THE SALVATION ARMY
AUSTRALIA SOUTHERN TERRITORY
ALCOHOL & OTHER DRUGS STRATEGY
2013-2016
FOREWORD

The strategy for The Salvation Army Australia Southern Territory has been produced by the Territorial Alcohol and other Drugs (AOD) Unit. It is a response to the needs of people with drug and alcohol issues within the Southern Territory. This plan focuses on improving the health and quality of life for people with AOD issues and sets the strategic vision for the next three years in order to meet these needs.

The strategy addresses the needs of people across all age groups. It is informed by local and national policy: National Drugs Strategy 2010-2015 – A framework for action on alcohol, tobacco and other drugs; stakeholder experience, as well as partnership objectives. It illustrates the need to transform local services in order to ensure that people who experience AOD problems can access the most appropriate services. This strategy sets out the priorities for The Salvation Army across the Southern Territory and local action which is required in order to:

→ Improve health and quality of life
→ Reduce inequalities in health and social services
→ Improve the delivery and experience of health and social services
→ Minimise harm to individuals and communities.

The Salvation Army Australia Southern Territory has developed a Territorial AOD unit which will act as the ‘knowledge hub’ in relation to AOD expertise and practice. This will ensure that services are strategically relevant and aligned with national, regional and local policy, as well as ensuring evidence-based practice.
INTRODUCTION

Alcohol and other drugs can have a negative impact on the lives of individuals and families. The type of dependency that an individual can develop whilst using a range of substances can vary from individual to individual. Alcohol and drug misuse problems are unfortunately not particularly well understood by the wider community due to fear and stigma. The AOD services across the Southern Territory aim to promote good health and well-being, to enable individuals to access health and social care services as early as possible and in a timely manner.

NATIONAL POLICY

The development of AOD services within Australia is currently been driven by the development of the National Drug Strategy. It builds on previous strategies.

The aims of the current national strategy are:

→ **Demand reduction** – to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs; and support people to recover from dependence and reintegrate within the community.

→ **Supply reduction** – to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

→ **Harm reduction** – to reduce the adverse, health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The above three areas apply across the range of drug and alcohol services nationally. Demand and harm reduction are more relevant to The Salvation Army services. The National Strategy emphasises the need to apply the above three areas with sensitivity to age and stage of life, disadvantaged communities and the context within which the interventions are being delivered.

KEY AND CROSS CUTTING STRATEGIES

This plan has been shaped by a number of national and local strategies/strategic documents:

→ **New directions for alcohol and drug treatment – A roadmap – Department of Health - Victoria (2012)**

→ **Victorian framework for recovery – oriented practice (2011) – mental health sector**

→ **Tasmanian Drug Strategy 2005-2009**

→ **Alcohol, Tobacco and other Drug Services – Tasmania – Future Service Directions – A five year plan 2008/09 – 2012-13**

→ **Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015**

→ **South Australian Alcohol and Other Drug Strategy 2011-2016**

→ **Northern Territory – Alcohol and Other Drugs – Strategic Directions for 2009-12**

→ **The Road Home – A National Approach to Reducing Homelessness**

→ **National Standards for Mental Health Services 2011.**
The Salvation Army Australia - Southern Territory covers the following locations:
1. Victoria. 2. Western Australia. 3. South Australia. 4. Tasmania. 5. The Northern Territory (NT).

**The Salvation Army**

The Salvation Army is a modern community based-Christian movement. The Salvation Army is also one of the largest and most diverse social welfare providers in the world. It recognises that not all people share equally in the benefits in Australian society and it is imperative that options exist for those most disadvantaged. It believes that the natural environment of God’s creation should be treated with reverence. Therefore, people coming to The Salvation Army for help:

- Should be served without discrimination
- Should be treated with respect so that their dignity as individuals is preserved
- Should be recognised as people capable of making decisions and choices for their own lives.

The Salvation Army strives to provide high quality service provision for those individuals who experience alcohol or drug problems in a dignified and respectful manner. The Salvation Army combats discrimination and stigma for individuals who are marginalised and oppressed due to their alcohol and drug issues.

**Structure of The Salvation Army**

The chart below provides an overview of The Salvation Army structure:

1. **International Headquarters (IHQ)**
2. **Territorial Headquarters (THQ)**
3. **Divisional Headquarters (DHQ)**
4. **Social Programmes and Corps (Churches)**

**Map of the Australia Southern Territory**

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2 Getting to know the Salvation Army – Loving God, Caring for people.
The Australia Southern Territory demographic data is illustrated in the table below:

<table>
<thead>
<tr>
<th>STATE</th>
<th>TOTAL POPULATION**</th>
<th>OVERSEAS BORN POPULATION*</th>
<th>INDIGENOUS POPULATION**</th>
</tr>
</thead>
<tbody>
<tr>
<td>WESTERN AUSTRALIA</td>
<td>2 293 510</td>
<td>29.3%</td>
<td>3.4%</td>
</tr>
<tr>
<td>SOUTH AUSTRALIA</td>
<td>1 644 582</td>
<td>21.5%</td>
<td>1.8%</td>
</tr>
<tr>
<td>VICTORIA</td>
<td>5 544 932</td>
<td>25.4%</td>
<td>0.7%</td>
</tr>
<tr>
<td>TASMANIA</td>
<td>507 643</td>
<td>11.3%</td>
<td>3.8%</td>
</tr>
<tr>
<td>NORTHERN TERRITORY</td>
<td>229 711</td>
<td>15.1%</td>
<td>30.4%</td>
</tr>
</tbody>
</table>

Data captured from Australian Bureau of Statistics: *census data 2006 **census data 2011

The above table illustrates the diverse population across the Southern Territory. Each state and the Northern Territory within the Southern Territory deliver AOD services. Therefore, The Salvation Army acknowledges the varying needs across the population which it covers and the need to contextualise AOD services across the alcohol and drug treatment systems in order to meet the needs of the local population.

Some of the issues which influence this strategy are highlighted below:

→ The cost to Australian society of alcohol, tobacco and other drug misuse in 2004-05 was estimated at $56.1 billion, inclusive of costs to the health and hospital system, absence from work due to alcohol and drug misuse, road accidents and crime. Tobacco accounted for $35.1 billion (56%), alcohol 15.3 billion (27.3 %) and illegal drugs, $8.2 billion (14.6 %).3

→ Drinking alcohol excessively is a major cause of health and social care issues.

→ Illegal drug misuse can significantly harm an individual’s health. Unsafe injecting drug use is also a major driver to blood-borne virus infections like hepatitis C and HIV/AIDS.

→ Disadvantaged groups are at greater risk of harm from alcohol, tobacco and other drugs.

→ Legally available substances can cause serious harm to individuals and families.

→ Heavy alcohol and drug misuse by parents can have a detrimental effect on the development and functioning of the family unit.

The relationship between substance misuse and social inequalities is interlinked. For example, having an alcohol or drug dependency can reduce an individual’s ability to retain employment thus leading to social isolation, which consequently exacerbates the problem. Furthermore, social inequalities can increase the risk of substance misuse within communities.

The National Drug Strategy 2010 – 2015 – A framework for action on alcohol, tobacco and other drugs identifies that alcohol misuse and illegal drug usage remain a priority including; pharmaceutical drug misuse, stimulant use, poly-drug use, as well as cannabis use. Substance misuse is influenced by many factors including childhood experiences, life events, ability to cope, levels of social support, adequate housing, employment, financial security, and access to health and social care services. Groups who face a high risk of developing an AOD issue include: culturally and linguistically diverse groups, homeless people, prisoners, individuals with a mental illness and people with physical illnesses.

It is difficult to reliably determine the level of AOD misuse within a population. Short-term or mild usage is difficult to capture from data available. Therefore, it is important that services are easily accessible and flexible in their delivery in order to provide the right support—first time.

CURRENT SERVICES

There is a broad and diverse range of existing AOD services across the Southern Territory, including health, social care services, non-government organisations, user/carer-led and self-help/peer-led initiatives. Much has been achieved in recent years.

The Salvation Army is responsible for directly providing approximately 52 services. The total investment is $23,863,960 (2011/12). This is made up of state funding, commonwealth funding, as well as Salvation Army funding. The services comprise of residential units, as well as a range of community based services. The services across the territory are eclectic in nature and reflect the local drug and alcohol treatment systems within each respective state.

FUTURE DIRECTION AND DEMAND

The demand for AOD services has continued to grow over the years. The National Alcohol and Other Drugs Strategy emphasises the need for services to be holistic in their approach and partnership orientated. There is a strong emphasis on partnership working in order for individuals to be integrated or reintegrated back into their communities. The Salvation Army recognises the need to deliver services which are holistic and systemic in their approach. There is also a strong commitment to work in partnership (internally and externally) to enhance service provision.

The Salvation Army has seen an increase in the number of referrals to community based services. Through undertaking a needs assessment and gap analysis in 2012 The Salvation Army has acknowledged the need to further develop:

→ Christian spirituality in programme content
→ Links to corps services
→ Robust partnerships
→ Clear models of treatment
→ Holistic/Integrated service provision
→ Family centred practice
→ Outcome based service provision
→ Evidence based practice
→ Wrap around services
→ Clear pathways to treatment
→ After-care
→ Care coordination and care management
→ Workforce skills and competence – including cultural competence.

WORKFORCE DEVELOPMENT

The Salvation Army values and recognises the dedication and commitment from the skilled and competent workforce it employs. There is a commitment to enhancing existing staff selection and retention systems and processes, as well as further developing creative and flexible working environments.

Local services need to have systems and strategies in place to build a workforce that reflects the diversity of the local population and to promote cultural competence in the workforce.

The Salvation Army recognises the importance of developing a competent workforce. A new workforce plan is currently being developed. The plan identifies the need to provide training for all workers which
reflects the national agenda in regards to harm minimisation, harm reduction, working in partnership and ensuring that the needs of vulnerable people are met and safeguarded. The plan will ensure that staff are suitably qualified and competent in delivering evidence-based interventions and that they are able to demonstrate a sound knowledge, skill and value base. This will ensure that the services which The Salvation Army provides are compliant with all relevant clinical/practice guidelines and standards. There are plans to work in partnership with Booth College to provide accredited training to increase the knowledge, skills and competencies of the workforce.

**OUR SERVICE VISION**

The Salvation Army has a rich tapestry of services that have modernised over the years across the Territory. They have also demonstrated an ability to meet a range of diverse needs. However, The Salvation Army recognises a need to make a step-change and modernise services in line with the National Drugs Strategy. Services need to ensure that individuals with AOD issues and their families/carers/significant others have their needs met, wherever they are in the system or in the community, without encountering discrimination or barriers whilst accessing timely and effective interventions.

**MISSION VALUES OF THE SALVATION ARMY AUSTRALIA SOUTHERN TERRITORY**

**Our Vision**

The Salvation Army - a growing, loving community of people dynamically living God’s mission in a broken world.

**Our Mission**

The Salvation Army raised up by God for the work of:

→ Transforming Lives
→ Caring for People
→ Making Disciples
→ Reforming Society.

**Our Values**

Recognising that God is always at work in the world we value:

→ Human Dignity
→ Justice
→ Hope
→ Compassion
→ Community.

The above vision and values are embedded throughout service provision. The Salvation Army is a church based organisation which welcomes individuals from all backgrounds and beliefs. The AOD services will provide holistic treatment to individuals and their families – which will include spirituality as a part of the treatment process. Christian spirituality is key to our primary mission and this will be reflected in service provision.

We recognise the need for services to continue improving and developing. The Salvation Army will achieve this by using existing investment to redesign services - ensuring that they meet the needs of users and carers in the most effective way. This will ensure that services are productive, effective and efficient. Therefore, we will further develop the good practice and strengths of our existing AOD services.

The Salvation Army will begin to transform our services in line with national best practice and the new model of care will be focussed on delivering high quality services which are delivered at a high standard.
Where areas of development are identified we will drive up quality standards and practice through taking corrective action through our risk management and performance management, as well as governance processes.

**COMMUNITY INTEGRATION MODEL**

The new model for The Salvation Army - Australia Southern Territory AOD services is called the Community Integration Model (CIM). This model focuses upon the potential for personal growth and improvement in the quality of life for individuals with AOD issues - which has been developed by integrating medical, psychological and social interventions, as well as utilising community resources and networks of support. The model is based on:

- **Connectedness**
- **Integration**
- **Meaningfulness**.

The model sees individuals as active participants in their own change process – setting their own goals. The Salvation Army services are driven by the values underpinning harm minimisation and harm reduction.

The model is based on the premise that services need to work in a person-centred way with individuals seeking to address their AOD misuse, as well as significant others. Services need to be delivered in a systemic/holistic way that ensures that individuals are integrated/reintegrated into their community. Through this approach services will ensure that the individual’s personal, cultural and social needs are met. Individuals will be able to access the breadth and depth of services within their community - to support them and eliminate the isolation and discrimination, which they may experience as a part of their recovery process.

The Community Integration Model will use the strengths of a ‘stepped care’ model and the principles of the ‘recovery’ model in order to ensure that services are enabling individuals to achieve their potential within the community. Through this approach individuals will be supported to receive the right care and treatment according to their identified needs within an existentialist approach. This is based on the premise that as individuals we are located in communities and we are not autonomous and do not self-regulate.

**STEPPED CARE MODEL**

Stepped care is a model of delivering and monitoring the intensity of interventions according to need, based on the principle of ‘Least Intervention First Time’. The stepped care model promotes choice and open access. It embodies a philosophy which builds on strengths and avoids dependence.4 A stepped care model includes:

- interventions of different levels of intensity are matched to the service user’s needs
- careful monitoring of service user outcomes, allowing interventions to be ‘stepped up’ or ‘stepped down’ if required
- service users usually move through less intensive interventions before receiving more intensive interventions (if necessary)
- clear referral pathways between the different levels of intervention
- the direction of travel being two way – people can step down, with appropriate support, as well as up
- self-care is recognised as an important aspect of managing demand.

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4 New Ways of Working for Primary Care Mental Health: a briefing document. DH 2009.
There is good evidence for both the clinical and cost effectiveness of stepped care models.\(^5\) Potential benefits include:

- increased recognition and recovery rates
- reduced disability and impairment related to work, family and social participation
- reduced socio-economic and ethnic inequalities in mental health and addiction
- economic and social benefits associated with fewer individuals developing more severe mental health and addiction problems
- a more cost-effective way of delivering services.

The Community Integration Model will be informed by the above and be shaped by the philosophy of the stepped care approach.

**RECOVERY MODEL**

In recent years there has been increased recognition that recovery refers to a person’s improved capacity to lead a fulfilled life that is not dominated by alcohol and drug misuse and treatment. The recovery model is well established within mental health services and more recently demonstrating success within AOD services. The recovery model provides individuals with greater independence, choice and control over their lives and does not necessarily equate to a 12 step or other abstinence based approaches. However, 12 step and other abstinence based interventions will be offered as a part of the continuum of treatment options - alongside pharmacotherapy and a range of other interventions. There is an emphasis on individuals experiencing an improved quality of life and higher levels of functioning despite their alcohol and drug use. **The individual is at the centre of the recovery process and defines their own outcomes.**

There is no single definition of the concept of recovery for people with a substance dependency. However, there are five processes which encapsulate the recovery approach:\(^6\)

- **Connectedness**
- **Hope**
- **Identity**
- **Meaning in life**
- **Empowerment**.

The recovery model believes that we are not self-regulating and autonomous as individuals – we are located in communities. The model concentrates on the strengths and resilience of individuals and their own resources – which includes inner resources and relationships, housing and employment.

The principles of recovery from alcohol and other drug treatment are:\(^7\)

- There are many pathways to recovery
- Recovery involves a personal recognition of the need for change and transformation
- Recovery is holistic
- Recovery has a cultural dimension
- Recovery exists on a continuum of improved health and wellness
- Recovery emerges from hope and gratitude

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\(^7\) Best, D. Lubman, D. Reprinted from AUSTRALIAN FAMILY PHYSICIAN VOL 41, NO. 8, AUGUST 2012.
Recovery involves a process of healing and self-redefinition
→ Recovery involves addressing discrimination and stigma
→ Recovery is supported by peers and allies
→ Recovery involves (re) joining and (re)building a life in community
→ Recovery is a reality.

The new Community Integration Model for services will aim to promote social inclusion and recovery with an emphasis on:

→ Promoting independence, choice and control
→ Increasing access to services and networks of support
→ Promoting employment and training opportunities
→ Enabling individuals to achieve their potential.

There is a whole area of life and activity outside the traditional confines of AOD services. This overall social context, within which people live their lives, has a crucial effect on their quality of life and the development and maintenance of health and wellbeing for everyone in the community.

AOD services must link with other agencies and programmes to promote the wellbeing and social inclusion of people with substance misuse needs. Agencies must work together to provide a seamless service. The strategy outlines the direction in which AOD services should travel in order to achieve better outcomes for service users and their families.

THE WAY FORWARD

The key areas of the Community Integration Model have been highlighted within this section of the strategic plan. They have been identified and informed by local and national policy, stakeholder experience, as well as local strategic partnership objectives.

Christian spirituality will be offered as a part of the treatment process as it is an integral part of the identity of The Salvation Army. Furthermore, evidence suggests that spirituality in AOD treatment can assist an individual in their recovery process.8 Our services will ensure that spirituality is a part of the assessment, treatment planning, delivery and after-care process.

The above areas are key to transforming The Salvation Army AOD services in order to ensure that people who experience alcohol and drug problems can access high quality and person-centred services. They have been broken down into the following categories:

1. Advice, Guidance and Support
2. Navigation and Bridge Building Services

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ADVICE, GUIDANCE AND SUPPORT (ELEMENT 1)

(UNIVERSAL SERVICES)

DEFINITION

These services can deliver drug and alcohol related information, advice, guidance and support, as well as screening and referral to AOD services. These services are not drug and alcohol services within the community. These services can provide basic information and guidance. For instance, leaflets through to more substantial support in the form of a referral to drug and alcohol specific services. The level of intervention and support will be dependent upon the skill level, competence and partnership arrangements with other drug and alcohol treatment services.

CONTEXT

Drug and alcohol advice, guidance and support will be provided by a broad range of Salvation Army services, ranging from corps based groups, Doorways services, through to the local shops (Salvo Stores). This will enable services to seek opportunities for promotion of AOD services through existing partnerships or developing new ones. Services will proactively provide information within the community about alcohol and drug misuse. This will raise awareness of AOD services and engage individuals within the community and provide brief advice, guidance and support about drug and alcohol issues.

INTERVENTIONS

→ Basic drug and alcohol screening – early identification
→ Referrals to specialist drug and alcohol services
→ Alcohol and other drugs advice, guidance and information
→ Generic services should also provide their services to drug and alcohol misusers – and some may be specifically designed for drug and alcohol misusers
→ Partnership development
→ Basic information – leaflets (Salvos Stores and corps groups).

SETTINGS

→ Corps based groups
→ Doorways (community support services – including appointment based services, walk-in services, home visit based services, intensive outreach services, shop front services, social programme based services)
→ The Salvation Army Shops – Salvos Stores
→ Youth and family services
→ Family and domestic violence services.
NAVIGATION AND BRIDGE BUILDING SERVICES (ELEMENT 2)

(TARGETED SERVICES)

DEFINITION

Navigation Services

The interventions in this element include provision of drug and alcohol related information and advice, triage, assessment, brief psychosocial interventions, referrals to structured drug and alcohol treatment, harm reduction interventions (including needle syringe programmes) and aftercare.

Bridge Building Services

These services will open up new opportunities for individuals with a focus on providing new skills for individuals who wish to access training/vocational opportunities or gain paid employment.

CONTEXT

Navigation Services

Within this component services will support individuals within a range of settings, from accommodation based provision—such as emergency/crisis accommodation through to needle syringe programmes. These services will enable individuals to access services through referrals, as well as signposting them to appropriate support and services. Brief interventions may be delivered, as well as information provided. For instance, sensible drinking advice and safer using information. They will raise awareness of blood-borne viruses, overdose prevention, sexual health, health promotion and primary health care services. Within element 2, the services should utilise a range of evidence-based interventions and treatment options, (including, but not exclusive to advice and information, motivational (therapies) enhancement techniques, psycho-social interventions, cognitive behavioural therapies, as well as other therapies, 1-1 support etc.) dependent on service user needs, to support:

→ Recovery
→ Harm reduction
→ Stabilisation
→ Relapse prevention.

These services provide less complex interventions than element 3. They will work closely with other services to increase their understanding of AOD services and ensuring that clients access the appropriate ‘wrap around’ services that they need.

Care plans can be used within these services when delivering brief interventions. Some of the brief interventions delivered within this service will be similar to those in the Social Inclusion and Treatment Services (element 3). The needs of the client and treatment intervention will determine the type of service required by the individual. For instance, brief intervention (element 2) or more intensive case management / care coordination/treatment and support (element 3).

Bridge Building Services (New opportunities)

These services concentrate on opening up new opportunities for people. The services will provide awareness raising, as well as skills training for individuals to utilise community resources in order to achieve greater independence, choice and control over their lives. They will assist individuals and families to overcome some of the barriers which they experience on a day-to-day basis in order to combat and address the social stigma and fear which they may experience whilst accessing mainstream-universal services.

Some of this work happens within existing services. However, there is recognition within The Salvation Army, in line with the National Drugs Strategy, that services need to be re-designed in order to place the individual at the centre of their change process and enable them to access a broad range of universal services as a part of their recovery process. For instance, paid employment, training, vocational and leisure opportunities.
Element 2 services can be a component of after-care services as a part of the individual’s alcohol or drug related support in relation to relapse prevention, advocacy services, access to user groups, peer-support, (AA/NA) or non-drug related services - such as education and training, social networks and employment services.

**INTERVENTIONS**

- Offering spiritual counsel (chaplaincy) and inviting links with faith communities
- Information & advice
- Referral and sign-posting to other services
- Screening (using validated tools, such as Audit)
- Alcohol and other drugs brief advice
- Triage & initial assessment for primary health care needs
- Prioritisation (risk assessment)
- Interventions to reduce harm and risk due to BBVs and other infections for active drug users
- Interventions to minimise the risk of overdose and diversion of prescribed drugs
- Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if an individual does not require intensive structured treatment)
- Brief interventions for specific target groups including high-risk and other priority groups
- Drug and alcohol related support for clients seeking abstinence
- Drug and alcohol aftercare support for those who have left ‘care planned’ structured treatment
- Liaison and support for generic providers of interventions within universal services
- Outreach services to engage clients into treatment and to re-engage people who have dropped out of treatment
- A range of the above interventions for drug-misusing offenders.

**SETTINGS**

**Navigation Services**

- Needle syringe programmes
- Emergency and crisis accommodation
- Sobering up/ dry houses
- Primary Health Care – including pharmacotherapy services
- Accommodation based services
- Non-residential-after-care
- Outreach Services
- Pharmacotherapy services.

**Bridge Building Services**

- Accommodation based services
- Community support services
- Education and training based services
- Employment pathway focussed services
- Vocational and leisure groups
- Peer-led groups – including buddying/mentoring and networks of support.
(Specialist Services)

Definition

Specialist interventions will be provided to clients within the community and accommodation based services. In this element specialist drug and alcohol consultation and liaison services will also be provided. Care and treatment will be coordinated and planned.

Context

In this element services will work with clients who have complex health and social needs, poly/dual diagnosis and co-morbidities. Specialist services will have the ability to deliver high quality service provision and achieve effective outcomes for individuals.

These services will provide a comprehensive assessment and the key worker /support worker will develop a treatment plan with the service user based on their needs. These services will provide brief interventions. However, services within this element will concentrate on delivering more intensive interventions, which will be based on client needs.

The services have responsibility for liaising with a wide range of health and social care professionals to manage risks and ensure the delivery of effective evidence based services through case management and care coordination.

Evidence–based therapies which may include: motivational enhancement techniques, ACT, SBNT, psychosocial interventions, CBT & other therapies, 1-1 support, will be provided by the key/support workers dependent on the individual’s needs, to support:

→ Recovery
→ Harm reduction
→ Stabilisation
→ Relapse prevention.

The services shall pro-actively and intensively engage and support service users to sustain and maintain motivation to address their drinking and drug taking behaviours- taking positive health and lifestyle changes & choices; and improve the quality of their lives. This can be achieved through the provision of:

→ an intensive programme of help and care for individuals and their families
→ support and treatment interventions
→ practical help and support to address social issues
→ facilitating engagement with both primary and secondary care and other statutory and non-government organisations.

Initially clients should be offered low intensity treatment in line with the stepped care approach. However, higher levels of treatment need to be provided to those clients who do not benefit from low intensity interventions. The treatment will be structured and the client will consent to treatment. The client will be followed up in treatment and regular reviews will be held with the individual in order to ensure that the treatment is effective in meeting the individual’s changing needs. The health and social care outcomes will be recorded accurately and the treatment plan will be reviewed and updated frequently.

Interventions

→ Offering spiritual counsel (chaplaincy) and inviting links with faith communities
→ Comprehensive drug and alcohol assessments
→ Care planning, coordination and review for all in structured treatment, often with regular key
working sessions as standard practice

→ Harm reduction activities, as integral to care-planned treatment

→ A range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviour

→ Liaison with a range of other services

→ Inpatient specialist drug and alcohol assessment, stabilisation, and detoxification/assisted withdrawal services

→ A range of drug and alcohol halfway houses or supportive accommodation for substance misusers

→ Residential drug and alcohol crisis intervention units (in larger urban areas)

→ Joint initiatives between a range of partners. For instance, working closer with in-patient units.

**Settings**

→ In-patient

→ After-care

→ Home-based withdrawal services

→ Residential rehabilitation services

→ Outreach based services

→ Community rehabilitation programmes

→ Psycho-social therapy services/counselling services

→ Pharmacotherapy services.

**Community Integration Model**

Below are three diagrams which illustrate the community integration model. The first and second diagram (A) and (B) shows the model within the stepped care approach and diagram (C) shows the model alongside other services within the community.

**Diagram A**
Whether service users are in treatment (including individuals on substitute opiate medication), or leaving treatment, they should have access to social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains they have made in treatment.

Service users who are stable but who wish to be maintained on substitute opioid medication should have opportunities to receive social support, education and employment where appropriate. For stable individuals who do not need to continue in specialised alcohol or drug treatment, there should be clear pathways into maintenance and monitoring within primary care settings with ongoing community integration interventions and support. This is an area of expertise which The Salvation Army has developed and wishes to further enhance through developing robust partnerships with a range of organisations that share a similar vision, in order to improve the quality of life for service users.

**Diagram C**

*Community Integration Model within a broader context*

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OUTCOMES AND COMPETENCES

The Salvation Army are committed to delivering high quality services which deliver evidence-based interventions. The staff will be skilled and developed in order to deliver a range of interventions. This part of the strategy is a brief guide to the outcomes and evidence-based psychosocial interventions delivered within each element of the model. This section of the plan is aimed at practitioners, service managers, and department of health funders, service users and carers – in order to inform the individual about the treatment options available. The list is not exhaustive and is only a summary.

The plan is that within the next 12 months there will be ‘practice guidelines’ for each element of the model, which will provide further detail in regards to the breadth and depth of the interventions offered within each element. The guidelines will further develop the Community Integration Model and demonstrate how practice will be shaped and delivered. There will be an emphasis on therapeutic activity being delivered within a broader context of networks and community support.

ADVICE, GUIDANCE AND SUPPORT (ELEMENT 1)

Basic advice, guidance and support will be provided within this element.

**Outcomes**

→ Improved advice guidance and support within the community
→ Increased awareness of drug and alcohol issues
→ Safer use of drugs and alcohol
→ Individuals will be aware of appropriate support in regards to health and well-being
→ Greater partnership working.

**Generic Competences**

→ A knowledge and understanding of drug and alcohol misuse problems
→ A knowledge and understanding of mental health problems
→ A knowledge of different services within the locality
→ An ability to identify risks and refer individuals to support and treatment services.

NAVIGATION AND BRIDGE BUILDING SERVICES (ELEMENT 2)

Low intensity interventions will be provided by clinicians/practitioners, drug and alcohol key workers. Drug and alcohol specific interventions are defined as motivational and treatment engagement tools are used to reduce substance misuse. For common mental health problems, they are defined as those interventions that retain an element of self-help where the staff member acts as a facilitator of the use of a particular psychosocial intervention. This may include self-guided help, structured interventions or computerised cognitive behavioural therapy.

**Outcomes**

→ Greater awareness of drug and alcohol issues
→ Closer working between different agencies
→ Better client engagement
→ Structured support for individuals to address their drug and alcohol issues.
**Generic Competences**

- A knowledge and understanding of drug and alcohol misuse problems
- A knowledge and understanding of mental health problems
- A knowledge of different services within the locality
- An ability to identify risks and refer individuals to support and treatment services.

**Specific Competences**

- A knowledge of and ability to operate within professional and ethical guidelines
- A knowledge of motivational interviewing and the application of the model in practice
- An ability to communicate effectively with professionals about the nature of the service user’s difficulties, the intervention(s) and the outcomes
- Use of appropriate information gathering techniques
- Use of agreed protocols to assess risk to self and others and self-neglect (distinguishing between ideation and intent)
- Draw out, identify and discuss the service user’s intrinsic motivation for change
- Ability to ‘roll with resistance’ and avoid direct confrontation of resistance
- Knowledge of basic principles of stages of change (pre-contemplation; contemplation, preparation; action and maintenance)
- An ability to elicit ‘change talk’ in a collaborative manner through: (1) recognising, empathising and reflecting on desire, ability, reasons and need focussed change statements (2) recognising and strengthening commitment language.

**Social Inclusion and Treatment Services (Element 3)**

High-intensity interventions are defined as formal therapies—psychosocial therapies delivered by a trained therapist/worker. These therapies will not be delivered in isolation and without an understanding of the individual’s community and network of support.

**Outcomes**

- Person-centred practice
- Services promoting greater independence, choice and control
- Structured health and social care treatment provision
- Holistic care provision
- Better engagement and retention of service users and their families
- Joined up care pathways and service provision.

**Generic Competences**

- Knowledge and understanding of alcohol/drugs and mental health problems
- Knowledge of, and ability to operate within professional and ethical guidelines
- Knowledge of a model of therapy and the ability to understand and employ the model in practice

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10 A framework and toolkit for implementing NICE-recommended treatment interventions, ROUTES TO RECOVERY: PSYCHOSOCIAL INTERVENTIONS FOR DRUG MISUSE, National Treatment Agency for Substance Misuse (2010).
→ Ability to: (1) engage client (2) foster and maintain a good therapeutic alliance and to grasp the client’s perspective and ‘world view’ (3) deal with emotional content of sessions (4) manage endings (5) undertake generic assessment (relevant history and identifying suitability for intervention) (6) make use of supervision

→ Knowledge of: (1) basic principles of CBT and rationale for treatment (2) common cognitive biases relevant to CBT (3) the role of safety-seeking behaviours

→ Ability to: (1) explain and demonstrate rationale for CBT to client (2) agree goals for the intervention

→ Ability to structure sessions: (1) sharing responsibility for session structure and content (2) adhering to an agreed agenda (3) planning and reviewing practice assignments (homework) (4) using summaries and feedback to structure the session (5) use measures and self-monitoring to guide therapy and to monitor outcome (6) devise a maintenance cycle and use this to set targets (7) problem solving (8) ability to end therapy in a planned manner and to plan for long-term maintenance of gains after treatment.

**Specialist Competences**

→ Exposure techniques

→ Activity monitoring and scheduling

→ Guided discovery and Socratic questioning using: (1) thought records (2) identifying and working with safety behaviours (3) detecting, examining and helping client reality test automatic thoughts/images (4) elicit key cognitions/images (5) identifying and helping client modify assumptions, attitudes and rules (6) identifying and helping client modify core beliefs (7) employing imagery techniques (8) planning and conducting behavioural experiments

→ Ability to: (1) develop formulation and use this to develop treatment plan/case conceptualisation (2) understand client’s inner world and response to therapy

→ Capacity to: (1) use clinical judgment when implementing treatment models (2) adapt interventions in response to client feedback (3) use and respond to humour

→ 1) Implement CBT in a manner consonant with its underlying philosophy (2) formulate and to apply CBT models to the individual client (3) select and apply most appropriate BT and CBT method (4) structure sessions and maintain appropriate pacing (5) manage obstacles to CBT.