

BOOK 3

SELF DIRECTED LEARNER'S GUIDE

ON ASSESSING &
REFERRING CLIENTS

NEW SOUTH WALES
DEPARTMENT
OF EDUCATION
AND TRAINING



N.A.D.A.

Non Government Alcohol and Other Drug Treatment Workers Training and Workplace
Assessment Resource Package for "Assessing and Referring Clients"

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OVERVIEW TO THE LEARNER'S GUIDE

THE ROLE OF ASSESSMENT AND REFERRAL IN ALCOHOL AND OTHER DRUG AGENCIES

From telephone counselling services to residential rehabilitation programs, most AOD agencies do some form of client assessment. Workers in these agencies are usually listening to, and asking certain question of clients to ascertain the nature of the issues that the client has approached the agency about. Clients come wanting some form of help; this could be information, support or treatment. Workers need to assess the problem and give the client assistance that is both appropriate to the client and fitting into the boundaries of what their agency can offer.

The purpose of the learner's guide

This learner's guide has been designed to assist workers in gaining skills that are appropriate for conducting a successful client assessment. It also includes information on how to develop and follow through a case management plan with a client and to make an appropriate referral. Many workers may be in agencies where their contact with clients is very brief and the extent of the information in this guide may not be part of their job role. Others may be carrying out comprehensive assessment, case plans and referral every working day. Sometimes the information will be different from how you work in your agency. Please bear in mind that the guide comes from *DET module Assessment and Referral 3260B* and the content areas are in line with national competency standards covering all AOD workers. If you are not sure what is meant by a national competency standard, please read our accompanying *Book 1: Agency Handbook*.

Whether you are extremely experienced or not used to having this type of contact with clients, what you have to gain by studying this guide is a link into formal training that is nationally recognised. Other advantages are that you get to study in the workplace and apply this knowledge directly to the clients with whom you are working. Hopefully it will give it more meaning and purpose.

Please note: One of the basic skills required for being able to carry out the tasks in this learner's guide is counselling or interpersonal skill. The guide is written for someone with these skills and there is an assumption that the learner has gained these skills already. If you are concerned about whether you have these skills, check Appendix 1 for a description of them.

As an added bonus, most of the information in the guide is also based on techniques that have been developed and researched at the National Drug and Research Centre, University of New South Wales.

You can gain more information about these techniques by reading:

Jarvis, T.R., Tebbutt, J., Mattick, R.P. *Treatment Approaches for Alcohol and Drug Dependence an Introductory Guide*. John Wiley and Sons. Chichester. 1995

It is suggested that every agency have a copy of this textbook. It will assist in your learning for this guide but overall it is a great Australian text for this field. It can be purchased through National Drug and Research Centre, University of New South Wales. It is at TAFE libraries.

LEARNING OUTCOMES

In each section of this guide there is a set of what are called learning outcomes.

Learning outcomes simply refer to what you should be able to do at the completion of that particular section of the guide (your performance).

Competency-based learning focuses on what you can *do*. It is therefore organised around learning outcomes and the standards or criteria for performing them.

The learning outcome relates to Competency Standard CHCAOD8.

Don't become too concerned if you do not understand these principles. It is just an educational technique to break what we do in the workplace down into segments that can be demonstrated.

Below is a list of all the learning outcomes for the guide.

Learning Outcome 1:

Assess the needs and status of the client/s.

Learning Outcome 2:

Prepare a case management plan with the client.

Learning Outcome 3:

Demonstrate knowledge and skills required to work with clients with mental health and AOD issues.

Learning Outcome 4:

Review progress with the client.

Learning Outcome 5:

Refer clients.

Learning Outcome 6:

Evaluate work undertaken with clients.

Issues that relate to this guide

There is an emphasis in this guide on the development and practice of skills. As workers in the field, you can use some of the skills with your clients. However, if the skills are new to you it is probably best to practise with colleagues for a while. With the permission and support of your manager, this will require setting aside time and enlisting colleagues to assist you by playing the role of a client. It is **important** that you arrange this early so that you can carry out the activities successfully. You will need the assistance of others for several activities. In total this may add up to a few hours. It is best that you read through the guide and discover where you need people and then ask them accordingly. Instructions for your helpers are in Appendix 4.

In this guide there are case studies (Appendix 5) to be used to practise skills. In each client case study you will need to show you understand the social and cultural needs of that particular individual.

REFERENCES AND RESOURCES

Below is a list of useful textbooks and articles. These are not essential to read but can expand your knowledge in the area of alcohol and other drug work, and especially in assessing and referring clients.

Main text

Jarvis, T. Tebbutt, J. Mattick, R., *Treatment Approaches for the Alcohol and Drug Dependence An Introductory Guide*, John Wiley and Sons. Chichester, 1995.

General

Miller, W. Rollnick, S. *Motivational Interviewing Preparing People to Change Addictive Behaviour*. The Guilford Press. New York. 1991.

Egan, G. *The Skilled Helper A systematic Approach to Effective Helping*. Third Edition. Brooke / Cole Publishing. 1986

CEIDA Manual. *Working with Clients stage 2*. Assessment, Treatment Planning and Referral.

Suicide

Donaghy, B. 1997. *Leaving early: youth suicide – the horror, the heartbreak*

Pymble, NSW. Harper Collins

Lifeline Ballarat (presenter) 1994 *Suicide: crisis in community and rural health*
Ballarat University

Mckillop, S. (editor) 1990 *Preventing youth suicide: Proceedings of a conference held July 1990*. Australian Institute of Criminology.

Appleby, M., King, R. 1997. *Tell, Tell, Tell. Preventing Youth Suicide*. Rose Education, Training and Consultancy – a student handbook.

Axten, D. Waters, R. Evans, R. Evans, B. (video) 1993. *Walking on the edge Suicide Intervention*. Communication and Counselling Skills. Lifeline Queensland.

1994 (video) *Unlived lives – Adolescents and suicide Guide for rural workers* funded by rural health support.

Training Health and Educational Videos. 1995. *Teen Suicide: Who, Why and How you can prevent it*.

Domestic Violence

Healey, K. (editor) 1996. *A culture of violence?* Balmain, NSW. Spinney Press.

Dual Diagnosis

Evans, K, 1990. *Dual Diagnosis: counselling the mentally ill substance abuser*. New York. Guilford Press.

Daley, D. 1993. *Dual Diagnosis: counselling clients with chemical dependency and mental illness*. Center City. Minn. Hazelden.

Articles

Connexions Magazine *Model Treatment A New Approach to Dual Diagnosis* February/ March 1995

Connexions Magazine *Dual Diagnosis where to from here and Talking with the Stake holders*. October/November 1996

Connexions Magazine *Dual Diagnosis* October 1992

Connexions Magazine *Dual Diagnosis* November/December 1992

Connexions Magazine *Family Violence* Jan/Feb 1990 Vol 10 No. 1

Connexions Magazine *Child Sexual Assault* May/June 1993 Vol 13. No. 4

UNIT OF STUDY NO:1

ASSESSING THE NEEDS & STATUS OF THE CLIENT

OVERVIEW

In Unit 1 you will be examining the purpose, function and procedure involved in a client assessment. This guide is written for those working with individuals who have alcohol or other drug problems or issues. Many agencies are also working with families, couples, or significant others who may be dealing with a relative or friend who has a drug problem. **Please use your agency's assessment forms** to carry out the exercises if you so desire. However, if your agency does not have an assessment form there is a general, comprehensive assessment form provided in Appendix 3.

You will begin this guide by expressing your understanding of the principles of a client assessment in the exercises provided – in other words, your knowledge behind the process. Next you will examine an intake form (the initial form used for brief details on a client when they first approach an agency) and a comprehensive assessment form (detailed background on the client). In your own time and with the help of colleagues you can then practise carrying out an assessment. There are various case studies (in Appendix 5) in the format of intake forms available to use for this practice. They are written in a manner such that when conducting the assessment you will have to consider social and cultural concerns of that particular client. Finally the issues involved in working with an interpreter will be examined.

NOTE: You will use the information you collect in assessment practice on the case studies throughout this guide. That is, you can use the same case/client for the other sections – case planning, review, evaluation and referral.

CLIENT ASSESSMENT: *WHAT IS IT? HOW DO WE DO IT AND WHY?*

The what and the why!

Introduction

When most clients approach an agency regarding a drug use problem or issue we need to gain some particulars on them in order to give them appropriate information to assist with this issue. They may approach us over the phone or in person. We usually begin by getting a brief outline of the issue that they are concerned about. In this guide this will be

referred to as an intake assessment. Once we have this information it is usually decided either by the individual worker or the agency whether this client requires referral to another agency or will be assisted further by your agency. If this client is to stay with your agency it is appropriate at some stage that a further more comprehensive assessment of the client is conducted. This is so details of the client can be gained and appropriate interventions/treatments can be suggested to the client.

There is an emphasis in this approach that the client is treated as a whole person, not just a drug problem. Today, research and experience in the field has indicated that people who have difficulties with their drug use have usually experienced other difficulties in their life. This could be as a result of the drug use, or occurring before they took up using. Issues such as mental illness, sexual assault, homelessness and unemployment are just a few. If the worker does not have knowledge of some of these other issues, any treatment or intervention just based on the drug use could be doomed to fail. This often leaves clients feeling they are failures and reluctant to try for further assistance.

If the client is comprehensively assessed early on in their meetings with your agency it's more likely they will receive appropriate help, or at least acknowledgment of all their issues. This goes a long way towards preventing the drug problem from reoccurring in the client's life.

Definition of assessment

Assessment is a semi-structured interview where together, the client and the worker compile a history of the client's life.

The interviewer may be guided by a checklist of the important areas (you will be introduced to these when you examine the assessment form in Appendix 3).

The overall purpose of assessment

Assessment is to provide essential understanding of the client in their own right. You will examine together their present situation and its connection to their past. All of this is to see how their drug use fits in with the rest of their life.

Your overall purpose in collecting this information is to see the client as an individual and match them to the appropriate intervention.

The type of intervention the client will be involved in following assessment will depend a great deal on various factors:

- **What the client is willing and available to take part in**
As the assessment worker you may feel that the client would benefit from an inpatient detoxification program. However, this may be impossible due to work or family commitments. The final decision is up to the client, but the worker needs to give information that is appropriate to the client's particular circumstances.

- **What interventions are available**

This is affected by a number of things.

1. Where you and the client are living. As we move further away from large cities the number of available interventions is limited.
2. Some services (interventions) are in existence but have long waiting lists for people entering the service.
3. If you choose to be the worker carrying out the intervention with the client, the level of your skill will affect what interventions you carry out.

The functions of assessment

- Assessment should revolve around what the client is requesting. Taking into account the previous information, if the client is asking for some intervention, assessment will also be affected by what interventions are available and the assessment worker's ability to match the client to the appropriate one.
- It is not necessarily appropriate for everyone to receive the same assessment.
- Assessment aims to gather information on the client and see their life as a whole rather than just focusing on the problem.
- Assessment aims to interpret this information in the light of treatment objectives and strategies.
- Assessment provides a two-way interaction giving the worker and the client time to develop rapport.
- It gains information for appropriate referral.

The how! – Process of conducting an assessment

Assessment is essentially a **process** rather than just a procedure for collecting a whole lot of information on the client. The development of rapport with the client is one of the **most important aspects** of the assessment. It could be said that how the worker conducts the interaction is probably in the long run more important than the collection of information. This is because the development of a **trusting, supportive relationship** will affect future outcomes in case planing and possible referral.

NOTE: Any information written on a client may be subpoenaed to a court of law; therefore, you must at all stages be conscious of what you write. You will learn more about this record-keeping in Unit 4.

Assessment is usually done in two parts. In most agencies there is usually a worker who will first take down initial information from the client either over the phone or in person. This is called the **intake assessment** (an example of an intake form is on page 18-19). This is usually a brief assessment which is conducted with the client when they ring up or arrive at the service. This assessment serves several purposes:

- to ascertain whether the client is at the right service for their needs;
- to determine whether the client is in crisis or needs immediate assistance;
- to gain basic information on guage whether the client is appropriate for this service;
- to find out what type of help they are requesting;
- to keep a record of the type of clients coming to the service and their requests for statistical and further funding requests.

A comprehensive assessment

This is usually carried out with the client when they have entered the appropriate service. (A copy of a comprehensive assessment form is in Appendix 3).

The process of assessment

The role of the worker in conducting an intake or comprehensive assessment is as follows :

- preparing for the interview by becoming familiar with the assessment form and procedure of the agency;
- preparing the interview room so that it is comfortable for both the client and the worker (e.g. provide an area that is private and free of distractions such as ringing phones);
- initiating contact and establishing rapport with the client, always introducing yourself and explaining your role;
- explaining the parameters to the client, e.g. how long an assessment should take, what will follow , confidentiality issues, any policies and procedures of the agency that are relevant to the client;
- clarifying questions of confidentiality;
- explaining the roles of worker and client and their responsibilities;
- conveying that you are emotionally available and attending to the client using basic counselling skills such as active and reflective listening and open questions, always being non-judgmental;
- listening attentively to feelings communicated both verbally and non-verbally;
- inviting the person to describe their needs and explain why they are there by asking open questions;

- acknowledging any discomfort or distress the client may be feeling and recognising that it may be very difficult to ask for help or answer personal questions from a stranger;
- recognising your own emotional reactions to the client, making sure you don't stereotype the person, over-identify with them or disempower them;
- choosing a culturally appropriate way of communicating.

Social and cultural issues

With each individual you see, you will need to take into account their social and cultural background and how this may affect your interaction. Their gender, race sexual preference, and ethnicity – and yours – will have some sort of impact on the assessment process.

CONTENT OF COMPREHENSIVE ASSESSMENT (INFORMATION REQUIRED)

The following are broad topic areas and not every client would need the same information in each covered. Most assessment forms now have these areas covered in some format.

You will find these same topic areas on the comprehensive assessment form in the Appendix 3.

1. SUBSTANCE USE AND ABUSE

Current use

In order that the person receives the appropriate treatment you need to understand their present drug use pattern in detail:

- **dose** – how much are they using?
- **route** – how are they using it, e.g. are they injecting?
- **frequency of use** – how often are they using?
- **pattern of use** – when does it happen, e.g. just on weekends or every day?.

All of the above questions affect how detoxification may occur if this is necessary.

Pattern of use

- **Age**
At what age did they first start using this substance? This is often important as it may give you an understanding of what started them and what else was happening in their life at the time.
- **Tolerance**
Has the amount they have used increased over time? If the answer is 'yes', by how much? When has the change occurred?
- **Withdrawal symptoms**
Do they experience any withdrawal symptoms, e.g. headache, feeling sick in the mornings, 'the shakes'. This is important if you and the client are considering detoxification.
- **Narrowing of repertoire**
This means, is much of their life centred on using/drinking?
- **Preoccupation with use**
It is important to know whether they think a lot about drinking/using during the day.

- **Prescription medication**
Often clients are taking prescription medication legally or illegally. As workers we often forget about this use of drugs, and so does the client because this is something the doctor gives them. We need to know what they are using and for what reasons. Certain detoxification and rehabilitation centres will not accept a client who is on certain prescription medication.
- **Previous use**
Have they used before, stopped for a period of time and then taken it up again? Maybe this time a different drug? This gives us more understanding of the pattern of their use and what other life events affect it.
- **Treatment history**
What sort of treatment have they had before? Was it successful? Again, these questions give us valuable information on what works and doesn't work for this particular client.

2. FAMILY AND SOCIAL RELATIONSHIPS

Discussion of these helps provide an understanding of crucial early relationships that may have contributed to the individual's strengths and vulnerabilities today. Also it explains the family and cultural meaning given to drug and alcohol use. Also needed is information on present relationships, children etc.

3. EMPLOYMENT AND FINANCIAL STATUS

How does the person support themselves and possibly their family?

4. MEDICAL PROBLEMS

Are there any present medical problems that are affecting their health and would affect an intervention plan?

5. LEGAL STATUS

Are there any legal problems affecting them at present that would affect an intervention plan?

6. PSYCHOLOGICAL STATUS

How does the individual see their present psychological state?

Note

In **Appendix 3** is an assessment form which covers these areas in detail. For the exercises in this unit you can use this form or the one at your agency.

If you use the assessment form in this book study it closely.

REMEMBER, this is a very thorough assessment form and each agency should devise one to suit its own clientele. The questions in the assessment form are only examples. You would ask questions according to what you felt was appropriate for the client. The amount of information you are collecting on the client may seem extensive, but here you are learning to assess a person in a holistic manner. It is very important to find out about how their drug use fits in with and affects the rest of their life. Asking questions about their family or financial situation may seem personal; however, these situations may greatly affect the eventual treatment plan. It is always important to explain to the client why you are asking these questions so they do not think you are just prying into their life. They always have the right to refuse to answer anything they consider too personal.

Factors that will impact on assessment

1. From the client's point of view

- The reason for and source of referral may have some impact on the assessment process. If the person is sent to you by the court as opposed to coming to you voluntarily this may influence their attitude toward the assessment. However, the coerced person is not necessarily uncooperative.
- If your client has had previous treatment this may influence their attitude to this assessment depending on how they have been treated before.

2. From the assessment worker's point of view

- You will be affected by your own belief system about drug use.
- You may also be influenced by the source of referral.
- You will be affected by your attitude to the client and their problem, and the manner in which the client presents, e.g. hostile, cooperative etc.
- Of course 'the stage of change' that the person is at will impact on the assessment process. If you can't remember the 'stages of change' model, examine the information in the Appendix 2.

Activity 1

This is the first activity for you to apply the knowledge you have just read. To carry out this activity forget your present position and imagine that you are an AOD worker in your local community health centre and one of the people in the following case studies has come to see you or has been sent to you for assessment. Choose **one** of the following people from the four cases on the following pages.

Your task is to:

1. read the case studies
2. choose one case study only
3. answer the questions that follow the case studies

Note: Bear in mind that you are not being asked to solve the problem of the client, just to describe the:

- process (how you would conduct the assessment from beginning to end);
- content (areas of information you feel would be required to understand this person);
- social or cultural issues to be taken into account when dealing with this person;
- stage of change the person is at (see Appendix 2).

Case No. 1

David is a 25 year-old-journalist for a rock music magazine. He drinks heavily but only on Friday night after work and during the weekend with friends and associates. He is also known to have the occasional line of speed and smokes marihuana when it is around at parties. He has come to you for help because he is worried about the effects of his drinking. He suffers bad hangovers and is concerned that it is affecting his work. David really wants to change his behaviour but does not know how. His main goal is to reduce his consumption without missing out on the fun of socialising.

Case No. 2

Megan is a 28-year-old Aboriginal woman. She is also a single mother with three children aged six, three and two. Megan has been using a variety of pills over the past 10 years. However, she has also had long periods of abstinence, usually after entering rehabilitation. Megan recently began using again after a breakup with her partner. She is having problems with finances, housing and this recent use of pills relates to the stress that she has been under. Megan comes to you because she is afraid her children will be taken from her if her district officer finds out about her use.

Case No. 3

Brendan is 18 and has virtually lived on the streets for five years. He has committed a variety of crimes such as stealing, car theft, etc. but this was as a juvenile.

He is now going before the adult court on a charge of using and possessing heroin. He is frightened of being sent to jail. His probation officer has sent him to you for an assessment of his drug use. Brendan does not think he has a drug problem, he just uses what all his friends use. But he is willing to cooperate for the sake of his court appearance.

Case No. 4

Spiros is a 60-year-old Greek man. His doctor has referred him to you as he does not seem to be able to reduce his drinking or smoking although it is causing a variety of health problems. Spiros has suffered a series of heart attacks over the last three years. He is married, and has five grown-up children. He has just retired from his own business because of his health problems. Spiros knows he has a problem but wonders whether he is too old to change.

Questions

1. What process would you use in order to assess the person you have chosen?

2. What are the special social and cultural issues this person brings to the assessment which you would have to consider during the process?

3. What information do you require from this person to assess their situation properly?

4. At what 'stage of change' is this person?

5. What impact does the person's 'stage of change' have on the process?

INTAKE AND ASSESSMENT FORMS

Purpose of intake form

When a client comes to an agency there is usually an introductory procedure whereby the client is seen by a staff member to ascertain preliminary issues.

These include:

- client's reason for coming to this agency;
- any problems that require immediate attention;
- determining whether they have come to the right agency.

The worker gains the information set out on the questionnaire or form and decides from this point whether it is appropriate that this person stays with this agency (if so a more comprehensive assessment will be done later) or whether they need more immediate referral, for example they require medical attention.

Sometimes when a client has entered a residential program an intake assessment is done and then the client is given time to settle into the program before a more comprehensive assessment is carried out.

A typical intake form has the following information areas:

INTAKE FORM

Date of interview: _____

Interviewer: _____

Client details: _____

Name: _____

Address: _____

Phone: _____ Date of birth: _____

Sex: _____ Country of birth: _____

Next of kin: _____

Referral details (source and reason): _____

Client's main concerns: _____

Substance use issues: _____

Social situation (employment, finances, legal, environment and living situation, interpersonal concerns): _____

Comments: _____

Note how in the intake form only brief details of the person are taken down.

A COMPREHENSIVE ASSESSMENT FORM

Introduction

If the client is to stay with your agency for further assessment, more information is required before treatment options can be decided. While recognising that a full holistic assessment is not feasible or necessary for each client, it is important for you to have a thorough understanding of the process/content of a holistic assessment so you can use it if required as AOD workers.

Activity 2

1. Read the assessment form thoroughly (in Appendix 3). If you are using your agency's form it is still worthwhile to read this assessment form and compare it. Go through each section thoroughly and really become familiar with it all. Recognise that each section is there to give you a holistic understanding of the client not just their drug problem. The questions that are set out are only examples. After you have practised with this one it is best for you to design your own questions according to the needs of your agency and your own style.

2. After you feel comfortable with the form you will have a practice session, with a colleague acting as a client. Try to become familiar enough with the form that you can ask questions of the client without always referring to the form. The reason for this is that you are trying to build rapport with the client. Continually looking down to read the next question breaks eye contact and also the flow of the interaction between you. It can seem quite stilted and more like integration rather than developing an understanding of the person's life and how drug use fits into that life. *So just to emphasise it again: really become familiar with your assessment form, write some appropriate questions of your own before beginning the practice session.*

Activity 3: Practice session

The process

Ask colleague to spend some time (at least an hour) with you doing a role-play. Give them information on one of the cases (Appendix 5) to study beforehand and the information on how to do role-plays is in Appendix 4.

Procedure for conducting assessment

1. Spend the first few minutes introducing yourself by describing your role, the process and reason for the assessment.

Here is an example of how to begin – you do not have to use these words, it is only an example of how to start :

"Hello, John, I am Amanda Smith. I am one of the alcohol and other drug workers here at Kingsland Centre.

You came here the other day and saw my colleague Wendy, who took some brief particulars on you and you agreed to come back for a full assessment so we could assist you with treatment regarding your alcohol use. Is that correct?

If the client answers 'yes' you can then move on. If the client says 'no', you need to find out where the difference is in understanding of why they are there.

"Before we begin I want to spend some time explaining what we will be doing today and why we are doing it. For example, what happens after the assessment, issues about confidentiality of the information and so on. Please feel free to ask me any questions at any time if you are unsure about what is happening.

I have been asked to conduct an assessment with you on your present situation. With this information that I collect today we hope to be able to assist you with the most suitable treatment available to you. At this centre our philosophy is to treat everyone as an individual and therefore what we do today together is gather information on the whole of your life and see how drug use fits into that life. Without this information we cannot ascertain the most appropriate treatment for you.

I will be asking a series of questions about your life. Some of these questions may seem very personal – please stop me at any time, and I will explain the purpose behind the questions before we continue."

Explain:

- issues regarding confidentiality;
- any important issues relating to your agency's policies and procedures;
- their role, e.g. further appointments;
- time it will take;

Check with them that the needs expressed on the intake form are correct.

Generally carry out all that has been mentioned before about the worker's role.

3. Begin with practice assessing the drug history.

Now in reality this maybe not where you begin. You will need to decide this according to what you already know about the client especially if you have an indication of the stage of change they are at. However for the purpose of this exercise, practise asking questions about their drug history.

Remember that skills practised in a practical way may feel uncomfortable especially having to play a role in front of a peer. (Read information on role-plays in the Appendices 4 and 5.) However, if you put effort into it can be a fabulous way of learning the skill and gaining confidence in your ability before having to try it on real clients.

When you have finished the role-play debrief with your colleague, asking them how they felt whilst playing the role, ask them for feedback on your performance. Talk to them about how you felt .

Once you have completed you client assessment you will need some time to write up your notes and a summary of your findings. You will be arranging for another interview with your client to give feedback on the assessment and work together towards a case plan . You will be discussing how to do this in your next unit.

Activity 4

Answer the following questions:

What are the social and cultural needs of your particular client in the assessment procedure ? _____

How did you deal with them? _____

What difficulties did you have being an assessment worker ? _____

What did you learn from this activity and what would you do differently next time?

What feedback did the person playing the client give you?

In the main text by Jarvis, Tebbutt & Mattick there is a "Severity of Alcohol Dependence Questionnaire" on pages 30-34. Read this and become familiar with the questions. If you have the opportunity practise using it with your client in the role-play. It can be added to the information you received as a clear guide to their alcohol/drug use.

FEEDBACK SESSION

Introduction

After you have completed the assessment you will analyse the information collected and summarise the issues. In the feedback session (next appointment) you feed this information back to the client. Together you will decide what is the next step. You will discuss a plan for possible future treatment options with the client.

In this session, skills in counselling, as well as a good understanding of the 'stages of change' model, are once again very important tools to have.

Procedure for feedback session

- Present information from assessment summary in a quiet, non-judgmental manner.
- Avoid 'scare' tactics.
- Always follow up feedback of information by seeking your client's response.
- Any feedback may raise strong emotions – empathy and reflective listening will assist at this point.
- Remember, any motivation for change is promoted when people perceive a discrepancy between where they are and where they want to be.
- This is a crucial time and we need to be conscious that we are talking about some sort of change for the client involving some action. Many workers fall into traps at this stage.

Traps

1. Forgetting or ignoring ambivalence. This is where we forget what we have learnt about the 'stages of change' model. Clients may feel genuinely motivated to change, but all change has pluses and minuses and we need to be aware of what they are for the client.

2. Overprescription. Many clients have multiple problems, not just with their drug use but with the law, their family, their health. We may feel we have the answer with various referrals to a variety of agencies. We can give them too much rather than taking into consideration their capabilities and their own desires.

3. Introducing plans without discussion. This means deciding on what we think is a great idea without discussing it with the client first.

4. Insufficient direction. Not giving enough appropriate feedback and suggestions to help them make decisions.

What we can do to avoid these traps

- Make a summary of the client's own perceptions of the problem.
- A summing-up of the client's ambivalence. Ambivalence is when the client is in two minds. In other words, there are reasons to change and there are reasons to stay the same. The 'stages of change' model considers ambivalence as a very important factor that we must not ignore. If we try and push someone towards change when they are really ambivalent they will resist us. If you examine it with the client they can put forward the reasons for change.
- A review of whatever objective evidence you have regarding the presence of risks and problems.
- A restatement of any indications the client has offered of wanting, intending, or planning to change.
- Your own assessment of the client's situation, particularly at points where it converges with the client's own concerns.

Activity 5 – Feedback session

Go through the information in your assessment form. Use the summary sheet at the back to make your summary. Organise another role-play with your friend playing the client. Practise a feedback session with the client., then ask for feedback.

After the session answer the following questions:

1. How did you go at giving feedback to the client ?

2. Did you fall into any of the traps? What were they ?

WORKING WITH AN INTERPRETER

Many of you may have already worked with an interpreter and are familiar with the appropriate techniques to be used. If you haven't, or feel you need to learn more, a videotape is available from the TAFE library to assist you with this.

It is called

Counselling with interpreters. Sexual assault. (Sydney) Health and Media and Education Centre 1987.

Although the person in the video is a sexual assault counsellor, the way she learns to work with an interpreter is the same for all welfare situations.

After you have watched the tape, answer the following questions.

Activity 6

1. What might be some difficulties for you in using an interpreter?

2. Do you prefer simultaneous or consecutive interpreting? State why you prefer this type of interpreting.

3. The tape outlines appropriate key ways for working with an interpreter. What were they?

UNIT REVIEW

Now you should be able to assess the needs and status of a client.

Can you answer the following questions confidently?

1. What is the purpose of a client assessment?

2. What is the procedure for a client assessment?

3. What is the difference between an intake and comprehensive assessment?

4. What are the important issues to remember when you are feeding back information to the client on their assessment?

It is good practice to note any outstanding and unresolved questions and issues and discuss these at the earliest opportunity with your manager or supervisor.

Unit summary

In this unit you have learnt about the purpose and function of client assessment. You have carried out a client assessment and in doing so demonstrated the procedure. You have followed up with a feedback session. Finally you have examined the appropriate use of an interpreter. In the next unit you will be learning to recognise special conditions that may exist for your client and are relevant to the assessment and treatment phase, especially in the area of dual diagnosis when the client has both a AOD problem and a mental illness.

UNIT OF STUDY NO: 2

IMPORTANT ISSUES IN ASSESSMENT

OVERVIEW

In the AOD field it is recognised that other conditions in clients' life may affect their drug use. Sometimes their drug use has caused further complicating conditions in their life. It is important to discuss this at the point of assessment as it will affect the client's treatment outcomes and the possible referrals. The most common predominating conditions are:

- **psychiatric co-morbidity (dual diagnosis)**
- **alcohol-related brain damage (ARBD)**
- **sexual assault**
- **domestic violence**

Note: In the mental health field, dual diagnosis refers to someone with two co-existing mental illnesses.

In this unit you are given some basic information; you can investigate other aspects of this topic by reading various articles. All these issues are difficult because there few facilities work with clients and deal with both conditions simultaneously. In other words, there are very few referral agencies. AOD workers are often the ones trying to assist people with their AOD problem when the clients are also experiencing or have experienced one or more of the above conditions. This unit does not give you all the answers of how to deal with these conditions – as a society we are yet to develop that knowledge. This unit gives you some background knowledge and hopefully some understanding of the conditions and their connection to AOD use. It is a beginning, to raise awareness that unless we recognise these conditions treatment plans and case management can not always be successful. This is not the fault of the client or the worker. Some workers will ask, “why bother considering these issues at all if we have few facilities to deal with the clients?” The answer is that unless workers start keeping records on the predominance of these conditions in our drug-using population, there will be no evidence to put forward to justify creating worthwhile treatment centres.

Although all of these areas are important, in our assessment of clients dual diagnosis has become a particularly important issue because of the large numbers of clients experiencing it.

You will start with this area first.

PSYCHIATRIC CO-MORBIDITY – DUAL DIAGNOSIS

References for this section:

- *Connexions Magazine; Model Treatment – A New Approach to Dual Diagnosis*. February/March 1995;
- *Connexions Magazine; Dual Diagnosis – where to from here? and Talking with the stakeholders*. October/November 1996;
- *Connexions Magazine; Dual Diagnosis*. October 1992;
- *Connexions Magazine; Dual Diagnosis*. November/December 1992.

Definition

The presence of both a psychiatric disorder and a substance abuse (AOD abuse) disorder in the one individual.

Terms that are used for this :

- dual diagnosis
- mental illness
- co-existing psychopathology
- co-morbidity

GLOSSARY OF PSYCHIATRIC TERMS

Psychotic disorders

Psychiatric disorders characterised by 'leaving' normal reality. Features or symptoms of each are not reality-based, e.g. 'hearing voices', delusions or hallucinations.

Schizophrenia

A psychotic disorder where the person's senses of reality becomes extremely fragmented. The sufferer will report hallucinations (in any sensory modality); seeing things that are not present, hearing externally based 'voices', delusions (experience or beliefs not based in reality, e.g. believing they are controlled by another, or by the radio or TV). There are various types of schizophrenia, e.g. paranoid or catatonic.

The common misconception with this disorder is that it refers to a 'split personality'.

Treatment: Anti-psychotic medication and supportive counselling.

Manic depression

Also known as bi-polar affective disorder, or cyclothymia

A psychotic disorder where the person experiences extreme variations in mood. In the manic or hypomanic phases, the person's behaviour will become very aroused and excited. They may go without sleep for up to days at a time, have spending sprees, talk rapidly or show any

behaviour greater than their normal level of functioning. In the depressed phases, people experience very low mood, disturbances in sleep, general arousal, libido and excessive experiences of guilt and hopelessness. Mania or depression can occur alone.

The common misconception is the belief that manic depression refers to a very severe depression only, rather than a mood disorder involving depression and extremely elated states.

Treatment: medication; lithium carbonate.

Major depression/psychotic depression

In a major depression, the source of the depression is not a reaction to external circumstances (e.g. loss or grief). Rather, the cause is biological, i.e. a 'chemical imbalance'. In major depression, people experience very low mood, disturbances in sleep, appetite, general arousal, libido, excessive experiences of guilt or hopelessness, and in some cases suicidal ideas or attempts. In psychotic depression there is also the presence of delusions in the person's thinking.

The misconception is that depression is not distinct from and more severe than everyday experience of sadness.

Treatment: Anti-depressant medication, e.g. Prozac, Parnate, Prothiaden.

Anxiety disorders

Phobic disorders

(Simple, social or agoraphobia)

The person has a severe and irrational fear of an object or situation.

Simple phobia

The sufferer will avoid or intensely fear contact with a particular object or setting (or any representation of this), e.g. fear of snakes.

Treatment: Anti-anxiety medication, plus a range of behaviour therapies; relaxation, imaginal or 'in vivo' desensitisation.

Social phobia

Intense and irrational fear of social situations, specifically, experiencing difficulties in eating in public, using public toilets, writing in front of others or answering questions in public.

Treatment: Anti-anxiety medication plus cognitive behaviour therapy.

Agoraphobia (with or without panic disorder)

Fear of being in places or situations from which escape might be difficult or embarrassing. Common situations include being outside the home, in a crowd, in a line, in a bus, train or car.

Treatment: Anti-anxiety medication plus cognitive behaviour therapy, especially 'in vivo' exposure therapy.

Misconceptions can often develop in **two** manners;

1. Overestimation of the problem, e.g. the person is diagnosed or 'labelled' as socially phobic when essentially their problem is shyness.
2. Underestimation of the problem, e.g. the person displays symptoms of a phobia but is accused of not taking responsibility for themselves.

Obsessive-compulsive disorder

This disorder displays obsessions and compulsions. Obsessions are intrusive, senseless, persistent and discomforting ideas that are extremely difficult to dismiss, e.g. fears of contamination, of accidental or intentional harm, of impending catastrophe. Compulsions are behaviour or thoughts performed in an excessive, ritualistic or stereotyped manner. The aim of the compulsion is to 'neutralise' the anxiety evoked by the obsessional thoughts. E.g. a person with obsessional fears about contamination washes compulsively all day to neutralise the anxiety.

Treatment: Specific medication – clomipramine (Anafrnil) or fluoxetine (Prozac) plus cognitive behaviour therapy (exposure plus response prevention).

The extent or severity of this disorder is often missed due to the person's embarrassment or 'silence' over this.

Post-traumatic stress disorder

The main features are the development of characteristic symptoms, e.g. 'flashbacks', nightmares, intrusive thoughts or recollections following a traumatic incident. The traumatic incident is defined as an event outside 'usual' human experience that would be markedly distressing to almost anyone' e.g. being in an earthquake, a combat zone, a victim of rape or robbery, motor vehicle accidents or natural disasters.

Treatment: No one designated treatment currently exists, but various medications can be used (either anti-depressant or anti-anxiety) plus a variety of psychological treatments, e.g. supportive counselling, behaviour therapy, and psychotherapy. A new emerging treatment for this disorder is called eye movement desensitisation and reprocessing (EMDR). This approach is still to be empirically validated.

Problems may emerge if the disorder goes untreated.

Adjustment disorders

The essential feature these is a maladaptive reaction to identifiable psychological stressors, e.g. death of a loved one, marital separation or occupational loss.

Treatment: Treatments vary and may include anti-anxiety or anti-depressant medication and/or a range of psychological treatments, e.g. relaxation training and various counselling methods.

Problems may emerge if the disorder goes untreated.

Personality disorders

These disorders refer to behaviour traits, characteristic of the person's recent and long-term functioning, that interfere with the person's life. The primary personality disorders that present with alcohol and other drug problems are anti-social personality disorder (often referred to as sociopathic or psychopathy) and borderline personality disorder.

Anti-social personality disorder

This is characterised by a long-standing pattern of irresponsibility and/or anti-social behaviour dating back to the person's adolescence or childhood. Examples of anti-social behaviour in adulthood are stealing or illegal activities, impulsive or aggressive behaviour and manipulating or 'conning' others.

Borderline personality disorder

This is characterised by a pattern of instability in self-image, relationships and mood, starting by early adulthood. Examples include unstable and intense relationships involving extremes of overvaluation and devaluation, self-damaging impulsiveness, mood shifts, inappropriate and intense anger and suicidal or self-mutilating behaviour.

Treatment: There is no treatment program for a personality disorder; rather, this needs to be acknowledged in treating particular individuals. There is also the view that many personality disorders are not amenable to treatment.

Misconceptions: Similarly to phobic disorders, an under- or overestimation of personality disorders can occur.

DUAL DIAGNOSIS

Categories

1. **Primary substance abuse:** This is where the person has started using a drug (e.g. alcohol) and have what is called a psychotic episode. In other words, they start displaying the symptoms of a mental illness. The drug use has come first.
2. **Primary psychiatric disorder:** This is where the person has experienced the symptoms of a mental illness and then they start using alcohol or other drugs. Often this is referred to as self-medicating. The individual does not like experiencing the symptoms of the mental illness so takes drugs to try and deal with the pain, distress or discomfort of these symptoms.
3. **Dual primary diagnosis:** This is a category which most appropriately fits the label 'dual diagnosis' as we see it in the field. It is where two initially unrelated events may interact to exacerbate each other. People have both the mental illness and the drug-using behaviour but there is no indication that one has triggered the other.
4. **Dual diagnosis reflecting common predispositions:** In this category, common underlying factors may predispose a person both to mental disorders and to substance abuse. This is controversial because it relates back to a genetic predisposition to certain conditions, e.g. alcoholism.

The social face of dual diagnosis

People who suffer from the symptoms of dual diagnosis are faced with two of society's major stigmas, i.e. mental illness and AOD abuse.

Literature suggests those with dual diagnosis problems also tend to have other life problems. They have high rates of suicide, worse psychiatric symptoms, fewer and poorer social supports, are more resistant and non-compliant to treatment and medications, more likely to turn to crime and to be homeless or itinerant.

Many people with mental illness appear to become readily dependent on alcohol and other drugs. A certain number of mentally ill people who would once have been institutionalised find it difficult to maintain relationships with family, friends or in group homes. Many will become transient and homeless. These people are often considered unmanageable by both mental health and AOD services. Neither sector has come to terms with treating clients with dual diagnosis appropriately.

This is because of:

- traditionally different philosophical background and attitudes towards the treatment of clients – education of workers has been different and kept separate;

- lack of appropriate education and training for mental health and AOD workers in ways to treat people with dual diagnosis;
- lack of liaison, networking and referral between mental health and AOD agencies;
- growing numbers of itinerant people with dual diagnosis moving through country areas with less services;
- lack of comprehensive and appropriate case management;
- lack of outpatient or residential treatment facilities for people with dual diagnosis;
- generally speaking, no integrated approach between the two community health sectors of AOD and mental health.

Each agency will have its own policies and procedures for working with clients with mental health problems. Unfortunately, very few agencies are willing to work with people with dual diagnosis. It has been a difficult situation for many years. This has left us with organisations that are only resourced to deal with one or the other problem. Slowly it is being recognised that we have many clients with dual diagnosis and the two fields of welfare need to train their staff to assist these clients. Part of your training is the information that you have received here. AOD workers need to learn and understand more about mental illness so they can recognise symptoms and assist clients accordingly.

Another area of mental illness which needs to be studied in detail is suicide.

SUICIDE

Definition: Suicide is when a person kills him or herself.

A very important aspect of mental health issues is recognising and dealing with potential suicide cases. Below is some general information to assist you with these issues in your clients.

The following information is from:

Axten, D., Waters, R., Evans, R., Evans, B., *Walking on the Edge – Suicide Intervention* Communication and Counselling Skills, Lifeline Queensland. Queensland University of Technology.

Clients at risk of suicide

Anyone can be at risk of suicide and it can be for a variety of different reasons. However, there are some high risk groups:

- men, particularly young or older;
- young Aboriginal men/adolescents;
- people who are functionally alone, e.g. never married, separated, divorced or widowed;
- those with psychiatric disturbances;
- those who have problems with substance abuse.

Verbal indications someone may be thinking of suicide:

Statements such as:

- “When I’m gone ...”
- “I won’t be bothering you anymore”
- “It doesn’t matter now – nothing matters anymore”
- “It’s hopeless. Nothing’s going to change the situation.”
- “I can’t handle this anymore.”
- “I’ll show (so and so)... they’ll be sorry... I hope they’re satisfied”
- “You won’t need to worry about me for much longer”
- “I can get one step lower”

Behavioural indications someone is thinking of suicide:

Direct:

Previous suicide attempt

Indirect:

- Sudden uncharacteristic behaviour change – withdrawn instead of outgoing (or vice versa);
- increase or decrease in level of energy and activity;
- putting things in order (“I have given away some of my things”);
- saying goodbye to people, withdrawing;
- disturbed eating pattern;
- change in sleep patterns;
- unkempt appearance;
- giving away prize possessions;
- increase in minor or psychosomatic illnesses or visits to the doctor for no apparent reason.

A special case – sudden improvement:

After a time of deep depression, sudden uncharacteristic improvement where the person seems at peace.

Situational context

Any situation can be involved – what’s important is the perception of the person regarding that situation and their level of sadness. They include:

- situations involving major loss for the person;
- diagnosis of terminal illness;
- recent move to an institution;
- physical, emotional or sexual abuse;
- divorce or separation of parents (youth or children);

- running away from home;
- court involvement;
- failure in areas of importance e.g. exams.

Assessing the risk

As with any assessment, you will use your counselling skills to listen to the client. Empathy and non-judgmental approach is required. Giving the client plenty of time to talk about the issue.

Given that the indicators of a suicidal person may not be absolutely clear, it is important for the assessment worker/counsellor to assess the degree of risk.

From the outset, if the worker is alerted to suicidal potential, it is very important for the worker to confront the client in a caring manner about the worker's observations. Ask about suicide: "I have a very important question to ask you... Are you thinking about suicide?..... about killing yourself?..."

This can be one of the most difficult, but also one of the most liberating questions to ask. It is difficult in that it raises the fears of the worker in triggering a suicide response. It is liberating in that it allows the client to ventilate pent-up feelings and fears which have been adding to the psychological pain.

If suicide is indicated, ascertain the risk.

1. **The suicide plan.** Is there a definite suicide plan, with available weapons or other means?
2. **The sources of stress.** Are there significant (multiple) changes and/or losses and/or unmet needs felt or perceived by the client?
3. **Internal coping mechanism.** What is going on within the client in order to cope with the stressors?
4. **External mechanisms of coping.** Is this client functioning alone or are supports available and accessible for the client?

Intervention

Having established that the client is at risk of suicidal behaviour, and having assessed the degree of risk involved, the counsellor is then ready to move to the next stage of the process, intervention.

At this point the form of the intervention will differ according to the assessed degree of risk. Basically, the higher the risk, the more quickly and directly the counsellor will act to ensure the client's safety.

This may involve progressively increased intervention or action to expand options, to set up and to make contact with support systems, to seek additional professional help, to reduce lethality, to buy time, and to

conclude a 'no-suicide' contract with the client.

A characteristic of the suicidal person is tunnel vision. It is, therefore, not easy to expand their options. It is possible, however, to explore their ambivalence. Explore openly with the client what it is to be walking on the edge. Walk with them on the edge, looking not only at the pull towards killing oneself, but also looking at the pull towards life, however small it may be. If possible, attempt to reframe self-directed expressions of anger; attempt to challenge irrational statements. Focus, if possible, on life-related issues. Remember, however, that a person in the depths of suicidal despair may not be at all logical. Gradually moving the client's focus from emotional and impulsive responses to more rational responses is an important step in the helping process. Short-term goals will be important. Longer-term goals at a later stage can include developing coping skills and environmental change.

The matter of setting up support systems and referral to additional professional help is a clinical judgement requiring good sensitivity and timing. It will also depend on the counsellor's experience and intuition. A rule of thumb for those counselling suicidal people is, '**If in doubt, DO!**' Suicide is not simply an individual and personal problem, but is also a social/community issue. Counselling processes, which tackle systemic issues, will be important once the more immediate issues of the safety of the client are assured. Contact may include family, school and workplace as well as any professionals involved in current treatment and the involvement of a variety of helping agencies. As clinical depression is evident in many suicidal people, counselling in conjunction with medical or psychiatric treatment can be very important. If the client is already receiving help from another professional, support your client in using this help.

Referral Agencies

Each agency needs a list of appropriate referral agencies in their geographical area. It would also help to have a regular meeting between agencies so workers are not trying to contact agencies only in times of emergency.

Activity 1

1. What are some of the agencies for mental health referrals in your area? Include contact phone numbers.

ALCOHOL-RELATED BRAIN DAMAGE

Reference: *Connexions Magazine; Alcohol-Related Brain Damage.*
March/April 1989 Vol. 9 No. 2.

Definition and types

Frontal lobe deficit

Damage occurs in the front part of the brain, we think as the direct result of toxicity of alcohol.

Although frontal lobe deficit usually occurs before there is evidence of other types of brain damage it is difficult to detect, particularly in its mild form. The problem in detecting frontal lobe deficit is compounded by the fact that there is no firm scientific evidence to indicate the precise level of alcohol consumption likely to lead to its onset. The difficulties faced by people with frontal lobe damage are the ability to:

- form concepts;
- plan tasks and organise information or ideas;
- be flexible;
- learn from mistakes.

Wernicke-Korsakoff's Syndrome

This type of brain damage was originally defined as two separate brain diseases – Wernicke's encephalopathy and Korsakoff's psychosis. Later they were seen to be linked. Wernicke's disease is the result of poor nutrition, specifically a deficiency of thiamin (vitamin B1). The most common but by no means only cause of this deficiency is alcohol consumption.

People suffering from Wernicke's disease usually show one or more of the following signs:

- nystagmus, or paralysis of the eye muscle;
- ataxia or an awkward way of walking;
- confusion.

Administering thiamin, or vitamin B1, can reverse these effects and, in cases where alcohol is not the cause of the problem, there can be complete recovery.

When alcohol is the cause of the thiamin deficiency, administering thiamin can reverse that part of the problem but most people are left with another legacy: the type of brain damage known as Korsakoff's syndrome. This is believed to be caused by the toxic effect of alcohol on the thiamin-depleted brain. The main characteristics of Korsakoff's syndrome are memory problems, sometimes described as recent or short-term memory loss. Severe cases are easy to detect but milder forms can only be identified by neuropsychological testing.

People with mild memory problems may find these become more obvious if they are in demanding jobs or have to learn new information.

As the disease progresses, people:

- become incapable of holding down even the simplest of jobs unless they have held those jobs for many years;
- find that anything new is beyond them;
- feel quite disorientated in a new environment or in the face of new information.

People with complete Korsakoff's syndrome cannot retain any new information for more than about three minutes. Their longer term memory is not affected in the same way, but memories are usually confused and out of chronological order.

DOMESTIC VIOLENCE

Reference:

Connexions Magazine; Family Violence. January/February 1990 Vol.10 No.1 P7-18.

Definition

Domestic violence is defined as violence, usually against women and children by men in family situations such as the home.

Exists on a continuum from verbal, emotional, psychological and physical abuse to murder.

Includes destroying property and pets; isolating the individual; social abuse disempowering the individual; systematic control over another with regulation of their behaviour; withholding money or use of phones; controlling access to family and friends; can include sexual assault in the relationship.

Basically domestic violence arises from inequality and differences in power between the sexes. The problem is greater for women who:

- have never worked;
- have small children;
- no money of their own.

Relevance to AOD workers

People who are experiencing domestic violence may be using alcohol/drugs as a coping mechanism.

Alcohol can play a part in the perpetration of domestic violence but there is no proof that there is a cause/effect relationship.

Alcohol and other drug use often used as an excuse for being out of control. Usually this is not true.

Myths about domestic violence

- “It is a working-class issue.”
- “It is to do with lack of education.”
- “Men are frequently jailed for it.”
- “It is the result of AOD abuse.”
- “There’s no point in helping the victim, she will only return to him the next day.”
- “The victim deserves it or enjoys it and could leave if she didn’t.”
- “A woman is the property of her husband/boyfriend.”
- “It is a private matter.”

Needs of survivors of domestic violence

- First priority is the safety of the woman and her children from the perpetrator.
- Do not underestimate her fears. She needs to be believed and taken seriously.
- Support.
- Information on social services available for her and her children.
- Somewhere to live, finances, education for the children.
- Help to decide on legal action.

Legal problems for victims of domestic violence/AOD problem

- The woman may be unable to give a statement due to the effects of drug/alcohol.
- The matter is more likely to be dismissed unless an independent witness was present.
- The legal system may frame the woman as “just another drunk”, blames her for the violence and leave her with no protection.
- If the matter does proceed she may be looked upon as an unreliable witness if she cannot remember events.

Impact of traditional treatment programs for the AOD-dependent victim of domestic violence

- AOD treatment programs often do not assess for adult domestic violence.
- Even if domestic violence has been identified, it is often assumed that the treatment for the AOD abuse must occur before the violence can be addressed.
- Concerns with “sobriety first” approach is that it does not consider the increased risk of violence that a woman’s recovery may precipitate.
- Perpetrators are often resistant to their partners attempts to seek help regarding their drug use.
- Even if a victim of domestic violence completes a treatment program for drug use and returns home to the perpetrator it is likely that she will relapse if the violence has not been addressed.

Role of the assessment worker

- To try and ensure the safety of the woman and her children by being aware of facilities that will provide this safety.
- To be supportive, to allow the client to unburden herself without shame or fear.
- To inform client of options available to her and her children.
- To provide crisis intervention and possible short-term counselling
- To assist with follow up referrals – including court support.

The effect that domestic violence can have on treatment plans

- The woman may need a female assessment worker/counsellor.
- If wanting help for AOD issue, consider safe rehabilitation in your referrals.
- Women who experience domestic violence often have low self-esteem and require treatment programs that address these issues

Referrals

Domestic Violence Line 1800 656463 or 1800671442

Child and Family Crisis 1800 425288

Women’s Information and Referral 1800 817227

Kids Helpline 1800 551800

Referrals in your area include:

SEXUAL ASSAULT

Reference

Connexions Magazine; Child Sexual Assault. May/June 1993 Vol. 13 No. 3

Definition

Sexual assault is an offence where an adult or someone bigger than the person uses their power or authority to involve them in unwanted sexual activity.

Sexual assault does not just refer to sexual intercourse. It can include fondling genitals; masturbation; oral sex; vaginal or anal penetration by the finger, penis or any other object. It may also include exhibitionism and suggestive behaviour.

Why is this an important issue in the AOD field?

It is estimated that 70% of women presenting to agencies with AOD problems are survivors of adult or child sexual assault.

The Australian Institute of Criminology reported a high incidence of drug abuse in women in prisons and a high level of child sexual or physical abuse in their history.

A study with the Family Planning Association found that out of 73 women at a shelter in 1990, 34 said they were incest survivors, 46 said that they had been raped as adults and 61 were abusing alcohol and/or other drugs.

Studies at Macquarie University on Sydney Street Kids has found that 82% of females and 29% of males said they had an unwanted sexual experience by the time they were 11. They also found that sexual abuse and regular and heavy use of drugs especially via injection were significantly associated.

The role of the assessment worker

As a worker you need to be aware that sexual assault issues may come up at any time during the assessment. Unless you realise this you may not be of any help to someone who has been sexually assaulted.

It is appropriate to listen to them because that is exactly what did not happen to them when they were sexually assaulted.

Many clients that have been sexually assaulted need safety and privacy; a non-judgmental attitude; understanding of the trauma; an opportunity to talk at their own pace; their experience validated as significant; encouragement to accept help and support.

How may treatment plans be affected?

Clients because of their sexual assault experience may feel mistrust, and scared this may surface early in recovery from alcohol or other drug abuse. Research has shown that women who have been sexually assaulted are more often likely to complete treatment if they are in a women-only treatment centre.

The percentage of males who have also been sexually abused is also very high amongst AOD clients. Traditionally these issues have not been dealt with well in any rehabilitation setting and further research on worthwhile treatment need to be supported and encouraged.

Activity 3

1. What are the referral agencies in your area for clients who have experienced sexual abuse?

AGENCY POLICIES AND PROCEDURES

Each agency should have policies regarding working with clients that have both alcohol and other drug problems co-existing with mental illness and/or alcohol-related brain damage. They should also develop policies and procedures for working with clients who have experienced sexual assault and/or domestic violence. It will take further education and development before many agencies begin to work together and deal appropriately with clients that experience these conditions.

UNIT SUMMARY

You have now covered the areas of dual diagnosis, ARBD, sexual assault and domestic violence. All of these areas are very relevant to the AOD field. When appropriate, clients should be assessed to ascertain whether they have any of these special conditions in their life. At the various agencies at which you will work, questions should be designed to fit into the assessment form to address these areas. If we ignore these special conditions it will have consequences for the effectiveness of treatment.

UNIT REVIEW

Now you should be able to understand the special conditions of dual diagnosis, ARBD, sexual assault and domestic violence and their important links to the AOD field.

Can you answer the following questions confidently ?

1. What is dual diagnosis in the AOD field?

2. What are some of the problems people experience getting treatment when they are suffering from dual diagnosis ?

3. Describe some of the indicators of suicide risk.

4. Why is important to know about the issues surrounding domestic violence if you are an AOD worker?



UNIT OF STUDY NO: 3

CASE MANAGEMENT

OVERVIEW

Most agencies that work with clients over a period of time develop a system of case management. The system at your agency may very different to what is expressed in this unit. Remember that the knowledge in this unit is based on competency standards and the latest research in the area.

In this unit you will further your skills in working with clients. This is where you learn how to support and guide a client towards a case management plan, but remaining mindful of the importance of encouraging the client, to make their own decisions. You will learn the importance of creating a balance between informing the client of the possible options, but avoiding jumping in and playing the expert with set answers.

The principle behind this case management process is to empower the client, show them there are steps towards solving problems through developing goals and work out strategies to achieve those goals. You will gain an awareness of this process through a goal-setting exercise of your own. Hopefully through this exercise you can recognise that ambivalence always exists regarding introducing change into our life. Hence we need to continually acknowledge and respect this situation with our clients and adjust our interaction accordingly.

GOAL SETTING

After some feedback on the assessment, a first step in instigating any change is to set clear goals towards which to move. This is the beginning of a case management plan. In other words, the client needs to name what they want to achieve. A goal is an outcome, an achievement. Counselling in the case plan stage is about assisting the client to become more intentional. (At the assessment level you are defining the problem and all the issues surrounding it.) Clients often get stuck or blocked in their ability to problem-solve. They have certain ways of dealing with life's problems, e.g. drinking or drugging. They are looking for new ways to deal with the issues. Setting goals is about describing a new place or scenario, developing a picture of what the problem situation would look like if it were being managed more effectively. In case planning it is our job as AOD workers to assist clients in setting goals for themselves. We can do this by asking some key questions. You do not have to ask all these questions, but choose a few that you feel will help to make it easier for the client to set goals.

Questions are from Egan, Gerard. *The skilled helper A systematic approach to effective helping*. Chapter 9, Stage II: Creating New Scenarios and Setting Goals. Brookes/Cole Publishing Company Monterey, California, 1986.

Key questions to use with your client

Questions for you to ask

- How would you like things to be different ?
- What is it you want to change ?
- What would this problem/situation look like if it were managed better?

Questions for the client to ask themselves

- What changes would take place in my present lifestyle?
- What would I do differently with the people in my life?
- What current patterns of behaviour would be eliminated?
- What patterns of behaviour would be in place that currently are not?
- What would exist that doesn't exist now ?
- What would be happening that is not happening now ?
- What would I have that I don't have now ?
- What decisions would be made and executed?
- What accomplishments would be in place that are not now?

The advantages of goal-setting

There are many advantages to assisting your client in setting goals. It helps the client focus their attention and action. Setting goals starts the client moving forward and teaches them ways for resolving issues rather than getting stuck.

However, we also need to help clients evaluate their goals. You do this by assisting them to always state goals as accomplishments rather than behaviour. Goals also need to be realistic, within the control of the client and adequately address the problem situation that they are trying to manage. The goals also need to be the client's goals rather than ones we impose on them.

In summary goal-setting helps your client arrive at a plan of action which they have created themselves.

For further information on this read

Egan, Gerard, 1986. *The skilled helper A systematic approach to effective helping*. Chapter 9 Stage II: Creating New Scenarios and Setting Goals. Brookes/Cole Publishing Company Monterey, California 1986

Activity 1

To illustrate issues around change and developing goals you can do an exercise where you consider some change that you want in your life.

Instructions:

1. Think of something in your life that you would like to change. Try and keep it simple, e.g. I would like to lose two kilos, give up biting my nails, take up exercise.
2. Draw a picture of yourself as you imagine you will be in the new scenario when you have achieved your goal or goals, e.g. a picture of yourself slimmer, with longer nails or lifting weights. Do not worry about your drawing skills, that's unimportant – just have fun with the exercise and use your imagination.
3. When you are finished, describe your drawing in terms of how you see yourself achieving these goals or goal. Remember write your goals as accomplishments.

How did you go? Was that a useful exercise in helping you imagine your goals ?

Do you think you could use the exercise with clients? How would they look being a non-drug user or a controlled drinker?

Reason for this exercise

People aware they have a problem with drug use come to us as an AOD worker because they want some sort of change in their life. They have a goal of change even if they are uncertain of what strategies will get them there. That is where they want assistance from you. Case planning is about creating “a new scenario” with the client for their life. The visual expression of this scene can give the client that clear image of how good the change can be. It is something that they can look back at if the going gets tough at any time.

THE BEST STRATEGY OR STRATEGIES

After you feel you have exhausted every possible strategy in your brainstorm, it is time to examine the strategies and to choose the most appropriate ones to achieve the goal. You would use this same technique with a client. Decide the best strategies.

The criteria for choosing strategies are:

- Does it adequately suit the goal?
- Is it realistic and set in a reasonable timeframe?
- Does it fit with the your values?

Write down here your best-fit strategy or strategies that meet the criteria.

PROBLEMS ASSOCIATED WITH DEVELOPING PLANS

There are always problems when setting plans. How many times have we set that goal to give up smoking or go on that diet? We may have even worked out some strategies that seem to sound realistic. However, when the day comes for action we put it off. If you have worked with clients you may have seen this happen as well. What you need to examine next is all the gains, but also especially the losses, if you chose that course of action. The reason for this is to examine whether it is the appropriate action.

The decisional balance sheet will achieve this. Again you will test this system out on yourself first. You would also use the same method with a client.

Decisional balance sheet

Activity 3

Fill out this decisional balance sheet for yourself in accordance with the strategies that you have chosen.

Write down your chosen strategies and then fill in the boxes.

Strategies

- 1.
- 2.
- 3.
- 4.

The self

Gains for self (what will I gain by using this strategy)	Acceptable to me because (This strategy is acceptable to me because)	Not acceptable to me because (This strategy is not acceptable to me because)
Losses for self (If I use this strategy I will lose)	Acceptable to me because	Not acceptable to me because

By using the decisional balance sheet hopefully you will tease out some of the underlying ambivalence/resistance towards the strategies you have chosen that you may have not been aware of. The next step will illustrate how to assist with these issues. There is another step to go through to assist with this resistance to bringing about some change in your life. The client would experience similar internal resistance and you would need to work with them in the same manner.

You need to ask yourself:

“Now that I have this plan, what may stop me from acting on it and what will assist me to act on it ?”

Activity 4

Carry this through yourself with your goal

To achieve success

What are the things that will stop me achieving my goal?

How do I decrease these? _____

What are the things that will help me achieve my goal? _____

How do I increase these? _____

WRITING A CONTRACT

Finally, to increase the possibility of achieving the goal the client writes a contract for themselves. This helps them to commit to action. The contract needs to be clear, stating the goal and the decided strategies. It also needs to be signed. A date for review can be put into the contract.

A sample contract

On 10th October, 2000, I, John Smith, will commence a regular walking program to become fit, energetic and trim.

My goal is to establish a regular walking program in two months. This program will then become a normal part of my life.

Strategies.

- *Walk for at least 30 minutes, three days a week .*
- *Go on the days that I do not have an early work starting time.*
- *Go to bed early on the nights before I walk.*
- *Get work clothes ready the night before.*
- *Pamper myself when I reach the goal.*
- *Walk the scenic route around the park.*
- *Acknowledge the difficulty in change and pat myself on the back often.*
- *Visualise the feeling of achievement and satisfaction.*

Signature

Activity 5

Write your own contract. State in it the goal, the strategies that you will undertake to achieve the goal and a time by which you will achieve the goal.

Don't forget to sign your contract.

Activity 6

Go through this procedure with the colleague who is acting as the client in your role-play.

1. Discuss with the client's preferred scenario with them.
2. Get them to set their goals.
3. Work out strategies to achieve these goals.
4. Use the decisional balance sheet.
5. Discuss 'restraining forces' and 'facilitating forces'.
6. Help your client develop a self contract

Write down all the different stages below as you have for yourself.

1. The client's goals _____

2. The brainstorm _____

3. The preferred strategies _____

4. Decisional balance sheet _____

5. Restraining and facilitating forces _____

6. The contract _____

Activity 7

1. What were some of the problems when carrying out this task? _____

2. Did you want to jump in and tell them what to do? _____

3. How difficult was it to keep a balance between supporting and guiding your client but allowing them to make their own decisions? _____

4. What are the social and cultural needs of your client at the point of case planning? _____

5. Each of your clients has one of the conditions mentioned before in the previous unit e.g. ARBD etc.
How would this affect your approach to case management? _____

Treatment options

Once the client has decided on some realistic strategies, you may be able to assist the client with available treatment options. It is best to allow the client to work out their own strategies first before jumping in with the options. The reasons for this are:

- The process of case management, setting goals etc. is a method of problem-solving. This is a skill that they can transfer to help solve other problems.
- They get the opportunity to see themselves working it out – this is empowering.
- Once they are set on the process they can then consider options. Be aware of what can help them there

You are the person with the knowledge on available options but it is important to introduce them at a time when the client feels ready to hear them as possibilities. They can then discuss the pros and cons of options through the method of the decisional balance sheet rather than just rejecting them out of fear.

Relapse prevention

In the 'stages of change' model, relapse is considered a normal part of any attempt to change behaviour. The example often given is that smokers usually go through the cycle three to five times (hence relapsing three to five times) before being able to finally give up completely. There is no reason to think this does not happen with all drugs, if not with all behaviour change. In the past in AOD work, relapse was often seen as failure and that the individual had to go back to the beginning, virtually in disgrace. This occurred even if people had experienced years of abstinence from drug use.

Now we look at relapse as a valuable learning period and we do not forget all that has been gained during the other stages, especially the maintenance stage.

Despite this we naturally want to work with our clients to do everything that we can to prevent the relapse from occurring. If it does happen, we need to at least equip them with the skills to not feel a failure and to be able to get back on track again.

Jarvis, Tebbutt and Mattick (1995) state that:

“relapse prevention training is about demystifying relapses. That is, it aims to help clients move away from the belief that staying abstinent is only having a sufficient amount of ‘will-power’. It also aims to reduce the overwhelming dread of ‘failure’ by emphasising that behaviour change is not an ‘all or nothing’ event.”

1. Find out about previous relapse

Chances are that your client has tried to give up using, perhaps in a variety of different ways, before coming to see you. This is something that can be discussed at the assessment stage. Sometimes it is something they volunteer easily because that is why they have come to you, because they see the other times as failures. Learn what happened last time in detail. What did they attempt before to change what led to the relapse? It is all valuable information in avoiding future relapses.

2. Discover the risk situations for your client and then grade them from high to low.

Everyone has different triggers that will set them off using/drinking again. You need to find out from your client what the areas of risk are for them. Then there are levels of risk. For one person, maybe walking past the pub is a high risk for starting again. To another, it may be feelings of anxiety. To other clients these may be low-risk situations. Each individual has their own pattern. Do not make assumptions about what your client's relapse patterns are; work with them to discover what they are. Sometimes clients have not thought about this themselves. The trigger for them can be a subconscious impulse. So discovering it with them may take time and effort.

3. Work out new ways of coping with risk situations

Basically once you have discovered risk situations, you need to work with your client on how to cope with them. This may mean a series of different techniques to deal with the variety of risks and their different levels. It has been thought in the past that avoiding high risk situations was the answer, but the client really needs to learn successful ways of dealing with them.

For example, someone's high risk maybe walking past the pub, however it is their only way to the supermarket so they will need to work with you on strategies on how to deal with this.

4. Develop your own way of dealing with the high risk

Each client needs to develop their own plan of action of dealing with risk situations. It is something that you can assist them with, but they need to develop their own strategies and skills.

5. Reward yourself for your success

Giving up or modifying using/drinking means that the client is losing something they like. So as not to feel deprived – as this could be a high-risk situation – they need to instigate some rewards that will make them feel proud of their achievement. That does not mean that instead of a drink they have a chocolate bar. However, perhaps if their trigger is anxiety and they have been successful with coping with that they could treat themselves to a massage once a week. People often find it difficult to reward themselves, so you will need to work with your client to develop strategies for rewards as well.

6. Skillpower vs willpower

Introduce the idea that dealing with the possibility of a relapse is about learning new skills, not about willpower. Willpower relies on guilt.

7. The technique in summary

- Identify specific risk areas – what are the triggers to using/drinking again?
- Brainstorm strategies to deal with every risk situation.
- Choose strategies that best fit the individual.
- Work out an action plan to put these strategies in place.

This information was adapted from: Jarvis, T. Tebbutt, J. Mattick. R, *Treatment Approaches for Alcohol and Drug Dependence - An Introductory Guide*. John Wiley and Sons. Chichester 1995.

Preparing for a lapse

Often nowadays we speak of a 'lapse' rather than a relapse. This is to distinguish between the times that someone doesn't go right back to their original behaviour, but just steps into it again. To avoid the sense of guilt and condemnation this can bring about, which can often lead to more using, there is a technique to deal with this.

The relapse drill

The client lists the conditions (both situational and emotional) under which they would be most likely to continue to drink or use drugs after an initial slip.

Then encourage your client to brainstorm a number of different strategies that he/she could use to stop further use.

Generate an action plan

When appropriate, "relapse drills" could be role-played.

Talk about the bigger picture of lapses and relapses

Learning anything new involves making mistakes.

Other lifestyle issues important in maintaining change

Always consider the rest of the person's life and how treatment has to work in with this. Identify rewarding activities to replace what they have lost in using.

AGENCY POLICIES AND PROCEDURES

In each agency there would be appropriate policies and procedures concerning assessment of suicide risk, detoxification, alcohol-related brain damage and psychiatric co-morbidity. This would have to be integrated into your case management plan.

UNIT OF STUDY NO: 4

REVIEW AND EVALUATION

OVERVIEW

You have gone through the process of assisting the client to set some goals, decide on some strategies, discuss the problems about maintaining the plan and then preparing a contract. The client, with your assistance, will set these plans into action and hopefully they will reach goals they set out to achieve. Part of the plan should include reviewing times and a time for completion. Written records of all these plans must be kept so you can assess and evaluate the progress of the client as well as your own work in accordance with organisational policies and available resources. Each agency requires a care plan for the clientele they serve, so you can evaluate your work against it.

Information needs to be given to the client about how records are kept and the level of confidentiality about these. Sometimes clients require a report to be written to another agency regarding these plans and their progress. Each organisation will have its own methods but there are certain guidelines to follow, which are set out in this unit.

REVIEWING PROGRESS

At the time of developing a plan you will also need to decide on how often this plan will be reviewed between you and your client. Some clients require more assistance than others and this will need to be discussed. In residential programs, workers will be able to view clients' progress more readily. In an outpatient service, whenever the client comes to see you there will need to be set times for reviews to take place. In most organisations there are policies and procedures regarding review of the client's progress and this will need to be adhered to wherever you are working.

Sometimes goals will change and therefore new strategies will have to be developed. For example, occasionally people who start a controlled drinking program may later decide that abstinence is a better goal for them. Therefore, strategies will have to be adjusted. Sometimes clients will relapse and you need to examine the trigger, but not view it as a failure. Remember the 'stages of change' model and how relapse is just part of the cycle. It is when we haven't foreseen all the possible triggers and planned accordingly that relapse occurs. This is no failure on the part of the client or the worker and it is just a matter of using the case planning again with the potential relapse triggers involved.

A time for the client to either exit a set program or move on from receiving your assistance needs to be negotiated. Many organisations have set limits on how long a person can stay in a program or seek assistance from a counsellor. The client needs to be aware of this from the time they enter the program or the counselling.

Exiting a program or leaving the support of a counsellor can often be a very stressful time for a client, no matter how well they are doing. As a worker you need always take this into account and prepare the client for this ending. You can do this by discussing, right from the very beginning, the limits of the organisation and what they can expect at the end. Sometimes it is appropriate to refer clients on to other agencies but this also needs to be discussed with them. You will learn more about this in the next unit on referral.

Each agency will have its own program of how to assist people with an AOD problem. Below is just an example of a way of working with a client to assist them. It is a cognitive behavioural technique called cognitive reconstructing.

For more of these techniques and ideas read :

Jarvis, T. Tebbutt, J. Mattick, R., *Treatment Approaches for the Alcohol and Drug Dependence - An Introductory Guide*, Part II p65, John Wiley and Sons, Chichester 1995.

Cognitive reconstructing

This is a technique where the worker assists the client in turning their negative self-talk into positive self-talk. After the assessment process with the client, goals are set in order to deal with the client's problem. All the planning of goals, strategies, etc we do as workers with our clients will amount to nothing if the person's negative self-talk convinces them that they are unable to carry it out because of a negative self-image.

Many human beings suffer from negative self-talk. This is where we have an 'internal voice' which continually puts us down and criticises us. We tell ourselves that we can't reach our goals or be successful because of a variety of labels we have for ourselves such as 'stupid' or 'lazy'. This view of ourselves usually comes from our upbringing in some way. The worker using a cognitive behavioural technique is not that concerned about the origin of our negative self-talk but rather how we can help our clients to change it.

Cognitive restructuring is one strategy workers can use with their clients. It helps them to understand firstly, how they may have been unable to overcome this problem before because of the negative self-talk and secondly, how to change it.

Activity 1

Monitor yourself for a week

- 1) How much of your thought and ACTION is based on negative thinking?

Activity 2

1. What are some of the programs used at your agency to assist clients to maintain their goals? _____

2. How do these programs fit into the overall philosophy of your agency?

3. Are the programs regularly evaluated to see whether they are meeting the clients' needs? _____

GENERAL RULES FOR RECORD-KEEPING

Introduction

It is important that all agencies keep clear, precise and appropriate records on their clients and activities that occur in the agency. In the past units you have been studying you have collected a lot of information. It is essential that when you collect information on a client the rules for record-keeping are followed. There are set rules for any record-keeping within the Community Service Industry that must be followed for funding purposes and legal requirements. Keeping client records is a vital channel of communication. Accurate and relevant case notes can save a great deal of time and improve the quality of client care. Accurate records help to track the client's process of change. Even if you are very familiar with keeping records it is worthwhile to read the following points and then do the following activity.

The rules

- Write with a consciousness that the client may see your records.
- Abide with agency regulations regarding record-keeping.
- Accurately record the date and time of each session.
- Write legibly.
- Write clear, brief, objective statements.
- Detail the client's perception of the problem, not your interpretation of what has been said.
- The worker should discuss with the client why records are being kept and their degree of confidentiality.
- Notes should be taken as soon as possible after seeing the client to ensure accuracy.
- When making appointments with clients, allow time between clients for note-taking and review.
- Support any opinions.
- Document the reasons behind any decisions.
- Record the assessment procedure that led to a decision.

Document the following when applicable

- intake and assessment notes
- client contracts
- particular interventions
- goals and expected outcomes
- process of each session

REPORT WRITING

Purpose

Reports are often part of our record-keeping. The way a report is written will depend on its purpose. Reports may be needed for various reasons. They may be:

- requested by the client or their solicitor in response to impending legal action;
- initiated by the worker as they advocate for the client's welfare services/housing needs;
- requested by the probation service or children's services to assist them in case management;
- for the purpose of referral.

Before you write a report

Be clear about your objectives

- What is needed ?
- Why is it needed ?
- How will it be used ?
- By whom ?
- What approach is best ?

Collect your information

- What information is needed ?
- What sources of information will be used ?
- Which part is vital and which part is secondary?
- Do your conclusions follow the facts?
- Does your recommended course of action follow the conclusion ?

Report-writing language

Jargon

Reports should be written in simple, straightforward language – avoid jargon.

Value-laden terms

- Facts and opinions need to be clearly differentiated.
- Avoid using labels and judgments e.g. 'manipulative'
- Keep to the facts and use verbatim quotes where possible.
- Describe rather than interpret.

Tone

Choice of words can affect the tone of a report. Maintain an unbiased stance by using neutral words e.g. "client stated that ..."

First or third person

Either is fine.

First person: "I assessed Mr. Smith on the 2.3.96"

Third person: "An assessment on Mr. Smith was conducted on 2.3.96"

Activity 2

You are to take the case you worked on in Unit 1 (one of the intake examples you used in the role-play for an assessment) and write a report to the referral agency that sent them to you, outlining the important issues of the assessment. Of course much of this you will need to make up or take from the role-play you did with your colleague. Remember the person has been sent to you mainly for your expertise as a AOD worker. This means that the referral agency wants some information on the person's drug problem and your recommendations regarding this problem. Information you gained that is relevant to the drug problem from their family, social, employment sections may be included. It is best that reports keep to about one and a half typed pages. At this stage you've only had contact with the client and have no idea of the accuracy of the information they give, so when making statements use expressions such as:

- "He/she said ..."
- "Joe Bloggs stated ..."

Most reports are easy to read if set out under headings. Below is a formula , however, many agencies will have their own format.

Name of the agency: _____

Date: _____

Referral agency: _____

Date of referral : _____

Reason for referral : _____

Name of the client: _____

D.O.B: _____

Introduction _____

Family and social background _____

Education and employment background _____

Drug use history _____

Action plan or recommendations _____

EVALUATION

Regular evaluation of our work done with clients needs to occur to safeguard the client's right to the best possible care at all times. The client has the right to evaluate the work done with them. In addition, the funding body needs to evaluate the work of the agency in order to justify further funding. Workers also need to have their work evaluated at certain intervals to see whether they are in keeping with the guidelines of the agency. Sometime this is stressful for the worker. They may see themselves as being judged. If evaluation is done properly this can also be a time for the worker to look back and not only see how the client has progressed but also how they have progressed as a worker.

Aspects that are important in the evaluation process.

Each agency should develop an evaluation plan. The key tasks are :

1. Decide on the kind of evaluation to be undertaken.
2. Develop evaluation tools.
3. Develop written policies and procedures.

The role of the worker is to be aware of the particular agency's evaluation process and gear their work accordingly. In some agencies, the clients have the opportunity to evaluate the service given to them through questionnaires and surveys. This gives the agency an opportunity for feedback directly from their customers.

Workers need to undergo evaluation of their work with clients at regular intervals with their supervisor. This is to ascertain whether they are following the policies and procedures of that agency.

Clinical supervision

Clinical supervision is another way that workers can gain some evaluation of their work and assistance for further development in their work with clients. Clinical supervision is where an experienced practitioner in your field assists you on a regular basis, for example a meeting either once a fortnight or weekly to discuss your therapeutic relationship with the client. Clinical supervisors are usually from outside the organisation or from another section of your organisation. They are not your immediate supervisor. Some organisations in the AOD field are now conscious of the importance of providing their workers with clinical supervision in order to develop the professional standards of their workers.

UNIT REVIEW

Now you should have a good understanding of the importance of maintaining good client records. In your continued work with clients, keeping records of their action plans and reviewing their progress is essential to their development. It will also assist you in understanding your progress as a worker.

Can you answer the following questions confidently ?

1. Why is it important to review client's progress regularly against the stated goals?

2. What are the general rules for record-keeping ?

UNIT OF STUDY NO: 5

REFER CLIENTS

OVERVIEW

Trying to refer a client in practice can be very difficult. This is because there may be very few options available in the first place and where there are agencies available, there may be long waiting lists. Not all agencies are clear about their procedures and sometimes cooperation between agencies can be limited. Many people refer clients because they see their problems as too difficult and they are unable to cope. Assessment of the client may not have been carried out thoroughly and the client may be referred too soon or to an inappropriate agency.

In this unit you will examine needs and issues for the client, the worker and the referral agency in the process of referral. Hopefully with this understanding you may be able to go into the field and address some of the difficult issues around referral.

REFERRAL INDEX

It is important that each worker develops their own referral index appropriate to their client group and geographical area they are working in. This can be developed through the help of more experienced colleagues, interagency meetings, visiting agencies or phone calls to connect with appropriate places. Don't leave it till the last moment when your client is in crisis to be flicking through a phone book to find an appropriate referral. This makes it a crisis for your life as well.

Collection of not just agency names but good contact people at the agency always helps when you need to make that referral.

These days there are many referral indexes from which you can draw your information:

- CEIDA's *Annotated Index*
- ADIS
- the internet

Activity I

Just to check your prior knowledge on this subject answer the following questions.

1. What is referral ?

2. Who are the people involved in referral?

3. What are the issues for the client in being referred ?

4. What are the issues for the referral worker ?

5. What are the issues for the agency referred to ?

REFERRAL SKILLS

Below is information on the basic skills of referral.

a) The client needs:

- to feel referral has been chosen, not imposed;
- to feel direction and support from sending agency;
- follow-up and continuity of care;
- appropriate information about the agency, to know what to expect;
- to feel that referral is appropriate and practical.

b) The client's responsibilities:

- to examine options available to him or her;
- to be open to accepting referral;
- to learn to take responsibility for his/her treatment choices and with a worker, to choose what is most appropriate for them;
- to share in the referral process, e.g. talk to prospective agency to be realistic about his/her situation and needs;
- to be give information and facilitate worker's job in matching client up with appropriate referral.

c) Worker's role

What information does the worker need ?

- Information about client's needs in a referral;
- up-to-date information about agencies/services available for your agency's clientele.

d) Worker's skills in referral

- Summarising and clarifying client's problems and needs from the assessment;
- deciding which information is most crucial when determining client's referral needs;
- appropriately matching client information with agency information;
- liaising with the client and other involved workers to determine need and expectations;
- explaining the process and involving the client in the process;
- writing an appropriate referral letter if necessary;
- using as wide a range of services as possible in implementing the referral.

- gaining the client's permission and explaining reasons why certain information must be passed on to the referral agency;
- providing appropriate follow-up.

e) Prospective agency's role in referral

- Making admission criteria clear;
- making clear the type of referral they require and their expectations of worker and client;
- letting the referring agency have follow-up information on progress of the client;
- consulting with the referring worker if substantial changes are to be made to plans for client.

Making a referral phone call

Steps:

1. Explain who/what you are phoning about.
2. Find out whether the referral seems appropriate in principle, by giving an outline resume of the client's situation, history and needs
3. Explain why you are contacting this agency.
4. Check the agency's response to this point.
5. Ask about their expectations of a referral and the client.
6. Ask if they wish to speak to the client.
7. Ask further questions to get any further information you need from the agency.
8. Determine the next step for the client with the agency (e.g. to travel to the agency).
9. Determine whether a referral letter is necessary.
10. Let the agency know they can contact you if they have any problems.

Handy hints

- Make a referral part of the counseling process: your relationship with your client is just as important here too.
- Clients may feel many mixed emotions about referral and making their choices, e.g. fear, ambivalence, confusion. These need to be discussed with the client.
- Be ready to reassess if circumstances change or further information from agency or client upsets your plans, i.e. keep your options and your mind open.
- Be prepared for difficulties, e.g. no available beds at the detox centre.

- Keeping up to date on agencies is important as staff and procedures change.
- Personal contact and familiarity with agencies works best.
- Be aware when it is appropriate to terminate your contact with the client.

Activity 2

Write down three AOD services that you have visited or had contact with through your work. State the name of the agency. Describe what type of agency it is (e.g. rehabilitation centre for women and their children) and their criteria for admission of a client (e.g. client must contact agency themselves / need to be detoxed etc.).

Agency 1

Name: _____

Description: _____

Admission criteria: _____

Agency 2

Name: _____

Description: _____

Admission criteria: _____

Agency 3

Name: _____

Description: _____

Admission criteria: _____

Activity 3

Now go back to the client who you have been working with throughout this learner guide. You started with this client in Unit 1 with an assessment and you have now written a report on this same client. Imagine that you are having to refer them to another agency. Decide what type of agency you think would be appropriate (this of course would have come out of discussion with the client). Now answer the following questions.

1. From the knowledge you have gained through special issues, case planning and this unit, how you would prepare your client to go to one of the referral agencies ?

2. Role-play a discussion with the client about referring them to the agency.
10-15 mins

3. After the role-play answer the following questions.

a) What were some issues affecting the referral to come up in the role-play ? _____

b) Ask the person playing the client how it felt being referred?

c) What did you learn from this activity that would help you next time you referred a client? _____

UNIT REVIEW

Now you should be able to understand how referral fits into the whole process of working with clients. It is a vitally important part but needs to be done well to facilitate worthwhile change in the client's life.

Can you answer the following questions confidently?

1. What are some of the needs and responsibilities of the client in referral? _____

2. What does the worker need to find out regarding referral?

3. What are some of the pitfalls that need to be avoided when making a referral? _____

APPENDIX

APPENDIX 1 – Basic communication and counselling skills

APPENDIX 2 – ‘Stages of change’ model

APPENDIX 3 – Comprehensive assessment form

APPENDIX 4 – Information on role-plays

APPENDIX 5 – Case studies

APPENDIX 1: BASIC COMMUNICATION AND COUNSELLING SKILLS

If you would like more detailed information you can purchase:

Interpersonal Skills 4341A – learner's guide from
OTEN
51 Wentworth Rd
Strathfield NSW 2135

Basic skills are

- understanding non-verbal communication;
- attending skills;
- active listening;
- reflective listening;
- open questions.

Non-verbal communication

Verbal communication is the spoken word. Non-verbal communication is all that may go along with or without the spoken word, e.g. gestures, facial expressions body posture. Non-verbal communication is often referred to as body language. It has been suggested that non-verbal behaviour contains 93% of the emotional impact of a message.

If so much of the message someone is sending to us is through their non-verbal communication, it is therefore vitally important that we take note and begin to understand this type of communication. It is also crucial that we become aware of our own non-verbal communication so we are sending the appropriate message.

One of the primary reasons for considering non-verbal communication in the context of effective communication with clients is that it gives valuable cues to the client's emotional state of being, thus enhancing the depth of the communication between you.

Attending behaviour

The other part of non verbal behaviour is "attending behaviour". This is our actions, gestures, etc. that we display to the client. This also includes the environment the client encounters in our agency and how this is designed to welcome the client.

As workers in this field we need to be conscious of the impression we give in what we say and in our body language. Also important is the complete picture of how we present ourselves and our agency.

If working in an agency the first thing to consider is the environment and what that communicates to the clients.

What is the space that clients/customers are to enter like?

Appropriate and effective attending behaviour is about developing rapport with the client.

A safe and comfortable environment expressed through the surroundings and the workers' behaviours invites the client in. It provides an atmosphere where they can discuss their problems. It conveys your desire to listen and understand them.

Active listening

Active listening is the process by which the worker hears what the client has to say, while physically and psychologically paying careful attention to the person who is talking. It refers to listening to the meaning as well as the words.

Most of us are not good listeners. We listen at about 25% of our potential, which means we ignore, forget, distort or misunderstand 75% of what we hear.

Active listening means giving the client full, undivided attention.

This means that you are there not only physically but mentally as well. You are not distracted by other thoughts, e.g. other jobs you might feel you should be doing.

Steps to ensure that you are physically prepared

Physical barriers

You need to ensure physical barriers to effective communication are removed by freeing the environment of distractions (e.g. try to provide a quiet, private space away from other noises).

Ensure you are at the same eye level as your client. If we are standing and the client is sitting we cannot have level eye contact. When you look down at someone they can feel that you are in a position of authority over them. Chairs need to be at the same level to ensure this.

Sit facing your client, leaving room to manoeuvre

Facing the client indicates that you are there ready to listen to them. Leaving room for them to manoeuvre gives them a feeling of space. Too far away would give the impression that you are too distant to connect with them. Too close is an invasion of personal space.

Maintain appropriate eye contact

Different cultures have different values attached to eye contact. Generally speaking in white western culture, it is considered appropriate to look someone in the eye when you are speaking to them. People are often thought to be dishonest if they do not look you in the eye. This is not the same for all cultures. In some cultures it is thought a mark of respect to look down if you are speaking to someone in authority.

Maintain an open, relaxed body posture

An open relaxed posture does not mean that you are slumped in the chair. However, if we go back to what you learnt about non-verbal behaviour, think about how you would present yourself to indicate that you were relaxed but ready to listen.

Communicate warmth and empathy with appropriate gestures

Quite often in the early stages of developing rapport with a client, it is best to keep your talking to a minimum and let the client express what the problem is or why they have come to you for assistance.

Of course this does not mean that you don't introduce yourself and give a brief outline of your role or function at the agency but the first step is listening.

To show that you are doing this you can:

- use one-word encouragers (“mmm”, “uh-huh” etc.)
- nod to communicate attention.

Use appropriate facial expressions, tuning into the client's feelings.

Use non-coercive ice-breakers

A non coercive ice- breaker is, for example, offering them a cup of coffee before you begin if that is appropriate.

Use silence positively

Often as workers and also in our personal life when someone is telling us a problem if there is a moment of silence we become uneasy and want to fill it up with words. We often think this is the moment to give advice, solve the problem for them etc. One of the important things we need to learn to be good listeners is to cope with these uneasy feeling when there is silence. Allow the other person this silent time to reflect and collect their thoughts.

Do not rush the client

People are usually upset, anxious or distressed in some way when they are trying to discuss a problem with you. They may never have spoken about it before and not have a clear way of expressing what they need or what the issue is. The best thing we can do for them is give them time. If we rush them this will only escalate the distress. This takes tolerance and awareness that we need to set aside time for this to happen.

Active listening is not an easy skill to acquire. Even in classroom activities when students have been instructed to actively listen for only two or three minutes they find it difficult to do. Usually the problem is wanting to jump in with advice. It can be particularly difficult as a worker in this field, because workers often feel that they should have answers for clients. When they are trying to listen their mind is operating on overtime, trying to think of the solution to problems.

Even in our everyday life active listening can be very difficult. We all have our own needs that we want met when communicating. It is hard to

turn them off and listen to the other person. But don't give up once you master this skill, it is the basis for all the other skills to follow.

Reflective listening

Reflective listening means that we attend to the meaning of the person's verbal and non-verbal communications and respond in a way that promotes further exploration of both the feelings and content of what is being said.

Reflecting content

The reason why we reflect content (the words that people say) is that the person telling us the story will be keen to know that we have received at least the significant components of the message sent. As workers in this field it is our responsibility to feedback our understanding and encourage the client to correct or affirm until an accurate understanding is drawn for both of you.

The basic ways that you reflect content is by:

Paraphrasing

When we are paraphrasing we're not just repeating what the person has said to us. It is an attempt at communicating an understanding of the essential aspects of what the person has said. It needs to be used appropriately so the person is encouraged to continue with the story. It is a concise rewording.

Paraphrasing helps as it feeds back to the client your understanding of what has been said. The client then can inform you that your understanding is correct or clarify it if it is wrong. It also indicates to the client that you have been listening and are trying to understand the issue. This builds rapport with the client.

Summarising

A summary is when you offer back the key ideas and feelings they've been giving you. It is a synthesising of your understanding of what has been communicated over a period of time. Counsellors often do this at the end of a session with a client as a way of summing up the key elements that they have covered in the session. They may also do it at the beginning of a session as a reminder of what happened in the last session. Although you may not be counsellors it can be a useful tool when you have spent some time listening to someone's problem or story. It is a way of expressing what you see as the whole picture and seeing whether you have understood correctly.

A summary may:

- pull together the important elements of both information and feelings conveyed in the message delivered over several minutes;
- rearrange the content of the message into an order that gives fresh insight;
- be useful when you are losing touch with the story.

Reflecting feelings

Many people find it hard to express some feelings in words but may show it in their body language or non-verbal behaviour.

When we reflect someone's feelings back to them it can show that we care enough to listen. It can also indicate to the person that feelings are normal. It can facilitate the development of a genuine and meaningful relationship between worker and client. Giving people permission to talk about feelings may lead to further exploration of emotions. The process can enable the client to identify, label and acknowledge their emotions. By acknowledging a client's feelings the worker can communicate empathy and understanding.

Questioning

Open questions

- can encourage exploration of thoughts and feelings;
- Often start with the words in bold following:
 - what** – this is when you are asking for facts;
 - when** – the time something has occurred;
 - how** – the way the process or feeling has transpired;
 - where** – the location of the event;
 - would/ could** – open the focus or for decision-making.

Closed questions

- usually begin with **is, are, have, has, do, did, does, can or why**;
- should be used carefully as “why” questions may be seen as threatening or judgmental;
- usually allow a single-word answer, e.g. “Yes/No”;
- may not encourage the client to talk further.

APPENDIX 2

'STAGES OF CHANGE' MODEL

This information is adapted from Jarvis, T.R., Tebbutt, J. Mattick, R.P., *Treatment Approaches for Alcohol and Drug Dependence an Introductory Guide*, P24, John Wiley and Sons. Chichester, 1995.

If you are unfamiliar with this model it is best to study it in depth rather than just the information below. It is also important for you to become familiar with 'motivational interviewing' techniques so you can work appropriately with your clients at the different stages. All this information is available in the above text.

'Stages of change' model

This model was developed by two psychologists, Prochaska and Di Clemente.

It is a useful tool to assess what stage of change your client is at so you can respond appropriately to them, i.e. build rapport and avoid resistance. Below is a list of the stages.

Precontemplative stage

During this stage the client is usually not considering change. They are what we call 'happy users'. They do not consider the drinking or drug use a problem.

They may be before you because they have been coerced. Action-orientated intervention (e.g. goal setting) will probably not be appropriate at this stage. It is best if you use motivational interviewing techniques at this point. If you are unfamiliar with motivational interviewing techniques please refer to the above textbook.

Contemplation stage

This is usually when the client is in two minds about their drink or drug use. They are what is called 'ambivalent'. They are aware that there are good reasons for them to change their behaviour but they also have good reasons to stay the same. Again motivational interviewing techniques are the best techniques to use to encourage the client to explore the pros and cons of drinking/drug use and might culminate in a firm decision to take action.

Preparation stage

This is where the client is preparing to take action. They have decided that the cons of drinking or drug use outweigh the pros. This is the time to use the goal-setting exercise in Unit 3 on case management.

Action stage

During this stage the client is actively involved in attempting to stop or reduce their drinking or drug use. They may be in a treatment centre or an outpatient program. It is always important at this stage to remember 'ambivalence' and support your client through doubts and problems that change can bring about.

Maintenance stage

This is when clients have changed their behaviour and are focused on maintaining that change. Often this is a time when clients can relapse. It is best to prepare them for this with a well-established relapse prevention program which is covered in Unit 4 of this guide.

Relapse stage

This is of course when the client returns to drinking or drug use. It may be a brief or prolonged period of use. This is not a time for criticism or blame from you, but a time to systematically examine what brought about the relapse and build their motivation again toward change again.

APPENDIX 3: COMPREHENSIVE ASSESSMENT FORM

NOTE: It is best if you photocopy the assessment form on the following pages as you will need to use it several times for the exercises.

Assessment form

ESSENTIAL INFORMATION AREAS

1. SUBSTANCE USE AND ABUSE
 - current use
 - previous use
2. FAMILY AND SOCIAL RELATIONSHIPS
3. EMPLOYMENT AND FINANCIAL STATUS
4. MEDICAL PROBLEMS
5. LEGAL STATUS
6. PSYCHOLOGICAL STATUS

INFORMATION AREA I: SUBSTANCE USE AND ABUSE (AOD USE HISTORY)

CURRENT AOD USE

Although drug history appears first you may not deal with this session first in assessing your client. You would have to judge how willing the client was to talk about their using openly before you embarked on this section. If they have come directly to deal with the issue they are probably more than willing. If you gain the impression from the intake that they do not see they have a problem (precontemplative) this maybe not where you start.

However, for this exercise you have clients that are interested in receiving help so you can start with the drug history.

Examine all the different areas of information required. Work out appropriate open questions that you feel comfortable asking. The ones that are written here are only examples. Often questions like such as "Tell me about your life and how your drinking/using fits in" or asking them to describe to you a 'typical day' for them and how the drug fits in are useful. Get them to explain it to you in detail. Receive all information in a non-judgmental way. This way you will probably find out about all these areas of use in a conversational way without having to ask these separate questions.

Document drug use pattern :

Start with what the client thinks is the major problem substance (Drug No. 1)

Repeat the questions for any other drug that they are using currently (Drug No 2, Drug No. 3 etc.).

DRUG No 1:

DOSE – How much are they using?

.....

ROUTE – How are they using it?

.....

FREQUENCY OF USE – How often are they using?

.....

PATTERN OF USE – When does it happen? e.g. Perhaps it is just on weekends or is it every day?

.....

AGE: At what age did they first start using this substance?

.....

TOLERANCE : Has the amount they have used increased over time? If the answer is yes, by how much? And when has this occurred?

.....

WITHDRAWAL SYMPTOMS

Do they experience any withdrawal symptoms, e.g. headache, feeling sick of a morning, the shakes. What are they?

.....

NARROWING OF REPERTOIRE

Do they feel that a lot of their life is revolved around using/drinking?

.....

PREOCCUPATION WITH USE

Do they think a lot about drinking/using during the day?

.....
.....

Is the client taking any prescription medication? If so what, and for what reason?

.....
.....

Is the client receiving prescriptions from more than one doctor?

.....
.....

GO THROUGH EACH DRUG THEY ARE USING AND GET THIS INFORMATION

DRUG No 2:

DOSE – How much are they using?

.....
.....

ROUTE – How are they using it?

.....
.....

FREQUENCY OF USE – How often are they using?

.....
.....

PATTERN OF USE – When does it happen? e.g. Perhaps it is just on weekends or is it every day?

.....
.....

AGE: At what age did they first start using this substance?

.....
.....

TOLERANCE : Has the amount they have used increased over time? If the answer is yes, by how much? And when has this occurred?

.....
.....

WITHDRAWAL SYMPTOMS

Do they experience any withdrawal symptoms, e.g. headache, feeling sick of a morning, the shakes. What are they?

.....

NARROWING OF REPERTOIRE

Do they feel that a lot of their life is revolved around using/drinking?

.....

PREOCCUPATION WITH USE

Do they think a lot about drinking/using during the day?

.....

Is the client taking any prescription medication? If so what, and for what reason?

.....

Is the client receiving prescriptions from more than one doctor?

.....

DRUG No 3:

DOSE – How much are they using?

.....

ROUTE – How are they using it?

.....

FREQUENCY OF USE – How often are they using?

.....

PATTERN OF USE – When does it happen? e.g. Perhaps it is just on weekends or is it every day?

.....

AGE: At what age did they first start using this substance?
.....
.....

TOLERANCE : Has the amount they have used increased over time? If the answer is yes, by how much? And when has this occurred?
.....
.....

WITHDRAWAL SYMPTOMS

Do they experience any withdrawal symptoms, e.g. headache, feeling sick of a morning, the shakes. What are they?
.....
.....

NARROWING OF REPERTOIRE

Do they feel that a lot of their life is revolved around using/drinking?
.....
.....

PREOCCUPATION WITH USE

Do they think a lot about drinking/using during the day?
.....
.....

Is the client taking any prescription medication? If so what, and for what reason?
.....
.....

Is the client receiving prescriptions from more than one doctor?
.....
.....

OTHER QUESTIONS THAT CAN BE ASKED TO GAIN A CLEARER PICTURE OF THE PATTERN OF USE

Why does the client take drugs now? e.g. To avoid withdrawal symptoms

.....

What effects does the client get from using?

.....

Does the client believe that they can stop using drugs if they want to?

.....

Does the client consider that that they are dependent?

.....

If yes, how do they feel about this?

.....

Circumstances surrounding introduction to problem drug use e.g. peer pressure, anxiety.

What gains does the client receive from using drugs? e.g. reduction in anxiety, to be 'normal', increased social confidence.

.....

How is drug use supported ?

.....

Are drugs usually used alone or with associates ?

.....

PREVIOUS USE

Are there any drugs that have been used in the past that are not being used now?

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.....

What was the pattern of use then and why did they stop?

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.....

Use the same questions as before. e.g. At what age were they using , how much?

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.....

When did they stop using ? What made them stop using?

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.....

INFORMATION AREA 2: FAMILY AND SOCIAL RELATIONSHIPS

FAMILY BACKGROUND

Here it is appropriate to ask a variety of open questions that will allow the client to talk freely about their family background. Remember they are just a guide and you should design ones of your own which you think are appropriate to the client. You are trying to gain an impression of the influences the client has had from their family background. You could start with :

How would you describe your family upbringing ? How would you describe your growing up years?

If they give one word answers like 'terrible' or 'fine', ask them to elaborate:

What does fine mean to you?

Who was the most important person in your family?

What are the most significant things you can remember about growing up in this family?

What is your relationship with your family now?

Where did you come in the family (e.g. are they first child, second, only child)

Were they brought up by both parents? Ask for details

What was your family's attitude to alcohol and drug use?

Who do you consider to be your family now?

What is your relationship like with these people?

INSTITUTIONAL CARE

Was the client ever in any institutional care, if so what was it, and the ages they were there?

Comments:

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Other significant factors (open-ended section based on self-report)

Comments: Overall impression of their upbringing – including parent use of alcohol and other drugs

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SOCIAL RELATIONSHIPS

Currently : Are they married, single in a de facto relationship etc.

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Comments: How does the client describe their relationship.

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Previous significant relationships : Any other previous significant relationships.

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Comments: reason for breakdown. e.g. effect of drug use in the relationship.

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Children: Does the client have any children? What are their ages, sex, in their care?

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.....

Who have been and are now the most important people in the client's life?

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.....

LIVING ARRANGEMENTS

Current accommodation . e.g. flat , house, room. (owned or rented)

.....

With whom does the client live?

.....
.....

Previous accommodation pattern

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.....

INFORMATION AREA 3: EMPLOYMENT AND FINANCIAL STATUS

EDUCATION

Again, you can start with some opened ended questions. This is to gain some overall image of the clients experience of school and education.

How would you describe your school experience?

.....

.....

What do you remember most about school?

.....

.....

Were there any problems at school?

.....

.....

If they started using in their school years, how did that affect their learning and relationships with others?

.....

.....

What schools did you attend?

.....

.....

Comments: (Especially how they felt about school. Were there any problems.)

Age left school?

What educational standard was attained?

.....

.....

Do they have any trade certificates, qualifications?

.....

.....

EMPLOYMENT

Are you currently employed?

.....

.....

If yes, what is the organisation and the nature of the work?

.....

.....

To what extent does the current employment provide financial and job satisfaction?

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.....
.....

Is the current job in jeopardy due to his/her drug use?

.....
.....
.....

Employer's knowledge of drug use and their attitude?

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.....
.....

Previous employment history. (e.g. Where have they worked, for how long , reasons for leaving previous employment.)

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.....

Did the client ever have to leave their job due to drug use?

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.....

What are the client's goals, if any regarding future employment?

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.....

SOURCES OF INCOME

Document current sources of income/assets. If on government benefits, please indicate how much and which ones.

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.....
.....

Detail any financial difficulties.....

INFORMATION AREA 4: MEDICAL STATUS

You need to find out the client's present state of health as this could affect any future plans you have for them regarding treatment facilities.

How would you rate your general health?

Do you have any physical/medical problems at present?

Comments:

HOSPITALISATIONS

How many times have you been in hospital?

What are the reasons for these hospitalisations?

INFORMATION AREA 5: LEGAL ISSUES

You need to find out whether you client has any present legal problems, again this could affect any treatment plans?

LEGAL STATUS

Are there any current cases pending hearing?

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If yes, document current charge, solicitor, probation officer, date for hearing, expected outcome, current legal status.

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Document any previous legal convictions (juvenile and adult)

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PREVIOUS TREATMENT FOR DRUG AND ALCOHOL PROBLEMS

How many self-withdrawal programs has the client undertaken?

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To what extent were they supervised and/or successful?

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Comments:

What benefits did the client notice when they were not using drugs?

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What problems did the client experience when they were not using drugs?

.....

Under what circumstances did the client resume their drug use ?

.....

Past Inpatient/residential treatment for drug use:

Location:

When:

How long did they stay:

Reason for admission:

Reason for leaving:

Any comments they have about the time there. Was it useful for them in any way?

.....

INFORMATION AREA 6: PSYCHOLOGICAL STATUS

Here you are trying to gain some impression of their current thinking and feeling about themselves. This is very relevant in regard to suicide and possible mental health issues. You do not need to ask all these questions, only if you consider them relevant.

SELF SCRIPT

What does the client like or not like about themselves, including attitudes, characteristics, behaviour, personality?

.....

ANGER/RESENTMENTS

What makes you angry? How do you generally express your anger? To what extent does your drug use help to express your anger?

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.....

DEPRESSION

Do you experience depression? how often? how long do these episodes last, can you attribute your depression to any specific event?

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SUICIDAL THOUGHTS

Do you ever think of taking your own life?

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ANXIETY

Have you ever experienced attacks of anxiety?

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SEXUALITY

Document sexual preference and any difficulty that the client experiences regarding their sexual behaviour:

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PREVIOUS PSYCHIATRIC ADMISSIONS

Document previous psychiatric/ psychological consultations/admissions for problems other than directly drug-related problems. Diagnosis, length of admission etc.

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WHAT ARE THE MAIN PROBLEMS PERCEIVED BY THE INTERVIEWER?

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WHAT ARE THE CLIENT'S GOALS?

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WHAT ARE THE POSSIBLE INTERVENTION OPTIONS?

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APPENDIX 4: INFORMATION ON ROLE-PLAYS

Often people do not like role-plays because they have experienced difficulty with role-plays previously. If they are new to it they may be reluctant to play a role in front of others especially their peers.

Role-play is important because complex new skills are not established without practice. These exercises provide an opportunity to try out these skills and gain feedback.

Role-play is not the real thing, but it can be very close to it! When learning to fly, for example, one may first learn the basic information and principles, then practise in a flight simulator, then receive guided practice before taking to the skies on one's own. So it is the same in learning new skills to work with clients.

Instructions for role-plays or skills practice

Role for assessment worker

In this role-play or skills practice you are playing the role of the assessment worker at your agency. Sometimes you may feel uncomfortable in this role and worry whether you are 'good enough'. It is difficult to perform in front of your peers. However, it is an excellent opportunity to practise the skills you have been learning in conducting an assessment.

Avoid trying to resolve the client's issues, you just need to practise conducting a client assessment. Remember what you have learnt regarding process and content so far.

In your agency you also may be used to conducting assessments in a different manner. However, in this exercise concentrate on practising the skills that have been discussed.

It is your job to prepare your colleague for their role as the client. Choose one of the cases (from Appendix 5), read all of them first and decide which one you would like to work with. The alternative is you can make up a client case study based on the type of client that comes to your agency. Avoid using a real case, more just a combination of the type of characteristics the typical client would have. Firstly give your colleague the information on how they are to play the client (role of the client – next page).

Give them time to read and discuss with them any problems. Give them your chosen case. Give them time to read it thoroughly. Discuss with them how you both think this person would present so they have clear idea about how to play the role. When you consider that you are both ready start the role-play.

Now just relax into the role and have fun practising these skills.

Role as a client

In this role-play you will be acting in the role of a client for about 30-40 minutes.

You may at times feel uncomfortable in the role and wonder whether you are doing it correctly. Just remember that it is an opportunity for your colleague to practise the new skills they are learning.

Read the case your friend has given you and try and get the basic feel of the client, their life and their drug use.

It is not important if you do not remember everything on the form, just get the basic idea and ad-lib the rest. They are just made-up characters, so what you add will enhance the situation.

It is important for you and the exercise that you stay with the role.

Avoid bringing in any of your own personal issues because this can be upsetting for you.

Just relax into the role and enjoy being on the client's side for a while.

APPENDIX 5: CASE STUDIES

INTAKE QUESTIONNAIRE: Case 1 - Wes

DATE OF INTERVIEW:

CASEWORKER:

CLIENT DETAILS

NAME: Wes

ADDRESS:

PHONE:

D.O.B.: 2.4.41

SEX: male

COUNTRY OF BIRTH: Australia – Aboriginal

NEXT OF KIN: wife

REFERRAL DETAILS (SOURCE AND REASON): Referred by the Aboriginal Medical Service. Dr. Smith would like a full D.& A. assessment done on Wes and a report sent to him.

CLIENT'S MAIN CONCERNS: Wes is concerned about his health. He is a diabetic and having problems with his circulation and walking at present. Of late he has noticed his memory is not what it has been. His wife keeps complaining that he forgets what he did a few minutes ago.

CLIENT'S MAIN NEEDS: Wes said that he needs some help to give up the grog.

SUBSTANCE USE ISSUES: Wes has been a heavy user of alcohol since age 15. He also uses marijuana and is a heavy smoker. He has been in detox 7 times but relapses soon after leaving. he does not like AA. In the past month he has cut down his drinking to 3 a night and does not smoke any marihuana. He tried to stop smoking but it only lasted a day.

SOCIAL SITUATION (EMPLOYMENT, FINANCES, LEGAL, ENVIRONMENT AND LIVING SITUATION, INTERPERSONAL CONCERNS): Wes lives with his wife and 3 of his children. He has been unable to work for 10 years and is on a pension.

COMMENTS: This referral came over the phone . The Doctor felt that Wes was keen to do something about his health problems and could see that drinking and smoking was not helping. He was willing to attend for an assessment to look at options.

INTAKE QUESTIONNAIRE: Case 2 – Carrie

DATE OF INTERVIEW:

CASEWORKER:

CLIENT DETAILS

NAME: Carrie

ADDRESS:

PHONE:

D.O.B.: 19.4. 70

SEX: Female

COUNTRY OF BIRTH: Australia

NEXT OF KIN: Husband

REFERRAL DETAILS (SOURCE AND REASON): Referred by her District Officer. Carrie has 2 children and is pregnant with the 3rd. She is thinking about having this child adopted as she does not feel she can cope with any more children.

CLIENT'S MAIN CONCERNS: Carrie has a number of concerns.

1. her husband's drinking, argumentative nature and the effect this has on the family
2. her pill use because nerves
3. her 3rd pregnancy and not being able to cope

CLIENT'S MAIN NEEDS: Help with her family, and her nerves. She would like help in reducing her pill use but she doesn't know how she could cope without them if her nerves got worse.

SUBSTANCE USE ISSUES: Carrie has been using tranquillisers on and off for 3 years. She has become very dependent on them and is going to more than one doctor to get the tranquillisers. She is also a recreational user of marijuana and alcohol. She is concerned about her pill use and the effects on the baby but does not know how to stop.

SOCIAL SITUATION: (EMPLOYMENT, FINANCES, LEGAL, ENVIRONMENT AND LIVING SITUATION, INTERPERSONAL CONCERNS): Lives with her husband and 2 children in a housing commission home in the inner city. Her husband is unemployed and they are on social security benefits. Her relationship with her husband is poor because of his drinking and she wants help in this area.

COMMENTS: Carrie came to the centre on the advice of her district officer. The officer suggested that she be assessed and would like a report on the matter. Carrie seemed depressed and fed-up but cooperative at intake and agreed to being assessed. She seemed to like the interest taken in her.

The intake worker noted that there were some bruises on her arms that she tried to conceal when asked about them.

INTAKE QUESTIONNAIRE: Case 3 – Kim

DATE OF INTERVIEW:

CASEWORKER:

CLIENT DETAILS

NAME: *Kim*

ADDRESS:

PHONE:

D.O.B.: *20.2. 80*

SEX: *male*

COUNTRY OF BIRTH: *Cambodia*

NEXT OF KIN: *Uncle*

REFERRAL DETAILS (SOURCE AND REASON): *Referred by his solicitor for a court report. Kim is on several use and possess heroin charges. He goes to court in 2 months.*

CLIENT'S MAIN CONCERNS: *Client is concerned about the possibility of a jail sentence. He has been in jail before and tried to commit suicide because of his fear of the other prisoners and officers and their hatred of Asians.*

CLIENT'S MAIN NEEDS: *Kim said that he would like a wife and family and to be considered Australian.*

SUBSTANCE USE ISSUES : *Kim has been using heroin for many years. He was vague about how much and for what length of time.*

SOCIAL SITUATION: (EMPLOYMENT, FINANCES, LEGAL, ENVIRONMENT AND LIVING SITUATION, INTERPERSONAL CONCERNS) : *Kim came to Australia as a refugee with his uncle. He was only a young boy, his uncle is his only family as the rest were killed. He works for his uncle's grocery business when he is capable.*

COMMENTS: *Kim tried very hard to be cooperative in the interview but he seems disconnected in his thought pattern. It was difficult to tell whether this was to do with his drug use or an underlying psychosis. He seemed a lonely and isolated young man but eager to please.*

INTAKE QUESTIONNAIRE: Case 4 – Jamie

DATE OF INTERVIEW:

CASEWORKER:

CLIENT DETAILS

NAME: *Jamie*

ADDRESS:

PHONE:

DOB: *12.7. 78*

SEX: *female*

COUNTRY OF BIRTH: *New Zealand*

NEXT OF KIN:

REFERRAL DETAILS (SOURCE AND REASON): *Jamie was referred by her probation officer. She has just been placed on supervision after a stealing conviction. Her probation officer is very supportive but would like assistance in how to help Jamie with her drug problem. She has asked for a formal assessment and a report.*

CLIENT'S MAIN CONCERNS: *Her future – she is 18 and does not want to go to jail.*

CLIENT'S MAIN NEEDS: *Client said she wants to get a life. She is too old to be on the streets. She would like an education but does not want to go back to school.*

SUBSTANCE USE ISSUES: *Jamie's drug of choice is speed. However, she has been a long-term glue and lighter fluid sniffer.*

SOCIAL SITUATION: (EMPLOYMENT, FINANCES, LEGAL, ENVIRONMENT AND LIVING SITUATION, INTERPERSONAL CONCERNS): *Jamie left home when she was 12 because of physical and sexual abuse from her stepfather. She has lived on the streets since that time. She occasionally stays at refuges and was also locked up in some juvenile detention centres over the last 6 years. She said that she was also sexually abused by the officers when she was locked up. Jamie is very streetwise and has support herself over the years through prostitution and stealing. Her attachment is to the street kids she lives with but she said that she misses her mother and sister who she has not seen for 6 years.*

COMMENTS: *Jamie presents as an intelligent and articulate young woman. She does not know if she has a drug problem. She is willing to go along with the assessment to please her probation officer. She seems to have formed a trusting relationship with this officer. The probationer officer's support and obvious concern about her welfare has allowed Jamie to think a little about her own needs and possible future.*

INTAKE QUESTIONNAIRE – Case 5 – Tommy

DATE OF INTERVIEW:

CASEWORKER:

CLIENT DETAILS

NAME: *Tommy*

ADDRESS:

PHONE:

D.O.B.: *4.4.65*

SEX: *male*

COUNTRY OF BIRTH: *Fiji*

NEXT OF KIN:

REFERRAL DETAILS (SOURCE AND REASON): *Tommy has been referred by Albion St Clinic.*

CLIENT'S MAIN CONCERNS: *Tommy has just found out he is HIV positive. He is scared of getting sick and dying.*

SUBSTANCE USE ISSUES: *Tommy has used a number of drugs over the years – anything that is going and is fun. His favorites are ecstasy, acid, speed, coke, and amyl nitrate. He does not see himself as addicted to anything except cigarettes.*

SOCIAL SITUATION: (EMPLOYMENT, FINANCES, LEGAL, ENVIRONMENT AND LIVING SITUATION, INTERPERSONAL CONCERNS): *Tommy runs and owns a business, a sex shop which is very successful. Tommy has lived with Michael for 10 years but they have an open relationship and Tommy has had sex with many men. Tommy said that because they have been financially very well off they have lived the high life – lots of parties, drinking and drugging.*

COMMENTS: *Tommy is keen to concentrate on improving his health and he knows this involves using less drugs and probably giving them away altogether. He wants help.*



