Community Drug Summit

June 2001

Broadening The Provision Of Treatment For Drug Users Through Other Human Services, Including The Health, Justice, Welfare And Youth Sectors, And Its Integration With Specialist Alcohol And Drug Services.

This is an Issues Paper. The Community Drug Summit Office has formed no conclusion on any issue mentioned in this paper. The purpose of the Issues Papers are to encourage discussion in the lead up to the Community Drug Summit and to encourage persons or organisations to make submissions to the Community Drug Summit Office. The Issues Papers are not meant to restrict persons or organisations in any way. Respondents should feel free to raise other relevant issues.

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1.0 Introduction

1.1 The Scope of this Report

In this report, the term 'treatment' was interpreted to include a range of responses (eg; medical treatment, counselling, advice and information) to people affected by drug use. 'People affected by drug use' was used as a term to include people who use drugs and others affected by this use (eg; parent, child and friend).

Drug related harm is found on a continuum. Some people who use drugs will have few if any drug related problems, others will experience moderate levels of harm, while some will experience a wide range of severe problems. Responses to drug related harm should reflect these varying levels of need.

A wide range of professions and organisations are involved in responding to people affected by drug use. The provision of responses by human services, in addition to specialist drug services, is fundamental in providing an integrated service to people affected by drug use. In this report, the term 'professions' is used broadly and inclusively (eg; it includes GPs, corrective service staff, welfare staff etc). 'Organisations' is also used broadly and inclusively.

1.2 Background

It is not contentious to conclude that a large proportion of the Western Australia community are affected by their own or another's drug use. For this reason alone, it is not surprising to find that specialist drug services are not the only services that come into contact with people effected by drug use. Specific examples include:

- ambulance and other emergency medicine staff responding to a heroin overdose;
- a youth worker talking to a young person about various drugs;
- crisis services approached by a distressed person with drug related housing or financial problems;
- GPs being consulted by a patient who has drug related sleeping problems; and
- mental health services unsure about the relationship of a psychotic episode to amphetamine use.

The aim of this paper is to explore how to ensure that these different services effectively respond to people affected by drug use. This will involve exploring the:

- services involved in providing responses to people affected by drug use;
- required attributes of people working in these different services;
- need for collaboration among these services; and
- barriers to, and facilitators of, effective practice.

1.3 The Reasons Why Broad Human Services Should be Included in Responding to the Needs of People Who Use Drugs

Firstly, while some people affected by drug use attend specialist drug services, it is not sufficient to respond to drug use and ignore housing, mental and physical health, finances, family relationships and employment. Effective responses are those that attend to all the needs of the person affected by drug use (National Institute on Drug Abuse, 2000). Specialist drug services have to collaborate with the broader human services in order to ensure all the needs of people affected by drug use are addressed.

Secondly, drug related problems are relatively common, represent substantial cost (human and economic) to our community (Collins and Lapsley, 1996) and have relevance outside the specialist drug services. Some people never use specialist drug services, but do use the broad human services. People working in health, welfare, law enforcement, education, family and corrective services regularly respond to people affected by drug use (Roche, 1998).

These services can have significant impact on the well being of people affected by drug use. Drug use has relevance for antenatal care, dietary problems, financial problems, relationship breakdown, safety and shelter and legal concerns. Ignoring drug use can compromise care. For example, ignoring drug use in a client with mental health problems will reduce the effectiveness of mental health treatments.

Finally, drug use has relevance for staff in a range of agencies. A growing concern for many agencies is the issue of drug related critical incidents for staff and clients. Good occupational health and safety procedures demand that staff and agencies are well equipped to respond to such incidents.

Consequently, a wide range of professions and organisations need:

- knowledge about drug use and its relationship to other problems and needs;
- awareness of how a client's drug use is important when responding to health, welfare, social, legal and employment needs;
- recognition that they have a role in responding to people affected by drug use; and

- recognition that they can be effective in responding. A wide range of human service staff are credible and effective agents of change.

2.0 Western Australian Context

This section very briefly reviews the situation in WA. It is not comprehensive. More detail can be found in the Community Drug Summit Office Paper Illicit Drug Use: Facts and Figures 2001.

2.1 Coordination

Two local plans are relevant:

- the previous State Government's drug strategy (Together Against Drugs, 1997) stressed the need for a comprehensive and enhanced approach across the various human service providers. The implementation of this plan has been coordinated by the WA Drug Abuse Strategy Office (WADASO) supporting and encouraging practice development in a range of human services;

- the Health Department of WA's (HDWA) focus on drugs is described in the 'InterAction' strategy (Health Department of WA, 1999). This emphasises a 'whole of organisation' response, coordinating services of a number of purchasing and provider units; and

- other departments and organisations also coordinate responses to drug related harm (eg; Ministry of Justice, Family and Children's Services and WA Police Service).

2.2 Post Secondary Education

Education on understanding and responding to drug use is included in many post-secondary education programs. However, the subject is not a significant core curriculum item for any profession.

2.3 Continuing Education and Training

Next Step Specialist Drug and Alcohol Services, funded by the HDWA, provide a range of continuing education and training programs. Other organisations also provide a range of opportunities. Such programs serve important functions. However, they can be difficult for some staff to attend (eg; due to time, geographical or staffing constraints) and are often reliant on staff self selecting to attend (ie; penetration into a large proportion of services may not occur).

Other projects funded by the HDWA target key organisations. For example, one project specifically targets the education needs of GPs and another aims to disseminate 'brief interventions'[1] across health services.

2.4 Capacity Building[2]

WADASO and the HDWA have committed funds to build the capacity of broad human services. Strategies include:

- practice development projects, supported by WADASO, and relevant government departments, including Family and Children's Services, Education and the Ministry of Justice;

- increasing the capacity and expertise of health services in drug service provision by placing key change facilitators in mainstream health services (eg; Graylands Hospital and Sir Charles Gairdner Hospital in Perth) and creating a specialist team in Next Step charged with expanding the capacity of the broader health services to manage drug withdrawal;

- funding Next Step Specialist Drug and Alcohol Services to provide a Clinical Advisory Service to medical practitioners; and

- the establishment of a Joint Services Development Unit at Graylands Hospital to build the capacity of services to respond to clients with coexisting drug and mental health problems.

2.5 Examples of Practice

Four examples of practice are provided to illustrate the issues that can arise for broad human services in WA.

2.5.1 Youth Services

A significant proportion of people who go to youth support services are affected by drug use. Responding to a distressed young person can be complicated by drug use. For example:

- most emergency accommodation services for youth are unable to provide suitable care for an intoxicated young person (eg; inadequate staffing levels, no capacity to manage behaviour) and exclude them from the service, at least in the short term;

- family mediation services are compromised when the relationship has been exposed to lengthy disputes over a young person's drug use, which may become a single focus replacing any attempt to consider other important issues (eg; communication and relationship building); and

[1]Brief Intervention is a term which describes interventions that are brief in time. Research indicates that a 'brief intervention' for non-dependant drug users with problems can be as effective as long term treatment, and far more effective than doing nothing. Brief intervention is a useful skill for non-specialist health and welfare workers who are in contact with drug users.

[2]Capacity Building describes a range of strategies aiming to improve the ability of workers and others in responding to drug use issues. Capacity Building may include initiatives such as staff education, policy development and business planning.

- police who take a young person into protective custody under either the *Child Welfare Act 1947* or the new *Protective Custody Act 2000* must hold that young person until a responsible adult can be found to take care of them. In the time spent waiting, the police must manage the care of young people who may be affected by a variety of drugs. Poor management of this situation may exacerbate harm and frustration for the young person, guardians and the police.

What happens now?

- most professionals working with young people have some training in responding to drug related harm;
- community facilities with stretched resources attempt to provide adequate care for quite disadvantaged and often ill young people; and
- young people may have to move from service to service to get a full support program.

What could be done?

- shared care case management and specialist drug treatment offered as a part of multidisciplinary youth teams;
- greater coordination between service delivery points (eg; different services could use common assessment procedures); and
- action learning within youth specific services to facilitate improved holistic treatment options.

What are the barriers?

- current funding arrangements necessitate competition between agencies; and
- lack of clarity around the most effective treatments, specifically for adolescents.

2.5.2 Health Professionals

The public and private health industry has considerable contact with people affected by drug use. Anecdotal and evidence based reports indicate there may be room to improve the outcomes for such clients. The most commonly identified health professionals who come in contact with people effected by drug use, are described in Table 1. These professionals have the potential to positively intervene in the care of people affected by drug use. This may be optimised by considering the following points:

- awareness of all the needs of people affected by drug use (eg; shelter, security, finances, general support in the community for themselves and family, access to specialist drug treatment); and
- enhanced professional skills, including:
  - knowledge about illegal drugs and current evidence about interventions;
  - knowledge of mental health diagnosis, and an ability to access treatment options and a good working knowledge of the limits and scope of pharmaceutical treatments and psychotherapy;
- willingness to respond to the treatment of people affected by drug use should be core business, people affected by drug use deserve optimal treatment options (like any other member of society);
- a willingness to work in a team structure and maintain network and communication skills within health and with other key organisations, with access to expert advice; and
- regional coordination of service provision.

2.5.3 Social and Welfare Services

Some individuals affected by drug use have housing, stable relationships and employment. Others are living chaotic lifestyles, faced with homelessness, unemployment, physical and mental health problems and social marginalisation. Staff roles in social and welfare services can range from emergency material relief, crisis accommodation, general support and referral and relationship counselling to in depth casework mandates. Sometimes staff have to manage quite complex psychosocial problems.

In this environment people working in welfare, support, counselling and social work roles need a greater capacity to respond to people affected by drug use within a holistic psychosocial approach. The most effective responses occur where a worker has professional and ongoing training, where supervision and support are consistently provided and a restricted caseload enables work to be both in depth and flexible.

Australian and international research on best practice with people with complex needs points to models of professional case management (sometimes known as a 'wrap-around service'). These have the capacity to be mobile and flexible, provide assertive outreach, engage with marginalised people and build a therapeutic relationship of trust and respect. Essential ingredients are organisational alliances and collaboration.

2.5.4 Justice Services

The following represents an example of a service attempting to enhance its response to people affected by drug use.

In order to provide cost effective services, Community Based Services of the Ministry of Justice (MOJ) targets interventions at high risk offenders. Given that significant numbers of offenders subject to community supervision orders are affected by drug use, there was a need to enhance the skills of Community Corrections Officers and Juvenile Justice Officers by developing appropriate brief intervention strategies and referrals to specialist treatment agencies. The program was funded by WADASO and collaboratively resourced by the MOJ and the Alcohol and Drug Authority (now Next Step).

Work commenced in 1997 with three day accredited training courses. This approach lacked follow up and support processes to ensure that the skills gained in this training were implemented back on the job. Consequently, a Practice Development Drug Management Project was introduced which aimed to assist the translation of learning into practice through an action learning methodology.

A review of the project by Sheridan and Associates (2000) found a substantial change in the work practices of Community Corrections Officers and Juvenile Justice Officers. The most substantial change, involving the integration and transference of learning, was reported in work units that had been involved in extended action learning programs.

Consideration is currently being given by Community Based Services (MOJ) to the introduction of a 'Coaching Model' in formal settings, such as case management meetings or in informal settings amongst peers. If high value is placed on staff engaging in reflective practice, then a strategy such as 'coaching' will provide supportive supervision and thereby enhance workers' skills and resources to ensure effective practice. The ability of supervisors to provide guidance and coaching to both individuals and teams is deemed to be a core competency within modern, effective organisations. Training senior field staff as coaches will sustain the gains started by the Drug Management Practice Development project.

3.0 Issues For Consideration

3.1 Relevant Organisations and Professions, and Their Roles

As stated above, drug related harm has relevance for many organisations. Allsop, Cormack, Addy, Ashenden, Ask, and Beel (1998) identified some examples of the roles of major organisations, including:

- general medical hospitals;
  - heroin, alcohol, benzodiazepine overdose;
  - drug related accidents;
  - chronic drug related illness, such as hepatitis;
- mental health services;
  - amphetamine related psychosis;
  - schizophrenia associated with and complicated by cannabis or other drug use; depression, anxiety and poor coping skills in some people affected by drug use;
- family and children's services;
  - children neglected or abused in relation to parents' drug use;
- welfare services;
  - employment;
  - shelter;
  - financial problems;
- youth services;
  - information about drug effects;
  - intoxication problems;
  - legal problems;
  - homelessness related to drug use;
- Aboriginal health services;
  - responding to drug related injury;
  - preventing and responding to drug related infectious disease;
  - housing, family, finance, employment and community needs;
- police services;
  - managing intoxicated people in the community and in custody;
  - responding to heroin overdoses;
  - drug related domestic violence;
  - diversion from justice into health services;
- justice services;
  - managing drug withdrawal;
  - managing drug users in the prison system;
  - preparing for release, especially avoiding risk of overdose; and
  - ensuring continuity of care within the community.

A summary of the professions and various roles is provided in Table 1.

Table 1

The most commonly identified professions responding to people affected by drug use

Medical and Allied Health	**Examples of Roles**
Medical practitioners	Diagnosing and treating drug related illness (physical and mental health) and injury; providing health care to people affected by drug use; brief interventions; referral; shared care; pharmacotherapies.
Nurses	Identification of drug related harm; assessment; withdrawal management; brief interventions; referral.
Pharmacists	Provision of advice and information; safe medication; provision of sterile injecting equipment.
Occupational therapists	Enhance access to employment, rehabilitation.
Ambulance officers	Responding to heroin and other drug overdoses; responding to drug related accidents and violence.
Psychologists	Counselling people who use drugs and others affected by drug use; advice; responding to problems that pre-date and exacerbate drug use (eg; sexual abuse, other trauma).
Social workers	Counselling to people who use drugs and others affected by drug use; family support and interventions meeting welfare, finance, housing and other needs of people effected by drug use.
Youth workers	Providing information; protective care; juvenile justice; accommodation assistance and family support.
Welfare staff	Shelter; finance needs; shared care; family support.
Aboriginal health workers	Identification; advice; counselling; community interventions; shared care.
Police and Criminal Justice	
Police	Ensuring safety of intoxicated people; referral/diversion to health system.
Corrections Staff	Counselling; advice; referral to drug specialist and other services.
Education	
Teachers	Information about drug use and effects; informal counselling and advice; protective care; referral.
School Support Staff	Providing advice, referral and counselling about drug use by students and others who affect the student.

(Allsop et al 1998)

While a variety of professionals and organisations have been identified, the role of medical and hospital services (eg; nurses, GPs, emergency medicine staff and psychiatrists) has been emphasised as particularly important. Allsop et al (1998) identified other important groups, or subcategories of professionals, including peer and drug user groups, telephone counselling and crisis services, infectious disease and Sexually Transmitted Diseases staff and obstetric and gynaecology staff. The literature suggests regional and remote staff form a special case due to isolation from community resources and referral options, rapid staff turnover and lack of institutional support and supervision (Dwyer, Allsop and Reilly 1998). The argument for service collaboration is even stronger in rural and remote WA, both for providers and people accessing these services.

Important Questions

- What needs to be done to ensure that the relevant broad human service professionals and organisations respond effectively to people affected by drug use?

3.2 Links Between Drug Specialist and Other Human Services

Some people affected by drug use sometimes require, or choose to use, the particular resources of specialist drug services. They usually have a broader range of needs (eg; housing, finances, general health and legal). If they are to adequately meet the needs of their clients, specialist drug services need to collaborate with other human services for the benefit of the client. Models of shared and coordinated care and case management can guide such collaboration.

Specialist drug services also have a critical role supporting other human service providers through:

- development, trialing and dissemination of innovative approaches to responding to drug related harm;
- facilitating the development of the skills of professions and organisations. This can be through ensuring 'drug studies' are included as part of pre-service, post-graduate and continuing education and provision of expertise, consultancy and support (eg; through clinical advisory services; supervision; mentorships; practice audits); and
- shared, or coordinated, care of individual clients who are located with other human service providers.

Important Questions

- How can we better integrate specialist drug services with broad human service providers so that:
  - integrated care is provided for clients; and
  - specialist drug services provide development and support to broad human services?
- How can services better coordinate their activities to ensure a more appropriate response to local issues?

3.3 Barriers to, and Facilitators of, Effective Practice in Responding to Drug Related Harm

By engaging the wide range of human services we can significantly increase the level and continuity of care, and coincidentally help those services operate more effectively. Unfortunately, there is often an artificial segmentation of service provision based around organisational structures rather than individual need. This might be for a variety of reasons. Organisations may not have relevant policies or performance indicators, or the available resources. Individuals may feel they do not have the knowledge or skills. These reasons can be divided into:

- professional factors;
- personal factors; and
- organisational factors.

3.3.1 Professional Factors

A number of factors can act as barriers, including:

- lack of organisational or professional support and endorsement. Consequently, staff do not see responding to people affected by drug use as their role;
- lack of support in responding to drug issues (eg; even when a person does attempt to respond to drug problems, they find it difficult or impossible to get supervision, support or advice);
- lack of adequate training about drug related harm. Most professions do not have drug issues as a component of core training;
- lack of incentives to respond to drug related harm;
- many of the relevant groups are already overstretched and stressed. The capacity to take on new or extended roles is limited, unless resources and supports are put in place; and
- lack of professional champions to support change.

3.3.2 Personal Factors

Many groups hold negative and pejorative views about people who use drugs, which can lead to discrimination and reduced service provision ('They brought it on themselves, why should we help?'). The marginalisation of people affected by drug use has contributed to belief systems developing about the value of responding (eg; 'There's no point helping - they're too difficult') and the most effective ways to respond to drug users, irrespective of what the evidence tells us ('A tough approach is always best').

Even when a person is highly skilled and well supported, such attitudes will militate against effective practice. Negative stereotypes and attitudes towards people affected by drug use are major barriers to the provision of effective responses to drug related harm.

3.3.3 Organisational Factors

Simply developing the expertise and enthusiasm of individuals, without addressing organisational factors, will not ensure effective responses. A number of organisational factors can act as barriers, including:

- often, the relevant organisations are managed, funded and have priorities set by different government departments. There is a lack of common policy, goals or models of working with people affected by drug use. These factors inhibit communication, collaboration and continuity of care;

- competitive tendering and funding processes reduce the likelihood of collaboration between organisations. The funding models do not encourage partnerships, multidisciplinary approaches or holistic care for clients, even within the specialist drug sector, let alone across human services. It is currently possible for a client to have drug use addressed in one agency and legal problems in another, health needs in another, and family and housing concerns in several others, each time enduring a process of assessment and needs identification;

- many organisations do not have responding to drug related harm as part of their performance indicators or funding contracts, even when they see large numbers of people affected by drug use. Consequently, there is often no incentive or policy about responding. Indeed, some organisations specifically exclude people who use drugs from their service; and

- even when organisations do intend to respond to drug related harm, it is difficult to do so within existing resources and with limited access to expertise. There is also very little to guide quality practice for individual staff and organisations.

Given that effective interventions often involve more than one organisation, it might not be sufficient to tackle such barriers in one group of individuals or one organisation. Change may need to occur across several organisations or sectors. For example, to ensure effective practice in pharmacotherapy, we may need to address staff and organisational structures in a range of services, such as hospitals, psychiatrists, GPs, pharmacists, police and so on. In short, effective practice will often mean changing the system, not just individual practitioners or organisations.

Important Questions

- How can the various government and non-government organisations be persuaded to take ownership of the need for an integrated treatment approach?

- How can existing resources and services be structured to better respond to people affected by drug use and what additional resources and structures will be needed?

- How can partnerships be facilitated across the various service providers and professional groups?

- How can models of shared care, agreed goals and standards of practice be developed across human services to best assist people affected by drug use?

- What can be done to ensure that 'drug studies' become a core part of professional education curricula?

- What are the most effective education, training and support strategies to change practice?

- What continuing education, support, supervision and consultancy services are needed for the broad human services to enhance expertise?

3.4 Effective Practice

3.4.1 Developing and Maintaining Effective Practice

Traditionally, much professional education and training has focussed on influencing individual beliefs, attitudes, knowledge and skills. While these factors clearly influence professional behaviour, organisational, economic and community environments are important (National Health Service Centre for Reviews and Dissemination, 1999). The most effective education and training programs are likely to have limited impact if a highly skilled and enthusiastic graduate returns to a work environment that does not value the newly acquired skills.

Neither should we simply expect organisations to change in political and social environments that do not support this change. It is not helpful to simply argue that mental health staff should respond to drug related harm if performance indicators, management structures and the expectations of government and the broad community are not supportive.

Organisations can be assisted to support effective practice by investing in:

- organisational development;
    - ensuring funding formula and contracts include performance indicators on responding to drug problems and organisational collaboration;
    - ensuring management clearly articulates support at the highest level;
- workforce development;
    - making knowledge and skill development strategies available, coupled with supervision, support and/or mentorships. It is important to recognise that people learn new skills in a variety of ways;
    - developing support systems for staff (eg; supervision, access to expertise, mentorships, clinical advisory services);
    - ensuring access to information;
    - developing and disseminating practice guidelines to facilitate informed decision making at the individual client or organisational levels. These are most effective when adaptable to the local context;
- development and maintenance of partnerships;
    - develop and implement models of shared care;
    - identify and support expertise and champions within a profession and organisation;
    - develop and maintain lines of communication between key stakeholders. This includes:
        - developing memoranda of understanding and explicit documentation of expectations;
        - resources committed to collaboration;
        - expertise shared; and
        - leadership.

Resource allocation may be required for these strategies to be implemented and maintained (based on NSW Health, 2000).

4.0 Summary

There is a need to provide specialist drug services. A range of other human service providers also has relevance for people affected by drug use. If successful responses to such people are desired, it is critical that we enhance the capacity of these services. Those who attend specialist drug services have needs outside of drug use. Attending to these needs, through collaboration across the services, improves outcome. Some people do not attend specialist services, but use other human services. Ignoring drug use in these services can compromise care. Responding to drug use across the broad human services can improve outcomes for clients and improve the general effectiveness of the services.

To engage broad human services, we need to attend to organisational, personal and professional factors. Such activities require consideration of the ways in which these services are resourced and supported and how all relevant services, including specialist drug organisations, collaborate and integrate service provision.

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