



Strengthening the Alcohol and Other Drugs (AOD) Service System in the East

Service Guide



Strengthening the AOD Service System in the East

A consultation with services and clients in the East identified a number of challenges in the local service system including:

- No clear and consistent understanding of the role of Care and Recovery Coordination (CRC)
- Inconsistency in how the CRC model was being delivered by agencies across the East
- Inconsistency in the sharing of client and service information between agencies in the catchment
- Risks associated with the unplanned discharging of clients

In response, the Outer East Primary Care Partnership, supported agencies to come together to address these challenges by developing greater consistency of practice.

The following Guide outlines the agreements and resources developed in the areas of Care and Recovery Coordination and Information Sharing and Discharge Planning.

The OEPCP would like to acknowledge Access Health and Community, Anglicare, EACH, Inspiro, SalvoCare Eastern and Turning Point for their involvement.

Criteria for Care & Recovery
Coordination in Inner and Outer Eastern
Melbourne



Care and Recovery Coordination

1. Eligibility criteria for CRC

Agencies agreed that a CRC client should have:

1. Complex needs including problematic substance use that requires substantial services and supports from multiple agencies
2. Had recent engagement with services where there is a pressing concern about their substance use and/or related issues (eg., hospital admission related to their substance use)
3. Clearly articulated AOD treatment goals and/or AOD is their primary concern
4. Consented to being involved in CRC

If the person does not meet the eligibility criteria, agencies will ensure that the person receives advice on what other supports are for them. The criteria is to be used in conjunction with the Department of Health and Human Services AOD Program Guidelines.





Care and Recovery Coordination

2. Role of a CRC Worker

It was agreed that the role and function of a Care and Recovery Coordination worker should include:

Role of a CRC worker

- prepare referrals to internal/external services
- build service pathways & support client access to other services
- arrange & facilitate care team meetings
- brief intervention counselling
- attend appointments with clients
- review of individual treatment plan prior to discharge including making referrals where appropriate
- goal setting & care planning
- work collaboratively with multiple services/organisations
- harm education
- advocacy
- provide a pathway to peer support (where available)
- outreach when required to engage client and/or deliver service

CRC workers will engage with existing case managers and/or service providers that may have a role in the care of their client and ensure that the focus of CRC remains on coordination and does not shift to a case management focus.

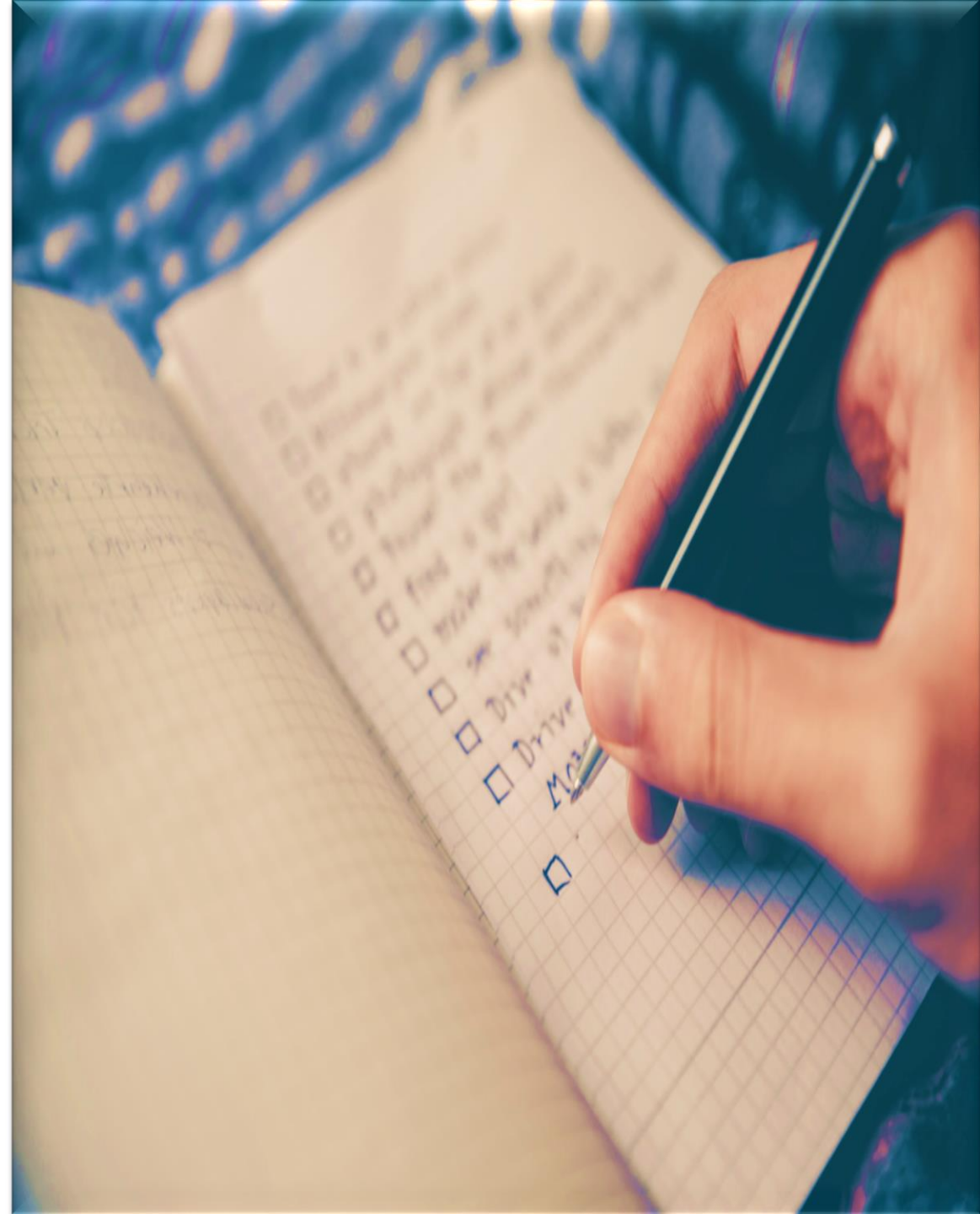
Care and Recovery Coordination

3. CRC client experience

Agencies agreed shared commitment to reviewing a client's experience could include asking CRC clients 3 short questions:

1. Has having access to CRC support assisted you in reducing problems associated with your alcohol and/or drug use? Please describe.
2. Has having access to CRC support assisted you to get the other supports you need? Please describe.
3. Would you recommend CRC to others?

These questions can be asked at any point during the client's involvement with CRC. For example, at review or as part of the discharge planning process. The questions can also be incorporated into existing internal client feedback processes.



Information Sharing and Discharge Planning





Information Sharing and Discharge Planning

1. Client centred discharge planning and information sharing processes

A set of regional principles were agreed to. The principles are outlined under the five following areas:

Admission and Planning

Early Discharge and Follow up

Information Management/Sharing

On Discharge

Change Management and Review

Resources

Several resources have been developed to promote and support the implementation of these agreements.

1. [Care and Recovery Coordination in the East](#)

Care and Recovery Coordination in Inner & Outer Eastern Melbourne

Inclusion Criteria for CRC in the East:
The client has:

- complex needs including problematic substance use that requires substantial services & supports from multiple agencies
- had recent engagement with services where there is a pressing concern about their substance use and/or related issues (eg, a hospital admission related to their substance use)
- clearly articulated an AOD treatment goal and/or AOD is their primary concern
- consented to being involved in CRC

If a person does not meet the eligibility criteria for CRC, agencies will ensure that the person receives advice on what other supports are available in the community.

Agencies who provide CRC:
ECADS Connected
Turning Point
Access Health
Inspire
Link Health
SalvoCare Eastern
SUBS Co-ordinator
Australis

Role of a CRC Worker

<ul style="list-style-type: none"> • engage referring to services • build service pathways & coordinate referrals to other services • provide case management • self-referral • attend appointments • identify individual and community needs 	<ul style="list-style-type: none"> • goal setting & case planning • work collaboratively with multiple service organisations • harm education • advocacy • provide a pathway to recovery • connect with relevant services
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CRC workers will engage with existing case managers and/or service providers that may have a role in the care of their client and ensure that the focus of CRC remains on coordination & does not shift to a case management focus.

This document is to be used in conjunction with the Department of Health and Human Services Alcohol and Other Drugs Program Guidelines.

Priority supported by Outer East Primary Care Partnership

2. [Principles of Effective AOD Discharge Planning](#)

Principles of Effective AOD Discharge Planning

Vision: Clients have the opportunity to participate in discharge planning (DP) processes that support their recovery

Admission and Planning

- DP commences at the beginning of treatment and in conjunction with the development of a client's ITP. Client & families will be encouraged to actively contribute to discharge planning.
- On admission, client consent to share information with other service providers, is collected.
- DP is continually reviewed and updated throughout treatment eg, at weekly clinical review meetings, at the end of a set number of sessions, or when circumstances change.

Early Discharge and Follow up

- Where clients are lost to follow up, there will be documented evidence of all reasonable and feasible assertive follow up attempts to contact the client.
- Where feasible, ensure continuity of care post discharge occurs through assertive telephone follow up.

On Discharge

- The discharge plan will include a relapse prevention plan & service re-entry plan to the same service.
- A discharge summary that includes additional relevant and useful treatment information, including any identified risks, is provided to service providers.
- If services are likely to be involved in a client's care post discharge, with client consent, they will be notified and involved in discharge planning.
- A discharge summary that contains information that is relevant and useful to the client is provided to them on leaving the service.

Information Management/Sharing

- Discharge summaries are created at the end of all client treatment episodes and recorded in the client's case file.
- Discharge letters are comprehensive and indicate diagnosis, treatment, progress of care.
- With client's consent, comprehensive liaison & handover will occur with all other service providers who will contribute to ongoing care. Relapse patterns & risk assessment/management information including who is holding any identified risks, will be recorded in client's health record.

Change Management and Review

- Provide staff with orientation and training in AOD service discharge planning processes.
- Include DP conversations in forums such as clinical reviews, appraisals and supervision.
- Discharge surveys includes the client's reported experience through routine discharge practice.
- Conduct regular audits of client health records to assess client discharge practice and identify where improvements can be made.

This document provides a set of regional principles that facilitates effective client-centred discharge planning and information sharing processes in Inner and Outer Eastern Melbourne areas. It is to be used in conjunction with the DHHS AOD Program Guidelines.

Proudly supported by Outer East Primary Care Partnership

3. [ECADS CRC Flyer](#)

Care and Recovery Coordination

Want support with your journey towards recovery from alcohol and/or drug use?

Care and Recovery Workers are available if:

- Alcohol and/or drug use is causing you problems
- You have other needs that are not being met such as your mental health, housing, legal, other health and social needs
- Difficulty getting the right supports at the right time

Our Care and Recovery Workers will help you:

- Develop a recovery plan
- Access the right combination of services
- Coordinate the services you need to work towards your recovery journey

Recovery

ecads Phone intake: 1800 778 278

4. [SURE CRC Flyer](#)

Care and Recovery Coordination

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Recovery

SURE Phone intake: 1300 007 873

Eastern AOD Resources

About

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Eastern AOD Resources

AOD agencies in Eastern metropolitan Melbourne are committed to providing their clients with opportunities that support their recovery.

The accessibility of information that allows for greater transparency about local AOD services and informs clients, carers, workers, service partners and others has led to the development of this portal.

In this portal you will find the following:

- **LEARN** more about AOD in the East. As a new AOD worker in the Eastern region this information will provide you with a regional perspective of the service system
- **SHARE** a welcome pack for new clients. The content in the pack can be provided to clients as they start their journey with services in the Eastern region
- **CONNECT** with local services.

Learn

Share

Connect

Where to find information

To support agencies to share information with each other, as well as with clients, a dedicated [Eastern AOD Resources section](#) has been set up on The Well.

The OEPCP is available to assist AOD agencies to upload and share information through this platform.

