedents, Behaviour and Consequences (ABC's) and fully explore the person's history, current conditions, information processing (style) and motivational state which all work to influence how people show up (respond/react/behave) as described by Clements (1992, p. 32).

Eco-map, by Lyn Mahboub

Appendix 2 - Family Engagement and Education

Information and inclusion of families, where appropriate, can often increase the likelihood of positive AOD and MH outcomes and reduce likelihood of MH issues with family members. The following information is to be given to families as part of the initial information packs and discussed as part of the recovery journey where appropriate by:

- Promoting attitudes of the value of involving families
- Prioritising resources to support involvement of family/carer
- Recognition, valued and supported in care giving role
- Clearly defined roles and responsibilities for clinicians, recovery workers and carers
- They should be consulted & engaged ASAP in an episode of care
- Clinicians, consumers & carers need to communicate effectively with each other - Key Principles for working with carers/families
- Identifying practical ways in which family/ carer can be involved at various points in diagnosis, treatment and rehabilitation
- Examples from co-design action plan s- Overcoming Barriers (example)
- Support for carers – Accessible information for carers – Carer involvement in treatment and planning (e.g. early contact, review points, discharge) – Support for
- Consumer rights not to involve family to be respected – but explore reasons.

Where it has been identified by the Consumer that the opportunity to involve the family is appropriate and welcomed, a range of engagement options can be considered:

- Development of groups
- Education on the recovery journey in family support groups
- Participation in service planning
- Participation in case conferencing

Support Services on offer

- Holyoake Alcohol and Drug support for families

  08 9416 4444, email **clientservices@holyoake.org.au**

- Alcohol and Drug Support phone line – Mental Health Commission, 24hr, 7 days a week

  Metro (08) 9442 5000

  Country1800 198 024

Appendix 3 – Consumer Feedback and Incorporation

It is recognised that the voice of the consumer was essential in forming this framework to inform the approach, language and practical aspects of service delivery. The consumers and staff need a shared dialogue and understanding, to create a realistic platform for real conversations and interactions. The following actions were formed from the working group, consultations with an AOD Counsellor and the anonymous survey information gathered from 12 Service users.

Action topic	**Inclusions in Framework**
Staff Training	Implement a half-day training in a systematic approach starting with Recovery Workers, the Support Workers and Reception staff
	Create five AOD Champions to support staff throughout the organisation
Language	Establish a common language and unified approach and include in all staff training across all core training units
Specialised AOD help	Increased involvement of specialist counsellors - recent change to Snr role at Ngulla Mia to be an AOD specialist
	Review MOUs with partners
Considerations	A separate facility for Consumers with AOD, MH and Homelessness issues
	A separate site for Consumers with AOD, MH and Homelessness issues – currently Ngulla Mia
Increase open conversation	**1. Intake process stage**
	Changes to intake procedures to ensure informed choice for Consumer prior to entry
	Communicate that we work on AOD and MH goals jointly, what the recovery program entails
	Staff knowledge on the range of RW services and alternatives available for people
	Clarity on site conditions of no AOD or equipment allowed on site and how breaking this condition is dealt with, then consistently apply that process
	Clear communications on our Duty of Care and their Dignity of Risk to make choices in AOD outside of the site
	Communications about what we must report to the police

	2. Recovery journey
	Set the tone, and create a non-judgemental safe space to engage in AOD discussions (links to training and language above)
	Incorporate AOD goals in recovery planning and use a whole of person-centred approach
	Provide Specialist AOD Counselling
Create Groups	Provide and promote group sessions focussing on behaviours and impacts (trauma is dealt with in therapy)
	Form group structure – rules, process, topics, weekly goal setting (break down into what, how, when, where)
Create peer support	Establish peer support groups with lived experience leaders – maybe from other sites
	Invite guest speakers with AOD lived experience to talk about how they turned their lives around.
Engage and involve families	Education of Family/Supporters to understand the journey and how they can help to promote good MH outcomes – where appropriate to engage
AOD affected presentation at site	Consistently apply the risk assessment process if Consumers present under significant effect of AOD to site

Survey Response Information

Questions	Answers – closed questions	Comments
Do we provide a safe space to talk about substance use?	Yes 12 No 2	-
What would prevent you from talking about AOD?	-	• Shame • Language and cultural barriers • Nothing • Neglect of the topic in conversation and denial of the effect of use • Future police action – persecution

Do staff use the same words to talk about drugs and alcohol?	Yes 5 No 4	• Yes and No • Not sure, I don't talk about AOD
Do the types of language used matter to you?	Yes 3 No 5	• Not really • Non-Blaming language is better • Needs to be non-critical
Is AOD a good term to use?	Yes 11 No 1	• I think it should be split into legal and illegal issues • Yes, it makes it easy to speak about especially for people who have sleep issues, anxiety and OCD related issues • Happy with AOD easy to understand, clear • It is new age terminology, understandable, leads to open communication
How can we improve our language and approach?	• AOD qualified people • Training of staff	• Staff need AOD training • I think it is great • Create group meetings x 2 • More conversations about people and residents • Maybe they are addicted to AOD because of underlying health and mental health issues so maybe start from there • More conversations about AOD use so people feel more comfortable to raise issues. Drugs is a very broad term – clear definitions between medications and illegal drugs • Talk more about it, use personal intuition – staff to use to know when to approach people • Understanding other names of illicit drugs and a non-judgmental approach

Questions	Answers – closed questions	Comments
What's the best AOD issues worker or service you know of?	• Shalom House – high % recovery • Holyoake	• Narissa – RW NDIS worker – very helpful even though I don't have AOD issues
What else can help someone with substance misuse in their MH recovery journey?		• Lived experience, peers support, AOD appropriate service, up to date knowledge and street talk and AOD Counselling • Not scaring you out of substance misuse and having correct advice for the person • The interpretation of people's experiences • A good recovery program • Anxiety support and strategies • Lived experience working for RW • Having family and friends to support them • An action plan and easy to follow goals • Have therapy meetings with the clients Lived experience, someone who knows their stuff working for RW • Have therapy meetings with clients • Having family and friends to support them • Patience, understanding, everything takes time, it's a survival technique and lesser of evils • Honest and cooperation • Anxiety prevention and support methods • Surround yourself with good people

Appendix 4 - AOD Incident Procedure

Procedure for care of an individual under significant influence of AOD who returns to a site. To provide clarity on appropriate actions (accountability and responsibility):

- Site safety is the responsibility of staff regarding entry or redirection for Consumer to return later
- Dignity of Risk relates to the choice of the consumer to become under the influence of AOD
- Clear, consistent information is required at intake to inform how situations are dealt with in a consistent way, and are well documented
- A clinical level of consumption of AOD requires clinical care

Actions

Perform a Risk Assessment – what risk level is the consumer to themselves and others, determine the likelihood of: requiring an ambulance, causing high risk events with other residents or staff. The level of risk results determines the decision to give site entry or to redirect the Consumer, the response actions listed below:

- Call clinical team 8am – 5pm (3pm on Friday)
- Call "on-call" clinical team 5pm - 10pm
- Call MHERL 10pm - 8am – using agreed salient points and language format
- Call 000 – give clear guidance on situation and approach required with Consumer
- Explain redirection in a calm manner, be in a location that is safe for you
- Redirection – please return at a later time when the effects have worn off
- Redirection to other local services – e.g. Salvation Army, Sobering up site at Highgate or similar local services where available
- Room search decision is made in preparation for consumers return to site as appropriate and conducted as per Room Search guide and procedure

Approach following the 1st incident

- Next day conversation to identify and understand underlying issues/triggers
- If room search has occurred discuss findings
- Review planned goals, etc. and adjust/different options to assist in way forward
- Revisit commitment agreement
- Review safeguarding plans, update triggers and responses if necessary
- Explain process and advise of first warning (covered in Intake and Commitment agreement), ensure consumer is aware of next steps in process if event reoccurs

Approach following 2nd incident

- Next day conversation to understand underlying issues
- Arrange for a case conference asap include the consumer and family/next of kin if appropriate, agree actions, changes etc. and next steps
- Issue second warning and reiterate the process and the choices available

Approach following 3rd incident

- Eviction process commences

Appendix 5 – Room Search Guide and Procedure

A search will only be carried out if there are strong grounds of immediate significant risks to the safety and security of the individual or others, which make it necessary for the search to be authorised. The manager will decide to proceed, depending on necessity and is proportionate to the risks identified. The resident's consent for room search is documented in the Living Agreement and signed at commencement of residency.

A search will not be carried out without the permission of the manager or on-call duty manager. Care or support staff are not allowed to carry out a search without the appropriate authorisation.

If a consumer loses control at any time during the process and becomes aggressive or violent, the service will invoke its response to behaviour and challenges and may need to call the police. The service is aware that such responses could trigger the need for an alert to be made to the case manager.

A search might also be authorised if a service user has taken "unauthorised absence", which puts the person and others at risk of harm and the search might produce evidence of their intentions and whereabouts.

The service recognises that the searching of a service user's room is an intrusive measure. Staff carrying out the searches must act in a professional manner throughout and show respect for the individual, their feelings and their property. Before any search, the consumer will have the opportunity of voluntarily disclosing the location of any illegitimate substances or instruments — or whatever the focus of the search is.

The consumer whose room is being searched will always have the opportunity of being present as an observer (only) and allowed a "friend" (someone of their own choosing, who might also be a named advocate for that person), to be present, also as an observer. A person whose room is being searched as a "best interests" decision will be afforded similar representation.

If staff find any dangerous objects or illegitimate substances, which is against the service's rules and terms and conditions, they are authorised to remove those items for safe keeping or disposal pending post-search enquiries and investigations.

If sufficient evidence or clear incidents have occurred, the inspection of bags and pocket contents may be utilised with manager's approval, as part of the site duty of care to all residents.

Only staff who are deemed competent by way of training to carry out a search will do so, and, wherever practical, the search should be carried out by a senior staff member or manager. There must always be at least two staff members carrying out a search; one should be the same gender as the person whose room is being searched.

All staff will be made aware of the risks when carrying out any search process, i.e. that the person could be hiding an item used to self-harm or intended to be used to harm others, or suspicious or dangerous substances. All staff must be vigilant at all times when suspicion of concealment has occurred to ensure the safety of service users and work colleagues. Communal areas must also be searched regularly for AOD.

In certain circumstances, the police may seek to carry out a search as part of a criminal investigation. If there are clear risks arising from the evidence, suspicions and search proposals, or issues arise as a result of the search, the case manager will be informed.
Search and Disposal Procedures

Room Search Procedure

The person's consent has been obtained in the Community Living agreement and it is considered that there are sufficient grounds for carrying out a room search with manager's approval, the following procedures will apply.

1. The service user can attend the room search.

2. The search is carried out by two members of staff, trained and competent in the procedure, one of whom will be nominated as the lead person; one of whom should be of the same gender as the service user wherever practically possible.

3. Staff involved will wear protective gloves against needle stick injuries and any other protective equipment deemed effectively in line with the assessed risks (shared knowledge, Connect notes).

4. The search is systematic, starting at one side of the room and working to the other.

5. To ensure that nothing is missed, the lead staff member will start, with their colleague following and searching the exact same area as the lead person. Staff following each other around the room and do not search separate areas.

6. The search will be thorough, from top to bottom, ensuring that, for instance, the tops of wardrobes/shelving are searched, as well as drawers, cupboards, under beds, baggage, etc.

7. All items in the room will be replaced as originally found, except any dangerous or banned items, drugs or alcohol, which will be removed and disposed of.

8. The implications of the search findings will be subject to further enquiry and investigation in the light of any discovery. If a service user is found to be in breach of their terms and conditions, they could be asked to leave, and a period of notice served.

9. The event will be recorded and subject to a management review to determine what has been learned from the individual and in general.

10. Any items removed will be logged (Appendix 6) and kept safe pending a decision on their future, which would include the possibility of the items being returned if they prove to be harmless and legitimate.

11. External agencies such as the NDIS safeguarding team and the Case Manager or GP/Clinical team will be alerted or notified if the results or situation presented meet their criteria.

12. The consumer will be informed of their right to make a formal complaint if dissatisfied with the procedure.

Disposal of illegal substances, equipment and weapons

When illegal substances, associated equipment and weapons are discovered, they are to be confiscated and staff contact the Local Community Engagement Division of the Police contacted with a request to attend to collect the items (note they will not collect small amounts of illegal drugs). All residents will be advised of this procedure prior to confirmation of residency, during the site tour and familiarisation and in general communications as relevant and the room search consent in the Community Living Agreement.

- The Police have advised that **small amounts of substances and equipment** can be placed in the bin. Care must be taken that residents are not aware of this practice to prevent attempts to repossess the substances or equipment. Small amounts of drugs can also be placed in the sharps bin, again without any resident knowing their location. Alternatively, they can be logged on the record Appendix 6 and stored in a safe until sufficient quantity is achieved that will be accepted by the Police.

- Significant amounts of substances - between confiscation and disposal, secure the items in the safe, or in a lockable cabinet. Inform the Police who collect it from site.

- For significant amounts - a record is kept of the find; name of substance or equipment (if known) or a description, number of tablets, the search staff names, the date and time of discovery, signatures of both searching staff members and an identification number made up of the date and time found in 24hr clock, e.g. 21.11.21/ - 09:00hrs

- When confiscated substances are handed to the police documentation of what is given to whom, when, and by whom as below.

It is not legal for staff to transport/carry an illegal substance to the police station or pharmacy or return the substance to the original owner.

When weapons have been confiscated, they may not fit into the safe and will need to be stored in a secure location and documented until the Police can collect these items.

Appendix 6 - Confiscated illegal items record

Date confiscated e.g. 21.11.21/	Time 24 hr clock e.g. 09:00	Name & signature staff member 1	Name & signature staff member 2	Substance/Item. No. of tablets or description	Date collected by police	Name and no. of police officer	Name of staff handing over items

Review Timeframe and Responsibility

Date of effect:	21 April 2021
Review period:	2 years
Next review date:	21 April 2023
Prepared by:	Manager Service Quality and Innovation
Preparation date:	20 April 2021
Reviewed by:	Chief Operations Officer
Review date:	21 April 2021
Reviewed by Consumer and Family Reference Group:	
Approved by:	Chief Operation Officer
Approval date:	21 April 2021