

Australia's Alcohol and Other Drug Telephone Information, Referral, and Counselling Services: A Guide to Quality Service Provision

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Executive Summary

The National Centre for Education and Training on Addiction (NCETA) was engaged by the Australian National Preventive Health Agency (ANPHA) to develop a guide to the provision of quality services for Australia's alcohol and other drug telephone information, referral, and counselling services.¹

The purpose of this document is to provide a benchmark for states and territories to assist them to provide consistent telephone services, whilst recognising that there may be minor variations between the services provided within each jurisdiction. This document provides a basis on which jurisdictions can appraise their existing policies and service standards and is designed to assist in the provision of an appropriate, high-level service to the community.

Development of the guide was undertaken with cognisance of the various levels at which alcohol and other drug telephone services may be provided. It was in this context that the following were addressed:

1. Nationally consistent minimum levels of staff training for the level of service provided
2. Approaches for enhancing consumer² care, reflecting current variability in services
3. Requirements of a 24/7 service in all states and territories
4. The data necessary to evaluate quality service provision and treatment outcomes.

The relative emphasis placed on telephone services in the mix of service delivery options differs across the country. Differences among jurisdictions are reflected in funding arrangements, population needs, and geographical factors. In order to ensure that the services delivered meet the needs of the community, diversity is essential and should be incorporated into all service planning, delivery and evaluation (Australian Government Department of Health and Ageing, 2009). However, this need for diversity must also be balanced against the imperative for consistently high quality service delivery.

This guide recognises the diversity which exists among organisations and jurisdictions in the delivery of alcohol and other drug telephone services as each discrete telephone service has evolved according to local need and available resources. Differences may be found in domains such as:

¹ Please note that throughout the document these services will be generically referred to as telephone advice services. 'Advice' is a generic term employed to demonstrate the information and knowledge provision functions of telephone services. It is not intended to cover the diverse range of counselling and treatment practices employed by such services. Rather, it denotes the consumer-centred perspective and motivation involved in accessing such services.

² Throughout this document the term consumer has been used in preference to client/patient as per the Australian Commission on Safety and Quality in Healthcare, 2010.

- Service size
- Complexity
- Maturity
- Service type
- Technology.

However, while diversity is required in order to deliver innovative and flexible services, such diversity may challenge the ability of services to provide consistent and evidence based treatment (Victorian Auditor-General, 2011). To-date, little guidance has been available to service providers with respect to national consistency regarding staff qualifications, accreditation, minimum standards or a wide range of other service level activities delivered by alcohol and other drug helpline counselling services. Adopting national consistency with respect to staff qualifications, accreditation, minimum standards or a wide range of other operational activities across a disparate service delivery system will require considerable support and institutional 'buy-in' from all service providers.

Parameters of the Guide

In establishing this guide, the following activities were undertaken:

1. a review that examined quality frameworks, standards and guidelines currently available nationally and internationally
2. consultations with 23 key government, sector and organisational stakeholders to ascertain the nature of services currently provided and the resources and tools utilised by alcohol and other drug telephone services
3. a public call for submissions to incorporate the perspectives of consumers and others in regard to the role of alcohol and other drug telephone services.

Who This Document is Intended For

This document is intended to be used by policy makers, funders and providers of information, assessment, treatment and referral services to the community. This document should be used alongside existing quality management and improvement tools, which inform the provision of a comprehensive service capacity.

Development of the Guide

The process of developing this guide involved close consultation and input from the jurisdictions, together with an examination of the current state of play and local considerations. In addition, an assessment of the wider alcohol and drug treatment system and the role played by telephone advice services at present and potentially into the future was undertaken (see Parts 1 & 2). This was coupled with an examination of the wider health

care system and specifically issues pertaining to quality care and continuous quality improvement (see Part 3). The issues considered range from quality frameworks, governance, consumer needs, stepped care, clinical pathways, screening and assessment, organisational requirements, and data collection.

This broader examination then informed the development of the key elements of the guide (see below). Some of these elements are generic and apply across all alcohol and drug service types and indeed all treatment services in general. Nonetheless, they are included in this guide where they are considered to be of central importance and applicability.

Consultation Summary

Jurisdictional feedback identified the following:

1. There is a high level of support for ensuring high quality service provision and a commitment to continuous quality improvement.
2. Jurisdictions welcome opportunities and mechanisms for achieving system enhancements over time.
3. Jurisdictional officials highlighted innovations implemented to improve service delivery.
4. Jurisdictions recognise the increasing emphasis being placed on e-health methodologies for improving health outcomes for individuals and populations.
5. Jurisdictions confirmed their commitment to participate in the delivery of national campaigns to ensure the most effective and efficient means for reaching target audiences.
6. There is general support for the principle of national consistency; however, jurisdictions also noted the importance of services being designed to meet local needs.
7. All jurisdictions share concerns with respect to funding constraints that inevitably impact on the capacity to further enhance existing services.

Literature Review Summary

An extensive national and international literature on the provision of online health care services was undertaken, with particular emphasis on telephone advice services. The literature identified growing awareness of this form of health care provision, and especially its capacity to address issues related to inequalities and social inclusion. The literature provided a basis on which to inform the key elements of quality services outlined below.

These elements were synthesised from a review of quality service frameworks applicable to the general health, mental health sectors, and alcohol and other drug sectors, as well as evaluations undertaken of existing alcohol and other drug telephone services and the alcohol

and other drug sector in general. Existing frameworks and guidelines emphasised the need to ensure that systems and organisations adopted continuous improvement processes and provided services which were consumer-centred, clearly defined, and appropriately staffed.

It was noted that this approach needed to be incorporated into strategic plans and performance and compliance measures at a systems level, with organisations also giving consideration to the role of alcohol and other drug telephone services in the context of:

- the broader alcohol and drug system;
- the needs of consumers accessing services;
- the organisational structures and staff required to deliver the service.

The literature also highlighted that extensive consultation was required when developing a quality service and that input from consumers was an essential component of this. The range of stakeholders interested in the delivery of quality telephone services need to be consulted and their rights and responsibilities clearly defined when designing and delivering services. This consultation was considered particularly relevant for Indigenous people and CALD groups accessing the services. Resources aimed at increasing consumer literacy and providing them with an avenue for feedback needed to be developed to achieve this.

Other matters are specific to the provision of quality telephone advice services and pertain specifically to this type of service. This guide also draws upon related quality guidelines. In this way, synergies are created and harmonisation across the respective arms of the treatment sector can be maximised.

It is recognised that there are a number of other specialist drug and alcohol helplines (including Family Drug Support's national helpline) and specialist advisory services in most jurisdictions that address issues such as Hepatitis C, Clean Needle Programs, methadone specific advice and targeted health professional advisory services. Recommendations with respect to the key elements for quality service provision identified in this report are equally relevant to these specialist alcohol and other drug helpline services.

Helplines have also been established to address other health-related issues, particularly in regard to chronic disease. The move in many states to co-locate a wide variety of health telephony services into a single system is also acknowledged. However, this guide is predicated on the provision of alcohol and drug information and counselling telephone services as an integral component of each state and territory's alcohol and drug service system.

Levels of Service

The nature of the service or services provided is fundamental to the development of standards and guidelines. As noted, there is variability in terms of the services offered through alcohol and drug helplines across Australia. Consultations with management and service providers in the majority of jurisdictions identified the three core levels of service offered by alcohol and drug helplines across Australia.

These are characterised as follows:

Level 1	<ul style="list-style-type: none"> • The provision of alcohol and other drug specific information and advice targeted to general members of the public (population based model), individuals seeking advice reassurance and guidance on behalf of others, and individuals self identifying as having problems related to their use of alcohol and or other drugs. • Referral to specialist services where appropriate. • Provision of advice to health professionals and other relevant professional workers with respect to specialist services.
Level 2	<ul style="list-style-type: none"> • Provision of screening, assessment, triage and appropriate referral to specialist advice and assistance. • Provision of brief interventions and counselling preparatory to active engagement in a specialist treatment program.
Level 3	<ul style="list-style-type: none"> • Provision of ongoing specialised counselling services (including relapse prevention). • Ongoing case management including call back and engagement with other professional service providers. • Provision of information and advice to other professional case workers (verbal and written).

It is recognised that all three service levels above may be provided concurrently by each of the jurisdictional helplines.

Key Elements of Quality Service Provision

A total of 26 key elements for quality service provision are identified in the guide. These are detailed below and mapped out in Part 3 of this document:

- | | | |
|-------------------------------------|----------------------------------|---------------------------|
| 1. Service and Treatment Philosophy | 6. Accreditation | 11. Staff Development |
| 2. Role Delineation | 7. Governance | 12. Work Environment |
| 3. Policy Orientation | 8. Performance Indicators | 13. Staff qualifications |
| 4. Strategic Plans | 9. Evaluation | 14. Staffing Requirements |
| 5. Evidence based | 10. Workforce Development Issues | 15. Efficiency |
| | | 16. Duty of Care |

17. Cultural Diversity	22. Technology Management	26. Regular National Forums
18. Consumer Driven	23. Data Management	
19. Access & Equity	24. Data Collection	
20. Safety and Quality Delivery	25. Marketing and Promotions	
21. Referral Pathways		

Implementing the Key Elements

Implementing many components of the key elements for quality service provision recommended and achieving adherence to this guide for quality service provision may be feasible largely within existing resource allocations and may not necessarily require more funding to be sourced in the short term. There is evidence telephone and E-health services represent value for money, as phone counselling sessions tend to be shorter in duration than one-to-one counselling sessions with no need to adhere to fixed appointment times. As such, rather than requiring new resources, funding and staff may potentially be redirected from the formal one-on-one counselling environment. In the future, it is predictable that telephone advice services will feature more prominently in the complement of services offered and will take on increasingly complex and demanding client needs.

How to Use this Guide

The variability in current service provision notwithstanding, this guide offers a tool whereby a greater degree of consistency can be achieved within and between jurisdictional services with the goal of achieving greater harmonisation, improved consistency and quality of treatment and care in this key service delivery area. It is anticipated that the guide will be used to shape and inform the ongoing process of establishing and maintaining optimal quality care.

Structure of this Document

This document is presented in the following five sections:

1. Alcohol and other Drug Telephone Services in the Context of the Broader Drug and Alcohol System
2. Methodology and Key Findings
3. Key Elements for Quality Service Provision
4. Implementing This Guide
5. Developing Quality Services

Each section is preceded by a brief summary of its contents; thus, enabling the reader to quickly and easily glean the key points in the document overall.

Parts 3 (Elements for Quality Service Provision) and 4 (Implementing this Guide) form the hub of the document and the essence of the report pivots on these sections.

Part 1. Alcohol and other Drug Telephone Services in the Context of the Broader Drug and Alcohol System

Alcohol and other drug telephone services fall within the domain of telehealth.

Telehealth services were originally implemented as an adjunct to core treatment and support services to redress inequitable access to healthcare services, particularly for rural and remote communities and marginalised people.

The centrality of the role played by telephone services has increased due to technological growth and these services should be incorporated in strategic plans to ensure integrated and continuous service delivery. A national focus will assist in the development of high quality and consistent services being made available to all Australians.

The rapid uptake of these technologies by the community has potential to engage those who would otherwise not use alcohol and other drugs services due to stigmatisation and discrimination. In this area, there is increased ability to engage with consumers seeking advice and assistance before harm occurs.

Working within the three levels of care, telephone services have potential to address many of the access and equity issues identified by the Australian Commission on Safety and Quality in Health Care during consumer consultations.

Research is needed to redress significant knowledge gaps regarding what constitutes an effective and efficient use of alcohol and other drug telephones services.

Continuous attention is required to investigate options for enhancing this arm of the service delivery system into the future. Adequate regard needs to be given to ensuring the definition of the service (i.e., telecare, telephone advice) reflects the scope and level of care of the service provided, mapping the formal and/or informal characteristics of the systems adopted, and ascertaining consumer and staffing needs.

Due to differences in service environments and provision of treatment, service treatments and philosophies should be clearly defined, communicated and understood by providers, staff and consumers.

Learning from other health-related sectors may be applicable to considerations of quality within the alcohol and other drug treatment sector, and telephone services in particular.

The advent of the E-health era and the burgeoning technology associated with a range of electronically delivered services, coupled with the community's rapid uptake and utilisation of such technologies, has changed the centrality of the role played by telephone delivered

services. Technological growth has increased the capacity for these services to play a greater role in service provision and support and services have increasing potential as a pivotal, first line response component of the continuum of services provided to address alcohol and drug related problems in the community. It is envisaged that helplines may take greater prominence in the array of services provided across all jurisdictions in the future.

The provision of alcohol and other drug telephone services falls within the domain of telehealth (see Table 1). Telehealth 'is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education, and information across distance' (Kirby, Hardesty & Nickelson, 1998; Stephenson, Bingaman, Plaza et al., 2003). When alcohol and other drug telephone services, or 'helplines' as they are also commonly known, were originally established in the early 1980s, they were seen as an adjunct to core treatment and support services.

Telehealth services also seek to redress inequitable access to healthcare services through offering health care opportunities to isolated communities and marginalised people (Knight, Endacott & Kenny, 2010; Liaw & Humphreys, 2006; Peck, 2005). To this end, the provision of alcohol and other drug helplines represent a significant component of rural health care and play an instrumental role in engaging people in the alcohol and other drug sector that might not otherwise be possible due to the stigmatisation and discrimination that such consumers experience (Hegney, Fahey & Nanka, 2004; Knight et al., 2010; O'Meara, Burley & Kelly, 2002; Skinner, Feather, Freeman & Roche, 2007; Zeitz, Malone, Arbon & Fleming, 2006).

Consumer consultations by the Australian Commission on Safety and Quality in Health Care identified access and equity as pivotal issues, including:

- Safety and quality risks associated with delays and an inability to access specialist and primary care services
- Importance of ensuring equity of access for people living in rural and remote regions, Indigenous populations, and disadvantaged and vulnerable groups
- Short appointment times and inflexible services
- Alternate service models such as outreach services, technology such as videoconferences and telephone help lines, superclinics, and expanded roles of nurses
- Cost barriers to accessing services
- Difficulties in accessing services due to transport issues (Australian Commission on Safety and Quality in Healthcare, 2010).

Anticipated Growth and Expansion

It is widely considered that there will be an increasing availability and utilisation of non-traditional (i.e., non-'face-to-face') therapeutic interventions in the near future. Utilisation of social networking media and other forms of access to information, advice and assistance (from simple to complex) will increasingly become the norm. Telephone helplines established to address issues related to alcohol and drug use are well positioned to expand in these new media environments. To do so will require a national focus, if the evolving systems are to be made available to all Australians, and if high quality and consistent services are to be delivered.

These services also offer considerable untapped potential as vehicles for prevention. To-date, relatively little emphasis appears to have been directed to this aspect of the service's response repertoire. Nonetheless, with growing interest and attention focussed on prevention and with the emergence of new technologies showing promise as prevention tools, further consideration of this aspect of their operation is warranted together with its workforce development implications.

Despite technological advances and greater utilisation of non-traditional interventions, the delivery of information, support, and treatment via the telephone remains a relatively under researched mode of service provision (Ellis, 2004). As a result, there are significant knowledge gaps regarding what constitutes an effective and efficient use of these technologies (Ellis, 2004; Liaw & Humphreys, 2006), and systematic attention should be paid to investigating options for enhancing this arm of the service delivery system into the future (see Part 3 Key Elements for Quality Service Provision).

Strategic Service Planning

In recognition of the integral and expanding part that alcohol and other drug telephone services play in each jurisdiction's range of service provision (see Appendix 1), the role and services provided by alcohol and other drug telephone services should be specifically identified in the Strategic Plans developed by states and territories (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009) (see Part 3 Key Elements for Quality Service Provision). The inclusion of helplines in state and territory Strategic Plans is necessary to ensure the policies and practices of alcohol and other drug telephone services are supported by overarching departmental policies and strategies to facilitate an integrated approach to service provision.

Quality Frameworks and Continuous Improvement

This guide is predicated on the importance of the provision of high quality service. Considerable attention is currently being paid to the requirement for quality systems to be incorporated within all aspects of the healthcare system. The Commonwealth, as well as each jurisdiction, is focused on the implications of the broader health system quality

initiatives for the alcohol and other drug sector. Even though significant progress has been made with respect to incorporating quality systems as a core element of mental health service delivery, the quality literature identifies key components of quality systems irrespective of the type of service being delivered, the client populations served, or the outcomes sought. Learnings from the mental health and other health-related sectors may be particularly applicable to considerations of quality issues within alcohol and other drug treatment settings. It is further noted that quality is not categorical, but a process of continuous improvement of services for consumers (KPMG, 2011).

Models of Service Delivery

While service providers may employ different philosophies to achieve treatment outcomes (e.g., abstinence, harm reduction) and the range of services that may be offered via helplines is extremely wide and variable (see Table 1), the overall prevailing philosophy is one of harm minimisation as defined in the National Drug Strategy 2011-2015.

In addition to this shared philosophy, helpline service providers also operate in an environment which is driven by consumers seeking impromptu information, support, and/or treatment. Due to the range of treatment philosophies employed and the variety of interventions offered, a need exists to ensure that the service and treatment philosophy is clearly defined, communicated, and understood by providers, staff and consumers (see Part 3 Key Elements for Quality Service Provision). However, at the most fundamental level, the language and terminology involved in this area lacks precision and specificity.

Table 1. Definitions of telehealth services

Terminology	Definition
<i>Telemedicine</i>	Transfers medical information from one distant site to another utilising electronic communications. Purpose is to prevent illness, maintain health, provide and monitor patient care, educate patients and healthcare providers, and support healthcare providers from other disciplines (Sharpe, 2001, p. 6).
<i>Telenursing</i>	Nurses use telecommunications technology to enhance patient care. Electromagnetic channels (e.g. wire, radio and optical) are used to transmit voice, data and video communications signals. Also defined as distance communications, using electrical or optical transmissions, between humans and/or computers' (International Council of Nurses, 2000).
<i>Telecare</i>	Describes any service that brings health and social care directly to a user, generally in their homes, supported by information and communication technology. Covers social alarms, lifestyle monitoring and telehealth (remote monitoring of vital signs for diagnosis, assessment and prevention)' (NHS Purchasing and Supply Agency, 2009).
<i>Telephone advice</i>	'Telephone Advice Lines are formally established and specifically funded to provide staff and resources to provide telephone advice with regard to health issues. Telephone Advice Lines are intended to provide advice in situations where a client is seeking verbal advice on a health issue and/or how to access appropriate health services' (Australian Nursing Federation, 2006).
<i>Telephone consultation</i>	Elicit patients' concerns, listen, and provide support, information, or education in response to patient's stated concerns, over the telephone' (Bulechek, Butcher & McCloskey Dochterman, 2008).
<i>Telephone follow-up</i>	Provide results of testing or evaluate patient's response and determine potential for problems as a result of previous treatment, examination, or tests, over the telephone (Bulechek et al., 2008).
<i>Telephone triage</i>	Determine the nature and urgency of a problem(s) and provide directions for the level of care required, over the telephone (Bulechek et al., 2008).

(Adapted from Knight et al., 2010)

To-date, the inconsistent application of terminology has limited understandings of telephone interactions as a healthcare service (Sharpe, 2001) as interactions can differ greatly in their aims and outcomes (Knight et al., 2010). Further to this, two distinct forms of telehealth service delivery have been identified. These are essentially 'informal' and 'formal' systems. Characteristics of informal and formal systems are illustrated below (see Table 2 and Figure 1).

Table 2. Differences between formal and informal telephone health services

Formal Interactions	Informal Interactions
<p>Structured approach in client interactions using evidence based protocols or guidelines to support information collection, assessment, decision-making and the provision of health care recommendations to the consumer (Greatbatch, Hanlon, Goode et al., 2005; O’Cathain, Sampson, Munro, Thomas & Nicholl, 2004; Wahlberg, Cedarsund & Wredling, 2005).</p>	<p>Tend to be ad hoc, unregulated, performed without appropriate organisational guidelines and based on inconsistent approaches to assessment and decision-making (Fatovich & Jacobs, 1998; Fifield, 1996; Larson-Dahn, 2002; Rutenberg, 2000).</p>
<p>Operator is supported in their information giving and decision-making is able to point the client in the right direction. Uses risk management processes, including policy and procedures, structured assessment approaches and evidence based clinical decision support tools that identify the most appropriate disposition for the level of client’s clinical urgency.</p>	<p>Create anxiety for interactions as the operator carries the responsibility of being the sole provider of information by offering their own solution to the problem based on personal experience (Tchernomoroff, 2006) (i.e., the operator is the ‘destination’).</p>
<p>Services meet consumer-generated demand and also attract high levels of consumer satisfaction (Fatovich, Jacobs, McCance, Sidney & White, 1998; Hanson, Exley, Ngo et al., 2004).</p>	<p>No guidelines or safe guards exist to protect the client, staff member or organisation.</p>
<p>Most research and data is obtained from centralised services (Bolton, Gannon & Aro, 2002; Cariello, 2003; Greatbatch et al., 2005; Larsen, 2005; Marklund, Strom, Mansson et al., 2007; Niemann, 2004; O’Cathain et al., 2004).</p>	<p>Advice given is not documented, client outcomes are unknown.</p>

Differences in some of the key characteristics of informal versus formal systems are displayed in Figure 1 below, with examples drawn from telenursing.

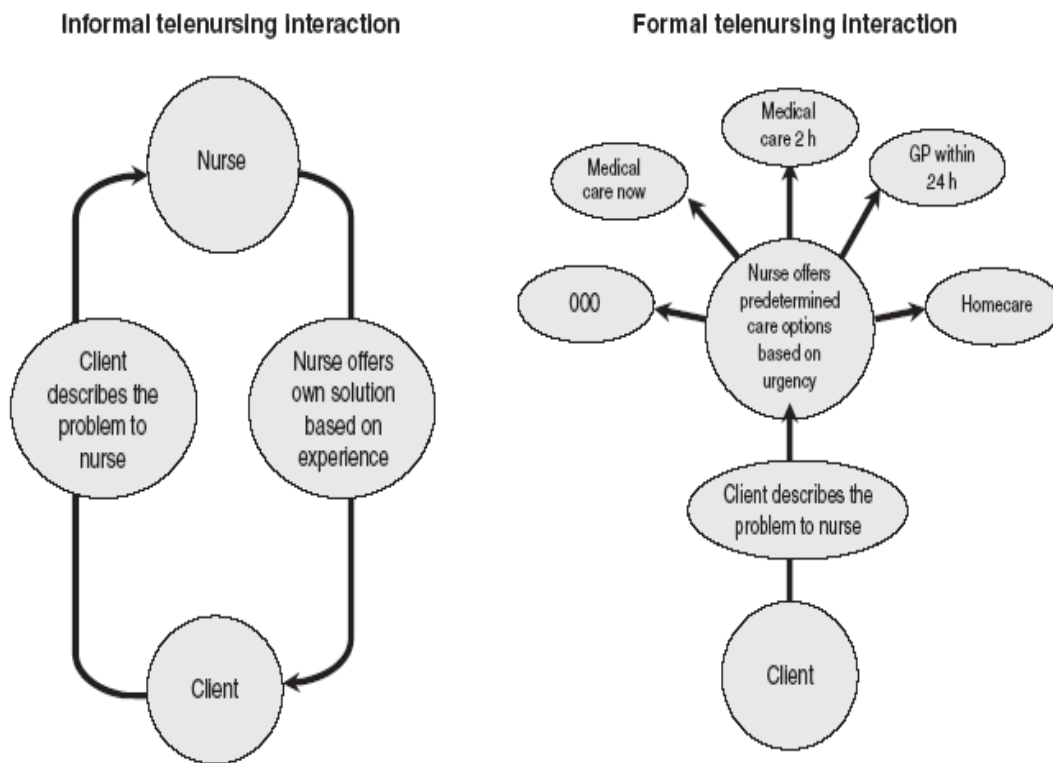


Figure 1. Differences between formal and informal telephone interactions

(Tchernomoroff, 2006 cited in Knight et al., 2010)

Australia's alcohol and other drug helpline services have evolved from relatively informal interactions to much more formal and structured systems. This process continues to this point in time. Therefore, in order to build the evidence base for future service directions it is essential to:

- Clearly define the nature of the service to be provided
- Map where the service sits on the evolutionary scale
- Understand patient and carers' experiences and expectations
- Encourage and apply research to improve safety and quality
- Continually monitor the effects of healthcare interventions (Australian Commission on Safety and Quality in Healthcare, 2010).

The potential formats that telehealth services may take is also realised in the provision of alcohol and other drug telephone advice services that are operated by the various jurisdictions across Australia.

The array of alcohol and other drug telehealth services currently provided by states and territories can be characterised as falling within three levels of care, with each involving increasing degrees of intensity and client contact and followup. These three levels are outlined below:

Level 1:	<ul style="list-style-type: none"> • The provision of alcohol and other drug specific information and advice targeted to general members of the public (population based model), individuals seeking advice reassurance and guidance on behalf of others, and individuals self identifying as having problems related to their use of alcohol and or other drugs. • Referral to specialist services where appropriate. • Provision of advice to health professionals and other relevant professional workers with respect to availability of specialist services.
Level 2:	<ul style="list-style-type: none"> • Provision of screening, assessment, triage and appropriate referral to specialist advice and assistance. • Provision of brief interventions and counselling preparatory to active engagement in a specialist treatment program.
Level 3:	<ul style="list-style-type: none"> • Provision of ongoing specialised counselling services (including relapse prevention). • Ongoing case management including call back and engagement with other professional service providers. • Provision of information and advice to other professional case workers (verbal and written) with respect to appropriate management of clients.

The different clinical services, outcomes and experiences provided by these different levels of service provision are acknowledged. Each draws on slightly different evidence bases to inform best practice. Any expansion into new and alternative approaches to care provision requires health professionals and service providers to identify the appropriate evidence base and skill required for its implementation (Australian Commission on Safety and Quality in Healthcare, 2010; Liaw & Humphreys, 2006).

Part 2. Methodology and Key Findings

In establishing this guide, the following activities were undertaken:

1. a review that examined quality frameworks, standards and guidelines currently available nationally and internationally
2. consultations with 23 key government, sector and organisational stakeholders to ascertain the nature of services currently provided and the resources and tools utilised by alcohol and other drug telephone services
3. a public call for submissions to incorporate the perspectives of consumers and others in regard to the role of alcohol and other drug telephone services.

This guide was informed by three activities: a review which examined quality frameworks, standards and guidelines currently available nationally and internally; consultations with key government, sector and organisational stakeholders in order to identify what services, resources and tools were being utilised by alcohol and other drug telephone services, and a public call for submissions that examined consumer perspectives on the role of alcohol and other drug telephone services.

A Review of Frameworks, Standards and Guidelines

The review found that several states had quality frameworks and standards for alcohol and other drug services in place and that there were some relatively common areas of practice and dimensions of quality across various states and territories (see Table 3). Common themes addressed throughout the frameworks included:

- Governance
- Appropriateness and Effectiveness
- Access and Equity
- Efficiency
- Safety
- Systems & Technology
- Accountability
- Staff
- Consumers.

These themes informed the elements included within the guide to quality service provision outlined in this document.

A wide and diverse range of current frameworks, standards and guidelines exist and inform quality service provision (see Table 3

Table 3). While there is some overlap between many of these quality frameworks, there are also barriers and constraints which may affect areas of practice and dimensions of quality in the delivery of alcohol and other drug telephone services.

Barriers and constraints which may affect service delivery include:

- Inadequate implementation guidance and monitoring of compliance with the frameworks
- Lack of specificity in strategic documents regarding the appropriate role of alcohol and other drug telephone services and how these services dovetail into the whole treatment system
- Differences in organisational structures, terminology and workforce development needs
- Unstructured and inconsistent data collection methodologies
- Inadequate use of data to inform future planning and development of alcohol and other drug telephone services
- Variability in education and training provided, as well as the qualifications required of service staff.

These barriers and constraints may impact on the efficiency, accessibility and equity of alcohol and other telephone services and may affect the manner in which the services are utilised, consumer safety and continuity of care, as well as consumer satisfaction (Victorian Auditor-General, 2011).

Table 3. Existing quality frameworks, standards, and guidelines

Framework	Application (e.g., state-based, national, organisational)
Western Australia Alcohol and Other Drug Sector Quality Framework	State-based (WA)
Service guideline on gender sensitivity and safety: Promoting a holistic approach to wellbeing	State-based (VIC)
Telephone Counselling - Service Plan Implementation and Program Guidelines 2001/2002	State-based (VIC)
Victorian Clinical Governance Policy Framework	State-based (VIC)
Victorian Alcohol & Other Drug Quality Framework	State-based (VIC)
Quality and Safety Standards Framework	State-based (TAS)
EQuIP	External Accrediting Agencies
National Health Care Standards	External Accrediting Agencies
Health Quality and Complaints Commission Standards	External Accrediting Agencies
Guide to Best Practice – Helplines Australia	External Accrediting Agencies
WA Health Cultural Respect Implementation Framework	State-based (WA)
Strong Spirit Strong Mind - Aboriginal Drug and Alcohol Framework for Western Australia 2011- 2015	State-based (WA)
Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015	State-based (WA)
Better Quality, Better Health Care: A Safety and Quality Improvement Framework for Victorian Health Services	State-based (VIC)
Evaluation: A guide for good practice	National (Australian Government Department of Health and Ageing)
Quality framework for telephone counselling and internet-based support services	National (Australian Government Department of Health and Ageing)

Submissions

A public call for submissions was undertaken via an advertisement in *The Australian* 12 November 2011 and through relevant list serves. Submissions closed on 28 November 2011. The submission package is included at Appendix 2. Eleven submissions were received; four were from organisations, seven were from individuals. Findings from the call for submissions are included in Appendix 3.

Consultations

NCETA conducted 23 consultations with states and territories to ascertain:

- Services currently provided, including the extent of service provision (e.g., assessment, counselling, referral, information) and the tools and resources used
- Staffing, education and training, and other workforce development arrangements
- Community and client need and demands, including what options are provided for consumer collaboration in service planning and delivery
- Organisational factors and constraints
- Whether there are any current frameworks and guidelines to which the services adhere, and
- Evaluation processes undertaken by services to monitor organisational and staff performance, and treatment outcomes and the data collected to inform these processes.

Consultations included Inter-Governmental Committee on Drugs (IGCD) representatives, departmental officials, as well as alcohol and other drug service managers (see Table 4). The consultation package is included at Appendix 4.

Table 4. Consultations with state and territory organisational representatives

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
Departmental Representatives	1	2	-	2	1	5	1	-	12
Organisational Representatives	1	2	-	2	2	-	2	2	11

The consultations highlighted that alcohol and other drug telephone services throughout Australia currently use several different operational frameworks, standards, and guidelines. A summary of the current alcohol and other drug telephone services provided by the states and territories and the quality frameworks, evaluations, minimum staffing requirements, and the tools used are outlined in Table 5 and Table 6.

Table 5. Current alcohol and other drug telephone services provided by states and territories

State	Current Standards Applied	Method of Monitoring Safety and Quality of Service	Minimum Staffing Qualifications
ACT	Best Practice for AOD Interventions Working Group Guide (200) Evidence based Interventions 2007	EQUIP5 Quality and safety Unit (ACT Health) ACT Health Complaints	Alcohol and Other Drug Knowledge Minimum Requirements for Core Competencies Telephone Training (CARM) Record-keeping
NSW	Minimum Standards for Australia's Quitline Services (adapted to fit ADIS)	St Vincent's Hospital Mental Health and Drugs and Alcohol Office	Suitable tertiary qualifications, knowledge and commitment to the field and its issues; however, there are no specific qualifications required
NT	Turning Point operates these services; it is assumed to be the same as Victoria's.		
QLD	Quality Framework for Telephone Counselling and Internet-based Support Services 2008	Service is accredited through ACHS. Safety and quality is monitored through CQI Committee who are responsible for the development of service-wide work unit guidelines.	Six weeks induction training.
SA	QMS Guide to Best Practice - Helpline Australia	Previously QMS, Now EQUIP5	Staff are qualified social workers, registered nurses or psychologists. Job and person specifications also provide that it is desirable to have experience in the AOD field or some counselling experience at a minimum.
TAS	Turning Point operates these services; it is assumed to be the same as Victoria's.		
VIC	Victorian Alcohol & Other Drug Quality Framework Guide to Best Practice - Helpline Australia	Quality Improvement and Community Services Accreditation (QICSA)	Minimum Qualification Strategy (MQS) implemented on 1 July 2006. AOD treatment workers were required to obtain a qualification equivalent to, or above, the Australian Qualifications Framework's Certificate IV in Alcohol and other Drugs Work.
WA	Western Australia Alcohol and Other Drug Sector Quality Framework Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.	ADIS is not accredited	Degree in human services and counselling experience in AOD sector

Table 6. Tools used by services

State	Screening Instruments Employed	Counsellor Scripts Used	Referral Pathways Used
ACT	Drug Abuse Screening Test (DAST) AUDIT-3 Suicide Risk Assessment Severity of Dependence Scale Computer-generated NDMS data Health History	Suicide Risk Assessment	Yes
NSW	AUDIT AUDIT-3 ASSIST DALI Suicide Risk Assessment Severity of Dependence Scale		Determined by client need and location
NT	Turning Point operates these services; it is assumed to be the same as Victoria's.		
QLD	AUDIT AUDIT-C Drug Abuse Screening Test (DAST) Triage Assessment Tool Severity of Dependence Scale Substance Use Outcomes Matrix Fagerstrom Tobacco Questionnaire Biopsychosocial Framework Tools Readiness to Change Questionnaire Kessler-10 Quality of Life and Self-perceived health status	Used specific instances: Structured brief interventions Management plans for regular/difficult callers Opioid Treatment Monitoring Enquiries from Doctors.	Formal pathways developed with: Mental Health Services A&D Services Police Ambulance HADS/DABIT teams at RBH Formal pathways developed for specific consumers (i.e., those with comorbidity issues) Informal links with other services Receive incoming referrals from police, ambulance, Royal Brisbane Hospital
SA	ADIS staff have access to a range of instruments including AUDIT, CAGE, SAD, ASSIST, SOS (Severity of Dependence Scale), SOWS (Subjective Opioid Withdrawal Scale).	Scripts are not used	No formalised referral pathways for external agencies, cases by case assessment based on client needs. Triage forms used for internal referrals.
TAS	Turning Point operates these services; it is assumed to be the same as Victoria's.		
VIC	Optional: Kessler-10 AUDIT Gambling Severity Scale Psych Distress Ongoing assessment and adaptation of tools	Scripts are not used Have developed guidelines and protocols	No formalised scripts used Reliant upon knowledge of sector
WA	ADIS counselors draw on a number of evidence-based approaches, practice models and assessment tools to provide a tailored response to the client and their problems.	No counsellor scripts are employed	ADIS WA have a number of formalized referral pathways into the Service. These include: Alcohol Pharmacotherapies Callback Service for GP clients, Drug and

			Alcohol Withdrawal Network (DAWN) callbacks, and callbacks to waitlisted clients of Community Drug Services. In terms of referral to services, ADIS maintains an up-to-date database of AOD services and matches the client to the service best suited to their needs.
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Part 3. Key Elements for Quality Service Provision

26 key elements were identified as relevant to the development, implementation and continual improvement of alcohol and other drug telephone services.

The elements provide a basis from which service delivery quality may be assessed and benchmarks created for further improvement.

The elements were identified with cognisance of the differences in the levels of service provided and the populations treated by the states and territories.

Having examined the range of factors of relevance to the development, implementation and continual improvement of telephone services, as outlined above, the following 26 service delivery elements have been identified as key for quality service delivery in this area. These 26 key elements reflect the core components essential to be addressed in the development and delivery of a quality telephone advice service, and provide a basis from which service delivery quality can be assessed and benchmarks created for further improvement.

The key elements have been developed with cognisance of the varied range of services, described above as comprising three distinct levels of service provision in this area in Australia. Where applicable the elements reflect these different levels of service provision and indicate the steps entailed in shifting from one level to a higher level of service provision.

Service providers can use these 26 elements as a checklist against which they assess current performance and future progress.

1. Service and Treatment Philosophy	The service and treatment philosophy is clearly defined, and communicated to, and understood by service providers, staff and consumers.
2. Role Delineation	<p>The service has clearly identified and documented its functions (e.g., crisis intervention, counselling advice, support).</p> <p>The service is integrated with and complementary to the array of different services and types of treatment offered in the jurisdiction.</p> <p>The service has an open and transparent plan that is documented, implemented</p>

	and reviewed; based on a consultative process utilising feedback from consumers, other service providers, staff and funding bodies, current and projected needs identified in area planning, general statistics/trends and service data collection (Western Australia Quality Framework Steering Committee, 2005).
3. Policy Orientation	<p>The service is consistent with the National Drug Strategy and relevant jurisdictional strategies.</p> <p>The service provides appropriate harm minimisation and risk reduction information and support to consumers with risky/potential risky behaviour (Western Australia Quality Framework Steering Committee, 2005).</p>
4. Strategic Plans	Strategic plans developed by states and territories specifically include and identify the role of alcohol and other drug telephone services in service provision (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009).
5. Governance	<p>The telephone advice service has appropriate governance structures in place. Roles and responsibilities of the senior leadership, policy and operational staff with management responsibilities are clearly defined and documented.</p> <p>All staff are knowledgeable about their roles and expectations and are supported by appropriate policies and procedures.</p> <p>Roles and responsibilities, and policies and procedures are regularly reviewed.</p> <p>Executive and leadership staff seek to create linkages between the alcohol and other drug telephone services and the wider alcohol and other drug sector and the primary care sector.</p> <p>The service collaborates with primary care stakeholders and other community services and has developed policies, procedures, and partnership agreements for continuous improvement of systemic interagency and inter-sectoral relationships to ensure optimal outcomes for consumers (Western Australia Quality Framework Steering Committee, 2005)</p> <p>The service has developed written policies and procedures which inform respectful, sensitive and non-judgemental work practices (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Reviews of the service are regularly undertaken.</p>
6. Evidence	All aspects of the service ensure evidence based clinical protocols and systems

<p>Based Practice</p>	<p>of care are in place (de Crespigny & Cusack, 2003).</p> <p>The service is informed by clearly demonstrated up to-date evidence and/or accepted practice, guided by clinical practice/governance principles and negotiated with the consumer based on individual needs (Western Australia Quality Framework Steering Committee, 2005).</p> <p>The service ensures tools used for intakes and assessments are evidenced-based.</p> <p>Standardised screening and assessment tools are utilised by the service. Such tools are drawn from an appropriate set of options including the following: AUDIT, AUDIT-C, ASSIST, DAST, Kessler-10, T-ACE, and TWEAK.</p>
<p>7. Accreditation</p>	<p>The service is accredited by a recognised accreditation system, which has the capacity to assess all relevant aspects of the service.</p>
<p>8. Performance Indicators</p>	<p>The service has established performance indicators which measure changes in key areas of consumer functioning to provide evidence of service outcomes and to inform planning processes (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Key performance indicators are aligned with the current evidence-base.</p> <p>The service ensures the organisation operates according to its contractual obligations and service descriptions as negotiated and determined in its service agreement (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Policies and procedures are in place which assist staff in managing difficult, challenging, aggressive and suicidal callers.</p>
<p>9. Evaluation</p>	<p>The service seeks to continuously improve quality and safety by undertaking regular evaluations.</p> <p>The effectiveness and quality of the service is monitored and managed to assure the best outcomes for clients.</p> <p>The service adopts a consumer focus when measuring outputs so that consumer outcomes are also evaluated (KPMG, 2011). Areas of evaluation may include:</p>

	<ul style="list-style-type: none"> • Utilisation • Clinical outcomes • Client satisfaction • Counsellor feedback, and • Efficiency (Stephenson et al., 2003). <p>The service measures performance by monitoring transactional data.</p> <p>The service measures quality by assessing performance against these standards.</p>
<p>10. Workforce Development Issues</p>	<p>The service has written and regularly reviewed HR management policies and procedures (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Service providers and staff are knowledgeable about the quality standards which influence their organisational policies and practices.</p> <p>Appropriate opportunities are in place to ensure that staff can upskill as required and debrief with peers and supervisors.</p>
<p>11. Staff Development</p>	<p>“Role profiles” have been developed for staff that identify:</p> <ul style="list-style-type: none"> • The range of competences they require (ie the tasks and activities they need to be competent in) to do their job properly, and • The knowledge, understanding and skills (know-how) needed to perform each of these to the standard required. <p>Staff are regularly assessed against their role profile either through clinical supervision and/or performance reviews, to identify any shortfalls in their competence and underlying know-how.</p> <p>Staff development is actively supported to improve knowledge and understanding of service provision issues for diverse population groups and working collaboratively with other relevant agencies (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Opportunities are provided for staff of the service to participate in and contribute to education and professional development on alcohol and other drug issues (de Crespigny & Cusack, 2003).</p>
<p>12. Work</p>	<p>Facilities, equipment and work processes have been designed for safety</p>

<p>Environment</p>	<p>(Australian Commission on Safety and Quality in Healthcare, 2010)</p> <p>Safety is a high priority in the design of health care. The service ensures organisational structures, work processes and funding models recognise and reward taking responsibility for safety (Australian Commission on Safety and Quality in Healthcare, 2010).</p> <p>The service complies with the relevant OHSW legislation and discrimination/equal opportunity legislation and regularly reviews staff safety policies and procedures in line with these statutory requirements.</p> <p>Where telephone services are outsourced, work environments are reviewed by service management to ensure they are safe and fit for purpose.</p>
<p>13. Staff Qualifications</p>	<p><i>In general:</i></p> <p>Competency levels, knowledge, and qualifications align with the level of service and care provided to, and expected by, the consumer.</p> <p>Staff should have the appropriate skills, knowledge and/or qualifications consistent with their roles and responsibilities in the service being provided.</p> <p>Staff have skills to manage clients presenting with complex issues.</p> <p>Staff are aware of their own values and beliefs on alcohol and other drug issues and ensure that these do not impede quality care (de Crespigny & Cusack, 2003).</p> <p><i>Specifically:</i></p> <p>Level 1 service staff should hold appropriate skills and qualifications such as the Certificate IV in Telephone Counselling, or equivalent (including approved in-house training), and at a minimum the skill set in alcohol and other drugs</p> <p>Level 2 service staff should hold the Certificate IV in Alcohol or Other Drugs, or equivalent, at a minimum</p> <p>Level 3 service staff should hold a professional qualification (e.g. nursing, psychology, social work) and a Certificate IV in alcohol and other drugs or its equivalent.</p> <p><i>Future Development:</i></p> <p>Consideration should be given to the development of a 'skill set' in telephone counselling for alcohol and other drug workers.</p>
<p>14. Staffing</p>	<p>The staffing complement is determined with regard to consumer demand and the</p>

<p>Requirements</p>	<p>complexity of the service provided.</p> <p>Systems are in place to monitor failed calls and call dropout rates and staffing levels will be reviewed regularly to correspond with these rates.</p> <p>Ideally, two staff should be on roster at any given time to ensure support and debriefing of critical incidents. Beyond this level, service demand will dictate the necessary staffing level to ensure stipulated levels of quality service provision are met and maintained.</p> <p>In unavoidable instances where staff are rostered alone protocols should be in place to ensure adequate safety and support.</p>
<p>15. Service Efficiency</p>	<p>Opportunities to capitalise on existing infrastructure to support service delivery including co-location of staff to utilise management structures, tools and resources, and to up-skill staff members to work across multiple lines or areas.</p>
<p>16. Duty of Care</p>	<p>Caller safety is ensured through the development of procedures and policies aimed at managing challenging situations/events (suicidal, intoxicated callers) and maintaining confidentiality.</p> <p>The legal and ethical rights of people and their family members are ensured (de Crespigny & Cusack, 2003).</p> <p>Staff are aware of their obligations in maintaining confidentiality and privacy of caller information, as well as their legal obligations with respect to mandatory reporting (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009).</p> <p>Privacy, confidentiality, information-sharing, and mandatory reporting policies and procedures are routinely revisited to maintain currency and adherence.</p>
<p>17. Cultural Diversity</p>	<p>Policies and procedures are implemented which ensure service providers operate within an environment which is culturally appropriate and which recognises and respects the differences of all individuals.</p> <p>Services are culturally safe and improve safety by creating partnerships with people of different backgrounds (Australian Commission on Safety and Quality in Healthcare, 2010).</p> <p>The service has developed cultural standards which:</p> <ul style="list-style-type: none"> • Define and understand the target community

	<ul style="list-style-type: none"> • Outline rights and responsibilities • Represent consumer focussed practice • Are evidence based • Support staff and their development. <p>The cultural standards are included throughout the agency's management procedures and protocols, as well as in the organisational governance structures.</p> <p>Indigenous-specific policies and/or services have been developed.</p> <p>Strategies have been developed and sustained to engage CALD and Indigenous clients. Examples include:</p> <ol style="list-style-type: none"> 1. engaging bilingual employees 2. advertising services in community newspapers 3. using translation services. <p>Opportunities are sought for collaboration with organisations which have particular expertise in working with specific communities (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009).</p>
<p>18. Consumer Driven</p>	<p>The service works in partnership with consumers to determine expectations, enhance continuity of care, and minimise risk.</p> <p>The service recognises clients as 'health consumers' with concomitant rights and responsibilities and has a written statement of consumer rights and responsibilities which is provided and discussed with the consumer in a manner which is understandable as early as possible when contact is made.</p> <p>The service ensures all staff are aware of, and support, the rights and responsibilities of consumers.</p> <p>Consumers are assured that when something goes wrong, actions are taken to prevent or minimise the chances of healthcare errors happening again (Australian Commission on Safety and Quality in Healthcare, 2010).</p> <p>The healthcare rights of callers are promoted and caller's know their rights (Australian Commission on Safety and Quality in Healthcare, 2010).</p>

	<p>Callers who receive inadequate care or who are harmed during care can expect to be treated fairly, obtain an apology and a full explanation (Australian Commission on Safety and Quality in Healthcare, 2010).</p>
<p>19. Consumer Access & Equity</p>	<p>The service is structured to maximise consumer access with particular emphasis on ready and appropriate access to services by Indigenous Australians, people from CALD backgrounds, parents with under school-aged children, young people, families and significant others, people with disabilities, people with co-occurring conditions, and people of different genders and sexual orientations (Western Australia Quality Framework Steering Committee, 2005).</p> <p>The service is routinely examined to ensure resource allocation aligns with current demands and addresses of equity of access.</p> <p>The service has written and regularly reviewed policies, procedures, and strategies to maximise access, supporting consumers to either access the service in an acceptable timeframe or be referred to another organisation (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Call response rates are regularly reviewed.</p> <p>Costs to access the service are minimised for the consumer.</p> <p>To assess whether services are accessible it is necessary to consider who needs the services and when they need them, equity and timeliness of access, barriers to access, and access by smaller cohorts of the population (Victorian Auditor-General, 2011).</p>
<p>20. Safety and Quality Delivery</p>	<p>The safety and quality of care is of greater importance than the budget or financial focus of care provision (Australian Commission on Safety and Quality in Healthcare, 2010).</p> <p>Governments, healthcare managers and staff all recognise their responsibilities for safety (Australian Commission on Safety and Quality in Healthcare, 2010).</p> <p>The service has completed a risk assessment and developed written policies and procedures for identified risks, reviewing processes as needed to ensure risks are minimised (Western Australia Quality Framework Steering Committee, 2005)</p> <p>The patient journey is optimized by the sharing of assessment processes and development of information sharing protocols.</p>

	<p>The service has regular reviews of consumer entry criteria informed by the expertise of the staff to ensure that it is clear and transparent and the service is able to be provided (Western Australia Quality Framework Steering Committee, 2005).</p> <p>Compliance with quality standards is actively monitored.</p>
<p>21. Referral Pathways</p>	<p>Clear referral pathways and information sharing practices have been established.</p> <p>Referral pathways and information sharing practices are regularly revised and updated.</p> <p>Ensure staff have detailed knowledge of referral pathways and information sharing practices.</p> <p>Tools aimed at streamlining referrals to a range of health, welfare and support services are available and utilised as deemed appropriate.</p>
<p>22. Technology Management</p>	<p><i>Information Management:</i></p> <p>The service has implemented a centralised, reliable and accessible point of reference containing policy and procedure manuals and other key information.</p> <p>The maintenance of this system is the responsibility of an appropriately qualified person.</p> <p><i>Telephone Infrastructure:</i></p> <p>The service has a documented contingency plan for system outages.</p> <p>The service provided by the operator is compatible with the capacity of the technology adopted.</p> <p>Enhancements to telephone infrastructure are implemented after incremental feasibility assessments, using change management strategies, and coupled with adequate investment and training of staff.</p> <p>When choosing technological requirements, consideration will be given to the:</p> <ul style="list-style-type: none"> • adequacy of the technology to ensure effective operation of the telephone

	<p>service</p> <ul style="list-style-type: none"> • ability of technology to facilitate appropriate collection of KPIs in relation to service provision • need for the service to manage, centralise and maintain the information that they deliver to clients (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009). <p>The systems (technology platforms) will be accessible, reliable, responsive and secure and adaptable with/to compatible technologies (Australian Government Department of Health and Ageing, 2009).</p>
<p>23. Data Management</p>	<p>Strategies are in place to ensure that data capture which is essential to ensure the effective and efficient operation of the service is understood by management and staff.</p> <p>A common, purpose-built database has been developed and regularly updated.</p> <p>Staff receive regular data-collection and database management training.</p> <p>An appropriately qualified person is responsible for reviewing and updating the database, as well as extracting data for the production of reports.</p> <p>The service collaborates with researchers so that data collected may be analysed to inform policy.</p> <p>The service has written policies and procedures in place to ensure the integrity of data collected and is open and transparent in how data is used (The Quality Framework Steering committee, 2005).</p>
<p>24. Data Collection</p>	<p>Services are required to implement a systematic approach to data collection and evaluation of effectiveness and efficiency of services, as specified by the Australian Quality Framework for Telephone Counselling and Internet-based Support Services (2009).</p> <p>Types of data collected</p> <p>To effectively monitor service effectiveness, quality and safety, measures of service utilisation and performance, client needs, service outcomes, and client satisfaction should be collected.</p> <p><i>Service utilisation and performance measures</i></p>

	<p>Measures of service utilisation include:</p> <ul style="list-style-type: none">• Number of calls received• Time & date of call• Location of caller• Reason for call• Source of referral where appropriate. <p>Measures of service performance include:</p> <ul style="list-style-type: none">• Number of calls unanswered• Wait time for call to be answered• Call duration• Calls completed/abandoned. <p><i>Measures of Client need</i></p> <p>Measuring client need involves assessing client demographic and drug use profiles. Measures of client demographic profile include:</p> <ul style="list-style-type: none">• Age• Gender• Cultural background (language/NESB/Indigenous)• Residential location• Relationship to user - if call is about other person(s)• Previous caller status. <p>Measures of client drug use profile include:</p> <ul style="list-style-type: none">• Drug(s) of concern• Screen/assessment of use & dependency• Drug use patterns• Mental health issues• Physical health issues• Critical incident (suicide/self-harm/harm to others)• Previous quit/treatment attempts• Other help sought.
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Client history data collection includes:

- Types of drugs used
- Date/time of last use
- Amount used on last occasion
- Route of administration
- Previous withdrawal experiences
- Onset/type and intensity of symptoms
- History of seizures or psychosis.

Screening Tools Used include:

- **Alcohol:** Alcohol Use Disorders Identification Test (AUDIT), Michigan Alcoholism Screening Test (MAST), CAGE
- **Alcohol dependence:** Alcohol Dependence Scale (ADS), Severity of Alcohol Dependence Questionnaire (SADQ), Short Alcohol Dependence Data Questionnaire (SADD)
- **Illicits:** Drug Abuse Screening Test (DAST), CAGEAID
- **Illicit dependence:** Severity of Dependence Scale (SDS), Substance Dependence Severity Scale (SDSS)
- **Tobacco:** Revised Fagerström Tolerance Questionnaire (RTQ), Fagerström Test for Nicotine Dependence (FTND)
- **Combined alcohol, illicits, smoking & dependence:** Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- **Psychological functioning:** Kessler psychological distress scale (K10), PsyCheck; Dartmouth Assessment of Lifestyle Instrument (DALI)
- **Other:** World Health Organization Quality of Life-BREF (WHOQoL-BREF), Short-form Health Survey (SF-12)

Measuring Outcomes

Measures of outcome follow-up include:

- Referral uptake
- Referral outcome
- Drug use behaviour change
- Further help/treatment seeking.

Measuring service outcome involves recording the outcome of the call and following up the outcome.

	<p>Outcome categories include:</p> <ul style="list-style-type: none"> • Advice given (including type of advice given) • Information sent (including type of information sent) • Referral given (including details of referral) • Counselling provided (including type of counselling). <p>Measures of client satisfaction involve assessing clients' levels of satisfaction with the service and their perceptions of service effectiveness.</p> <p>Measures of client satisfaction include:</p> <ul style="list-style-type: none"> • Service satisfaction level • Service congruence with client expectations • Likelihood of recommending the service to others • Service effectiveness.
<p>25. Marketing and Promotions</p>	<p>Appropriate marketing and promotion of the service is undertaken, as lack of information about services is one of a number of barriers to service access for those in need of treatment, including CALD groups (Victorian Auditor-General, 2011).</p>
<p>26. Regular National Forums</p>	<p>In order to ensure that services are meeting nationally agreed benchmarks, regular forums are recommended so that jurisdictions might compare and contrast their performances, challenges and responses each with the other. In this way, national standards can be set and maintained and this aspect of quality assurance met.</p>

Part 4. Implementing this Guide

Due to the differences in services provided and populations treated, the key elements may have distinct meanings and implications for different services.

Services should implement the key elements using a planned change management approach incorporating changes over time through streamlined and integrated structures, systems and processes. There are several change management project management structures available to assist services in achieving this.

As noted above, telephone advice service provision varies considerably across Australia in terms of the range of services and roles offered. Hence, the implementation of the key elements contained in this guide will have different meaning and implications for the various services involved. In some settings, implementation may have implications for recruitment, retention and payment of staff employed in alcohol and other drug telephone services. In addition, resources may be required to train the workforce already employed within this field, as well as providing ongoing training and skills development in database management and new technologies. However, in other settings relatively little change may be required.

Administrative costs may also be increased where structural adjustments are made to the organisation and the manner in which it works. Any changes will need to be implemented using a planned change management approach. Further, as telephony and E-health services adopt more varied approaches and complex modes of delivering treatment, there is likely to be a need to employ skilled IT professionals in order to manage the IT infrastructure as well as develop and implement contingency plans for system outages.

The Western Australia Quality Framework Steering Committee recommends adopting a plan-do-check-act template to manage the type of changes which may be involved for some telephone advice services. This model is part of the Six Sigma project management structure; however, other change models could also be used.

Sustainable improvements to service provision needs to occur over time through streamlined and integrated structures, systems and processes which enable agencies to:

- Increase the effectiveness of interventions
- Contribute to the proliferation of best practice
- Improve consumer safety
- Enhance service accountability to the community

- Build productive, collaborative working relationships with other services
- Manage change and adapt to changing working environments
- Decrease the work burden of staff in the long term and enhance workforce sustainability and
- Attract, satisfy and retain consumers, meeting their health needs in a more responsive manner (Western Australia Quality Framework Steering Committee, 2005).

Application of the elements contained in this guide will go some considerable way to achieving this and to ensuring the delivery of quality telephone services and will assist ongoing quality improvement processes in the alcohol and drugs field into the future.

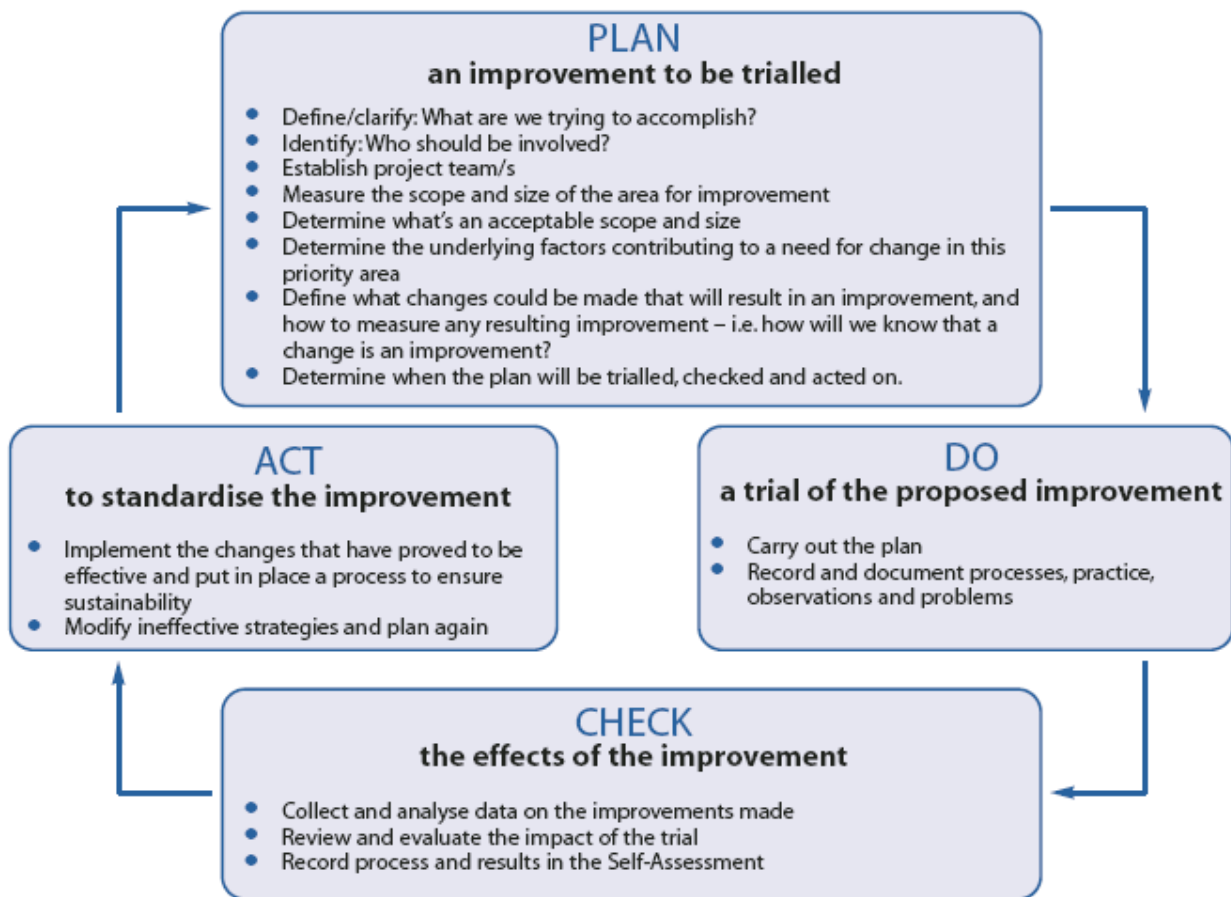


Figure 2: PLAN-DO-CHECK-ACT Template

(Western Australia Quality Framework Steering Committee, 2005)

Part 5. Developing Quality Services

System design and service delivery have a greater impact on treatment outcome than variations in the knowledge and behaviour of the practitioner.

The range of stakeholders interested in the delivery of quality telephone services need to be consulted and their rights and responsibilities clearly defined when designing and delivering services.

The development of quality frameworks are important tools which add value to the service design and delivery and have lasting benefits.

There is a dearth of quality literature specific to alcohol and other drug telephone services, therefore, the quality literature developed in other health-related fields was applied. This literature identified 10 strategies to improve service delivery within the healthcare system generally.

Appropriate and effective strategy implementation requires consideration be given at a strategic and management level to the role of alcohol and other drug telephone services in the context of the broader alcohol and drug system; the needs of consumers accessing services; and, the organisational structures and staff required to deliver the service.

Quality can only be achieved when the management culture and systems, staff culture and the way they work, and the clinical evidence are aligned with client needs and values.

Service models need to be centred on the consumer's needs and the consumer needs to be an active participant at the centre of the care process. This is particularly relevant for family services, Indigenous and/or CALD services. Regular consumer analyses and collaborations need to be undertaken so as to understand the needs of the consumer base. Resources need to be developed to assist these initiatives.

The Australian Charter of Healthcare Rights defines the rights consumers have in accessing care, which is of high quality and safe.

A wide range of treatment approaches and tools may need to be utilised so as to achieve the best outcome for the consumer. However, where possible, only validated and standardised instruments and measurements that have good reliability and validity should be utilised. Tools and approaches selected should be appropriate for the service level

provided, the client needs, and the experience and competency of staff using them.

The alcohol and other drug workforce come from a variety of backgrounds. At present, there are few professional drug and alcohol specific accreditation systems for these workers.

Some states have implemented a minimum qualification for alcohol and other drug workers. Commitment to accreditation can serve the purpose of repositioning the alcohol and other drug sector in line with mainstream areas of healthcare. However, other personal skills such as empathy and patience are also highly valued among the alcohol and other drug work force.

It is essential to ensure that competency, knowledge, skill and qualification levels of staff employed in alcohol and other drug telephone services correlate positively with the level of service provided and expected by the consumer. Developing role profiles helps achieve this.

Despite the positive associations with accreditation, at present there is no formal requirement for a treatment service to be accredited in Australia. This is largely due to the costs involved and the limited availability of programs with only two major accreditation bodies

Effective data collection is required to ensure services are able to monitor their performance, provide benchmarks to other services and monitor the quality and safety of the service provided.

In this section, we draw on the quality literature to identify key components of a service delivery system which need to be considered in the development of a guide for quality care, irrespective of the type of service being delivered, the client populations served, or the outcomes sought. The issues examined range from quality frameworks, governance, consumer needs, stepped care, clinical pathways, screening and assessment, organisational requirements, and data collection. While this examination is not exhaustive, it nonetheless canvasses significant issues of relevance and provided the basis for the identification of key elements for a quality service. These key elements of the guide are explicitly articulated in Part 3, Key Elements for Quality Service Provision.

The work cited here is not specific to the alcohol and other drug telephone information and counselling sector. In part, this reflects the paucity of information available on quality within this domain. Nonetheless, many of the learnings from other areas are transferable and applicable in this context.

In order to address the gap between what can and should be available and what exists, it is essential to consider the range of key stakeholders who share an interest in the quality delivery of alcohol and other drug telephone services. Pivotal stakeholders and their rights and responsibilities are outlined in Table 7, and to the extent that it has been possible the views and perspectives of this array of stakeholders were incorporated within the development of this guide.

Table 7. Stakeholder rights and responsibilities

Stakeholder	Right	Responsibility
<i>Consumers of services include alcohol and other drug users, families, carers and friends, and the wider community</i>	<ul style="list-style-type: none"> Consumers of services need to be assured that services are relevant and responsive to their needs, of high quality and based on evidence, are accessible, equitable and inclusive, and that services support individuals by treating them with respect and integrity. 	<ul style="list-style-type: none"> Quality Improvement Provide feedback to support Quality Improvement Become involved in planning, implementation, and delivery of services where appropriate Improve health literacy
<i>Referrer's expectations include that the services are:</i>	<ul style="list-style-type: none"> Relevant Of a consistent high quality Responsive to clients' needs, including availability, access and equity Address needs of referrers to respond appropriately to needs of consumers. 	<ul style="list-style-type: none"> Quality Improvement Quality Assurance Provide feedback Continuously familiarise self with available organisations
<i>Staff delivering this service need confidence that their organisation:</i>	<ul style="list-style-type: none"> Supports this type of servicing approach, is of a high order and includes clear role definitions Promotes shared values and commitment Includes access to training and development Provides mechanisms for valuing individual contributions and staff support Ensures health and safety is guaranteed, including provision of debriefing and supervision as necessary 	<ul style="list-style-type: none"> Quality Improvement Quality Assurance Provide feedback Continuously familiarise self with evidence based practices Become involved in planning, implementation, and delivery of services
<i>Managers of the organisation ensure that:</i>	<ul style="list-style-type: none"> Community and stakeholder expectations are met Accountability and reporting requirements are met Services are well managed, high quality, relevant to client needs, produce identifiable outcomes and are value for money 	<ul style="list-style-type: none"> Quality Improvement Quality Assurance Quality Management
<i>Directors of organisations will to ensure that:</i>	<ul style="list-style-type: none"> All accountability and reporting requirements are met The reputation of the organisation is enhanced by 	<ul style="list-style-type: none"> Quality Improvement Quality Assurance

	<ul style="list-style-type: none"> the delivery of high quality services Good governance and management processes are in place 	<ul style="list-style-type: none"> Quality Management
<p><i>Government and funding bodies will wish to be assured that the services:</i></p>	<ul style="list-style-type: none"> Have a good reputation in the community Consistently delivers high-quality services Are responsive to community and clients' needs Are accessible and equitable Are continually improved by incorporation of evaluation feedback and sound research evidence Have good governance and management processes in place Are high quality Are based on clinical evidence Are accountable Provide value for money Enhance government mental health program objectives 	<ul style="list-style-type: none"> Quality Improvement Quality Assurance Quality Management

(Adapted from Australian Government Department of Health and Ageing, 2009)

Quality Frameworks

The US Government's Institute of Medicine report (2006) on improving the quality of health care for mental health and substance use, states that:

Although science continues to advance our knowledge about the aetiology of mental and substance use problems and illnesses and how to treat them effectively, health care for these conditions—like general health care—frequently is not delivered in ways that are consistent with science, ways that enable improvement and recovery. Moreover, care is sometimes unsafe; more often, it is not delivered at all. This gap between what can and should be and what exists is so large that, as with general health care, it constitutes a “chasm” as defined in the 2001 Institute of Medicine report, Crossing the Quality Chasm: A New Health System for the 21st Century (Institute of Medicine, 2006).

System design and service delivery have been shown to have a greater impact on treatment outcome than variations in the knowledge and behaviour of the practitioner. Whilst the importance of staff development and training are acknowledged, better system design has a greater influence over improvements to outcomes for treatment populations (Institute of Medicine, 2006).

The development of quality frameworks are important tools which add value to the service design and delivery by assisting organisations to:

- Plan, design, implement and review services against agreed industry standards by:
 - Identifying and applying processes that improve overall quality.
 - Undertake ongoing self-assessment for continuous improvement so as to:
 - Build the knowledge base and capacity of the sector.
 - Inform practice development.
 - Clarify and define expectations of the service for all stakeholders.
 - Set and maintain high standards by:
 - Providing benchmarks for evaluating service and sector performance.
 - Promoting innovation in the sector within agreed quality guidelines.
 - Develop and apply quality indicators to performance evaluation of all aspects of the organisation thereby contributing to overall sector growth.
 - Enhance sustainability and demonstrate the value of the services to funders and purchasers by
 - Increasing public awareness and understanding of the value of services provided, and
 - Enhancing public accountability
- (Western Australia Quality Framework Steering Committee, 2005).

The benefits of quality frameworks:

- Include a sector-wide approach to quality that support services
 - Enables the incorporation of a variety of accreditation models that agencies currently use or could use in the future
 - Promotes reflective practice on a sector-wide scale
 - Enhances integration options
 - Supports flexibility and diversity
 - Enhances a broad promotion of the sector, aiding referral and through care
- (Western Australia Quality Framework Steering Committee, 2005).

In response to issues identified during consultations with the Australian Commission on Safety and Quality in Health Care (see above), a framework was developed which identified 10 strategies to improve service delivery within the healthcare system generally. These strategies included:

1. Develop service models that improve access to healthcare for patients
 2. Increase health literacy
 3. Involve patients so that they can make decisions about their care and plan their lives
 4. Provide care that is culturally safe
 5. Enhance continuity of care
 6. Minimise risks at handover
 7. Provide case management for complex care
 8. Facilitate patient-centred service models
 9. Promote healthcare rights
 10. Inform and support patients who are harmed during health care
- (Australian Commission on Safety and Quality in Healthcare, 2010).

Governance

The 10 strategies shown above are relevant to informing the provision of high quality safe and ethical practice with respect to the delivery of optimum telephone based services. However, in order to ensure that these strategies are implemented appropriately and effectively by helplines, specific consideration needs to be given to the:

- Role played by helplines in the context of the broader drug and alcohol system
- Needs of the consumer accessing helpline services
- Organisational structures and staffing complement needed to deliver helplines.

Further, when considering whether a service is appropriate and effective, there is a need to determine whether the service being delivered is fit for its purpose (Cole, 1998; KPMG, 2011). This necessitates governments, funding bodies and organisations taking into consideration the requirements of consumers accessing the service, as well as potential consumers, and asking:

- What is the right thing to do? (appropriateness)
- Do we do the right thing? (appropriateness)
- Do we do the right thing in the right way? (effectiveness) (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009).

These considerations need to occur at a strategic and management level and incorporate a whole of system approach with regard to care that is consumer focussed, and respectful of and responsive to individual preferences, needs, and values. Strategic plans developed by states and territories need to specifically include and identify:

- The role of:
 - Alcohol and other drug telephone services in service provision overall
 - Consumers in enhancing clinical governance. Consumers include clients, families, carers, general practitioners, and the community in general. Clinical governance is 'the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimizing risks to consumers and for continuously monitoring and improving the quality of healthcare' (The Australian Council on Healthcare Standards (ACHS)).
- The compliance and performance roles of services.
 - Performance relates to establishing the strategic direction of the service and the development of policies and strategies to support the work of the organisation.
 - Compliance relates to the accountability and monitoring and supervision roles to ensure adherence to policy and service delivery standards, as well as the funder (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009).
 - Monitoring performance and compliance requires data to be collected, analysed, and interpreted. Data is required to identify service use patterns, need within communities, and specific drug use patterns. This data is required to maximise the usefulness of the services, develop feedback loops and contribute to the broader alcohol and other drug knowledge base (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009).
 - Increased utilisation of data collected through developing research opportunities and partnerships with universities, other drug and alcohol treatment agencies, area health services, and government (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009)
- Roles of Steering Committees, BOM etc need to incorporate the setting of the strategic directions for the services, driving continual improvement activities, providing high level management, oversight and governance (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009)
- Opportunities to increase the level of engagement and partnerships between services which provide significantly different interventions so that there was collaboration, complementary service operation and sharing of lessons learned (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009)
- Regularly monitoring and evaluating effectiveness in the delivery and quality of alcohol and other drug education in educational institutions (de Crespigny & Cusack, 2003).

It is important that all alcohol and other drug treatment service providers are able to demonstrate that they:

1. Have integrated a quality system through which they work to achieve better outcomes for their consumers, staff, organisation, funding bodies and the community. Such a demonstration of quality must incorporate the work of the telephone services provided by the jurisdictions.
2. Regularly review policies and procedures for assessment, engagement, case management, clinical pathways planning, referral when entry is denied, and engagement requirements of CALD groups including significant others has been stressed

(Western Australia Quality Framework Steering Committee, 2005).

The embedding of a quality culture as part of the shared beliefs and assumptions of employees is integral to effective quality management (KPMG, 2011), and quality can only be achieved when the management culture and systems, the staff culture and the way they work, and the clinical evidence are aligned with client needs and values. An effective and sustainable approach to quality needs to encompass all of the elements contained in the table below.

Table 8. Organisational elements of quality

Clients	Organisations will demonstrate a client-centred approach to ensure the needs and wellbeing of clients are the focus of their activities.
Service Delivery	Organisations will provide services that are informed by evidence and subject to ongoing review.
Staff	Staff are valued within the organisation and demonstrate competence relevant to the organisation's objectives.
Accountability	Organisations will meet the funding, legal, financial, ethical and professional requirements in delivering core business. Leadership, innovation and governance. Organisations will demonstrate leadership and innovation in response to the changing needs of service users, stakeholders and the broader community.
Systems	The systems (technology platforms) will be accessible, reliable, responsive and secure and use adaptable and compatible technologies.

(Australian Government Department of Health and Ageing, 2009).

Emphasis on Consumer Needs

To develop integrated service models which optimise access to health care for consumers, organisations need to select interventions most likely to produce the desired outcome and ensure that services are delivered in an effective manner and achieve the desired outcomes (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009). The perspective taken in this guide is that care should be 'centred' rather than 'focused' on the consumer. This emphasises the consumer as an active participant at the centre of the care

process, rather than as a passive receiver of care. It has also been suggested that there is a need for greater consideration of the importance of families, carers, and substitute decision makers in ensuring safety and quality, rather than only patients and consumers (Australian Commission on Safety and Quality in Healthcare, 2010). In addition, Indigenous populations and those from culturally and linguistically diverse backgrounds also have a low uptake of treatment services and cultural and institutional barriers result in underutilisation of services (Drug and Alcohol Multicultural Education Centre, 2007), and greater consideration of their specific and variable needs also requires attention.

The Needs of Consumers Accessing Alcohol and Other Drug Telephone Services

Strategic quality management places the consumer in the central role. It seeks to define the needs of the consumer and measure how well it meets those needs. The consumer centred model is increasingly relevant to the delivery of alcohol and other drug services due to endorsement of the Australian Charter of Healthcare Rights. This charter provides that consumers have a right to access care, which is of high quality and safe.

The Australian Charter of Healthcare Rights provides that consumers have a right to:

1. Access services which address their healthcare needs
2. Receive safe and high quality health services which are provided with professional care, skill and competence
3. Receive care which respects the individual and their culture, beliefs, values, and personal characteristics
4. Receive open, timely and appropriate communication about health care options in a manner which is understandable
5. Participate in making decisions about their care options and health service planning
6. Be confident that their personal privacy will be maintained and that any personal information will be handled in a proper manner
7. Provide feedback and complaints about the service they receive and expect that these concerns will be addressed properly and promptly (Australian Charter of Health Care Rights).

Confidentiality is particularly important in the alcohol and drug sector (Mental Health Drug and Alcohol Office (MHDAO) NSW Health, 2009). While these rights may affect the way in which organisations deliver their services, they are not the only factors which impact on the provision and delivery of alcohol and other drug telephone services.

Consumers who access drug and alcohol telephone services are not homogenous. Alcohol and other drug telephone services need to undertake regular consumer analyses to assess individual consumer needs, their support and treatment requirements, and whether they

were voluntary, coerced, or from a specific population group. The Victorian Auditor-General's report (2011) noted that:

Clients accessing services may have differing needs, duty of care and risk management considerations are central to the application of a quality framework.

Consumer groups accessing drug and alcohol telephone services generally fall into three categories which are not mutually exclusive:

- Information seeking
- Support seeking, and/or
- Treatment seeking (see Table 9).

While many agencies are able to provide evidence which suggests that consumers are satisfied with the level of service they receive (Family Drug Support, 2009), other consumer surveys undertaken to review alcohol and other drug treatment services overall have found that consumers accessing more than one service report:

- Inconsistent approaches in relation to initial assessments, referrals, and follow up after treatment after residential stays due to the diversity of service models
- Difficulty navigating system pathways into, through, and beyond treatment (Victorian Auditor-General, 2011).

There is a role for alcohol and other drug telephone services to assist consumers to access appropriate treatment by ensuring all persons with alcohol and other drug problems are provided with relevant health information and the opportunity for access and referral to alcohol and other drug specialist and other relevant services as required (de Crespigny & Cusack, 2003). Increasingly, client expectations are that their information and advice related needs will be accommodated with minimal requirement to 'repeat their story' to numerous providers, and preferably at a 'one-stop-shop'. Comprehensive telephone helplines can greatly assist in meeting this client expectation, where they have the technological and human resource capacity to do so.

Consumer collaboration can be facilitated by:

- Clarifying the organisation's priorities for consumer involvement
- Working with the Board and senior management to create and support a culture and environment wherein consumer participation is the norm
- Contributing to policies and protocols that embed consumer participation in the organisation

- Developing processes for involving consumers and the community in different ways in different parts of the organisation
- Assisting with the development of strategies to enable effective consumer and community participation, e.g., setting clear expectations, sourcing appropriate consumer groups, developing education and strategies, presentation of information
- Facilitating consumer input into relevant policy and its implementation, for example, open disclosure (The Victorian Quality Council, 2004).

Effective community and consumer involvement requires leadership, a planned approach, and education and training for both health services staff and the consumer and community members involved. There is no one size fits all approach and organisations should employ a variety of strategies to obtain information from their consumers (The Victorian Quality Council, 2004).

There are several mechanisms which need to be developed in order to support consumer involvement in organisational decision-making structures. Resources which increase health literacy are also required to assist consumers to ask questions. Advocates also need to be available, and health professionals supported to share knowledge and disclose information.

In addition, organisations need to be committed to monitoring progress with the consumer centred plan by receiving information on areas such as demonstrated evidence of:

1. Changes as a result of complaints and feedback
2. Numbers of consumers involved in strategic and service improvement, and
3. Updated treatment, safety or service information and processes as a result of individual or collective consumer involvement (The Victorian Quality Council, 2004).

Examples of factors that might be considered in a consumer-centred approach are outline in Table 9.

Table 9. Consumers of alcohol and other drug telephone services

Consumer Characteristics	Consumer-Centred Considerations for Services					
Age	Consumer type	Reasons for seeking service	Service sought	Service provided	Knowledge and skills competency required	
Gender Comorbidities Employment Status Living Arrangements	Information Seeking	<ul style="list-style-type: none"> • Research, general knowledge • Concerned about own alcohol and drug use • Concerned about another person's alcohol and drug use 	<ul style="list-style-type: none"> • Information about alcohol and other drugs • Information about treatment and/or support services available • Advise on action to take 	<ul style="list-style-type: none"> • The service provides the consumer with verbal and written information about alcohol and other drugs. • Consumer provided with information on a comprehensive range of treatment options available in their region 	Level 1 service delivery	<ul style="list-style-type: none"> • Information provided is appropriate to consumer enquiry and characteristics. • Information is provided in a timely manner.
Indigenous/CALD status Health literacy	Support Seeking	<ul style="list-style-type: none"> • Affected by another person's alcohol and drug use • Affected by own alcohol and drug use 	<ul style="list-style-type: none"> • Information about coping mechanisms and/or looking for empathy, reassurance • Advise on action to take • Managing and coping with withdrawal symptoms 	<ul style="list-style-type: none"> • Referral to appropriate service • Ongoing support • Ongoing case management 	Level 2 service delivery	<ul style="list-style-type: none"> • As above, plus the support sought is assessed and provision of options for suitable care provided is appropriate to the needs of the caller. • Support seeking maybe a pathway to entry into treatment therefore a capacity to assess treatment needs and options is required.
	Treatment	<ul style="list-style-type: none"> • Motivated to change alcohol 	<ul style="list-style-type: none"> • Referral 	<ul style="list-style-type: none"> • Case management 	Level 3 service	<ul style="list-style-type: none"> • Provision of treatment/support options available enables

	Seeking	<p>and drug use</p> <ul style="list-style-type: none"> • Motivated to change responses to another person's alcohol and drug use 	<ul style="list-style-type: none"> • Intake service • Call back service 	<ul style="list-style-type: none"> • Counselling 	delivery	<p>consumer to make an informed choice about which treatment option may be appropriate for their needs.</p>
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Stepped Care

People with substance use problems come from a wide range of backgrounds and present to services with varied issues and goals, from seeking advice to requiring treatment for dependence as illustrated in Table 10. A stepped care framework can assist in understanding and directing people to appropriate services. Stepped care allows service providers to offer interventions that meet a range of goals.

Broadly, a number of steps might apply to telephone services as follows:

1. Responding to crisis calls
2. Provision of advice for people who are curious about an aspect of alcohol or other drug use
3. Structured advice and brief interventions for people who are at risk of harms but do not need or want treatment for alcohol or other drug problems to reduce harms
4. Brief intensive counselling, such as brief cognitive behaviour therapy, brief motivational intervention or brief solution focused approaches that focus on goal setting and behaviour change
5. Referral for intensive treatment options, including community based and residential treatment.

Any algorithm for choosing the starting ‘step’ involves best clinical judgement, or a pre-identified set of threshold criteria, about the least intensive intervention that is most likely to be successful, taking into consideration the caller’s stated requirements.

Table 10. Examples of alcohol and other drug treatment types

Information and education only	Consumers do not receive any treatment beyond information and education.
Assessment only	Assessment identifies the nature of the drug issue, including the extent and associated health implications, the consumer’s needs (which form the basis of the treatment plan) and which treatment would be most appropriate for the client (National Centre for Education and Training on Addiction (NCETA), 2004). Assessment may be undertaken by a specialist agency or as part of the initial session in a course of treatment. Brief interventions may be provided as part of an assessment and there is evidence that these may increase a consumer’s motivation (Flannery & Farrell, 2007).
Counselling	Counsellors work with consumers to develop mutually agreed treatment plans with alcohol and drug clients ((AIHW, 2009b; National Centre for Education and Training on Addiction (NCETA), 2004). In general, counselling includes:

	<ul style="list-style-type: none"> • A holistic approach which: <ul style="list-style-type: none"> ○ Links patients with other services which may assist the client on a practical level (e.g., housing) ○ involves others who may support the client and improve outcomes outside the therapeutic environment • Anticipating difficulties and developing coping strategies with the consumer • Providing appropriate evidence based interventions (e.g. goal setting, cognitive behavioural therapy, motivational enhancement therapy and problem solving) • Affirming the consumer's positive internal and external resources and successes • Acknowledging the consumer's problems and disabilities (Best Practice in Alcohol and Other Drug Interventions Working Group, 2000).
Support and case management only	<p>Support and case management may occur in a variety of forms.</p> <p>'Support' encompasses activities that do not fall into other treatment types (AIHW, 2009a). For example, in situations where the contact could not be classified as information and education only, occasional contact with a consumer who requires emotional support is an example of this type of intervention.</p> <p>'Case management' has been described as assessment, planning, linking, monitoring and advocacy (Vanderplasschen, Wolf, Rapp & Broekhart, 2007). Like counselling, case management takes a holistic approach, looking at general welfare needs, such as housing, together with drug-related issues. There are numerous models of case management with some incorporating counselling (Vanderplasschen et al., 2007).</p>
Withdrawal and pharmacotherapy management	<p>People are supported through the process of detoxification. Consumers are monitored through the withdrawal process, and medical intervention is provided if required (Shand, Gates, Fawcett & Mattick, 2003), depending on the drugs involved and the severity of dependency. Support may be given in an inpatient or outpatient clinic or a home-based setting.</p> <p>Pharmacotherapy refers to medication that has one or more of the pharmacological effects of the substances believed to be relevant to the addiction. Substitutes are effective in preventing withdrawal from the abused drug and so in many cases can be started once a decision is made to stop using the abused drug. Pharmacotherapy reduces cravings and the desire to use the abused drug (Nutt, Lingford-Hughes & Chick, 2012).</p>

Rehabilitation	<p>Rehabilitation refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention.</p> <p>Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration.</p> <p>Rehabilitation activities can occur in residential or non-residential settings (AIHW, 2009a).</p>
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(Definitions adapted from the AIHW, 2010)

Clinical Pathways

Clinical pathways, or care pathways, are a tool to manage the standardisation of health care practices and they are designed to reduce variability in practice and aid the application of best practice. A care pathway goes beyond guidelines and protocols and outlines the care that clients can reasonably expect under specific circumstances. It is, however, not prescriptive and must allow for:

- Clinical judgement
- Client preferences
- Flexibility.

A clinical pathway for telephone services may incorporate mandatory and optional actions when callers meet one of the above stepped care steps. For example, when a suicide call is received, the care pathway may include: mandatory requirements about undertaking a risk assessment and how and when that is conducted, additional counsellors listening-in, tracing the call and reporting requirements within the organisation and outside.

Screening and Assessment

Screening and assessment is an important first step in responding to consumers with alcohol and other drug problems who contact helplines. *Screening* identifies individuals with symptoms that may require further assessment and treatment (Croton, 2007). *Assessment* involves the collection of more detailed information relevant to client diagnosis and treatment planning. It is recommended that a range of diagnostic dimensions be considered when undertaking screening and assessment including, the presence of alcohol and drug use, patterns of use, severity of dependence, readiness to change, co-occurring mental health issues, co-occurring physical health issues, social and cultural issues, and demographic background.

There is a range of instruments and measures that can be used to undertake screening and assessment. The decision regarding which instrument or measure to use depends on the

assessment goal. For example an instrument that screens for the presence of alcohol or drug problems may not provide information on patterns of use, while an instrument that provides information on patterns of use may not provide information on levels of dependence.

Where possible, only validated and standardised instruments and measures that have good reliability and validity should be utilised. There are a number of different criteria of reliability and validity, but in essence an instrument or measure is reliable if it consistently produces the same result and is valid if it measures what it is designed to measure.

The choice of screening and assessment instruments may also vary according to client needs and demographic background. For example, screening for alcohol problems may be best suited to an alcohol specific screen such as AUDIT-C, while screening for illicit drug problems may be best suited to an illicit drug screen such as DAST. Similarly, while the AUDIT-C is suitable as an alcohol screen for the general population, sub-groups may require more specific measures. For example, the T-ACE and the TWEAK, were developed specifically for the purpose of screening for hazardous drinking in pregnant women.

In addition, the choice of screening and assessment instruments is likely to vary according to the level of service provided. For example, brief alcohol and drug screening instruments may be sufficient for level one service providers, however, level two and three service providers may need to use more complex measures of dependency, mental health diagnosis, and readiness to change.

Despite the need for flexibility in the range of screening and assessment instruments available, consolidating and standardising the number and range used of instrument used would improve consistency across sector and increase capacity for agencies to share assessment information (Victorian Auditor-General, 2011).

In implementing the use of any screening and assessment tools, services are required to ensure that adequate training and supervision is provided to ensure that the tools are used appropriately and effectively by staff.

Organisational Requirements

Competency, Knowledge and Skills of Workforce

The competency, knowledge, skill and qualification level of the Australian alcohol and drug workforce has been identified as a particularly important workforce development issue facing the alcohol and drug sector (Roche & Pidd, 2010). The Australian alcohol and other drug workforce is drawn from a variety of professional and experiential backgrounds which may include but are not limited to medicine, psychology, nursing, social work, occupational

therapy, counselling, mental health and the broad area of welfare.

While it is the case that an increasing number of those working within the alcohol and other drug sector in Australia have professional qualifications there is currently no standard requirement across the country with respect to an appropriate curriculum for the addictions field. The only exception to this is the relatively recent establishment by the Royal Australasian College of Physicians of a Chapter of Addiction Medicine.

The establishment of the Chapter of Addiction Medicine³ within the Royal Australasian College of Medicine has been an important step forward for the profession of Addiction Medicine in Australia. The Chapter provides a professional base for medical specialist and a recognised training opportunity for those medical practitioners wishing to specialise in addiction. However, for other professions such as nursing, psychology and social work, and other specialist qualifications no accreditation system exists.

A similar issue is apparent for alcohol and drug workers who do not hold professional qualifications relevant to alcohol and drug work. Until relatively recently, few of these workers held formal alcohol and drug specific qualifications (Roche & Pidd, 2010). This situation is improving with the establishment of the vocational education and training Certificate IV in Alcohol And Drugs Work as a formal minimum qualification in Victoria, the ACT and the Northern Territory and an informal minimum qualification level in other jurisdictions. However, despite this improvement in qualification levels, there is some dissatisfaction with a vocational qualification at certificate level as a minimum qualification for the alcohol and drug workforce.

While most alcohol and drug treatment agency managers support a minimum qualification, the majority of managers believed it should be at a higher level than Certificate IV, with a preference for university level qualifications with additional alcohol and drug specific training (Pidd, Roche & Carne, 2010; Pidd, Roche, Duraisingam & Carne, in press). In addition, there is also a substantial level of dissatisfaction with the quality and content of vocational education and training, with agency managers indicating a need for more emphasis on core topics such counselling, intervention and comorbidity and greater provision of clinical work placements (Pidd et al., 2010; Pidd et al., in press).

While an adequate level for minimum alcohol and drug qualifications is considered an important issue, the costs of increasing workers' remuneration commensurate with these qualifications and the costs associated with release of workers to attend training have been raised as a major impediment to the implementation of this requirement nationally (Pidd et al., 2010; Roche & Pidd, 2010).

³ Chapter of Addiction Medicine
www.racp.edu.au/page/australasian-chapter-of-addiction-medicine/

It has been suggested that accreditation can play a legitimatising function for the alcohol and other drug sector (see below). There is a significant and enduring issue of stigma associated with those who are in the care of alcohol and other drug services, as well as those who work in alcohol and drug services. Commitment to accreditation can serve the purpose of repositioning the sector in line with the mainstream areas of healthcare. However, to-date there is no formal accreditation process for alcohol and drug services or workers.

The quality and effectiveness of alcohol and other drug treatment services largely depends on the staff who counsel, treat, rehabilitate and support clients. While a qualified workforce may assist in guaranteeing service quality (Victorian Auditor-General, 2011), several respondents in the call for submissions concerning alcohol telephone service guidelines noted that skills such as empathy, patience, and compassion were also important for the alcohol and other drug telephone workforce. A recent survey of alcohol and drug treatment agency managers also identified these skills as desirable in the treatment workforce (Pidd et al., 2010; Pidd et al., in press).

The workforce within alcohol and other drug telephone sector range from volunteers who may offer informal support services to psychologists and addiction medicine specialists with extensive clinical experience and qualifications. It is essential to ensure that competency, knowledge, skill and qualification levels of staff employed in alcohol and drug telephone services correlate positively with the level of service required and/or expected by the consumer. For example, where an alcohol and other drug telephone service only provides information and education, employees may require fewer skills and lower qualification levels than workers employed in services which provides intake assessment and counselling.

The first step in ensuring a competent workforce is to compile 'role profiles' for staff. Role profiles identify the range of competencies required by staff (i.e., the tasks and activities they need to be competent in) to do their job properly, and the knowledge, understanding and skills (know-how) needed to perform each of these to the standard required (Federation of Drug & Alcohol Professionals (UK)). In addition to this, telephone services face challenging situations and challenges about how to deliver services to clients who may be affected by drugs and alcohol, risking overdose, and legal and ethical issues and as such may require specific training and qualifications.

Hence, at the lower level of service provision, a skill set may be an appropriate level of qualification (in alcohol and other drugs for telephone counsellors, or in telephone counselling for alcohol and other drug workers). As staff work with complex clients a Certificate IV, Diploma, Advanced Diploma, Undergraduate, or Post-graduate qualification may be required. A knowledge and skills matrix based on Table 9 should be developed detailing appropriate knowledge and skills for each level of intervention.

Accreditation/Performance Indicators

Accreditation relates to agency accreditation, as well as the accreditation of individual workers. Accreditation systems utilised in other areas of health care that may have applicability within the alcohol and other drug sector were considered. In examining accreditation issues relevant to the development of this guide, accreditation was considered in the light of the diversity of the alcohol and other drug workforce and with particular regard to the current and likely future composition of the workforce.

State and territory governments have established quality requirements for funded alcohol and other drug services that involve developing drug and alcohol specific quality frameworks (VIC/WA), encouraging or requiring participation in recognised quality frameworks (QLD/SA/NSW/ACT), or developing a broader framework to which alcohol and other drug services are required to work (Tasmania). There is, however, no requirement for a specific formal quality approach for the Non-Government Organisation Treatment Grants Plan (NGOTGP) except that services provide evidence of minimum standards in their application for funding (KPMG, 2011). The focus on minimum standards by funding organisations implies that quality management is an activity that takes place at a particular point in time (e.g., accreditation) rather than an ongoing process of continual improvement (KPMG, 2011).

In Australia, there is no formal requirement for a treatment service to be accredited in terms of its ability to deliver safe and effective alcohol and other drug treatment services. It is the case that government-run treatment services are likely to be part of a formal accreditation process, simply because other aspects of their parent healthcare organisation undergo a regular accreditation cycle. Individual worker accreditation is required in Victoria and the ACT through minimum qualifications policies which are referred to elsewhere in this report.

Agency accreditation has been shown to be positively associated with:

- Client engagement
- Higher contact hours
- Treatment comprehensiveness
- Development of aftercare plans.

The Canadian Network of Substance Abuse and Allied Professionals (CNSAAP⁴) defined accreditation as:

A process that is undertaken by an independent authoritative body for the purpose of recognizing that an organization or program meets a set of quality standards in the provision of specific services. The accreditation process often involves both self-assessment and peer review, and results in a work plan designed to improve on identified weaknesses and capitalize on existing strengths of both parties to ensure that

⁴ [www.cnsaap.ca/eng/developingthe workforce/pages/default.aspx](http://www.cnsaap.ca/eng/developingthe%20workforce/pages/default.aspx)

the organization is continually striving to meet established quality standards and best practices review this work plan regularly.

In addition to ensuring that best practices are being implemented in the field, thereby improving standards and services across the entire continuum of care, accreditation also:

- *Provides clients with the assurance that they are receiving the best-quality care,*
- *Demonstrates accountability and professionalism, and*
- *Highlights an organization's commitment to excellence.*

At this point in time, there is no formal accreditation system required for specialist alcohol and other drug services in Australia. This in large part reflects the cost involved in undertaking formal accreditation and the limited availability of specialist programs.

The two major Australian accreditation providers relevant to the alcohol and other drug field are the Australian Council on Health Care Standards (ACHS)⁵ and the Quality Improvement Council (QIC).⁶

The ACHS was established in 1974, as an independent, not-for-profit organisation with a Council comprising representation from governments, consumers and peak bodies. ACHS is the largest accreditation agency in Australia. ACHS is a healthcare assessment and accreditation provider whose mission is to improve the quality and safety of healthcare delivered across all settings. ACHS develops performance measures and also delivers quality improvement programs. Governments have tended to prefer to use the ACHS EQUiP for hospital accreditation. ACHS has undertaken developmental work with the NSW Network of Alcohol and Other Drug Agencies (NADA) in order to increase the uptake of accreditation.

ACHS bases its accreditation on the International Society for Quality in Health Care (ISQua) that lists a set of principles which should underpin accreditation standards. These principles are:

- Leadership through effective planning, governance and management
- Customer focus to meet the needs of internal and external customers, both existing and potential
- Organisational performance through the management of processes and outcomes and the transparency of decision-making
- Continuous quality improvement based on innovation, evidence, best practice and evaluation to better meets the needs of customers
- Valuing people by appropriately selecting, training and appraising personnel and maintaining good relationships
- Safety by providing safe work environments and complying with statutory requirements.

(www.isqua.org/accreditations.htm)

⁵ www.achs.org

⁶ www.qic.org.au

The Quality Improvement Council is the second accrediting organisation. It has been in existence for over 20 years providing accreditation services in the healthcare environment, primarily focussed on the primary healthcare setting. They describe their role:

To promote continuous quality improvement in health and community services through the provision of standards, accreditation programs and developmental resources for the benefit of health services users, staff and the wider community (Quality Improvement Council).

Quality Management Services (QMS),⁷ is an agency that delivers the QIC accredited programs within their health and community services. The core module includes a module on alcohol, tobacco and other drug services. The core components of this module are:

1. Promote health and wellbeing
2. Contribute to prevention or reduction of harm
3. Place drug use in broad context
4. Facilitate continuity of care
5. Engage consumers
6. Assess consumers
7. Develop program and care plans
8. Review interventions.

QMS has worked closely with a number of alcohol and other drug non-government organisations who have received accreditation via the ATODS standard. In particular, QMS has worked with the Western Australian Network of Alcohol and Other Drug Agencies (WANADA) to assist indigenous alcohol and other drug services to achieve QIC accreditation.

There are indications that QMS may cease to offer this module, as they believe that the module for community and primary health care services provides a broad enough umbrella to capture the interests of the alcohol and other drug sector.

Data collection

Effective data collection is also a key component of a quality service and it can serve a number of purposes. First, it enables organisations to monitor their performance. Performance monitoring focuses on measuring service delivery activities and outputs. The collection and monitoring of performance data provides an indication of service effectiveness by allowing for the benchmarking of performance within the organisation and for comparisons of performance with other similar organisations.

⁷ www.qms.org.au

Effective data collection also enables the monitoring of the quality and safety of the service provided. Quality and safety monitoring involves assessing service performance against established standards. Monitoring and managing the effectiveness, quality, and safety of services ensures the best outcome for clients by ensuring that client needs are met. It also provides evidence of effective service outcomes, allows for quality and service output improvement, and informs the planning process for future service design and delivery (see Part 3. Key Elements for Quality Service Provision for specific details).

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Appendix 1: States and Territories Services Provided

States and Territories	Organisational Name	1. What are your hours of operation?			1.A. If your services are not 24/7 what arrangements are in place (if any) to manage calls the rest of the time?
		Monday-Friday	Saturday-Sunday	24 hours/7 days p/w	
					Out of hours
Tasmania	Pharmacotherapy South	8:30-17:00	8:30-16:00		Answering machine advises clients the opening hours of the clinic and asks them to leave their name, number and a short message. In the event of an emergency they are asked to contact the Royal Hobart Hospital on 6222 8308.
	Inpatient Withdrawal Unit South			24 hours/7 days p/w	In the event that reception is unattended calls are put through to the nurses station.
	Community Team South	9:00-17:00			Out of hours an answering machine advises clients to contact, if it is urgent, the Inpatient Withdrawal Unit which is open 24/7; the opening hours of the clinic; the ADIS 1800 number and the Mental Health Hotline. A message can also be left.
	ADS North	8:30-17:00			Out of hours answering machine advises clients the opening hours of the clinic; the drug and alcohol ADIS 1800 number; and in the event of a medical emergency to go to the Launceston General Hospital.
	ADS North West	8:30-17:00			Out of hours answering machine advises clients the opening hours of the clinic; the drug and alcohol ADIS 1800 number; and in the event of a medical emergency to go to the North West Regional Hospital or the Mersey Hospital.
ACT	ACT Health Alcohol and Drug Program (ADP) Intake and Helpline			24 hours/7 days p/w	After hours the operation of the Intake and Helpline is transferred to the ADP Withdrawal Unit and incoming calls are answered by Withdrawal Unit nurses who are rostered on for evening and night shifts.
NT				24 hours/7 days p/w	
NSW		8:30 - 17:00			
SA				24 hours/7 days p/w	

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States and Territories	Organisational Name	1. What are your hours of operation?			1.A. If your services are not 24/7 what arrangements are in place (if any) to manage calls the rest of the time?
		Monday-Friday	Saturday-Sunday	24 hours/7 days p/w	Out of hours
QLD				24 hours/7 days p/w	
VIC				24 hours/7 days p/w	
WA				24 hours/7 days p/w	11pm -7am called transferred to Inpatient Withdrawal unit. (Calls taken by registered nurses on shift)

States and Territories	2. Do you provide the service in-house or have you contracted it out to a private organisation and if so who is that organisation?	3. Is your service combined with any other states and/or territories?	4. How many calls does the service currently receive in an average month and what is the average call time (ie how many minutes)?	Comments	Unanswered call rate	Average call time
Tasmania	Contracted out to Turning Point, Alcohol and Drug Centre, Victoria, ADIS (Alcohol & Drug Telephone Information Service) and DACAS (Drug & Alcohol Clinical Telephone Advisory Service)	Victoria	1416 calls annually during 09/10. Minus hoax and administrative calls = 1238	1056 calls were about drug use/concerns. 544 calls were from specific drug users		Average: 9mins, 51 secs Percentage of calls less than 10 mins = 69.50% Percentage of calls between 10-20 mins =

Appendix 1: States and Territories Services Provided

States and Territories	2. Do you provide the service in-house or have you contracted it out to a private organisation and if so who is that organisation?	3. Is your service combined with any other states and/or territories?	4. How many calls does the service currently receive in an average month and what is the average call time (ie how many minutes)?	Comments	Unanswered call rate	Average call time
						17%
ACT	Inhouse. Contracted to Turning Point during Xmas and Easter closures.	No				
NT	NT Govt fund Turning Point to provide the ADIS service	No	201 calls received in 6 months, ranging from 22-65 calls per month.	Drugs of concern are mainly alcohol (55%) and Other Narcotics (18%)		
NSW	Inhouse	No	2,800 on average			Average call time: 7 minutes
SA	Inhouse	No	2,300/month			6 minutes
QLD	Inhouse	No	2597 calls	Unlike most other States, ADIS is also the central distribution point for all alcohol and drug publications (including campaign material) for Queensland through a centralised Stock Control System. Health and Welfare agencies access bulk supplies through this service.	7.50%	10 mins 27.5% = under 2 min 57% = 4 – 15 mins 15% > 15 mins

Appendix 1: States and Territories Services Provided

States and Territories	2. Do you provide the service in-house or have you contracted it out to a private organisation and if so who is that organisation?	3. Is your service combined with any other states and/or territories?	4. How many calls does the service currently receive in an average month and what is the average call time (ie how many minutes)?	Comments	Unanswered call rate	Average call time
				Police referrals through Supportlink – approx 32 per month and rising		
VIC	Department of Health contract the delivery of this service to Eastern Health- Turning Point, DirectLine	No, however, Turning Point also provide AOD helpline services for Northern Territory and Tasmania. The service is operated on a shared infrastructure model and also provides gambling helpline services for Northern Territory, Victoria, Queensland and Tasmania. Two national online services are also operated by Turning Point: gamblinghelponline.org.au and counsellingonline.org.au	45,677 calls annually during 09/10.			8 min and 33 seconds
WA	Inhouse	No	1400 occasions of service. In bound 75%; Out bound 25% (call-back).			12 minutes

States and Territories	5. What are peak times? How do these differ from average times ie what % increase of calls would you normally expect?
Tasmania	Monday = 17.80%

Appendix 1: States and Territories Services Provided

Tuesday = 17.30%
 Wednesday = 16.40%
 Thursday = 16.10%
 Friday = 15.60%
 Saturday = 9.60%
 Sunday = 7.30%

Busiest time is 1 pm. Bell curve from 9 am - 4pm.

ACT	
NT	Peak times are Mon to Fri (80%) in business hours
NSW	Monday is the busiest day with 20% of call volume. Peak times: 10 am – 1pm = 28% of total daily calls. 7 – 10am: 13%; 1 – 4 pm: 24%; 4 – 7pm: 15%; 7 – 10pm: 9%; 10 – 1 am : 8%; 1 – 3 am: 2%; 3 – 7 am: 1%
SA	Approx 70% of calls occur during BH ; 30% after hours
QLD	8% of calls received between 11 p.m. and 7 a.m.; 76% of calls received between 7 a.m. and 5 p.m.; 16% of calls received between 5 p.m. and 11 p.m.
VIC	Almost 75% of calls are received between the hours of 9am and 5pm including weekends.
WA	Early in week very busy in mornings and afternoons. 20% increase

States and Territories	6. What sort of response times do you require? ie call waiting times.	6.A. What are current staffing levels?	6.B. Are these adequate for current call volumes?	6.C. Could they cope if call volumes increased by 10, 15 or 25%?
Tasmania	ADIS Contract requires: provision of the service to a member of the public within one hour, 24/7; that all callers receive service from ADIS and that ADIS responds to 'crisis calls'. DACAS contract requires provision of the service to a member of the public within ½ hour, 24/7. We have not received any			

Appendix 1: States and Territories Services Provided

States and Territories	6. What sort of response times do you require? ie call waiting times.	6.A. What are current staffing levels?	6.B. Are these adequate for current call volumes?	6.C. Could they cope if call volumes increased by 10, 15 or 25%?
	information/indication from Turning Points, either in their yearly reports or other correspondence, that their staffing levels are not adequate for the current call volumes.			
ACT				
NT	Information not available as the service is run by Turning Point.			
NSW	Max speed of answer is shown as the maximum time a call waited to be answered . Times in HH:MM:SS. (i.e. Average Speed of Answer for Oct is 42 seconds, Maximum Speed of Answer for Nov is 19 minutes 49 seconds & Average Handling Time for Dec is 6 minutes 38 seconds)	17 Telephone Counsellors & 11 FTE	Yes	No
SA		10 FTE Counselling staff; 3.0 Admin staff		No, not if the calls occurred during business hours. Could manage an increase in calls during after hours only
QLD	Callers are called back if they cannot be connected to a counsellor immediately; Callers are placed in a queue if all phones are engaged	12 FTE	More staffing would be required at peak times if call volumes were to increase.	
VIC	We work with an 85% response rate as our benchmark. 2009-10 completion rate was 87.2%. 2009-10 average call wait time was less than 60 seconds.	Turning Point maintains a staff pool of 40-50 counsellors working various levels of EFT.	Staffing levels for particular shifts are matched to demand levels based on historical data and meeting service benchmarks.	We have the technical infrastructure to cope with increased volumes of 10-25%. Increased staff levels would be required to maintain service benchmarks.
WA	Average wait time 1.30 min; Abandonment rate varies can be up	9.5 FTE		10%

Appendix 1: States and Territories Services Provided

States and Territories	6. What sort of response times do you require? ie call waiting times.	6.A. What are current staffing levels?	6.B. Are these adequate for current call volumes?	6.C. Could they cope if call volumes increased by 10, 15 or 25%?
	to 20%			

States and Territories	7. What experience and training do you currently require for ADIS counsellors/staff?	8. Who is the target audience in each state and territory?	9. Who uses the service currently – are there any statistics available?
Tasmania	ADIS: Suitably trained, experienced and qualified alcohol and drug workers. DACAS: Only medical practitioners with extensive clinical experience will deliver the DACAS.	Members of the public with drug and alcohol issues.	Turning Point's report has an extensive Caller Profile: Type of call; Gender of caller; Age of caller; Caller location; Reason for call; Type of referral received; Drug(s) of concern; Source of referral; Pattern of drug use; Consequences of drug use
ACT	The Intake and Helpline staff have extensive AOD knowledge and experience, crisis intervention and referral skills. Staff have a variety of tertiary training such as social work and nursing. All Intake staff are required to have or be in the process of attaining, the ACT minimum qualification in AOD.	Substance dependent people, families, carers, friends. Other professionals.	As above – data collection and reporting are currently being standardised.
NT	Turning Point is a training organisation so it is assumed to be provided.	Clients who do not adequately access the service are rural and remote clients.	The current service users are mainly 25-35 yrs old, and Darwin based. Stats on client demographics available, but Indigenous status is to be provided in future.
NSW	Degree in Psychology or Nursing or Certificate in Alcohol & Drug Counselling for counsellors and staff.	General population in NSW whose lives have been impacted by the use of alcohol and/or drugs.	General population 16 – 64 years (Oct – Dec 2010 statistics attached).
SA	All staff are qualified social workers, registered nurses or psychologists. Expected (ie desirable on the J&P) to have exp in AOD field or at the very least some counselling experience	Anyone affected by AOD substance misuse	Yes, many statistics can be made available; 63% = Primary Target group (ie AOD user or love ones); 37% Secondary Target Group (ie Health service providers, General public etc);

Appendix 1: States and Territories Services Provided

States and Territories	7. What experience and training do you currently require for ADIS counsellors/staff?	8. Who is the target audience in each state and territory?	9. Who uses the service currently – are there any statistics available?
QLD	No mandatory qualifications. Formal counselling qualifications highly regarded. 6 week in house training prior to commencement on phones	Anyone with concerns related to alcohol, tobacco or other drugs. Health and welfare workers	Self callers = 40%; Parents = 8.6%; Partners & children = 5.6%; Relatives & Friends = 6.7%; Health & Welfare Agencies = 38%

States and Territories	7. What experience and training do you currently require for ADIS counsellors/staff?	8. Who is the target audience in each state and territory?	9. Who uses the service currently – are there any statistics available?
VIC	<p>The DirectLine/ADIS staffing profile is comprised of various professional groups including the disciplines of psychology, social work, nursing, teaching, social sciences [addiction studies], and related welfare studies. Some staff possess further specialist counselling qualifications.</p> <p>ADIS counsellors are trained in line protocols, supervised and provided with professional development structures geared to enable them to apply principles of best clinical practice to the telephone environment and develop competencies in the micro skills of effective telephone intervention and support. Included in the essential key selection criteria for helpline counselling staff is a Certificate IV in AOD or completing a tertiary degree with some experience in AOD, gambling or other content related field.</p>	<p>DirectLine was established in 1986 to provide a 24-hour telephone counselling, information and referral service for anyone in Victoria wishing to discuss an alcohol or drug related issue. DirectLine provides a readily available first point of contact for people who may otherwise have not made contact with other alcohol and drug services. A confidential service of this nature reduces the fear of stigma often associated with disclosing alcohol or drug problems. Accurate information is readily available over 24-hours, when most services are closed and often when parents and young people are in need of assistance and support. DirectLine's target groups include: individual drug users, relatives and friends of those using drugs, people seeking drug information generally and health, welfare and allied services.</p>	<p>DirectLine provide annual data to the Department as contracted and outline caller demographics including sex, age, type of caller, location etc</p>
WA	Degree in human services and counselling experience in AOD sector	Concerned about their own or another's alcohol and other drug use. Secondary	Mostly users of alcohol, tobacco and other drugs; parents of children who are using; health

Appendix 1: States and Territories Services Provided

target health care professionals.

care professionals.

States and Territories	10. How do your jurisdictions currently promote the service?	11. Are there any events over the year in your state/territory that could be used to promote the national number?	12. Is there any other information you think may be relevant to describe your service, or any other issues you wish to raise?
Tasmania	Department Health & Human Services website accessible by the public; Mental Health Hotline; Holiday Notices in newspapers to the public; On display in all ADS operational units; In some of our Unit's out-of-hours answer machine messages	Drug and Alcohol Action Week	Tasmania contracts this service to an external provider as it is not cost effective for Tasmania to provide this service.
ACT	The service is promoted through a number of channels: the local AOD peak body – ATODA (online and published AOD Service directories, the ACT Health website, and health promotion activities.	Drug Action Week, June; Youth Week, April, Mental Health Week, October; and, 'O' week for ACT universities.	
NT	Promoted on the NT Government Internet and also through AOD services.	Remote community Open Days/ festivals eg. Oenpelli Open Day, Merrepin Arts Festival, Beswick Wugularr, Garma Festival (further information on NTG website Bush Tel)	
NSW	Via other Agencies / Health / Welfare services; Phone book; ADIS cards/ posters; Directory assistance; Other website; Publications; ADIS website	Mental Health And Drug And Alcohol Office (MHDAO) festivals, events, and campaigns. See http://www.health.nsw.gov.au/mhdao/	ADIS provides a confidential 24 hours a day, 7 days a week telephone information, education, crisis counselling and referral service to the people of NSW.

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States and Territories	10. How do your jurisdictions currently promote the service?	11. Are there any events over the year in your state/territory that could be used to promote the national number?	12. Is there any other information you think may be relevant to describe your service, or any other issues you wish to raise?
			<p>Other Services provided in NSW include:</p> <ul style="list-style-type: none"> • DASAS (Drug and Alcohol Specialist Advisory Service) offered to professionals of NSW • MACS (Methadone Advice and Conciliation Service) established to improve the Opioid Treatment Program of NSW • STP (Stimulant Treatment Program) established to provide specialist advice to cannabis users • Cannabis Caution, working with NSW police to educate cannabis users and divert them from the justice system.
SA	National & State driven advertising campaigns, AOD & other health service providers,(telephone book seems to be most effective)	If \$ is no object there are many events eg Clipsal, Womad, Fringe festival, Football & cricket events, Big Day Out, Drug Action week, Mental health week	No
QLD	White pages; yellow pages; all related publications; media associated with specific campaigns; promotional material through other Departments eg. Child Safety etc.; Servicing Supportlink (electronic referral system for Police)	Yes. Various campaigns, service activities, Conferences etc.	ADIS (Qld) provides 24 hour telephone counselling, referral, information and consultancy. The Service also provides a central dissemination point for all alcohol and drug literature for the State including campaign material. ADIS also provides a clean needle helpline and provides an after hours service for the Drugs of Dependence Unit. ADIS is also currently undertaking a Brief Intervention research project for people with low or no dependence e.g. binge drinkers, involving a 1 hour face to face session with 3 follow up telephone sessions.

Appendix 1: States and Territories Services Provided

States and Territories	10. How do your jurisdictions currently promote the service?	11. Are there any events over the year in your state/territory that could be used to promote the national number?	12. Is there any other information you think may be relevant to describe your service, or any other issues you wish to raise?
VIC	Broader marketing initiatives handled by DoHA as part of targeted campaigns. TP maintains stocks of printed collateral which are distributed as part of general dissemination activities. Materials are also posted out to services on request. The service is also promoted on TP websites. Ad Hoc opportunities – eg advertising of number in ad breaks when Ben Cousins documentary was aired	Many options – really a question of budget and defining a clear marketing plan	Possible issues: Naming – DirectLine is a well established brand in Vic; Back up procedures eg if Vic service has an outage which state do calls get directed to; How do we handle Vic related calls that are dialled from out of the state or in border-town areas
WA	Media, sector forums, brochures, pamphlets, promotions officer 1 day a week.	Yes	ADIS at present provides a 24/7 service to Western Australians and meets most of the demand most of the time.



Guidelines for Alcohol and Other Drug Telephone Information, Referral, and Counselling Services

CALL FOR SUBMISSIONS

Closing date: Monday 28 November 2011

The Australian Government Department of Health and Ageing has contracted the National Centre for Education and Training (NCETA) to develop Guidelines for Alcohol and Other Drug Telephone Information, Referral and Counselling Services. As part of the development of these Guidelines, NCETA is conducting a call for submissions to ascertain stakeholder expectations about the services which are currently provided, and whether these services are responsive to community and client need and demands, including what options are provided for consumers to give feedback. Further to this, NCETA is seeking input from stakeholders about what data should be collected from clients and shared between services to improve treatment outcomes and inform policy and practice development, as well as suggestions about which key performance indicators are necessary to monitor the provision and quality of alcohol and other drug telephone services.

An electronic version of the submission forms can be downloaded from the NCETA website: www.nceta.flinders.edu.au or by telephoning NCETA on 08 8201 7535. Telephone enquiries can be made directly to Tania Steenson at NCETA on this number.

Submissions must be received by **5.00pm EST, Monday 28 November 2011**.

Submissions can be **e-mailed (preferred method)** to nceta@flinders.edu.au, subject heading: "Attention: Alcohol and Other Drug Telephone Services Guidelines", or sent by mail or fax (see Guidelines for Preparing Submissions for further details).

Appendix 2: Call for Submissions

Guidelines for Preparing Submissions

1. Submissions should be brief, preferably limited to **6 pages or less** and should address the key questions outlined below.
2. Electronic submissions are preferred. They must be saved as an MS Word Document and e-mailed to nceta@flinders.edu.au. Please use the subject heading “Attention: Alcohol and Other Drug Telephone Services Guidelines”.
3. Mailed or faxed submissions should be typed or written clearly in black or blue ink on A4 paper.

Mail to:

“Attention: Alcohol and Other Drug Telephone Services Guidelines”

National Centre for Education and Training on Addiction (NCETA)

Flinders University

GPO Box 2100

Adelaide SA 5001

Fax to: 08 8201 7550

4. The **Submission Coversheet** (see attached) must be completed and forwarded with your submission.

5. Confidentiality

If you wish for all or part of your submission to be treated as confidential, please indicate this on the coversheet and highlight the relevant sections in your submission.

Appendix 2: Call for Submissions



Telephone: 08 8201 7535

Fax: 08 8201 7550

Email: nceta@flinders.edu.au

Submission Pro-forma

Cover Sheet (below)

Please complete the coversheet and forward with your submission to the review.

Instructions

Please structure your submission around the issues below, providing comments or examples where relevant/applicable.

You are not required to address all issues. Please select items of relevance and address your responses to these matters.

Please retain the numbering as shown for each of the questions.

For convenience, please cut and paste the question and its number into your submission document.

Consultation Questions

Guidelines for Alcohol and other Drug Telephone Information, Referral, and Counselling Services

Select and address only the items of relevance.

Retain numbering as shown below.

Question 1

What is the appropriate role and place for telephone advisory services in delivering alcohol and other drug information, referral, and counselling on alcohol and other drug issues to the community?

Question 2

Think about the times you have used alcohol and other drug telephone services, what services and/or information did you expect to receive from these services? Did they meet your expectations? What was good about these services?

Question 3

If they did not meet your expectations, can you tell us in what ways your expectations were not met and how they might be improved?

Question 4

How should we measure the services to ensure that alcohol and other drug telephone advisory services are being delivered in the most appropriate way?

Question 5

Certain groups in the community can be disproportionately affected by levels of harm associated with alcohol and other drug problems. Who are these groups, and how might services best meet their needs?

Appendix 2: Call for Submissions

Question 6

In order to deliver effective services, what knowledge or skills do you think the staff of telephone advisory services should have?

Question 7

What data should be routinely collected by alcohol and other drug telephone services in order to provide useful information which could be used by services to assist them in enhancing service delivery and treatment outcomes, as well as to inform future policy development?

Question 8

What issues arise concerning the balance between information-sharing and data collection measures and the need to protect the privacy of personal information?

Question 9

Is there anything we can learn from experiences within other sectors or settings with respect to the delivery of telephone information, referral and counselling services?

Question 10

How should consumers be informed about access to alcohol and drug telephone counselling services?

Question 11

What essential links should be in place between drug and alcohol counsellors and other services (e.g., crisis supports, mental health services, gambling addiction counselling etc)?

Appendix 2: Call for Submissions

Question 12

Would telephone services be enhanced by offering call back programs (i.e. proactive follow up calls) to both callers and people referred by health professionals?

Other issues:

If you wish to address issues not covered above, please do so at the end of your submission.

Guidelines for Alcohol and Other Drug Telephone Information, Referral, and Counselling Services

Submission Coversheet

TYPE OF SUBMISSION (TICK ONE): <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> ORGANISATIONAL <input type="checkbox"/> OTHER (PLEASE SPECIFY)	
Title (Dr/Prof/Mr/Mrs/Ms/Miss): Name :	
State/Territory:	
Name of organisation (if applicable): Your position in organisation (if applicable):	
Contact person (if applicable):	Authorised by (if applicable):
Postal address:	
Contact number:	E-mail address:
Is all or part of your submission to be kept confidential? <input type="checkbox"/> No <input type="checkbox"/> Yes – all <input type="checkbox"/> Yes – part (indicate in submission which part)	

Appendix 2: Call for Submissions

Which stakeholder group do you belong to or are writing on behalf of? [please tick one only]

- | | |
|--|--|
| <input type="checkbox"/> AOD treatment provider | <input type="checkbox"/> Law enforcement |
| <input type="checkbox"/> General health care provider
(e.g. general practice, primary care, hospital) | <input type="checkbox"/> Pharmaceutical company |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Medical specialist (pain, addiction, psychiatric) |
| <input type="checkbox"/> Policy making | <input type="checkbox"/> Regulator of drugs and poisons |
| <input type="checkbox"/> Consumer group/rep | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Peak body | <input type="checkbox"/> Academic/researcher |
| <input type="checkbox"/> Other (<i>please specify</i>) | <input type="checkbox"/> Advocacy organisation |

Please forward this form with your submission to nceta@flinders.edu.au. Thank you.

Appendix 3: Call for Submissions Findings

Call for Submissions – Summary of Findings

Role of Service

Respondents generally reported that alcohol and other drug telephone services should offer alcohol and other drug:

- health promotion information
- advice
- support
- referral services.

Some respondents noted that there was scope to expand services so that the following options were also routinely available:

- counselling
- brief interventions
- crisis interventions.

All respondents noted the importance of maintaining and building upon existing telephone services as they provided a central point of assistance accessible to a large portion of the population.

Respondents noted that the traditional augmentation role played by telephone services could be enhanced due to increased technology and greater connectivity amongst all generations. One organisation was keen to see pilots of phone services acting as intake systems to improve accessibility to AOD help and support.

However, several submissions noted that while alcohol and other drug telephone services did not always offer formal counselling, the accessibility of the services often enabled support, as opposed to counseling, to be given to those who were either geographically or socially isolated, or those who may not attend face-to-face counselling due to stigmatisation. In this regard, it was noted that telephone services were effective in aspects of client engagement such as reducing stress, demonstrating responsiveness, and assisting clients who may be involved in traditional services to stay on task as they offered consumers real time access and support.

Service providers having knowledge about coping strategies was considered to be critical to the ability of phone services to assist consumers. It was emphasised that whatever the nature of the services provided, it was important to ensure that they were always delivered in a:

Appendix 3: Call for Submissions Findings

- non-judgmental
- empathetic
- patient
- reassuring manner.

To this end, the ability to be able to link individuals with support networks, and those with shared experiences, was noted as a crucial feature for family drug support services. Empowering telephone service consumers to cope effectively with their issues was a consistent theme throughout the submissions.

Information and advice provided by alcohol and other drug telephone services needed to:

- be evidence-based
- reflect best practice
- provided in a timely and appropriate manner.

That is, because consumers generally accessed alcohol and other drug telephone services on a voluntary basis, the service provided needed to respond to the specific needs of the caller. It also needed to provide the caller with community focused information to inform them about local services and systems. It was noted that alcohol and other drug telephone services were able to offer 'real time' counselling to individuals who required impromptu support and/or assistance, rather than at some obscure point in the future. However, it was also acknowledged that further research was required to ascertain which types of intervention were most effective for these situations.

Submissions noted that this research needed to be directed towards discovering the treatment outcomes and demographics of current consumers, as well as assessing the reasons why some cultural groups did not readily access these service modes. Ongoing examination was also required to discover the emergence of new client groups. Regular consultation with consumers was recommended as a strategy to determine whether services were meeting the treatment needs of these emerging groups.

In addition, it was reported that in order to affect optimal uptake of the telephone service delivery mode:

- Services needed to be provided at a low cost or no cost and more collaboration with mobile phone providers needed to be undertaken to ensure that costs associated with accessing the service were not passed onto the consumer
- Specific services and/or knowledges (e.g., translation services, specialized knowledge) were required to meet the needs of different cultural groups and/or population groups and that the delivery of services needed to be regularly evaluated to ensure services were being delivered in a culturally competent manner

Appendix 3: Call for Submissions Findings

- Changes in service structures needed to be implemented in consultation with individuals, communities and other health services.

Submissions generally noted that call back services could be beneficial if the consumer consented to it, otherwise confidentiality and anonymity may be breached. It was noted that some services already provide this and that the provision of call back services aligned with notions of continuing care, as well as informing AOD phone services about the efficacy of their referral practices. Further to this, call backs helped support and connect those consumers who felt isolated, increasing their confidence and empowering the consumer. Several respondents noted the importance of ensuring that call backs occurred at planned times so as to ensure confidentiality was maintained as well as develop confidence and trust with consumers. However, the ability to provide call backs was not considered to be the most important issue facing alcohol and other drug telephone services, with several respondents noting that answering messages and responding to queries left on answering machines was an issue of greater import.

Staff Knowledge, Skills and Qualifications

Submissions noted that telephone staff needed:

- Extensive working knowledge about available services and how the services operated when referring clients
 - This is needed to support clients in approaching the service
- Knowledge about services providing support for families and family relationships as these are particularly affected by alcohol and other drug issues
- Staff credentialing and clear procedures and policies for escalating matters
- Clearly developed pathways for referrals to relevant support services (e.g., domestic violence)
 - Pathways need to be regularly reviewed
- To provide services which were consistent with best practice and not driven by consumer demand
- To develop and work in partnership with other organisations and services due to the increase of highly complex clients which present to services
 - This was noted as an issue which affected the whole AOD sector
 - Assist in building cross-sectoral and evidence-based practices and attenuate existing silo mentalities which exist within a number of service systems.

Several respondents noted that, at a minimum, it was necessary to ensure that alcohol and other drug telephone services can provide preliminary advice and referral to callers regarding the wider health and welfare service system. It was noted that using qualified counsellors to provide this minimum level of service would be costly and that 'specially

Appendix 3: Call for Submissions Findings

trained appropriate people' could provide the initial phone service and act as conduits to further treatment and support services.

Referrals

While acting as a referral service was a recognised role for alcohol and other drug telephone service providers, several respondents also noted that the referral process they encountered when using alcohol and other drug telephone services was unsatisfactory. One person stated that consumers used these services due to their increased accessibility; however, when the consumer was then referred to another service, they encountered the same accessibility issues (e.g., difficulty in accessing referred service due to economic, transport, and mental barriers). Another respondent stated that when they were referred to other services, they 'felt as though they [the telephone operators] don't really care and have just been fobbing me off'. This participant noted that the experience had been frustrating and had increased their anxiety about accessing other services because services providers 'are only doing a job, but don't really care'.

The referral process was noted as being the greatest detriment of alcohol and other drug services as respondents noted that they had 'to go through one person to another to another to get to the right place'. However, this dissatisfaction and sense of disenfranchisement could be reduced if consumers had greater awareness of the nature and role of the service. For example, one submission noted that consumers needed to be aware that alcohol and other drug telephone services were primarily referral services, not counselling services. Despite the need for greater clarity regarding their referral role, however, several submitters noted that even where a service could not 'treat' consumers, the consumer needed to be able to 'talk to the first person who answered the phone'. That is, if a consumer was in crisis, operators should have the skills necessary to 'manage' the crisis prior to referring the person on. Lack of responsive interpersonal skills demonstrated by telephone service staff was noted as frustrating by several submissions.

Submissions noted it was important for AOD services to remain knowledgeable about local services so they can make effective referrals and make appropriate advice. Telephone advisory staff needed to ensure that the agency to which they were referring consumers had available capacity and suitable programs for the consumer. Maintaining up-to-date knowledge of organisations abilities was considered necessary to ensure there was minimal inconvenience for the consumer and risk of attrition for consumers who may easily become disillusioned and reluctant to seek assistance.

The onus to ensure AOD telephone services are knowledgeable about local treatment providers was a shared responsibility with the onus also on the treatment providers who should communicate regularly with telephone service providers about their capacities and programs.

Appendix 3: Call for Submissions Findings

Marketing and Promotions

Respondents noted that the contact number should be readily accessible and advertised widely. However, promotional activities were noted as costly and not the core of the business. As such, it was also noted that there should only be one number for consumers to call as then the cost of promotional activities could be more broadly distributed amongst organisations. Suggestions of where advertising could occur included:

- All health and government-related literature and websites
- The telephone directory
- On alcohol and pharmaceutical packaging
- Licensed premises (e.g., like gambling services currently are)
- Information brochures and posters disseminated by GPs, health centres, community centres, drug and alcohol services, hospitals, emergency departments, as well as educational institutions
- Promoted at health-related events like drug action week as well as commercial events such as schoolies and festivals
- Social networking sites and other social media, including electronic apps
- TV and radio announcements
- Newspapers, magazines, billboards, films and DVDs.

One submission did caution against overexposure as they considered that the message/service would not become targeted enough and then consumers would start to ignore it.

Measuring effectiveness

Submissions noted that current data systems for the AOD sector were fragmented and had varying levels of transparency and accessibility. This impacted negatively on the development of appropriate and responsive AOD policies and strategies. Respondents noted that there was a need for overall transparency in data collection and collation and AOD phone service data should seamlessly fit within and complement existing data systems with a view to compatibility with more advanced and nuanced AOD data systems. However, it was cautioned that while obtaining data would assist in providing an optimal level of service, the paramount consideration in the execution of AOD phone services was to provide assistance to callers. The necessity to provide assistance should not be compromised by the inability of services to collect and collate data.

While measurable KPIs included measuring the amount of calls received, respondents highlighted the importance of not just measuring transactional data such as this. Having the ability to make follow up calls with consumers where possible and identify the progress of the consumer through the AOD system was considered to be an important outcome measurement. This was due to the role played by alcohol and drug telephone services as

Appendix 3: Call for Submissions Findings

gateway services, the notion of continuous care, and the allocation of resources to those service users with complex needs. In this regard, having the ability to record data about domestic violence, hospital admissions, rates of incarceration, and improvements in life expectancies over a period of time were considered necessary.

Evaluations of services needed to be carried out on a regular basis and in a consistent fashion, and evaluated against other AOD interventions with a view to short term and longitudinal impact on service user health. One respondent considered that such evaluations should occur on an annual basis at a minimum. Further, it was suggested that telephone staff could assist users to navigate the various service systems and assist in mapping out appropriate treatment plans.

As such, monitoring the outcome of calls was necessary (e.g., was verbal information or support given, information sent, referring to another service, etc). Determining referral points was noted in one submission as particularly useful in ascertaining the value of AOD phone services and where modifications in service may be required.

Most submissions considered that client assessments and satisfaction were an integral component of measuring the appropriateness and effectiveness of services. Methods suggested included:

- measuring rates of repeat callers
- using caller surveys at the end of the phone call
- implementing complaints/feedback lines where consumers could lodge complaints if they were dissatisfied with the level of service provided or feedback generally -
 - Feedback lines needed to be well advertised and readily accessible
 - Document consumer complaints to identify gaps in service delivery and review accordingly
- Arranging formal/informal engagement with user/stakeholder groups to understand needs and expectations
- Implementing a tracking scheme to assess the uptake of referrals and cross-pollination to other AOD or other services (e.g. mental health, youth, pharmacotherapy advocacy and support), as well as assess the number of referrals from other services (i.e., how did you hear about this service).

Implementing quality assurance mechanisms such as scripted responses, call centre pathways, auditing skills and knowledge of staff, well documented and implemented policies and procedures, and conducting regular monitoring to ensuring continuous improvement and quality assurance were also methods recommended to ensure that drug and alcohol telephone services were being delivered in the most appropriate way.

Appendix 3: Call for Submissions Findings

Privacy

Respondents noted the importance of ensuring:

- telephone services maintained anonymity and privacy (i.e., names and personal information was not sought unless the service provided a function where it was necessary, for example a call back service)
- staff were knowledgeable of Commonwealth and jurisdictional codes of ethics and legislation in matters of privacy and information sharing.
 - Of particular note in this regard was the importance of securing consumer consent wherever possible prior to sharing information with other agencies, as well as providing data to research organisations in a de-identified format
- organisations had policies and procedures around record management, information sharing, and disposal practices (e.g., personal information was not kept with treatment information)
- information sent to consumers was provided in a manner which did not place the consumer at risk (i.e., the envelope was not marked with logos etc).

Several respondents did note that one inherent problem in delivering an anonymous service was where the anonymity impacted negatively on both caller and staff safety. It was reported that consumers could become quite abusive over the phone, and/or threaten violence to themselves and others. These situations were very difficult for staff as there was no ability to 'follow up, to make sure they [the consumer] are ok or ring police'.

Lessons to be learned from other settings and sectors

These included how to deliver:

- culturally appropriate services
- family-based supports and education about how to cope when a family member is experiencing alcohol and other drug problems
- services which share information (with client's consent) in order to achieve the best outcomes for consumers and minimise the need for clients to constantly retell their story to different providers
- services which empower clients to find solutions to their own problems and are not driven by political agendas and/or moral philosophies
- services which are locally-based.

Appendix 3: Call for Submissions Findings

Other services and settings could be used to benchmark outcomes. More research needs to be undertaken to explore the experiences and outcomes of these other services and settings.

Part 6. Guidelines for Australia's alcohol and other drug telephone information, referral and counseling services

The Australian Government Department of Health and Ageing has contracted the National Centre for Education and Training (NCETA) to develop a set of Guidelines for Alcohol and Other Drug Telephone Information, Referral and Counselling Services. As part of the development of these Guidelines, NCETA will consult extensively with state and territory representatives across Australia to ascertain:

- services currently provided, including the extent of service provision (e.g., assessment, counselling, referral, information) and the tools and resources used
- staffing, education and training, and other workforce development arrangements
- community and client need and demands, including what options are provided for consumer collaboration in service planning and delivery
- organisational factors and constraints
- whether there are any current frameworks and guidelines to which the services adhere, and
- evaluation processes undertaken by services to monitor organisational and staff performance, and treatment outcomes and the data collected to inform these processes.

Consultations will include individual and/or group meetings with nominated state and territory representatives, and a public call for written submissions. Findings will inform the development of draft guidelines due to be submitted to the Australian Government Department of Health and Ageing on 16 December 2011. Once developed, the draft guidelines will be sent to all state and territory representatives for their feedback and further refinement. Suggested changes will be incorporated in the final document which will be submitted to the Australian Government of Health and Ageing on the 29 February 2012.

It is noted that all states and territories provided information to the Australian Government Department of Health and Ageing earlier in 2011. The information which you provided has been included in this package. Please let us know whether the information provided is still current.

Appendix 4: States and Territories Consultation Package

Appropriateness of Service

What is the appropriate role and place for telephone advisory services in delivering alcohol and other drug information, referral, and counselling on alcohol and other drug issues to the community?

Numerous standards/guidelines and quality frameworks have already been established for the alcohol and other drug sector, as well as other health care services. Has the alcohol and drug telephone service in your state adopted any of these established standards/guidelines/ quality frameworks?

Yes

No

If yes, which standard/guideline/framework have you adopted?

Has this been adapted to suit organisational and/or consumer needs?

Yes

No

In what ways has the policy been adapted? If the policy has not been adapted, can you explain why?

Appendix 4: States and Territories Consultation Package

Does your organisation endorse any particular treatment model and/or philosophy?

Yes

No

Please describe...

Did this treatment model/philosophy influence the guidelines, standards, and/or framework chosen?

Yes

No

Please describe...

What other factors influenced your decision to adopt this framework? Were any consultations with consumers and consumer advocacy groups, and frontline staff undertaken?

Who is responsible for ensuring that these strategies are implemented effectively?

Appendix 4: States and Territories Consultation Package

Did staff receive training in the delivery and implementation of the selected strategy?

Yes

No

Please explain...

Clinical Assessments

Are screening instruments, counsellor scripts, and referral pathways used by alcohol and other drug telephone services in your jurisdiction?

Screening instruments

Counsellor scripts

Referral pathways

Yes

No

Yes

No

Yes

No

If yes, please
answer

If yes, please
answer

If yes, please
answer

Section
1.2.a.

Section 1.2.b

Section 1.2.c

If you answered no to all of the above, please go to Section 2.

Screening Instruments

Which screening instruments are employed?

Appendix 4: States and Territories Consultation Package

The Alcohol Use Disorders Identification Test (AUDIT)

AUDIT-3

CAGE/ CAGEAID

Michigan Alcoholism Screening Test (MAST)

Drug Abuse Screening Test (DAST)

Timeline Followback Method (TLFB)

Dartmouth Assessment of Lifestyle Instrument (DALI)

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

T-ACE and the TWEAK

Other. Please describe...

Does your jurisdiction use any drug and alcohol severity screening and assessment tools?

Yes

No

If yes, please indicate which tool you use and explain why this instrument is utilised. If you do not screen for dependency, please explain why.

Do you screen for anything else (i.e., mental health issues, pregnancy, psychosocial background) in an alcohol and other drug assessment?

Yes

No

If yes, please indicate which tool you use (if any) and explain why this instrument is utilised. If you do not screen for anything else, please explain why.

Appendix 4: States and Territories Consultation Package

What essential links should be in place between drug and alcohol counsellors and other services (e.g., crisis supports, mental health services, gambling addiction counselling etc)?

Are any other strategies employed in your jurisdiction to manage complex cases, enhance continuity of care, and minimise risks to consumers?

Yes

No

Please explain...

Counsellor Scripts

If counsellor scripts are used, how often are they used and how, when, why they developed?

Appendix 4: States and Territories Consultation Package

How do you measure the effectiveness of counsellor scripts in treatment outcomes and service delivery?

How effective are the counsellor scripts in treatment outcomes and service delivery?

If you have not found the counsellor scripts to be useful or do not use them at all, why?

Appendix 4: States and Territories Consultation Package

Referral Pathways

If referral pathways are used, how often are they used and how, when, why they developed?

How do you measure the effectiveness of referral pathways in treatment outcomes and service delivery?

How effective are the referral pathways in treatment outcomes and service delivery?

If you have not found the referral pathways to be useful or do not use them at all, why?

Would telephone services be enhanced by offering call back programs (i.e. proactive follow up calls) to both callers and people referred by health professionals?

Appendix 4: States and Territories Consultation Package

Yes

No

Please explain...

Acceptability of Services

In order to deliver appropriate and effective services, what knowledge or skills do you think the staff of telephone advisory services should have?

Certain groups in the community can be disproportionately affected by levels of harm associated with alcohol and other drug problems. Who are these groups, and how might services best meet their needs?

Does your jurisdiction have a policy about culturally safe practices?

Yes

No

Please explain...

Appendix 4: States and Territories Consultation Package

Are staff trained to provide care which is culturally safe?

Yes

No

Please explain...

Do you involve consumers in the planning and delivery of services?

Yes

No

If yes, please explain how consumers are involved in the planning and delivery of services. If consumers are not involved, please explain why.

Besides mandatory reporting of child abuse, does your jurisdiction have any other information-sharing protocols by which your organisation abides?

Yes

No

Please describe...

Appendix 4: States and Territories Consultation Package

What issues arise concerning the balance between information-sharing and data collection measures and the need to protect the privacy of personal information?

Effectiveness of Services

When constructing guidelines, standards, quality frameworks, several states and territories have developed checklists. Does the alcohol and other drug service in your state/territory use these checklists to monitor and evaluate safety and quality in service delivery?

Yes

No

Please explain...

What other strategies have the alcohol and other drug telephone services in your state/territory employed to monitor and evaluate safety and quality in service delivery?

Please describe...

Appendix 4: States and Territories Consultation Package

Are treatment outcomes measured?

Yes

No

How are these measured? What are the limitations and constraints in measuring treatment outcomes for alcohol and other drug telephone services?

What client, organisational, and performance data should be routinely collected by alcohol and other drug telephone services in order to provide useful information which could be used by services to assist them in enhancing service delivery and treatment outcomes, as well as to inform future policy development?

Is benchmarking available to assist alcohol and other drug telephone services to contextualize their own performance?

Yes

No

Appendix 4: States and Territories Consultation Package

Please explain...

Is there anything unique about your jurisdiction which may be utilised to enhance the services provided in other jurisdictions?

Yes

No

Please explain...

Is there anything we can learn from experiences within other sectors or settings with respect to the delivery of telephone information, referral and counselling services?

Yes

No

Please explain...

Access to services

How should consumers be informed about access to alcohol and drug telephone counselling services?

Appendix 4: States and Territories Consultation Package

Has your jurisdiction employed strategies to improve access to alcohol and other drug telephone services for consumers?

Yes

No

If yes, what strategies have been employed in your jurisdiction to improve access to alcohol and drug treatment telephone services for consumers?

How were these strategies developed? What consultation processes occurred?

Have the strategies been evaluated?

Yes

No

If yes, what measurements were employed and what were the outcomes of the evaluation?

Appendix 4: States and Territories Consultation Package

Safety of services

How important is it that governments, managers, and clinicians recognise their responsibilities for ensuring services are delivered in a safe manner?

Does your jurisdiction employ strategies or develop information to improve health literacy and help consumers make decisions about their care options?

Yes

No

Please explain...

Are clinicians trained to identify and support clients with low health literacy?

Yes

No

Please explain...

Are clinicians supported to assist in developing managerial skills and supervising staff?

Appendix 4: States and Territories Consultation Package

Yes

No

Please explain...

Do staff receive regular performance reviews, clinical supervision, and/or debriefing? Please indicate which.

Performance Reviews

Clinical Supervision

Debriefing

If yes, please describe what activities are undertaken...

When receiving these reviews, do staff have access to data about the quality of the care they provide and the outcomes of their clients (including after referral or while under the care of other providers or institutions)?

Yes

No

Please explain...

Appendix 4: States and Territories Consultation Package

Other Matters

Are there any other matters that you would like to raise with us today?

Thank you for your time.

Appendix 5: Services

Services

This guide addresses issues relevant to state and territory based alcohol and drug helpline services and specifically includes the following:

ACT:	Community Health Helpline
NT:	Alcohol and Drug information Service
TAS:	Alcohol and Drug Information Service
SA:	Alcohol and Drug Information Service
WA:	Alcohol and Drug Information Service
QLD:	Alcohol and Drug information Service
VIC:	Direct Line
NSW:	Alcohol and Drug information Service.

The content of the guide, and the principles contained herein, may also be of relevance and have applicability to other similar services.