



REFERRAL PROCESS

Referrals are accepted by telephone, letter, self, significant other/family member, GP, employer, etc.

TREATMENT FORMAT

After referral and applicable screening if indicated, and on first appointment, each client is provided with a comprehensive biopsychosocial assessment to determine the most appropriate level of care and to develop a treatment/care plan. An individualised treatment/care plan contains concrete and behaviourally measurable short and long term goals. Treatment/care plans are updated every three months at a minimum. A risk assessment is also completed. A risk assessment is a systematic collection of information which would determine the degree to which an identified risk would present or would be likely to present problems in the future. The risk assessment and management of an individual should be aimed towards harm reduction. Removal of all risk within an individual's environment is unrealistic. Risk is often difficult to predict because it would be determined as much by situational factors/circumstances as it would be by an individual's thoughts and actions. If an individual disclosed thoughts or actions associated with risk behaviours then a number of guidelines need to be followed –is there a specific plan in place to commit harm to self or others; are the thought processes related to risk occurring on a regular basis; recent and past history of harm to self and others; does the individual have the ability to exercise risk behaviour; has the individual been able to manage risk behaviours and cognitions in the past, enabling harm reduction strategies to be used; what are the prohibitive factors which have influenced the individual from not acting out risk behaviours.

Treatment involves therapy determined by the client's needs. If the Service can not meet the individual needs of the client, the client is referred to another service/program that can best meet their needs. Individual counselling is the core treatment modality.

Treatment Approach

This clinical approach takes into account the biopsychosocial perspective of the client's various needs. This approach recognises that the client is continuously faced with the pressures and stressors of daily life and has access to psychoactive drugs. Treatment should take into account that a driving motivational force for the chemically dependent person is the severity and intensity of drug craving behaviours, the desire to self medicate the symptoms of drug withdrawal and the compulsive need to change the way they feel. It also recognises that for any treatment setting, the client is always free to leave treatment; accordingly, strong emphasis is placed on therapeutic engagement and retention strategies.

Duration of Treatment

A distinguishing feature from the best practices research is the variable length treatment format. The length of a client's participation from admission through completion can range from several weeks to many years as determined by modality of treatment and the objective measures of clinical progress (i.e. providing clean urines, attending scheduled sessions, exercising adaptive (non-drug) problem solving skills, and developing a support network that includes self help, 12 step facilitation, etc). With regard to opioid substitution treatment which can last for a lifetime, reducing medication dose levels and/or defining a medication/treatment program date are not necessarily goals in the client's treatment.

Compatibility with other treatments

Operating from a basic philosophy of using what ever best practice treatment intervention seems to work best, these best practice standards are compatible with a variety of other treatment approaches, e.g. there is no anti medication bias so long as the medications offered are clinically appropriate (pain medication, antidepressants, antipsychotics, OTC's, etc.) to the given needs of each client.