"Just another manic monday"

The challenge of working with clients with alcohol and other drug issues in community service organisations

Teresa Hinton
Social Action and Research Centre Anglicare Tasmania

ANGLICARE TASMANIA

"Just another manic monday"

The challenge of working with clients with alcohol and other drug issues in community service organisations

Report title by Jon Morrison
Design by Clare Bradley

ISBN
PB: 978-1-921267-10-9
Web: 978-1-921267-11-6

For further information contact:
The Social Action and Research Centre
Anglicare Tasmania
GPO Box 1620
Hobart 7001

Tel: 6234 3510
Fax: 6231 9589
Email: t.hinton@anglicare-tas.org.au
Website:www.anglicare-tas.org.au

Acknowledgements

The author would like to thank the members of the Project Reference Group, Roslyn Alexander (Alcohol and Drug Service), Kathleen Flanagan (Anglicare), Belinda Jones (Anglicare), Leon Liaubon (Glenorchy Illicit Drug Service), Kris McCraken and Jenny Siddons (Alcohol, Tobacco and other Drugs Council of Tasmania) and Georgina McLagan (Centacare) for their advice on the development of the research and the recommendations which have grown from it. The author would also like to thank David Clements from the Alcohol, Tobacco and Other Drugs Council of Tasmania for his time in considering the wider implications of the research findings.

The research findings, conclusions and recommendations of this report are those of Anglicare and should not be attributed to any members of the reference group. Any errors in the report are the responsibility of the author.

The author would also like to thank all the Anglicare workers who gave up their time to participate in the research and to freely express their views. In particular the author is very grateful for their participation in designing the survey and identifying and approaching clients to participate in the research. Especial thanks must go to Jon Morrison for finding such an appropriate title for the report. Most importantly the author would like to thank those service users who agreed to take part and to share their knowledge of services. Theirs is a most valuable contribution.

Abbreviations

ATDC	Alcohol, Tobacco and other Drugs Council of Tasmania
ATOD	Alcohol, tobacco and other drugs
CSO	Community service organisation
DEN	Drug Education Network
DHHS	Department of Health and Human Services, Tasmania
GIDS	Glenorchy Illicit Drug Service
NCETA	National Centre for Education and Training on Addiction
IDRS	Illicit Drug Reporting System
NDSHS	National Drug Strategy Household Survey
NGO	Non-government organisation
NMDS	National Minimum Data Set – Alcohol and Other Drug Treatment Services
SAAP	Supported Accommodation Assistance Program

Contents

Contents continued

Executive Summary and Recommendations

Problematic alcohol, tobacco and other drug (ATOD) use is associated with a range of indicators of social exclusion including homelessness, unemployment, under-achievement at school, crime, family breakdown, financial problems and mental health problems. This means that community service organisations (CSOs) operating a range of programs to respond to these needs inevitably encounter ATOD issues among their clients. This research quantifies the extent to which workers in Tasmanian CSOs, outside the specialist ATOD sector, work with clients who have substance use issues. By profiling the work of one CSO, Anglicare Tasmania, it explores the nature of that work, the views of clients and how the response to these issues can be made more effective.

The research found that in almost half (46%) of all client contacts in a two week period Anglicare workers were dealing with problematic alcohol and drug issues which impacted negatively on the service which they could provide and on the outcomes for their clients. Given the stigma attached to problematic use and dependency these were not issues that clients presented with, rather they emerged as relationships developed with workers. However they meant that clients' accommodation and employment options were severely compromised, that budgets and relationships were strained and that mental health problems were exacerbated. Neither is this a population who readily seek and gain access to specialist ATOD services like counselling, withdrawal and rehabilitation services. Fifty nine per cent of this population either did not identify that they had a problem or if they did were not ready to begin to tackle it.

Workers spend up to one fifth of their contact time with ATOD affected clients making interventions directly around substance use. This is across accommodation, employment, disability, counselling, family and mental health support programs. These interventions include establishing a positive rapport and stabilising what are often crisis situations, providing information, promoting the motivation to change, harm minimisation and referring on to other services. Yet the research also documents how workers struggle to provide an effective response and are unable to offer a model of service which fits with the needs of many of these clients. They only rarely can offer the intensive support that many clients require, do not necessarily have the training and skill levels to provide effective interventions and are limited by shortfalls in access to specialist expertise and services and appropriate accommodation options. These difficulties are indicative of a wider Tasmanian ATOD sector which has suffered from a lack of strategic planning and underinvestment in infrastructure and where the role of CSOs in working with this population is unrecognised and unsupported.

Clients themselves highlighted the difficulties they faced in acquiring the motivation to address ATOD issues, their reluctance to seek help and, if they do, the problems they can encounter in trying to access appropriate specialist services in a timely manner. They also highlighted the importance to them of positive relationships with workers in CSO services and how these can not only assist them to address crisis situations but also to operate as a 'vehicle for hope' so that they are able to believe that change is still possible.

Given the extent of problematic use, its impact on individuals, families and communities and the limitations of the current ATOD sector in Tasmania these matters are urgent. The experience and expertise of CSOs in engaging with disadvantaged and excluded populations means that they have a unique and important role in working with problematic alcohol and drug use and providing early intervention responses, particularly with those who are not ready or willing to access the specialist sector. Using the views of clients about the key factors integral to providing quality ATOD services, this report makes a number of recommendations about how the role of CSOs can be reinforced to provide a more effective response and how this can help to build a more comprehensive and coherent ATOD sector in Tasmania.

Recommendations

- **Recommendation 1:**That the State and Federal Governments acknowledge the significant role played by non-specialist CSO services and other human services systems in addressing ATOD issues..

- **Recommendation 2:** That the Department of Health and Human Services, through the Future Directions Plan, invest in additional resourcing to support collaborative practice across the specialist and non-specialist ATOD sector. This will entail:
    - instigating a cultural shift to promote joint working between specialists and non-specialists and the building of local partnerships to improve client outcomes;
    - ensuring that time to network is recognised and resourced as integral to the delivery of better quality outcomes for clients;
    - informing clinical staff about the role of CSOs in working with ATOD issues and how to engage in collaborative practice;
    - ensuring that confidentiality and privacy issues do not become a barrier to effective joint working; and
    - implementing a monitoring and reporting mechanism to ensure this is achieved.

- **Recommendation 3:** That the Department of Health and Human Services allocate beds in psychiatric wards for those with co-morbidity issues supported by specially trained workers.

- **Recommendation 4:** That the Department of Health and Human Services develop a comprehensive workforce development strategy applicable to all non-ATOD funded agencies working with clients with problematic ATOD use.

- **Recommendation 5:** That the Department of Health and Human Services conduct a state wide survey of non-specialist workers' training needs specific to ATOD use to guide and inform future service planning and provision.

- **Recommendation 6:**That the Department of Health and Human Services invest in supporting non-specialist CSOs to access appropriate ATOD training and skill development.

- **Recommendation 7:** That the Department of Health and Human Services' Quality and Safety Framework incorporate skills development in the ATOD workforce as a core component of improving client outcomes.

- **Recommendation 8:** That CSOs review all policies and procedures relating to clients with alcohol and drug issues including the approach to intoxicated clients and supervision and debriefing mechanisms for staff engaged in this work.

- **Recommendation 9:**That CSOs undertake a staff skills audit to identify where skills in dealing with ATOD issues are located in the organisation so that other staff can draw upon them.

- **Recommendation 10:** That CSOs ensure that a basic introduction to ATOD issues is incorporated into any induction processes.

- **Recommendation 11:** That the Department of Families, Housing, Community Services and Indigenous Affairs extend their current initiative to train Aboriginal workers in alcohol and drug issues to non-Aboriginal workers working with Aboriginal clients.

- **Recommendation 12:** That CSOs encourage staff to take up training and improve their skill levels in working with Aboriginal clients with alcohol and drug issues.

- **Recommendation 13:** That there is significant investment in the expansion of the ATOD treatment sector across Tasmania as outlined in the Future Directions five year plan.

- **Recommendation 14:** That the Department of Health and Human Services, as a matter of urgency, establish a mechanism for providing consultation liaison services including specialist advice, guidance and on-call support to non-specialist CSOs working with clients with ATOD issues. This should include the ability to offer on site consultancy, a community training element and on-going staff mentoring in the ATOD field.

- **Recommendation 15:** That the Australia and Tasmanian Governments in the National Affordable Housing Agreement include a commitment to funding that will allow for an increase to 100% in the proportion of people discharged from hospitals and detoxification and residential rehabilitation facilities into confirmed, secure and appropriate accommodation.

- **Recommendation 16:** That the Department of Health and Human Services resource the development of a model of consumer advocacy for people with alcohol and drug issues so that their experiences and views are routinely taken into account in the planning, development and delivery of policy and services.

1. Introduction

Community service organisations (CSOs) in Tasmania respond to a wide range of needs including homelessness, mental health problems, disability, access to employment, financial and relationship counselling and family support. They are often the first port of call for troubled people and can be the gateway into more specialist services. Although rarely a presenting problem workers report that they regularly encounter alcohol and drug issues among their clients which become a strong underpinning element in support needs and which workers struggle to address. Despite this there is a dearth of research which explores the impact on and response of generic welfare services to alcohol and drug use (RADAR, 2007) and how this response might be improved. This research sets out to address this gap.

1.1 Background

Tasmania, like the rest of Australia, is a drug using society where alcohol, tobacco and other drugs (ATOD) are used medically, therapeutically and recreationally. Some people get into problems with their ATOD use where it impacts negatively on their lives and the lives of those around them. This problematic use is strongly associated with a range of indicators of disadvantage and exclusion including unemployment, underachievement at school, high rates of crime and incarceration, difficulties in securing and maintaining housing, family breakdown, financial problems and long term health problems (House of Representatives, 2003). It is also associated with guilt, shame, isolation and high social costs. A recent study has estimated the social costs of drug abuse in Australia in the financial year 2004-05 at $55.2 billion (Collins & Lapsley, 2008) with alcohol accounting for $15.3 billion, tobacco $31.5 billion and illicit drugs $8.2 billion. Tasmania's per capita share of these costs can be calculated at $1.34 billion each year. This is equivalent to the entire Department of Health and Human Services (DHHS) budget allocation. This means that tackling problematic ATOD use is an urgent issue for Tasmania.

Commonwealth and state programs across Australia fund a range of strategies and interventions to tackle problematic use. Yet despite the allocation of significant resources towards supply reduction, demand reduction and treatments ATOD use remains a major concern for the community and there are no simple responses to these issues. Indeed the national position has been moving towards a zero tolerance approach with, for example, controversial calls for the children of addicted parents to be removed into care (House of Representatives, 2003) rather than investing resources in treatment services. As complex and deeply entrenched psychosocial behaviours consumption patterns remain problematic. At the same time services cannot meet either the need or the demand for treatment and in an environment where there are shortfalls in the availability of specialist services, CSOs struggle to provide an appropriate and effective response. This is despite the fact that CSOs can be ideally placed to provide a gateway into specialist services and/or to undertake intervention work to ameliorate the harms caused by substance use and to prevent problems escalating.

The DHHS recognised the difficulties experienced by the ATOD sector in meeting the expectations of clients, families, service providers and the community and commissioned a review to identify a model of best practice for service provision in this area in order to meet these needs (HMA, 2008). The review revealed a service system in urgent need of intervention and outlined broad strategic directions to develop and build the capacity of the sector, including the capacity of CSOs. The review did not however provide concrete recommendations or an explicit path of structural reform. This leaves the way forward unclear and open to debate, particularly for CSOs grappling with these issues. At the time of writing the Government had instigated a consultation process to finalise a plan for developing services over the next five years (DHHS, 2008).

1.2 Aims of the Research

This research aimed to provide a clear account of the actual and potential role of non-ATOD funded Tasmanian CSOs[1] in responding to the needs generated by substance use across a broad range of services. In particular it aimed to:

- profile the nature and extent of alcohol and drug issues presenting to CSO services including changes over time;
- assess the costs and impact on CSO service delivery of alcohol and drug issues and shortfalls in specialist services;
- highlight approaches and gaps in service provision to clients presenting with these issues and what this means for the wider ATOD sector; and
- formulate recommendations about how best to improve the quality of response to these clients.

Although the research is relevant to service delivery across the health and human services field it describes the work of one Tasmanian CSO, Anglicare, in order to address these issues in detail and it focuses on front line service delivery from both a worker and a client perspective. The research was conducted over a seven month period from January to July 2008.

1.3 Anglicare Tasmania Services

Anglicare Tasmania operates a range of services across the State in five main service streams (see Appendix). They are:

- accommodation support services including assistance for those who are homeless or at risk of homelessness, private rental support to assist low income earners into private rental accommodation, supportive residential facilities, an emergency accommodation telephone service and specific services for young people;
- disability support and aged care services including group homes for people with acquired brain injury or spinal injury, support to those living independently in the community and group homes for people with intellectual disabilities;
- counselling and family support services including financial and relationship counselling, assistance with gambling and services for young people at risk of homelessness and family conflict;
- employment support services including assistance to those with disabilities, young people at risk of homelessness and Centrelink clients to access employment; and
- mental health support services including two social support programs and an intensive outreach program, residential facilities for those with long term mental health problems and a community housing project.

[1] Throughout this report the term 'Tasmanian CSOs has been used to refer to not-for-profit non-government programs and services which fall outside the specialist ATOD sector and are not ATOD funded.

The response of these services to alcohol and drug issues is the subject of this research.

In addition Anglicare Tasmania operates two specialist alcohol and drug services. The Glenorchy Illicit Drug Service (or GIDS) provides support and counselling to young people with alcohol and other drug issues, community education and support for families. The Court-Mandated Diversion Program provides specialist support and counselling to offenders of drug-related crimes. As specialist alcohol and drug services, they have not been included in this research.

1.4 Research Methods

The research proceeded in four main stages:

- **interviews with Anglicare staff** about their experiences of dealing with ATOD issues and the impact it has on effective practice. Altogether over 120 staff were interviewed from across the state and from across the spectrum of Anglicare services using a semi-structured interview schedule. This included staff from accommodation support services, counselling and family support, employment support, mental health services and disability support services – a total of 38 different programs and services (see Appendix). They were asked for their views on the number of clients with ATOD issues, changes over time, the impact on service delivery and job satisfaction and how to improve the response to these clients.

- **a snapshot survey** to quantify the issues. A two-page survey form was developed in conjunction with staff in order to monitor all client contacts over a two week period in April 2008 across the spectrum of Anglicare services. Forms were completed after contact with each client for both face-to-face and telephone contacts. Workers were asked to operate with a 'heightened awareness' of alcohol and drug issues but not to alter their work practices in any way or to ask any additional questions. Data was collated on 1,306 client contacts in appointment-based services from across the state providing a rich source of information about the prevalence of ATOD issues and their impact as well as basic information about client characteristics and service responses including worker time involved in making interventions. In addition data was also collected about ATOD issues arising in 62 shifts in residential and social support programs. The forms were analysed using a survey analysis package, Statistical Package for Social Sciences.

- **in-depth interviews with a small sample of service users** to explore their pathways into services, perceptions of service responses to ATOD issues and their views on the kind of assistance they would like to see available. A range of programs were asked to identify 'typical' clients with ATOD use and invite them to participate in the research. A total of 11 interviews were carried out using a semi-structured interview schedule. They included both men and women spread across the age spectrum and with a variety of ATOD needs and difficulties. Interviews took approximately one hour and clients were remunerated for their participation.

- **interviews with other relevant stakeholders**. Although the research focussed on Anglicare services, there was a concern that it should be relevant to the Tasmanian CSO welfare sector generally. This entailed conducting interviews with other key CSOs to ensure that their experiences in service delivery did not differ markedly from those of Anglicare services.

Research, policy and statistical information, including any data already collected by Anglicare services about alcohol and drug issues, was collated as a backdrop to the research. The project was guided by a reference group with representatives from the Tasmanian Alcohol and Drugs Service, the ATDC, Centacare (another welfare CSO), an alcohol and drug worker and an Anglicare service manager.

Interviews with staff and clients were taped and transcribed. Quotes from interviews have been used throughout the report to illustrate experiences and perspectives. However all names and identifying details have been changed to protect the privacy of individuals.

1.5 Definitions

What is problematic use? It is usually identified when usage reduces or threatens the health and well being of the individual and involves injury, loss of income or employment and relationships and/or where there is harm to society either economically or socially through the impact on health or law enforcement. Definitions vary significantly across studies and surveys and the point at which substance use moves from being experimental or recreational to problematic is often difficult to determine. Practitioners generally refer to the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) as the standard for classifying substance users. Other studies have used prevalence estimates based on national definitions of, for example, risky alcohol consumption.

For the purposes of this research workers were asked to define whether their client was a substance user and whether their usage was problematic or not. This means that the data presented in this report relies on worker perceptions which can be coloured by training and skills levels as well as values. Judging whether intake is problematic or not can reflect the worker's own use and what they consider to be the norm and this can differ widely from the views of the clients themselves. These factors must be taken into account when considering the findings of the research.

What is the ATOD sector and what is ATOD treatment? In this report these terms are used to refer to specialist drug and alcohol services like clinical treatment, residential rehabilitation, drug counselling and those services funded by ATOD funding streams including services located in the CSO sector. However, given that drug use behaviours are complex and strongly linked to issues like housing, poverty, co-morbidity and socio-economic circumstances human service systems not formally funded for ATOD work regularly encounter ATOD issues with their clients. This means that no single intervention or sector is likely to have a significant impact on problematic use. Rather it requires sustained and comprehensive action on a number of fronts (Spooner & Hetherington, 2004), offering an holistic approach which can address multiple health, social, economic and other needs. For instance in terms of effective treatment, providing a secure home could be seen as equally effective and valid as safe withdrawal services. It also means that a variety of professions and both specialist and generalist workers are involved in responding to alcohol and drug issues including nurses, doctors, psychologists and social workers as well as frontline welfare workers. The challenge then becomes to create a structured system from this diversity and join it up so that both specific drug treatment services and housing or other welfare services are seen as different parts of the same system and can work together to create a smooth pathway through services.

1.6 Alcohol, Tobacco and Other Drug Use in Tasmania

Information about alcohol and other drug use comes from two main sources – data about those seeking treatment and data from population surveys. The key mechanisms for collecting this data are:

- **Alcohol and Other Drug Treatment Services National Minimum Data Set (NMDS)**. This is a nationally agreed set of common data items collected by government-funded service providers for clients registered for alcohol and other drug treatment in all jurisdictions. The most recent collection (2005-06) has data based on 1,512 closed treatment episodes in 10 alcohol and other drug treatment services in Tasmania. Using treatment figures however is problematic because it is assumed that they are generally a poor reflection of actual problematic use.

- **The National Drug Strategy Household Survey (NDSHS)**. This is the most comprehensive data collection on licit and illicit drug use patterns, attitudes and behaviours in the Australian population. Six surveys have been undertaken since 1985 and the latest survey conducted in 2004 covers over 29,000 Australians living in residential households[2]. However the NDSHS does not capture a significant proportion of the illicit drug using population – those who are homeless or institutionalised.

A number of other surveys and databases provide some information about drug use among sub-sections of the population including minority and disenfranchised groups like those involved in the criminal justice system or psychiatric care. These databases include the Illicit Drug Reporting System (IDRS) which collects information about illicit drugs through interviews with those regularly injecting and from professionals in drug related fields. It includes information about problematic substance use among Indigenous people (ABS, 2004). There are also data sets on the number of hospital episodes and bed days related to drug use and drug related deaths.

What these data sources show is that substance use in Tasmania largely tracks national trends. The key facts are:

- tobacco and alcohol are the most widely used drugs in Tasmania and cause significantly more harm than others including high rates of mortality and morbidity (AIHW, 2007).

- tobacco is the leading preventable cause of mortality and morbidity in Australia and the NDSHS shows that Tasmania has the second highest rate of daily smoking (after the Northern Territory) with 21.5% of the population aged over 14 years smoking daily compared to the national average of 17.4%. Seventeen per cent of Tasmanian adolescents are smokers and there are increasing rates among 16-17 year old females (Cancer Council of Tasmania, 2003).

- the state has high rates of risky drinking with 40.1% of the population aged over 14 years risking alcohol-related harm in the short term compared to 35.4% nationally (AIHW, 2005).

- overall illicit drug use in Tasmania mirrors the national average and the numbers of people who self-report ever using illicit drugs is proportionate to that of other jurisdictions. However recent data (Bruno, 2004) highlights some important differences:

[2] The 2007 survey is due to be published in October 2008.

- use of pharmaceutical products such as pain killers and psycho-stimulants is proportionally higher in Tasmania.

- use of heroin and cocaine is lower than other jurisdictions.

- the injection of methadone syrup and illicit physeptone is recorded as the highest in Australia.

- use of cannabis and crystalline methamphetamine (or 'ice') is comparable to the prevalence nationally. There is however anecdotal reporting of the decreasing age of cannabis users.

- accidental death due to opioid use is significantly higher in Tasmania – with an average of 53.7 per million people compared to the national average of 32.5 per million. This is accompanied by dispensing rates of opioids which are 300% the national rate suggesting an urgent need to address this with the medical profession.

- there are clear indications that the ecstasy market in Tasmania is expanding demonstrated by increasing seizures by the police (AIHW, 2007). However the prevalence of ecstasy use is too low to reliably identify trends.

- treatment data (AIHW, 2007) shows that alcohol is the drug most commonly involved in treatment episodes (38%), followed by cannabis (34%), amphetamines (12%) and opioids (11%). Morphine accounts for 5% of treatment episodes. Men are more likely to access treatment than women and account for 60% of all closed treatment episodes and the median age of those seeking treatment for their own use is 30 years. The most common form of treatment provided is counselling (62% of episodes) followed by information and education (17%) and rehabilitation (8%).

Socioeconomic status is strongly associated with substance use although research has been unable to conclusively establish a causal link between drug use and poverty. For example 33% of men and 28% of women in the most disadvantaged areas report daily tobacco smoking compared to 16% of men and 11% of women in the most advantaged areas (ABS, 2004). The Victorian Alcohol and Drug Association (VAADA, 2003) have made some key points about this relationship and what it means for appropriate interventions:

- problematic use is associated with difficulties in gaining and retaining employment, finishing school or acquiring qualifications. This means adequate resourcing is required for employment programs for people with these problems.

- the cost of drug treatment and pharmacotherapies can be a significant burden for those living on low incomes. This means adequate funding is required for drug treatment, bulk billing and subsidies for pharmaceutical drugs and pharmacotherapies.

- illegal drugs and high rates of imprisonment affect access to employment. This suggests enhanced funding of drug diversion programs for those convicted of non-violent minor drug related offences is required to break the cycle of drug use and poverty.

- a history of use can be a barrier to securing affordable housing particularly in the private rental market which again can impact on access to employment. This means housing assistance programs are required for those leaving treatment.

- breakdowns in family and support networks which occur due to drug use mean a higher risk of poverty. This means more support programs are required.

These issues are reflected in the recent review of ATOD services in Tasmania (HMA, 2008) which undertook a survey of 41 government and non-government welfare organisations working outside the specialist ATOD sector. This showed that a significant proportion of clients presented with substance use. Indeed for the DHHS's Children and Families Division, crisis accommodation, correctional primary health services and mental health services it was more than half. Forty-five per cent of these organisations indicated that they provided specific alcohol and drug interventions including health promotion, information and referral to the specialist sector. They also indicated that substance usage had increased.

As well as socio-economic disadvantage generally some sub-groups in the population have particularly high prevalence rates of problematic use. These groups are:

- **people with mental health problems** where drug use is very common and reduces the chances of recovery while the mental illness makes it harder to give up. For example there is high correlation between mental illness and tobacco smoking where people with mental health problems are twice as likely to smoke as other people. Those with schizophrenia have a smoking prevalence of 90%. Indeed people with mental illness consume 42% of all cigarettes smoked (SANE, 2007). A recent study (Department of Health and Ageing, 2007) has pointed to the need for an urgent national mental health, alcohol and drug health system to be developed which is adequately resourced to integrate treatment, recognise illicit drug users as mental health service users and integrate treatment options.

- **homeless people** where substance use can be a key factor in becoming homeless or where the experience of homelessness leads to drug use. A survey of homeless people in inner Sydney refuges found that over one third interviewed were alcohol dependent and one third were dependent on or using other drugs in the previous 12 months (Teesson et al, 2000). Nineteen per cent of Supported Accommodation Assistance Program (SAAP) clients have reported substance use problems and these figures are likely to be an underestimate as clients do not necessarily disclose these issues (AIHW, 2007).

- **young people**. Patterns of substance use tend to be set in adolescence. In contrast to national trends for other age groups the prevalence of daily smoking is increasing among those aged 14-19 years from 11.4% to 17.2% between 2001 and 2004 (Bruno et al, 2007). Alcohol is the most widely used substance after tobacco and there are high rates of binge and 'at risk' drinking among young people. The percentage of 16-25 year olds drinking at harmful levels has increased from 16% in 1999 to 21% in 2005. The most widely used illicit substance is cannabis with recent use reported by 14% of school-age students (White et al, 2004).

- **Aboriginal and Torres Strait Islanders**. Over 60% of Indigenous people drink at harmful levels (AIHW, 2005) and half are daily smokers (ABS, 2004). The Government have recently announced $14.5 million for the Indigenous Tobacco Control Initiative to close the gap in smoking rates between the Indigenous and non-Indigenous population.

The DHHS has stated that there are significant challenges in achieving a sustainable and best practice ATOD service sector in Tasmania. Adding to this challenge is the complex way in which ATOD use interacts with other areas like children and family services, mental health, housing and homelessness, disability and the police and justice sector.

1.7 The Policy Environment

The principle of harm minimisation forms the basis of Australia's national drug strategy and underpins policies and programs. The thrust of policy is to both prevent or delay the onset of substance use and to moderate and intervene in the risks and harms which can follow if it does occur. This means approaches which focus on supply reduction, demand reduction and harm reduction for individuals and communities. The key strategies and initiatives which guide policy and service provision at a national level are:

- the **National Drug Strategy 2004-2009** (Ministerial Council on Drug Strategy, 2004). This is the national policy framework which focuses on both licit and illicit drugs. It is based on harm minimisation principles and identifies a number of priority areas including prevention, supply reduction, reduction in use, improved access to treatment, workforce development, stronger partnerships and the identification of and response to emerging trends. The **National Illicit Drug Strategy** (NIDS) forms a significant part of the National Drug Strategy and in addition to supply reduction focuses on co-morbidity issues, research into prevention and treatment, support to families, diversion from the criminal justice system and the expansion of treatment programs. There is also the **Illicit Drug Diversion Initiative** (IDDI) which aims to divert minor drug offenders from the criminal justice system into compulsory assessment, treatment and/or education.

- the **National Co-morbidity Initiative** (NCI). This has been developed by the Commonwealth Department of Health and Ageing. It aims to address the high prevalence of co-morbidity in the Australian population by improving coordination across mental health and drug treatment services, developing best practice guidelines for service delivery and increasing professional education and training. It incorporates the **Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative** which aims to build capacity in CSOs to better identify and respond to people with coinciding mental illness and substance use issues. A Tasmanian Co-morbidity Project for those with substance use and mental disorders was established in 2004-05 to provide specialist training and support.

- the **National Preventative Health Taskforce** has recently been announced. It is to develop a national preventative health strategy by 2009 with three priority areas – obesity, tobacco and excessive consumption of alcohol.

- a **National Binge Drinking Strategy** to address binge drinking among young Australians. This will invest in community level initiatives to confront the culture of binge drinking, intervene earlier to assist young people in difficulties and fund advertising to confront young people with the costs and consequences.

In Tasmania there is:

- the **Tasmanian Drug Strategy 2005-2009**. This outlines whole of government and community activities to reduce the harm associated with drug use. It supports the directions identified in the national strategy and again is underpinned by the principle of harm minimisation. It aims to promote partnerships and collaboration, build capacity, focus on prevention, early intervention and equity of access to services as well as research, evaluation and data collection. It encompasses the development and implementation of:

    - the Alcohol Action Plan with a focus on public education and health promotion, professional training, increased access to treatment and control policies on availability;

    - the Tobacco Action Plan providing a coordinated cross-sectoral approach and reducing take up especially among young people. A Tasmanian Tobacco Coalition was also established to provide the framework for the coordination, implementation and review of the Action Plan.

    - the Psycho Stimulant Action Plan targeting amphetamines, ecstasy and cocaine use and prioritising a reduction in supply, work with the dance industry, information resources and timely interventions.

  There is also the Tasmanian Aboriginal and Torres Strait Islander Complementary Action Plan.

  Government agencies are required to set out how they will contribute to overall strategy through the development of Agency Action Plans which include performance indicators. Implementation and monitoring of the strategy, including the Action Plans, is overseen by the **Inter-Agency Working Group on Drugs (IAWGD)**. It comprises a number of agencies with responsibility for progression of drug related policy, initiatives and services.

- the **Review of Alcohol, Tobacco and Other Drug Services in Tasmania 2008** aimed to provide a model of best practice for the provision of ATOD treatment services in Tasmania. The review identified a service system under pressure struggling to meet the growing needs of clients, shortfalls in pharmacotherapy services and prescribing practices, inadequate resources for early intervention, workforce training and information systems, poor linkages with other sectors and less than optimal use of the CSO sector. As well as a range of service improvements it also recommended the commitment of funding to implement recommendations and $17.1 million has now been allocated from the 2008-09 State Budget. The Review acknowledged that the CSO sector plays an important role in early intervention as people seek their services for particular problems and that this role requires more clarification.

- The Review led to implementing the **Future Directions consultation process** (DHHS, 2008) to finalise a five year plan for developing an effective service system. It outlines a service framework and identifies strategic priority areas for investment. This will lead to the development of more detailed implementation plans.

- the **Alcohol, Tobacco and Other Drugs Council of Tasmania (ATDC)** was established in 2004 and is the peak body representing the non-government, not-for-profit ATOD sector in Tasmania. It provides leadership, support and advocacy for the sector by building capacity and extending opportunities for inter-sectoral collaboration and partnerships. It is currently running a series of projects about professional development, clinical supervision and quality improvement.

1.8 The Service Network

Tasmania has a range of services and programs to respond to alcohol and other drug needs. These are coordinated by the DHHS which also administers funds from the National Illicit Drug Diversion Initiative and National Drug Strategy grants program to CSOs. Services include:

- **a DHHS managed state-wide Alcohol and Drug Service**. This has a strategic and coordination role and provides a range of programs, interventions and treatment services. These include inpatient substance withdrawal, a detox centre, a pharmacotherapy clinic and needle exchange and three regional community teams offering counselling, education and training, information and health promotion, outreach support, a pharmacotherapy program (with GPs and pharmacists) and home detoxification. There is a specialist antenatal clinic at the Royal Hobart Hospital for babies born to substance-using mothers.

- **CSOs funded by government to provide specialist ATOD services**. These include two residential rehabilitation programs run by the Salvation Army and City Mission (which include 'places of safety'[3] services), outreach support, non-medical sobering up facilities in Burnie and Launceston, health promotion initiatives, harm reduction, education and training and youth specific services including alcohol and drug workers in youth health facilities. Holyoake Tasmania assists families affected by addiction and offers education and support programs. The Court-Mandated Diversion Program, introduced in 2007, provides counselling and support through CSOs to those convicted of drug related crimes.

- a **State-wide Needle and Syringe Program** with partnership arrangements with several local councils to provide safe public disposal.

There is also the Hobart Clinic which offers services to private patients and regionally based self-help groups like Alcoholics Anonymous, Al-ANON and Narcotics Anonymous.

However overall at a state wide level the establishment of services has been ad hoc and unplanned and this has resulted in a mix of services which do not necessarily meet needs or demand. There are shortfalls with an inequitable distribution of services across the state particularly in rural and remote areas and with different CSOs in different areas doing different things. There is also a general perception that the south has more services and that the north west is particularly poorly served.

[3] These provide care for those referred by the police who are intoxicated and require support whilst they sober up.

The recent review of ATOD services (HMA, 2008) showed that whilst substance use in Tasmania largely tracks national trends the size of the treatment sector is significantly lower compared to the national average. There are fewer counsellors, clinical psychologists and psychiatrists per capita than elsewhere – perhaps by 50%. This means that many of those in difficulties cannot access suitable treatment services which puts strains on the available workforce and additional pressures on the non-specialist CSO sector.

1.9 Limitations of the Research

This research combined both qualitative and quantitative methods to build up a picture of the impact of alcohol and drug issues on non-specialist CSO services in Tasmania. However the scope of the research was limited by some methodological constraints.

- **identifying problematic use**. As already outlined frontline workers were asked to define whether someone was a substance user, whether their use was problematic or not and their level of motivation to address any ATOD issues they had. No assessment tools were used and clients were not asked specific questions about their usage unless this came up during contact. This means that the data presented in this report relies on worker perceptions which can be coloured by value judgements. For instance, for some workers recreational use of an illicit substance was problematic, for others it was not. It is also the case that substance use may not be identified for some time after initial contact and not until a relationship has developed between worker and client. These issues must be taken into account when considering the findings of the research.

- **response rates**. The snapshot survey aimed to quantify the extent to which ATOD issues were apparent in all client contacts across Anglicare over a two week period. Although the response rate was good and information on over 1,300 client contacts was returned this was a slight shortfall in terms of the anticipated number of client contacts over that period. This shortfall was due to staff absences for leave, sickness and training, the non-attendance of clients for booked appointments and vacant posts. It means that the figures used in this report are likely to be an underestimate of the number of clients with ATOD issues and the extent of the work undertaken in this area.

  There are of course questions about how far a two week snapshot can be representative of Anglicare's work generally and whether it is possible to potentially extrapolate annual figures from the data. Taking into account the slight shortfall in the anticipated response rate evidence suggests that the survey period was typical in terms of workload.

- **representativeness of the data**. The research aimed to gain a comprehensive picture of the impact of ATOD issues across welfare CSOs in Tasmania. In order to explore these issues closely it did this by profiling the work of Anglicare Tasmania which has a broad range of programs spread across the state. This does raise concerns about drawing parallels with the work of other CSOs. In order to counter this interviews were carried out with key organisations to test the validity of the research findings across the sector. Another CSO was also represented on the

research reference group. Indications are that the findings of the research closely parallel the experiences of other CSOs in the state.

The findings of course raise implications for all those working in health and human services in both CSOs and the government sector. This includes child and family, mental health, primary health care, probation and youth justice services to name a few. It is anticipated that all services will be facing similar issues.

- **disability support services**. The full range of Anglicare services were included in the face-to-face interviews with workers. However the interviews showed that there were fewer ATOD incidents in residential and community support services for people with disabilities and difficulties in monitoring those incidents in these environments. This means that alcohol and drug work carried out by disability support workers was not captured in the snapshot survey.

- **talking to clients**. Inevitably the clients who volunteered to participate in the research were those who both identified that they had a problem and wanted to do something about it. In that respect they do not represent large numbers of Anglicare clients with ATOD issues, who could be described as pre-motivational and unwilling or not ready to change. However the sample were able to reflect on their past experiences which included periods of time when they could also be described as pre-motivational. This means they were able to offer valuable insights into how best to work with this population and what is required from services in order to do this work effectively.

The sample is small. This reflects the difficulties workers had in encouraging their clients to participate and the stigma still attached to talking openly about these issues. It also reflects problems many clients have in making arrangements and keeping appointments due to ATOD use.

2. Clients with Alcohol and Drug Issues

Anglicare services do not collect data about alcohol or other drug use on a routine basis. This is for good reasons. For those accessing services for assistance with accommodation, employment and other forms of support substance use is rarely a presenting issue and unless the client identifies these problems during an initial assessment asking directly about them would be considered a barrier to engagement by many workers. Although referring agencies may include this information, if they have it, in reports (for instance in employment services) what data there is is usually confined to support information and recorded in case notes rather than generating statistics. This means that the only way to quantify these issues is to conduct a specific monitoring exercise.

This chapter details the findings both from the snapshot survey of client contacts and interviews with staff to describe the extent to which workers are dealing with alcohol and other drug issues and the nature of those issues.

2.1 Numbers

How many clients with ATOD issues are there? Workers in appointment-based Anglicare services collected data on 1,306 contacts with clients over the two week monitoring period[4] . Forty-six per cent (or 596) of these contacts involved clients identified by workers as having alcohol or drug issues. One third (35%) of client contacts where ATOD issues were identified were generated by clients who had contacted services more than once during the monitoring period. This means that the 596 contacts with alcohol and drug issues translates into 455 individual clients with 76 (or 17%) of these having contacted Anglicare more than once.

In addition to client contacts in appointment-based services detailed information was also collated about 62 worker shifts in two residential and two social support programs. Work around ATOD issues was reported in approaching three quarters (or 73%) of all shifts with 128 service users or ex-service users.

It was left up to workers to decide who was using substances problematically. They described clients who were managing their ATOD consumption well so that it was not having an impact on their life. They also described clients who considered their consumption normal and under control but where it was having a significant impact on their life as well as those where both worker and client agreed there was a problem:

> *There are quite a few who use cannabis and drink regularly but certainly I wouldn't say it's an issue and they don't identify it as having any impact on their way of doing anything. They are buying their groceries, paying their bills on time. It's not impacting on them financially, it's not stopping them from getting out and about. (Mental Health Services)*

> *We have a lot of clients who would say they don't have a drinking problem because they smoke a lot. So they tend to separate the two very clearly. Marijuana is seen as the norm, a daily part of their routine. They don't always acknowledge that this is even illicit, it's just normal. So they don't actually see marijuana as a problem and it's quite often cheaper than alcohol for them. When you say 'not have a drinking problem' what they are actually demonstrating is they binge drink at payment periods but they don't drink daily. (Accommodation Support Services)*

[4] These figures exclude residential and day services, group homes and disability support work in the community.

The number of clients identified with ATOD issues varied between programs from a handful in some counselling services to approaching half of all clients with problematic ATOD use in accommodation support. A residential facility for young people reported nearly 100% of residents had ATOD issues.

Table 1: Programs x Number of Client Contacts with Problematic ATOD Issues

Programs	Number of client contacts with ATOD Issues
Accommodation	266
Employment	142
Mental Health	99
Counselling/Family Support	89
All Programs	596

However, although overall accommodation services were dealing with the most substance use issues, it was employment services closely followed by mental health services which had the highest proportions of their clientele falling into the ATOD-affected population. This could reflect the higher likelihood of ATOD issues being identified in these programs due to the nature of the contact with clients.

Table 2: Programs x Percentage of Clients with Problematic ATOD Issues

Programs	% of client contacts with ATOD Issues
Employment	69
Mental Health	63
Accommodation	41
Counselling/Family Support	28
All Programs	46

Whatever the actual rates, the majority of services described ATOD issues as 'a large part of what we do' and even if the substance use issue was not current many of the clients (14%) had a history of alcohol and drug use which was impacting on their current circumstances.

> *With the clients we see we might have eighty per cent who are currently struggling with alcohol and drug issues but the other twenty per cent have, in all likelihood, at some other time been struggling with it. The majority will say they have a history of drug and alcohol problems. With every client you'll see it as an issue at some point, pretty much almost every client. That's why a lot of the time we don't see it as an issue because it's what you deal with every day. (Accommodation Support Services)*

The snapshot survey showed that the majority of clients with ATOD issues (or 74%) did not present with these problems and although some services, particularly those working with young people, might ask direct questions about consumption the majority do not:

> *It is a question I'll ask, what drugs do you do, how often do you drink? Given their age they are going to be experimenting with drugs and alcohol. They are honest with me because that's what it's all about, what's going on for you. But alcohol and drug issues might be hidden and you only see the tip of the iceberg. We might see heaps of people who actually have drug and alcohol problems but whether it emerges…. (Youth Counselling Services)*

In 50% of the client contacts monitored workers considered that ATOD issues were an underlying or suspected issue which was affecting the client's circumstances. It was something which was likely to emerge over a period of time either because it became obvious (for instance in compiling a budget) or because the relationship of trust which developed with the worker allowed clients to talk about other issues:

> *They don't come in here saying hi I've got a drug or alcohol issue. They come in here saying I've got nowhere to live or I'm getting chucked out. So some don't identify it straight away but it will often come out because their budget is just so bad. So when you really pin them down to where they did spend their money and why they haven't got enough money to pay the rent or how they got into trouble before then it will sometimes come out. So it can be piecemeal. They are not always honest but you usually know anyway. (Accommodation Support Services)*

There are also those who may be hiding substance use because they are concerned it might impact on the kind of service they receive:

> *Generally they don't name that up at the beginning of the support period. They know what their accommodation options are and that we may not offer some things if we're aware they have a drug or alcohol problem because it's inappropriate. (Accommodation Support Services)*

As one family support worker described, it can take a long time to get the bigger picture. One of her clients had been in contact for nine months before she actually mentioned an alcohol problem. This reluctance to name up the problem means that the figures identified in the snapshot survey are likely to be an underestimate of the extent of ATOD issues among clients.

2.2 A Profile of the Clients

Many services found it difficult to identify a typical profile for clients with drug and alcohol issues and said that 'it's right across the board': young people, old people, single people, families. As another worker said 'we get such a huge array of people coming into the service'. They described people with long term dependence, those just using substances recreationally, binge drinkers, those who had not identified a problem, those who were trying to break away from it and those who were relapsing. They described those using substances to cope with difficult situations, depression, anxiety and relationship breakdown.

> *Drug and alcohol issues for a lot of people are about feeling bad about themselves or their circumstances. They are using alcohol and drugs as a way of escaping their unhappy circumstances at the moment but it's not necessarily something they always do or that they want to continue doing. It's used as a means of relieving symptoms of whatever is happening in their lives. (Counselling Services)*

> *I am often working with parents who are battling depression and anxiety and use alcohol as a coping mechanism especially if there's been a past history of abuse of some kind: verbal, psychological, physical, sexual abuse. They are trying to drown their feelings by stepping out of reality for a while and it's having negative consequences. (Counselling Services)*

There were also those caught in the revolving door of crisis and substance use:

> *I have a couple of clients right now who are managing their drug addiction or feel that they have until there is another crisis and then they are back using pretty quickly. There is a lot of getting rid of the habit and then a crisis and it comes back. It becomes very much a vicious circle because to cope with the situation of being in crisis and nowhere to stay they drink. The clients we see don't tend to have a lot of good things in their lives. They are not living happy lives and they happen to have an addiction. (Accommodation Support Services)*

The snapshot survey showed that although more women than men contacted Anglicare during the monitoring period those identified with ATOD issues were slightly more likely to be male (54%) than female (46%). They also tended to be a young population with approaching one fifth (18%) aged under 20 and with under-30s accounting for 44% of all client contacts with ATOD issues. Only 10% were aged over 50 years. Thirty per cent of clients (or 138 individuals) with ATOD problems were contacting Anglicare services for the first time.

Seven per cent (or 31 individual clients with ATOD issues) were identified as Aboriginal or Torres Strait Islanders and two thirds of these clients were women. Again this is likely to be an underestimate as workers do not routinely ask clients for their Indigenous status. In the snapshot survey prevalence rates for problematic ATOD use were higher among Aboriginal clients than non-Aboriginal clients. Forty-five per cent of non-Aboriginal client contacts during the survey were identified as having ATOD issues, compared with 62% among Aboriginal client contacts.

The survey recorded clients using a range of substances. The most common was alcohol which was identified in over half (57%) of client contacts, with 36% recorded as having harmful or dependent use. This was closely followed by illicit drugs (50%). Eight clients were identified as being on methadone programs. Patterns of use varied according to the age and sex of clients. Those using alcohol tended to be older men and males were two thirds more likely than women to be identified as drinking to harmful or dependent levels. Women were more likely to be dependent on prescription drugs (15% compared to 9% among men) and to be using illicit drugs at harmful levels (30% compared to 25% among men). The most common illicit drug used was marijuana but also included amphetamines and opioids. Many clients could be described as polydrug users[5]. This matches both state and national trends.

[5] Polydrug use is the use of more than one drug or type of drug by an individual, often at the same time or sequentially and usually with the intention of enhancing, or counteracting, the effects of the drug.

Table 3: ATOD Use x Type of Substance and Level of Consumption		
Substance	**% of contacts where identified as an issue**	**% of contacts where harmful/ dependent use reported**
Alcohol	57	36
Illicit drugs	50	27
Tobacco	45	34
Prescribed drugs	18	12

Young people were consuming a range of substances from alcohol and tobacco to marijuana, ecstasy and amphetamines as well as valiumn and even some steroid use. The snapshot did identify a group of younger men with a chronic marijuana habit and illicit drug use reached 40% in the under 20s falling to 19% in the 41 plus age group. Workers emphasised how many of this younger population were proud of their drug use, identified with particular substances, and were happy to talk about it.

> *In my experience young people who consume vast amounts of cannabis don't drink, or very little, and those that drink a lot smoke less. There are younger people who do both to excess but usually if they're cone heads then that's it. It's a social thing too like oh no I don't drink, I smoke. I don't like the cones, I love my grog. And then there are those who love everything, ecstasy and whatever they can get. (Counselling Services)*

For many people, including workers, smoking tobacco is a norm and as one worker said 'we don't even think about tobacco and most of my clients have a smoking habit.' This means that the extent of problematic tobacco use is likely to have been underestimated in the snapshot survey despite the fact that it can be a major issue for the majority of service users in many programs. For example clients may be spending up to $200 a week on cigarettes at the expense of food. As another worker said 'it's massive, [but] it doesn't even feature on the Richter scale'.

Despite these being more controlled environments workers in residential services – boarding house accommodation, the youth shelter, supported accommodation for those with disabilities and long term mental health problems also described a broad range of ATOD issues.

> *Alcohol is a big, big, issue and combined with that is usually a mental illness or a disability. Other drugs have also been an issue but we haven't been able to prove it. A lot of them will use outside and come back off their faces and some will smoke it here but it's just proving it. (Boarding House)*

And although these issues were not common in accommodation for people with disabilities when they did occur they could have a significant impact on both workers and other residents.

As Table 4 demonstrates the snapshot survey also recorded a range of other issues for clients dealing with ATOD problems. At the top of the list were financial problems, housing and mental health problems and workers regularly encountered clients with both ATOD and mental health issues. For example employment programs where up to 70% of their clients had ATOD issues also reported similar proportions with mental health problems. In particular tobacco consumption was seen as impacting on almost 100% of clients with mental health issues and as one mental health worker said 'I can't think of a client who doesn't have a tobacco issue'.

There are a lot of instances where drug and alcohol problems are mixed in with mental health issues. That is a regular occurrence, not only diagnosed mental illness but also undiagnosed and personality disorders that we are not trained to recognise. From the training that we have had we have a pretty fair idea that it's more complex than hitting the grog or smoking a joint. It's very often self-medication for something else and that complicates the whole deal. (Accommodation Support Services)

Table 4: Other Issues Impacting on clients with ATOD Issues

Issues	Percentage of client contacts
Financial problems	54
Mental health	52
Housing and homelessness	51
Health and/or disability	38
Employment	28
Domestic violence	10
Gambling	8
Family relationships	3
Other	4

Note. 'Other' includes legal and education issues, sexual abuse and social isolation.

Overall Table 4 reflects a population with complex and multiple needs.

One question is whether the high numbers of client contacts with substance use issues are in fact generated by a small number of individual clients with complex and acute needs who are contacting services on a regular basis. In order to look at this in more detail regular clients (76 individuals) were analysed separately. They were most likely to be accessing accommodation and mental health services and were a population with particularly high needs. They were more likely than other clients to actually present with an alcohol or drug issue and to have harmful or dependent use or to be relapsing. Workers were also more likely to consider that their training and skill levels were an issue in responding to the needs of these clients.

Some clients approach Anglicare for help in coping with the ATOD problems of others – their partner, their child, a parent or friends. The snapshot survey recorded 8% of client contacts where this was the case and was most commonly about partners where ATOD use was impacting on the household budget, parenting abilities and relationships with children. One worker described a situation where her client was accessing marijuana for her partner because if he did not get it she would find herself in a domestic violence situation. Others were anxious parents concerned about their teenager's consumption of cannabis and alcohol.

2.3 Changes over Time

Workers were asked whether they had perceived any changes in the profile of clients with ATOD issues in the last few years. Those who had been in the field for three years or more identified:

- an increase in the quality, purity and strength of illicit drugs and in their range and availability, particularly hydroponically grown cannabis, an increase in the black market for methadone and a rise in the injecting of amphetamines;

- an increase in people's willingness to talk about ATOD issues and to expose their behaviours;
- the normalisation of marijuana use with more acceptance that daily use is not a problem because 'everyone does it';
- a greater acceptability in teenage culture of amphetamines and ecstasy;
- a lowering of the age range for using substances down to 11 and 12 year olds;
- more inter-generational effects, with substance-using parents socialising their children; and
- a change in public perceptions with a move from substance users being seen as young and on the streets to a recognition that it happens across the age spectrum and across socioeconomic groups.

Workers also pointed to improvements in pharmacotherapy, an increasingly visible lack of specialist treatment services and a greater delineation between mental health and drug and alcohol services. All these factors were impacting on the profile of clients which they saw in the course of their work. Overall they considered that substance use was now a significant and growing part of their work.

2.4 Impact on Service Delivery

The impact of alcohol and drug issues upon the kind of service workers could deliver to their clients could be profound. It affected the ability of clients to engage with the service and the ability of workers to promote positive outcomes.

The snapshot survey showed that 2% of all client contacts entailed dealing with clients who were intoxicated or drug affected when they presented to services. This could mean that they were unable to provide the information workers required to assess their circumstances or to understand the consequences of engaging with the service. In some cases this meant postponing the appointment until a later date.

> *They may be drug affected so they are not actually taking in the full consequences of their situation. They are also not taking in the full extent of their options because they are stoned or under the influence. If they are affected by drugs then that intervention might not be meaningful because they are not understanding what we are saying or rejecting it because they think it's stupid. There have been a few instances where we have had to ask people to make another appointment because they've been so affected that you know they're not taking in anything. They have been in that shut down zone and there is really no point in continuing. You just have to ask them to come back another time. One of the reasons that we can't continue is from the point of view of confidentiality because they don't understand the confidentiality agreement, the consent form that they are signing so they cannot give informed consent. (Accommodation Support Services)*

Workers also commented on erratic behaviour and difficulties in keeping appointments:

> *Depending on the severity of the drug use, working with someone can be very erratic. Once the drug use is under control then the work starts. They can be really transient, difficult to get hold of, difficult to send invitations to appointments. (Employment Support Services)*

Apart from being unable to effectively communicate with clients ATOD issues had two major consequences – they impacted on a worker's ability to promote financial stability and their ability to provide secure and affordable accommodation. They described the large sums being paid out of small budgets for alcohol, tobacco and drugs which took precedence over food and other living expenses. These affordability issues could affect their chances of gaining or retaining housing and their ability to meet power bills and rent. Addictions and associated behavioural problems could also limit the housing options available; for instance for someone with alcohol dependence it would be inappropriate to place them in hotel or other accommodation with easy access to alcohol:

> *You do the budget up with them and they are over the budget and they say I'm going to give up smoking or cut down to make that property affordable and we all know how hard that can be. The security of their accommodation is affected, whether they are in housing properties or private rentals. If they are alcohol affected their behaviour is affected, their care for the property is affected. They might not get a bond back, they might not get a reference, they get behind in their rent. So it has a very long term cumulative affect on their housing prospects just from the limited group we see. (Accommodation Support Services)*

> *With private providers we have to be careful not to broker any clients who may cause a disturbance because then we may lose the accommodation provider and we only have a limited number we can work with. The shelters are fairly flexible with that sort of thing but they have to keep the safety of everyone there in mind as well so they may say someone is a risk and then that person is left with family and friends if they are lucky enough to have them. But again they are usually surrounded by people who are using which exacerbates the problem. Then we are just left with detox or residential rehabilitation which they are either going to agree to or they're not. If they are not wanting to actually get off the stuff at the moment they are not going to go for that either. (Accommodation Support Services)*

As workers pointed out really the only suitable accommodation they could refer to for people with major drug or alcohol issues were the detox and residential rehabilitation facilities which only provide temporary accommodation and are in short supply. Employment services were also finding that ATOD use was severely compromising clients' employment options. Sporadic attendance can impact on participation levels and clients' ability to meet job search obligations. At the same time the funding available to employment services does not allow providers to raise the levels of support available to drug affected clients with many and complex needs.

It meant that workers were often working with clients who had 'burnt their bridges', who had previous housing debts and/or records with debt collection agencies or criminal records, all of which impacted on their ability to access housing and employment. They described a circle where clients committed crimes to get drugs which then meant they were unable to get a job or accommodation through a real estate agent. This could act to reinforce the drug habit and more criminal activity and caught the client in the revolving door of substance use and crisis:

> *There have been people known to us for a long period of time. A lot of the people we see now are the same people we saw back in 2001. I had a client who knew his pay came into the bank at midnight and he would see his dealer at 2 am, he would wait up. So by the time the supermarket opened and it was time to be buying his groceries he would have no money left and in fact was already under the influence of his latest hit so the next 14 days were once more crippled again. I have clients who go to their dealer every day and spend $50 on their hit (of morphine). That is $350 a week so how would*

they survive in their rent situation? So what happens is they steal. So then we have the stealing behaviour and they keep on that track until they come to a sticky end. Usually as a rule of thumb they are not serious about stopping. They just verbalise they want to stop but they don't demonstrate that readiness for change. (Accommodation Support Services)

For those services working specifically with people with mental health problems the impact of alcohol and drug use could be particularly severe. Not only did substance use impact on the effectiveness of clients' mental health medication but it could also be difficult to identify whether an individual was unwell or whether they were affected by drugs. Some workers described difficulties in communicating with clients at any level unless they had access to a supply of cigarettes.

It's a hugely compounding factor in mental health. It makes it a huge obstacle to be able to make headway so you are working on two fronts really. There are also the drugs prescribed for mental health and the effect it does have on their body. They would be chain smokers if they had the money to buy cigarettes and they collect butts and it makes them vulnerable to people preying on them for their tobacco. (Mental Health Services)

With one client I can't do any meaningful work with her unless she's got this cigarette thing out of her head. The only way you can do that is to make sure she's got a packet of cigarettes in the morning before you can work with her. Then you can do meaningful stuff about her social isolation. So it's working with it in the best way you can. (Mental Health Services)

Disability support workers working both in residential and community based services are not immune to these issues and encounter drug use as well as drug-using equipment like needles, water pipes and smoky environments in the homes that they visit. Staff can refuse to work in these environments or they can ask clients to refrain from use while the support worker is there. There can also be situations where it becomes difficult to achieve the aims of the program because of uncontrolled substance use. In the short term this can lead to the temporary withdrawal of a service. In the longer term case managers are appointed to coordinate the relevant services to address alcohol and drug issues. Disability support workers also reported incidences where there had been difficulties with the intoxicated relatives or friends of clients who could be abusive.

A number smoke heavily and staff may be required to support that by lighting the cigarette. Staff can choose not to be in a smoking environment. There is a fine line between respecting the importance of a social network but also needing to ensure a safe working environment for staff. This leads to conversations with clients about their responsibility to staff to provide a safe environment with no tobacco smoke or needles. (Disability Services)

We always say that if we feel uncomfortable about a situation then we don't have to put ourselves through it. We have a duty of care, but we also have a duty of care to ourselves as well if we feel bad about something. Everyone handles a situation differently and I might be able to handle it and someone else couldn't. We all have our opinions but you don't force that on the client. (Disability Services)

Disability services workers are keen to point out that they work to the principle of client choice within a reasonable spectrum and they want to be able to balance normality with rehabilitation and health needs and offer an holistic approach. Clients can be reliant on staff to access their alcohol or tobacco for them which they do as long as it is not contraindicated by their medication. This may mean lighting the cigarette of a spinal injury client if they feel comfortable with that. Indeed most workers stated that they were prepared to work alongside levels of use and the client's choice.

> *One lady used to start her day with getting you to decant wine from a cask into a two litre fruit juice bottle and that is all the sustenance she would have all day with cigarettes in between. It was a really, really depressing thing to see but that was her choice. Probably the hardest part for us of working with people with brain injury or any diminished capacity is asking is it an informed choice that they're making? How do you know they know the consequences of the choices they are making? If you are limited in your lifestyle you should have some pleasures and for them it's a pleasure. (Disability Services)*

In residential services drinking or smoking to excess in a shared environment can cause difficulties for other residents and for workers. Reusing butts can be a hygiene issue or borrowing cigarettes from other residents can cause violent incidents when it is not reciprocated. Substance use among residents can also encourage others and this can be a big problem in youth services:

> *One of the biggest problems we have here is that often boys will come and won't be using anything but after a short stay they are. Sometimes they would have been through rehab and come back here and this is the worst place for them because they end up back smoking pot or taking speed. We try and deter them as much as we can. (Youth Shelter)*

Some workers spoke about the longer term impacts, for example the impact on the welfare of children. They described situations where young people were unable to stay at home because of their parents' drug use but had few housing options due to the shortage of public housing and the reluctance of real estate agents to rent to under-18s.

Some services said that ATOD issues did not impact on the service because it was only an issue if it was an issue for the client. This was especially true in counselling services where practitioners are trained to work with the issues identified by the client as the presenting problem:

> *I tend not to focus in specifically on a pathological event like drug use or alcohol. If the client doesn't define an aspect of their life as a problem it's not a problem for me, because it's not a problem for them, so I don't get into it or develop a discourse around it. If they haven't asked me for help with it I don't explore it at all. (Counselling Services)*

2.5 Impact on Workers

Dealing with alcohol and drug issues can have an impact, not only on the service being delivered, but also more personally on the workers themselves and some described a heavy personal toll. It meant lower levels of job satisfaction, taking problems home with them, feelings of helplessness, hopelessness and inadequacy in trying to respond to the scale of the need. They also described high levels of frustration and disappointment when clients relapsed or were unable to reach goals that they had set for themselves.

For me it has a huge impact. People I work with come in often feeling hopeless. A third of the cheque gets spent on the cigarettes and the alcohol or the marijuana and they are immersed and enmeshed in all of that. They are feeling really stuck so I have to work with that stuff. I can't really do anything about it except engage with this person, believe what they are saying and try to find what strategies for them may help. I also recognise that they go back out that door and there's no services, no follow up to be able to get the help you need when you need it. (Counselling Services)

You are passionate about helping them but you see very minimal change and you get a lot of abuse. They try to attack you personally and most of the time that doesn't affect you but now and again you hear so much personal attack you think why do I do this? So people are putting in a lot and seeing very little return. You have to give so much of yourself personally all the time and because the changes and the outcomes are so few and so slow in coming it can be quite difficult to maintain that because you are getting all the negative stuff back. Things change, but very slowly and very minimally so it's frustrating. (Accommodation Support Services)

They might also be dealing with intoxicated clients who could be abusive and elicit fears about their personal safety.

Last week we had a chronic alcoholic, quite abusive, so that affected people in the building. People also come in under the influence of drugs and are not really present. That's very difficult. You go into overdrive about their safety and your safety and the safety of other people in the building. There have been incidents where people come in and threaten to do all sorts of stuff and the police have been called. It isn't common but they do happen. We had the glass put in here for that reason. I know if I've got someone I will leave my door open or tell another worker. We all have alarms as well. (Employment Support Services)

These pressures meant that for some workers the ability to debrief was very important:

Professionally it requires a lot of debriefing. They are in deep shit and we feel helpless and that there is nothing we can do. That is the hardest frustration. So we end up with two people feeling helpless because nothing can be done and the client gets angry because we didn't fix it. (Accommodation Support Services)

I get disheartened some times and I've spoken to my manager and he reminds me of the little changes. We have to really be focused on tiny changes but they add up eventually. It can take years. It's like taking five steps forward and three steps back. It takes a lot of patience and it is a very frustrating industry. (Accommodation Support Services)

It was noticeable that those with more experience and/or more training felt better able to weather the storms, to gain satisfaction from witnessing small successes and changes and being more realistic about expectations.

I used to absolutely hate it until I had decent success with one client. It was just an absolute roundabout. You would have the client coming in discussing their homelessness issue and you could see quite clearly where that was coming from but they were unwilling to change any behaviours associated with the situation and you could also see why they were unwilling to change the behaviours. You think yes I'm in a similar position to the client, this feeling of helplessness. Then you have to distance yourself from that and regain that hope so you hope you can transfer that to them. It's very

difficult to do on a daily basis so you pull yourself back from that and in my first year of work here I did. But then I decided to actively facilitate things and as soon as I saw any kind of contemplation occur I'd jump on it. (Accommodation Support Services)

At the start I felt oh my god what am I doing here, I can't help anybody. So I was helpless within myself as a worker. But then I started to see that people are making a choice and it is their responsibility. That is the only way I survived within that role. As a worker to stay resilient you have to say I can give opportunities for change. I am more likely to vent my frustration at the system that we live in because I feel if we change the global stuff the local stuff will shift. (Mental Health Services)

The significant impact that clients with ATOD issues can have both on service outcomes and more personally on workers means that developing effective responses should become an urgent priority.

3. Interventions

Given the high numbers of clients with drug and alcohol issues how do workers tackle these problems and what kind of interventions are they able to make? As one worker said 'this is the sixty four thousand dollar question'.

The snapshot survey showed that in two thirds of client contacts where there was an ATOD issue workers were making specific interventions with substance use problems. Most described using a combination of strategies which included getting to know the client and building a positive relationship, providing information and making them aware of their options, harm minimisation work and promoting the motivation to change and supporting that change. This may or may not involve referral to specialist alcohol and drug services. It might also involve stabilising their situation generally as well as encouraging some kind of occupation or activity.

Table 5: Interventions

Type of Intervention	Percentage of client contacts where interventions made
Building a rapport with the client	52
Promoting motivation	47
Providing information/education	38
Harm minimisation	23
Stabilising the client's situation	18
Referral to other services	13
Referral to specialist alcohol/drug service	7
Other intervention	4

It was interesting to note that men were more likely to receive a specific intervention; over two thirds (67%) of male clients got some kind of intervention compared to 59% of the women. One explanation for this is that as men are more likely to be using illicit drugs workers are more likely to identify their usage as problematic.

Interventions could be time consuming. Overall workers in the snapshot survey recorded spending 555 hours in contact with clients who had alcohol and drug issues over a two week period. This was mostly face-to-face but also on the telephone. Over one hundred (102) of these hours were spent dealing specifically with ATOD issues. This represents approaching one fifth (18%) of their contact time with these clients. This is an underestimate and as workers pointed out working with substance-using clients does not necessarily mean working directly with those issues. There were 75 client contacts where, although workers reported building rapport, promoting motivation and stabilising a client's situation, no time was recorded because it became problematic to separate these interventions from general interaction with the client. In addition some programs were involved in facilitating group work during the two week monitoring period where substance use issues were discussed and tackled. In residential services workers averaged 40 minutes per shift dealing specifically with alcohol and drug issues.

3.1 Building Relationships

Clients were not generally presenting to Anglicare services with drug and alcohol issues, neither is it part of any initial assessment. This means it is more likely to be identified only as a relationship of trust builds between client and worker. The ability to build such a relationship will vary from service to service depending on the nature and length of contact with individual clients. For instance the work of the Private Rental Support Service is often done within a one-off contact which limits the opportunities to both raise the issue and to begin to address it. At the other end of the spectrum are services where there may be ongoing contact over a period of months or years and these offer numerous opportunities to forge positive relationships and to intervene. Over half of all interventions described by workers were about building a relationship and rapport with the client.

> *A lot of the time we have a brief window of opportunity with people. If we had the resources to spend more time then we could probably create the rapport and build the trust and do those things that make it possible to raise the topic of referral because of drug and alcohol issues. You can't do that in an hour interview. It's really not a very easy thing to do with a lot of people because there's a resentment and a denial. Sometimes you're lucky and budgets bring up all sorts of opportunities. I have had quite a few people tell me how much they spend on dope and I've put that in the budget. (Accommodation Support Services)*

> *You can make a record of what they're indulging in and at the end you just show them, here's the map of what you drink, would you say that's reasonable? If it's affecting an area in their life then you can produce that as a concrete thing. (Accommodation Support Services)*

Doing a budget can open the way to discussing these issues and to identifying them as a problem. By putting actual expenditure on alcohol and drugs down on paper clients were presented with stark options, for instance about whether they wanted to keep their accommodation or smoke. However it could be a very delicate balance where asking directly about these issues could cause offence or an aggressive response as well as raising the client's fears that admitting to difficulties would affect the service they got. This could be particularly difficult when workers were able to identify a problem (for instance with heavy consumption of marijuana) but for the client it was just the norm or they classified themselves as a 'social' rather than a 'problematic' smoker. As another worker said 'you have to pick your moment, you can't just jump in there'. If someone has accessed a service to get secure housing they were unlikely to want to jeopardise that with potential landlords by admitting to a substance use issue.

> *We offered to give them one of our community tenancies on a three month lease which could be renewed up to 12 months. They could have had that property but they needed to be open and honest about their usage and how much money does go on it and maybe try and get into one of the specialist services. They didn't want to. I don't have a problem, I don't know what you're talking about. I was holding a carrot over them and saying you can have this place but you have to work hard but they weren't ready. I talked a lot with my senior about that being their choice. We've done all we can do and the rest is up to them. (Mental Health Services)*

Even when issues are identified there are then decisions to be made about how they are prioritised or which issues are tackled first. As many workers said the drug or alcohol use is usually a symptom of something else and a manifestation of an underlying issue, for example sexual abuse. This means making decisions about how and when to tackle the underlying

issues. Targeting one sub-set of problems like substance misuse in isolation from the wider context was seen as doing little to improve a client's situation:

> *Alcohol and drugs is never an individual issue. It sits within a much larger context and for case managers it's a question of the chicken and egg. Is it worth working on alcohol and other drugs without working on the financial side or the relationships? (Accommodation Support Services)*

> *You need to be able to prioritise because if you can sort out priority issues you then have a better head set to move on and deal with the other ones. So number one is to give them accommodation and help set up their financial side so they will be fed and have a roof over their head. All those ongoing effects from drug and alcohol can affect relationships – no trust, and they've let people down, all that sort of stuff and people can't believe they are going to do anything for themselves or going to be reliable anymore and that pulls them back under. So sometimes relationship stuff can be the number one and longer term it's more about training, employment and finding other longer term accommodation if that's what they're looking for. (Accommodation Support Services)*

Overall interventions needed to be multi-faceted and able to address the range of issues facing the client. Indeed the most effective intervention around alcohol and drug issues can be about stabilising a client's situation generally to ensure they have enough money for food and somewhere to stay. It is only once these basic needs have been met that the client may have the time and energy to address substance use issues. Workers were also concerned to work with whatever the client themselves had identified as the priority.

> *She's doing very well in a housing association property. If that accommodation hadn't have been there, she would have been homeless. She would have spent her money on a caravan and smoking dope and she'd have these people after her. Luckily because that accommodation was there she had the stability, she could continue with her focus and her goal. She had already obviously made that emotional and mental shift. She was ready and luckily we were able to give her that accommodation to enable that to be seen through. Most people don't have the luxury of that. (Mental Health Services)*

3.2 Promoting Motivation

Despite problematic levels of consumption a significant proportion of clients in the snapshot survey – more than one third (34%) – did not identify themselves as having difficulties with alcohol or drugs. In addition a further 25%, although recognising the impact of their consumption, were not willing or ready to change their behaviours. This means that well over half (59%) of clients with ATOD issues could be described as 'pre-motivational' or not at a stage where they are ready or willing to address their substance use. They considered they did not need help and especially help from specialist drug or alcohol services like drug counselling. These tended to be younger clients under the age of 30 years.

Table 6: Clients' Perception of their Alcohol and Drug Use	
Clients' perception	**% clients with ATOD issues**
Not identified as a problem	34
Recognises impact	25
Ready to make changes	5
Taking action	10
Sustaining changes	10
Relapsing	6
Unknown	10
Total	100

The snapshot survey also revealed that a quarter (25%) were either ready to make changes or making them and sustaining them and could be described as the population most likely to be seeking assistance from specialist alcohol and drug services. Six per cent were described as relapsing by workers.

Given the significant numbers of pre-motivational or pre-contemplative clients it is no surprise that one of the commonest interventions being made by workers (in 47% of client contacts) was about promoting a client's motivation to change using a variety of strategies. A first step was knowing what stage of motivation people were at and their readiness to take action. This was crucial in identifying how to best work with them and a number of workers were informally assessing people using the 'stages of change framework'[6] for people with addictive behaviours. Under this framework people may be pre-contemplative or not considering change, contemplative or considering change or in an action phase where they are actually in the process of making change. They can also be maintaining change or relapsing.

For example work might begin by raising the client's awareness of the impact of their use, by providing some information about it or by using motivational interviewing techniques[7]. As one worker said using motivational interviewing was something they all did in their conversations with clients although they would not necessarily name it up as such. This might be accompanied by using written resources or information to back up discussions.

> *I try to raise awareness of their physical symptomology of use. As an example I had a client who couldn't come and see me by 11 in the morning because he woke up so aggressive and angry. He would state that it was sleeplessness and that he had to get up at 4 in the morning and have another bong in order to go back to bed. But what I began to raise with him was that the aggression and the bad mood and anger that overwhelmed him in the morning was quite simply due to the withdrawal and overload from the marijuana. So one way I facilitate change is by acknowledging it. We set an appointment that suits him which immediately gives him that avenue of acknowledgement that he has a problem. The second thing we might do is I might raise the mood swings. So I begin to make him more aware of his own personal mood swings because the girlfriend is already stating that she can't live with that. But what I try to do is build that personal awareness so that the person over a long period of time begins to believe they could change some of those things. (Accommodation Support Services)*

[6] The 'stages of change' model was developed to describe the process people go through to give up smoking or other forms of addictive behaviours (Prochasaka & DiClemente, 1986). It has heavily influenced treatment services.

[7] Motivational interviewing is a counselling approach developed by clinical psychologists which is non-judgemental and non-confrontational. It aims to increase the client's awareness of the potential problems caused by and the risks faced due to behaviours. It helps them envisage a better future and motivates them to achieve it.

> *A good example is of a young woman who had significant alcohol issues. We intervened in a gentle, unassuming way so instead of saying you need to do something about your alcohol issues, we would talk with her about the consequences of her behaviour and what would happen if you do this and this. (Family Support Services)*

But as workers pointed out trying to elicit some interest in change could be a long term project and there was always the real fear of driving people away if the issue was raised. Some considered that people stopped using when they were ready, regardless of what interventions were available.

> *If someone doesn't want to change and they don't want to work on that then that's okay. We will try and do some motivational interviewing and get that change happening. But we find whatever else it is that they do want to change. And where possible hopefully we can work with that person where the drugs and alcohol is really impacting on them in their ability to do that. See this thing here you really want to achieve, what is the one thing standing in your way and getting them to name up the drug and alcohol. That can sometimes be a motivator but it can sometimes be a de-motivator to wanting that other goal, oh I won't do that anymore. From my understanding of addiction, telling someone to stop is useless and can be counterproductive and gets their back up. (Mental Health Services)*

Workers might also be supporting changes which have already occurred so that they are sustainable or helping someone to fight relapse:

> *People often come to me and they really have started doing something about their drug issue and tell me really good things about what they've done, the way they've changed to tackle it and how they are standing up to the temptation. In that situation I don't do a lot of exploring around how this is a problem but around where they find that strength and resilience and motivation. I might express surprise around the fact that they are able to do this and to what extent did they know they had the capacity to respond in this way to this problem they've had in their lives. (Counselling Services)*

A high percentage of clients identified as pre-motivational are adolescents (21%) or young people and they can be particularly difficult to work with. As one worker pointed out, 'they normally tell you how much they smoke or drink because they want to convey how cool they are'. But it also means they are a long way away from being ready to make any changes, particularly if they are under 16 years. Workers talked about more effective interventions with older teenagers who were beginning to see the negative impact of their substance use.

3.3 Harm Minimisation

Harm minimisation involves a range of approaches to prevent and reduce drug related harm including brief interventions or interventions aiming to encourage people to consider their substance use and to reduce identified risk taking behaviours. There is a growing body of evidence suggesting that these interventions are beneficial in reducing use, particularly when they are used with motivational techniques and without the stigma of treatment. For heavy drinkers they have been shown to be as effective as more intense interventions and more cost effective as they are shorter and can be used in a variety of settings (NDARC, 2003). They have also been shown to have positive outcomes with cannabis and amphetamine users (Turning Point, 2003).

Workers were using a range of harm minimisation strategies with their clients. This might involve encouraging the client to smoke roll ups rather than ready made cigarettes or wearing a nicotine patch during the day and only smoking at night to reduce the financial outlay and minimise the health impact.

> *If someone comes and presents with an accommodation issue but it's because of their drug and alcohol issue then you can make that connection on paper to a person and that's where the harm minimisation will come in. I had a client who was a pretty hard core alcoholic. He's made progress just this year which has been really good. I've worked with him to not start drinking until 5 and stop again at 7 or not to drink on a Tuesday. From drinking every single day from am to pm to that has been massive. He's never gone into a program though, never wanted to go into a program. But he has come a long way with that kind of work. (Accommodation Support Services)*

> *With one woman we did try to work a lot on the smoking. Once she went onto administration[8], the Public Trustees gave her three packets of 50 cigarettes a week, that was it. Almost invariably she would smoke them before the end of Sunday. It got to the point where she was picking up cigarette butts off the gutters and footpaths to get tobacco to roll cigarettes. We did things like get 25 empty cigarette packets and divide them all up into days so that's today's packet and when that's gone if you choose to smoke the next day's packet you know you will run out tomorrow. You have to make that decision. (Mental Health Services)*

Tobacco can be a particularly problematic area because although it is very damaging to health and to budgets many workers also smoke and it elicits concerns about imposing individual value judgements on clients.

> *I would feel as the worker that I was imposing my values on this person. They are choosing as an adult to have cigarettes rather than bread and who am I to come in and say you really need to cut down on cigarettes and buy bread and milk and cheese. They would sit in her fridge and not be used. She wouldn't care if she had no food. As long as she had cigarettes she was happy. (Mental Health Services)*

For some workers it was about intensively sticking with the client and seeing them through. Just maintaining some kind of contact with them could operate as a positive harm minimisation strategy:

> *I worked with a person intensively for a couple of years which involved sometimes daily home visits. There was raging intravenous drug use and alcohol problems. Just sticking with that family through thick and thin, that person doesn't use those drugs anymore and they were all the time. If it's really heavy duty like that it requires serious commitment to people, that's an intervention. Nothing is going to change overnight. We weren't really working on the drug issue, we were working on homelessness and getting that stuff under control. It was not an easy road, there were tears and tantrums. It's that intensive walking along beside people as they rebuild a new way of living their life or a different way of living their life that actually supports that. (Accommodation Support Services)*

[8] Under financial administration by order of the Guardianship Board.

> *There are some people where we've had to say if we turn up at your door and you are really, really drunk, I think I should come back another time. Trying to make some contract around when I will work with you can sometimes be useful. If you are clear about saying I am here, I am happy to support you, we can talk about things you want to achieve but only if you're sober or not stoned, then that's up to them to choose which they want more, the support or the addiction at that time. If they can see here's a support worker whose going to turn up this time, this day to see how I'm going, that may just give them enough to hang on to, to say well I won't smoke this morning, I'll wait till after the appointment or maybe then they might not get around to doing it that day. (Mental Health Services)*

It could also be about providing day time occupation – for example attendance at a day centre or participating in sport or other recreational activities – which provided a sense of purpose, activity, more stability and a distraction from consumption. One worker described participation in Green Corps as producing a 'virtually overnight change in daily habits'.

> *Most of them aren't at school, they are not working, they don't have a lot of positive family networks, they don't have their own home. What are they going to do? There's no motivation to change and the drug use just continues and gets worse. The more they have to do the less they seem to smoke. The guys who have been involved in Green Corps say they actually have money because they only spend a third of what they normally do on drugs. So the more things they have to do the less they seem to smoke or take. (Accommodation Support Services)*

Workers were clear that effective harm minimisation work progressed slowly through a series of small steps.

> *We move in millimetres, we are not moving in miles. Sometimes when we see that client three or four times over a year we gradually begin to see that readiness develop and they finally take the referral to the service that they really need or they begin to stop swearing about the detox centre and start saying oh yes maybe that's a possibility. So we are actually moving in those millimetres over a long period of time. (Accommodation Support Services)*

3.4 Residential and Social Support Services

Staff in both residential and social support services were interviewed and data collected about ATOD interventions during 62 shifts in two residential and two social support programs during the snapshot survey.

Most commonly interventions involved informal conversations or reinforcing house rules about drug and alcohol issues. In 20% of shifts workers were dealing with intoxicated clients. For example there was one instance at a boarding house where an intoxicated ex-resident had returned and assaulted a current resident. This had resulted in the police being called. They were also providing information, building motivation and rapport and doing harm minimisation work. They might be engaged in more structured information sessions, monitoring the supply of substances or monitoring the resident mix to ensure that the rights of other tenants to an alcohol and drug free environment were not overlooked. They might also be dealing with the friends and relatives of residents or service users who were intoxicated.

These are controlled environments which can set rules and policies about the consumption of alcohol, tobacco and other drugs on the premises and include adherence to these rules in tenancy and lease agreements. All these services prohibited the consumption of illicit drugs on site and some also used a range of other strategies to limit consumption and ensure that they could manage a mix of residents or service users. These strategies included:

- permitting drinking or smoking only within certain hours;
- designated smoking areas and wet areas;
- establishing contracts with individuals – for example a three-drink per day contract which was then monitored by workers;
- trial tenancies for those with an ATOD history and a requirement to attend counselling; and
- evictions for violent and disruptive behaviour associated with ATOD consumption.

Despite this framework workers were concerned to emphasise that residents' independence was also encouraged and that they were entitled to the same rights as anyone else to smoke and drink alcohol. As one disability support worker said 'we are here to do normal things' like assist someone to go to the pub, but there could be potentially difficult decisions about whether an individual is capable of making appropriate choices given their level of injury. This means negotiating a level of consumption which finds the right balance between the impact on any medication, the level of injury or disability and the need for independence. It also means ensuring that one person's use does not impinge negatively on others but this can be difficult to manage and can require close monitoring:

> *In assessments we are very, very careful to see what the mix is here. We could have someone who's had a long term serious drug problem and who is just getting on their feet and we could have someone coming in that has had a big drug problem and has smoked heavily. It's quite a risk factor to bring in someone like that and combine them with someone who's just getting their act together. (Boarding House)*

> *Generally contracts are drawn up stating that they will not consume alcohol on the premises and they can only consume a certain amount of alcohol per day that goes with their medication. It is very clear cut and when they overstep the mark they are put on a 24 hour contract which is reviewed every 24 hours stating no substances, no alcohol. That works. With a mental health condition and alcohol they start becoming very unwell and they can end up in hospital. We've had clients who've become very unwell and come back and been very disruptive and violent. We have evicted for those reasons. (Mental Health Services)*

In one residential facility for people with long term mental health problems some independently controlled their tobacco consumption while others were on tobacco programs to prevent them from chain smoking and support them in reducing their intake. This involved working out with the resident how many cigarettes they wanted to smoke in a day and administering the cigarettes accordingly.

Residential and day facilities also offer opportunities for working more informally and opportunistically with service users including providing written resources, structured educational sessions and quit smoking groups and encouraging peer education.

> *You can have information on hand for people with an interest to read. We are also in the throes of having Drug and Alcohol [Services] come in and do sessions. We are in a very good situation here to do that kind of work. I have found requests for it here, for all kinds of information sessions. But this is probably a fairly unique situation where as the group grows they are a community and perhaps that puts them more at ease. We have a smokers' area outside and if you stand there they are talking about anti-smoking programs so some group motivation is going on. We'll wait until that's reached its top level and pounce on it. (Mental Health Day Centre)*

> *Developing a positive rapport is very important so that they enjoy relaxing with the workers. They seem to like the informal stuff to get them thinking in a different way or moving from pre-contemplative thinking which in itself is a victory. They are 13 to 20 year olds and most of them are pre-contemplators. Sitting around on the couch with the guys there might be one conversation there that they will chew on which then six months, twelve months, two years down the track is still there for them which can be a catalyst for change. When they do choose to make changes we can help them. Quite often we are the first person they've met who gave a shit, that is really interested in who they are and what they're doing. You'll get the older ones trying to educate the younger ones. They will say this did this to me and you shouldn't do it. All the drugs I've tried have really stuffed me up. (Youth Shelter)*

3.5 Pathways to Specialist Services

It can be a difficult step for clients to both admit that they have a problem with alcohol or drugs and then to accept that they might need specialist help. Workers commented on those clients who, in their judgement, obviously needed help but were not looking for it and certainly were not seeking access to specialist services. Previous bad experiences with specialist services could also mean that clients were reluctant to try again and felt that it did not work for them.

> *There are drug and alcohol services and if you're ready and keen you can go. But there are a bunch of people out there with drug and alcohol issues and I'm sure they need assistance and support but they are not ready or looking for that. Those are the ones I'm interested in because if there's a gap or a bunch of people who slip through the cracks somewhere then that's them. (Accommodation Support Services)*

The snapshot survey showed that in 25% of client contacts where there was an identified alcohol or drug issue clients were ready to make changes and/or were taking some kind of action. This may or may not have involved specialist services. Workers were asked about their experiences of referring into specialist ATOD services and they talked about encouraging their clients to access services, arranging appointments, escorting clients and monitoring the progress of referrals. However the survey also showed that only 7% of client contacts involved a referral to a specialist service and 18% to another service during the two week monitoring period. These included residential rehabilitation and detox, Salvation Army outreach services, the Quit Line, the Alcohol and Drug Service and Holyoake. What was clear from talking to workers was that many had little experience of referring. Clients were not willing to be referred or were not at the right

stage, or the worker was not familiar with the service network and unsure who to contact or an appropriate service was not available at the right time.

> *We are client driven so we work on what they feel is important and I find that drugs and alcohol are the last issues they want to deal with because that is how they're getting by most of the time. So I haven't referred a whole heap of people to Drug and Alcohol mainly because the person hasn't been in a situation where they want to be there. A lot of them go because it's a necessity for getting into housing (i.e. public housing). They have to go and have an assessment, to say that they've been to Drug and Alcohol Services but from what I've seen that's the only visit they end up doing. (Mental Health Services)*

These findings are not surprising and other research has shown that alcohol, cannabis and amphetamine users are commonly reluctant to seek help. A 2001 analysis (NDARC, 2001) found that less than 30% of those with alcohol dependence sought help and many thought treatment was stigmatising. There are similar results for amphetamine use (Kamieniecki et al, 1988). It is a fact that many of those with problematic ATOD use will never come into contact with specialist services.

Some workers, particularly those with more experience of referring in and more contact with the specialist sector reported good experiences of getting clients access to services and in supporting that engagement.

> *We have got some good referral points for drug and alcohol counselling for the people who are willing to go. They are quite easy to refer to and they do a good job if you can convince the clients to go. The Mulgrave Street Centre[9] is quite formal and some people like that and they feel like they've got a professional. The Bridge[10] outreach counselling is a lot more informal and more of a support worker type relationship which other people respond to. (Accommodation Support Services)*

> *It's about always keeping in touch with how that referral is going when you see them. Did you go to see that person, don't tell me what happened, but are you getting anything out of that referral? Do you want to continue going there? Do you want me to find somebody else to go to? (Family Support Services)*

Others however reported delays in access and long waiting lists which meant that clients who were ready and willing cooled off and changed their mind or were drawn back into substance using environments. In particular the inability of many specialist services to work with clients and provide them with coping strategies while they waited for appointments was considered to be a significant gap.

> *When people come in and they are ready you can't get them into a service because there's a waiting list. It could be weeks, it could be months especially for residential programs and then you miss that window because people can only resist so long. While they're on that waiting list they are without accommodation, they are staying between friends, being surrounded by people using and they just weaken and slip away again. That point of readiness can sometimes go past. (Accommodation Support Services)*

[9] 'The northern regional community team run by the state Alcohol and Drug Service provides counselling, education and training, information and health promotion, outreach support, a pharmacotherapy program and home detoxification.

[10] The Bridge Program run by the Salvation Army provides a residential rehabilitation program in southern Tasmania and outreach support in the south and the north of the state.

> *Trying to get them into detox or the Bridge program is very difficult. Even the process of getting an appointment that day in detox, there is next to no chance. After that it can be three or four weeks before there's a vacancy for Bridge. Then that person would be left unsupported. I had a lady who had been released from prison and used all her money on alcohol. We supported her for that fortnight, her next pay day came and I couldn't get her into support around her alcohol use. She was saying I would be better in prison. I would at least then have someone to support me not to drink and I'd have a roof over my head. (Mental Health Services)*

One worker went so far as to say that specialist services did not seem interested in taking their clients because positive results were harder to achieve and they were classified as being in the 'too hard basket'. At the same time several reported instances where clients had been turned away because their problems were not considered serious enough.

There were also particular issues for couples with the realisation that unless both partners tackled the issue at the same time the chances of success in making changes were compromised. This meant services being able to offer treatment to both parties simultaneously which was not always possible.

> *One young girl was saying she was ready but it had to be something that her and her partner did together. She could see either of them returning to the relationship with some progress to find themselves enticed into further drug use. Her idea was for them to access the service together. (Employment Support Services)*

Even when they were able to gain access for their clients workers commented that the kind of service clients received was not necessarily appropriate. They reported many instances where their clients did not engage and expressed low levels of satisfaction with the service they had received or felt judged. There were also concerns about the Christian philosophy and environment of residential rehabilitation facilities and how this operated as a real barrier to access for many people. Having to maintain housing, child care and financial commitments while in residential rehabilitation was also a major issue for many potential users.

> *There have been a few who have said I need help and I've referred them to Mulgrave Street but that hasn't really worked out. They have been once and never gone back. You say to them how did it go and they say oh I didn't like it, I don't want to go back. So I'm not really sure why that is. They get offered some counselling, they see someone and then they come back months after and they find there's a different person and they have to start all over again and they don't like that so they say no I'm not going through the counselling. That leaves a gap. We don't really know where to refer clients to. It's a gap that's always there. (Employment Support Services)*

Workers were very keen on developing better working relationships with specialist services to both ease the referral process and enable informed joined up working around the needs of the client. However they also commented on the difficulties they experienced in facilitating these kinds of relationships with the specialist sector. Relationships could be well developed in the North West where the community was small, services were thin on the ground and people knew each other. In particular the north west service providers' meeting was considered a good networking opportunity and a way of finding out about referral points. As one worker in the region said 'we actually have a really good network with our providers and with other organisations'. This was not necessarily the case elsewhere and for most workers contact was

on an 'as needed' basis and it made any joint working around the needs of particular individuals potentially problematic. Workers talked about having to be very proactive in order to get any feedback about referrals, even when the client had given consent. Communication was often solely dependent on personal relationships between staff rather then embedded in collaborative protocols between agencies. This divide was especially apparent in working across CSO and government services.

> *A lot depends on the worker from different services. You might have a particular worker who gets on very well with a case managed client and does correspond very well with other support networks the client has. Then you have someone that doesn't include other support workers. There are some I work very well with and some I don't really hear from. (Accommodation Support Services)*

> *The only relationships I have with people in other organisations is all individual. If you ask the right question and they've been helpful you write their name down and make sure you go back and ask for them. That's what it comes down to. (Employment Support Services)*

Employment support services described situations where government services had referred their clients to residential rehabilitation but not informed them. This could mean they were no longer able to meet their contracted obligations – for example a monthly meeting with the client. They commented on the common failure of intake services in the government sector to link in with referrers and felt government services underestimated their level of experience and skills which made them reluctant to work collaboratively with CSO workers.

Similar issues were reported when referring clients to other services for assistance with substance use issues – for example GPs – and workers identified obstacles to working jointly in the interests of their clients and emphasised the difficulties of overcoming attitudinal barriers.

> *When we approach a lot of those services it's like well, what do you know, and they don't really listen to us or even want to know too much about what our program's about. I have taken people to doctors for assessments on the basis that I need an assessment so that we can actually get started and plan. I've left the person alone with the doctor who has immediately made the assumption that this person is only here to get some drugs. So instead of opening their eyes in terms of what can we really do with this person, they have shut down and it's gone nowhere. People will give me permission to talk to the psychiatrist but they never return your calls so you can't get anywhere. (Employment Support Services)*

> *The workers may have had experiences and be informed about that person and sometimes they have got good ideas about all sorts of things. You might like to be involved in some of those decision making processes that will affect people you work with. You find that every single time you deal with other health professionals as a support worker you are undervalued. Some people can have 15 or more carers in the space of a week from different agencies, doing domestic stuff, the day support people, the rehabilitation, physios. A lot of these people are above reading our strategies – a physiotherapist won't read our strategies for instance, it's beneath them. Strategies work if everybody pulls together. I wouldn't go so far as to say that the professionals don't listen, because they do, but whether they take things on board? Quite often we spend a lot more time with the clients than they do. (Disability Services)*

These issues had led some workers to question the scope of their practice and the value of referring clients into a specialist service when potentially much could be achieved through a relationship of trust with an Anglicare worker. There is a continuing debate about the most effective balance between interventions by a specialist versus a generalist service system in the alcohol and drug field (Ritter, 2007). This focuses on what level of specialisation is required to produce a good clinical outcome and what is the best investment mix and it certainly raises questions about how and when specialists should be accessed and the value of being able to truly work alongside each other:

> *I often refer people to Drug and Alcohol but this is where the debate is. Is it better to stick with one worker who knows less but at least they've got a relationship and might keep on coming or is it better to refer off to someone who is specialised? (Family Support Services)*

Workers commented very favourably about having access to an internal specialist service like the Glenorchy Illicit Drug Service (GIDS) both to make internal referrals and as an accessible source of expertise:

> *One of the things I've found really helpful is having GIDS in our building. It's only for younger people but it's meant that because people have already come into the building and are familiar with it we can personally say there's a really good counsellor here if you want to link in with them. It's easy, just step into reception and make a booking. It helps us and it's much easier for people to get in and utilise that service instead of sending them away to New Town. If we have a client that we're both seeing we can have a signed agreement and it can be really useful to have someone on board to go and chat to a client. (Accommodation Support Services)*

The ability of GIDS to do outreach had been particularly highly valued:

> *GIDS are very good because they do outreach to us. It was successful when Cheryl [the worker] was coming out [to see the clients]. They engaged really, really well with Cheryl. She doesn't come across very threatening and she would just hang out with the boys and to me that was a success, that she got on really well as an outside service coming in. We do have other services come to our residents' meetings in the hope that the boys, once they put a face to who some of those people are, might be more inclined to engage. (Youth Shelter)*

Overall workers identified a number of gaps in the specialist response to their clients' alcohol and drug issues. As well as difficulties in access and appropriateness they also commented on the lack of outreach services, an absence of support for families dealing with substance use issues and very few accommodation options for those exiting treatment services, especially young people.

> *Not being able to get drug and alcohol services to visit is an issue. They will make appointments if we refer and the client accepts but it's whether the client keeps the appointment. The income that they have is quite low so trying to access the service with transport is pretty hard for them and frustrating for me. So it's very frustrating when they don't do outreach work. (Boarding House)*

To send them straight back here from detox, that couldn't be a worse scenario if you tried. You might as well not even send them to detox. So it is a waste of government money sending them into detox. They need residential facilities but we don't have one. Referrals won't ever be that successful until we can get a residential facility otherwise they go back here or onto the streets after detox. (Youth Shelter)

3.6 Outcomes

Without conducting longitudinal work it is difficult to assess how far interventions have good outcomes. However workers were asked for their perceptions about whether the strategies they employ with clients led to positive results. Many pointed out that they did not necessarily know what the outcome was or that, as one worker said, 'sadly there are less success stories than no change stories'. It could also be hard to identify any success when the worker only saw the client for a brief period, particularly as eliciting any change is likely to be a long term process:

There are successes but we don't necessarily always see them because we're a crisis service and a point of contact at their worst. There are things that one of us might say and they might learn something but they won't come back again for a number of months or at all and that could be a success. You will see them on the street and if they've been going really well they can't wait to tell you. I think there are a lot more successes than we see. I might leave this place and ten years later run into someone who has actually made some good choices and you know that somewhere along the line you've created a good memory. (Youth Shelter)

They also described situations where they could see improvements in the way clients were dealing with their substance use, for instance where they were cutting back or starting to think about it as an issue:

I can certainly see people might not have completely got on top of things, but things may have improved in terms of the level. They might get their alcohol consumption down to what is medically considered reasonable, or been able to cut back on their marijuana so they are on the path. Once they have got over that hurdle of it being too hard and making some change in their life they have done something and that's a success. (Counselling Services)

There is one particular fellow who has come on in leaps and bounds. Six months ago he was in a completely different space and he was struggling with issues, pot, but mainly alcohol. Through the opening up of that centre [Anglicare day centre] he has been down there every single day. We are open four days a week. He has gone onto a drug which means if he drinks he will become very ill and he's done that through his GP and no one had to suggest it to him. The change in him is just huge. It was about having something meaningful to do and the catalyst was a desire to grow, to be a part of this social group. It's a real success story. (Mental Health Services)

We have just finished our second year with our original existing clients and it's just starting to kick in. One client has reduced his alcohol consumption from about 100 equivalent standard drinks right down to about 20. It was the client's work really, there was no other service involved. It was through the tools that we have and rapport and trust. It was pretty difficult because this guy had a primary mental problem but also a secondary intellectual disability. (Mental Health Services)

Some said that the ability to change and alter behaviours was linked to ageing and that as people matured so their consumption reduced. Once people reached 40 they tended to slow down and could no longer physically tolerate high levels of consumption. This meant that one positive role for workers was about promoting safe choices until they reached this stage and were able to address their substance use issues. Overall any success was usually measured by workers in small steps rather than radical changes to people's lifestyle and choices.

> *I count it as a success if you can pass on some information really, just education. That's a real win if you can pick a moment and pass some information on. (Family Support Services)*

3.7 Barriers to Intervention

Workers were able to identify a number of barriers which prevented them from doing effective intervention work. These included the client's own motivation and circumstances, the nature and extent of contact within particular programs, the lack of appropriate accommodation and the skill level of workers. A similar pattern was recorded in residential and day services where the biggest barrier was client motivation and limitations on workers' time.

In only 4% of appointment-based client contacts was access to specialist services described as a barrier and only two workers in residential and day services mentioned this as an issue. This clearly illustrates how little of the substantial reservoir of need for assistance with alcohol and drug issues translates into a demand for specialist services and interventions.

Table 7: Barriers to providing a better response to clients with alcohol and drug issues

Type of barrier	% of client contacts with ATOD issues
Client motivation	35
Time	17
Lack of appropriate accommodation	13
Training/skill level of worker	8
Inappropriate specialist services	6
Slow or no access to specialist services	4
Working with other agencies	4
Other barriers*	8
No barriers	38

* These include communication difficulties and ATOD issues not being considered a priority in that instance.

As so few clients are putting up their hands for help it is no surprise that by far the biggest barrier to working around these issues was client motivation. And even if there was some motivation the client's social network or neighbourhood would conspire against them.

> *I have had tenancies fall over because I just can't get my clients to acknowledge the issue and really work with me on it. The client is about to be evicted and she told me before she moved in she had a problem in the past with alcohol. She is still saying she's drinking at low levels, makes up reasons why there are all these empty bottles but the way she's*

behaving it's clear and she can't tell me where her money has gone. The more I try and seriously sit down and discuss this as an issue with her, she has now completely gone into hiding and won't talk to me at all. (Accommodation Support Services)

When someone genuinely wants to give up and move on it's so incredibly hard because of debts, or friendship circles they have to give up and the isolation from that. There are huge barriers to them moving on. They have often run friendships into the ground because they've stayed at people's houses for too long. It's the hardest thing because of that social network that they have to leave and move on from it. It's really, really hard because you are taking away whatever it is which helps them to deal with whatever else is not going well. It's almost an impossible ask. (Accommodation Support Services)

In 17% of client contacts time was recorded as being an obstacle to effective intervention.

We have one hour a month but people need a lot more than that once they engage with you and you have that trust going and the window of opportunity opens. You end up doing a lot more than that. Without more time to spend with clients it's hard to go any further. (Employment Support Services)

One worker described a situation where a client had recently been stabilised and was now managing successfully in temporary accommodation. Ideally the worker would continue to have weekly contact and provide ongoing support to prevent further crises. The workload demands however meant that his time was consumed by responding to the crises of other clients which meant that this more preventative work fell by the wayside.

It was not only the lack of time available but also the nature of particular programs and how this was perceived by clients themselves. Not all clients attend Anglicare services voluntarily and an element of compulsion can influence what interventions are acceptable. This was particularly true in employment services where continuing to receive Centrelink benefits is contingent upon attending monthly appointments with the Personal Support Program:

For most people it's compulsory for them to come, it's not a choice, it's the activity they do to keep getting paid their unemployment benefit. We have to see someone once a month and it can be for up to two years so it can be a long relationship but there can be real variation in quality of contact if people don't want to be in the program. There have been a few who have said to me if I didn't have to be here I'd probably try harder. People don't like being told what to do. We have huge reporting requirements to Centrelink about what's talked about in a session and I think people are very aware of that. They clam up and there is a lot of dishonesty and it's a long way from where you would like to be with them. Where is the evidence to show that compliance and punishment and recovery are linked and go hand-in-hand? We are under pressure from the funding body to ensure all our activities are linked to the barriers [that people have to employment] so that people are forced to follow up their issues and if they don't they have their payment reduced. I wonder if there is any research to show this works? Has it been proved that this is a really good method to get people back on track? You are meant to develop this great relationship with someone but if they don't do the right thing you have to turn around and put the other hat on and report them. I worry about how this damages the relationship. (Employment Support Services)

> *Quite often people see us as an accommodation service as opposed to a support service. So once someone secures accommodation, which is the time when we should be inputting those additional supports and working with the person to address ongoing needs to build resilience, is also the time when the person is looking at the worker and thinking well what the hell do I need you for? I have a house. So although we are more than happy to provide support they just don't come back after that initial appointment. (Accommodation Support Services)*

The lack of appropriate accommodation was a significant barrier and as one worker said 'how can you work on alcohol and drugs if you have no home?'

> *It's around accommodation. You see people coming out of jail with "I'm never going back there, I'm going to change my life". But then because of the barriers to work, to everything else, they are just not able to get that accommodation. They might go to a crisis shelter and find there's drugs and alcohol there or no vacancies so they are back with friends or there's no friends anymore. So maybe after six weeks they are back into self-medicating and it starts the whole cycle again. Some of them think I'll just break the law again and get back into prison because at least I'll get a roof over my head and meals. (Accommodation Support Services)*

Lastly some workers considered that they did not have the skills to be able to deal with these issues effectively. In appointment-based services during the snapshot skill levels were identified as a barrier to intervention in 8% of client contacts over a two week period. This rose to 15% in residential and day services. This lack of confidence could manifest itself in concerns about driving the client away and provoking an adverse reaction if they identified alcohol and drug issues.

> *I tend to keep a little bit at arm's length when it comes to drug and alcohol issues. I tend to refer to counselling support services. It is really difficult when the box is open and you find yourself in that space between the access to your service and the service that would be most appropriate to move on to. It's tricky. Perhaps some workers do tend to leave it alone a little bit and there's a reluctance. (Employment Support Services)*

> *I've had too many experiences of when I get involved in someone's substance use they don't want to work with me on other things. If she's going to stick her nose into that kind of stuff I'm not going to come back and see her. Sometimes it's just like the last barrier. People don't want you to go there. These people are under stress anyway or in a situation where they don't need to be provoked. (Accommodation Support Services)*

Anglicare aims to provide weekly peer debriefings and manager supervision. However in residential and day services inadequate supervision levels were identified as a barrier to working with alcohol and drug issues in 8% of shifts.

3.8 Dealing with Mental Health Issues

Substance use is very common in mental illness yet the status of substance misuse as a mental health problem is unclear and there is little coordination between sectors which use different models of intervention and work in different cultures. It means that they often operate as parallel universes where clients are shunted from one to the other. Workers described significant

co-morbidity issues and particular difficulties in working with clients who had both mental health and substance use issues. Grappling with this does not only fall to workers in mental health services. The snapshot survey showed that up to 52% of client contacts with ATOD issues spread across Anglicare programs were identified by workers as also having some kind of mental health issue. For example the workers in the Personal Support Program, where 42% of client contacts had alcohol and drug issues, also estimated that up to 70% of their clients would have mental health issues.

Difficulties in working with clients in this group included a perception that change was unlikely, challenges in finding appropriate accommodation, problems in getting access to specialist services and in getting mental health and alcohol and drug services to work together.

> *A lot of people in the field seem to think they fall into a no-hopers category which is not necessarily true. Mental health clients get labelled enough as it is but if on top of that you're seen as a pot smoker or a drunk then that makes it very hard for people to treat them with any sort of hope that they could recover, the hope that something could be different. If you are working with people like this you need to have some sort of hope. If they don't have hope, you have to have the hope and hang onto it. So maybe they are not doing well today, maybe next time. You just have to keep going. (Mental Health Services)*

> *There is a huge need for housing for mental health clients and then you can probably start to address the other needs. We accommodate them out in the community where their behaviour is not acceptable and they don't conform to the norm. Consequently we lose providers. The other day the landlord was reluctant to let one in even though they have a worker working on their behalf. If you go out to these higher density single person developments in public housing there is a massive culture of drug and alcohol usage there which is not good for a lot of clients we are trying to get into public housing. They might be alright and then they move into one of those communities and it's pushed on them. If we can get housing sorted we can work on the other stuff. (Accommodation Support Services)*

Some teams had been able to establish reasonably successful relationships with both mental health and alcohol and drug services which benefited their clients and which enabled them to work alongside each other to provide intensive levels of support:

> *He had a good mental health worker who actually knew our service and sent him here for that reason. I have access to her and can talk to her with his permission. She will also ring me. That means we can support him. I know how she's working and how I'm working and we are working to a similar model. The mental health is still there but he's taking his medication and there are two of us to nag him and that seems to work. It's not like waiting for a month to see the mental health worker. (Employment Support Services)*

However other workers described difficulties in accessing services for their clients and in then getting services to work together collaboratively. This could leave them picking up the pieces and filling the gaps left by the specialist sector, often with little support.

> *Mental health services don't want to see a client with drug and alcohol issues. Drug and alcohol don't want to see a client with a mental health issue and they just keep pulling*

against each other. They do the assessment and say it's not mental health, it's drugs and drug and alcohol say the same thing. We all know how the co-morbidity works, that they feed into each other and are self-medicating. They say when you get your alcohol thing sorted out come and talk to us. We are left on the outside looking in thinking well where the hell do we go, what do we do with this person? We are meant to be able to fix the problem that those two organisations are fighting about. (Accommodation Support Services)

We get so frustrated referring people to mental health services and they are knocked back because they are just not mad enough. It's that simple. If they have a neurological disorder they will jump on it but things like depression, personality disorder they haven't got the time and with the co-morbidity stuff it falls into the same hole, they're just not mad enough. People present at A and E hoping to get into the psychiatric ward but depending on how they front up they drug test. If the urine is drug positive it's highly likely that person won't be accepted even though we know they are having an episode. Or they tell you you're doing a good job and keep going and we are supposed to accommodate them in a boarding house. (Counselling Services)

Workers conveyed a strong sense of being forced to operate as the final safety net. They described clients being delivered by the police when they had failed to get them into psychiatric services through the Accident and Emergency Department. One worker described a client on a reducing dose of methadone with significant pain issues where they had tried to get the Alcohol and Drug Service to coordinate with the pain management clinic but with little success. A particular barrier was about negotiating confidentiality issues between services where despite clients signing consent forms, information was not necessarily forthcoming.

I gave a presentation at the hospital and the nurses on the psychiatric ward were stunned to find we would work with someone with dual diagnosis. I was saying well why wouldn't you? Our clients come from that pool. If you put up a sign and said we'll work with anyone who doesn't have a drug and alcohol problem you would be sending them all away. But they were surprised we were going to work with that group. A previous team leader here had an instance with a client who he repeatedly took down to A and E. He was always drinking, smoking pot or whatever he could get his hands on. He was only 18, very symptomatic and constantly hearing voices, quite paranoid with delusions and to mask that he was taking whatever he could. They went repeatedly to A and E to try and get an assessment and they repeatedly said he has a drug and alcohol problem and until he's dealt with that we can't do anything. The end of the tale for that young man was that basically he ended up being incarcerated for a period of time and that was the only way he received any mental health treatment. He was medicated and treated. It was a horrendous way to go about it. (Mental Health Services)

Workers were finding ways to intervene around these issues and make some headway in tackling the alcohol and drug issues to reduce consumption but it could be slow work.

His case manager attempted to get some referral into Drug and Alcohol but I don't think it went any further. The latest tactic is saying to him if you back off the pot a bit we won't have to give you such big injections because the two are fighting against each other and he said yes I really understand that. With this particular client it's really difficult to work with him. Sometimes you think you've taken a step forward and then you realise you've taken five steps back and it's just a case of keeping on going. Basically

just turning up and saying how is it today, that's all you can do sometimes. I think it's possible to make some inroads when they have a bit more insight into their condition. It's a case of hanging in there until they feel like they can make a small change. (Mental Health Services)

There have been no problems referring in but there is no collaboration. Mental health services will refer to alcohol and drug services and hope that they can provide the appropriate support but they are not able to provide that intensive support that we are able to provide. They are always happy to accept our clients but they've got a model that sometimes is not appropriate to people with mental health issues and they don't have the time to spend on building rapport. We have been in the box seat basically because we are able to provide that intensive, long term support and effect some change. And we have the rapport. We can work with them in excess of three years and that can be five to ten hours a week. It gives you some really good quality time to get in and enable them to reduce or abstain from taking drugs. (Mental Health Services)

What workers wanted to see was a case management system which was able to join all the services up together – mental health, alcohol and drug services, accommodation and family support.

3.9 In Summary

Dealing with alcohol and drug issues is a significant part of the work of Anglicare staff across services, with interventions taking up to a fifth of their working time. Large numbers of clients affected by these problems are pre-motivational and either consider they do not have a problem or are not ready to make any changes to their behaviour. This means that workers concentrate on strategies which can promote the motivation to change rather than referring clients into specialist ATOD services. This illustrates the mismatch between the level of need which is visible to workers and the level of demand for specialist interventions. It also illustrates the key role of CSOs in working with clients who have not and are unlikely to access the specialist sector and the lack of support they have in this role.

Workers emphasised the importance of aiming for small breakthroughs or as one worker put it 'working in millimetres'. They also emphasised the constraints imposed on them in providing a more effective response, such as the lack of time available, being unable to access appropriate accommodation for clients and their own skill levels.

4. The Views of Clients

A sample of Anglicare clients with alcohol and other drug issues were interviewed in order to explore their experiences of using services and what kind of help they would like to see available for people in their situation. They included people using accommodation, employment and mental health support services and in some cases a mixture of these. Some had only recently got in touch with Anglicare, others had been using Anglicare services regularly over a number of years. They were:

- a 19 year old male poly drug user;
- a 26 year old female refugee with alcohol problems;
- a 26 year old man with cannabis issues;
- a 28 year old man with problematic use of marijuana, a history of amphetamine use and a recent diagnosis of bi-polar disorder;
- a 28 year old man with alcohol problems and contact with mental health services;
- a 31 year old woman with alcohol issues, particularly binge drinking, and contact with mental health services;
- a 37 year old man with a history of poly drug use who was now on the methadone program;
- a 39 year old woman recovering from cannabis and alcohol use;
- a 40 year old man with some alcohol issues;
- a 42 year old male alcoholic with undiagnosed depression; and
- a 50 year old man having issues with alcohol and marijuana who was a long term user of mental health services.

This chapter describes their experiences and assesses the implications for developing more effective responses in both CSO and specialist ATOD services.

4.1 Alcohol and Drug Use

Interviewees were asked to describe how their problems with alcohol and drugs began, what impact this had had on their life generally and what their current situation was. Without exception all those in the sample described how they had initially started to use tobacco and alcohol and/or illicit drugs during their adolescence until it developed into a pattern of dependent use in their late teens and early twenties. They talked about their experiences with alcohol, cannabis, ecstasy and amphetamines, morphine and magic mushrooms as well as benzodiazepines like valium. As addiction levels with illicit drugs increased some talked about the move into drug dealing and criminal activity to fund their addiction. Others talked about fines and in some cases prison terms for drink driving and for violence and assaults related to alcohol use.

Although the interviews did not explore in depth the reasons why people felt they were consuming at problematic levels, interviewees did identify a range of issues which they felt had

led to their consumption increasing. These included coping with traumatic events in their past, including abuse, and dealing with the symptoms of mental illness.

> *I used to drink from shyness, stress, financial problems, although drinking just gives you more financial problems. You hide yourself behind the drink to cover stress, depression, shyness. I was not a very good conversationalist and it helped that. The more you drink the better you felt and you could socialise with people. I have never been diagnosed with depression but I'm sure I've got it. (Male, 42, using Accommodation Support Services)*

They were asked at what stage and why they had identified that they had a problem with their consumption. Most were able to pin point a period of time when they were in denial, when although using at high and dependent levels they had not acknowledged that they had any difficulties. In some cases this period covered a number of years and as one man who had been injecting amphetamine said:

> *I was in denial for a fair while. I said I haven't got a problem I'm just a casual user, I'm not a junkie like so and so down the road. I'd say it was about five years into using when I realised I had a problem. I was into any injectible by that time. At one time I even tried injecting vegemite. It's nothing to be proud of. Anything that would crush up and put in a syringe I pretty much tried. You are denying it full stop. You don't tell anyone, it's all hidden. That's when you're at your worst but you don't feel you've got a problem until it's too late. You have but you don't think so. Everyone else can see you've got a problem but you can't yourself. That's what the drugs do to you. You look at yourself as just a social user but that's not the case at all. All my experiences with people I know it's all pretty much the same. (Male, 37, using Employment Support Services)*

What kind of event motivates people to acknowledge their difficulties? This varied but among our sample it usually involved the increasing impact drug use was having on their life. For some people it was witnessing their peers overdosing, committing suicide or being imprisoned or admitted to psychiatric wards and having near misses themselves. For others it was the impact on their family, the distress of their parents, partner or children, or losing custody of their children. It was also the impact on themselves, such as having difficulties controlling their anger and aggression, losing weight, feeling unwell, losing their memory or a combination of all of these factors.

> *I went from owning a car and just about buying a house to being rock bottom, jumping through people's windows and unemployed because of the drugs. My family split up and my relationship with my lady friend who I'd been with for nine years. The children are still in care at their grandmother's. I've lost my family and I don't have any contact with my biological family. They wiped me because of what you have to do to support your habit. Everything just blew up and I was looking at imprisonment for running around all the time and shoplifting. I spent some time in prison not actually through drugs, but mainly traffic offences. So I've been lucky not to be caught out. When my family split I was living on the streets. You don't worry about rent if you're a drug user, that's the last thing you're going to worry about. I realised I had to do something otherwise I was going to end up dead in the gutter somewhere. It's destroyed my life and I've not been happy since I've started using drugs. I exist, I don't call what I do living. (Male, 37, using Employment Support Services)*

It made me start stealing. I had to start stealing to keep me going otherwise I would just snap and do stupid things. It built up a lot of trouble and I started to do bigger and worse things. I was doing robberies and stuff like that, got involved with guns and went over to the mainland. I've done some pretty serious stuff and I went to Ashley and then to Risdon. My grandfather he took me on board for a little while and I even started slapping him. I've actually scuffed my own grandfather and put him up against the wall. I felt bad about it. It wasn't worth it. I could have learnt a trade or done something proper. Once I got to jail it scared the shit out of me and I decided I just didn't want to go back there so I should start to look at myself and get my life on track. (Male, 19, using Accommodation Support Services)

I was walking the streets, nowhere to stay. I was shaking with coldness. I thought Jesus this is the worst I've ever been. I've lost everything. I had just been kicked out of my last rental. I had no further to go apart from being dead. (Male, 42, using Accommodation Support Services)

Some interviewees were still in the process of coming to terms with the fact that they did have a problem. They had acknowledged the severe impact it was having on their life and that they needed to do something but at the same time felt ambiguous about taking action or did not necessarily believe that change was possible.

I don't think nothing would ever help me. I don't really want any help with alcohol. If I was bad enough I would ask for help. I have alcohol issues and it makes me very sick physically and mentally. I do want help but I don't. I am not an alcoholic. I just have alcohol issues. (Female, 31, using Accommodation Support Services)

4.2 Getting Help

When interviewed all the participants were accessing support from an Anglicare program. They were asked whether they had ever asked for or received any help with their alcohol and drug problems from any source. Some said they did not want any help and their consumption was under control:

I don't want help. I see it as being a bit of a problem now but I'm not taking the quantities that I used to or as frequently. You can step off. You can either be a drug user or abuser. It's okay – not all right but okay – to be a drug user and that's how I classify myself. It is not okay to be a drug abuser. The difference between those two is a drug user doesn't get a habit, it's not routine, you pay for it with your own hard earned money, you don't take it to excess, you take it for a reason to go out and enjoy parties, enjoy a rave. Drug abusers will take it for no particular reason at all. You steal, lie, cheat to support the habit. They [services] might have offered help and I've said no. (Male, 28, using Employment Support Services)

It was striking how many of the sample described accessing specialist alcohol and drug services yet said that they had received very little help with their problems. Any services they had received or assistance from family had not been appropriate or had not met their expectations. This included drug counselling, withdrawal services and residential rehabilitation.

I've used drug counselling and it didn't do anything for me. I thought I needed some counselling and I thought they would be able to help me but they couldn't. I had a couple of sessions but it just doesn't do anything for me because all you do is sit there and talk and they listen and it's not going to stop me from going out and drinking in the pubs. I went to see if they really could help me but these services haven't helped me to be quite honest over the years. (Female, 31, using Accommodation Support Services)

I've been to drug and alcohol. You have your once a week meeting and they just tell you the same thing over and over again. You say I'm struggling with this and struggling with that and they say let's just go over it again. I know these things and breaking things down into small jobs, planning your days, see where your time goes, all that sort of thing. I try it but it just gets back to the whole motivation thing. (Male, 28, using Accommodation Support Services)

One man who had used drug counselling had not found it useful because of the lack of continuity among the staff. His lack of confidence in the services on offer meant that he considered imprisonment a solution although he was very aware that unless there was support on release making any changes sustainable was problematic.

I've tried to speak to psychologists – probably six. I've told them my whole life story and then I'm fobbed off two weeks later dealing with someone else because they've just changed their job so I have to tell someone else my whole life story again. So you don't seem to get anywhere. You go round like a dog chasing its tail. The information I was giving and receiving I didn't see where it was going. It was all give and no return. So I didn't get any help out of that, from talking to people. One answer is imprisonment. It's a very hard way of doing it but at least you cut off and you're clean. But then you're back out with the same people, doing the same things again. A lot of my friends, associates come and go from prison. They go in, clean themselves up, get out, go and do a robbery, go back in. They get institutionalised. I was talking to a friend of mine in the mall the other day. He had just got out of prison and he's sitting there twiddling his thumbs and he's got nothing to do. If you've got nothing to do you bump into Joe Blow and it's drugs again. (Male, 37, using Employment Support Services)

Interviewees also described their experiences of thinking about and accessing residential rehabilitation programs. One man had received a lot of support from his mother who had persuaded him to try a residential rehabilitation program but he had struggled with his motivation.

I went to the Salvation Army Bridge Centre a couple of times. I graduated with them and I knew I had a problem but something was stopping me. I went there because mum had a big influence in that. But I was only half hearted about it and I was only doing it for her and not for me. I thought it was a big bore. (Male, 50, using Mental Health Support Services)

Others described difficulties with the Christian focus of some residential rehabilitation services in Tasmania and complying with the rules and regulations.

I went to Missiondale[11] *but I found out I can't see my daughter for weeks or have visitors for the first so many days so I thought no, I can't handle that. I wasn't prepared to do it and I'm not religious at all. (Male, 42, using Accommodation Support Services)*

[11] A residential rehabilitation facility in northern Tasmania run by City Mission.

And one woman had considered residential rehabilitation but was concerned about leaving her children:

> *I did consider going. The reasons why I didn't is I didn't want to give the kids up at the time. It was too scary to think I'd be there for so long. (Female, 39, using Employment Support Services)*

Another man had accessed the methadone program through withdrawal services when he found himself homeless and although this had stabilised his situation it had not, in his view, provided a solution:

> *I was rock bottom, no money, no income, nowhere to live. So detox was somewhere to stay. I was staying at a friend's place and he'd had enough of me by then. He helped me get into detox. I was there for two weeks and just about dried up and came clean but I realised that as soon as I got back out of them doors I'd go straight back. So I decided to go on the methadone program. You get a dose daily, your medication is there and you don't have to steal or cheat or destroy families or your life. I knew I couldn't come out of rehab and just go straight. It just wasn't possible because I came out with again nowhere to go. So it was the only way out for me. So that has helped me a great deal. I've been on it for 6 or 7 years. I started on a high dose and now I've been reducing and it's levelled off at a much lower dose but I don't know where to go from here. It still hasn't actually solved anything. (Male, 37, using Employment Support Services)*

Interviewees varied in the extent to which they felt their contact with Anglicare services had assisted with alcohol and drug issues. One young man was currently accessing drug counselling through accommodation support services. He had not chosen to do so and it was part of his probation conditions but he was finding it helpful and particularly valued the opportunity to talk to someone who understood the issues:

> *I like it there, it's good. It's just good to talk about it and let some things out. You don't talk to your mate because some of them are really immature and they just laugh about it. But to talk to someone who actually knows what they're talking about. (Male, 19, using Accommodation Support Services))*

Another had found the Disability Employment Network very helpful. Again he especially appreciated the continuity of being with the same worker. This had made an enormous difference:

> *He gives me hope. It's like having someone looking in through the window, just someone I can talk to who is out of my circle and seeing my life from someone else's perspective. He gives me a big boost of confidence and really makes me feel good when I see him. He is there to help me find work but sometimes we just sit and talk about my problems and I find that's good. He hasn't been pushy, he's a bit of a mentor, a friend. I look at my life from where I'm sitting and it's not hopeful but he comes along and puts another perspective on it. He spins it around and makes positives out of my negatives. We've built a relationship, a bond sort of thing. He knows my history and I go in and see him and feel good for that day and I get off my arse and put in applications and it makes you strive. With his support it's been the closest I've looked to see if I have a future after drugs. (Male, 37, using Employment Support Services)*

A number of interviewees were very appreciative of the way Anglicare workers had stuck by them through crisis after crisis, helped to stabilise their situation and provided an opportunity to talk even though they had not directly tackled alcohol and drug issues.

> *He has been a great help, just supporting me and finding housing and talking. It's been very important and helped me a lot. I'm chronically homeless all the time because of my alcohol issues. Then I spend the rent money. (Female, 42, using Accommodation Support Services)*

Given that most interviewees had been problematic users for some time before acknowledging the problem and before accessing any support they were asked whether they considered any help could have been made available to them earlier. There was a general consensus that nothing could have been done because it was up to the individual to motivate themselves and unless they can do so there is very little that anyone else can do. As one man said 'I was heading in that direction and I wanted to have those experiences'.

> *It's a question of whether someone is interested in getting help. If they're not there is nothing anyone can do. You can use scare tactics with some. With others it's about time and some people just need to be supervised, others may need rehabilitation. Others are just happy living day to day and supporting their habit. You can give them help or suggest they give up but they will just say no. There's nothing you can do. (Male, 28, using Employment Support Services)*

> *You have to want to. You can cry out for all the help you want. You can go in for eight months and come back out and two weeks later start up again. I know people who've done that. You have to want to do it. It's not easy. (Female, 39, using Employment Support Services)*

4.3 Improving support

All interviewees were asked what kind of help they would like to see available for people with alcohol and drug issues and they discussed a variety of approaches. One man wanted more pharmacotherapy and in particular something he could take which would mean that 'every time I smelt dope I dry retched and couldn't cope with it. That would mean I would have to give it up'. Another talked about the limitations of other approaches like methadone or safe injecting rooms.

> *I disagree with safe injecting rooms. It makes it too easy. Some people don't do it because they are scared. This makes it safer so they do use and then they decide to use outside the injecting room and do it elsewhere. I do agree with needle exchanges but you should have to bring back the old ones and track down what's gone out rather than what comes in. Methadone, it's just a substitute and works for some but you just get addicted to something else. (Male, 28, using Employment Support Services)*

All interviewees discussed some of the barriers people face in trying to address their issues including having to separate from their peer group. This can be especially difficult in a small place like Hobart and a number expressed a wish to start a new life somewhere else.

> *Tasmania is such a small place. It's hard to get away from it once you've started and I've never been out of Tasmania either. Living in Hobart, it's not a big area. You bump into people and even if you try to get away it's still knocking at your door. Unless you cut yourself right off which is pretty hard because I look on those people as friends. No matter where you go there is always someone saying hey, have a look at this, do you want this. It's bloody hard to come out of it. I'd need to get out of Tasmania to get away from the drugs. (Male, 28, using Employment Support Services)*

What they wanted to see was a range of options which were always available:

> *The door should always be open, not just a narrow hallway but wide open. Somewhere where you can walk in and you know where the exit is. Where if you don't want to give up you can still find out about your options to slow it down and gradually come off. Somewhere where you can find out about the psychological effect. It's about individual solutions and everyone is completely different. (Male, 28, using Employment Support Services)*

Interviewees commented on wanting to see more awareness among workers and in the general community about the difficulties people with ATOD issues face. They also identified the importance of having younger drug and alcohol workers. A person in their 20s does not want to talk to a counsellor in their 40s because it becomes a parent/child situation. Peer support and education could also be helpful and as one client said 'perhaps if someone older who had been through it had told their story it might have helped'. And the overriding importance of having some kind of occupation to fill the time and draw people away from substance use.

> *There is not enough stuff to do here, there's not enough money, there is too much free time and you just go crazy. Maybe I feel down and you have one drink and then you just can't stop. I smoke and drink because it changes the way I think and feel. You feel so empty inside you have to get rid of it. Even if they had small groups for a week or two on camp. Just getting you out doing activities is a good thing, just keeping people busy.. There is nothing to do. (Male, 28, using Accommodation Support Services)*

One woman wanted to have a facility where her money could be managed for her temporarily to allow her to regain more control over her drinking:

> *Alcohol takes most of my money each fortnight because that's my escape. It might be a good idea, not just for me but for other people, that someone manage their money like a trustee. Your rent is paid, you have enough food in the cupboard, you're clothed, you have your hair cut and your bills paid. I don't know whether I could cope with it and I probably would resent it. It might be very hard but it would teach me a lesson. I am only 31. I've got to do something and I have to do it now but I don't know what. I probably do need someone to manage my money for me for a while so I can have stability in my life. (Female, 31, using Accommodation Support Services)*

But people's responses were heavily coloured by their own experiences and witnessing the experiences of other people in accessing services, for example acquaintances who had used residential rehabilitation one or more times and were still using substances. This meant that there was a general feeling of despondency about the ability of services to assist and high levels of self-blame about their current difficulties. Some people could not offer any answer:

I'm trying to find examples of what should be out there but it's a tough question because I've never found the right thing to get me out of it. So it's not out there whatever it is. You really have to want to do it yourself as well. Once the drugs have got you it's hard to get away from. I wish I could give you the perfect answer that you could put out there to really help people. There is not just the one answer and different people need different things to get away from it. I thought I would be able to help you out more than I actually am. I thought I would have more answers for you. But now you put it to me like that, I really wish I could say this is what you need and I would be the first to jump in. It would be really good to have something out there to fix the problem. (Male, 37, using Employment Support Services)

The only thing that would help me is to get my children back. I drink because I don't have my children. I want to give up not reduce but I can't reduce what I drink because if I have any at all I just want more. If I could have my children to stay over the weekend I wouldn't drink. (Female, 26, using Accommodation Support Services)

4.4 In Summary

The interviews demonstrate a number of key factors in thinking about developing appropriate responses to ATOD affected clients. They show that:

- positive relationships are critical and can make all the difference. Having someone who knows the history, is constant and can operate as a sounding board can be crucial.
- a key role for workers is operating as a 'vehicle for hope' so that clients retain the idea that change is possible.
- many clients use services during times of crisis which can be the starting point for thinking critically about consumption levels and instigating the motivation to change.
- in order to provide continuity the retention of staff with motivational skills is important and requires focused workforce management strategies.
- having occupation can be an essential part of developing the motivation to change and of sustaining it.
- a major barrier for clients in tackling ATOD use is the difficulties they experience in breaking away from drug-using environments.
- those clients who have used ATOD services in the past have often had disappointing experiences. This means that they approach services with low expectations about outcomes and high levels of self-blame about their situation.

Many CSO programs are well placed to offer the kind of assistance and support problematic substance users require. However it does mean boosting their capacity to offer motivational interventions, intensive support and continuity in care. These findings also reinforce arguments for specialist services to be able to adopt more holistic approaches which not only address the alcohol and drug issue but can also take into account the range of other needs clients have. One way to do this is to establish more effective collaborative working relationships with CSO services.

5. Improving the Response

Workers were asked for their views on how to improve the response of non-specialist services to clients with ATOD issues and this chapter explores those views. It looks at what kind of role workers considered was appropriate, training issues, better working relationships with other organisations and the place of specialists in supporting more generic welfare work.

5.1 The Role of Workers

For most workers who participated in the research alcohol and drug issues were part of the client profile and therefore had to be embraced in order to achieve a positive outcome. As one worker said 'you have to treat them holistically and that's part of who they are.'

> *Unless you can actually help them work on some of these issues they are not going to get there. It might be you're only supposed to get them a job but it doesn't work that way. If they are not going to any other workers it is you, and if they trust you, you may be able to get them to someone else. (Employment Support Services)*

They saw themselves both as the first port of call and gateway into other services as well as the final safety net, or 'the last drop off point'. This meant that for many workers they were 'at the forefront of the fight against addiction' and it was a duty of care issue that if they became aware of problematic substance use they also then become responsible for at least offering some kind of support with it.

> *We are, in many Anglicare services, at the very ground level. They can walk in off the street, sit down and just have a chat to someone. They are not waiting three weeks for an appointment. You can just come in and have a yak. You only have to say at reception I want to talk to someone about my accommodation and that gets you in. It's a simple sentence to say. (Accommodation Support Services)*

> *We are about to get a client with extensive alcohol issues. She is at the point where no one is interested in working with her because of her problem. She has lost her housing, lost her family, lost her children, has no support networks and it's now handed over to us to pick her up and to start building her up again. (Accommodation Support Services)*

Although views varied according to the type of program, nature of contact with clients and the level of training individuals had around alcohol and drug issues, most workers outlined a role which entailed identifying ATOD issues, stabilising clients' circumstances, providing general support and information and facilitating, supporting and monitoring access to specialist services. Some programs were engaged in more assertive interventions where they would proactively identify and raise substance use with clients. Others were more supportive in approach where these issues would only be explored if the client themselves raised them as a priority. However in both instances once the issue had been raised a key role was acting as a catalyst for change within a framework of information-giving and general support.

> *There is a role around something inspirational with people, a bigger picture. Something I have said to clients is what do you want for you? If you could have your life a certain way what do you want? Sometimes you can see there is that tiny light bulb and it's like, maybe I can have some kind of choice and control. Homelessness is so stressful. Get a house and get stable and then I'll have the motivation and the strength to stop the drug use or not stop it but certainly try and cope with it better if I'm not worrying about*

where I'm going to sleep tonight. That stability needs to be there to enable people to work through their issues. But also being linked up with someone who can support with that more internal stuff. It's a holistic thing and it has to be approached from all angles. (Mental Health Services)

In disability services some support workers felt that although specific interventions were beyond their scope or remit it was their role to assist clients to become more independent. This inevitably meant that they could be involved in prompting and encouraging an individual to address substance use. Like other workers they also considered that they could be doing more work in this area. And all workers questioned whether their skill levels were adequate to provide effective interventions with substance use issues and what level of expertise was required of them.

You could argue that it is not necessarily within the parameters of the job but you can justify it as being so and you want to do it. But that raises another question about the job generally. Do you have to be an expert at everything? Are you going to be an expert in trauma? Are you going to be an expert in depression? There are so many things, so I tend to think I'll refer on. It's our role to provide information and make referrals but I don't feel qualified to do drug and alcohol counselling as such. (Accommodation Support Services)

Given their views about their role a common concern was that they should receive more recognition of the extent to which they were working with alcohol and drug issues both internally within Anglicare and externally, particularly from government services. The difficulties workers had in setting up effective collaborative partnerships served to reinforce this sense of a lack of recognition of what they were doing and in some cases achieving with clients. They considered that the frustrations and stress levels the work entailed could be eased by more acknowledgement of the pressures involved and better strategies to deal with it, for example more debriefing for staff.

Anglicare need to be debriefing staff about the effects. How does it affect you personally? How can we support our staff to deal with this? It's hard seeing someone who is homeless, let alone seeing someone who is homeless and has a mental health issue and a substance abuse issue because it's going to be fifty times harder for them to find accommodation and sustain it. (Mental Health Services)

In addition they wanted to see this recognition extended to increasing the resources and hence the time available to them to provide more in-depth and intensive support with substance use issues.

I wonder how much frustration and apathy is setting in in workers across Anglicare because of drug and alcohol issues, the frustration because it's the revolving door syndrome again. All of us work here because we're passionate about it otherwise you wouldn't do it. We do work one on one and the demands are very high and the recognition is non-existent. Recognition is important because it is such a draining job. (Youth Shelter)

You only have so many hours to support people and new people come in every day. What we need is more funding for our services so we can actually spread the load a

little bit. You can spend double the time because often disclosure comes while you're off driving in the car to look at a property. It's having the time in the car where you develop more trust and disclosures are more likely to take place. But the way the system is set up it's rush, rush, rush. (Accommodation Support Services)

Staff suggested that this recognition could be demonstrated internally by a review of the relevant policies and procedures including those relevant to dealing with intoxicated clients and a review of debriefing and supervision mechanisms. They also wanted to see a boost to the ability of programs to provide referral support to improve the take up of specialist services and to have more flexible resources to meet individual needs, for example promoting peer education approaches in day and residential facilities. One worker suggested that the requirement to promote change and possibly to do motivational interviewing should be built into all job descriptions.

5.2 Training

Workers varied widely in life experiences, in training levels and in skill levels associated with alcohol and drug issues. Although they were a highly qualified workforce with an estimated 43% of those in appointment based services holding degrees and a further 46% holding diplomas or certificates, only a minority had specific drug and alcohol qualifications. Some had attended workshops or seminars or it had formed a small part of their degree course for social work, psychology or counselling. They had also covered counselling techniques including motivational interviewing. Others had no training at all about ATOD issues and had learnt on the job or drawn on the skills of more experienced members of their team. Many workers considered that their training or experience did not allow them to deal effectively with substance use and even those who had done courses were likely to feel that 'it just opened the door to realise what you don't know.' This meant that they lacked confidence in dealing with these issues. Given that working with ATOD-affected clients was an accepted part of their role and that many were pre-motivational, what they wanted were very practical tools about how to raise these issues and 'start the ball rolling' and how to then work with them. They also wanted information about how to identify usage and the different signs and symptoms to watch out for, how to distinguish between substance use and mental health episodes and more information about referral options.

To get clients to disclose what is actually happening in their lives you need training to know how to ask those questions to get a truer picture. Quite often for workers there is a barrier to asking the challenging questions so the client will disclose. The size of case load can also affect the ability or desire to fully identify what is happening in someone's life. The thought oh god if I go there it will take up so much time. It's about asking the right questions as well to try and find what is underlying. It's about how we open up that bag of worms without it influxing on us. Sometimes I feel I don't know what to ask. It is not doing the right thing by your client if you just open up Pandora's box and then say bye-bye, good luck. That's irresponsible. (Accommodation Support Services)

I'm not skilled up enough in that area. You may think people have an amphetamine problem but you can never really be sure. It could be that they're having an episode – so distinguishing between episodes and usage. Or maybe that's not my job to be able to identify that but I would feel more confident if I was able to identify those issues. I think anyone in a situation of counselling or social work cannot do any harm to be training in drug issues. It's such a big part of our society. At the very least having knowledge of the

drugs and the effects that you may see in people. Also perhaps counselling techniques specifically around drug and alcohol issues and issues of change. I would certainly feel more confident with that training. (Mental Health Services)

Those who had received some training expressed differing views about its usefulness. Some had been to courses which they considered inappropriate. The courses had focused on knowledge and attitudes rather than boosting skills levels and had not recognised the extent to which they worked with substance use issues. This meant that they had given them little insight into how to proceed:

Whenever I've been to any training that involved drug and alcohol it was about becoming familiar with the scene, usage, how it affects people, indications that someone might be under the influence. But it doesn't tell you how you work with it and what you do. The training we seem to end up going to is for people who work in that field, or are identified as working in the field and we are not identified as working in the field but we do. So we need training about how we work. We don't need to know the scientific language around the drugs that people are using. We need to know how to help them manage the issues, how do we support them with their budgets, how we live with that as an issue when we're helping them deal with other stuff? And that's quite different to going to an alcohol and drug training. (Accommodation Support Services)

Others had undertaken training which addressed the practicalities of the work. They had learnt about non-judgemental working and avoiding judgemental language, how to reaffirm their own and societal boundaries and values and how to assess and work with the client/worker relationship. This had made them much more confident about providing support with substance use issues and about getting positive outcomes. Particularly praised was the training associated with the Court-Mandated Diversion Program[12] and how this had enabled workers to improve their practice generally and use it in other programs:

It's really helped me so much in working with clients. Previously I always referred them off to some specialist organisation but I feel more competent now to deal with them myself and also refer if needed. It's more the motivational interviewing that I actually use. So it's looking at decisional balances, the positives you're getting out of using whatever you're using and then looking at the negatives so people get an idea that that list is short but this one is really long. They start to get a picture of what's going on and then look at where they are in the cycle of change. It was so much clearer the mistakes I'd made with previous clients. (Family Support Services)

It just crystallised for me what kinds of therapy are appropriate at different stages so the more insight orientated stuff when you're trying to build motivation and not worrying about the action stuff until they get down to the action phase and are ready for action. Health programs from health departments are very action orientated and you lose a lot of people because they're not ready for that and they are not motivation orientated. There is a whole wad of people that they never touch. Up until now because I didn't feel that competent I would refer out. Now I feel I can deal with it to a certain point and then I can refer out. I feel more competent that I can do something with the client to begin with when they first talk to me about it. (Family Support Services)

[12] The training was provided by Turning Point Alcohol and Drug Centre, Victoria.

There was a general consensus that all workers could make use of more training around addiction issues and that its aim should be to arm them with practical strategies and tools to work proactively, particularly with non-motivational clients and to use a non-judgemental approach. This would enable them to do as much as possible within the constraints of the service and the time available to them.

> *It would be beneficial if we had the funding to do more training. We can't be everything for everyone which is why it's important that we are able to access those other specialist services. But hopefully it's all the other stuff we're doing which is working towards that end. Again the more skilled up us guys are the better. (Accommodation Support Services)*

These findings reflect the results of a training needs assessment carried out by the Drug Education Network (DEN, 2007) which identified the training needs of rural community health and human service providers working with substance using clients. These needs were information about relapse prevention, ATOD facts and effects, models of intervention, prescription medication interactions and harm minimisation. They also wanted guidance about maintaining worker motivation and preventing burnout, working with specific groups, motivational interviewing, basic assessment and working with families living with substance use.

5.3 Working with Other Agencies

There was a concern both to improve working relationships with other organisations and to see the gaps in the external service network filled in order to improve the service options available to clients. Workers emphasised the need for easier referral pathways for their clients and to overcome the 'huge divide' between government and non-government services. For some workers this was about making links with individuals in other agencies at a personal level. For others the rate of staff turnover in different agencies meant that it was about developing more formal protocols between agencies. This also improved the chances of relationships being sustainable:

> *It helps once you've met somebody and you know the face and you can then give them a call and say what do you reckon about this? If you don't know anyone you think shall I call them, no probably not. It's about forming those relationships out there. Do we get enough time to network? I think you have to make time and block out the calendar. (Employment Support Services)*

> *The biggest thing that Anglicare needs to promote are working protocols with other services that really impact on people's lives. That then paves the way for us workers to already have a foot in the door instead of trying to bash the door down. Perhaps the managers are already doing it but if they are I'd love to hear about it. We really do need pathways for workers. SAAP clients are the most complex needs you can get and we are dealing with them in isolation because we don't have any links or pathways with state government services, with alcohol and drug services, with mental health services, with Housing Tasmania. It's the split high up in the bureaucracy which is the problem. (Mental Health Services)*

Several programs were especially keen on developing better links with health services, especially GPs, in order to better deal with the impact on physical health of long term substance use among their clients.

> *It's about having two or three GPs where you can pick up the phone and actually talk direct – can you see my client? And reassuring the GP that this client is not doctor shopping but they do need some benzos to help them get off. Individual workers have to do it from time to time, to short circuit things, because they go through the normal referral process and it takes weeks and weeks and quite often they are knocked back. (Counselling Services)*

In terms of the shortfalls in the external service network workers prioritised the general lack of specialist options for clients, especially young people. The recent establishment of a new residential rehabilitation facility for those aged 16-25 years may fill one of these gaps. But Anglicare's residential services in particular wanted to see specialist services operating more flexibly and especially having the ability to do outreach work so they could come to the client rather than the client always having to go to them. They commented on the failure of mental health and alcohol and drug services to work together and wanted to see more beds in psychiatric wards for those dealing with co-morbidity issues with specially trained workers. They also wanted a change in attitudes so that someone with a drug induced psychosis was seen as part of the prime target group for mental health services.

> *Why can't mental health and drug and alcohol work together? One of the reasons is the different ideologies, mad or bad, and deserving or undeserving, which don't recognise how people are pushed into substance misuse in the first place and then how that drives the mental health problems in a vicious circle. There needs to be some political will to put money where it's not popular because it won't be a popular political decision. There needs to be a resource where someone can go and dry out for 24 hours in a supervised environment so they can then get into the hospital, but somewhere where there's medical care around. Someone who is taking a lot of drugs, a lot of alcohol and trying to wipe out symptoms, is sobering up – it's a very scary place to be. (Mental Health Services)*

They commented on the lack of access to supported housing for those with substance use issues. Housing has a key role to play in tackling problematic drug use and is a first and crucial step in the rehabilitation process. Nevertheless substance users remain marginal to community care provision and supported housing. Workers wanted 'to see bricks and mortar' in the form of more residential rehabilitation options, accommodation for intoxicated people, supported accommodation for those with substance use issues and a greater availability of accommodation where people would not be exposed to alcohol and drug use.

> *We have to accommodate these people somewhere in the community. It's really hard to find that accommodation when they're an alcoholic or a drug dealer. You can't put them into a pub. All these behaviours associated with drugs like stealing, what do you do with that? So supported accommodation, as expensive as it might be, for someone who is on drugs and alcohol and who needs more time out. For people with psychiatric problems, intellectual disability and drug and alcohol problems there needs to be somewhere secure and safe where they can go. Now that ultimately would be extremely expensive because you have to put security in as well. No one wants to go there because the cost would be millions. (Accommodation Support Services)*

5.4 Specialist Staff

Although most workers considered that they needed to raise their own skill levels through training they also welcomed the idea of having easier access to specialist staff who could provide a secondary consultation role and to whom they could refer or whose expertise they could tap into. Some programs, for instance the Recovery Program (see Appendix), are able to provide intensive levels of support over long periods of time and work alongside clients while they access alcohol and drug services. Others are dealing with large numbers of clients with whom they only have brief contact and they face time and skill level constraints.

Two different models were discussed – floating specialist alcohol and drug workers available to CSO staff across the state and/or specialist workers or a team of specialists within Anglicare available to all programs. Workers favoured an approach which allowed them to internally refer for specialist support and talked about the positive benefits they had experienced of having in-house referral pathways to other Anglicare programs. Those who had experience of working with GIDS expressed high levels of satisfaction with the service. They commented on how it could smooth the path for clients to a specialist response by offering a single door approach into services, easing the process of referral, increasing uptake and reducing the risk of people falling through the cracks.

> *I find the programs we've got in Anglicare are fantastic. I can be sitting with my client and they talk about other issues, like housing or financial stuff and I can say there's somebody here to talk with and can book an appointment. Or I can even call the financial counsellor in to talk with them if they want that. Just for a few minutes and so they know the face and what they do and they are then more likely to go onto that service for support. You could have a couple of specialist workers within Anglicare that could float around and educate and step in and out with different programs. A flexible sort of role to keep up to speed with things that are changing and so other staff members have a link. They could get someone straight in the door, get that assessment, and get that stuff put in place for someone they might not see again (Counselling Services)*

> *From the client's point of view it is not a positive thing to be going to another program in another organisation. They get sick of retelling the story and they might think their privacy is compromised by sharing their information. You can do referrals until you turn blue, it doesn't mean that person is going to turn up at that appointment. Having an on-site drug and alcohol worker would be wonderful. It could be a seamless progress and for us to have an internal pathway that we can set a person onto when they've made the decision or even when they're pre-contemplative. You can say how about having a yarn with so and so, just a talk to see what you think. And just get them actually doing something towards heading along that track. What you have already done is establish a rapport with them and that is the really important part, the window that you don't want to lose. It doesn't make sense not to because all the programs would use it and it's needed across the board. (Accommodation Support Services)*

Some workers called for an expansion of the GIDS model across Anglicare services or for opening up the Court-Mandated Diversion Program as an additional resource that other Anglicare services could use. It was also suggested that it would be useful to map where staff with alcohol and drug qualifications are in the organisation and use them as a local resource in order to maximise the skills already available.

5.5 In Summary

Workers who participated in the research considered that while it is their role to intervene in the ATOD issues of their clients, they could be doing so more effectively. What they needed was access to opportunities to raise their skill levels, to work more collaboratively with other agencies, and to be able to draw on specialist expertise when required.

Previous work which has examined the role of frontline workers (Shaw et al, 1978) identified three factors which influence the likelihood of them intervening in the ATOD problems of their clients. These are:

- role competence or having the skills and knowledge to respond;
- role confidence or belief in their own competence; and
- role legitimacy or a perception that responding is a legitimate part of their work role.

Most workers certainly considered that responding was a legitimate part of their role, yet many lacked the competence and confidence to intervene and believed that they required highly specialist skills to be able to do so.

6. Conclusions and Recommendations

6.1 Summary

This research has shown that working with people who have ATOD issues is a large part of the work of CSOs. Approaching half (46%) of all client contacts in appointment-based services in Anglicare involve issues associated with the problematic use of alcohol and other drugs. A significant percentage of this population (59%) could be described as pre-motivational. Either they do not identify themselves as having a problem or if they do they are not ready to take action to change their behaviour. Similar issues are regularly encountered by residential and day services and by disability support workers working in the community. This leaves frontline workers struggling both to moderate the impact alcohol and drug issues have on the service they can deliver and the outcomes for clients whilst simultaneously working to promote clients' motivation to change. In most cases this work is being undertaken without recourse to specialist ATOD services and in an environment where there are shortfalls in the time, resources and skills available to workers to engage in this role. This situation is repeated in CSOs across Tasmania as workers attempt to provide an appropriate response to a large reservoir of need which does not translate into a visible demand for specialist ATOD services.

These findings raise a number of questions about the future development of a comprehensive and coherent ATOD sector in Tasmania. In particular they prompt debate about the best mix between specialist and generalist services, the part that could and should be played by non-specialist health and human service programs and how to provide what can be intensive and time consuming interventions as part of routine care and support.

6.2 Recommendations

6.2.1 Joined Up Working

Frontline CSO services have a vital role to play in constructing a coherent ATOD sector. They can be ideally placed to develop a good rapport with clients to address problematic and high risk use before it becomes entrenched, to work with clients to promote and sustain behaviour change and to ease the path into specialist services. They can often work holistically providing multi-faceted interventions which address housing, employment, financial and relationship issues. Specialist services concentrate on the severe end of the spectrum whereas CSOs can reach those populations who may be less seriously affected but for whom problematic use is having a negative impact on their lives as well as those who are severely affected but reluctant to access the specialist sector.

The recent review of ATOD services in Tasmania (HMA, 2008) proposed a four-tiered model of service delivery be adopted with population based prevention initiatives at one end and specialist treatment at the other. It was anticipated that the tiered approach would promote the integration of services, clear linkages, role delineation and partnerships with providers in other tiers. Non-government community-based services are located in Tier 2 together with primary health care. Yet currently they are rarely seen as an integral part of this spectrum of services and the research highlighted the difficulties they experience in trying to access appropriate training and develop effective collaborative partnerships with specialists.

Recommendation 1: That the State and Federal Governments acknowledge the significant role played by non-specialist CSO services and other human services systems in addressing ATOD issues.

Recommendation 2: That the Department of Health and Human Services, through the Future Directions Plan, invest in additional resourcing to support collaborative practice across the specialist and non specialist ATOD sector. This will entail:

- instigating a cultural shift to promote joint working between specialists and non-specialists and the building of local partnerships to improve client outcomes;
- ensuring that time to network is recognised and resourced as integral to the delivery of better quality outcomes for clients;
- informing clinical staff about the role of CSOs in working with ATOD issues and how to engage in collaborative practice;
- ensuring that confidentiality and privacy issues do not become a barrier to effective joint working; and
- implementing a monitoring and reporting mechanism to ensure this is achieved.

Achieving collaborative practice across sectors is challenging. One way forward is to identify a senior position within the DHHS to lead on these issues and promote initiatives. These initiatives might include exploring opportunities for government and non-government sectors to meet as well as ensuring participation by CSOs in any DHHS induction processes for new department employees in order to foster better understandings.

This failure to work together is particularly acute in the mental health field where mental health services find it problematic to work with people with alcohol and drug issues and vice versa. This can leave CSOs operating as the final safety net with little support when clients are turned away from other services. There is an urgent need to develop an integrated and adequately resourced alcohol and drug and mental health system which recognises drug users as mental health service users. The National Co-morbidity Initiative is addressing some of these issues including raising awareness of co-morbidity among clinicians and health workers and improving treatment models and outcomes for people with co-morbidity. A particular difficulty for workers in this research was accessing acute mental health services for clients with substance use issues.

Recommendation 3: That the Department of Health and Human Services allocate beds in psychiatric wards for those with co-morbidity issues supported by specially trained workers.

6.2.2 Workforce Development

Problematic substance use is widespread and affects a large number of people who come into contact with CSO services where few staff have training about the nature of these problems or how to respond to them. Staff have an important role in identifying whether substance use is an issue, raising awareness about its impact, encouraging change and promoting access to specialist services. However they are limited in this role by skill levels. The research found that what workers needed were short courses of practical relevance which could arm them with strategies about how to raise these issues with clients and then how to initiate and sustain behaviour change. They required training in assessment skills, motivational interventions, harm minimisation and relapse prevention. Managers also require training to ensure consistent

management styles around these issues. These findings are consistent with work carried out by the National Centre for Education and Training on Addiction (NCETA, 1998) to identify the education and training needs of frontline professionals in responding to ATOD problems.

Yet at the current time there is no comprehensive framework at either a state or a national level to support and guide ATOD training or workforce development. In Tasmania there is no lead agency in this field and no training calendar. What training is available is delivered in an ad hoc manner with more consideration to the needs of specialist alcohol and drug workers than the needs of those delivering generic welfare services. Ultimately what is required is work to define core competencies along with practice standards for working with clients with ATOD issues in non-specialist services and programs. However in the shorter term a significant impact on client outcomes could be achieved by raising workers' skill levels in assessment, motivational interviewing, harm minimisation and relapse prevention. These are not high level skills nor would they be costly to promote. Training workshops recently conducted to give rural community health and human service providers a basic introduction and practical skills in working with substance using clients were positively evaluated (DEN, 2007). The cost was approximately $525 for a workshop with 18 participants and excluding venue, catering and overnight accommodation costs for the facilitator.

Accessing training is expensive. It means back-filling posts and managing training budgets. Additional costs are incurred when it is set within the broader framework of workforce development, recruitment and retention in order to ensure that any training investments are fully utilised.

Recommendation 4: That the Department of Health and Human Services develop a comprehensive workforce development strategy applicable to all non-ATOD funded agencies working with clients with problematic ATOD use.

Recommendation 5: That the Department of Health and Human Services conduct a state wide survey of non-specialist workers' training needs specific to ATOD use to guide and inform future service planning and provision.

Recommendation 6: That the Department of Health and Human Services invest in supporting non-specialist CSOs to access appropriate ATOD training and skill development.

Recommendation 7: That the Department of Health and Human Services Quality and Safety Framework incorporate skills development in the ATOD workforce as a core component of improving client outcomes.

There is currently some discussion about the establishment of an education and training unit to lead training strategies in the ATOD sector. This could provide an important focal point for implementing a comprehensive education and training strategy for non-specialist CSO workers, remove wasteful competition in provision and explore the value of adapting resources developed in other jurisdictions. There are questions about where such a unit would be located – in the government or non-government sector – which should be the subject of on-going debate. However Anglicare would fully support such an initiative as an important step towards improving skill levels in the sector.

6.2.3 Good Practice in Service Delivery

Whatever collaborative relationships are developed between CSOs and the specialist sector there will continue to be a population who are reluctant to use specialist services but who can benefit from interventions delivered by workers with whom they have developed a rapport. These can be delivered opportunistically. Discussions with both workers and clients who participated in the research identified a number of key factors in delivering a quality service to clients with problematic substance use. These are:

- a positive relationship with staff who are non-judgemental, well trained, committed and approachable;
- person-centred, flexible and informal service delivery which fosters client choice;
- continuity of staff;
- an holistic response which can respond to multiple and complex needs including ATOD issues;
- a one stop shop approach with smooth pathways between services; and
- support to access and make effective use of specialist services.

As well as boosting the capacity of the workforce to deliver this through training and skills development the research highlighted potential strategies which would provide a firmer base for workers to become more proactive in working with alcohol and drug issues and the following are recommended:

Recommendation 8: That CSOs review all policies and procedures relating to clients with alcohol and drug issues including the approach to intoxicated clients and supervision and debriefing mechanisms for staff engaged in this work.

Recommendation 9: That CSOs undertake a staff skills audit to identify where skills in dealing with ATOD issues are located in the organisation so that other staff can draw upon them.

Recommendation 10: That CSOs ensure that a basic introduction to ATOD issues is incorporated into any induction processes.

Some sub-groups among CSO service users have particularly high rates of problematic substance use, including people with mental health problems, young people, people who are homeless and Aboriginal and Torres Strait Islanders. A recommendation has already been made about the particular needs of people with mental health problems and concurrent substance use. This research found that Indigenous service users had higher rates of problematic use than non-Indigenous users (62% as opposed to 45% of all client contacts in the snapshot survey).

Recommendation 11: That the Department of Families, Housing, Community Services and Indigenous Affairs extend their current initiative to train Aboriginal workers in alcohol and drug issues to non-Aboriginal workers working with Aboriginal clients.

Recommendation 12: That CSOs encourage staff to take up training and improve their skill levels in working with Aboriginal clients with alcohol and drug issues.

6.2.4 The Specialist ATOD Sector

The research found shortfalls in specialist services in Tasmania. These were clearly outlined in the recent review (HMA, 2008) and this research particularly highlighted waiting times to access services and a limited range of service options, the inability of services to provide outreach and a lack of collaborative working. Workers also emphasised the difficulties their clients could have in engaging effectively with specialist services which meant increasing pressure on them and their own workloads. As the review pointed out, the size of the treatment sector in Tasmania is significantly smaller than the national average creating difficulties in accessing services and again putting pressure on non-specialist services.

Recommendation 13: That there is significant investment in the expansion of the ATOD treatment sector across Tasmania as outlined in the Future Directions five year plan.

New responses are required to improve the range and appropriateness of treatment and referral pathways for those who are reluctant to use specialist services. If one way forward is about boosting up the capacity of the non-specialist sector to give a stronger response this must also consider more integrated and outreach models to deliver holistic services so that specialist input can be accessed by programs which have developed relationships with clients. Certainly workers wanted to see easier access to specialist workers and to be able to draw on their expertise in working with clients. They described models where the presence of a specialist alcohol and drug program within the organisation had enabled easy access to a pool of expertise and smooth referral pathway when responding to complex substance using clients. These models would be of value across the sector.

Recommendation 14: That the Department of Health and Human Services, as a matter of urgency, establish a mechanism for providing consultation liaison services including specialist advice, guidance and on-call support to non-specialist CSOs working with clients with ATOD issues. This should include the ability to offer on site consultancy, a community training element and on-going staff mentoring in the ATOD field.

6.2.5 Housing

A history of substance use can be a barrier to securing housing and certainly the lack of appropriate housing for those with current or previous ATOD issues was a major issue for workers in trying to stabilise clients' situations. Despite the fact that it is the first and crucial step in rehabilitation there is no supported housing for those recovering from substance use issues. Assistance with housing must become an integral part of the support given to those tackling alcohol and drug issues and those leaving treatment and Anglicare has long advocated for a range of housing options for people with complex needs.

Recommendation 15: That the Australia and Tasmanian Governments in the National Affordable Housing Agreement include a commitment to funding that will allow for an increase to 100% in the proportion of people discharged from hospitals and detoxification and residential rehabilitation facilities into confirmed, secure and appropriate accommodation.

6.2.6 Consumer Participation

The service system is currently marked by an almost complete absence of consumer participation in the developmental stages of services and in the delivery of services. Existing models of consumer feedback are typically passive – for example post-service feedback questionnaires. This undermines the effectiveness and legitimacy of the ATOD sector.

Recommendation 16: That the Department of Health and Human Services resource the development of a model of consumer advocacy for people with alcohol and drug issues so that their experiences and views are routinely taken into account in the planning, development and delivery of policy and services.

References

Australian Bureau of Statistics, 2004. *Experimental estimates and projections, Aboriginal and Torres Strait Islander population 30 June 2001 to 30 June 2009*. ABS cat.no. 3238.0. Canberra

Australian Institute of Health and Welfare, 2005. 2004 *National Drug Strategy Household Survey*, AIHW cat.no. PHE 61. Canberra

Australian Institute of Health and Welfare, 2007. *Alcohol and other drug treatment services in Tasmania. Findings from the National Minimum Data Set. 2005-06*. AIHW: Canberra

Australian Institute of Health and Welfare, 2007. *Homeless SAAP clients with mental health and substance use problems 2004-05*. Report from the SAAP National Data Collection. Bulletin 51. AIHW: Canberra

American Psychiatric Association, 1994. *Diagnostic and statistical manual of mental disorders*. Fourth edition, Washington D.C: American Psychiatric Association

Australian National Council on Drugs, 2008. *Supporting the families of young people with problematic drug use. Investigating support options*. ANCD Research Paper

Bruno, R., McLean, S., 2004. *Tasmanian Drug Trends 2003: Findings from the Illicit Drug Reporting System (IDRS)*, NDARC Technical Report No. 178, University of NSW, Sydney

Bruno, R., Ong, S., de Graaf, B., 2007. *Indicators of Drug Use in Tasmania*. School of Psychology. University of Tasmania

Cancer Council of Tasmania, 2003. *Prevalence of Cigarette Smoking among Tasmanian Secondary School Students in 2002*. Cancer Council Victoria, Carlton.

Collins, D., Lapsley, H., 2008. *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/2005*. National Drug Strategy Monograph Series Summary Verion No. 66

Commonwealth of Australia, 1998. *National Drug Strategic Framework*. Canberra

Department of Health and Ageing, 2007. *Barriers and incentives to treatment for illicit drug users with mental health co-morbidities and complex vulnerabilities*. Monograph series No. 61. National Drug Strategy. Commonwealth of Australia

Department of Health and Human Services, 2008. *Future Directions. A five year plan*. DHHS, Tasmania

Drug Education Network, 2007. *Introduction to working effectively with alcohol and other drug issues and Participant Needs Assessment*. DEN: Tasmania

Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, S., 2007. *Impact of a statewide home visiting program to prevent child abuse*. Child Abuse and Neglect. September 2007

Healthcare Management Advisors Pty Ltd, 2008. *A Review of Alcohol, Tobacco and Other Drug Services in Tasmania*. Final Report

House of Representatives, 2003. *Road to Recovery. Report on the inquiry into substance abuse in Australian Communities*. Standing Committee on Family and Community Affairs. Parliament of the Commonwealth of Australia. Canberra

Kamieniecki, G., Allsop, S., Lintzeris, N., 1988. *Models of interventions and care for psychostimulant users*. National Centre for Education and Training on Addiction

Media Release, Bronwyn Bishop MP. Chairman House of Representatives Standing Committee on Family and Human Services. *Winning it for the kids: protecting families from illicit drugs*, 13th September 2007

Ministerial Council on Drug Strategy, 2004. *The National Drug Strategy. Australia's integrated framework 2004-2009*. Commonwealth of Australia

National Centre for Education and Training on Addiction, 1998. *Education and Training Programs for Frontline Professionals Responding to Drug Problems in Australia*. Summary Report. NCETA

National Centre for Education and Training on Addiction, 2006. *The South Australian alcohol and other drugs workforce development audit and capacity building project*. NCETA

National Drug and Alcohol Research Centre. 2001. *Who Seeks Treatment for Alcohol Dependence*. NDARC. University of NSW, Sydney

National Drug and Alcohol Research Centre 2003. *The Treatment of Alcohol Problems. A Review of the Evidence*. NDARC. University of NSW, Sydney

New South Wales Health, 2005. *Interagency guidelines for the early intervention, response and management of drug and alcohol misuse*. NSW Department of Health

Prochaska, J., Di Clemente, C 1986. *Towards a comprehensive model of change*. In: Miller W., Heather N (Eds) Treating addictive behaviours: Processes of change. New York: Plenum Press

RADAR, *Register of Australian Drug and Alcohol Research*. Alcohol and Other Drugs Council of Australia. National Resource Centre

Ritter, A., 2007. *Priority Areas in Illicit Drug Policy*: *Perspectives of Policy Makers*. In Drug Policy Modelling Program Bulletin No. 2. August 2007

SANE, 2007. *Smoking and Mental Illness: Costs*. A report by Access Economics for SANE Australia

SAAP National Data Collection. 2007. *Homeless SAAP clients with mental health and substance use problems 2004-05*. A report from the SAAP National Data Collection

Shaw, S., Cartwright, T., Spratley, A., Harwin, J., 1978. *Responding to Drinking Problems*. London: Croom Helm

Spooner, C., Hetherington, K., 2004. *Social Determinants of Drug Use*. National Drug and Alcohol Research Centre, University of NSW, Sydney

Tasmanian Drug Strategy 2005-2009. Interagency Working Group on Drugs. Tasmania

Tasmanian Psychostimulants Action Plan 2007-09. Interagency Working Group on Drugs. Tasmania

Teesson, M., Hall, W., Lynskey, M., Degenhardt, L., 2000. *Alcohol and drug use disorders in Australia: implications of the National Survey of Mental Health and Well Being*. Vol 34, No. 2. Australian and New Zealand Journal of Psychiatry

Turning Point Alcohol and Drug Centre, 2003. *Pathways: A Review of the Victorian Drug Treatment Service System*.

Victorian Drug and Alcohol Association, 2003. *The links between alcohol and drug use and poverty: VAADA's submission to the Senate Inquiry into Poverty.* VAADA

White, V., Hayman, J., 2004. *Australian secondary students' use of alcohol in 2002*. National Drug Strategy Monograph Series No. 55. Department of Health and Ageing Canberra

Appendix: Anglicare Services

Accommodation Support Services

- **ACCESS** (State wide) provides case planning and transitional support services to individuals and families who are homeless or at risk of homelessness. It assists them to secure accommodation and other support and provides early intervention, crisis support, information and referral.

- **Emergency Relief** (Burnie, Glenorchy and East Coast) assists people in financial crisis to overcome their immediate difficulties and prevent ongoing hardship through the provision of short-term, emergency financial assistance.

- **Emergency Accommodation Service** (State wide) is a telephone service that organises accommodation for people who are homeless and refers them to ACCESS which can assist them with longer term accommodation options.

- **Private Rental Support Service** (North and North West) provides financial assistance to low income earners to establish or maintain private rental accommodation.

- **Staying Put** (South) assists young people up to 25 years to maintain their own tenancy in either public or private housing.

- **Supported Residential Facilities** (state widw) for low income people with a range of social, health and wellbeing needs who are at risk of homelessness.

- **Youthcare Shelter** (South) provides crisis accommodation for up to six young males aged 13-19 years who are homeless or in need of a safe place to say.

Disability Support and Aged Care Services

- **Aged Care** (North and North West) providing in-home personal support, registered nursing care, care by allied health professionals and social support services.

- **Anglicare Tasmania Acquired Injury Support Service** (State wide) provides a number of group houses for people with acquired brain injury and/or spinal injuries requiring high levels of care and units and attendant care for those with lower level support requirements.

- **Home Care Support Services** (Statewide) provide in home support for older people and younger people with disabilities.

- **Independent Living Program** (North and South) provides support to people with disabilities living in independent accommodation in the community.

- **One to One Support** (South) provides supported accommodation to an individual with high and complex needs.

- **Shared Homes Program** (South and North) provides supported accommodation for people with intellectual disabilities within the community.

- **Respite Services** (State wide) provide recreational and in-home respite to older carers of adult children with disabilities.

Counselling and Family Support Services

- **Anglicare Reconnect** (North West) works with young people aged 12-18 years and their families where the young person is at risk of early home leaving or homelessness.
- **Break Even Problem Gambling Services** (State wide) provide counselling to clients who are experiencing difficulties with gambling.
- **Communities for Children** (North) supports families to improve outcomes for children and their well being across health, early learning and development. The approach is grounded in community development, building stronger partnerships and collaborative action.
- **Compass** (South) provides mentoring for young people facing problems with education.
- **Court-Mandated Diversion Program** (State wide) provides specialist support and counselling to offenders of drug related crimes.
- **Early Support Program** (South) provides intensive support for families at risk.
- **East Coast Counselling and Family Support Service** (St Helens) provides counselling and family support to people in the Break O'Day area.
- **Family Relationships Counselling** (State wide) provides counselling to anyone in a relationship or after a relationship has ended.
- **Family Matters** (North) provides support to families at risk of homelessness in the Launceston area.
- **Family Support** (North West) provides counselling and support to families.
- **Financial Counselling** (State wide) provides information, options, support and advocacy about finance, credit and debt.
- **Good Beginnings** (North West) provides mentoring and support by volunteers for families with children aged 0-4 years.
- **Hassles** (North) assists parents and adolescents to resolve conflict and prevent youth homelessness.
- **KITCASS** (King Island) provides accommodation and support for young people aged 13-18 who need a safe place to stay
- **Marriage and Relationships Education** (South) organises regular workshops for couples to improve their relationships.

- **Options** (South) assists young people and parents to resolve conflict and prevent the risk of homelessness.

- **Placement and Support Services** (PASS) (State wide) assists young people aged 13-16 who need somewhere safe to live and provides temporary care in community placements with host families.

- **Relationship Abuse of an Intimate Nature (RAIN)** (North West) assists people experiencing family violence to make decisions and plan for their future.

- **Rural and Remote Tasmania Reconnect** (North West) is a free and confidential support service providing support on an individual basis or to the whole family.

- **Tools for Men** (South) provides support to men who are experiencing relationship and/or parenting difficulties. It targets unemployed men, men in prison and men who are socioeconomically disadvantaged.

Employment Support Services

- **Disability Employment Network** (South) provides pre-employment assistance to Centrelink-registered job seekers with a disability.

- **Job Placement, Employment and Training (JPET)** (State wide) assists young people who are homeless or at risk of homelessness to get access to education or vocational training and gain and maintain employment.

- **Personal Support Program** (North and South) provides up to two years support to Centrelink clients who are vulnerable to social isolation and find it difficult to become part of the workforce and the community.

- **Tenancy Support Service** (South) provides support to people to maintain their own tenancy in either public or private rental housing.

Mental Health Support Services

- **Club Haven** (North West) is a recreational, social and personal development program for people with psychiatric disabilities.

- **Curraghmore** (North West) provides clients with psychiatric disabilities with accommodation in the community in a group setting whilst recovering from mental illness.

- **Family Mental Health Support Service** (South, North West) provides support for families and their carers affected by mental illness.

- **Recovery Program** (North and South) is an outreach service providing intensive one on one support for individuals diagnosed with a mental illness.

- **Pathways** (North) provides structured social activities and skills development for people with severe and persistent mental illness.
- **Personal Helpers and Mentors** (South) provides community-based support for people with severe and persistent mental illness.
- **Towards a Model of Supported Community Housing (TAMOSCH)** (North West) is a community housing project for people with a mental illness providing long term supported accommodation.
- **Respite Services** (State wide) provide recreational and in-home support for carers of people with mental illness. Centre-based care is provided in the North-West.

Alcohol and Other Drug Services

- **Glenorchy Illicit Drug Service (GIDS)** (South) provides support and counselling to young people with alcohol and other drug issues.