CHCAOD001

Work in an alcohol and other drugs context.

Assessment 1 of 3

Short Answer Questions ASSESSOR GUIDE

Version #

Assessment Details

This section is for SUT VE Quality and Compliance review and feedback and must be deleted in the student version of the assessment.

SECTION 1		
UNIT OF COMPETENCY DETAILS		
Code	Title	
CHCAOD001	Work in an alcohol and other drugs context	
COURSE AND MODULE DETAILS *Assessments may be published in more than one course. Add lines for additional courses as needed.*		
Course Code (UPed)	Module Number (Order)	Module Code (UPed)
SOE4AOD01A	10	M00638A
ASSESSMENT TYPE		
Assessment Method: *Select all that apply.*	**Questioning** Choose an item. Choose an item.	

SECTION 2
STUDENT INSTRUCTIONS *The following instructions detail the requirements of the assessment and are captured in the LMS assessment page. This includes a description of the student instructions, associated files and submission instructions.*
Student instructions
This is assessment 1 of 3 assessments for CHCAOD001 Work in an alcohol and other drugs context This assessment requires you to answer 34 short answer questions to test your knowledge required of this unit. To be assessed as competent, you must complete all tasks in the spaces required. You are required to download your assessment by clicking on the assessment document icon below (see Let's begin) and upload your completed assessment for submission.
Supporting documents
To answer some of the questions, you will need to access the following documents: • ACE Staff Handbook • Client Report Template
Files for submission

Submit the assessment document with all tasks completed in the spaces provided.

Submission instructions

PDF File Submissions

Please save all Word documents as PDF files before submitting.

IMPORTANT: Word documents will **not** be accepted.

Most modern web browsers can open and display a PDF file. If you have an older operating system, however, you may need a PDF reader installed on your device such as the Acrobat Reader, available from Adobe.

Windows: Word 2013 and newer

Choose **File** > **Export** > **Create PDF/XPS**.

Windows: Word 2010

1. Click the **File** tab
2. Click **Save As**
   - To see the Save As dialog box in Word 2013 and Word 2016, you have to choose a location and folder
3. In the **File Name** box, enter a name for the file, if you haven't already
4. In the **Save** as type list, click **PDF** (*.pdf).
   - If you want the file to open in the selected format after saving, select the Open file after publishing check box.
   - If the document requires high print quality, click Standard (publishing online and printing).
   - If the file size is more important than print quality, click Minimum size (publishing online).
5. Click **Options** to set the page to be printed, to choose whether markup should be printed, and to select output options. Click **OK** when finished.
6. Click **Save**.

macOS: Office for Mac

To save your file as a PDF in Office for Mac follow these easy steps:

1. Click the **File**
2. Click **Save As**
3. Click **File Format** towards the bottom of the window
4. Select **PDF** from the list of available file formats
5. Give your file a name, if it doesn't already have one, then click **Export**

For more detailed instructions refer to Microsoft Support.

SECTION 3

ASSESSMENT TASK CRITERIA AND OUTCOME

This assessment will be graded as Satisfactory (S) or Unsatisfactory (US).

To achieve Satisfactory; valid, sufficient, authentic, and current evidence of meeting the criteria must be submitted.

Refer to the mapping spreadsheet for details for this unit.

SECTION 4

ASSESSMENT DETAILS

Please refer to SECTION 2 to confirm how the assessment tools will be built and the methods that will be used to collect evidence i.e., Student's will type answers directly into LMS or will upload of files of completed assessment tasks.

The STUDENT INSTRUCTIONS above will be added directly into the LMS.

All associated files will be accessed via the LMS, as will any Assessor Guides, Matrix, Templates etc.

Students and Assessors have restricted permissions in the LMS. Assessor Guides, including model answers, will be available to Assessors ONLY.

The following pages contain the draft assessment which will be built into the LMS once reviewed. This includes:

☒ Instructions to students

☒ Questions /tasks

☐ Templates /tables where applicable

☐ Links to supporting files /websites

☒ Instructions to assessors

☒ Sample answers /examples of benchmark answers

SECTION 5

STAKEHOLDERS AND SIGN OFF

List all that apply for each of the stakeholder roles below.

UPed Learning Designer/Author name	Estelle Zivanovic
SOE Quality and Compliance Manager name	
SUT VE Quality Compliance name	
Date approved	

Assessment Instructions

Task overview

This assessment task is divided into 34 questions. Read each question carefully before typing your response in the space provided.

Assessment Information

Submission

You are entitled to three (3) attempts to complete this assessment satisfactorily. Incomplete assessments will not be marked and will count as one of your three attempts.

All questions must be responded to correctly to be assessed as satisfactory for this assessment.

Answers must be typed into the space provided and submitted electronically via the LMS. Hand-written assessments will not be accepted unless previously arranged with your assessor.

Reasonable adjustment

Students may request a reasonable adjustment for assessment tasks.

Reasonable adjustment usually involves varying:

- the processes for conducting the assessment (e.g. allowing additional time)
- the evidence gathering techniques (e.g. oral rather than written questioning, use of a scribe, modifications to equipment)

However, the evidence collected must allow the student to demonstrate all requirements of the unit.

Refer to the Student Handbook or contact your Trainer for further information.

Please consider the environment before printing this assessment.

QUESTION 1

Describe each stage in the behaviour change model. Explain how this model is useful in a community service setting.

(50-70 words for each explanation)

STAGE	**STAGE NAME** *(exemplar answers are compulsory)*	**EXPLANATION** *(answers must reflect these explanations)*
Stage 1	*Precontemplation*	*The client is not thinking sincerely about changing and can be defensive about drug use. At this stage, they may not see their drug use is problematic. The way they see it, the pluses of using outweigh the minuses or negative consequences, so they are content to continue using.*
Stage 2	*Contemplation*	*The client ponders the prospect of quitting or decreasing their drug use but is unsure about taking the next step. They still enjoy taking drugs but are starting to experience negative consequences, such as personal, psychological, physical, legal, social or family problems.*
Stage 3	*Preparation*	*The client has tried to change their using habits in the last 12 months. They have now recognised the negative consequences of continuing to use outweigh the pleasures brought by taking the drug, and they have become more serious about the next steps to sobriety. The client understands they must make changes and that the time for change is on the horizon. However, some people will decide not to make any changes at this stage.*
Stage 4	*Action*	*The client will take active involvement in the steps required to start changing their using habits and may take huge strides towards meaningful changes in their behaviours. The client may try various methods of giving up or reducing drug taking. During this part of the process, clients are at their biggest risk of relapse. Some clients may still feel ambivalent about change at this stage.*
Stage 5	*Maintenance*	*The client can avoid the temptation to go back to their past using behaviours. They have learned how to anticipate and manage their impulses to use and have learned new ways of coping that they can employ. It is normal for clients to have minor setbacks at this stage, but these setbacks are not seen as failures*

QUESTION 2

Discuss when the public health model came into existence and the evidence base for it in AOD practice.

(200-300 words)

Responses must include the following concepts in the answer below:
The public health model has existed in Australia since the mid-1980s. The National Campaign Against Drug Abuse developed as part of the National Drug Summit in 1985 and later as part of the National Drug Strategy in 1992–1997 and 1998–2003. This strategy continues to inform treatment and prevention programs under the National Drug Strategy 2017–2026.
This model acknowledges that no single factor is considered sufficient for understanding drug use or the problems that may arise from it. Because of this, the public health approach:

- acknowledges that drugs can be both beneficial and hazardous
- recognises significant individual differences in susceptibility to drug problems
- stresses the relevance of social and environmental factors in determining rates of drug use and related problems
- highlights the importance of influences such as the availability and promotion of drugs.

Drug use is understood as occurring for several reasons and occurs along a continuum between abstinence and harmful drug use.
It is an integrated approach that recognises three pivotal factors and how they interrelate. These are the individual (the user and their characteristics), the agent (the drug or drugs of choice and its characteristics) and the environment (the context in which the drug is used). These categories can also help identify the range of harms that people may experience as part of their drug use and help focus on the strategies to help reduce harm related to drug use as part of the Interaction Model.
A range of interventions is offered to suit the many different types of people affected. From a public health perspective, these would include harm reduction strategies, structural environmental changes, and treatment interventions.

QUESTION 3

Sometimes, a client may disclose something to you, and you are required by law to break confidentiality and report it. Identify when you need to disclose such information and the limitations as per National Privacy Principles. Give two examples.

(150-200 words)

Responses must include the following concepts in the answer below with two examples:
An organisation is allowed to disclose personal information without gaining consent if it is necessary to lessen or prevent a serious and imminent threat to an individual's life or health. The National Privacy Principles (NPPs) also allow secondary use and disclosure if it is necessary to lessen or prevent a:

- serious and imminent threat to an individual's safety; or
- serious threat to public health or public safety.

You will also find that you may be required to disclose personal information if a client has been sentenced to attend the organisation or service through court. Otherwise, personal information is only to be disclosed with the consent of the person.

Some examples of times when information must be disclosed are:

- when a client threatens to harm themselves
- when a client threatens to harm others
- when a client discloses sexual abuse of a child
- when a client discloses information which leads you to believe that a child may be or may have been at risk of sexual abuse.

QUESTION 4

Describe the role of codes of practice in providing AOD support, referencing the code of practice relevant to your sector or organisation.

(100-200 words)

The student must reference the code of practice relevant to their organisation or community services sector. Responses must include the following concepts in the answer below:
A code of practice is a set of written rules which explains how people working in a particular profession should behave. It includes a greater level of guidance and detail than would generally be in legislation or regulations. Codes of practice can be easily updated to reflect developments in best practice, and each state in Australia may have a different set of standards. Therefore, it is important to ensure you are familiar with your state's guidelines. For instance, in AOD support work, the number one standard is harm prevention, including the physical, psychological, devaluation of personal worth, social harms, economic harms, and legal harms.

An example of the principles of practice that underpin AOD care in NSW includes:

- Principle 1: services are person-centred.
- Principle 2: Services are safe.
- Principle 3: services are accessible and timely.
- Principle 4: Services are effective.
- Principle 5: Services are appropriate.
- Principle 6: Services use their resources efficiently.
- Principle 7: Services are delivered by a qualified workforce.

Related sources can include:

- National Drug Strategy 2017-2026
- The National Quality Framework for Drug and Alcohol Services
- National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-29
- The Strategic Framework for Integrating Care (NSW Health 2018)

QUESTION 5

Describe how the changing social, political, cultural, and economic contexts of AOD support and treatment might impact your practice.

(200 words)

Responses to this question will vary but should demonstrate similar to the following:
The Australian Institute of Health and Welfare regularly prepare a report to provide an overview and understanding of current alcohol and other drug use in Australia, with the aim to improve and implement strategic approaches to harm minimisation via union with the National Drug Strategy's three pillars: demand reduction, supply reduction and harm reduction. This report covers three general areas of impact: health, social and economic.
Being familiar with the trends in these areas will inform services on how likely their cultural mix of clients might be to suffer from particular health issues, how often clients may be engaging in risky or violent behaviour and the cost to both themselves and the economy because of their substance abuse. With this information, practices can more appropriately target their treatment strategies to promote harm minimisation within the alcohol and other drugs community.
In addition, changes in the political environment (such as elections or changes in leadership) can impact what services a practice may deliver since many supplement their budgets with government funding. Keeping a finger on the pulse of the political landscape will enable services to better predict what funding will be available for the next financial year.

QUESTION 6

Describe dignity of risk and its importance in self-determination and empowerment for people living with AOD issues.
(150-200 words)

Responses must include the following concepts in the answer below:

Dignity of risk is a balancing act between the duty of care and a client's right to undertake activities you think may put them at risk. It ensures their right to take risks, make mistakes and learn from them, just like everyone else.

Dignity of risk comes from the premise that every person has the right to decide how they want to live their life. It is about respecting each person's right to:

- *have choices*
- *take risks*
- *make and experience mistakes*
- *learn from their mistakes*
- *enjoy their own successes.*

The freedom to make decisions and take risks fosters a sense of self-worth and empowerment by allowing us to make choices we believe are right for us. Providing clients with dignity of risk is critical in supporting recovery as they have to be able to navigate their world and make choices that may put them back in contact with hard decisions.

QUESTION 7

Describe mandatory reporting as it applies to the health and wellbeing of children and young people.

ASSESSOR GUIDE:

(100-150 words)

Responses must include the following concepts in the answer below: *Mandatory reporting laws aim to identify child abuse and neglect cases and assist the individual children in these cases. They were first developed in response to the largely hidden nature of child physical abuse and neglect, with the purpose of bringing cases to the attention of child welfare. They require selected groups of people to report suspected child abuse and neglect cases to government authorities.* *However, the laws are not the same across all jurisdictions. Differences exist in who has to report, what types of abuse and neglect have to be reported, the 'state of mind' that activates the reporting duty (i.e., having a concern, suspicion, or belief on reasonable grounds) and who the report is made to.*

QUESTION 8

Although you may not be working directly with children and young people, there is the potential for you to become aware of potential child abuse or neglect in the course of your work. Mandatory reporting requirements vary by state and territory in Australia. Use the following table to identify mandatory reporting requirements relevant to your state or territory and your work role.

The student correctly completes the table according to the legislation for their state or territory. A sample for NSW is given below.

The following table can be found at: https://aifs.gov.au/resources/resource-sheets/mandatory-reporting-child-abuse-and-neglect.

STATE/TERRITORY	***NSW***
WHO IS MANDATED TO REPORT?	*In the course of his or her professional work or other paid employment, a person delivers health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children.* *A person who holds a management position in an organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children.*
WHAT MUST BE REPORTED?	*Reasonable grounds to suspect that a child is at risk of significant harm, and those grounds arise during the course of or from the person's work*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Emotional/psychological abuse* ▪ *Neglect* ▪ *Exposure to domestic violence*
RELEVANT LEGISLATION?	*Sections 23 and 27 of the Children and Young Persons (Care and Protection) Act 1998 (NSW)*

STATE/TERRITORY	VIC

WHO IS MANDATED TO REPORT?	*Any person believing, on reasonable grounds, that a child is in need of protection from physical injury or sexual abuse, and the child's parents are unwilling or unable to protect the child*
WHAT MUST BE REPORTED?	*A belief, on reasonable grounds, that a child is in need of protection from physical injury or sexual abuse, and the child's parents are unwilling or unable to protect the child*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse*
RELEVANT LEGISLATION?	*Children, Youth and Families Act 2005 (Vic)*

STATE/TERRITORY	QLD
WHO IS MANDATED TO REPORT?	*Anyone who suspects that a child has suffered, is suffering, or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse, or non-accidental injury*
WHAT MUST BE REPORTED?	*Reasonable grounds for a suspicion that a child has suffered, is suffering, or is at an unacceptable risk of suffering significant harm caused by physical or sexual abuse, or non-accidental injury*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Emotional/psychological abuse* ▪ *Neglect* ▪ *Significant harm from exposure to domestic violence*
RELEVANT LEGISLATION?	*Child Protection Act 1999 (Qld)*
STATE/TERRITORY	Western Australia
WHO IS MANDATED TO REPORT?	*Any person who, during the course of his or her employment, has reasonable grounds to believe that a child is in need of protection*
WHAT MUST BE REPORTED?	*Reasonable grounds to believe that a child is in need of protection*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Neglect*
RELEVANT LEGISLATION?	*Children and Community Services Act 2004 (WA)*

STATE/TERRITORY	South Australia
WHO IS MANDATED TO REPORT?	*Any person who, in the course of their professional work, reasonably suspects that a child is being or has been abused or neglected*

WHAT MUST BE REPORTED?	*Reasonable suspicion that a child is being or has been abused or neglected*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Emotional / psychological abuse* ▪ *Neglect*
RELEVANT LEGISLATION?	*Children's Protection Act 1993 (SA)*

STATE/TERRITORY	Tasmania
WHO IS MANDATED TO REPORT?	*Any person who has reasonable grounds to suspect that a child is in need of care and protection*
WHAT MUST BE REPORTED?	*Reasonable grounds to suspect that a child is in need of care and protection*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Emotional / psychological abuse* ▪ *Neglect*
RELEVANT LEGISLATION?	*Children, Young Persons and Their Families Act 1997 (Tas)*

STATE/TERRITORY	Australian Capital Territory
WHO IS MANDATED TO REPORT?	*Any person who has reasonable grounds to believe that a child or young person is in need of care and protection*
WHAT MUST BE REPORTED?	*Reasonable grounds to believe that a child or young person is in need of care and protection*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Emotional / psychological abuse* ▪ *Neglect*
RELEVANT LEGISLATION?	*Children and Young People Act 2008 (ACT)*

STATE/TERRITORY	Northern Territory
WHO IS MANDATED TO REPORT?	*Any person who, in the course of his or her employment or profession, has reasonable grounds to believe that a child is being or has been abused or neglected*

WHAT MUST BE REPORTED?	*Reasonable grounds to believe that a child is being or has been abused or neglected*
ABUSE AND NEGLECT TYPES THAT MUST BE REPORTED?	▪ *Physical abuse* ▪ *Sexual abuse* ▪ *Emotional / psychological abuse* ▪ *Neglect*
RELEVANT LEGISLATION?	*Care and Protection of Children Act 2007 (NT)*

QUESTION 9

Working in a community services role carries a number of legal and ethical obligations.

Identify your legal and ethical obligations to clients, their families, extended care networks, and your colleagues and other people in your workplace under the following headings. For each category name at least one relevant national or international legislation or regulation:

(100-200 words per row)

Responses must include the following concepts in the answer below

CATEGORY	NATIONAL or INTERNATIONAL LEGISLATION or REGULATION
Discrimination	*Discrimination happens when a person, or a group of people, is treated less favourably than another person or group because of their background or certain personal characteristics. This is known as 'direct discrimination'. It is also discrimination when an unreasonable rule or policy applies to everyone but disadvantages some people because of a personal characteristic they share. This is known as 'indirect discrimination'.* *In Australia, it is illegal to discriminate based on the following in most areas of public life (including in education and training and employment):* ▪ *age* ▪ *disability* ▪ *race* ▪ *sex* ▪ *intersex status* ▪ *gender identity* ▪ *sexual orientation.* ▪ *Australia's federal anti-discrimination laws are contained in the following legislation:* ▪ *Age Discrimination Act 2004* ▪ *Disability Discrimination Act 1992* ▪ *Racial Discrimination Act 1975* ▪ *Sex Discrimination Act 1984.*

	The company rules on discrimination in the organisational policy and procedures and codes of conduct may also apply to discrimination.
Duty of care	*Duty of care requires us to ensure that all the people we work with are safe and that we abide by relevant legislation. A duty of care exists where someone's actions could reasonably be expected to affect others. A duty of care is particularly acknowledged where there is a relationship of power and authority between two people, e.g., between a support worker and a client.* *Duty of care is the legal duty to take reasonable care so that others aren't harmed and involves identifying risks and taking reasonable care in your response to these risks. Duty of care is reciprocal – the organisation has a duty of care to the clients and support workers, and the support worker has a duty of care in the services they provide. A person also owes a duty of care to their colleagues, visitors to the organisation, and clients' children and families.* ▪ *Generally, 'reasonableness' is determined by considering what a group of ordinary people (peers) would see as reasonable in a given situation and considering the abovementioned circumstances.* ▪ *In most cases, the employing organisation will protect the worker from being sued, but they may not offer this protection if the community services worker:* ▪ *has failed to follow the organisation's policies and procedures* ▪ *has broken the law* ▪ *has clearly breached duty of care* *Section 19(1) of the WHS Act*
Human rights	*The UN defines human rights as the rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more.* *The Australian Government has agreed to uphold and respect many of these human rights treaties, including the:* ▪ *International Covenant on Civil and Political Rights* ▪ *International Covenant on Economic, Social and Cultural Rights* ▪ *Convention on the Elimination of All Forms of Racial Discrimination* ▪ *Convention on the Elimination of All Forms of Discrimination against Women* ▪ *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ▪ *Convention on the Rights of the Child* ▪ *Convention on the Rights of Persons with Disabilities.* *An organisation should adopt a 'rights-aware approach' to operational practices. This allows the organisation to understand its challenges and dilemmas from the perspective of all relevant stakeholders and to better manage social risk.*

	A human rights-based approach encourages organisations to: ▪ *identify all stakeholders that have a holding in their business, including clients* ▪ *identify the particular rights which these stakeholders have and the corresponding duties* ▪ *consider relevant stakeholders' capacity for participation* ▪ *assess the extent to which the organisation's practice currently meets or needs to improve in relation to key human rights principles.* ▪ *As a support worker, you will also need to ensure that your client's human rights are met.* *The Racial Discrimination Act 1975*
Children in the workplace	*In many societies, including ours, children are valued, and their health, safety and wellbeing are important. Protecting our children and young people from harm is everyone's job. In Australia, each state has laws to keep children safe and ensure their needs are met.* *Legal and ethical obligations to children in the workplace include mandatory reporting, Working with Children Check obligations, organisational policy and procedure obligations, relevant children and young workers legislation in each state, WHS legislation, privacy legislation and the 1989 Convention of the Rights of the Child.*
Code of conduct	*A code of conduct is intended to be a central guide and reference for users in support of day-to-day decision-making. It is meant to clarify an organisation's mission, values and principles, linking them with standards of professional conduct. The code of conduct relevant to your service or profession provides specific guidelines for individual volunteer and staff behaviour in the service.* *Along with professional codes of ethics, the code assists workers in guiding their behaviour to do what is best for clients. It outlines a worker's responsibilities to clients and their families, their colleagues, the community and the profession.*
Informed Consent	*Informed consent means that a person understands their condition and proposed treatment. People usually give their own consent to treatment. Without the information that relates to their medical condition and treatment, a person can't make a fully informed choice and give valid consent for their medical treatment. As a support worker, you can help them to gather that information and support them in their decision-making. Support workers cannot make treatment choices for the people they care for.* *When providing services to a client, you must ensure they understand what they are agreeing to participate in. When a client gives informed consent, it means that they have understood every aspect of the information that you have provided to them about the services they are participating in*

	Informed consent is part of the right to information in the Australian Charter of Healthcare Rights. *Australian Commission on Safety and Quality in Health Care: 'Ensuring informed consent is properly obtained is a legal, ethical and professional requirement on the part of all treating health professionals and supports person-centred care'.*
Specific AOD Legislation	*The National Drug Strategy provides the overarching drug policy framework in Australia. The Health Council (formerly the COAG Health Council) has responsibility for the National Drug Strategy. Each state and territory also have local strategies and action plans in place to address alcohol and other drug issues.* *Legislation regarding alcohol and other drugs is developed at both a national and jurisdictional level in Australia, with the Commonwealth and the State and Territories each having responsibility for different areas. Responsibility for the enforcement of legislation lies with national and local police, other law enforcement agencies and regulatory bodies.* *The Alcohol and other Drugs Council of Australia (ADCA) is the peak body representing the interests of the non-government sector services. The Australian Injecting and Illicit Drug User's League (AIVL) is the national peak organisation representing the state and territory-based drug user organisations and issues of national significance for illicit drug users.* ***New South Wales (NSW):*** • *The Drug Misuse and Trafficking Act 1985 (NSW) governs offenses related to drug possession, supply, and trafficking.* • *The Liquor Act 2007 (NSW) regulates the sale, supply, and consumption of alcohol.* ***Victoria:*** • *The Drugs, Poisons and Controlled Substances Act 1981 (Vic) regulates the manufacture, supply, and possession of drugs and poisons.* • *The Liquor Control Reform Act 1998 (Vic) governs the licensing and regulation of the sale, supply, and consumption of liquor.* ***Queensland:*** • *The Drugs Misuse Act 1986 (Qld) addresses offenses related to the possession, supply, and trafficking of dangerous drugs.* • *The Liquor Act 1992 (Qld) regulates the sale, supply, and consumption of liquor.* ***Western Australia:*** • *The Misuse of Drugs Act 1981 (WA) regulates offenses concerning the possession, manufacture, and trafficking of controlled substances.* • *The Liquor Control Act 1988 (WA) governs the sale, supply, and consumption of liquor.* ***South Australia:*** • *The Controlled Substances Act 1984 (SA) regulates the manufacture, supply, possession, and use of controlled substances.*

	• *The Liquor Licensing Act 1997 (SA) governs the sale, supply, and consumption of liquor.* ***Tasmania:*** • *The Poisons Act 1971 (Tas) regulates the manufacture, supply, and possession of poisons, including controlled substances.* • *The Liquor Licensing Act 1990 (Tas) governs the sale, supply, and consumption of liquor.* ***Australian Capital Territory (ACT):*** • *The Drugs of Dependence Act 1989 (ACT) addresses offenses related to the possession, supply, and trafficking of drugs of dependence.* • *The Liquor Act 2010 (ACT) regulates the sale, supply, and consumption of liquor.* ***Northern Territory:*** • *The Misuse of Drugs Act (NT) addresses offenses concerning the possession, supply, and trafficking of controlled substances.* • *The Liquor Act (NT) regulates the sale, supply, and consumption of liquor.*
Work Health and Safety	*Work health and safety legislation applies to all workplaces, employers, workers and visitors to workplaces. Safe Work Australia developed model WHS laws to be implemented across Australia. According to these, every employer has a duty of care towards their staff, volunteers, and visitors to the workplace. Not only do they have a responsibility to provide a safe environment, but they must also provide information and training about safe work practices and supervision where necessary to protect their workers' rights.* *Workers also must work in a manner that does not risk the health and safety of themselves or others in the workplace. This means they must follow existing workplace policies and procedures to protect themselves and participate in any workplace training and education to improve health and safety issues. Two key dangers for people working in AOD services are burn out and occupational violence.* ***New South Wales (NSW):*** • *Work Health and Safety Act 2011 (NSW)* • *Work Health and Safety Regulation 2017 (NSW)* ***Victoria:*** • *Occupational Health and Safety Act 2004 (Vic)* • *Occupational Health and Safety Regulations 2017 (Vic)* ***Queensland:*** • *Work Health and Safety Act 2011 (Qld)* • *Work Health and Safety Regulation 2011 (Qld)* ***Western Australia:***

	• *Occupational Safety and Health Act 1984 (WA)* • *Occupational Safety and Health Regulations 1996 (WA)* ***South Australia:*** • *Work Health and Safety Act 2012 (SA)* • *Work Health and Safety Regulations 2012 (SA)* ***Tasmania:*** • *Work Health and Safety Act 2012 (Tas)* • *Work Health and Safety Regulations 2012 (Tas)* ***Australian Capital Territory (ACT):*** • *Work Health and Safety Act 2011 (ACT)* • *Work Health and Safety Regulation 2011 (ACT)* ***Northern Territory:*** • *Work Health and Safety (National Uniform Legislation) Act 2011 (NT)* • *Work Health and Safety (National Uniform Legislation) Regulations (NT)*
Dignity of risk	*Dignity of risk is a principle that recognizes an individual's right to make choices and take risks as a part of leading a fulfilling life. It is particularly relevant in the context of supporting individuals with disabilities or those requiring care. While promoting safety is crucial, it's equally important to respect an individual's autonomy and allow them to make decisions that may involve some level of risk. Various legislation and frameworks in Australia emphasize the importance of balancing safety concerns with the dignity of risk, ensuring that individuals are empowered to make choices that contribute to their overall well-being. Legislation related to disability services, such as the Disability Act 2006 (Victoria) or equivalent laws in other states or territories.* ***New South Wales (NSW):*** • *Disability Inclusion Act 2014 (NSW)* • *Aged Care Act 1997 (Cth)* • *Mental Health Act 2007 (NSW)* ***Victoria:*** • *Disability Act 2006 (Vic)* • *Aged Care Act 1997 (Cth)* • *Mental Health Act 2014 (Vic)* ***Queensland:*** • *Disability Services Act 2006 (Qld)* • *Aged Care Act 1997 (Cth)*

	• *Mental Health Act 2016 (Qld)* ***Western Australia:*** • *Disability Services Act 1993 (WA)* • *Aged Care Act 1997 (Cth)* • *Mental Health Act 2014 (WA)* ***South Australia:*** • *Disability Inclusion Act 2018 (SA)* • *Aged Care Act 1997 (Cth)* • *Mental Health Act 2009 (SA)* ***Tasmania:*** • *Disability Services Act 2011 (Tas)* • *Aged Care Act 1997 (Cth)* • *Mental Health Act 2013 (Tas)* ***Australian Capital Territory (ACT):*** • *Disability Services Act 1991 (ACT)* • *Aged Care Act 1997 (Cth)* • *Mental Health Act 2015 (ACT)* ***Northern Territory:*** • *Disability Services Act (NT)* • *Aged Care Act 1997 (Cth)* • *Mental Health and Related Services Act (NT)*
Practice standards	*Practice standards are benchmarks that define the expected level of professional performance within a particular field. In the context of support work, adhering to practice standards ensures that services provided are of high quality and aligned with ethical considerations. These standards may be set by professional bodies, regulatory authorities, or industry organizations. Compliance with practice standards is essential to maintain the integrity of the profession, protect the well-being of clients, and ensure consistency in service delivery. Familiarity with and adherence to relevant practice standards contribute to the overall professionalism and effectiveness of support workers.* ***New South Wales (NSW):*** • *NSW Alcohol and Other Drug Treatment Guidelines* • *NSW Health Clinical Guidelines for Alcohol and Other Drug Withdrawal* • *NSW Health Opioid Treatment Program Clinical Guidelines* ***Victoria:*** • *Victorian Alcohol and Drug Treatment Services Framework*

	• *Victorian Pharmacotherapy Policy and Clinical Practice Guidelines* • *Victorian AOD Service Standards* ***Queensland:*** • *Queensland Alcohol and Other Drugs Treatment Service Delivery Framework* • *Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines* • *Queensland Opioid Treatment Program Clinical Guidelines* ***Western Australia:*** • *Western Australian Alcohol and Other Drug Interagency Strategy* • *Western Australian Methamphetamine Treatment Guidelines* • *Western Australian Alcohol and Drug Withdrawal Guidelines* ***South Australia:*** • *South Australian Alcohol and Other Drug Strategy* • *South Australian Clinical Guidelines for Alcohol and Drug Withdrawal* • *South Australian Methamphetamine Treatment Guidelines* ***Tasmania:*** • *Tasmanian Alcohol and Drug Service Delivery Framework* • *Tasmanian Alcohol and Drug Withdrawal Clinical Practice Guidelines* • *Tasmanian Opioid Treatment Program Clinical Guidelines* ***Australian Capital Territory (ACT):*** • *ACT Alcohol, Tobacco and Other Drug Strategy* • *ACT Pharmacotherapy Clinical Guidelines* • *ACT Alcohol and Drug Withdrawal Guidelines* ***Northern Territory:*** • *Northern Territory Alcohol and Other Drugs Strategy* • *Northern Territory AOD Service Standards* • *Northern Territory Clinical Guidelines for Alcohol and Other Drug Withdrawal*
Policy frameworks	*Policy frameworks are sets of guidelines, principles, and procedures that govern the operation of organizations or sectors. In the context of support work, policy frameworks provide a structured approach to addressing various aspects, including client rights, employee conduct, safety protocols, and organizational objectives. Support workers are expected to be well-versed in these frameworks, which can be established at the national, state, or organizational levels. Compliance with policy frameworks is essential for maintaining ethical practices, ensuring accountability, and promoting a consistent and standardized approach to service provision.* ***New South Wales (NSW):***

	• *NSW Drug and Alcohol Framework* • *NSW Alcohol and Other Drugs Policy* • *NSW Drug and Alcohol Plan* ***Victoria:*** • *Victorian Alcohol and Drug Prevention Strategy* • *Victorian Alcohol and Drug Treatment Services Plan* • *Victorian Drug Strategy* ***Queensland:*** • *Queensland Alcohol and Drug Strategic Plan* • *Queensland Alcohol and Other Drugs Action Plan* • *Queensland Opioid Treatment Program Policy* ***Western Australia:*** • *Western Australian Alcohol and Drug Interagency Strategy* • *Western Australian Alcohol and Drug Plan* • *Western Australian Methamphetamine Action Plan* ***South Australia:*** • *South Australian Alcohol and Other Drug Strategy* • *South Australian Alcohol and Other Drug Treatment Services Plan* • *South Australian Methamphetamine Action Plan* ***Tasmania:*** • *Tasmanian Alcohol, Tobacco, and Other Drugs Strategy* • *Tasmanian Alcohol and Drug Services Framework* • *Tasmanian Alcohol and Other Drugs Harm Reduction Strategy* ***Australian Capital Territory (ACT):*** • *ACT Alcohol, Tobacco, and Other Drug Strategy* • *ACT Alcohol, Tobacco, and Other Drug Action Plan* • *ACT Opioid Treatment Program Policy* ***Northern Territory:*** • *Northern Territory Alcohol and Other Drugs Strategic Plan* • *Northern Territory Alcohol and Other Drugs Service Delivery Framework* • *Northern Territory Methamphetamine Action Plan*
Records management	*Effective record management is crucial in the support work profession to ensure accurate documentation, accountability, and protection of client information. Laws and regulations, such as privacy legislation, dictate how records should be*

	created, stored, and accessed. Support workers must adhere to these regulations to safeguard client confidentiality and privacy. Additionally, organizational policies and procedures often outline specific record-keeping practices to maintain clarity, continuity of care, and compliance with legal and ethical standards. Adherence to proper record management protocols contributes to the delivery of quality care and supports transparency and accountability within the support work context. Privacy laws, such as the Privacy Act 1988 (Commonwealth) and state or territory-specific privacy laws, may regulate how records are managed. ***New South Wales (NSW):*** • *State Records Act 1998 (NSW)* • *Privacy and Personal Information Protection Act 1998 (NSW)* • *Health Records and Information Privacy Act 2002 (NSW)* • *Electronic Transactions Act 2000 (NSW)* ***Victoria:*** • *Public Records Act 1973 (Vic)* • *Privacy and Data Protection Act 2014 (Vic)* • *Health Records Act 2001 (Vic)* • *Electronic Transactions (Victoria) Act 2000 (Vic)* ***Queensland:*** • *Public Records Act 2002 (Qld)* • *Information Privacy Act 2009 (Qld)* • *Hospital and Health Boards Act 2011 (Qld)* • *Electronic Transactions (Queensland) Act 2001 (Qld)* ***Western Australia:*** • *State Records Act 2000 (WA)* • *Freedom of Information Act 1992 (WA)* • *Health Services Act 2016 (WA)* • *Electronic Transactions Act 2011 (WA)* ***South Australia:*** • *State Records Act 1997 (SA)* • *Freedom of Information Act 1991 (SA)* • *Health Care Act 2008 (SA)* • *Electronic Transactions Act 2000 (SA)* ***Tasmania:*** • *Archives Act 1983 (Tas)* • *Personal Information Protection Act 2004 (Tas)* • *Health Records Act 2001 (Tas)* • *Electronic Transactions Act 2000 (Tas)*

	Australian Capital Territory (ACT): • *Archives Act 1983 (ACT)* • *Information Privacy Act 2014 (ACT)* • *Health Records (Privacy and Access) Act 1997 (ACT)* • *Electronic Transactions Act 2001 (ACT)* ***Northern Territory:*** • *Information Act (NT)* • *Information Privacy Principles under the Information Act (NT)* • *Health Practitioners (Professional Standards) Act (NT)* • *Electronic Transactions (Northern Territory) Act (NT)*

QUESTION 1 10

a) Describe what is meant by work role boundaries. Reference legal and ethical considerations.

(100 words)

Responses must include the following notions concepts in the answer below.

Work role boundaries mean maintaining a professional distance from your clients' personal lives. When working with vulnerable people, you have a duty of care to cause no further harm to those people; harm can occur if you become too close to an individual in your professional role. All organisations that deal with AOD clients will have a code of conduct that you must follow, enabling you to maintain the safety barrier of work role boundaries.

b) Identify two work role boundaries. For each boundary, outline your responsibilities, limitations and why these are important working with AOD. Reference legal and ethical considerations.

(150-250 words)

Responses must include two out of the following three concepts in the answer below:

- *Privacy, confidentiality, and disclosure of information: It is your responsibility to limit the disclosure of the personal information of a client, including their connection on social media or sharing their personal contact details. This needs to be clarified and established through Consent for Collect and Share information. Workplace privacy and confidentiality policies and procedures should refer to the Privacy Act 1988 (Cth). This is important to set clear client expectations and be clear about the privacy and confidentiality of information. Policies and procedures will outline the requirements for the roles, such as privacy and confidentiality to ensure the safe handling of patient information and avoid legal disputes.*
- *Professional relationship: It is your responsibility to limit the disclosure of your personal information to a client, including your connection on social media or sharing your personal contact details. This is*

important to set clear boundaries with the client and be clear about your role. This ensures that the client knows this is a professional relationship and not any other type of relationship.

- *Accepting and/or giving gifts: As a support worker, you cannot accept or give gifts to a client. This includes gifts of money. While the patient may express appreciation, they may also attempt to gain special consideration. If you offer a gift or money, the client may misinterpret the gift as an offer of friendship. Both situations cause an improper relationship.*
-

Question 11

Complete the table below to outline the specific contexts (areas) for AOD work and their characteristics.

(approx. 50-100 words each row)

Responses must reflect the content in the answers below:

Context (Area)	Work Characteristics
Centre-based work	*It means working in a community location where some services may be available to meet the different needs of clients experiencing difficulties with AOD and seeking help. This type of work supports harm minimisation and early intervention, generally in a location within the community.*
Day program	*Provide clients with support, counselling, education related to AOD, comorbidities, and therapies such as group therapy or art therapy. These programs can be provided to people who are at any stage in the process of recovery, including sobriety and people who are at risk of relapse.*
Withdrawal services	*These provide assessment for residential, outpatient or home-based assistance. This includes the provision of medical support outside of the clinical setting as well as other services. Home-based is best if the withdrawal is unlikely to be complicated and is provided by a team including your doctor, a nurse, and a support person. Outpatient involves one-on-one consultations with a health professional over a short period, plus ongoing counselling and support. Residential is typically 5–10 days in a withdrawal unit or hospital with staff available 24 hours a day.*
Drop-in centres, recreational facilities	*Provide a safe, drug-free environment where clients can find support, information, meals, community connections, meals or meal vouchers and perhaps showers and washing facilities. They provide information and support in less formal settings and can often be used by clients who are still using rather than just those seeking sobriety or withdrawal programs. These facilities work in the context of harm minimisation and early intervention.* *They often can provide the first steps to recovery in a deliberately welcoming, inclusive, non-judgemental, and low-pressure environment, where people with mental health and trauma issues can begin to feel accepted and build self-esteem. The recreational services might include board games, pool tables, basketball,*

Context (Area)	Work Characteristics
	meditation, and yoga. These centres often are open outside of normal office hours to late into the night.
Housing and residential services	*These exist in different contexts for clients who have a variety of needs. Emergency accommodation is short-term housing provided in emergency situations for people experiencing immediate housing needs. It is a transition into some other housing services and is used by rough sleepers, women and children escaping domestic violence and others at risk of harm. Supported accommodation is a medium-tern option for clients who can live semi-independently. It lasts about 6 to 18 months. These clients are usually assigned a case manager who supports them in their recovery and in building life skills. Rent assistance is for clients who risk losing their privately rented accommodation due to loss of income or other issues relating to AOD use.*
Inpatient	*Inpatient services provide medical assistance to hospitalised clients in acute and non-acute AOD needs on an elective or emergency basis. This can include planned inpatient withdrawal, unplanned emergent withdrawal, and consultation and liaison with services within general and specialist hospital inpatient units.*
Outreach and home visits, streets, parks	*Outreach programs are provided within the community and may be executed through mobile services run by not-for-profit organisations or non-government agencies. They may take place in public places, such as parks where users are known to gather, festivals, community-organised events, schools, technical and further education (TAFE) or universities, and in other contexts where people with AOD issues may be reached. They provide services within the harm minimisation and early intervention context. They can provide education and information along with access to the internet or phones so that people can talk to service providers or family. You also have more professional services such as needle and syringe exchanges and sexual health and immunisation services provided by specialised AOD workers. It can also include hospital outpatient context where brief interventions, pharmacotherapy programs and withdrawal and psychosocial interventions are provided.*
Online AOD work, web-based, emails, discussion rooms and telephone contact	*Many not-for-profit and non-government organisations provide online, web-based, email and telehealth support for people seeking help with their AOD problems. Many people cannot access face-to-face services for various reasons, and online, and telephone support can provide safe, anonymous access to counselling and information.*

Question 12

Explain how the provision of AOD support and services in the following contexts might differ depending on the context:

- centre-based work

- day programs
- withdrawal services
- drop-in centres and recreational facilities
- housing and residential services
- inpatient programs
- outreach, home visits, street, parks
- online AOD work
- web-based
- emails
- telephone contact/services/support.

(approx. 400 words)

Responses must explain each point, answers may vary but should be similar to the following:

The provision of AOD support and services might differ depending on the context in several ways. For example:

Centre-based Work:

- *Centre-based work typically involves providing structured support and services within a designated facility. This may include group therapy sessions, individual counseling, educational workshops, and recreational activities. The focus is on creating a safe and supportive environment where individuals can access resources and engage in recovery-oriented activities.*

Day Programs:

- *Day programs offer structured activities and support services during daytime hours, providing opportunities for skill-building, socialization, and therapeutic interventions. These programs may include group therapy, vocational training, life skills development, and recreational activities tailored to meet the needs of participants.*

Withdrawal Services:

- *Withdrawal services focus on supporting individuals through the detoxification process and managing withdrawal symptoms safely. These services may be provided in a residential setting, outpatient clinic, or hospital-based program, depending on the severity of withdrawal symptoms and the individual's medical needs.*

Drop-in Centres and Recreational Facilities:

- *Drop-in centers and recreational facilities offer informal support and a welcoming environment for individuals to socialize, access information, and engage in recreational activities. These settings provide a low-barrier entry point for individuals seeking support and may offer peer support, harm reduction supplies, and referrals to other services.*

Housing and Residential Services:

- *Housing and residential services provide stable accommodation and support for individuals recovering from substance use disorders. These services may include transitional housing, supported accommodation, and residential rehabilitation programs. The focus is on promoting stability, independence, and recovery in a structured living environment.*

Inpatient Programs:

- *Inpatient programs involve intensive, 24-hour care provided in a hospital or residential setting. These programs are typically reserved for individuals with severe substance dependence or complex medical and psychiatric needs. Inpatient programs offer medical detoxification, psychiatric assessment and treatment, and intensive therapeutic interventions.*

Outreach, Home Visits, Street, Parks:

- *Outreach services involve engaging with individuals in their own environment, such as homes, streets, and parks, to provide support, harm reduction supplies, and referrals to services. Outreach workers build rapport, assess needs, and provide practical assistance to individuals who may be reluctant to access traditional services.*

Online AOD Work:

- *Online AOD work involves delivering support and interventions through digital platforms such as websites, emails, and telephone contact. This approach allows for flexibility and accessibility, particularly for individuals who may face barriers to accessing face-to-face services due to geographical, logistical, or privacy concerns.*

Web-based, Emails, Telephone Contact/Services/Support:

- *Web-based, email, and telephone contact/services/support offer remote assistance and counseling to individuals seeking help for alcohol and other drug issues. These modalities allow for confidential communication, information provision, crisis intervention, and ongoing support for individuals who prefer or require remote assistance.*

Question 13

Describe the Ottawa Charter and how it applies to AOD services.

(200-300 words)

Responses must include the following concepts in the answer below:

The Ottawa Charter for Health Promotion was developed in 1986 to identify actions to achieve the objectives of the World Health Organisation (WHO) Health For All by the year 2000 initiative.
The Ottawa Charter focuses on health promotion, which enables people to increase control over and improve their health. It identifies three basic strategies for health promotion, as taken directly from the charter:
Advocate – *good health is a major resource for social, economic, and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural, and biological factors can favour or harm health. Health promotion aims to make these conditions favourable through advocacy for health.*

Enable – *health promotion focuses on achieving equity in health. Health promotion aims to reduce differences in current health status and ensure equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for healthy choices. People cannot achieve their fullest health potential unless they can control those things that determine their health. This must apply equally to women and men.*
Mediate – *The health sector cannot ensure the prerequisites and prospects for health. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organisations, by local authorities, by industry and by the media. People from all walks of life are involved as individuals, families, and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.*
The three basic strategies for health promotion set out in the Ottawa Charter apply equally to the provision of AOD services as to any other health service. AOD workers should advocate for improvements in the overall health of all clients in a rights-based, equitable way. They should also collaborate with all stakeholders to promote health and wellbeing.

Question 14

List the three classes of drugs and outline their primary properties and harms for both low and high doses.

(approx. 100-150 words each row)

Answers may vary, but the response must reflect the content of the answers below:

Source: https://adf.org.au/drug-facts/#wheel

Class	Primary Properties	Harms	
		Low	High
Depressants	*Reduce stimulation and arousal as they slow the speed of messages sent between the brain and the body through the nervous system. They reduce an individual's ability to concentrate, coordinate body functions, and respond to what is happening around them. In small quantities, depressants can make a person feel relaxed and less inhibited.*	*Reduced inhibitions, enhanced mood, reduced anxiety, slowed reaction times, impaired judgement, slowed breathing, increased risk of accident or injury from lack of coordination.*	*Impaired judgement and coordination, vomiting, irregular or shallow breathing, blackouts or memory loss, unconsciousness, coma, death.*
Stimulants	*Increase the speed of the nerve messages between the brain and the body. Thy may cause the individual using them to feel more awake, alert, confident or energetic.*	*Euphoria, heightened feelings of wellbeing, increased heart rate and blood pressure, increased alertness, talkativeness, reduced appetite.*	*anxiety, panic, seizures, headaches, stomach cramps, aggression, paranoia, tension, increased body temperature, nausea, tremors, coma, death.*

Class	Primary Properties	Harms	
		Low	High
Hallucinogens	*Also known as psychedelics, they are psychoactive substances that change an individual's perception, mood, and cognitive processes. Hallucinogens affect perception and alter an individual's thinking, sense of time and emotions. They also cause hallucinations, meaning an individual might see, taste, smell or hear things that do not exist or are distorted.*	*The effects of hallucinogens vary greatly but include vomiting, blurred vision, rapid breathing clumsiness, confusion or trouble concentrating, dizziness, fast or irregular heartbeat, feeling of euphoria, numbness, seeing and hearing things that are not there, sense of relaxation and wellbeing, sweating and chills, 'bad trip' which leads to panic and unpredictable behaviour including self-harm.*	*The most common long-term effect is flashbacks.*
Cannabinoids	*These are every chemical substance, regardless of structure or origin, that joins the cannabinoid receptors of the body and brain and that have similar effects to those produced by the Cannabis Sativa plant. There are two main cannabinoids – THC has strong psychoactive effects, meaning it makes a person 'high', whereas CBD is thought to have an anti-psychoactive effect that controls or moderates the 'high' caused by the THC. CBD is also thought to reduce some of the other negative effects that people can experience from THC, such as anxiety. Cannabinoids produce their effects by interacting with specific receptors located within different parts of the central nervous system. They regulate*	*Loss of inhibition, spontaneous laughter, quiet and reflective mood, affected perception including sound, colour and other sensations, confusion, altered thinking and memory, anxiety, mild paranoia, altered vision, reddened / bloodshot eyes, relaxation, sleepiness, reduced coordination and balance, increased heart rate, low blood pressure, increased appetite.*	*Confusion, restlessness, excitement, hallucinations, anxiety or panic, detachment from reality, decreased reaction time, paranoia.*

Class	Primary Properties	Harms	
		Low	High
	how cells communicate – how they send, receive, or process messages.		
Dissociatives	*Causes people to feel separated or detached from their body or physical environment. They cause their effects by disrupting the actions of the brain's chemical glutamate at certain types of receptors on nerve cells throughout the brain. They may also alter the actions of dopamine, a neurotransmitter responsible for the euphoria and "rush" associated with many drugs.*	*Numbness, disorientation, confusion, loss of coordination, dizziness, nausea, vomiting, changes in sensory perceptions (such as sight, sound, shapes, time, and body image), hallucinations, feelings of detachment from self and environment, increase in blood pressure, heart rate, respiration, and body temperature.*	*Hallucinations, memory loss, physical distress, including dangerous changes in blood pressure, heart rate, respiration, and body temperature, marked psychological distress, including feelings of extreme panic, fear, anxiety, paranoia, invulnerability, exaggerated strength, and aggression.*
Empathogens	*Empathogens cause the release of dopamine and serotonin in the brain. Serotonin controls mood, appetite, and sleep and can make you feel relaxed. Using empathogens can cause the serotonin levels in the brain to become very low and can also lead to hyperthermia (over-heating).*	*Feeling connected, having a sense of belonging, feeling warm, feeling understanding, sexual arousal, becoming anxious, sweating, mood swings, having energy, depression, dehydration.*	*Restless sleep and exhaustion, anxiety, irritability and depression, paranoia (feeling extremely suspicious and frightened), difficulty concentrating, serotonin toxicity – confusion, agitation, sweating, increased heart rate, muscle spasms, death.*
Opioids	*They bind to opioid receptors which depress the central nervous system, which slow down messages between the brain and the rest of the body. The person's breathing and heart rate slow down. Dopamine is released, causing sensations of pleasure and pain relief. They are any natural or synthetic drugs*	*Extreme relaxation, drowsiness and clumsiness, confusion, slurred speech, slow breathing, and heartbeat.*	*Cold, clammy skin, slow breathing, blue lips and fingertips, falling asleep ('going on the nod'), death by respiratory depression.*

Class	Primary Properties	Harms	
		Low	High
	made from or related to the opium poppy.		

Question 15

In the following list of drugs, explain how they are administered and what class of drug they are.

(approx. 50 words each cell)

Responses must reflect the content of the answers below:

Drug	Class	How Administered
Alcohol	*Depressant*	*Alcohol is a liquid that is swallowed. It then enters the stomach and small intestine, where small blood vessels carry it to the bloodstream.*
Cannabis	*Cannabinoid, depressant*	*Cannabis can be smoked, eaten or vaporised, and its effects vary significantly depending on the form consumed.*
Tobacco	*Stimulant*	*Tobacco can be chewed, sucked, dissolved, or inhaled (smoked) through the mouth or nose.*
Illicit	*Opioids, empathogens, hallucinogens, cannabinoids, depressants, stimulants, dissociatives*	*Illicit drugs can be smoked, snorted, swallowed, or injected*
Prescription	*Opioids, depressants, stimulants*	*Generally taken by swallowing as they are usually in pill form.*

Question 16

The following table lists some commonly prescribed mental health medications. Describe the interaction and the risk factor of combining each medication with alcohol and marijuana.

(approx. 30-50 words each row)

Responses must reflect the concept in the answers below:

	Known interaction		Known risk	
Medication	**Alcohol**	**Marijuana**	**Alcohol**	**Marijuana**
Diazepam	*Increases the sedative effects of Diazepam.*	*Increased dizziness, drowsiness, decreased decision making.*	*Accidental death caused by respiratory depression.*	*More likely to be involved in an accident, make poor decisions, risk of depression.*
Risperidone	*Increases the nervous system side effects of Risperidone.*	*Is thought to reduce the effects of Risperidone.*	*Can increase the risk of impairment in judgement and decision-making.*	*Increases risk of depression.*
Efexor	*Can increase the side effects of anti-depressants; for example, fast heartbeat, dizziness, anxiety, panic, drowsiness, confusion, nausea.*	*Can increase the side-effects of anti-depressants; for example, fast heartbeat, dizziness, anxiety, panic, drowsiness, confusion, nausea.*	*Increase in severity of side effects can increase likelihood of non-compliance.*	*Increase in severity of side effects can increase likelihood of non-compliance.*

Question 17

a) List at least ten signs and/or symptoms that a person may be undergoing withdrawal from AOD.

Students must list at least ten signs and/or symptoms of withdrawal. For example:

- *anxiety*
- *panic attacks*
- *restlessness*
- *irritability*
- *social isolation*
- *fatigue*
- *loss of appetite*
- *insomnia*
- *poor concentration*
- *memory loss*
- *headaches*
- *dizziness*
- *feeling short of breath*
- *palpitations*

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- *fast heartbeat*
- *twitching*
- *tremors/shakes*
- *muscle pain*
- *sweating*
- *tingling*
- *seizures*
- *stroke*
- *heart attack*
- *hallucinations*
- *DTs.*

b) Describe the five stages of withdrawal.

(approx. 50 words each description)

Responses must include the following concepts in the answer below:

Stage	Description
Stage 1: Make decision to quit	*When the person acknowledges there is a problem is the first stage. During this time, the person may decide to seek help and should prepare by learning more about what withdrawal, detox and rehabilitation will consist of.*
Stage 2: Withdrawal symptoms begin	*This is when the first symptoms of withdrawal appear. It can be anywhere from when the last dose or drink was taken or up to a full day after. The start time will depend on the severity of the addiction as well as the type of drug being used.*
Stage 3: Symptoms increase in intensity	*In this stage, the symptoms begin to increase in strength. This can be around 24 hours after the last dose. It can feel like a bad case of the flu with symptoms like muscle aches, irritability, depression, anxiety, paranoia, insomnia, cravings, sweating or chills, and severe dehydration.*
Stage 4: Symptoms peak and then decline in intensity	*The symptoms climax and are at their strongest in this stage which is a sign that the person is coming to the end of the detox. A medical professional may be required at this stage to monitor that the symptoms don't become a medical emergency.*
Stage 5: Drug withdrawal can appear again in the form of PAWS	*The full withdrawal process can take one to two weeks. However, post-acute withdrawal syndrome (PAWS) can appear weeks or months into the recovery process. PAWS can consist of some of the original withdrawal symptoms as well as strong cravings, irritation, low energy, and lack of confidence.*

c) Explain how drug use affects a person's health, cognitive, social, and emotional development and how these effects impact others.

(approx. 500 words)

Answers may vary, but the response must include the following concepts in the answer below:

Drug use will affect each person's body in different ways as it depends on body size, general health, the amount and strength of the drug taken, and whether or not any other drugs are present in the system simultaneously. The health effects can be physical such as damaging your organ and causing issues such as weight loss, cancer, liver failure or ulcers. When using drugs, a person is more likely to have an accident, be more vulnerable to sexual assault or engage in unsafe sex practices. People may find it hard to think, reason, remember, sleep, and solve problems.

Drugs and alcohol can also change how your brain functions, which worsens with extended use. These substances affect the amounts of dopamine (which regulates emotional responses) released into the brain, causing the reward, motivation, and memory pathways to change and making the person unable to feel normal without them. They actually rewire our brains to crave the drug over everything else. In addition, new research shows that drugs and alcohol cause disruptions in the brain's frontal cortex and affect activities such as decision-making, response inhibition, planning and memory.

Drugs and alcohol impair social development as it affects our relationships with friends and family. A person will find themselves incapable of doing things with friends and family, such as gaming, sports, going to the movie, and just hanging out because they are high. This causes the user to spend more time alone or with others who use drugs. Drugs and alcohol can cause people to become more aggressive and violent towards others and can cause people to lie and steal to feed the addiction. Using these substances can also cause people to engage in risky behaviour that puts themselves and others in harm's way.

Negative emotions such as depression, anxiety, loneliness, and anger often go hand in hand with drug and alcohol abuse. People often use alcohol and other drugs to get rid of those emotions. This causes a circle of increasing use as when the effects of the drug wear off, those emotions are back and often worse than before. Additionally, the use of alcohol and other drugs can worsen the effects of anxiety as the substances often affect the parts of the brain that control it. There is often shame and guilt attached to addiction, and many of the people who use it engage in negative self-talk, which adds to those feelings. There is also a link to depression, although it isn't clear if the depression or the substance abuse comes first. And finally, there is a loss of interest in the activities that a person used to enjoy which adds to the depression and addiction. This leaves a person feeling like there is no joy in their lives.

When the health, cognitive, social, and emotional effects all come together, there are strong impacts on other people involved with the user. Friends and family may not enjoy the company of a person when they are high or may not want to associate with someone who uses drugs and alcohol. Conflict may become the norm in the family as trust erodes because the person hides their addiction or has become more aggressive. Communication with the user becomes difficult and frustrating. Overall, substance abuse damages the relationships an addict has in their life.

Question 18

a) List and briefly describe the four patterns of drug use.

(approx. 100 words)

Answers may vary, but the response must include the following concepts in the answer below:

- *Experimental use – is when a person tries a drug once or twice out of curiosity.*
- *Recreational/Social use – is when a person chooses to use a drug for enjoyment, particularly to enhance a mood or social occasion.*
- *Situational use – is when a drug is used to cope with the demands of particular situations.*
- *Dependent use – is when a person becomes dependent on a drug after prolonged or heavy use over time. They need to take the drug consistently to feel normal or avoid uncomfortable withdrawal symptoms.*

b) Explain how prevalent alcohol and illicit drug use is in Australia based on the latest data and statistics.

(approx. 150 words)

Answer below is based on current 2019 statistics, students must state the data and statistics and explain the culture/trends in the use of alcohol and drugs.

The 2019 National Drug Strategy Household Survey has shown that 20.9% of people 18 years and older choose not to consume alcohol and more men say they are cutting back. However, 1 in 4 Australians still consumes alcohol at dangerous levels on at least a monthly basis. And 1 in 6 are consuming alcohol in excess of the lifetime risk guidelines. Around 35% of pregnant women are consuming, while approximately 1 in 10 people who consume alcohol may be experiencing a form of dependence.

Illicit drug use has had a statistically significant increase in the number of people using some type of illicit drug at least once in their lifetime. This is the highest rate it has been in almost 20 years. The increases in lifetime use include:

cannabis – 1% increase to 36%

hallucinogens (like LSD or 'magic mushrooms') – 1% increase to 10.4%

ecstasy – 1.3% increase to 12.5%

inhalants (like nitrous oxide or 'nangs') – 0.6% increase to 4.8%

ketamine – 1% increase to 3.1%

cocaine – 2.2% increase to 11.2%.

When looking at the use in the past year, the biggest increase in illicit drug use has been cocaine which jumped from 2.5% in 2016 to 4.2% in 2019.

Question 19

a) Access the Privacy Act 1988 and outline the Australian Privacy Principles that apply to you as a support worker in community services.

(approx. 100 words)

Responses must include the following privacy principles:

APP1 – Open and transparent management of personal information.

- *Organisations must develop and implement a Privacy Policy, and employees must follow it.*

APP6 – Use or disclosure of personal information.

- *Clients should be informed about personal and sensitive information collection reasons and disclosure purposes.*

APP 10 – Quality of personal information.

- *Information collected and disclosed must be accurate and relevant.*

APP 11 – Security of personal information

- *Information collected must be protected from misuse, unauthorised access, modification or disclosure.*

APP12 – Access to personal information

- *Clients should have access to their personal information.*

b) List your state/territory legislation that applies to the privacy of information and records management.

Responses must include students' state territory legislation that applies to the privacy of information and records management as indicated below.

New South Wales

Privacy and Personal Information Protection Act 1998

Health Records and Information Privacy Act 2002

Workplace Surveillance Act 2005

Surveillance Devices Act 2007

Victoria

Information Privacy Act 2000

Health Records Act 2001

Surveillance Devices Act 1999

Charter of Human Rights and Responsibilities Act 2006

Queensland

Queensland Health Quality and Complaints Commission Act 1992

Health Services Act 1991

Information Standard 42 A – Information Privacy for Queensland Department of Health

Invasion of Privacy Act 1971

Western Australia

Freedom of Information Act 1992

State Records Act 2000

The Information Privacy Bill 2007

South Australia

There is no legislation that specifically addresses privacy in South Australia. However, the 'Code of Fair Information Practice' is based on the National Privacy Principles in the Privacy Act. This code applies to the South Australian Department of Health and the Department for Families and Communities.

Tasmania

Personal Information Protection Act 200

Health Complaints Act 1995

Australian Capital Territory

Health Records (Privacy and Access) Act 1997

Human Rights Act 2004

Northern Territory

Information Act 2002

Health and Community Services Complaints Act 1998

Reference: https://www.alrc.gov.au/publication/for-your-information-australian-privacy-law-and-practice-alrc-report-108/2-privacy-regulation-in-australia/state-and-territory-regulation-of-privacy/

Question 20

The method of working with AOD clients has evolved over the years into the person-centred approach we now use. Briefly explain each model and outline the evidence base used to promote it when it was popular.

(approx. 150 words per row)

Responses must include the following concepts in the answer below:

Model	Practice	Evidence Base
a) Moral model	*Substance users are made out to be misfits or no-hopers and viewed as objects of pity, essentially as helpless victims. The prevailing belief is one of "Once a junkie, always a junkie." This model reinforces a person's belief that they are inherently bad or worthless, leading them to find evidence to confirm this view. It reinforces the desire of many substance users to use self-blame, and self-hatred and to have a sense of extreme powerlessness which, in turn, creates learned helplessness and works against the idea of genuine change. It reduces motivation and allows the user to avoid taking responsibility for their actions.*	*This model holds that the root cause of addiction is a person's inherent moral weakness and lack of willpower. It is often associated with the idea that substance abuse is sinful or evil.*
b) Disease model	*This model suggests that a person has a disease, and the disease is lifelong and progressive. Practitioners use the twelve-step process that is seen in Alcoholics or Narcotics Anonymous. To change, the user must become enlightened by realising that change is only possible by relinquishing personal control to a 'higher power'. To succeed, a person must develop and maintain complete abstinence from all addictive substances and activities, as this stops the disease and places it into dormancy. Some practitioners also believe a genetic makeup predisposes some people to dependency on substances, which has led to a belief that there is an 'addictive personality' type.*	*This method asserts that addiction is a brain disease which is characterised by abnormalities in an individual's brain structure and functioning. It posits that addiction either exists or does not so it is not on a continuum, that it is irreversible and incurable and can only be treated by lifelong abstinence, and that addicted individuals are unable to control their intake of a substance as once they start using, they are powerless to stop.*
c) Psycho-dynamic model	*By teaching the addict to face underlying emotions, this form of therapy lowers the chances of relapse. Recovering clients learn skills to evaluate their thoughts, look into their minds, and identify the reasons for current behaviours. This skill helps prevent substance abuse and relapse and also leads to a generally happier and*	*The psychodynamic model is based on the theory that a person's past shapes their future. Unconscious personal experiences profoundly affect present mood and behaviour and can potentially contribute to problems with self-esteem, relationships, and addiction.*

Model	Practice	Evidence Base
	healthier life. This treatment model is often used in conjunction with cognitive-behavioural theory and dialectical behaviour theory to help round out an individual's skills in coping with the thoughts and feelings that have led to substance abuse.	
d) Social learning model	*Social learning interventions focus on changing the client's relationship with their environment. A key concept is a person's beliefs about their ability to perform tasks and achieve goals. These beliefs can influence the outcome of the attempt to cease using alcohol and/or drugs. The treatment uses coping skills and cognitive restructuring methods to assist people in changing and control their drug use. Prevention strategies find ways to make changes in individual environmental conditions that foster problematic behaviour.*	*In the 1960s, supporters of this model rejected the idea that people with drug problems are 'bad', 'mad', 'sick' or susceptible to the power of the substance. The social learning model holds that drug-using behaviour is learned and reinforced by peers, parents, partners and/or the media. Drug use is seen as neither good nor bad. The choice to use drugs is understood as a balance of the costs and benefits that must be considered in terms of the drug, the individual and the environment.*
e) Social-cultural model	*The sociocultural perspective looks at you, your behaviours, and your symptoms in the context of your culture and background. Multicultural counselling and therapy aims to offer both a helping role and process that looks at and defines goals consistent with clients' life experiences and cultural values. It works to recognise client identities to include individual, group, and universal dimensions advocate the use of universal and culture-specific strategies and roles in the healing process and balances the importance of individualism and collectivism in the assessment, diagnosis, and treatment of the client and their lives.*	*The social-cultural model poses that the cultural standards of any society, in particular the negative consequences of any culture on the way individuals behave, causes addiction. The model suggests that there are five major factors that put people at risk for addiction:* *The bonding experience* *Relief from stress* *Sense of community* *The allure of rebelling* *Lifestyle appeal.*

Question 21

Explain the rights and responsibilities of workers, employers, and clients and how they are applied in an AOD setting in terms of their legal and ethical considerations.

(approx. 400 words)

Responses must include then context from the answers below:

Employers, employees and clients have formal rights and responsibilities under discrimination, privacy, and work health and safety legislation.

The Disability Discrimination Act 1992 (Cth) and equivalent state and territory laws make it unlawful to discriminate against, harass or victimise people with disabilities – including temporary, permanent, past, present, or future, actual, or just presumed mental health conditions. The Act defines 'discrimination' to include both direct and indirect discrimination. This means an employer's failure to make reasonable adjustments for a worker with a mental health condition may constitute discrimination, even when no 'direct' discrimination has occurred. The employee must ensure they do not discriminate against other employees or clients, while the employer must make appropriate accommodations for employees to not discriminate against them.

Workplace health and safety (WH&S) legislation requires workplaces to be, as far as is reasonably practicable, physically and mentally safe and healthy for all employees and clients. This means steps must be taken to ensure that the working environment does not harm mental health or worsen an existing condition. Employees and clients are required to ensure they report any unsafe work practices to have them rectified as quickly as possible. This cooperation between employers, employees and clients makes for a safer work environment for everyone.

Under the Privacy Act 1988 (Cth) and similar legislation in some states and territories, employers must observe confidentiality and respect each employee's privacy. This means that an employee's and client information cannot be shared with anyone without their permission unless there is a direct risk to their health and safety or that of others. Any information collected by employers or employees on behalf of the employer, can only be used for the purposes for which it was disclosed.

Clients of AOD services have rights and responsibilities too. They have the right to:

be provided a service in a safe environment

be provided a service in a fair, honest and non-judgemental manner

be provided a service that is friendly and respectful

be given adequate information on all available services and treatment

participate in all aspects of service provision

have information about them kept confidential unless disclosure is otherwise authorised

be provided with a timely and effective service that responds to their needs

make a complaint and have that complaint addressed efficiently

be provided culturally sensitive services that take into account their values and beliefs.

As a client, they have the responsibility to help maintain a high standard of treatment. They are expected to contribute to maintaining a safe environment and treating others with courtesy and respect. They are asked to participate in the treatment process to the best of their ability and, if necessary, follow the organisation's complaints process.

Question 22

Summarise each of the following values and philosophies of the AOD sector.

(approx. 150 words each row)

Responses must include the following concepts in the answer below:

Harm Minimisation	*These are strategies meant to reduce the risks and harms of drug use and addiction and improve users' health outcomes. They are based on the knowledge that it is impossible to eliminate addiction, abuse, or misuse of drugs in the community and that certain drugs have inherent risks and harms associated with them. The goal is to identify and reduce the harms caused by AOD and provide assistance that will improve public health. These public health initiatives include needle exchange, safe injecting rooms, diversion programs and sobering-up services. The services aim to protect individuals as they sober up, but they can also provide brief/early intervention services.*
Recovery	*These are treatment options and support services that are successful in helping reduce risky drug use and related problems for individuals and the community. Recovery-oriented treatment acknowledges that a person's path to recovery is individual and unique, informed by their strengths and hopes, preferences, needs, experiences, values, and cultural background. Each person should be supported to make their own choices, listened to, and treated with dignity and respect. Each person is the expert of their own life, and support should assist them in achieving their hopes, goals, and aspirations. Recovery will mean different things to different people. A recovery approach should drive everything you do as a support worker and be reflected in your attitude, words, and actions. Various services and support are available, from peer-based community support to brief interventions in primary care, hospital services and intensive specialist treatment services.*
Person-centred Approach	*This is a treatment that is informed by the needs and desires of the client. It is tailored to the multiple needs of the client, not just their substance use. This approach supports people to be active and equal participants and partners in their treatment planning, considering their family, significant others, cultural circumstances, and any other needs. Support should focus on achieving the person's aspirations and be tailored to their needs and unique circumstances. Person-centred practices can be seen as a 'toolbox' or a variety of ways to listen to and gather information with people. Various evidence-based resources enable people to choose their own pathways to success. As*

	with any other tool they are only effective if the user has developed the skills to use them and continues to improve them through practice and feedback with others.
Empowerment	*Empowerment is a key part of recovery, person-centred and holistic approaches. This philosophy posits that those with power should endeavour to help those with less power recognise their power and how to use it to meet their goals more effectively. In AOD work, the therapeutic relationships that clients form with practitioners and the environments in which they participate are designed to work as 'microcosms' where empowerment can be experienced on a small scale to inspire understanding and belief about what can be achieved in a larger life. Empowerment involves a sense that choices or alternative courses of action are available to negotiate one's way through life and minimise the harms that may be encountered along the way. Empowerment can be developed by:* ▪ *being respectful and non-judgemental* ▪ *building a relationship where the person feels comfortable discussing their feelings and what they want* ▪ *focussing on strengths and abilities* ▪ *supporting and encouraging involvement in decision making* ▪ *respecting the decisions a person makes about their own life.*

Question 23

Describe current and emerging patterns of drug and alcohol use in Australia.

(approx. 150 words)

Responses must include the following concepts in the answer below:

As of 2019, the use of alcohol and tobacco is generally on the decline by Australians aged 14 and over. The amount of single-occasion risky drinking still remains highest among people aged 18-24, but it has decreased since 2001 from 57% to 41%, while over that same period, the same behaviour rose for people in their 50s and 60s. Most interesting though, was that the number of young adults (aged 18–29) who did not drink at all increased by more than double between 2001 and 2019.

A disturbing emerging trend is the appearance of crypto markets or darknet markets where people can purchase illicit goods and services. A recent study has shown that illicit drugs are commonly listed for sale to Australia, with cannabis, MDMA, cocaine and methamphetamines being the most common. Over the period studied (May 2019–May 2020), the listing of illicit drugs on the different darknet sites increased by 121%.

Source: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/younger-people

Drug use trends and statistics can include:

- *cannabis (52%) and amphetamine-type stimulants accounted for the greatest propotion of national illicit drug seizures in 2020-21 - https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/harm-minimisation/supply-reduction#IDDR*
- *in 2020-2022 3.3& of Australians aged 16-85 years had symptoms of a diagnosed substance use disorder in the previous 12 months. - https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions*

Question 24

What steps should an employer take to manage the risks when working with people affected by alcohol and/or other drugs? Describe the strategies used to help mitigate these risks.

(approx. 350 words)

Responses must include the following concepts in the answer below:

The same steps apply for risk management in all areas, including AOD.

The first step is to identify the hazards. In the case of alcohol and drugs, the employer must identify the hazards caused by an alcohol or drug-abusing employee. These might be a workplace culture or practices that encourage drinking, absenteeism or frequent tardiness causing a reduction in productivity, an altered state of mind that can lead to accidents, injury or loss of life, preoccupation with obtaining the substance that leads to a loss of focus or concentration, psychological effects of long-term use that affect performance or engaging in illegal activities. As these hazards arise, they must be recorded in a risk register. Having a well-defined, well-communicated, and legally binding workplace policy on alcohol and drug use will also help to mitigate these risks.

Step two is where the risk is assessed. The employer should determine who could be harmed by the hazard, what situations the hazard could cause harm or loss, where, when, and how exactly the hazard could cause harm or loss. This assessment allows the employer to determine the severity of the risk so an appropriate plan can be put into place to reduce the impact of the risk.

In step three, the employer looks to identify what existing controls are in place to manage the risks found. For AOD, it could be a drug and alcohol awareness seminar or the policy discussed earlier. The employer needs to ensure that the existing controls address all of the risks identified and be confident that those controls effectively eliminate the risk of harm or loss.

If the employer finds any risks that don't have existing controls, they need to proceed to step four and treat the risk. In this step, the employer puts in additional controls to ensure sufficient control to mitigate harm or loss. The risk should be eliminated where possible or minimised as much as possible when it cannot be completely eliminated. A risk treatment for AOD might be implementing a pre-employment drug testing program to avoid hiring anyone with AOD issues, followed by a regular, randomised drug screening regime to keep the existing staff safe.

Finally, the last step is to monitor and review the controls that have been put in place to ensure they are working. For instance, the drug and alcohol policy should be regularly reviewed to ensure it is up to date with the current hazards.

Question 25

Explain what intervention strategies, services and prevention strategies need to be available to AOD clients in Australia.

(approx. 300 words)

Responses must include the following concepts in the answer below:

A mix of government and non-government agencies deliver publicly funded AOD treatment services. There are three types of intervention strategies that the Australian alcohol, tobacco, and other treatment services system has. They are interventions to reduce harm, interventions to screen, assess and coordinate care and intensive interventions. These interventions are delivered in different service settings according to the needs of the clients and community. They can include:

stand-alone specialists such as the Australian Community Support Organisation (ACSO) who deal specifically with those who are engaged with or at risk of becoming engaged with the criminal justice system,

primary health care settings such as a general practitioner or public health initiatives which help to minimise the harm and risk to users such as needle exchange programs.

tertiary healthcare where the support workers focus on effectively treating conditions and preventing their reoccurrence.

These services offer a recovery-oriented approach and are available to all people, regardless of the particular drug or drug combination being used. Treatment objectives can include reduction or cessation of drug use as well as improvements to social and personal functioning. Assistance may also be provided to support the family and friends of people using drugs. Counselling is the most common form of treatment provided in Australia.

Australia uses many prevention strategies. The most common of these is the provision of information and education in schools across the country. Young people are the main focus since prevention strategies have the potential to positively influence behaviour that will last through their adult years. There are public health campaigns designed to inform people about the effects and harms associated with the use of alcohol and other drugs, as well as promoting positive role models for the public to think about. There are also harm reduction approaches such as opioid substitute programs and syringe exchange programs

Question 26

Identify at least 5 social constructs that are present in the Australian AOD sector, and explain how these constructs play a role in shaping attitudes, perceptions and behaviours relating to AOD.

(approx. 350 words)

Answers may vary, but the response must include the following concepts in the answer below

1. Stigma and Stereotypes:
Stigmatization of Substance Use: There exists a social stigma associated with substance use, which can hinder individuals from seeking help. Stereotypes about people with substance use disorders can contribute to negative perceptions and discrimination.

2. Cultural Norms and Acceptance:
Drinking Culture: Australia has a notable drinking culture, and alcohol is often associated with socializing and celebration. The normalization of alcohol consumption in social settings can influence individuals' attitudes toward drinking.

3. Policy and Legislation:
Regulatory Frameworks: The legal and regulatory frameworks surrounding alcohol and other drugs shape societal perceptions. Policies such as alcohol licensing laws and drug classification impact public attitudes and behaviors.

4. Media Portrayals:
Media Influence: Media representations of substance use can contribute to societal attitudes. Depictions in the media may perpetuate stereotypes or influence public perception of the severity and prevalence of substance use.

5. Treatment and Recovery Narratives:
Narratives of Recovery: The way individuals who have undergone treatment and recovery are portrayed in society can influence perceptions of the efficacy of interventions and the possibilities of successful recovery.

6. Health and Wellbeing Frameworks:
Public Health Approaches: Social constructs related to health and wellbeing influence the framing of substance use issues. Approaches that emphasize harm reduction and public health may contrast with more punitive or moralistic perspectives.

7. Access to Treatment and Support:
Treatment Accessibility: Social and economic factors, including access to treatment services and support, can contribute to disparities in how substance use is addressed across different demographics.

8. Gendered Perspectives:
Gender Roles and Expectations: Social constructs related to gender influence patterns of substance use. Stereotypes and societal expectations regarding gender roles can impact the way substance use is perceived in different genders.

9. Peer and Social Influences:
Peer Pressure: Social influences, especially among peers, can contribute to the initiation and continuation of substance use. Peer norms and acceptance play a role in shaping behaviors related to alcohol and other drugs.

10. Education and Awareness Campaigns:
Public Health Campaigns: Educational efforts and public health campaigns can shape societal understanding of the risks associated with substance use and promote responsible behaviors.

Question 27

Describe your attitude towards Alcohol and other drugs and explain how this could impact how the people/clients you work with in this sector.

(approx. 300 words)

Answer will vary based on students personal experience. Ensure that they describe their own attitude and consider the effects it has on clients that they will work with in the industry.

Example answer:

My attitude towards Alcohol and Other Drugs (AOD) is rooted in a non-judgmental and empathetic approach. I recognize that substance use can be a complex and multifaceted issue influenced by various factors such as personal experiences, mental health, and social circumstances. This perspective shapes my understanding that individuals may face challenges related to AOD use, and my role is to provide support without stigmatizing or moralizing their choices.
In the AOD sector, my attitude impacts the way I interact with people and clients. Firstly, maintaining a non-judgmental stance allows for open communication. Individuals struggling with substance use may already face societal stigma, and a judgment-free environment promotes trust and honesty. By creating a safe space, clients may be more inclined to share their experiences, concerns, and goals, enabling a collaborative approach to their care.
Empathy is a cornerstone of my attitude, recognizing that everyone's journey with AOD is unique. This approach helps in tailoring interventions to meet individual needs. It also contributes to a person-centered approach, where clients actively participate in decision-making regarding their treatment and recovery. Understanding the challenges they may encounter, I strive to provide support that aligns with their goals and aspirations, fostering a sense of agency in their recovery process.
Furthermore, my attitude influences my commitment to staying informed about evidence-based practices and treatment modalities in the AOD sector. This allows me to provide accurate information to clients, empowering them to make informed choices regarding their health. Additionally, it ensures that I can adapt and integrate best practices into my work, contributing to the overall quality of care.
Overall, my positive and non-judgmental attitude towards AOD recognizes the dignity and agency of individuals in their journey towards recovery. By fostering an environment of trust, empathy, and collaboration, I believe I can positively impact the well-being of the people and clients I work with in the AOD sector.

Question 28

Identify two historic, current and emerging patterns relating to alcohol and drug use in the table below.

(approx. 50 words each row)

Answers may vary, but the response must reflect context in the answers below.

HISTORIC	
Time Period	**The trend/ pattern**
19th Century	*In the 19th century, substances like opium and opiates were widely used for medicinal purposes. However, this period also saw the emergence of concerns related to addiction.*
1920-1933	*The Prohibition era in the United States led to a surge in illegal alcohol production and distribution, contributing to the rise of organized crime.*
CURRENT	
Time Period	**The trend/ pattern**
Current	*An increasing concern is the misuse of prescription drugs, including opioids, benzodiazepines, and stimulants.*
current	*Alcohol remains one of the most commonly used substances globally. Current patterns include social drinking, binge drinking, and cultural variations in alcohol consumption.*
EMERGING	
Time Period	**The trend/ pattern**
Emerging	*Microdosing:* *Microdosing, or taking small amounts of psychedelics for purported cognitive enhancement, is an emerging trend.*
Emerging	*Changing Attitudes Towards Psychedelics:*

	There is a growing interest in the potential therapeutic uses of psychedelics, leading to changes in public attitudes and policy discussions.

Question 29

Describe different types of services available in the AOD sector. Provide examples of how these services address the diverse needs of individuals with substance use issues.

(approx. 50-100 words)

Answers may vary, but the response must include the context from the answers below.

Counselling and Therapy Services: These services offer individual or group counseling sessions to address the psychological and emotional aspects of substance use.
Residential Rehabilitation Programs: Facilities providing structured, live-in programs designed to support individuals through detoxification and rehabilitation.
Outreach and Mobile Services: Programs that bring AOD services directly to communities, catering to individuals who may face barriers in accessing traditional services.

Question 30

Describe different types of prevention initiatives available in the AOD sector. Provide examples of how these services address the diverse needs of individuals with substance use issues.

(approx. 50-100 words)

Answers may vary, but the response must include the context from the answers below

Education and Awareness Campaigns: Public health campaigns disseminate information about the risks associated with substance use, promoting preventive behaviors.
School-Based Prevention Programs: Educational initiatives implemented in schools to equip students with knowledge and skills to make informed decisions about substance use.
Community Engagement: Involving communities in prevention efforts, fostering a sense of responsibility and collective action to address AOD-related issues.

Question 31

Describe different types of intervention strategies available in the AOD sector. Provide examples of how these services address the diverse needs of individuals with substance use issues.

(approx. 50-100 words)

Answers may vary, but the response must include the following concepts in the answer below

Harm Reduction Programs: Initiatives that aim to minimize the negative consequences of substance use, including needle exchange programs and supervised consumption sites.
Pharmacotherapy: The use of medications, such as methadone or buprenorphine, to assist individuals in managing opioid dependence.
Crisis Intervention Services: Immediate and targeted interventions to address acute situations, such as overdose response and crisis helplines.

Question 32

Explain the concept of polydrug use, and discuss the potential risks and challenges associated with individuals engaging in this behavior.

(approx. 300-400 words)

Answers may vary, but the response must include the following concepts in the answer below

Example Answer:

Polydrug use refers to the concurrent use of multiple substances, either simultaneously or sequentially, by an individual. This practice is prevalent among individuals with substance use disorders and can involve combinations of legal and illicit drugs. Understanding polydrug use is crucial in the Alcohol and Other Drugs (AOD) sector, as it presents various risks and challenges.

Concept of Polydrug Use:
Polydrug use involves the simultaneous or sequential consumption of different substances, such as alcohol, prescription medications, illicit drugs, or over-the-counter medications. Individuals engaging in polydrug use often seek to enhance or alter the effects of one substance by combining it with others, leading to a complex interaction of pharmacological effects.

Potential Risks and Challenges:

Increased Risk of Adverse Effects: Polydrug use amplifies the risk of adverse effects and overdose due to the unpredictable interactions between substances.
Compromised Mental and Physical Health: Combining substances can lead to mental health issues, physical health complications, and exacerbation of existing medical conditions.
Impaired Decision-Making: Polydrug use can impair cognitive functions, leading to poor decision-making, risky behaviors, and increased vulnerability to accidents or injuries.
Legal and Social Consequences: Engaging in polydrug use may result in legal consequences and social stigma, affecting relationships, employment, and overall quality of life.
Examples of Common Drug Interactions:

Alcohol and Benzodiazepines: Both substances depress the central nervous system. Combining them can lead to respiratory depression, sedation, and an increased risk of overdose.
Stimulants and Depressants: Combining stimulants like cocaine with depressants like opioids can lead to a contradictory physiological response, increasing the risk of cardiovascular issues.
Prescription Medications and Illicit Drugs: Interactions between prescribed medications and illicit substances can affect the metabolism and efficacy of both, potentially leading to unexpected health consequences.
Addressing Polydrug Use:

Comprehensive Assessment: Professionals in the AOD sector should conduct thorough assessments to identify polydrug use patterns, understand motivations, and assess associated risks.
Education and Harm Reduction: Providing education on the risks of polydrug use and implementing harm reduction strategies, such as needle exchange programs and supervised consumption sites, can help minimize harm.
Integrated Treatment Approaches: Offering integrated treatment programs that address co-occurring mental health issues and substance use disorders is essential for comprehensive care.

Regular Monitoring: Ongoing monitoring and support are crucial for individuals engaging in polydrug use, ensuring that interventions remain relevant and effective.

Question 33

Provide examples of common drug interactions, emphasizing the impact of polydrug use on the effects of prescribed drugs. How might the use of prescribed medications influence or be influenced by the concurrent use of other substances?

(approx. 300 words)

Answers may vary, but the response must include the following concepts in the answer below

Common drug interactions are important considerations in the field of Alcohol and Other Drugs (AOD), particularly when exploring the impact of polydrug use on the effects of prescribed medications. Here are examples of common drug interactions, emphasizing the potential consequences of concurrent use of prescribed drugs with other substances:

1. ***Alcohol and Benzodiazepines:***
    - ***Interaction:*** *Both alcohol and benzodiazepines depress the central nervous system.*
    - ***Impact:*** *Combining them intensifies sedation, leading to impaired cognitive function, increased risk of falls, and respiratory depression.*
    - ***Polydrug Use Impact:*** *Individuals engaged in polydrug use, combining alcohol and benzodiazepines, may experience heightened sedative effects, increasing the risk of overdose and respiratory complications.*
2. ***Opioids and Sedatives (e.g., Benzodiazepines or Sleep Medications):***
    - ***Interaction:*** *Combining opioids with sedatives can lead to severe respiratory depression.*
    - ***Impact:*** *Polydrug use involving opioids and sedatives heightens the risk of respiratory distress, potentially resulting in fatal outcomes.*
    - ***Polydrug Use Impact:*** *Individuals concurrently using opioids and sedatives may unknowingly increase the risk of respiratory failure, especially if the substances are taken in larger quantities or more frequently than prescribed.*
3. ***Antidepressants and Illicit Stimulants (e.g., Cocaine or Methamphetamine):***
    - ***Interaction:*** *Antidepressants that affect serotonin levels combined with stimulants can lead to serotonin syndrome.*
    - ***Impact:*** *Polydrug use in this context may result in symptoms such as confusion, agitation, rapid heart rate, and even life-threatening complications.*
    - ***Polydrug Use Impact:*** *Individuals using both antidepressants and stimulants may inadvertently increase the risk of serotonin syndrome, posing significant health dangers.*
4. ***Anticoagulants and Nonsteroidal Anti-Inflammatory Drugs (NSAIDs):***
    - ***Interaction:*** *NSAIDs may increase the risk of bleeding when used with anticoagulants.*
    - ***Impact:*** *Polydrug use involving anticoagulants and NSAIDs heightens the risk of excessive bleeding.*
    - ***Polydrug Use Impact:*** *Individuals combining anticoagulants with NSAIDs may experience an increased likelihood of bleeding complications, potentially impacting overall health.*
5. ***Antipsychotics and Cannabis:***
    - ***Interaction:*** *Cannabis may enhance the sedative effects of antipsychotic medications.*
    - ***Impact:*** *Polydrug use in this scenario may lead to heightened drowsiness, impaired coordination, and increased risk of accidents.*
    - ***Polydrug Use Impact:*** *Individuals using both antipsychotics and cannabis might experience amplified sedative effects, impacting daily functioning and safety.*

Understanding these examples illustrates the intricate nature of drug interactions, especially when considering polydrug use. Professionals in the AOD sector must be vigilant in assessing and addressing these interactions to ensure the safety and well-being of individuals concurrently using prescribed medications and other substances.

Question 34

Discuss strategies that professionals in the Alcohol and Other Drugs (AOD) sector can employ to address the complexities of polydrug use and potential interactions, ensuring the safety and well-being of individuals.

(approx. 300-500 words)

Answers may vary, but the response must include the following concepts in the answer below

Answer:

Addressing the complexities of polydrug use and potential interactions requires a comprehensive and client-centered approach by professionals in the Alcohol and Other Drugs (AOD) sector. Here are strategies to ensure the safety and well-being of individuals engaged in polydrug use:

1. ***Comprehensive Assessment:***
   - *Conduct thorough assessments to understand the individual's substance use history, patterns, and motivations.*
   - *Gather information about prescribed medications, dosages, and adherence to medical recommendations.*
2. ***Educational Initiatives:***
   - *Implement targeted educational programs that focus on the risks and consequences of polydrug use, including potential drug interactions.*
   - *Enhance individuals' awareness of the impact of combining substances on their physical and mental health.*
3. ***Harm Reduction Strategies:***
   - *Advocate and implement harm reduction strategies, such as providing access to needle exchange programs, safe consumption sites, and educational materials.*
   - *Encourage safer substance use practices to mitigate potential risks.*
4. ***Regular Monitoring and Check-Ins:***
   - *Establish regular monitoring systems to track changes in substance use patterns and assess potential interactions.*
   - *Conduct regular check-ins with individuals to discuss their experiences, challenges, and any changes in prescribed medications.*
5. ***Interdisciplinary Collaboration:***
   - *Foster collaboration among professionals from various disciplines, including medical practitioners, psychologists, and social workers.*
   - *Ensure seamless communication to address the multiple dimensions of an individual's health and well-being.*
6. ***Integrated Treatment Approaches:***
   - *Develop integrated treatment plans that address both substance use disorders and co-occurring mental health issues.*
   - *Coordinate efforts to provide holistic care, involving mental health professionals and addiction specialists.*
7. ***Medication Management:***
   - *Regularly review and adjust prescribed medications in collaboration with healthcare providers to minimize potential interactions.*

- *Monitor for side effects and evaluate the ongoing appropriateness of prescribed medications.*

8. ***Client-Centered Counseling:***
   - *Provide individualized counseling that considers the unique needs and motivations of the individual.*
   - *Utilize motivational interviewing and cognitive-behavioral approaches to address underlying issues contributing to polydrug use.*
9. ***Peer Support and Group Therapy:***
   - *Incorporate peer support programs and group therapy sessions to create a sense of community and shared experiences.*
   - *Encourage individuals to learn from others who have successfully navigated polydrug use challenges.*
10. ***Crisis Intervention Planning:***
    - *Develop crisis intervention plans in collaboration with clients to address potential emergencies.*
    - *Educate individuals on recognizing signs of overdose and empower them to seek help promptly.*
11. ***Cultural Competence:***
    - *Foster cultural competence to tailor interventions to the cultural background and beliefs of individuals.*
    - *Acknowledge and respect cultural factors that may influence substance use patterns.*

By implementing these strategies, professionals in the AOD sector can enhance their ability to address the complexities of polydrug use and potential interactions, ultimately promoting the safety, well-being, and recovery of individuals dealing with this challenging issue.

Congratulations you have reached the end of Assessment 1!