

Interagency guidelines for the early intervention, response and management of drug and alcohol misuse

A condensed guide



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SHPN (CDA) 050028
ISBN 0 7347 3797 1

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November 2005

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What is *Interagency guidelines for the early intervention, response and management of drug and alcohol misuse*?

Interagency guidelines for the early intervention, response and management of drug and alcohol misuse (Interagency guidelines) is designed to assist justice and human services agencies to develop their drug and alcohol related policies and plan associated workforce needs.

Most agencies delivering services to individuals and families will encounter service users who experience problems as a consequence of either legal or illegal drug use. This could involve an immediate crisis, such as an overdose, but will more often be of a medium to long-term nature, affecting a service user's family, social, physical, psychological or legal situation.

This document describes practice areas that agencies can incorporate in their core business and use to build their capacity to respond to harmful drug and alcohol use among their service users. Additionally, effective responses often require active collaboration between different services. As such, *Interagency guidelines* advocates an integrated service delivery system that addresses the needs of service users in a comprehensive and coordinated way.

Objectives

Interagency guidelines aims to:

- strengthen the capacity of agencies to identify and respond appropriately to harmful drug and alcohol use among their service users
- strengthen the coordination and collaboration between specialist and mainstream services to improve the effectiveness of responses to harmful drug and alcohol use among service users
- assist justice and human service agencies to define their roles and responsibilities for *Interagency guidelines* among their service users
- identify and describe the key practice areas that justice and human service agencies may engage in to respond to harmful drug and alcohol use among their service users
- provide justice and human service agencies with guidance on when, how and who might respond to harmful drug and alcohol use among their service users
- assist justice and human service agencies to review and develop drug and alcohol related policies, procedures and practices and plan workforce needs.

Target audiences

Interagency guidelines is aimed at NSW Government agencies that are funders, regulators or providers of justice and human services. It is designed for the following.

Chief Executive Officers of:

NSW Health, Attorney General's Department;
Premier's Department; Department of Corrective Services;
Department of Community Services; Department of Education & Training; Department of Housing; Department of Juvenile Justice;
NSW Police.

Policy makers and senior officers responsible for implementation within:

NSW Health, Attorney General's Department;
Premier's Department; Department of Corrective Services;
Department of Community Services; Department of Education & Training;
Department of Housing; Department of Juvenile Justice; NSW Police.

NGOs funded by:

NSW Health, Attorney General's Department;
Premier's Department; Department of Corrective Services;
Department of Community Services; Department of Education & Training;
Department of Housing; Department of Juvenile Justice; NSW Police.

Regional Coordinators

Community Drug Action Teams

Area Health Service Drug and Alcohol directors/coordinators

Employees of:

NSW Health, Attorney General's Department;
Premier's Department; Department of Corrective Services;
Department of Community Services; Department of Education & Training; Department of Housing; Department of Juvenile Justice;
NSW Police; Non-Government Organisations.

Service users of:

NSW Health, Attorney General's Department;
Premier's Department; Department of Corrective Services;
Department of Community Services; Department of Education & Training;
Department of Housing; Department of Juvenile Justice;
NSW Police; Non-Government Organisations.

Rationale

Justice and human service agencies regularly provide services to people who experience a range of problems as a result of drug use – family, social, physical, psychological and legal. The need to reach these people is more important than ever, given that research suggests:

- In 2004 10% of the population consumed alcohol in a way considered risky or a high risk to health in the long term and over one-third (38%) of the population aged 14 years and over had ever used an illicit drug
- individuals who are unemployed and have lower educational achievement are more at risk of developing drug and alcohol problems²
- low income and homelessness are risk factors for patterns of harmful drug and alcohol use³
- early and brief intervention offers substantial benefits when conducted by trained and resourced workers⁴
- drug treatment is effective in reducing harmful drug and alcohol use, hospital costs, drug-related harm, violence and welfare costs.⁵

1 2004 National Drug Survey.

2 The NSW Drug Treatment Service Plan 2000–2005, NSW Health, 2000.

3 National Survey of Mental Health and Wellbeing, 1999.

4 National Drug Strategic Framework Commonwealth of Australia, 1998.

5 Dawe S, Loxton N, Hides L et al, Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders (2nd Edition) 2002.

Implementation

Interagency guidelines provides the basis for reviewing and developing agency policies, procedures and practices and workforce development plans. Ultimately, its successful implementation will lie in the development of protocols and procedures that clearly address local needs and take account of the availability of local services.

Before this can be achieved:

- agencies must determine their roles and responsibilities
- ensure that these are authorised by their organisation's policy, procedure and practice
- have a competent workforce to action them.

In recognition of the substantial work required before the development of local protocols and procedures is feasible, a staged approach to implementation will be undertaken.

Stage 1 – Statement of roles and responsibilities

By December 2006, each of the agencies listed will produce a policy statement identifying its roles and responsibilities in relation to *Interagency guidelines*.

The policy statement will identify:

- the practice areas that the agency considers appropriate to its business
- when and how the agency will respond to harmful drug and alcohol use among its service users
- the positions within the agency that will have a legitimate role for responding in relation to a practice area.

The policy statement should communicate how the agency will respond to harmful drug and alcohol use among its service users as a service provider, as an employer and as a funding and regulatory body.

Stage 2 – Organisational development action plan

By June 2007, each agency will have completed a compliance audit of organisational policy, procedure and practice with *Interagency guidelines* and developed an action plan for addressing deficiencies. The action plan will include:

- agency policies, procedure and strategic plans providing direction to respond appropriately to harmful drug and alcohol use among service users
- organisational management structures to support responding appropriately to harmful drug use among service users
- agency plans to incorporate appropriate drug and alcohol responses in professional recognition and reward systems
- systems to monitor and evaluate appropriate responses to harmful drug and alcohol use among service users
- systems to improve the quality of appropriate responses to harmful drug and alcohol use among service users.

The action plan should:

- reflect the aims and practice areas of *Interagency guidelines*
- specify responsibilities and timelines for each action
- link to, and be consistent with, other related strategies.

Stage 3 – Workforce Development Plan

By June 2008, each agency will have developed a Workforce Development Plan to develop the competence of the positions it has identified as having a legitimate role in responding appropriately to harmful drug and alcohol use among service users. The Workforce Development Plan will include:

- an assessment of the competencies required by staff to respond appropriately to harmful drug and alcohol use among service users
- plans for on-the-job learning opportunities
- identification of training and development needs of staff
- plans for training that incorporate, where relevant, the national competency standards for drugs and alcohol
- development of systems to monitor performance of staff in practice areas ie supervision, performance management systems, and staff recognition
- review of occupational health and safety policies to ensure interactions with intoxicated service users are addressed in relation to worker safety measures.

Development by agencies of these plans will be overseen by the NSW Drug & Alcohol Workforce Development Council.

Stage 4 – Local infrastructure development

By June 2008, Area Health drug and alcohol services will have in place mechanisms to facilitate collaboration at the local level. These will include local referral pathways, eligibility and entry criteria, as well as agreements about how information will be shared.

Monitoring and reporting

Implementation of *Interagency guidelines* is to be achieved by agencies within existing resources. Implementation will be monitored by the Senior Officers' Coordinating Committee on Drugs and Alcohol.

Agencies will also be required to report progress on implementation in their annual reports.

Defining agency roles

A key challenge for agencies in responding to drug and alcohol related harm among their service users is defining precisely **what** their role is. Agencies need to think about where harmful drug and alcohol use is likely to overlap with core business and use *Interagency guidelines* to define the organisation's role boundaries for dealing with it. To assist in defining the role they can play, agencies should consider the following.

When you might respond

- When is *Interagency guidelines* part of core business?
- Are there any areas of service delivery that might be a priority for drug and alcohol responses?
- Are there groups of service users that may be a priority for drug and alcohol responses?
- How will our agency ensure that responses are timely and appropriate to core business?

How you might respond

- What are the appropriate practice areas for our agency to engage in?
- When and how can these be integrated with core business practices?
- What is best practice?
- How will our agency ensure quality responses occur?

Who you might authorise to respond

- Who are the workers in our agency who do not have alcohol or other drug use as a primary focus, but who are likely to have the opportunity to respond, have a client base with a high prevalence of drug and alcohol problems and can make a difference to many clients.
- Is the practice area consistent with the worker's broader role and skills?
- How will our agency ensure that its workers perform the practice area competently?

Practice areas

Following are the five key practice areas for justice and human service agencies to consider. **It is up to each agency to decide which practice areas are relevant to them.**

Please note that **all drug and alcohol interventions with parents/carers must have a child protection perspective whereby the safety and wellbeing of the child or young person is a paramount consideration.**

Mandated reporters under the *Children and Young Persons (Care and Protection Act) 1998* must comply with the Interagency Guidelines on Child Protection Intervention 2000. Medical and other health workers in obstetrics wards must comply with the NSW Health Neonatal Abstinence Syndrome Guidelines 2002/101.

Identifying and managing immediate risk

Identifying and managing immediate risk refers to the process of recognising and responding to an acute situation related to harmful drug and alcohol use.

This may be an emergency, crisis or other urgent situation that requires immediate action. Alcohol or other drug use may be a factor in a variety of acute situations, for example:

- psychotic behaviour such as hallucinations, confusion etc
- suicidal or other self-harming behaviour
- domestic violence
- child abuse and neglect
- medical emergencies such as collapse, fitting or unconsciousness
- threatened or actual violence to self or others
- aggressive, agitated or uninhibited behaviour.

In many of these situations, it may not be possible or even necessary to establish whether alcohol or other drug use is a factor in order to manage the situation. In other situations, the pattern and context of alcohol or other drug use may be a major factor in establishing

that the situation is acute, eg a service user displaying alcohol intoxication who intends to drive home.

Immediate risk situations that are specific to drug and alcohol use are:

- intoxication
- discarded injecting equipment.

When to respond

Duty of care provides the framework for action.

Workers in justice and human services have a duty of care to act reasonably in the prevention of injury and to protect life. Their actions should be based on their assessment of the best interests of service users and any potential harm to others. Managing immediate risk may prevent serious harm to the service user and others, eg any children, young people or elders in their care.

Identification of risk is an on-going process and should not be confined to the initial contact with the service user. The identification of immediate risk of harm relies on agency staff remaining alert.

How to respond

Identification of risk relies on observations.

Managing immediate risk relies on agency personnel being alert and applies to all situations where observations indicate harmful drug and alcohol use. Observations that might prompt concerns about harmful drug and alcohol use include:

- discarded injecting equipment
- signs of overdose, intoxication and withdrawal
- self-report by the service user about the patterns of drug and alcohol use or the context of drug use that may make it more harmful.

Appendix 1 describes features of overdose, intoxication and withdrawal. The information presented is a guide only and should be considered within the context of the service user's circumstances.

Identifying and managing immediate risk from harmful drug and alcohol use or withdrawal may prevent serious harm to the service user and any children in their care.

Practice areas

Direct questioning of the client regarding risk of harm to self or others (including the service user's capacity to care for children) may be required in order to ascertain immediate risk.

Policies and procedures

Policies and procedures for identifying and managing immediate risk from harmful drug and alcohol use should be integrated with existing emergency or incident response procedures where possible.

Agencies should have in place procedures that address some of the immediate risks that may arise from harmful drug and alcohol use, such as:

- mental health emergencies eg psychotic behaviour, hallucinations, threatened or actual self-harming behaviour
- medical emergencies eg collapse, suspected overdose, fitting or unconsciousness
- aggressive behaviour, threatened or actual violence
- child abuse and neglect
- domestic violence.

In terms of procedures for the above emergency situations, agency personnel are directed to the following services as appropriate:

- NSW Ambulance Service
- NSW Police
- Department of Community Services
- Area Mental Health Crisis Services
- PANOC services.

Agencies need to give special consideration to managing drug specific risks, ie discarded injecting equipment or intoxicated service users.

Who to respond

Agencies are referred to the *Training Needs Review 2000* which describes staff within justice and human services for whom drug and alcohol issues are not a primary focus but who contribute to the management of these problems.

Competency development

Agencies should ensure that workers are aware of the agency's policies and procedures for managing immediate risk. Some staff may need training to learn how to identify and manage immediate risk. This could form part of training in more comprehensive forms of assessment or risk identification.

Assessment

There are three levels of assessment that agencies, depending on their service role and capacity, may perform:

- **Simple (screening) assessment** – Provides a gateway to the process of care. It should be a helpful, non-threatening experience that encourages the service user to engage with the service. The information collected at this stage is likely to be relatively basic, typically about a person's drug and alcohol use and its likely impact on his or her ability to access services. Assessment at this level provides an individual with the opportunity to access primary services such as harm reduction advice and information.
- **Triage assessment** – May be used in justice and human services when an individual has made a direct approach, or has been referred for an assessment. This assessment covers more detailed information about drug and alcohol use and other psycho-social factors. Assessment at this level should provide an opportunity to make decisions about treatment, care, support or referral elsewhere.
- **Specialist (in-depth) assessment** – May be used when a client has been referred to a specialist service. Assessment at this level should provide an opportunity to develop a comprehensive treatment, care and support plan covering the nature and extent of drug or alcohol use, physical and psychological health as well as social and legal issues.

Table 1 describes the levels of assessment, all with a child protection perspective.

Table 1. Levels of assessment(Adapted from *Models of care for the treatment of drug misusers*, National Treatment Agency)

Level	Content	Outcome	Performed by
Level 1 Simple (screening) assessment	<ul style="list-style-type: none"> ■ Identification of harmful drug use ■ Identification of related or co-existent problems ■ Identification of immediate risks ■ Assessment of urgency of referral 	Identification of immediate and appropriate service for onward referral	Professionally qualified staff who are the first contact; vocationally qualified staff; and unqualified staff with training in assessment
Level 2 Triage assessment	<ul style="list-style-type: none"> ■ Risk assessment ■ Assessment of urgency of referral ■ Brief assessment of substance misuse problem ■ Brief assessment of client motivation to engage in treatment ■ Assessment of need for comprehensive assessment/care coordination 	<ul style="list-style-type: none"> ■ Identification of treatment/care needs ■ Need for comprehensive assessment ■ Need for onward referral 	Professionally qualified staff eg: <ul style="list-style-type: none"> ■ Area Health Service Central Intake Services ■ Alcohol & Drug Information Service (ADIS) ■ Drug and alcohol specialists ■ Agency staff with specific responsibilities for case management, counselling and psycho-social assessment
Level 3 Specialist (in-depth) assessment	<ul style="list-style-type: none"> ■ Risk assessment ■ Assessment of client motivation ■ Drug Use ■ Alcohol Use ■ Psychological problems ■ Physical problems ■ Social problems ■ Legal problems ■ Need for comprehensive assessment ■ Need for onward referral 	<ul style="list-style-type: none"> ■ Identification of treatment/care needs, based on comprehensive assessment ■ Development of a comprehensive care plan 	<ul style="list-style-type: none"> ■ Professionally qualified staff who may have recognised expertise ■ Vocationally qualified or trained staff in specialist areas where simple specialist assessment is needed ■ Professionally qualified or trained staff in specialist agencies eg drug and alcohol specialists

When to respond

All agencies aim to be alert to a range of harmful behaviour undertaken by their service users. In practice, most agencies prioritise particular service users that they assess to be at higher risk of harm (alcohol and/or drug-related or otherwise).

Assessments may be performed:

- **indicatively** – on an ad-hoc basis for example, prompted by observations of intoxication
- **selectively** – targeting specific groups of service users or a specific area of service delivery where risk of harmful drug and alcohol use is identified as high
- **universally** – with all service users.

Interagency guidelines recommends that, where appropriate, drug and alcohol-related assessment processes are integrated with other services.

Assessment of clients may be performed in conjunction with a simple (screening) assessment where there are concerns about harmful use.

Timing of assessments will vary between agencies.

Each agency will need to determine its appropriate client groups for assessment and the appropriate times for this to occur.

The assessment process could be multi-layered.

For example, the first assessment level may identify those clients with drug and alcohol use problems who require a further, more detailed assessment. A second level assessment may result in findings that allow a brief intervention or referral.

Assessments that identify emergency, crisis or other urgent situations must be prioritised and dealt with.

How to respond

Interagency guidelines recommends that where appropriate, agencies use standardised assessment tools. Assessment tools have two purposes:

- to aid the collection of information in a systematic way that can be measured and evaluated
- to help guide and structure the dialogue between a worker and a service user.

When used in the assessment of drug users, they commonly collect information on an individual's drug and alcohol use, risk behaviour and health, social and economic circumstances. Simple assessments can be undertaken using validated instruments such as AUDIT, DAST and CAGE questionnaire, or a range of other validated drug and alcohol assessment tools that exist.⁶ Other more direct procedures such as observing symptoms of intoxication, withdrawal or asking questions about consumption and associated problems, can also be used.

All assessment tools should be derived from evidence-based practice. Agencies will need to consider the relative merits of existing validated tools and select assessment tools that meet their needs and capacity.

In some instances, agencies may decide to develop their own tools or will already have a drug and alcohol assessment tool embedded with their routine assessment tool. For example, the Department of Corrective Services has the LSI-R tool which collects information about drug and alcohol use for the purpose of case management. NSW Health has a model substance misuse assessment for registered nurses in generalist health settings.

(See *The Drug and Alcohol Policy for Nursing Practice in NSW – Clinical Guidelines 2000–2003*.)

Agencies should ensure that where staff use assessment tools they are:

- appropriate, evidenced-based assessment processes and tools
- suitable to the service setting
- used only by authorised and competent staff
- identified and made available to staff.

Where alcohol or other drug harm is identified, available responses include:

- a further, more detailed assessment
- identification of appropriate service(s) for onward referral
- delivery of a time-limited (brief) intervention, eg advice and information.

Who to respond

Table 1 provides guidance on the skills required to perform each level of assessment. Agencies will need to determine which, if any, staff positions are appropriate for these roles and consider the implications for staff recruitment, selection and development.

Agencies are also referred to the *Training Needs Review 2000*. The Review describes the workforce within justice and human services for whom drug and alcohol issues are not a primary focus but who, because of their job role, contribute to the management of these problems.

Competency development

Agencies need to incorporate specific training in assessment and use of drug and alcohol assessment tools for positions nominated to perform this role.

Adequate training and supervision for staff expected to perform assessments requires:

- specific training for key staff at induction
- ongoing staff training and development
- performance management mechanisms that address drug and alcohol related assessment.

Agency staff performing this role will need child protection training that includes indicators of abuse, the impact of harmful drug and alcohol use on parenting and how to deal with avoidance and resistance.

The Child Protection Learning and Development Forum has developed a child protection training package and identified standards for the provision of child protection training across all government and non-government organisations. The package *Identify and Respond to Children at Risk of Harm (Child 1C)*, has been developed to ensure consistency of language and meaning across departments.

⁶ See Dawe S, Loxton N J & Hides L, et al 2nd Edition, Review of Diagnostic Screening Instruments for Drug and Alcohol Use and Other Psychiatric Disorders, National Drug Strategy Monograph Series No. 48, Commonwealth Department of Health and Ageing, Canberra, 2002. See also Mattick et al 2000.

Referral

Referral describes the formal process whereby service users are referred from one agency or service to another to meet their specific needs.

In most cases, the uptake of referral by a client is voluntary. However, specific programs operate in the justice system that allow for mandated referral of a person to a drug and alcohol treatment service.

In those circumstances where an individual declines a voluntary referral to another service, *Early & Brief Interventions* describes the option for addressing the service user's drug-related harm. This involves brief interventions and ongoing management by non-specialist services.

When to respond

Referrals are most likely to occur as a result of an assessment or support coordination of a service user.

To assist a child or young person to access drug and alcohol treatment to promote and safeguard their safety, welfare and well being, the DoCS Director General may request a Government Department or agency in receipt of Government funding, to provide services to the child or his or her family.

The department or agency must use its best endeavours to comply with a request made to it under Section 17 and Section 18 of the *Children and Young Persons (Care and Protection) Act 1998*, if it is consistent with the agency's responsibilities and does not unduly prejudice the discharge of its functions.

How to respond

There may be multiple pathways of referral.

These pathways may be intra-agency or inter-agency. They may include referral into the drug and alcohol and treatment services system, concurrently with referral and/or direct intervention in the following areas:

- psychiatric treatment
- risk behaviour management
- employment
- housing

- education and training
- family and parenting
- relationships
- financial issues
- legal issues.

Where referral to a specialist drug or alcohol service is needed the main options are:

- Area Health Service Drug and Alcohol Central Intake Service
- Alcohol and Drug Information Service (ADIS)
- general practitioners.

Area Health Service Drug and Alcohol Central Intake Services provide a single point of entry to the full range of drug and alcohol services – needle and syringe programs, withdrawal management (also known as detoxification), support coordination, counselling, maintenance pharmacotherapy (eg methadone), residential rehabilitation, aftercare – via one regional or local telephone number.

Telephone assistance is available during business hours by drug and alcohol clinicians who conduct a triage assessment and assist individuals to determine appropriate drug and alcohol treatment. Brief counselling and detailed information on drug and alcohol services, including their availability, is provided and the clinician is able to negotiate assessment appointments on the client's behalf.

The **Alcohol and Drug Information Service (ADIS)** is a 24-hour statewide service providing brief information, advice, referral, and after-hours telephone assistance where it is not available locally.

General practitioners – In addition to providing general health services, local doctors are a gateway to specialist treatment. Some GPs manage drug and alcohol problems independently; others may do so with the support of specialist drug and alcohol services.

NSW Health has established a statewide Drug and Alcohol Support Project to provide a GP liaison service in each Area Health Service. The project aims to support collaboration between drug and alcohol services and general practice in the management of clients with drug and alcohol issues.

Who to respond

Agencies are referred to the *Training Needs Review 2000*. The Review describes the workforce within justice and human services, for whom drug and alcohol issues are not a primary focus but who, because of their job role, contribute to the management of these problems.

Competency development

Agencies need to incorporate specific training in referral for workers nominated to perform this role. Agency staff will need information about the main referral pathways to the drug and alcohol treatment system and how to access them, specifically:

- Alcohol and Drug Information Service
- general practitioners
- AOD central intake services
- local drug and alcohol services.

Adequate training and supervision for staff expected to perform referral requires:

- specific training for key staff at induction
- ongoing staff training and development
- performance management mechanisms that address engagement with service users and drug and alcohol referral.

Early and brief interventions

Early intervention focuses on service users who are engaged in patterns or contexts of drug use that have the potential to cause harm. For example, a service user may have been using alcohol or other drugs for years but is yet to experience harm. Early intervention involves identifying drug use and assessing harm and intervening with service users who are consuming drugs in a potentially harmful way *before* problems become entrenched or dependence develops.⁷

Brief intervention refers to a wide variety of strategies, methods and techniques to change behaviour. They tend to be short, structured intervention (between five minutes and two hours), delivered on one occasion or spread over several visits. They often include the provision of self-help materials and may extend to the following:

- simple (screening) assessment
- providing advice (in a one-off session)
- assessment of the service user's readiness to change (motivational interview)
- problem solving
- goal setting
- relapse prevention
- harm reduction strategies to help modify alcohol or other drug use behaviour
- follow-up.

When to respond

Brief intervention can be done at any stage of a person's drug using career. Brief intervention for drug and alcohol use often takes the form of brief advice to the client regarding the risks of their consumption and motivating them to seek treatment if required.

Research indicates that brief interventions can be useful for service users who are experiencing few problems related to their substance use, have low levels of dependence or who are not wishing to substantially reduce their drug use. There is also a growing body of evidence that suggests brief interventions are useful in communicating and implementing harm reduction strategies.

Brief interventions are **not** considered suitable for:

- more complex clients with additional psychological/psychiatric issue
- clients with severe dependence
- clients with poor literacy skills
- clients with difficulties related to cognitive impairment⁸

Note: Service users with more severe or long-term drug use require specialist interventions. However, agencies can use brief interventions with these service users to enhance their motivation to seek help. It is recommended that where a service user's drug use has been identified as harmful and further intervention is declined, nominated staff should employ ongoing risk assessment and brief interventions as a management approach.

7 Jarvis, T.J, Tebbutt J, & Mattick R.P. Treatment approaches for alcohol and drug dependence: an introductory guide, John Wiley & Sons, Brisbane, 1995.

8 Heather, 1995

How to respond

Effective brief interventions are characterised by:⁹

- **feedback** of assessment results to client in a positive manner
- **responsibility** – an explicit message that ‘no one can make you change or decide for you. What you do about your drug use is up to you’
- **advice** – the essence of brief intervention, in written or verbal form
- **menu of options** – brief interventions seldom prescribe a single approach but advise a general goal or range of options
- **empathy** – a non-judgmental, reflective, empathic and understanding approach
- **self-efficacy** – encourage the client’s self-efficacy for change, rather than emphasising helplessness and powerlessness.

The range of brief interventions used will depend on the role of agency staff. Brief intervention activities may vary in terms of duration, number of sessions and types of interventions involved and can include:

- one-off advice and information
- mini-counselling programs of three to six sessions (for services that offer counselling)
- community-based interventions, eg information provided in service user areas, or written self-help information included in an introductory information package.

If a brief intervention consists of only one session it should include:

- advice on how to reduce drug use to a safer level
- the provision of harm reduction information
- discussion of harm reduction strategies.

The types of brief intervention activities and their duration should be determined by the agency.

Who will respond

General practitioners may have the capacity to offer the full range of brief interventions when supported by appropriate education and training and when part of local interagency networks, eg the GP liaison service.

Hospital and health workers have detailed advice on protocols for managing and referring people who present with concurrent drug and alcohol issues. The range of brief interventions employed will vary, but generally include simple (screening) assessments, information, advice, referral and follow-up.

Other agency staff may provide brief interventions depending on role and training, but will generally be limited to simple (or screening) assessments, advice and referral. This role should be reflected in the position descriptions of nominated positions.

Advice on written materials to support brief interventions is available through Area Health Service drug and alcohol services and health promotion units. Agencies are referred to the *Training Needs Review 2000*. It describes the workforce within justice and human services for whom drug or alcohol issues are not a primary focus, but who contribute to the management of such problems.

Competency development

Agencies need to incorporate specific training in brief interventions for positions nominated to perform this role with individuals and families. Agencies should ensure that staff who perform brief interventions are adequately trained, supervised and resourced. This includes having access to written materials that support brief interventions.

Adequate training and supervision for staff expected to perform brief interventions requires specific training at induction, ongoing training and development and performance management mechanisms that address drug and alcohol specific brief interventions.

9 Miller and Sanchez (1993) reproduced in the Drink Check Manual for Alcohol Brief Interventions

Support coordination

Support coordination refers to the process of planning and coordinating a service user's support package to effectively meet their needs using case management principles. Agencies may refer to support coordination by another name such as case management or care coordination. Its aims are to:

- develop, manage and review documented support or case management plans
- ensure that service users have access to a comprehensive range of services across the justice and human services system
- ensure coordination of support across all agencies involved with the service user
- ensure continuity of support
- maximise retention of service users within the justice and human services system and minimise the risk of service users losing contact with services
- re-engage clients who have dropped out of the justice and human services system
- avoid duplication of assessment and responses
- prevent service users falling between services.¹⁰

When to respond

Where a service user has been referred for specialist drug and alcohol treatment or is already engaged in drug and alcohol treatment, it is important to coordinate their support package with the other service providers involved.

How to respond

Support coordination should be client focused to ensure continuous effective care or intervention across a range of agencies or settings.

Case management principles should apply and underpin effective support coordination. Agencies need to ensure that a case management approach is adopted to coordinate the support package for service users engaged in harmful drug use.

Duty-of-care obligations are paramount in relation to child protection and mental health issues, and workers may be required to appropriately liaise with, and refer to, other agencies.

Responsibility for support coordination may be shared by one or more agencies.

Referral to, and service provision by other agencies should be coordinated by one designated case manager, where possible.

Support coordination is an active process where ideally goals and outcomes are negotiated and agreed upon by the client and the case manager. This may not be possible in situations of mandated referral and treatment.

Support coordination needs to be supported by the primary provider and by all agencies responsible for service provision to that client.

All agencies need to ensure that partnerships with Area drug treatment service providers facilitate effective support coordination. Enhanced Primary Care (EPC) Medicare Items provide a framework for engaging general practitioners in multi-disciplinary planning and case management.

Agencies need to comply with relevant privacy legislation and standards

for collecting and dealing with personal information that apply to their sector. (This includes NSW government agencies, non-government agencies of specific size and organisations within the jurisdiction of both Commonwealth and State privacy legislation.)¹¹ Staff should consult their agency privacy policy for guidance about how and what information can be lawfully exchanged.

To assist agencies to better understand how and what information can be exchanged without breaching privacy legislation, the Better Service Delivery Program Privacy Framework has been developed. It is anticipated that this Framework will be available to agencies in mid to late 2004.

Where the safety, welfare and well-being of a child or young person is concerned, the department of community services, other government departments and other prescribed agencies can lawfully exchange information under section 248 of the Children and Young Persons (Care and Protection) Act 1998.

¹⁰ Models of Care for the Treatment of Drug Misusers, National Treatment Agency, London, 2002.

¹¹ Detailed information and advice is being developed as part of the Better Service Delivery Privacy Framework (Draft only available).

Cross-agency planning for specific needs is particularly important as individuals may be clients of multiple agencies and be the target group for a wide variety of funding programs at local government, state and national levels. Target groups of service users with special needs may include the following services users:

- Aboriginal and Torres Strait Islander peoples
- people with disabilities
- people from linguistically and culturally diverse communities
- refugees
- people with co-existing mental health problems
- parents/carers with identified drug and alcohol problems
- children or young people with or at risk of drug and alcohol problems.

Agencies need to develop mechanism for cross-agency planning to address the specific needs of these service users. Where negotiation of respective roles and responsibilities in a partnership or coordinated service requires specific funding arrangements or approval from different tiers of government this may be best supported by an Interagency Memorandum of Understanding or Service Agreement. Program and policy inventories at regional and local levels may support coordinated activity at regional and local levels.

Directories of resources and services can support informed decision-making and efficient planning and coordination. They have a role at central, regional and local levels.

Who will respond

Agencies are referred to the *Training Needs Review 2000* for assistance. The Review described the workforce within justice and human services, for whom drug and alcohol issues are not a primary focus but who, because of their job role, contribute to the management of these problems.

Competency development

Agencies need to incorporate specific training in support coordination for positions nominated to perform this role. Adequate training and supervision for staff expected to perform support coordination requires:

- specific training for key staff at induction
- ongoing staff training and development
- performance management mechanisms that address support coordination.

Appendix 1

Features of overdose, intoxication and withdrawal

This is a guide only – these signs may be characteristic of other problems and care must be taken not to exclude other causes and appropriate actions.

Substance	Overdose	Intoxication	Withdrawal
Alcohol	<ul style="list-style-type: none"> ■ Cold and clammy skin ■ Changed mental state ■ Changed heart rate ■ Lowered body temperature ■ Slow and noisy breathing ■ Muscle twitching ■ Blue tinge around mouth lips ■ Stupor ■ Convulsions ■ Coma – (not responsive to sound, touch) <p>Symptoms of overdose can progress from less severe to life-threatening over a short period of time.</p>	Smells of alcohol, shuffling and poor balance when walking, slurred speech, confusion, inappropriate manner, depression, loss of consciousness	<p>Withdrawal can begin between six and 24 hours after the last intake of alcohol, but may be delayed if other sedatives have been taken.</p> <p>Symptoms of alcohol withdrawal: anxiety, sweating, shaking, vomiting, fits/seizures, hallucinations (hearing or seeing things), depression, disorientation/confusion, difficulty sleeping, agitation.</p> <p>Alcohol withdrawal can be a medical emergency and should be supervised by a medical professional.</p>
Benzodiazepines (Valium, Serapax, Normison, Rohypnol, Mogodon etc)	<ul style="list-style-type: none"> ■ Cold and clammy skin ■ Changed mental state ■ Changed heart rate ■ Lowered body temperature ■ Slow and noisy breathing ■ Muscle twitching ■ Blue tinge around mouth lips ■ Stupor ■ convulsions ■ Coma – (not responsive to sound, touch) <p>Symptoms of overdose can progress from less severe to life-threatening over a short period of time.</p>	Slurred speech, drowsy, loss of control of voluntary movements, trouble focusing eyes on speaker, drooling, disinhibition	<p>Benzodiazepines should not be stopped abruptly and a gradual reduction of the dose should be carried out. Withdrawal symptoms: anxiety, tremor, muscle twitching, fits/seizures, fatigue, nausea and vomiting, disorientation, hallucinations, fainting, paranoia.</p> <p>Benzodiazepine withdrawal can be a medical emergency and should be supervised by a medical professional.</p>
Cannabis		Red eyes, anxiety, drowsiness, person feels as though they are 'out of their body' or not involved in their surroundings, impaired movements, confusion, person feels persecuted, hallucinations	
Psycho-stimulants (amphetamine type stimulants (ATS) including ecstasy, cocaine)		Eye pupils large (dilated), fast pulse and breathing rate, raised body temperature, increased physical activity, agitation, fast speech, aggression, person feels persecuted, hallucinations, anxiety, convulsions, irregular heartbeat	
Hallucinogens		Hallucinations, heightened perceptions, derealisation, depersonalisation, nausea, dizziness	
Solvents		Shuffling and poor balance when walking, sore joints, dizziness, dribbling, nausea, vomiting, confusion, disorientation, hallucinations, slow or shallow breathing, irregular heartbeat	

*Adapted from Mental Health for Emergency Departments reference guide, NSW Health.

*Adapted from Saunders et al, 1997.

Appendix 2

Drug and alcohol central intake services

Metropolitan Area Health Services	Telephone numbers	
Northern Sydney / Central Coast	4320 2637	1300 889 788
South Eastern Sydney / Illawarra	9361 8060	1300 652 226
Sydney South West	9616 8586	9787 0272 Canterbury 9515 7611 RPAH
Sydney West	4734 1333	9840 3355

Rural Area Health Services	Telephone numbers	
Greater Southern	1800 809 423	1800 800 944
Greater Western	(08) 8080 1556	1300 887 000 1800 092 881 (local only) 6841
Hunter / New England	4924 6248	1300 660 059
North Coast	6620 7612	1300 662 263 (local only) 6588

Note – these telephone numbers are correct at the time of publication. Any updates thereafter will be available on NSW Health's website.

Appendix 3

Alcohol and Drug Information Service

Advice, information and referral is available on these numbers 24-hours, seven days a week:

Sydney	9361 8000
Toll free rural callers	1800 422 599

Appendix 4

Glossary of terms

ABS	Australian Bureau of Statistics
ADIS	Alcohol and Drug Information Service
AOD	Alcohol and Other Drugs
AUDIT	Alcohol Use Disorders Identification Test
Capacity building	An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over. ¹²
CCWT	Centre for Community Welfare Training
CDAT	Community Drug Action Teams
DAMEC	Drug and Alcohol Multicultural Education Centre – provides advice on the development of training programs that teach the skills required to work with culturally and linguistically diverse populations in terms of drug and alcohol issues.
DAST	Drug Abuse Screening Test
DoCS	Department of Community Services.
Drug	A substance that produces a psychoactive effect. Within this context ‘drug’ includes tobacco, alcohol, pharmaceutical drugs and illicit drugs.
EPC	Enhanced Primary Care – a framework for engaging doctors in multi-disciplinary planning and case management.
FACT Project	Family and Carers Training Project – a training package and set of resources for use by community workers with families or carers affected by the drug or alcohol use of a relative or friend.
Harmful drug and alcohol use	<p>A pattern of drug use that has adverse family, social, physical, psychological, legal or other consequences for a person using drugs, or people living with/affected by the actions of a person using drugs. Hazardous drug use is any drug use that puts the person using drugs, or those living with/affected by the actions of a person using drugs, at risk of these harmful consequences. Hazardous drug use includes any use of illicit drugs.</p> <p>These definitions are consistent with the definitions adopted by the National Drug Strategic Framework 1998–99 to 2002–03.¹³</p>
Harm minimisation	Refers to policies and programs aimed at reducing drug-related harm. Includes preventing anticipated harm, as well as reducing actual harm by employing supply reduction, demand reduction and harm reduction.

12 Have et al 1999 cited in: *A Framework for Building Capacity to Improve Health*, NSW Health, 2001.

13 National Drug Strategic Framework 1998–99 to 2002–03.

Appendix 4: Glossary of terms

Hearth Safety Assessment Tool	Tool for assessing the safety of children in drug use environments.
Interagency collaboration	Involves complementary organisations, in the same or different sectors, that commit to a common goal, or set of goals, and jointly make decisions about the way to achieve these goals. ¹⁴
IPC	Integrated Perinatal and Infant Care Initiative – a universal psycho-social risk assessment of all women as part of a comprehensive assessment during the ante and post-natal periods.
MERIT	Magistrates’ Early Referral Into Treatment – scheme that refers eligible people facing court with drug-related offences to treatment and rehabilitation services.
NAS	Neonatal Abstinence Syndrome – occurs in newborns going through withdrawal as a result of the mother’s dependence on drugs during pregnancy. It is characterised by signs of central nervous system irritability, gastro-intestinal dysfunction and respiratory distress. Symptoms also include yawning, sneezing, mottling and fever. This syndrome usually begins within 72 hours, but may appear up to two weeks after birth.
NGOs	Non-Government Organisations
PANOC	Physical Abuse and Neglect of Children services – provide services to children and their families where physical abuse, neglect or exposure to domestic violence has been confirmed by the Department of Community Services.
Practice areas	The five areas of agency response to people with drug and alcohol problems. These are risk identification and management of immediate risk, assessment, referral, early and brief interventions and support coordination.
SOCC	Senior Officers’ Coordinating Committee on Drugs and Alcohol.

¹⁴ Fine M, Pancharatnam K, Thompson C. *Coordinated and integrated service Delivery models: a report prepared for the NSW Cabinet Office and Premier’s Department*. Social Policy Research Centre, 2000.