

Model of Care

Practice guidelines for
facilitating effective change



Purpose of this document

The model of care aims to provide clinicians with practical guidelines in providing care for EDAS clients. It is intended to be a working document that is open for improvement, expansion and finetuning over time, and developed in consultation with all staff. Key objectives of the document include:

- An orientation to the delivery of services for new clinicians
- A framework for communicating to key stakeholders what EDAS offers clients
- A common starting point for clinicians to discuss and develop their clinical practice, and support each other in shared professional development.

The model of care does not aim to dictate how a clinician approaches the delivery of AOD counselling and support services, but offers an opportunity for greater transparency, accountability and innovation by verbalising the core principles of EDAS services.

EDAS as a whole service

Whole of client, whole of system approach

A client's contact with the service should be seen as a point of contact with the whole of health and community services – not just for themselves but for the significant others in the client's life, such as their children. Contact with EDAS presents an opportunity to evaluate if other interventions may also be helpful – e.g. access to GP care, link in with parenting supports. This includes:

- Routinely asking parents about their children's wellbeing
- Engaging in family-sensitive practice
- Being more proactive in attending to primary health needs.

Delivery of services within the broader Community Health framework

The strength of EDAS lies in the potential to integrate the delivery of specialist drug and alcohol treatment with the broader chronic disease management (CDM) focus of community health services. Based within community health centres, EDAS staff are actively encouraged to assess the benefits of clients accessing other services and programs within the community health setting, such as medical, allied health, health promotion and community development initiatives.

The Community Health setting provides a unique opportunity to engage some clients in a longer-term "team care" approach, where the EDAS episode of care is seen as one component of a broader suite of community health services offered to clients with chronic or complex needs. Clients may transition between EDAS to other departments, such as allied health services and programs aimed to improve food access, social connectedness and physical activity.

With increasing access to private services through Medicare, the priority target client group of community health are those clients who are unable to access services elsewhere, through lack of funding, access or opportunity.

All EDAS clinicians are encouraged to familiarise themselves with the core principles of CDM including:

- The Wagner Chronic Care model
- The principles and role of health promotion
- The social determinants of health and local community health outcome profiles.

As community health services are member-based organisations, clients are welcome to join the membership and have an avenue to advocate for service that best meet their needs.

Clinicians may also seek opportunities, in consultation with the service management group, to advocate for environmental changes that improve the wellbeing and safety of clients, such as improvements in legislation, venue licensing, policing, service delivery and service access. While EDAS work comes within the harm reduction component of the broader harm minimisation framework, EDAS clinicians may actively advocate evidence-based approaches to supply reduction and demand reduction where appropriate. Public statements must have the approval of EDAS management prior to publication.

EDAS as a component of the broader drug treatment sector

Contact with an EDAS clinician provides an entry point into the whole of drug services, where the EDAS clinician undertakes continual assessment of needs and facilitates referral to other services as appropriate.

In particular, given the physical impact of substance misuse, it is important that client's primary health needs are seen as a priority. EDAS counsellors should routinely enquire about whether the client has a regular GP and has regular health check ups. Where possible, it is recommended that clinicians seek consent to contact GPs to facilitate shared care. Where clients do not have an identified GP, clients should be given an opportunity to discuss their needs and possible referral to local medical services be explored.

All clinicians should be familiar with the State and Commonwealth funded services available to clients including:

- Other individual and group counselling programs
- Pharmacotherapy and other addictions medicine specialist services
- Withdrawal programs
- Residential rehabilitation
- Supported accommodation
- Specialist youth outreach
- Specialist AOD treatment for indigenous and CALD communities
- Needle Syringe Programs (NSP) and other primary care services

- Peer support programs
- Self help group programs
- Specialist consultation services for co-morbid mental health and acquired brain injury.

Core approach to the delivery of counselling services

The model of care outlines an overall approach to counselling to provide clinicians with a consistent set of principles with which to guide their work. Given the range of services EDAS offers, variance in clinician training and therapeutic orientation, and the diversity of client presenting issues, it is expected that the principles will be applied in diverse ways across the service while maintaining a core grounding framework.

EDAS provides client-centred counselling anchored within the expectation our priority goal relates to ceasing, reducing, stabilising or reducing the risks associated with the clients' alcohol or other drug use. Other concerns may be addressed in the course of counselling, but with clear lines of relevance to the presenting AOD treatment goals.

Drug use is viewed as a behaviour and it is accepted that client's use patterns, needs and co-occurring issues will be diverse and therefore so will treatment goals and interventions. In viewing the substance use as a solution to normal, human needs, the clinician seeks to validate those needs while maintaining optimism that other solutions are possible and potentially less harmful.

The approach is evidence-based with a commitment to:

- Above all, do no harm
- Utilise interventions with broad acceptance within health and counselling professions, and have solid demonstration of efficacy in research literature
- Maintain adherence to the highest ethical standards.

Client-centred counselling is based on the principles of:

- The work occurs within a collaborative relationship that respects and seeks to discover and work with the clients' experience, expertise, perceptions and goals
- Strengths based approach where the clinician aims to elicit the strengths, resilience and resources that already lie within the client that would be helpful for the client in attempting change
- The client's right to set their own goals, draw their own conclusions and make their own choices.

The clinician brings a strategic focus to these client-centred conversations, maintaining faith in the client's capacity to engage in positive behaviour change while accepting they may not choose to pursue such change at the present time. As such, we constantly seek to place possible change on equal footing with sustaining the current behaviour by seeking to elicit:

- Desire for change: how change would feel good, appealing or intrinsically valuable
- Reasons for change: how change would assist them to achieve other meaningful goals or experiences
- Need for change: how change would be important or necessary in their life
- Ability for change: the options and possible methods for change to occur
- Confidence for change: the belief that change would be possible and that they may be successful in their attempts to change
- Readiness for change: a belief that sufficient preparation has been undertaken that change seems possible in the immediate future
- Energy for change: a belief that they have the resources to assist them in making change
- Commitment to change: the intention to select and attempt specific change strategies.

Where possible, the clinician does not reinforce the current behaviour beyond validating the needs the behaviour is meeting and maintaining a non-judgemental stance toward the client's experience, past choices that have brought them to their present situation and the client's right to make their own choices about their future.

The change process



We recognise that we meet individuals at different stages of the change process and seek to meet them where they are at, with the curiosity to see whether it is meaningful and relevant for the client to move to the next stage.

- **Resistance:** We accept that some clients may not be ready or willing to make change and respect their decision. However, we are not passive in this process, recognising that the decision not to change may be the result of “settling for second best” rather than a true reflection of what they would deep down, truly want for themselves if they believed they could be successful and gave themselves permission to pursue their dreams. We maintain a faith that change may be possible, if not currently likely. Our first goal in this stage is to diffuse the resistance by ensuring the client feels heard, validated and supported.
- **Ambivalence:** This stage is seen as normal, even positive, as it indicates there is a contemplation of change even if not the pursuit of change.

Our main role in this stage is to explore the ambivalence and enhance the client's own sense of discrepancy between what they are currently doing and what they really want or desire for themselves. This stage also includes an exploration of the ways in which change might be consistent with other important goals or values.

- **Openness and commitment to change:** Active reinforcement of the client's own meaning and motivation for change is seen as a priority in these two stages. The clinician is alert to the transition into each stage, and continually seeks to build momentum for change, while remaining sensitive to the client's readiness.
- **Action:** The clinician seeks to empower the client and support their ability and confidence to engage in change, and assists in the action process as needed with the aim to increase the client's agency to initiate and achieve change through their own independent choices and action.

Counselling process

Counselling consistent of the following key elements:

- **Engagement:** The relationship with the client is fundamental. A safe, consistent therapeutic relationship is formed where the limits of the relationship and confidentiality are clear and understood.
- **Assessment:** The clinician engages in a process of gaining understanding of the client, their needs and broader context prior to developing the treatment plan and commencing interventions. The EDAS assessment process includes client-centred enquiry, DHS Specialist Assessment tool, the Modified Mini Mental State and other evidence-based assessment tools as appropriate to need and clinician training. Particular attention is paid to assessing the client's goals, the function of the substance use, dual diagnosis concerns and broader family issues and opportunities for family-sensitive practice.
- **Formulation:** Beyond diagnosis, formulation is a skill set aimed to develop a coherent understanding of the client's presenting concerns, underlying issues, function of substance use and opportunities for change. The formulation processes the information gathered in screening and assessment into an integrated whole that can be used to inform treatment planning and delivery.
- **Treatment planning:** Each episode of care requires a clear treatment plan, developed in collaboration with the client, based on client goals and those interventions appropriate to be delivered within the EDAS program. The treatment plan should be agreed, written and entered on the client file.
- **Treatment:** Clinicians select ethical, sustainable, evidence-based interventions that clients are willing to engage with and are appropriate to the individual treatment plan. Key treatment options include, but are not restricted to:

- *Motivational Interviewing*: a client-centred, directive approach that aims to build personal motivation and commitment to engage in positive behaviour change that would be meaningful from the client's perspective.
 - *Cognitive Behavioural Therapy*: e.g. functional analysis of the underlying needs being met by the drug use; assessment of the patterns of cravings and drug use to identify opportunities for realistic, meaningful change; identification of unhelpful thinking patterns and development of more helpful alternatives; identification of behavioural interventions that assist emotional regulation and increase positive experiences.
 - *Strength-based approaches*: e.g. solution focussed therapy, narrative therapy and positive psychology. These approaches aim to build resilience, empower the client and enhance the resources within the client. However, they are ideally used in conjunction with other approaches with a stronger evidence base, as research into these approaches is limited.
 - *Client-centred enquiry*: e.g. an open enquiring approach to assist the client to process their life story, dilemmas, and options to discover and deepen meaning, acceptance and inspiration and assist the client to relate these back to their substance use.
 - *Family systems approaches*: even when working with the individual, the work can be informed by family-sensitive practice, systems theory and attachment theory.
- **Referral**: The clinician assesses potential referral options throughout the episode of care, based on the client's level of interest, duty of care and risk assessment.

Harm minimisation

EDAS uses a harm minimisation framework, supporting the philosophy that as a community we need appropriate, evidence-based strategies in all three areas of supply reduction, demand reduction and harm reduction. Our role is to support the objective of harm reduction in particular, where abstinence is one of many strategies to reduce harm, and the selection of strategies will depend on the need and readiness of the individual client. It is considered important that counsellors assist clients to receive appropriate harm reduction information and skills, including linking them in with other services and sources of information if the skills are beyond the counsellor's knowledge (e.g. detailed description or demonstration of safer injecting).

Integrated treatment

Clients presenting for drug and alcohol counselling typically experience co-existing concerns, such as mental health, physical health, disability and lifestyle difficulties. All interventions provided by EDAS need to take the co-existing concerns into account to maximise the likelihood of an effective

outcome for the client and to minimise the risk of inadvertently exacerbating one or more problem.

Integrated treatment includes:

- Strategies that address both the substance use and co-existing concern at the same time (e.g. developing strategies to deal with cravings that also work for managing anxiety)
- Strategies that take the co-existing condition into account when delivering AOD treatment (e.g. accommodating ABI in selection of treatment and reinforcement strategies)
- Referral for concurrent treatment, with clear lines of communication between treating teams (e.g. referral to a GP for management of a client's diabetes while they attend drug and alcohol counselling with EDAS)
- Models of conceptualising the substance use that is consistent with underlying concerns (e.g. an understanding the function of adult substance use in the context of childhood trauma that empowers the client rather than further undermines self worth)
- Approaches to AOD treatment that build resilience to address co-existing concerns now or at a later time (e.g. strengths-based approaches, strategies to manage distress or strategies that foster self confidence).

EDAS programs

Adult CCCC

The EDAS CCCC services for clients 22 years old and above is funded to be primarily office based counselling. Priority access should be given to high need and urgent referrals, including Child Protection, mental health and homeless clients.

Clients with a history of multiple admissions to hospital emergency departments may benefit from a referral to the HARP Psychosocial Case Management service for short term, intensive outreach case management to link in with community based services and reduce the risk of future admissions.

Youth CCCC and outreach

EDAS youth services consider the developmental stage and needs of young people accessing the service. Rather than replicate other services specialising in outreach for young people in crisis, EDAS is well placed to offer supports that complement existing services.

The youth services have typically come from a philosophy of building resilience in young people to make empowered and informed choices for themselves, rather than to focus purely on protection from danger.

School-based programs aim not only to facilitate a useful process, but also build relationships with the schools and students to increase the likelihood

students will seek individual support earlier if they have concerns about their own or someone else's substance use.

The history of drug education is full of well-intentioned programs that research suggests at best achieved nothing through to at worst inadvertently increased the likelihood that young people exposed to the program went on to engage in drug use. It is therefore essential that program development includes attention to research recommendations and have a strong evidence-based rationale to ensure appropriate duty of care to students and parents.

Family program

The family based program offers support to anyone concerned about another's drug use, including parents, grandparents, partners, siblings, children and friends. The program seeks to alleviate the distress associated with caring for someone with substance misuse, through support, information, skill enhancement and access to other resources.

The program also offers an indirect opportunity to facilitate change for the person using substances by assisting and strengthening their immediate support networks.

The program may be offered in isolation to other EDAS services or as part of a broader intervention involving multiple family members.

ABI program

Service delivery for clients with an acquired brain injury (ABI) incorporates adult CCCC evidence based practices, but will need to be adjusted in response to the cognitive impairment. This often involves more time and resources, and a need to be more directive at times.

The clinical process commences differently depending on whether a diagnosis has been made of ABI, if a neuropsychological assessment has been conducted previously or if a clinician suspects the presence of ABI.

The diagnosis and assessment of ABI allows clinicians to take a strengths based approach to treatment and put in place management strategies for cognitive deficits. Depending on the recommendations within an assessment (normally a Neuropsychological assessment) or the observed impact the ABI is having on the client's ability to care for themselves, specialist or intensive support services such as case management or VCAT (expand) may need to be involved within a shared care format.

It is important to identify external or environmental supports that may be utilised to support treatment outcomes. The EDAS ABI clinician is available for secondary consultation and, in some cases, shared care with the client where consent has been granted. Care coordination and shared care approaches become integral to the treatment of clients with ABI within the medium to severe categories.

The primary adjustments to the counselling process required for clients with an ABI have been acknowledged by Government and outlined in the Victorian

Government's Clinical Treatment Guidelines for clients with co-occurring ABI and AOD issues.

Forensic AOD counselling

Forensic counselling draws on many of the principles central to CCCC counselling, but is also informed by an extensive body of literature on offending behaviours and working with the mandated client.

While the work may be identical at times, mandated AOD counselling is part of a broader government approach to offender rehabilitation, where reduction or cessation of substance use is viewed as both a client-centred benefit and an intervention to reduce offending in the community.

The clinical process is informed by research findings that indicate mandated treatment can be more effective than voluntary treatment; the referral for brokered forensic AOD counselling offers an opportunity to engage a client who may not otherwise present for treatment, but who still has the potential to make changes that are meaningful for them as a result of engaging in treatment.

The forensic work may require significant effort to engage the client and, even if the client is not able to form a therapeutic relationship based on trust and willingness to tolerate emotional vulnerability, the clinician can still aim to form an effective working relationship with the client where they work together toward common goals.

The Andrews and Bonta Risk-Need-Responsibility model highlights the difference between criminogenic and non-criminogenic needs. Criminogenic needs are those where positive outcomes are also associated with a reduction in offending behaviour, including substance misuse, antisocial attitudes, antisocial peers and poor problem-solving. Non-criminogenic needs are those where positive outcomes are unrelated to changes in offending behaviour, including self esteem, anxiety, depression, feelings of alienation, psychological discomfort and neighbourhood improvement.

This is not to suggest we do not address non-criminogenic needs at all, but rather they should be addressed in conjunction with, or following, the treatment of criminogenic needs. Otherwise, if there is little change in offending behaviour, there is likely to be little meaningful change for either the client or the community in terms of longer-term quality of life and well-being.

The principles of Motivational Interviewing are nicely aligned with the offender treatment goal that the client assumes responsibility for their actions. In order for a person to feel best able to take responsibility for their behaviour, they need to feel valued and respected by others (collaboration), feel competent and effective (evocation) and in control of their choices and actions (autonomy).

The work needs to take into account the likelihood of concerns around confidentiality, trust, maintaining appropriate boundaries and consequences for engaging in treatment, possible risk issues and the potential for the involvement of the client in court hearings. However, the principles of

working with offenders is not so much to do something different, as to deliver best practice at a disciplined, high standard with attention to process and the nature of the relationship being formed.

If a client has been referred through COATS, they have given consent for you to share information with the Community Corrections Officer. It is helpful to consider the CCO as a case manager. In which case the key question in terms of release of information is "What would the case manager need to know, to effectively work with this client and reduce their likelihood of more punitive responses from the criminal justice system?" For example, a client who has relapsed may benefit from the CCO increasing the frequency of urine testing or a variation of treatment to a withdrawal unit as strategies to minimise the current relapse and prevent an escalation to a more entrenched return to harmful substance use and offending.

The bigger picture

The treating team

While one worker may have the primary contact with the client, EDAS provides a multidisciplinary treating team that supports and informs the work with individual clients or programs.

The role of supervision and peer supervision

Clinical supervision is integral to maintaining a high quality counselling service as well as fostering professional development and ensuring accountability of staff. The role of supervision within EDAS aims to provide:

- Professional development through the opportunity to reflect on assessment, treatment and process issues
- Support and an opportunity debrief
- Transfer of knowledge and expertise
- Accountability to senior staff members
- A structured forum where service related issues can be openly raised and discussed
- Encourage connection between different clinicians and roles within the broader organisational structure.

While rewarding, counselling is a complex and often difficult process where unique relationships are formed and common principles of practice must be tailored to individual client concerns. The work requires us to be acutely aware of how we are being with and responding to the client. Even the most experienced clinician can benefit from checking in with a neutral third party to review processes and options.

Supervision should be responsive to the clinician's developmental stage and needs, and seek to enhance the ongoing development of perception, knowledge and skills relevant to the clinical role. The aim is not to advise, although direction may at times be necessary from an organisational objective, but to provide a safe and respectful environment in which

supervisees can explore options and identify the most appropriate course of action.

While supervision seeks to be a supportive, collaborative process, there may be times when the supervisor must also manage tensions that exist between themselves and the supervisee on the best way to manage the client's care. Ultimately, the supervisor is accountable to the client and to the organisation for the actions of the supervisee, and holds the responsibility to ensure the highest standards are maintained. Unresolved disagreements between the two may need to be taken to the next level of line management.

Peer supervision

Formal and informal peer supervision should be encouraged throughout the teams. More formal peer supervision may take the shape of case discussion, specialist interest groups or other forms of reflective practice. Day to day conversations about client care are also vital in maintaining healthy, enthusiastic, learning teams. Peer support may include the sharing of knowledge, skills or insights, or shared problem solving to resolve clinical dilemmas. All staff have a responsibility to ensure these conversations are positive, respectful and collaborative, with constructive feedback.

Internal staff mentoring program

Staff may request to seek mentoring from another regional EDAS staff member. Permission must be sought from both party's line managers and terms such as duration and frequency agreed upon. This allows staff to gain fresh perspectives or learn from a colleague with shared interests.

External consultations

Consultations with external agencies and organisations are an important part of clinical practice in all areas of our work. They provide specialist information relating to best-practice, and offer specific advice about the assessment, treatment and referral options best suited to the needs of the clients.

The process of external consultation is strongly supported and encouraged by senior management within EDAS, as it offers considerable benefits to clients, clinicians and the relationships between agencies.

External consultation might relate specifically to an individual client, or it could involve the exploration of themes, processes and the general skills required to work with a particular client group.

External consultations may be formal, with staff from agencies with which EDAS has an established agreement or relationship, such as the dual diagnosis services NEXUS, Eastern Dual Diagnosis Service and Southern Dual Diagnosis Service. Informal consultations may be sought with a range of other services on an as-needs basis, and examples of these organisations may include ARBIAS and Forensicare.

Issues to consider when undertaking external consultations include:

- Making the best use of the time available by being prepared (having as much information available) prior to contacting the relevant agency
- Speaking the “language” of the agency staff with whom contact has been sought, or at least being aware that they might not be familiar with the expectations and practices of the alcohol and drug sector
- Asking clear and concise questions
- Seeking appropriate permission from line management for more formal consultation processes, such as mentoring
- Clarifying roles, and being clear about what we can and can't do as clinicians.

All secondary consultations should be clearly documented in case notes. This should include the name of the agency, staff member spoken to, content of the consultation and the time and date.

Whilst shared care can provide huge benefits for clients, the following must be considered throughout this process:

- The client must have agreed to the shared care process, and have signed a release of information agreement with all services and/or programs involved, and may withdraw this consent at any stage
- Responsibility for case management and/or treatment remains with the agency to which the client has been referred as per their own processes and policies and procedures
- In instances where case workers disagree or there is a contradiction in treatment expectations, the matter should be referred to the EDAS clinician's line manager
- Each case worker or clinician retains responsibility for case noting and records management as expected by each service's policies and procedures
- The roles and responsibilities of clinicians involved need to be clarified at the commencement of the process.

Shared Care

EDAS clients often have complex issues such as mental illness, acquired brain injury (ABI), chronic medical conditions, homelessness, and legal problems. These clients will most likely have had contact with other agencies and some may have case workers managers from these organisations.

Within a community health service setting, shared care can relate to clients who have contact with two or more programs within the same agency (for example EDAS, mental health nurses and general practitioners). Otherwise, shared care pertains to clients who are linked into treatment at two separate agencies, such as EDAS and a mental health provider.

The major principle underpinning the concept of shared care is that the services or programs involved should work effectively together. This includes

providing the most collaborative, holistic and integrated approach to treatment possible for the client, utilising complementary elements of best-practice. This might include a joint process of assessment, case formulation and treatment, and some agencies have developed "Shared Care Plans" and pro-forma templates to reflect identified joint treatment goals.

Case conferencing

In instances where clients are receiving treatment and support from two or more sources simultaneously, but there is no shared care arrangement in place a case conference can be valuable to ensure that clinicians are not working at cross purposes. A case conference is usually a meeting which has been arranged at a specific time and place to discuss a client's progress, clarify roles and responsibilities of the workers involved and future directions

Case conferences may be internal to an agency where there are two or more programs involved with a client, or external when they involve different agencies. Issues to consider in case conferencing will be the same as those for secondary consultations.

Workforce development and training

Effective clinical practice can only be fostered and sustained by investing in workforce development strategies that encompass more than isolated training activities. Workforce development includes a full range of strategies relating to recruitment, retention, policy and procedures, education, supervision and mentoring to ensure effective practice.

EDAS management has a responsibility to promote effective workforce development by:

- Including evidence-based strategies and examples of good practice within training programs
- Ensuring that adequate resources are available to implement the proposed initiatives
 - Working collaboratively with all stakeholders
 - Considering the needs of different clinicians, such as part-time, regional or out-posted workers.

Training, where possible, is to be:

- Part of a broader workforce development strategy
- Delivered with learner-centred adult education principles that respects clinician's existing expertise and experience
- Evidence-based and consistent with endorsed clinical guidelines for best practice
- Reviewed, evaluated and modified
- Accredited and credentialed in its own right, or to form part of a broader credential
- Able to be integrated into current EDAS practice.

Relevant resources to support and embed training include: training needs assessment surveys; pre and post training evaluations; orientation and training manuals; professional supervision, clinical supervision and mentoring; and opportunities for networking and collaboration with other services.

It is expected that staff undertake to gain the four minimum Certificate IV AOD competency-based units or higher while employed with EDAS as required by the *Victorian Alcohol and Other Drugs Minimum Qualification Strategy*.

Statutory obligations and service protocols

Clinicians have a duty of care to monitor risk to self and others. This includes strict adherence to legal obligations, such as mandatory reporting of child sexual abuse, and legislation relating to health records and privacy, child protection and wellbeing, mental health and criminal behaviours.

Where a client is involved in Child Protection, Office of Corrections or the mental health system, there is potential for misunderstanding, conflict of interest, and poorer outcomes.

Each contact with professionals from other agencies such as these is an opportunity to form positive, collaborative relationships for the current client and to set up ways of working that may improve the way each system manages these shared clients in the future.

When engaging with professionals from other systems, it is useful to:

- Ensure there is a clear and accurate understanding by the other professional of what the drug and alcohol clinician is able to do, and what are the limits of the role
- Identify the common ground, even when the methods being used may differ
- Clarify goals and expectations for the client and counselling
- Clarify risk issues and warning signs that more intensive intervention may be required
- Provide a balanced view of strategies aimed at managing short-term risk (e.g. total disclosure to Child Protection) versus longer-term therapeutic benefit (e.g. limits on disclosure that assist engaging the client, building trust and maintaining the client in treatment long enough to gain benefits from the interventions).

While case-noting and report writing should always be of a high professional standard, risk issues and involvement of other statutory bodies requires meticulous documentation of assessment, treatment and risk management strategies. Reports being submitted to court should be sited by a line manager before submission, as the entire organisation is being represented though the report, not just the work conducted by an individual clinician.

Managing innovation

EDAS has a commitment to continual quality improvement, which involves an ongoing process of reflecting on our practice and questioning whether we can do what we do better. It is important to keep developing our skills and programs, which may include trying new approaches over time. However, our duty of care to clients and the community requires that we do no harm, and managing innovation includes managing the risks associated with trialling new approaches. This includes the expectation that staff will discuss with their line manager or organisational supervisor the proposed use of any approach that does not have an established evidence base, is not included in the model of care, or is in the model of care but is new for the clinician

EDAS as a learning institution

EDAS and the consortium partners are learning institutions that contribute to the professional development and evidence-based practice of future counsellors. This involves attending to both the immediate duty of care to current clients and making use of the opportunity to contribute to the quality of care offered to the community to ensure well-trained professionals are entering the health and community system, including:

- Supporting student placement and observation
- Investment in early career counsellors.