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Understanding the unique goals of complex support clients accessing alcohol and other drug treatment

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Abstract

Background Actively involving clients of Alcohol and Other Drug (AOD) services in selecting their own treatment goals may help to align clients' and service providers' expectations of treatment and improve engagement with services. This study explored the type and frequency of client-selected treatment goals; self-reported progress towards their goals; client and clinician views of their progress, and the acceptability of selecting and tracking goals in a non-residential AOD treatment provider in New South Wales, Australia.

Methods A mixed method study was conducted. Clients selected their goals during AOD treatment then self-rated their progress towards goals using the validated 11-point goal-based outcome (GBO) rating tool. Qualitative interviews were conducted with clients and clinicians. Mean GBO ratings were reported for each timepoint. Goals were thematically analysed to identify type, then descriptively analysed to identify frequency. Interviews were thematically analysed by one researcher and reviewed by a second.

Results Among the 22 clients who completed the GBO at least once, the median number of self-identified goals was 3. The most common goals included: (1) managing mental health and (2) developing strategies to prevent relapse and manage AOD cravings. Most participants reported improvements in their selected goals; there were no participants who reported lower GBO scores at the second timepoint compared to the first. Qualitative themes demonstrate that while the GBO approach provided clarity for clients, was acceptable to clients and clinicians, and considered client expectations of treatment, the approach was difficult for those with limited literacy and reflexive thinking. Those experiencing lapse or relapse reported the linear GBO rating approach was potentially demotivating.

Conclusions Findings demonstrate that a goals-based outcome approach can promote shared decision-making between client and clinicians about treatment goals which are valued by clients. Service providers should be aware of potential complexity of recalling selected goals and completing ratings particularly among clients with co-occurring mental illness and memory impairment. Goals that are time-specific, realistic and relevant should be prioritised to minimise risks of demotivation arising from non-linear progress towards goals.

Keywords Goals-based outcomes, Alcohol and other drugs, Complex support needs, Psychoeducation, Mixed methods

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Background

Alcohol and Other drug (AOD) related harms are far reaching, affecting family and partner relationships [1, 2], as well as causing premature death, disease [3], accidents and injuries [4, 5] and cost the Australian economy $80 billion in 2021 alone [6]. In 2021–2022, an estimated 131,000 people aged 10 and over received support from an Australian AOD treatment provider, most commonly for alcohol [7]. Engaging and retaining individuals in AOD treatment can be difficult and influenced by several barriers [8, 9]. These may include physical barriers such as a lack of transport and availability of service offerings in regional and remote communities [10], cultural or gendered barriers which reflect the varied understandings and expectations of diverse populations seeking treatment [11, 12] and psychological barriers, including hesitancy to access support due to stigma and discrimination [13]. For individuals with complex support needs, these barriers may be compounded as they can often experience and present with greater problems with cognitive functioning, co-occurring mental and physical illnesses, limited psychosocial supports, justice and social system involvement, and/or long histories of trauma and maltreatment [8, 14, 15]. It is possible that actively involving clients with complex AOD support needs in selecting treatment goals that are meaningful to them may help to identify tailored treatment goals that suit the individual, better aligning the expectations of clients and service providers around treatment outcomes and improving engagement.

Qualitative studies with clients with complex AOD needs have illustrated that the format of treatment (i.e., individual or group programs) and a myopic approach to treatment outcomes can be restrictive and uncomfortable, demonstrating the need for services to be flexible to preferences and needs [16]. For instance, there can be a misalignment between clients' preferred treatment goals and the overarching goals of AOD service providers which can result in suboptimal care and contribute to stigma rhetoric and the dehumanisation of clients accessing treatment [17, 18]. While principles of client centred care are endorsed and maintained in AOD treatment guidelines [18, 19], treatment program outcomes may not always reflect the values, goals and actual experiences of clients [16, 20]. Indeed, pre-defined program outcomes, which Rossi and colleagues [21] define as the *"state of the target population or the social condition that a program is supposed to have changed"* can sometimes be fed from funding bodies, service providers, policy makers and/or researchers, with little reflection regarding the outcomes clients may wish to achieve from accessing treatment [22]. These pre-defined program outcomes can include expected changes in a client's knowledge, attitudes, behaviours and quality of life, which are often assessed via minimum dataset requirements [22]. Further, researchers note that clients' involvement in service planning, design, delivery and evaluation can impact upon program outcomes, and can innovatively redefine what is needed to positively influence system changes to be responsive and flexible to needs [22, 23]. The identification and attainment of unique therapeutic goals, for example, has been recently identified as an important performance measurement for the AOD treatment sector [23]. In this paper, unique therapeutic goals represent carefully considered treatment objectives to improve client wellbeing and enhance their functional capacity, which are selected by clients in collaboration with clinicians.

This study aimed to:

1. Explore the type and frequency of goals selected by clients during AOD treatment.
2. Assess clients' progress towards their selected goals during AOD treatment using the self-reported validated 11-point goal-based outcome (GBO) rating tool; and the views of clients and clinicians towards their progress (using qualitative interviews).
3. Understand client and clinician views on the acceptability of the process used to track goals and goal achievement.

Methods

Design

This study employed a mixed method approach, including semi-structured qualitative interviews with clients and clinicians, client selecting AOD treatment goals and the utilisation of the GBO rating tool [24] among clients with complex AOD support needs in a non-residential AOD treatment service in New South Wales, Australia. It was conducted as part of a pilot study which developed and explored the feasibility, acceptability and changes in clinical outcomes from a new psychoeducational program in the service. The goals-based approach was developed as part of the new psychoeducation program and is a new addition to 'usual care' for the treatment service, which has customarily provided group and individual therapeutic interventions, including recreation and social activities to increase coping skills and motivation for positive change. This project received ethics approval from the University of New South Wales Human Research Ethics Committee (HC220331) and all participants provided informed consent prior to data collection.

Participant eligibility and recruitment

All clients completing the complex support needs program and who were able to give informed consent were eligible to participate in the study. To determine complexity of client needs the NSW Health Complexity

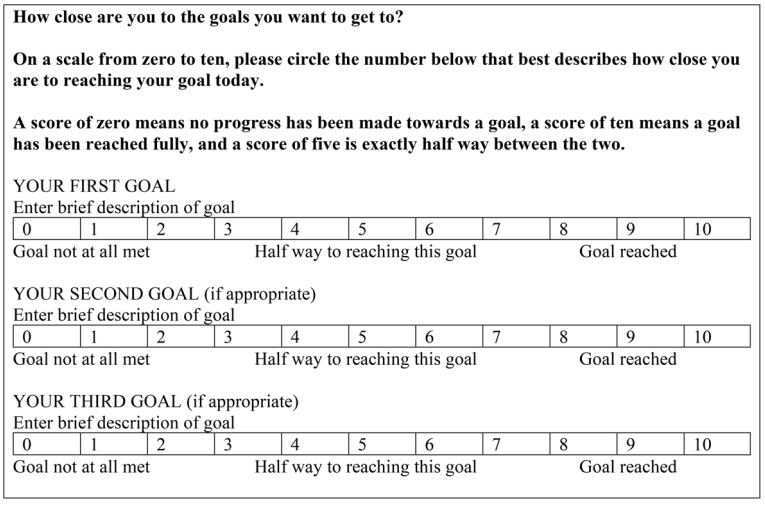
Rating Scale was used at intake which explores symptom severity and functional impairment across five domains: AOD use, physical health, mental health, cognitive function, and socio-economic factors [25]. Clients who were aged 18 years or older and who scored 7 or above on the Rating Scale (indicating complex needs) were eligible to participate. The program encompassed 10 psychoeducation modules, which included topics related to social supports, life skills, mental health, relapse prevention, dealing with difficult situations and physical health. Clients voluntarily received a minimum of three psychoeducation modules. Potential participants were informed about the study by site clinicians. If they were interested in participation, clinicians provided them with the study information sheet and they then contacted a member of the research team to discuss participation, complete informed consent and arrange a time for an interview. Participants had the option to participate in an interview and/or for the information collected about their treatment goals to be included in the study. Clinician interviews were also conducted to gain clinician perspectives about facilitating a goals-based outcome approach in practice. Interviews were conducted over the phone, via zoom, or in person/onsite and were semi-structured in nature. Interviews lasted between 20 and 60 minutes and averaged 30 minutes across the sample.

Goal setting

During the first psychoeducation treatment session clients and clinicians worked collaboratively through a recovery plan, which included identifying and writing short- and long-term goals, exploring pros and cons of changing behaviour (using motivational enhancement therapy (MET) techniques), linking their highest priority goals to program modules (treatment matching) and managing barriers to completing goals. MET is an approach used in psychotherapy which focuses on improving/evoking an individual's motivation to change, and is founded on the principles of motivational interviewing and the Transtheoretical Model of Change [26]. Clinicians used MET to support participants to explore the value of each identified goal (i.e. why was the goal important?), then facilitated an activity whereby participants prioritised and ranked their identified goals and explored client timelines for change (i.e. was it a short (few weeks or month) or a long-term goal (more than a few months)). Clinicians also worked with participants to ensure that goals were specific, measurable, achievable, relevant and time specific (SMART).

Data collection

At multiple timepoints during treatment, participants were asked to rate their progress towards achieving their written goal/s using the validated 11-point goal-based outcome (GBO) rating tool [24] (refer Fig. 1) [27]. Clients would rate on a scale from zero to ten the number that best described how close they were to reaching their goal (for example, 0– goal not met at all, 10– goal reached). Clients also provided a brief description of their goals. Clinicians then provided these data to the research team at the end of the study. A qualitative approach was then used to privilege the perspectives of participants. All clients were invited to participate in a one off 30-to-60-minute semi-structured interview with ED (Author One) to discuss their unique treatment goals and progress towards goals. Clinicians were also invited to participate in an interview to discuss their experiences in supporting clients to select their goals using the GBO. All interviews were audio-recorded and transcribed verbatim by an external transcription agency.



How close are you to the goals you want to get to?

On a scale from zero to ten, please circle the number below that best describes how close you are to reaching your goal today.

A score of zero means no progress has been made towards a goal, a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two.

YOUR FIRST GOAL
Enter brief description of goal

0	1	2	3	4	5	6	7	8	9	10

Goal not at all met — Half way to reaching this goal — Goal reached

YOUR SECOND GOAL (if appropriate)
Enter brief description of goal

0	1	2	3	4	5	6	7	8	9	10

Goal not at all met — Half way to reaching this goal — Goal reached

YOUR THIRD GOAL (if appropriate)
Enter brief description of goal

0	1	2	3	4	5	6	7	8	9	10

Goal not at all met — Half way to reaching this goal — Goal reached

Fig. 1 Goal-based outcome rating tool

Table 1 Clients' therapeutic goals

Unique Therapeutic Goals[a]	# of clients who chose each goal (*n* = 22)
Manage mental health, learn new strategies to cope	17
Relapse prevention and using strategies to cope with cravings	15
Reduce substance use / learning strategies to reduce use	13
Strengthen relationships / build healthy relationships	5
Learn strategies to improve physical health	3
Track and attend all appointments	3
Increase social outings	1
Getting into a detoxication program	1
Move out of current living arrangements	1
Seek employment	1
Save money	1
Learn and implement refusal skills (increased confidence to say 'no')	1
Learn strategies to regulate emotions	1

[a]Clients could choose more than one therapeutic goal

Analysis

To explore whether GBO scores changed during treatment, we reported the means in GBO score at timepoint two and timepoint one across participants who completed the GBO measure at least twice for one or more goals. As the sample size was insufficient to conduct multilevel modelling, a two-sided paired samples t-test was conducted to test whether mean GBO scores differed between the two timepoints, with an alpha level of 0.05. All quantitative analyses were done in R via RStudio.

Written goals were analysed thematically [28] by ED and reviewed by SF to identify the types of goals selected, with disagreements managed via discussion until consensus was reached. Using the goal types, goals were analysed descriptively to identify frequency. Interview data were deductively analysed [29] by ED and reviewed by SF. Disagreements were discussed until consensus was reached, and key themes related to the study aims were developed. QSR NVivo was used as a data management and analysis tool.

Results

Type and frequency of client goals

The median number of goals chosen was 3 (IQR = 2–3) among the 22 clients (88% of eligible client sample) who completed the GBO on at least one occasion during the study timeframe (January 2023– February 2024). The most frequently chosen goal related to mental health and coping, and implementing positive strategies to manage panic, low mood, anger, depression and anxiety, which was chosen by 17 participants (refer Table 1). This was followed by relapse prevention and craving management goals ($n = 15$) and implementing strategies to reduce or stop AOD use ($n = 13$). Other goals identified by clients included maintaining and/or strengthening healthy relationships ($n = 5$), learning strategies to improve physical health and wellbeing ($n = 3$), and attending all appointments ($n = 3$).

Clients' progress related to their selected goals during treatment

Of the 22 clients, 14 completed the GBO tool on at least two separate occasions (64% of participants; 14% did not complete any GBO and 23% completed only one occasion). Most indicated that they were closer to reaching their goal on the second GBO completion (mean = 8, SD = 2.04) compared to the first (mean = 4.5, SD = 2.26). The paired samples t-test showed that mean GBO score at timepoint 2 was significantly higher than at timepoint 1 (mean difference = 3.5 [95% CI = 2.91, 4.09], t = 12.08, df = 41, $p < 0.01$). Fewer than five participants indicated no change, and there were no participants who reported lower GBO scores at the second timepoint compared to the first.

Clients' perspectives on their progress related to their selected treatment goals

Nine clients and four clinicians participated in semi-structured interviews to explore the acceptability of the GBO tracker in practice and to qualitatively explore their progress towards goal achievement. Quotes are denoted by 'C' (clinician) and 'P' (clients).

More than half of clients relayed stories of success and progress towards their chosen goals. The following client identified improvements in physical health as important and positively reflected on a self-rated GBO of 9/10 at treatment completion. Using the GBO together with the psychoeducation program had allowed the client to identify physical health as a priority, which appeared to flow on to reducing his AOD use, as illustrated by the following interview excerpt:

> *"I'm getting healthier, I changed my food habits. I've stopped eating microwaved foods. I was mainly eating junk food and takeaway."*
>
> *Interviewer: Have you found that any of those changes has helped with your substance use?*
>
> *"Yeah it's good. It's a distraction, you just forget about it to be honest."* (P#5).

Another participant whose goals were to reduce cannabis use, and to implement more positive coping skills to manage her mental health, also reported improvements, as highlighted by the following quote:

> *"I wanted to be able to stop smoking and craving every time I left the house. So, in the beginning, me leaving the house without a cone that was (self-rated as) a 2, I didn't think I would be able to do it, it's about a 6 or a 7 now. My anxiety side…I wanted to be able to go to appointments without being anxious, that was a very low number and I finished that with a 9 or 10. I feel actually really good about myself and I feel really proud."* (P#7).

Some clients described how reflecting and tracking progress towards identified goals was a helpful way to understand if treatment was working for them, and where to continue to direct their efforts. Others appreciated that tracking goals *"showed me consistency"* (P#8) and that making progress was an empowering experience.

> *"I think one (goal) was a four (self-rated) at the start, like how confident I am about staying off (AOD) and getting well. And then by the end of it, it was a nine. One (goal) was a two and I think got to an eight, the other one. So that was good…what that did is gave me belief in myself that what (clinician) was talking about can help."* (P#6).

Similarly, the following participant also described feeling empowered and encouraged when reflecting on their progress towards goals:

> *"By the end of it especially with (attending) the appointments… it's easy for me just to really not go… So I've achieved those goals. I've improved them. I went from a two with appointments to a ten. I felt pretty good about it at the end."* (P#8).

Facilitating clinicians also observed positive changes in clients' AOD use behaviours, noting that many had been progressing towards goals and reflecting on their achievements:

> *"When they look back at it, they'll be like 'I didn't know anything about anxiety. I didn't know anything about anger management. And now I've got all these tools in place and I've been using it outside the treatment session,' so that's been really positive."* (C#1).

Client and clinician views on the acceptability of using the GBO tool

Two themes were developed related to the acceptability of applying the GBO tool to track treatment progress. First, the way in which the GBO process offered clarity and direction for clients, while considering their needs and desired treatment outcomes. Second, the use of the GBO tool was reportedly difficult for a few clients ($n = 2$, 22%) who had memory problems and low literacy levels, which made it difficult to implement in practice without adjustments made by clinicians.

Theme one: GBO approach provided clarity and considered the needs and expectations of clients

Clients relayed that because they identified goals early during treatment, they had a sense of clarity, purpose and a direction to work towards with their clinician. The GBO was largely conceptualised by clients and clinicians as a tool to consider individual needs, and clients appreciated the efforts of clinicians to understand their unique circumstances and desired treatment goals. Clients reported that the purpose of the first treatment session was to comprehend each client's situation and to use the GBO tool to identify and codesign goals to work towards, as illustrated by the following quote:

> *"Identifying what's going on for me in my life or what I would consider important to work on, narrowing that down, again specifically for what I'm going to get the most out of during the time."* (P#1).

Some clients appreciated that the approach was self-driven, and they could contribute to designing their own treatment goals, which was considered a novel approach when compared to other services and programs they had received:

> *"I've never had this sort of support before. I tried doing AAs [Alcoholics Anonymous] and what not, but I couldn't talk in a group, it was easier one on one."* (P#4).

As relayed by one clinician (C#3), *"AOD is not the sort of treatment that measures success easily"*, as she went on to further explain that historically, measurements had been fraught with assumptions about what improvements are expected by service providers' models of care and funding bodies (i.e. reduced AOD use), with little attention given to client's own goals. On the contrary, a GBO approach was viewed as embedding a client's perspective in the evaluative framework early in the treatment process and appeared to transfer a sense of agency to clients to identify achievable and realistic goals. For example, when asked how they felt about the GBO approach, the following client said:

> *"Good. I designed it. Something clicked. I went, well what I can do is I will measure, that's a standard drink instead of pouring what I think into a big glass and off I go. I'll break it right down to basics and I will measure. That was how I planned to go about it. I was doing a bottle a day, sometimes a bottle and half. And I said, let's just leave it at four*

bottles a week, but I will measure, literally measure. I've reduced my drinking. I feel back in control. This approach of measuring is working for me and I will keep it up." (P#9).

A GBO approach allowed clients to set their own goals, and as some clients reported, this meant they could identify relevant coping strategies related to their cravings, withdrawal symptoms and triggers, which were unique for each client. For some, mental health was reported to improve by scheduling and spending more time in nature, 'camping and fishing' and for others, learning specific grounding strategies to cope with panic attacks were identified as the root cause of mental health improvements. Clinicians also reflected that using a GBO approach allowed latitude in responding to each unique need: *"it really gives you that flexibility to cater to their needs"* (C#2).

Theme two: GBO approach was difficult for clients with low literacy and limited reflexive thinking

For clients with low literacy, disability and/or acquired brain injuries, extra support from clinicians to complete the GBO tool and subsequently reflect and track their progress was essential. Indeed, problems with memory and cognition were identified by some clients as significant barriers in retaining information at all and working towards set goals, as illustrated by the following quote:

"It is a barrier (to completing treatment) because I've got organic brain damage, where there's parts of the brain that's dead. So yeah, my memory has suffered." (P#6).

Clinicians also commented that the GBO approach required reflexive thinking skills, which for some clients was extremely difficult given their reduced capacity to comprehend, noting they adapted the tool to suit some individuals with disability or acquired brain injuries:

"Instead of going, on a scale of zero to one' we sort of did a different conversation, you know, do you feel you're halfway more, halfway less, sort of worked it out that way." (C#2).

For clients with cognition and functional impairment, clinicians spent extra time reviewing chosen goals and providing hard copy/take home versions for clients to revise, which was appreciated by clients: *"I've got a copy of it and it made it easier, because I said what I said, she (clinician) wrote it down, like my answers, and then she sent it out to me"* (P#4). Clients also valued that these clinicians spent time reflecting with them on progress they had achieved since the previous session, as this was not always recognised by clients who had limited reflexive thinking skills or the capacity to remember their previous GBO ratings:

"When they (clinicians asked me to) do the (GBO) at the start, I can't even remember what the numbers were back then. She told me, so I went, 'did I say that?!'" (P#6).

Some clients also had competing priorities, including for example, court attendances and additional health appointments, and described that the intentional time spent with clinicians reviewing their GBO ratings helped them to remember why they had sought treatment in the first place, and worked to reorient their efforts/focus when they had difficulties with motivation or memory.

Additionally, clients reported that the way the GBO operates (i.e. self-rating progress at each session) meant they could feel discouraged if they had a lapse in AOD use or experienced challenges progressing towards their identified goals. As explained by the following client, it was realistic to conceptualise AOD treatment as a non-linear experience, and that moving up and down on the continuum should be expected:

"Every day you don't use, you do good, or climb up a step right? So after 100 days, you've climbed 100 steps right? But something bad happens, you trip up… You haven't fallen down to the bottom; you've fallen down a couple of steps. It hurt, but you're still doing good. You're still on the up, doing better. You just had a slip-up, get up and keep climbing until you get to where you need to go." (P#6).

Another client reflected that if he hadn't made progress towards his goals, he may not have felt as optimistic about his treatment experiences and about using the GBO to track treatment outcomes: *"I felt pretty good about it (my process during treatment) at the end… I might not have liked it if it went worse"* (P#8).

Discussion

Our findings indicate that a goal-based outcomes approach is feasible within an AOD treatment setting, is a helpful addition to usual care of clients with complex support needs and is valued by clients and clinicians. Unlike previous studies which reported on the variable success of treatment programs, particularly for complex need populations, this study found clear and consistent evidence for clients reporting progress toward their chosen goals [30]. This goals-based outcome approach extends core principles of participatory action such as empowerment, collaboration and integration, that are used in other countries and with other vulnerable groups

(e.g., older people, families and people with disabilities) [31], indicating potential for this approach in other sectors.

This study raises three important implications for service providers seeking to implement a goals-based outcomes approach. **First**, while most participants indicated that they had made progress towards their specified goals, some noted that progress towards treatment outcomes was non-linear, contrary to the pre/post nature of GBO tracking, and this could be demotivating and lead to disengagement. Steps to mitigate these risks are important for service providers to encourage continued engagement and treatment completion. **Second**, most client-reported goals related to learning and developing new strategies to manage psychological distress (i.e. mental health), illustrating the importance of baseline skillsets among AOD workers and the need for cross-sector collaboration between the AOD and mental health services sectors. **Third**, consideration is needed for the barriers facing clients with functional and memory impairments to meaningfully engage with outcome metrics, including goals-based tracking tools.

In the current study, although clients who self-reported linear improvements toward achieving their selected goals noted increased self-belief and motivation to continue treatment, some clients expressed concerns about goals-based tracking if they experienced a lapse or relapse. Research shows that relapse can hold high levels of fear and worry for individuals seeking treatment, and that many clients and their families still have unmet needs regarding education and coping skills for relapse [32]. Qualitative research with young people accessing treatment for AOD problems also indicates that normalising relapse in treatment settings can enhance engagement and promote treatment completion [33]. It is therefore imperative that service providers and program evaluators be careful not to set up unrealistic expectations that clients will always move forwards and progress towards goals in a linear fashion. Increasing the frequency of goal assessment could be one way of mitigating these risks by providing a more regular picture of client achievements. Indeed, researchers have suggested that waiting until discharge to determine whether the treatment has been 'successful' holds ethical challenges due to the missed opportunities to guide / adapt treatment approach if clients are not progressing and for the early identification of clients who may be having an unfavourable response to treatment ('single-alarm cases') [34]. Evidence from psychotherapy suggests that ongoing progress monitoring of AOD program outcomes can support both clients and clinicians to 'see' progress which may increase treatment engagement and enhance recognition of treatment deterioration, pre-empting steps to re-evaluate the needs of clients and where to direct efforts [35].

The top concerns for clients in this study related to developing strategies to manage psychological distress and mental illness. Experiences of co-occurring mental illness was significant among clients, and managing mental illness was the most frequently chosen goal. Research shows that between 50 and 76% of clients accessing Australian AOD services met the diagnostic criteria for a least one co-occurring mental health disorder [36], indicating the importance of AOD clinicians being well-equipped and sufficiently trained to support clients with co-occurring and complex needs. The need for professional development in dual diagnoses/mental health and cross sector partnership work has long been recognised by the AOD sector, particularly when accommodating clients with complex support needs [36, 37]. However, researchers argue that existing cross sector collaboration models still fail to address factors which are imperative to mental health and AOD service delivery, with little consideration to client and carer participation in treatment, for example, and the adoption of recovery oriented practices [38]. Engaging clients with co-occurring mental health and AOD issues in shared decision making which considers best available evidence and individual preferences has been identified as one strategy to address this gap [39, 40].

Finally, study findings highlight the need to consider appropriate adjustments to support clients with limited executive functioning and cognitive impairment due to brain injury; which are highly prevalent in AOD misuse populations [41–43]. Cognitive impairment is one of the primary risk factors for AOD treatment disengagement [14] and can continue to negatively impact individuals beyond the treatment completion and connection with service providers [44]. Addressing apathy and indifference among clients has also been identified as a common challenges for clinicians treating those with brain injuries, which can manifest as a decrease in goal-directed behaviour and goal directed cognition [45, 46]. While researchers promote the application of cognitive rehabilitation within AOD treatment to improve executive functioning and goal attainment [43, 47], our findings highlight the difficulties in implementing these approaches in practice. Clinicians' reflections in this study confirm these challenges, who carefully adapted the numerical scale of the goals tracker to ensure the metric was more accessible for clients with cognitive impairments.

Limitations

This study was limited by the small sample size, short time frame, and a single treatment site, meaning findings and the acceptability of GBO to track goals may not be generalisable across other services and should be interpreted with care. Future research exploring a goals-based

outcome approach in multi-site studies with larger sample sizes is thus warranted.

Conclusions

This study demonstrates that a goals-based outcome approach can promote shared decision-making between client and clinicians about treatment goals which are important and valuable to the individual accessing support. AOD service providers wishing to implement a similar approach must also be privy to the complex support needs that clients may have, which often includes co-occurring mental illness and problems with executive functioning and memory impairment. The potential for non-linear progress towards AOD treatment outcomes should also be considered as this could potentially demotivate clients' in their overall progress and promote disengagement. As such, goals that are time-specific, realistic and relevant to the current program should be developed in collaboration with clients and skilled clinicians.

Abbreviations

AA	Alcoholics Anonymous
AOD	Alcohol and other drugs
GBO	Goal–Based Outcome
MET	Motivational Enhancement Therapy
NSW	New South Wales

Supplementary Information

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Supplementary Material 1

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Clinical trial number

Not applicable.

Authors' contributions

ED contributed to data collection and analysis and led the writing of the manuscript. WSY contributed to data analysis and write up. GE contributed to write up. AS conceptualised study and contributed to write up. SF conceptualised study and methodology, acquired funding, and contributed to write up.

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Data availability

The deidentified datasets generated and or analysed during the current study are not publicly available to protect privacy of participants but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

This project received ethics approval from the University of New South Wales Human Research Ethics Committee (HC220331) and all participants provided informed consent prior to data collection. Our research adheres to the ethical principles for research involving human participants as outlined in the Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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