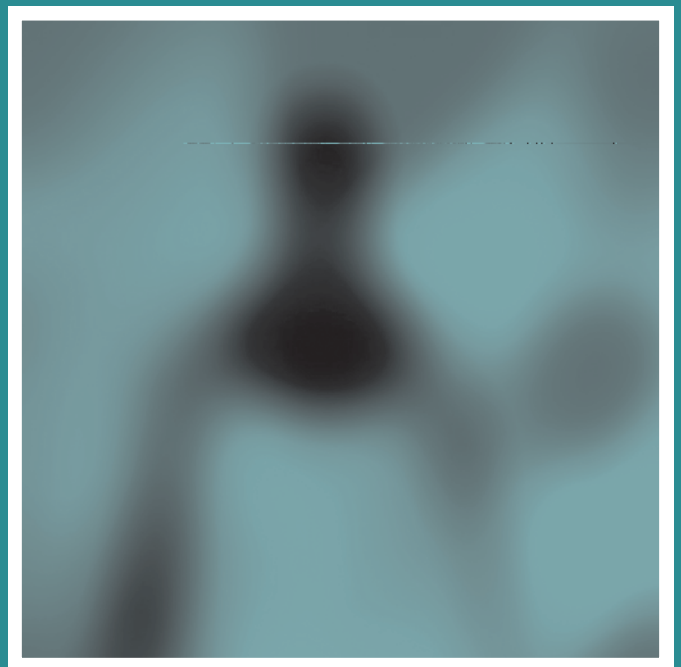


# Interagency guidelines for the early intervention, response and management of drug and alcohol misuse



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SHPN (CDA) 050065  
ISBN 0 7347 3791 2

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November 2005

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# Executive summary

## Purpose

Government agencies regularly provide services to people who use drugs, or to those who are living with users and are affected by their harmful drug or alcohol use. Given that research suggests drug use in the general Australian population is rising, there is a growing need for guidelines that will:

- enable agencies to identify and respond appropriately to drug use among their service users
- enhance collaboration between specialist and mainstream services, thereby improving the effectiveness of their responses to harmful drug and alcohol use.

*Interagency guidelines for the early intervention, response and management of drug and alcohol misuse* (Interagency guidelines) is designed to assist NSW Government agencies to achieve both, since appropriate intervention has a number of benefits. It reduces harm to users, their family members and others, including staff. It often prevents problems from escalating and can also improve case management outcomes.

## Target audiences

The guidelines in this document are aimed at agencies that fund, regulate or provide justice and human services. These agencies employ a variety of workers who have direct contact with service users and have the potential to respond to harmful drug and alcohol use. However, the way in which they respond will vary widely, depending on their job role, skill base and the organisation's authorisation of them to act.

Accordingly, Interagency guidelines is designed to help these agencies:

- define their roles and responsibilities for responding to drug use among service users
- identify and describe the key practice areas where they may respond
- provide guidance on when, how and who might respond

- develop and review drug and alcohol related policies and practices
- plan for workforce needs.

## Key areas of response

Interagency guidelines identifies five priority practice areas where justice and human services agencies may respond to harmful drug and alcohol use among their service users:

- risk identification and management of immediate risk
- assessment
- referral
- early and brief interventions
- support coordination.

To assist agencies to determine the practice areas that can be integrated with their core business and build their capacity to implement them, practice areas are described in terms of **when**, **how** and **who** should respond.

Interagency guidelines also sets out in detail how to manage issues that cut across all practice areas such as worker safety, child protection, domestic violence and cultural diversity. This is to enable agencies to address these issues effectively when developing policies and procedures for intervention.

## Implementation

Ultimately, the successful implementation of Interagency guidelines 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 be clear about their roles and responsibilities, ensure that these are authorised by their organisation and that a competent workforce is in place to action them.

## Executive summary

As implementation of Interagency guidelines is to be achieved within existing agency resources, and substantial work is required to develop local protocols and procedures, a staged approach to delivery is proposed:

<b>Stage 1</b>	Statement of roles and responsibilities in place	Dec 2006
<b>Stage 2</b>	Organisational Development Action Plan in place	June 2007
<b>Stage 3</b>	Workforce Development Plan in place	June 2008
<b>Stage 4</b>	Local Infrastructure Development in place	June 2008

## Helpful resources

To assist agencies in developing policies, practices and workforce plans in relation to drug and alcohol interventions, the *Further reading* boxes at the end of each section provide sources of additional information. The appendices also list resources that will assist in obtaining more details or contacts.

Additionally, a glossary of terms is included as a quick reference guide to acronyms and terms used throughout this document.

# Overview

## What is 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 targeted at NSW Government agencies that are funders, regulators or providers of justice and human services. It is designed for the use of the following:

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### 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.

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### 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.

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### 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.

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### Regional Coordinators

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### Community Drug Action Teams

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### Area Health Service Drug and Alcohol directors/coordinators

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### 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.

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### 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.

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## 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. Some may seek assistance from one or more agencies, but many never come into contact with any drug and alcohol specialist services.

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<sup>1</sup>
- between two per cent and seven per cent of the adult population in NSW would benefit from drug and alcohol treatment, particularly early and brief intervention<sup>2</sup>
- individuals who are unemployed and have lower educational achievement are more at risk of developing drug and alcohol problems<sup>3</sup>
- low income and homelessness are risk factors for patterns of harmful drug and alcohol use<sup>4</sup>
- excessive drinking is likely to have contributed to presenting problems at welfare and general counselling services<sup>5</sup>
- 30–80 per cent of people with mental disorders also have a substance use disorder<sup>6</sup>
- Many offenders are also drug users. In NSW, 70 per cent of prison inmates reported using drugs in the 24 hours preceding their offence and about half of the general prison population has a history of injecting drug use

- the Child Death Review Team estimates that drug and alcohol directly or indirectly contributes to nearly 25 per cent of all child deaths reported to the Coroner<sup>7</sup>
- early and brief intervention offers substantial benefits when conducted by trained and resourced workers<sup>8</sup>
- drug treatment is effective in reducing harmful drug and alcohol use, hospital costs, drug-related harm, violence and welfare costs.<sup>9</sup>

The NSW Drug Summit, 1999 identified the need to improve referral and case management. The Summit recommended developing ‘a framework to assist agencies across sectors who work with drug dependent individuals to provide improved and coordinated services delivery’.<sup>10</sup> The Summit also recognised that drug dependence is a complex health and social problem often linked to other issues including employment, mental health, housing, education and family issues.

The *Child Death Review Team Report 1998–1999* highlighted the link between parental substance dependence and child death and/or child abuse and neglect. It recommended that interagency guidelines should specifically address child-at-risk concerns due to harmful drug and alcohol use by a parent/carer.

The *NSW Drug Treatment Services Plan 2000–2005* specified the need for government-funded services to include the provision of drug and alcohol interventions into core business. It identified that “the sheer number of people, their geographical distribution and the services they are most likely to access, point to the necessity to involve other service providers” in drug treatment.

The *Training Needs Review Report – November 2000* noted that the workforce within justice and human services agencies, while not focussed on drug and alcohol issues,

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.

6 *The Management of People with a Coexisting Mental Health and Substance Use Disorder: Discussion Paper*, NSW Health, 2000.

7 Child Death Review Team Report.

8 Single and Rohl (1997) cited in *The NSW Drug Treatment Services Plan 2000–2005*, p1.

9 Mattick & Hall (1993) cited in *The NSW Drug Treatment Service Plan 2000–2005*, NSW Health, 2000.

10 *NSW Drug Summit 1999: Government Plan of Action*, NSW Government, 1999.

can contribute to the management of these problems. The report identified five practice areas – assessment, referral, case management (particularly across sectors), management of intoxicated clients and brief intervention – as priority areas for workforce development within these agencies because:

- they could have a significant impact on the management of drug and alcohol problems in the long term
- there are existing opportunities (eg resources), which could be effectively utilised to enhance these practice areas
- lack of competence in these areas results in barriers to effective management along the continuum of alcohol or other drug problems
- a large proportion of the workforce is engaged in the practice area.

The review also argued that organisational responsibility for a comprehensive and coordinated approach to drug and alcohol issues is fundamental.

## Development process

All NSW government agencies with a justice and human services role participated in the development of *Interagency guidelines*, with the NSW Health Centre for Drug and Alcohol acting as the lead agency.

The project has been overseen by the sub-committee of the Senior Officers' Coordinating Committee on Drugs and Alcohol (SOCC). The sub-committee ensured participation and cooperation across agencies and provided guidance and advice.

Regional input was also sought in the early stages of development of *Interagency guidelines* through the Regional Coordination Management Group of Illawarra/South East Region, together with the Premier's Department Regional Coordinators and the Drugs and Community Action Strategy Project Manager for the Region.

## 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 it
- 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.

# Policy context

## Guiding principles<sup>11</sup>

### Actions are based on the National Drug Strategy

Harm reduction underpins the National Drug Strategy and NSW Drug Summit Government Plan of Action. Harm reduction refers to policies and programs aimed at reducing drug-related harm. It includes preventing anticipated harm, as well as reducing actual harm by employing three main strategies:

- supply reduction – strategies aimed at reducing the production and supply of drugs
- demand reduction – strategies aimed at preventing the uptake of harmful and hazardous drug use
- harm reduction – strategies aimed at reducing the various forms of drug related harm (including family, social, physical, psychological, legal and financial problems) until a person is ready and able to change their drug use.

### Recognition of the broad spectrum of drug use

There are many different patterns of drug and alcohol use. The risk of drug and alcohol related harm is not only related to the amount and frequency of use, but also the context of drug use. (For example, occasional but heavy use of alcohol may present greater hazards than regular use of small amounts.)

### Drug and alcohol dependence is a chronic relapsing condition

While many drug and alcohol dependent individuals recover from dependent use, most take several attempts to do so, lapsing or relapsing in intervening periods. This means that engagement with the service system may be long-term and that drug and alcohol dependent individuals often require multiple interventions.

## Evidence-based practice

Responses in all settings should be based on research and standards. Evidence-based practice involves integrating the best available evidence with professional expertise to make decisions.

### There is no ‘one-size-fits-all’ approach

Matching settings, responses and services to an individual's needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace and society.

## Holistic approaches

Effective responses to harmful drug and alcohol use attend to multiple needs of the individual, not just his or her drug use. To be effective, approaches must address the individual's drug use and any associated medical, psychological, family, social, vocational, and legal problems.

### Drug related harm affects more than the user

The consequences of harmful drug and alcohol use may occur in one or more areas of an individual's life – physical health, employment, relationships, emotional health, financial – and may result in direct harm or risk of harm to dependent children, young people, spouses and others.

### Ongoing assessment and case plan revision

An individual's service or action plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. A person may require varying combinations of services and/or treatment components during their active engagement with services. It is critical that the approach be appropriate to the individual's age, gender, ethnicity and culture.

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<sup>11</sup> National Institute on Drug Abuse (NIDA), US Department of Health and Human Services. *Principles of Effective Treatment*. See also *The NSW Drug Treatment Service Plan 2000–2005*, NSW Health, 2000.

## Quality improvement

Service delivery that is effective and affects the health outcomes of individuals and their families involves a commitment to quality improvement processes – processes that monitor and address competence, information management, training and processes for standards compliance eg accreditation, benchmarking, audit etc.

## Inter-agency work<sup>12</sup>

As a basis for inter-agency work it is expected that agencies and practitioners will share the following:

- an understanding of the aims of *Interagency guidelines* in the community and what constitutes good practice in reducing drug and alcohol related harm
- an appreciation and respect of the different roles and contributions of practitioners
- a commitment to partnership between government and non-government sectors to achieve good practice responses
- an understanding of the context in which agencies work and acknowledgement of their constraints
- a preference for coordinated effort, rather than unilateral action by a single agency or uncoordinated action by a number of agencies
- a willingness to learn from each other
- a belief in accountability to clients, each other and to the community.

## Consistency with government and other related policies

A number of State policy and protocol documents have highlighted the importance of an integrated approach to service delivery in order to effectively respond to drug and alcohol problems. Interagency Guidelines for the Early Intervention, Response and Management of Drug and Alcohol Misuse aims to apply and integrate key themes from these documents, specifically:

- *NSW Drug Summit 1999 Government Plan of Action*
- *NSW Child Death Review Report 1999*
- *NSW Drug Treatment Services Plan 2000–2005*
- *NSW Drugs and Community Action Strategy 2000*
- *NSW Interagency Guidelines for Child Protection Intervention 2000*
- *Mental Health and Substance Use Disorder Service Delivery Guidelines 2000*
- *Families First 2002*
- *NSW Neonatal Abstinence Syndrome Guidelines 2002/101*
- *NSW Domestic Violence Interagency Guidelines 2003.*
- *Outcomes of the NSW Summit of Alcohol Abuse: Changing the Culture of Alcohol Use in NSW.*

<sup>12</sup> Adapted from *NSW Interagency Guidelines for Child Protection Intervention*, NSW Government, 2000.

# Roles and responsibilities

## 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.

This is particularly important in terms of workers within the organisation and the boundaries between the organisation and specialist drug and alcohol service providers. To assist in defining the role they can play, agencies should consider the following:

### When they might respond

- When is Interagency guidelines part of core business?
- Are there any areas of service delivery that may 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 the agency ensure that responses are timely and appropriate to core business?

### How they might respond

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

### Who they might authorise to respond

- Who are the workers in the 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 the agency ensure that its workers perform the practice area competently?

## Defining worker roles

Justice and human service agencies employ a variety of workers who have direct contact with service users. All of these workers have the potential to respond to harmful drug and alcohol use among service users. How they respond will vary widely depending on their job role, skill base and the organisation's authorisation of them to act.

The *Training Needs Review 2000* provided a snapshot of the front-line workforce that responds to harmful drug and alcohol use within NSW health and human service agencies. The review was informed by recent literature on practice development, organisational learning and work-based learning approaches.

While the project did consider key skills needed by key groups of workers, it did so within an organisational context acknowledging that training alone cannot resolve complex problems. Organisational responsibility for a comprehensive and coordinated approach to these issues is fundamental.

One of the key components of the project was to engage government and non-government human service providers to assess organisational policies, programs and protocols, workforce development strategies and training resource requirements. The report identified:

- the workers who in their current job are priority frontline workers
- their alcohol and drug related workforce development needs
- recommendations for key goals for practice change and organisational development
- recommendations for statewide action and resources to meet identified needs.

The kind of job a front-line worker has will influence the level of responsibility that he or she has for addressing problems. For example, a bilingual welfare worker has a different responsibility to a police officer or a community health counsellor, but they all may have opportunities to respond effectively.

# Practice areas

## Introduction

This section describes the key Practice Areas for justice and human service agencies. Agencies should consider these Practice Areas and determine for themselves which are relevant to them. The benefits to agencies of *Interagency guidelines* among service users include:

- a reduction in harm to service users, family members and others, including staff
- prevention of problems from escalating by early detection and intervention
- improvement of case management outcomes.

The *Training Needs Review 2000* identified five priority response areas for staff employed in justice and human services agencies:

- assessment
- referral
- case management
- management of clients who are intoxicated
- brief interventions.

*Interagency guidelines* captures these roles under the following practice areas:

- **Identifying and managing immediate risk** – This section addresses the process for managing acute situations where harmful drug and alcohol use may be a factor. Service users may be at immediate risk of serious harm due to drug overdose, intoxication, serious mental health problems or domestic violence. Managing immediate risk may prevent serious harm to the service user and any children in their care.
- **Assessment** – Assessment is the process of gathering information about harmful drug and alcohol use from a service user to inform an appropriate response. Assessment is distinct from identifying and managing immediate risk as described in the next column. This section outlines a three-tiered assessment system. The levels of assessment reflect the different levels of complexity and expertise required at each stage of assessment.

- **Referral** – Referral describes the formal process whereby service users are referred from one agency or service to another to meet their specific needs. This section outlines the main referral pathways to the drug and alcohol treatment system and how to access them.
- **Early and brief interventions** – This section addresses the options for intervening where harmful drug and alcohol use is identified among service users. The emphasis in this section is on **brief** interventions. Referral to a specialist drug and alcohol service provider is detailed among the options.
- **Support coordination** – This section addresses the process of working with drug and alcohol specialist providers to effectively plan and coordinate a support package for service users.

## 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.

## Practice areas

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.

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. (See the section on *Child protection* on page 24).

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

### Further reading

*Mental Health for Emergency Departments: Reference Guide North Sydney*, NSW Health, 2001.

*NSW Interagency Guidelines for Child Protection Intervention 2000*

<http://www.health.nsw.gov.au/policy/hsp/publications/2000interagencyguidelines.pdf>

Neonatal Abstinence Guidelines

<http://internal.health.nsw.gov.au/fcsd/rmc/cib/circulars/2002/cir2002-101.pdf>

Domestic Violence Interagency Guidelines: working with the legal system in responding to domestic violence

[http://www.lawlink.nsw.gov.au/cpd.nsf/files/DVIG%20130503.pdf/\\$FILE/DVIG%20130503.pdf](http://www.lawlink.nsw.gov.au/cpd.nsf/files/DVIG%20130503.pdf/$FILE/DVIG%20130503.pdf)

Australian Alcohol Guidelines: Health risks and benefits

<http://www.health.gov.au/nhmrc/publications/pdf/ds9.pdf>

## Assessment

Assessment is distinct from identifying and managing immediate risk as described on page 11. The World Health Organisation defines assessment as:

*'a process designed to reach a thorough understanding of a person's problems in the overall context of his or her life with the object of developing a treatment plan that stands the best chance of being helpful.'*

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 (see the section on *Child protection* on page 24).

**Table 1. Levels of assessment<sup>13</sup>**

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

**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.

Research recommends routine screening for alcohol related harm in:

- medical practices (generalist and specialist)
- general hospitals
- welfare and general counselling services.<sup>14</sup>

However, routine screening for illegal drug use is not indicated in the general population.<sup>15</sup>

*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.

13 Adapted from *Models of care for the treatment of drug misusers*, National Treatment Agency, London, 2002.

14 Mattick & Jarvis, 1993.

15 Dawe et al, 2002.

**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 as outlined on page 11.

**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.<sup>16</sup> 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. A guide to selecting assessment tools is included at Appendix 3.

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, for example advice and information.

All drug and alcohol responses with parents/carers must have a child protection perspective whereby the safety and wellbeing of the child or young person is a paramount consideration. (See the section on *Child protection* on page 24.)

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.

16 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.

### Who will 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.

### Further information

Babor T F, Fuente, JR., Saunders, J et al *AUDIT The Alcohol Use Disorders Identification Test: Guidelines for use in primary health care*, World Health Organisation, 1992  
[http://whqlibdoc.who.int/hq/1992/WHO\\_PSA\\_92.4.pdf](http://whqlibdoc.who.int/hq/1992/WHO_PSA_92.4.pdf)

*Drug and Alcohol Policy for Nursing Practice in NSW. Clinical Guidelines 2000–2003*, NSW Health, 2000  
<http://www.clininfo.health.nsw.gov.au/hospolic/aod/clinical%20guidelines1.pdf>

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.

Neonatal Abstinence Syndrome Guidelines  
[http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005\\_494.pdf.pdf](http://www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_494.pdf.pdf)

Drug & Alcohol Manual for Generalist Health and Welfare Workers, Barwon South Western Region, Vic  
[http://www.dhs.vic.gov.au/regional/barwon/drug\\_alc/Drug\\_manual.pdf](http://www.dhs.vic.gov.au/regional/barwon/drug_alc/Drug_manual.pdf)

## 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 eg MERIT, adult and youth drug courts, or the Children's Court.

In those circumstances where an individual declines a voluntary referral to another service, the section on *Early and brief interventions* (page 18) 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 (see page 13) or support coordination of a service user (see page 20).

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.

All drug and alcohol responses with parents/carers must have a child protection perspective whereby the safety and wellbeing of the child or young person is a paramount consideration. (See the section on *Child protection* on page 24.)

Mandated reporters under the *Children and Young Persons (Care and Protection Act) 1998* must comply with the Interagency Guidelines on Child Protection Intervention 2000 edition, revised 2005.

Medical and other health workers in obstetrics wards must comply with the NSW Health Neonatal Abstinence Syndrome Guidelines 2002/101.

Where referral for a specialist drug and alcohol service is needed the main referral options available 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.

Contact numbers for both of these services are provided at Appendix 5.

**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 (see the section on Assessment on page 13) and intervening with service users who are consuming drugs in a potentially harmful way before problems become entrenched or dependence develops.<sup>17</sup>

**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 (see page 13)
- 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.

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<sup>17</sup> Jarvis, T.J, Tebbutt J, & Mattick R.P. *Treatment approaches for alcohol and drug dependence: an introductory guide*, John Wiley & Sons, Brisbane, 1995.

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

- more complex clients with additional psychological/psychiatric issues
- clients with severe dependence
- clients with poor literacy skills
- clients with difficulties related to cognitive impairment.<sup>18</sup>

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.

## How to respond

Effective brief interventions are characterised by:<sup>19</sup>

- **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-judgemental, 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 3–6 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.

All drug and alcohol responses with parents/carers must have a child protection perspective whereby the safety and wellbeing of the child or young person is a paramount consideration. (See the section on *Child protection* on page 24.)

Mandated reporters under the *Children and Young Persons (Care and Protection Act) 1998* must comply with the Interagency Guidelines on Child Protection Intervention 2000 edition, revised 2005.

Medical and other health workers in obstetrics wards must comply with the NSW Health Neonatal Abstinence Syndrome Guidelines 2002/101.

## 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.

<sup>18</sup> Heather, 1995.

<sup>19</sup> Miller and Sanchez (1993) reproduced in the *Drink Check Manual for Alcohol Brief Interventions*.

## Practice areas

**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.

### Further information

O'Connor, M. Simmons M. *Creating Opportunities for Reducing Alcohol related harm in the Veteran Community: alcohol screening and brief intervention*, Commonwealth Department of Veterans Affairs, Canberra, 2002  
<http://www.dva.gov.au/health/younger/mhealth/alcohol/manual.pdf>

Chapter 19, Early Intervention in: Jarvis, T., Tebbutt, J., Mattick, R. *Treatment Approaches for alcohol and drug dependence an introductory guide*, John Wiley & Sons, Brisbane, 1995.

Chapter 4, Early & Brief Intervention in: *Drug and Alcohol Policy for Nursing Practice in NSW*. Clinical Guidelines 2000–2003, NSW Health, 2000  
<http://www.clininfo.health.nsw.gov.au/hospolic/aod/clinical%20guidelines1.pdf>

Drug & Alcohol Manual for Generalist Health and Welfare Workers. Barwon South Western Region, Vic  
[http://www.dhs.vic.gov.au/regional/barwon/drug\\_alc/Drug\\_manual.pdf](http://www.dhs.vic.gov.au/regional/barwon/drug_alc/Drug_manual.pdf)

## 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 the 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.<sup>20</sup>

### 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.

All drug and alcohol responses with parents/ carers must have a child protection perspective whereby the safety and wellbeing of the child or young person is a paramount consideration. (See the section on *Child protection* on page 24.)

Mandated reporters under the *Children and Young Persons (Care and Protection Act) 1998* must comply with the Interagency Guidelines on Child Protection Intervention 2000 edition, revised 2005.

Medical and other health workers in obstetrics wards must comply with the NSW Health Neonatal Abstinence Syndrome Guidelines 2002/101.

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.)<sup>21</sup> 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*.

<sup>20</sup> *Models of Care for the Treatment of Drug Misusers*, National Treatment Agency, London, 2002.

<sup>21</sup> Detailed information and advice is being developed as part of the *Better Service Delivery Privacy Framework* (Draft only available).

## Practice areas

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.

### Further information

General Practitioner Enhanced Primary Care (EPC) Plan Proforma – MBS items for Care Planning and Case Conferencing with other health care providers. Includes items aimed at child protection issues among drug and alcohol using patients  
<http://www.health.gov.au/epc/>

# Related issues

## Introduction

There are a number of issues that cut across all of the practice areas described in *Interagency guidelines*. Agencies need to ensure that these issues are addressed when dealing with service users. Issues operating across all practice areas include:

- worker safety
- children and young people presenting with substance dependence
- child protection, including substance dependent parents/carers and their children
- gender
- domestic violence
- those issues affecting Aboriginal and Torres Strait Islander peoples
- cultural diversity
- disability, including intellectual disability
- dual diagnosis (mental health and substance abuse).

## Worker safety

Agencies are required to ensure a safe and healthy work environment for employees under the *NSW Occupational Health & Safety Act 2003*. Interactions with service users regarding drug and alcohol use may increase the risk to worker safety, particularly where there are signs of intoxication. As described on page 11, *Identifying and managing immediate risk*, alcohol or other drugs may be a factor in a range of acute situations including threatened or actual violence and self-harm.

Agencies should have in place, or develop, a generic policy that covers the potential of violent, aggressive or self-harming behaviour. A model policy addressing worker safety should include:

- definitions/indicators of violent or aggressive and self-harm behaviours
- a procedure for dealing with violence or threatening behaviour
- reporting procedures
- incident report writing

- crisis intervention plan
- a follow-up plan.

### Further reading

NSW Health. *Zero Tolerance Response to violence in the NSW Health workplace: policy and framework guidelines 2003*.

## Children and young people

Where a child or young person may be at risk of harm from hazardous substance use, a report to the Department of Community Service may be appropriate. Health workers can seek advice from local PANOC services.

In some cases, the Minister for Community Services has parental responsibility for some children and young people in care. In recognition of the special needs of these children and young people, DoCS and NSW Health are currently negotiating a Memorandum of Understanding in relation to the health needs of these children and young people.

Substance abuse by adolescents is determined by many inter-related individual, family, social and environmental factors. Case management should be undertaken to link adolescents to other services and a partnership approach taken with these agencies.

Where possible, the families of young people should be involved in their treatment. Where referral is indicated, the most appropriate agencies are adolescent generalist services that can engage the young person and deal with the substance use as part of the complex range of other issues. Good practice for working with young people includes:

- interventions need to take a holistic and comprehensive approach. Targeting substance abuse alone, while ignoring other issues such as homelessness, unemployment and alienation from family and society, is ineffectual
- treatment should be within a harm minimisation framework
- treatment is to be based on a thorough

## Related issues

client assessment

- treatment is a process not an event
- services should avoid labelling young people
- services need to be appropriate to the developmental issues of adolescence
- treatment needs to provide practical and concrete strategies and provide some rules and boundaries.<sup>22</sup>

## Child protection

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

**It is important to accurately assess the potential risk of harm and NOT to assume that all parents/carers who misuse substances are unable to provide adequate care for the children and young people in their care.**

All mandated reporters under the *Children and Young Persons Care and Protection Act 1998* must comply with the *Interagency Guidelines on Child Protection Intervention 2000*. Agency personnel need to have appropriate tools and materials for actions arising from the identification of children and young people at risk of harm which relate to their responsibilities under the *Interagency Guidelines on Child Protection Intervention 2000*.

Child protection and drug and alcohol treatment services have a shared interest and responsibility in working with vulnerable families. Parents/carers with problematic drug and alcohol use form a large proportion of the families with whom the DoCS works – and many adult clients of drug and alcohol treatment services – are parents/carers.

Children and/or young people may also present with problematic drug and alcohol use, not just parents/carers. The response to a child or young person using drugs and/or alcohol may be different to that required to respond to an adult's use of the same. Additional information is provided in the section on *Children and young people* on page 23.

There are differences that characterise child protection interventions and drug and alcohol interventions:

- Drug and alcohol interventions focus on the adult or young person as the primary client and the goal is harm reduction. Engagement is on a voluntary basis.
- Child protection interventions focus on the child or young person and the goal is to ensure the child's safety, welfare and well-being. The statutory mandate that DoCS has to protect children means that engagement with parents/carers may be on a non-voluntary basis. DoCS can seek a range of orders from the Children's Court, including an order placing the child or young person in Out of Home Care.

As well as receiving and acting on reports of risk of harm, DoCS provides information, advice and referral to children and young people, families and agencies. Where the child or young person is not at risk of harm DoCS can provide information and advice which may or may not include information about service providers.

The principles underpinning the *Children and Young Persons (Care and Protection) Act 1998* apply when working with children or young people affected by drug and alcohol use – or when working with parents/carers with drug and alcohol issues which may impact on their capacity to adequately care for their children.

The *NSW Interagency Guidelines for Child Protection Intervention 2000* specify the role and responsibilities of workers in various agencies and provides detailed advice on processes and procedures to be followed.

Families generally provide for the safety and wellbeing of children and young people. If families are unable to provide safety from harm for a child or young person, professionals working with the family must seek to ensure the child's safety.

The safety and well-being of children whose parents/carers have problematic drug and alcohol use is more likely to be ensured when their parents/carers are provided with appropriate and effective drug treatment intervention.

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22 Source: Spooner, C., Mattick, R., Howard (1996) *The Nature and Treatment of Adolescent Substance Abuse*. NDARC Monograph No. 26 National Drug and Alcohol Research Centre, UNSW, Sydney

Where there is a conflict between client confidentiality and the responsibility of drug treatment services to ensure that children and young people are not harmed, the safety of the child/young person is paramount.

Once a report to DoCS has been accepted for further assessment, Child Protection caseworkers assume a case management role. However, there is a potential for NGOs to case manage in particular circumstances. Although other alcohol and drugs services may be responsible for specific tasks in relation to a child's safety and wellbeing, DoCS caseworkers assume the case management role and retain ultimate responsibility for attending to the safety and well-being of the child/young person.

The needs of parents/carers and children or young people in their care should be considered in a broad, holistic manner by the DoCS caseworker, the provider of drug and alcohol interventions and any other agencies involved in support coordination, to ensure that family functioning as a whole is maximised.

Effective service delivery to families is dependent on the provider of drug and alcohol interventions, DoCS and other agencies involved in support coordination working collaboratively, cooperatively and with a clear understanding of each other's roles and responsibilities.

Meeting the needs of children and young people assists in reducing the impact of intergenerational transmission of the negative consequences of parental problematic drug and alcohol use.

### **Substance dependent parents/carers and their children**

Central to the challenge of providing drug and alcohol interventions to parents/carers is that problematic drug and alcohol use is typically a chronic, relapsing condition. Recovery can be a long-term process. Children and young people however, have a right to a safe and stable home in which to grow. Their physical and psychological development cannot be put on hold. Balancing these factors is a key issue.

When working with parents/carers who use substances, it is important to **accurately assess the potential risk of harm to a child in their care whilst not assuming that all parents/carers who misuse substances are unable to provide adequate care for children or young people in their care.**

DoCS is currently piloting the Hearth Safety Assessment Tool – a tool for assessing the safety of children in drug use environments.<sup>23</sup> Comprehensive assessments of parents/carers who are substance dependent should be carried out by authorised and competent staff.

A comprehensive assessment of a parent/carer who is substance dependent should include an assessment of:

- parental drug and alcohol use
- accommodation and home environment
- provision of basic needs
- procurement of drugs
- health risks
- social network of support
- parents' perception of the situation
- pregnancy.<sup>24</sup>

Where it is suspected on reasonable grounds, that a child or young person is at risk of harm, a report must be made to the Department of Community Services. Many parents/carers with problematic drug and alcohol use are able to make arrangements that minimise the impact on their children or young people in their care. For some, however, the children or young person's safety and well-being is so compromised that DoCS must become involved.

The criteria and goals for successful intervention need to be considered carefully. Successful intervention can focus on issues that affect the child's emotional and physical safety and not merely the cessation of drug use. Bear in mind that for substance dependent parents/carers, the possible removal of their children or young people in their care is a powerful sanction that is widely feared, and may underpin reluctance to seek help.

23 Robinson F, Carmins K. Assessing the safety of children in a drug-using environment: the Hearth Safety Assessment Tool. In: One child's reality, everyone's responsibility: proceedings, 8th Australasian Conference on Child Abuse and Neglect. Melbourne, Vic: Department of Human Services, 2001.

24 National Treatment Agency. Models of Care for the treatment of drug misusers London: NTA, 2002.

## Related issues

This is especially an issue for Indigenous communities and reflects a historically difficult relationship with welfare systems.

It is important to set clear goals that are attainable and concrete. There is a need for interventions that incorporate harm minimisation and regard change as a process in which clients increasingly recognise the problematic effects of drug taking on their lives, including the impact on children and young people.

Prevention and harm minimisation strategies should commence from first contact with antenatal services. The Integrated Perinatal and Infant Care (IPC) initiative involves universal psycho-social risk assessment of all women as part of the comprehensive assessment in the ante and postnatal periods.

Psycho-social risk factors for poor health outcomes for mothers and infants identify a number of psycho-social risk variables including substance misuse in either the woman or her partner. This first level assessment links to a comprehensive local network of support and health related services commencing antenatally and linking to the universal postnatal Health Home Visiting initiative and Families First community support network. Health workers should refer to the *Neonatal Abstinence Syndrome Guidelines 2002/101*.

### Health workers in the obstetric setting

Medical and other health workers in obstetric wards should have access to health professionals with expertise in child protection to assist with the recognition of child protection issues arising from parental drug use and with appropriate case planning and referral. PANOC (Physical Abuse and Neglect of Children) services are able to provide consultation to workers in obstetrics and other NSW Health services.

The *Interagency Guidelines on Child Protection Intervention* recommend that medical and other health workers in obstetric wards are trained to recognise the indicators of substance use, and trained to deal with avoidance and resistance in substance using clients. Medical and other health workers need to apply the NSW Health *Neonatal Abstinence Syndrome Guidelines 2002/101*.<sup>25</sup>

Health workers should ensure that an accurate history is taken of maternal drug use, which includes frequency, amount and duration of use, for all women attending antenatal care. Prevention and harm reduction strategies should commence from first contact with antenatal services.

The Integrated Perinatal and Infant Care initiative involves universal psycho-social risk assessment of all women as part of the comprehensive assessment in the ante and post-natal periods.

### Neonatal Abstinence Syndrome Guidelines 2002/101

NSW Health has developed and published the *Neonatal Abstinence Syndrome (NAS) Guidelines 2002/101* to address recommendations from the Child Death Review Team and the NSW Pregnancy and Newborn Service Network to improve the health outcomes for opioid-dependent pregnant women, mothers and newborn infants, and their families.

The *NSW Neonatal Abstinence Guidelines 2002* (Health Circular No: 2002/101) apply to all Health Workers who are involved with the care of pregnant women and mothers and their newborn infants who are dependent on drugs. This includes maternity, neonatal and paediatric units, early childhood health services and specialist drug and alcohol services providing services to this target group.

The focus of the *NSW Neonatal Abstinence Guidelines 2002/101* is on:

- the care of the opioid-dependent pregnant woman from a drug and alcohol perspective based on the principle of harm minimisation
- the care of the newborn infant from a child protection perspective, whereby the safety and wellbeing of the child or young person is a paramount consideration.

Minimum standards on the management and treatment of the psycho-social and medical issues relation to NAS are established by the *NSW Neonatal Abstinence Guidelines 2002/101* through a multi-disciplinary, interagency approach.

25 These provisions comply with the recommendations of the *Child Death Review Team Report 1998/99* and the government commitments that flowed from the recommendations.

It is recognised that women who are dependent on other illicit drugs and alcohol may have similar care needs and issues. The care elements of the *NSW Neonatal Abstinence Guidelines 2002/101* also apply to this group.

The *NSW Neonatal Abstinence Guidelines 2002/101* should be read in conjunction with the *NSW Health Frontline Procedures for the Protection of Children and Young People (2000)*, and the NSW Department of Health Circular 2003/16 – *Protecting Children and Young People*.

## Women and substance use

As stated in Section 7.7 *Gender Issues*, service user families are more often-than-not headed by women and this raises special treatment issues about child rearing and substance abuse. An awareness of the particular treatment needs of women is thus vital when developing interventions aimed at parents/carers.

Good practice principles for working effectively with parents/carers with drug and alcohol use issues include:

- early engagement of women with substance misuse issues in antenatal and postnatal periods, with support from specialist services including consultation and shared care management with drug and alcohol services
- dealing with parent's/carer's substance abuse directly and in concert with other agencies with a view to minimising the harm to children, young people and adults
- enhancing the parent's/carer's knowledge and implementation of parenting skills to enhance the safety and development of the child
- providing concrete and practical help to ensure adequate care
- assisting the parent/carer with personal change and development goals
- enhancing the functioning of the informal social network and the formal service network around the family.<sup>26</sup>

## Child protection training

Agency staff 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 – a cross government learning and development forum, chaired by the Association of Children's Welfare Agencies 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.

## Family & Carers Training (FACT) Project

NSW Health has developed a training package and set of resources for use by generalist community workers with families or carers affected by the drug and alcohol use of a relative or friend. The training package is specifically designed for generalist support workers and is accompanied by a self-paced learning guide.

The first round of training was rolled out across NSW between March and May 2004 by the Centre for Community Welfare Training (CCWT). The program will then feature on the CCWT calendar. The resource kit is initially being disseminated through the training only. Copies are available from the Better Health Centre Publications Warehouse on 02 9816 0452.

## Child Death Review Team Report

The Child Death Review Team Reports outlined a raft of recommendations and actions for government and non-government agencies to improve their responses to parents/carers to prevent injury and death of dependent children or young people or any children or young people in their care.

<sup>26</sup> Source: Campbell, L. Service to Parents who Abuse Substances: Literature to inform a practice research initiative. Children Australia Vol22, No. 2.

## Related issues

Substantial recommendations concerned issues related to parental substance dependence. These recommendations have been addressed in a range of policy documents that *Responding to Harmful Drug Use* refers to including:

- *NSW Interagency Guidelines for Child Protection Intervention 2000*
- *NSW Neonatal Abstinence Guidelines 2002/101*
- *NSW Health Frontline Procedures for the Protection of Children and Young People*
- NSW Department of Health Circular, 2003/16 – *Protecting Children and Young People*.

*Responding to Harmful Alcohol and Drug Use* reinforces these policy responses to the Child Death Review Team report by:

- recognising 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
- assisting justice and human service agencies to define their role and responsibility for intervening with harmful drug and alcohol use among their service users
- identifying and describing the key practice areas that justice and human service agencies can engage in to respond to harmful drug and alcohol use among their service users
- providing justice and human service agencies with guidance on when, how and who should intervene
- assisting justice and human service agencies to review and develop drug and alcohol related policy, procedure and practice and plan for their workforce needs.

### Further information

*NSW Interagency Guidelines for Child Protection Intervention 2000*

<http://www.health.nsw.gov.au/policy/hsp/publications/2000interagencyguidelines.pdf>

*NSW Neonatal Abstinence Guidelines 2002/101*

[http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005\\_494.pdf](http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_494.pdf)

*NSW Health Frontline Procedures for the Protection of Children and Young People*

<http://www.health.nsw.gov.au/pubs/2004/pdf/childprotection.pdf>

NSW Department of Health Circular, 2003/16 – *Protecting Children and Young People*

[http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005\\_299.pdf](http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_299.pdf)

Domestic violence interagency guidelines: working with the legal system in responding to domestic violence

[http://www.lawlink.nsw.gov.au/cpd.nsf/files/DVIG%20130503.pdf/\\$FILE/DVIG%20130503.pdf](http://www.lawlink.nsw.gov.au/cpd.nsf/files/DVIG%20130503.pdf/$FILE/DVIG%20130503.pdf)

## Gender issues

Interventions concerning individuals with drug and alcohol issues need to be mindful of gender issues. It is important to note that, whether alone or with a partner, it is usually women who struggle with the demands of child rearing and substance abuse. Consequently, it is necessary to be aware of and incorporate the particular treatment needs of women, where appropriate, when developing interventions aimed at parents/carers.

Australian research has identified five main barriers to women receiving treatment. These include:

- ignorance of options
- lack of family/partner support
- fear/threat of the program
- isolation/lack of outreach service
- previous treatment experience.

Other barriers identified by the client groups were shame and guilt, and lack of childcare.



## Domestic violence

Domestic violence is any

*“violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman. Living with domestic violence has a profound effect upon children and young people and constitutes a form of child abuse.”<sup>27</sup>*

Drug and alcohol misuse may be concurrent with domestic violence. Use does not cause or provide an explanation for domestic violence. It adds an additional layer of management and intervention when responding to domestic violence situations.

Domestic violence is a serious and broad social problem. The ABS reported in 1996 that 23 per cent of all women who had been married or in a de facto relationship had experienced violence by their partners at some time during the relationship. Exposure to violence in the family also has traumatic and negative effects on the wellbeing of children. In addition, there are other economic and social costs of domestic violence.

Domestic violence is present in a high proportion of all child protection reports to DoCS – approximately 18.5 per cent relate to domestic and family violence issues. Many of these incidents involve either one or two affected parents/carers and risks for children and young people are substantially greater when both parents/carers are alcohol or drug dependent.

The *Domestic Violence Interagency Guidelines 2002* are aimed at reducing domestic violence and enhancing coordination between agencies and services. The *Domestic Violence Guidelines 2002* are intended for workers in the field working in, or dealing with, the legal system and/or working with women dealing with the legal system.

The *Domestic Violence Interagency Guidelines 2003* provide definitions of domestic violence, the principles that underpin the work, the roles of various agencies in intervention, ways for agencies to collaborate, and information on resources and services available to workers and to support women experiencing domestic violence.

The *NSW Domestic Violence Interagency Guidelines 2003* outline an agreed framework and the roles of respective agencies in response to domestic violence.

### Further information

Domestic violence interagency guidelines: working with the legal system in responding to domestic violence

[http://www.lawlink.nsw.gov.au/cpd.nsf/files/DVIG%20130503.pdf/\\$FILE/DVIG%20130503.pdf](http://www.lawlink.nsw.gov.au/cpd.nsf/files/DVIG%20130503.pdf/$FILE/DVIG%20130503.pdf)

NSW Health policy and procedures for identifying and responding to domestic violence

[http://www.health.nsw.gov.au/pubs/p/pdf/policy\\_dom\\_violence.pdf](http://www.health.nsw.gov.au/pubs/p/pdf/policy_dom_violence.pdf)

## Aboriginal and Torres Strait Islander peoples

The NSW Drug Summit 1999 and the NSW Alcohol Summit 2003 recognised that drug and alcohol problems present particular challenges for Aboriginal and Torres Strait Islander peoples, that mainstream services need to be culturally appropriate and that specific services are required.

Where non-Aboriginal and Torres Strait Islander agencies are providing services, contact with an Aboriginal or Torres Strait Islander worker or Aboriginal or Torres Strait Islander community member assists in building trust and ensuring that culturally appropriate methods of treatment are provided.

<sup>27</sup> Domestic Violence Interagency Guidelines: working with the legal system in responding to domestic violence, Violence Against Women Specialist Unit, 2003.

## Related issues

General principles of good practice for working with Aboriginal and Torres Strait Islander people apply to interventions for early detection and management of drug and alcohol misuse. Some of these are:

- including Aboriginal and Torres Strait Islander people in the staff and management of the service
- providing a culturally appropriate environment
- having culturally appropriate resources and materials
- staff having an awareness of and training in cultural issues and skills in cross-cultural communication
- working with existing Aboriginal service delivery frameworks
- interventions should focus on the place of drugs and alcohol in communities as well as on drug users as individuals
- a whole of government approach should be adopted when delivering services to Aboriginal people in accordance with the draft Aboriginal Affairs Plan, *Two Ways Together*
- interventions should promote Aboriginal clients access to community resources and government entitlements.

### Further information

Two Ways Together. Partnerships: A new Way Doing Business with Aboriginal People  
<http://www.daa.nsw.gov.au/policies/policy.html>

## Cultural diversity

The barriers to accessing appropriate services for people from diverse cultural and linguistic backgrounds have been well documented. These barriers include:

- lack of knowledge of services and systems of Australian society
- services not providing information in languages other than English
- cultural norms, such as reluctance to seek assistance, due to past experience in country of origin, eg police
- cultural barriers, such as potential loss of face or shame in seeking assistance
- service delivery that is not culturally appropriate.

Use of alcohol and drugs may have different meanings or diverse patterns of use in particular cultures.

Services need to become aware of the major cultural and language groups residing in their area, the pattern of changing settlement, if any, key ethnic organisations (social and cultural) and any ethno-specific services available for particular groups.

Good practice in working with people from diverse cultural and linguistic backgrounds in the early detection and management of drug and alcohol misuse include:

- training in cultural awareness and communication
- training in the use of interpreters and translation services
- networking with ethno-specific services
- information available in major languages other than English
- ensuring client can access community resources and government entitlements
- service provision that is respectful of cultural and religious beliefs.

The Drug and Alcohol Multicultural Education Centre (DAMEC) can provide agencies with advice on the development of training or training programs that address the knowledge and skills required to work with culturally and linguistically diverse populations around drug and alcohol issues.

DAMEC is also a central contact point for information relating to culturally and linguistically diverse communities. DAMEC annually publishes the *Drug & Alcohol Services Programs and Resources Directory for non-English speaking background people*; provides a telephone information service and supplies multilingual pamphlets and other resource material.

### Further information

Drug and Alcohol Multicultural Education Centre  
<http://www.damec.org.au>

*NSW Directory of Drug and Alcohol Services, Programs and Resources for People of Non-English Speaking Background (2000)*. The Drug and Alcohol Multicultural Education Centre, Sydney

*Bridging the Gap: Working cross-culturally with drug and alcohol issues*. Sydney: CEIDA, NSW Health, 1995.

## Disability issues

Good practice in working with people with a disability includes:

- having an awareness of the barriers to accessing services, including drug and alcohol treatment services, for people with a disability
- compliance with physical access provisions
- knowledge of interpreter services for hearing impaired people
- providing information in accessible formats
- having good linkages with relevant services for people with disabilities.

## Intellectual disability

There are practical aspects of ensuring ethical practice with individuals with cognitive and/or communicative disabilities and these will need to be considered in any intervention relating to drug and alcohol use. Good practice in working with people with intellectual disability includes:

### Check comprehension

When asked, "do you understand?" during a consultation, people with intellectual disabilities may well answer in the affirmative. A method found to be effective in determining whether the person has understood and retained important information is to invite them to repeat back what you have said.

### Identifying yourself

Identify yourself clearly as a frontline worker or practitioner charged with relating to the person. A person cannot make valid decisions if they are not sure who is working with them. It may be helpful to briefly re-introduce yourself at the beginning of each contact, as many people have trouble remembering faces and names.

## Eliciting and explaining

It is important to allow people to express their own perceptions of their problems. To this end, you should have a pen and paper on hand for yourself and the person. Communication through pictures and written words is favoured by some people over spoken language. Prepared materials exist which may help people with intellectual disabilities to describe what they are experiencing, or what has happened to them.

Concepts of time can be very difficult. Some people may have little idea of such measures of time as weeks or months and may struggle to distinguish questions about a single event from questions about duration of a state or condition.

## Negotiating consent

People with intellectual disabilities and others who have lived in institutions may be unaccustomed to making choices, although they may be competent to do so. It is useful to establish whether people have experience of making decisions in daily life using concrete examples. People with intellectual disability may have a concrete view of the procedures that you are proposing.<sup>28</sup>

## Dual diagnosis (mental health and substance abuse)

There are a considerable number of people with co-existing mental health and substance use problems. Their prevalence may be increasing.<sup>29</sup>

This is sometimes referred to as 'co-morbidity', 'dual disorder' or 'dual diagnosis' (if a diagnosis has actually been made). It varies in severity and degree of impairment and cannot be defined in terms of a specific syndrome with a discrete treatment approach.

28 Source: Thacker, A (2001) *Clinical Communication* at [www.intellectualdisability.info.com](http://www.intellectualdisability.info.com)

29 Depending on the population sample, between 30 per cent and 80 per cent of people with mental disorders have a co-existing substance disorder and corresponding rates of mental disorders are reported for people with substance disorders. Source: *The Management of people with a co-existing Mental Health and Substance Use Disorder: Discussion Paper*, NSW Health, 2000.

## Related issues

Diagnosis and treatment requires collaboration between mental health and drug and alcohol services, and other community-based service providers. Barriers to effective service provision have been identified by a number of specific projects, including:

- failure to detect substance use disorders in people with mental disorders
- misidentification of substance intoxication or withdrawal as symptoms of psychiatric illness
- exacerbation of acute psychiatric symptoms and severity of mental health disorders by substance use
- substance use to reduce the symptoms of psychiatric illness and the effects of medication, resulting in perpetuation of substance use disorders
- the onset of many mental disorders concurrently with the time of experimentation with substances ie adolescence
- organisational issues, including separate service systems, entry criteria to some AOD programs excluding dual disorders and vice versa, differing philosophies in the two systems, lack of cross sectoral training and support.

Despite the high prevalence of dual disorder, there is little evidence about the nature of best practice for this client group. Some early indications drawn from the research literature<sup>30</sup> include:

- treatment approaches which treat both disorders concurrently, priority being determined by the specific needs of clients
- preference to an integrated model of treatment (ie treating both disorders in a unified treatment program)
- designation of a primary care worker to ensure a holistic approach
- maximum cooperation between services, in particular to deal with clients with particular/ extreme problems.<sup>31</sup>

A Memorandum of Understanding exists between NSW Police and NSW Health that establishes a clear framework for the management of situations involving Police and Health staff and persons who may have a mental illness. It calls for special attention and consideration to be given to people with a drug and alcohol problem and mental illness.

### Further information

Management of people with a co-existing mental health and substance use disorder: service delivery guidelines

[http://www.health.nsw.gov.au/health-public-affairs/publications/mhsubuse/SDG\(D\\_paper\).pdf](http://www.health.nsw.gov.au/health-public-affairs/publications/mhsubuse/SDG(D_paper).pdf)

Memorandum of Understanding between NSW Police and NSW Health, 1998.

Joint Guarantee of Service for People with Mental Health Problems and Disorders: NSW Department of Housing, NSW Aboriginal Housing Office, NSW Health, Aboriginal Health and Medical Research Council of NSW, NSW Department of Community Services.

30 Cited in NSW Health (2000) *The Management of people with a co-existing Mental Health and Substance Use Disorder: Discussion Paper*.

31 Service delivery guidelines for health services are provided in *The Management of people with a co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines*, NSW Health, 2000.

# 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"> <li>■ Cold and clammy skin</li> <li>■ Changed mental state</li> <li>■ Changed heart rate</li> <li>■ Lowered body temperature</li> <li>■ Slow and noisy breathing</li> <li>■ Muscle twitching</li> <li>■ Blue tinge around mouth lips</li> <li>■ Stupor</li> <li>■ Convulsions</li> <li>■ Coma – (not responsive to sound, touch)</li> </ul> <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><b>Alcohol withdrawal can be a medical emergency and should be supervised by a medical professional.</b></p>
Benzodiazepines (Valium, Serapax, Normison, Rohypnol, Mogodon etc)	<ul style="list-style-type: none"> <li>■ Cold and clammy skin</li> <li>■ Changed mental state</li> <li>■ Changed heart rate</li> <li>■ Lowered body temperature</li> <li>■ Slow and noisy breathing</li> <li>■ Muscle twitching</li> <li>■ Blue tinge around mouth lips</li> <li>■ Stupor</li> <li>■ convulsions</li> <li>■ Coma – (not responsive to sound, touch)</li> </ul> <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><b>Benzodiazepine withdrawal can be a medical emergency and should be supervised by a medical professional.</b></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

## Patterns and contexts of harmful drug and alcohol use

### Be alert for patterns of harmful drug and alcohol use

#### Alcohol

The Australian Alcohol Guidelines provide guidance on low risk, risky and high risk drinking. Table 1 provides a Summary of guidelines for low-risk drinking. The Guidelines use the idea of a 'standard drink'. In Australia a standard drink is any drink that contains 10 grams of alcohol.

It can sometimes be difficult to work out standard drinks because:

- different types of alcoholic drinks contain different proportions of alcohol per volume
- different glass sizes are used in different drinking settings.

It is, however, possible to make some estimates:

- the label on any bottle, can or cask states how many standard drinks are inside the container
- you can use a standard drinks conversion guide (see <http://www.alcoholguidelines.gov.au/pdf/drinksguide.pdf>)

#### Poly drug use

Use of depressant drugs (ie alcohol, benzodiazepines, opioids) in combination eg alcohol and benzodiazepines, or alcohol and heroin or benzodiazepines and methadone. Depressant drugs depress the respiratory system. When taken in combination with other depressant drugs, either simultaneously or while there is still some effect from the drug, the depressant effect is magnified and may put the individual at risk of overdose.

#### Dependent use

Some people come to depend or rely on one or more drugs in order to function day by day. People can be dependent on a drug and manage without problems occurring or engaging in high-risk behaviour. If a person's drug use did begin to impinge on other areas of his/her life such as family or work, and the person is unable to change or lower that use, that person would be thought to be dependent on that drug.<sup>32</sup>

#### Things to consider when assessing harmful drug and alcohol use<sup>33</sup>

In some situations, the context of drug or alcohol use may be a major factor in assessing harm. Some of the contexts of drug and alcohol use to consider when assessing harmful drug and alcohol use may be where the service user:

- has responsibilities for caring for children or young people
- is about to engage in activities that involve risk or degree of skill (eg driving, operating machinery)
- is on medication
- is under 18 years of age
- is pregnant
- has mental health problems
- is involved in a domestic violence situation.

32 Alcohol & Other Drugs, Youth Substance Abuse Centre, 1999. Fitzroy, Melbourne.

33 Adapted from *Australian Alcohol Guidelines: Health Risks and Benefits*, NHMRC, 2001.

**Table 1. Summary of guidelines for low risk drinking<sup>34</sup>**

1. Alcohol consumption at levels shown below is **not** recommended for people who:
  - have a condition made worse by drinking (see page 9 of Australian Alcohol Guidelines)
  - are on medication (see page 12 of Australian Alcohol Guidelines)
  - are under 18 years of age (see page 15 of Australian Alcohol Guidelines)
  - are pregnant (see page 16 of Australian Alcohol Guidelines)
  - are about to engage in activities involving risk or a degree of skill (eg driving, flying, water sports, skiing, operating machinery).
2. Otherwise, risk levels for the following patterns of drinking are as follows:

For risk of harm in the short-term				For risk of harm in the long-term			
	Low risk (Standard drinks)	Risky	High risk		Low risk (Standard drinks)	Risky	High risk
<b>Males</b>				<b>Males</b>			
On any one day	Up to 6 On any one day, no more than 3 days per week	7 to 10 On any one day	11 or more On any one day	On an average day	Up to 4 per day	5 to 6 per day	7 or more per day
				Overall weekly level	Up to 28 per week	29 to 42 per week	43 or more per week
<b>Females</b>				<b>Females</b>			
On any one day	Up to 4 On any one day, no more than 3 days per week	5 to 6 On any day	7 or more On any one day	On an average day	Up to 2 per day	3 to 4 per day	5 or more per day
				Overall weekly level	Up to 14 per week	15 to 28 per week	29 or more per week

Note:

- It is assumed that the drinks are consumed at a moderate rate to minimise intoxication, eg for men no more than 2 drinks in the first hour and 1 per hour thereafter, and for women, no more than 1 drink per hour.
- These guidelines apply to **persons of average or larger size**, ie above about 60kg for men and 50kg for women. Persons of smaller than average body size should drink within lower levels.

(Table based on *International Guide for Monitoring Alcohol Consumption and Related Harm*, WHO, Geneva, 2000.)

<sup>34</sup> Australian Alcohol Guidelines [www.alcoholguidelines.gov.au](http://www.alcoholguidelines.gov.au)

# Appendix 3

## Guide to choosing assessment tools<sup>35</sup>

Factors to consider when choosing an assessment tool from existing validated instruments include:

- **Primary use:** Ensure that the stated use of the tool matches your requirements. Tools primarily designed for outcome evaluation tend to collect quantitative rather than qualitative information.
- Ensure that the tool has been validated for use with the **target client group**. Some tools have been found to be inappropriate for some client groups such as prisoners or clients with co-existing mental health problems. Often tools are too broad in their scope to highlight particular issues synonymous with specific client groups.
- Available assessment instruments for substance users have been designed with different purposes in mind and vary widely in the **timeframe** they capture. The assessor will need to be aware of the time frame covered by the instrument.
- Similarly, assessors should be careful to select a measure sensitive to the **type of substance use** involved. Many tools have a focus on opioid injecting behaviour: the focus and nature of questions within the tool may have limited relevance to people using non-opioid drugs and who do not inject.
- Many tools provide a **composite measure or score** of the severity of substance use. This formula approach, multiplying **frequency of use** by **amount**, might indicate that, by comparison, using cocaine twice daily is less problematic than using a similar amount of opioid three times in a day. Assessors will need to be aware of the variance in scoring methods and how this affects the resulting care provision.
- Assessors should recognise that **short periods of abstinence** may be more significant for substances associated with steady use, eg opioids or methadone than for those characterised by binge or episodic use, eg cocaine.
- The **time taken to complete** assessment tools may range from three minutes to four hours for the tools examined in the assessment tool study. Brief screening instruments tend to take less time to complete than comprehensive tools. On average, up to 30 minutes appeared to be a reasonable time to spend on a comprehensive assessment. Specialist or specific assessments, for mental state assessment or social enquiry report may take longer.
- **Administration:** tools that require scoring and/or inputting from paper to computer database will provide additional administrative work for frontline workers or require dedicated administrative support. Frontline workers score 61% of commonly used tools. One third of all tools reported in the study are stored on computer databases (Rome 2002, Type 2/3). The additional administrative requirements of each tool should be taken into consideration.
- **Training requirements:** Typically, training of one day or less was required on the use of specific tools. Service managers should ensure that initial training and updates are available to all staff who would use these tools. Training should include issues regarding the assessment process and specific guidance on the use of selected tools.
- Developers of new instruments must consider carefully their usefulness across a number of potential substance use disorders and settings. Before embarking on developing a new assessment instrument for substance use, **careful consideration should be given to evaluating whether an appropriate one does not already exist and could be used with no or minor modification for the task in hand.**

35 Integrated Care for drug users: Principles and practice. Scottish Executive. <http://www.scotland.gov.uk/library5/health/icdu-20.asp>



# Appendix 4

## Drug and alcohol central intake services

<b>Metropolitan Area Health Services</b>	<b>Telephone numbers</b>		
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	

<b>Rural Area Health Services</b>	<b>Telephone numbers</b>		
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 5

## Alcohol and Drug Information Service

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

<b>Sydney</b>	9361 8000
<b>Toll free rural callers</b>	1800 422 599

# Appendix 6

## Additional resources

- Guidelines for managing drug-related incidents in schools

<http://www.det.nsw.edu.au/policies/studwelf/manadrug/index.htm>

This is a resource to assist schools to respond to drug-related incidents. It refers to policy and procedures concerning the use and possession of both illicit drugs and legal drugs such as tobacco, alcohol and inhalants in schools. Management of incidents such as misuse of over-the-counter and prescribed medications is also included.

- ANTA Toolbox for the Alcohol & Other Drugs Competencies

<http://toolbox.vetonline.swin.edu.au/AOD/>

This interactive site from ANTA provides a library of discrete learning resources for web-based delivery. The resources provide a flexible set of learning materials for use in online learning programs. The learning units in the toolbox are based on the nine specialist drug and alcohols units of the competency from the Community Services Training Package.

Each of the nine competencies is made up of:

- learning units which contain information about particular aspects of the AOD sector
- learning activities to further develop skills and knowledge
- case studies of people within the sector
- library resources to assist study, including articles, recommended reading and suggested websites
- points of view of people who work in the AOD sector and other contributors who have an interest in AOD issues
- discussion starters specific to the learning being studied.

A detailed learner's guide contains information about the drug and alcohol competencies, qualifications and learning units.

[http://toolbox.vetonline.swin.edu.au/AOD/segments/articles/learner\\_guide.pdf](http://toolbox.vetonline.swin.edu.au/AOD/segments/articles/learner_guide.pdf)

- *Treatment Approaches for Alcohol and Drug Dependence: an introductory guide*

Jarvis, T.J, Tebbutt J, & Mattick R.P., John Wiley & Sons, Brisbane, 1995.

This resource is written for people whose work involves assisting clients to change their use of alcohol and/or other drugs. It provides brief, user-friendly descriptions of specific techniques that have been found to be effective in the treatment of substance abuse problems. This book explains how to use the techniques recommended by clinical experts to help clients change behaviour.

**This book is not designed to teach clinical skills,** but it may be a valuable resource for professionally qualified staff new to the drug and alcohols sector and trainers.

- *Drug and Alcohol Policy for Nursing Practice in NSW: Clinical Guidelines 2000–2003*, NSW Health, North Sydney, 2003.
- *Of Substance: the national magazine on alcohol, tobacco and other drugs*, Commonwealth of Australia, Canberra, 2003.

A national magazine specifically designed for professionals whose work involves the drug and alcohol sector such as primary care professionals, teachers, police, counsellors, managers and those who work in the specialist alcohol, tobacco and drugs services.

Available by subscription. Telephone 02 6279 1650 or email [editor@ancd.org.au](mailto:editor@ancd.org.au)

- *Motivational Interviewing: preparing people for change*, Miller, W & Rollnick, S. 2nd edition. New York: Guilford Press.
- *Workforce Development Resource Kit: a guide to workforce development for alcohol and other drug agencies*, NSW Health, 2002.
- *Evidence-based practice indicators for alcohol and other drug interventions: Summary*, Dale, A. Mars, A. Best Practice in Alcohol and Other Drugs Working Group, 2000. <http://www.wa.gov.au/drugwestaus/>

## Appendix 6: Additional resources

■ *Centre for Community Welfare Training Handbook*.  
Tel. 9281 8822. <http://www.acwa.asn.au/ccwt/>

■ NSW Health Families and Carer (FACT) Project.  
*Families and carers affected by the drug or alcohol use of someone close: A resource for generalist support workers*. NSW Health, 2004.

This resource provides practical and relevant drug and alcohol information for community workers.

■ NSW Health Families and Carer (FACT) Project.  
*Families & friends affected by the drug or alcohol use of someone close*. NSW Health, 2004.

This resource provides practical and relevant drug and alcohol information suitable for service users affected by the drug or alcohol use of someone close. For copies contact the Better Health Centre Publication Warehouse Tel. (02) 9816 0452.

# Appendix 7

## Glossary of terms

<b>ABS</b>	Australian Bureau of Statistics
<b>ADIS</b>	Alcohol and Drug Information Service
<b>AOD</b>	Alcohol and Other Drugs
<b>AUDIT</b>	Alcohol Use Disorders Identification Test
<b>Capacity building</b>	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. <sup>36</sup>
<b>CCWT</b>	Centre for Community Welfare Training
<b>CDAT</b>	Community Drug Action Teams
<b>DAMEC</b>	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.
<b>DAST</b>	Drug Abuse Screening Test
<b>DoCS</b>	Department of Community Services.
<b>Drug</b>	A substance that produces a psychoactive effect. Within this context ‘drug’ includes tobacco, alcohol, pharmaceutical drugs and illicit drugs.
<b>EPC</b>	Enhanced Primary Care – a framework for engaging doctors in multi-disciplinary planning and case management.
<b>FACT Project</b>	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.
<b>Harmful drug and alcohol use</b>	<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.<sup>37</sup></p>
<b>Harm minimisation</b>	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.

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

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

## Appendix 7: Glossary of terms

<b>Hearth Safety Assessment Tool</b>	Tool for assessing the safety of children in drug use environments.
<b>Interagency collaboration</b>	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. <sup>38</sup>
<b>IPC</b>	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.
<b>MERIT</b>	Magistrates’ Early Referral Into Treatment – scheme that refers eligible people facing court with drug-related offences to treatment and rehabilitation services.
<b>NAS</b>	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.
<b>NGOs</b>	Non-Government Organisations
<b>PANOC</b>	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.
<b>Practice areas</b>	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.
<b>SOCC</b>	Senior Officers’ Coordinating Committee on Drugs and Alcohol.

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38 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.