Findings from the 2017 Tasmanian Brief Intervention Survey

Drug Education Network Inc.

Contents

Definitions and Acronyms

Brief Intervention (BI): The definition of the term Brief Intervention varies throughout literature. In essence, a brief intervention is a *short interaction, often a conversation between a trained volunteer, worker or practitioner and an individual, with the aim of motivating positive behaviour changes or continuation.*

Cisgender: Denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex.

DEN: Drug Education Network Inc.

Extended Brief Intervention (EBI): A model of Brief intervention. A BI lasting more than 25 minutes, may extend over multiple sessions, may involve additional therapies. (Swan et al. 2008) Definition provided to survey respondents: *"More than 25mins, involved"*

Transgender: Denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex.

Very Brief Intervention (VBI): A model of Brief Intervention. A BI lasting no more than 25 minutes, generally not incorporating additional therapies, typically opportunistic. (Swan et al. 2008) Definition provided to respondents: *"Less than 25mins, simple"*

Introduction

The 2017 Tasmanian Brief Intervention Survey was conducted by the Drug Education Network to better understand how Tasmanian workers in Health, Community Services, and other sectors use, understand and respond to Brief Interventions and associated tools and screening tools. The data is used to inform the development of the *Tasmanian Alcohol and Other Drug Brief Intervention Framework*, a document in the final stages of development as of July 2017.

Method

The survey was conducted online via the SurveyMonkey online electronic survey system. Participants were invited through various vehicles, including the electronic newsletters of multiple organisations, and by word of mouth and accompanying flyers. Responses were collected over a period of approximately one and a half months, with the closing deadline being moved back several times to allow responses from participants who heard about the survey later than intended. Participants were presented with 13 questions (Appendix A) regarding their work, attitudes, beliefs and practices around Brief Interventions. Participants were also given the opportunity to contact DEN or provide contact details for follow up, however at the time of writing no respondents have been contacted outside of the survey.

Advance Summary

- The majority of responders were Cisgender Women (72%) followed by Cisgender men (24%).
- Community Services Workers (24%), School Health Nurses (20%) or General Practitioners (18%) were the most common job types represented in the survey.
- The average number of years of experience represented among respondents is 10.7 years, with the majority of responses falling at 5 and 10 years. Respondents held an average of 2.26 qualifications each.
- One third (33%) of respondents reported never having received Brief Intervention training.
- When looking at the type of Brief Interventions provided, 27.8% of respondents only provided Very Brief interventions. 25% of respondents preferred either Extended or Very Brief interventions respectively, while 16.7% provided both equally. The majority of respondents (53%) show a preference towards Very Brief Interventions.
- The ability of Brief Interventions to Increase the Capacity or Empower Clients (13%), the Responsiveness or 'Quickness' of Brief Interventions (11%), the ability to provide Harm Minimisation (11%) and the Effectiveness and Evidence Base for Brief Interventions (11%) were cited the most commonly as the benefits of Brief Interventions.
- Of settings where Brief Interventions are provided, Outreach settings were most commonly reported (12%) followed by Community Organisations (10%), Other (10%), General Practice Clinics (9%) and Youth Settings (9%).
- Ten 'activities' or 'content types' inside of Brief Interventions were identified as most common in Tasmania, with the most common being Building rapport and Engagement (11%) and Discussing Harm Reduction Strategies (10%), closely followed by Providing Written Information (9%), and Discussing Treatment Options (9%).
- The most commonly cited prompts for initiating a Brief Intervention were Something Mentioned in Discussion (14%), Direct Question from Client (13%), Related Health Issue (12%) or Open Discussion about Substance Use Habits (12%).
- The most commonly used Screening and Brief Intervention tools reported are the HEADDS Adolescent Health Check (13%) and ABC for Smoking Cessation (13%), the Kessler Psychological Distress Scale K10 (11%) and the Alcohol Use Disorders Identification Test AUDIT (9%).
- The top three cited barriers to providing Brief Interventions were Lack of Access to Brief Intervention Training (12%), Time Constraints (10%), and Competing Client Health Priorities (10%).

Responses

45 respondents from 16 identified organisations, across various fields, completed the survey.

Gender

The vast majority (72%) were cisgender women, followed by cisgender men (24%). A small proportion (2.2%) of respondents identified as Transgender Women, or otherwise preferred not to answer.

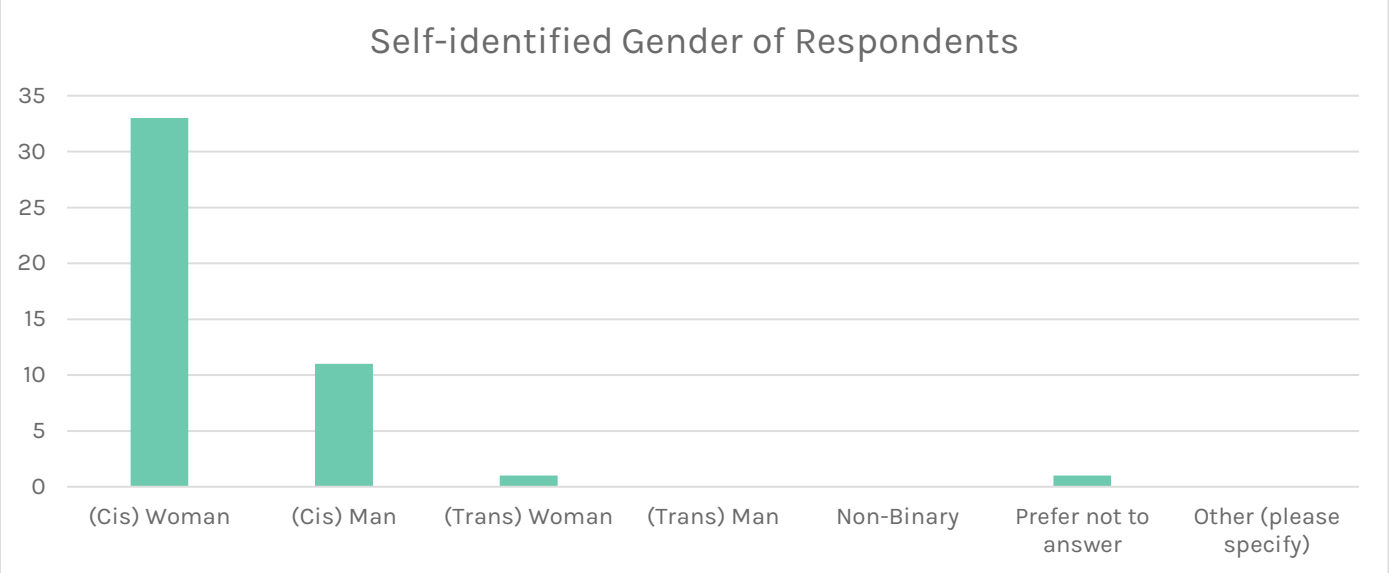

Figure 1 - Distribution of self-identified gender of respondents

Positions and Organisations

Of the positions held by respondents, the majority were Community Services Workers (24%), School Health Nurses (20%) or General Practitioners (18%). The remaining positions consisted of various management roles (9%) and AOD worker roles (9%), Social Workers (7%) and various jobs associated with the medical field (7%), Nurses (4%) and Teachers (4%).

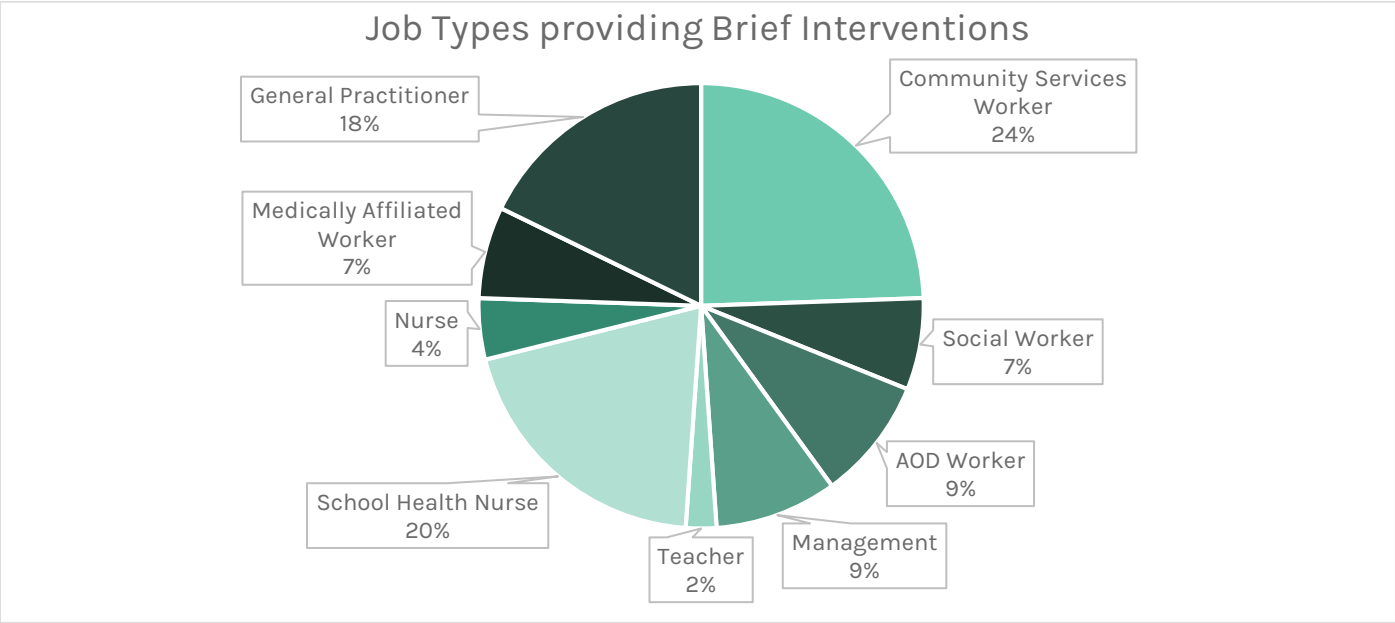

Figure 2 - Distribution of job types

As well as receiving responses from a range of job types, the survey attracted a variety of participating organisations:

Participating Organisations
Department of Education
The Link Youth Health Service
YourTown
Bethlehem House
Tasmanian Health Service
UnitingCare Tasmania
Huon Regional Care
George Town Medical Centre
Huon Valley Health Centre
Headspace
Partners in Recovery
The Salvation Army
Holyoake Tasmania
Alcohol and Drug Service
Child and Family Centre Chigwell
Alcohol and Drug Foundation

Table 1 - List of identified participating organisations

Experience and Qualifications

Respondents reported a wide range of years of experience, from no experience (0 years) to very extensive (more than 40 years). The average years of experience is 10.7 years, with the majority of responses falling at 5 and 10 years.

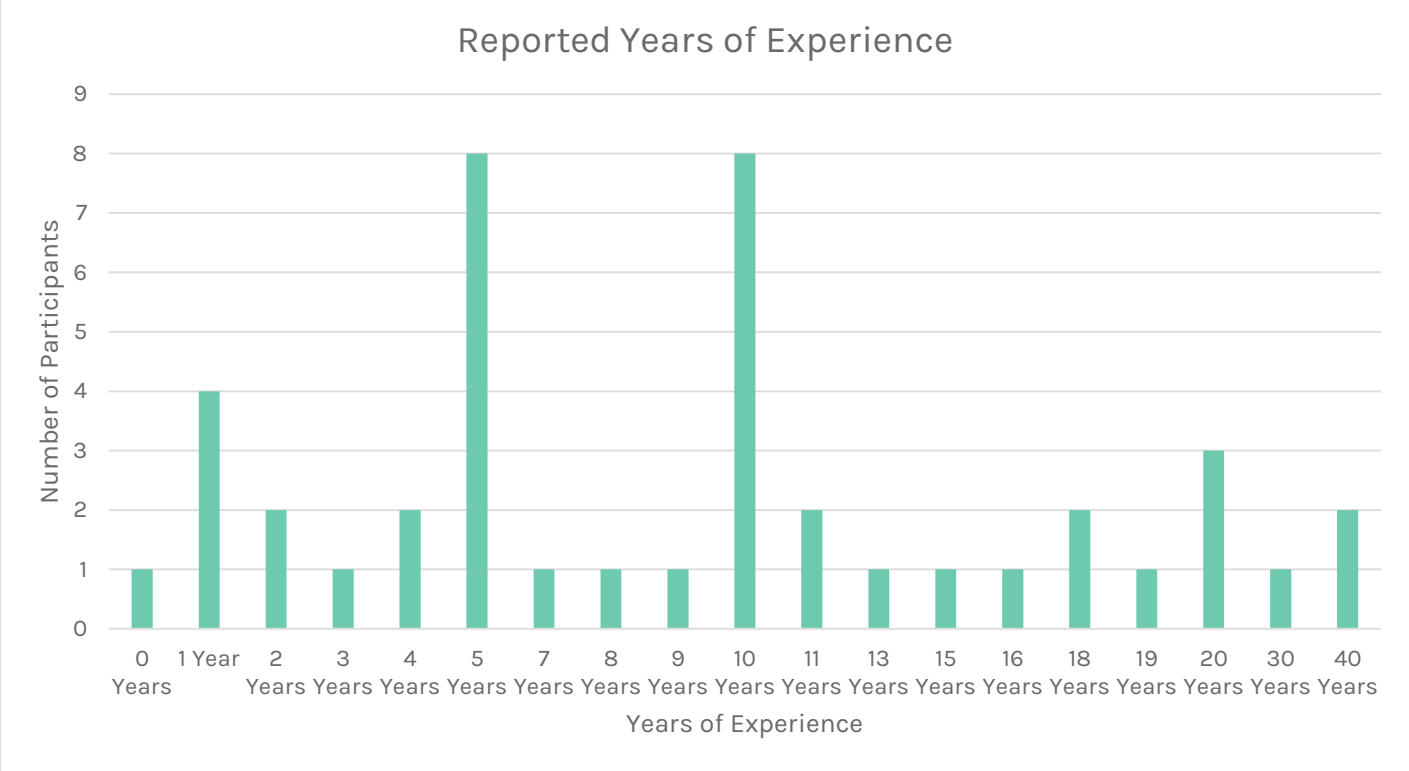

Figure 3 - Reported years of experience

Respondents reported an average of 2.26 qualifications, with qualifications cited ranging from multiple years of experience in specific areas, to Certificates, Diplomas, and various degrees.

Examples of participant qualifications*
Diploma of Community Services
Masters of Community Nursing
Registered Nurse Diploma
Post Graduate Certificate in Emergency Nursing
Bachelors of Science
Bachelors of Primary Education
Graduate Diploma of Psychology
Graduate Diploma of Psychological Science
Masters of Social Work
Graduate Certificate of Child Health
Advanced Diploma of Disability Work
Certificate IV of Community Services
Associate Diploma of Children's Services
Bachelors of Medical Science (Hons.)
Bachelors of Medicine, Bachelor of Surgery
Masters of Public Health
Experience at Headspace
Experience as Youth Worker in Community Organisations
Experience working in Hospital Emergency Departments
Bachelors of Social Work
Bachelors of Social Sciences
Management experience in private industry
Experience in Community Services
Diploma of Public Safety

Table 2 - Examples of respondent qualifications. Responses have been edited for brevity and clarity.

Brief Intervention Training

Two thirds (66.6%) of respondents reported having received Brief Intervention training. The remaining third (33.3%) reported never having received specific training.

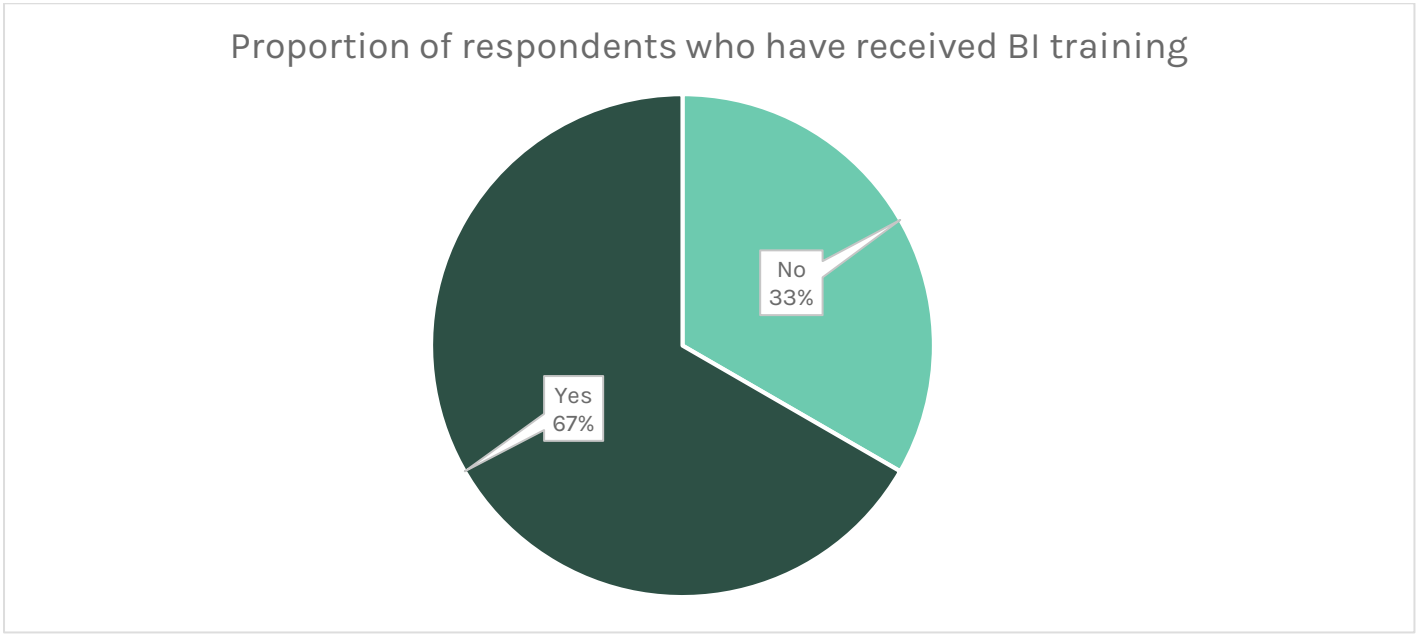

Figure 4 - Proportion of respondents who have received BI Training

Respondents who reported ever having received training were asked to expand on the type of training they had received. Responses were qualitative and mixed, with few respondents providing names of specific training, with others citing on-the-job training or induction, training while earning degrees or certificates, descriptions such as 'regularly' or 'too many over the years', or providing no response at all.

Responses have been grouped into 'Response Types', with some responses appearing in more than one type.

Training Response Type	Response Text
Specific named training	*"DEN training for School Health Nurses, various PD over the years around motivational interviewing"*
	"eg elearning modules for quit smoking"
	"Amovita Training on Motivational Interviewing. Social Work training involved solutions focused therapy training."
	"Motivational interviewing with GPTT, CBT training with RACGP; ACT training with Russ Harris online course"
	"NSP brief interventions, NPIC."
Job-related training	*"Induction"*
	"On the job training"
	"Throughout my career."
	"University and Profesional training."
	"During degrees and ongoing professional development"
Certificate or Degree related	*"General studies not specific"*
	"University and Profesional training."
	"During degrees and ongoing professional development"
	"during GP training"
	"I think I probably did as part of my GP training - I do not have a good recollection of the content covered."
	"Just undergraduate uni"
Frequent, Multiple, or Repeated training instances	*"MI & various other BI training over the years"*
	"Regularly"
	"Too many over the years"
	"multiple"
	"Throughout my career."
Other Responses	*"bi"*
	"Cant remember too long ago"
	"Several years ago"
	"need for regular updates"

Table 3 - "Training Type" Open-Ended Responses

Types of Brief Intervention

Respondents were asked to describe the types of Brief Interventions they provided using Very Brief Interventions (Very Brief), Extended Brief Interventions (Extended), or both. They were also asked to describe which of these two BI types were most prominent in their practice: Whether they only provided a specific type (only), if they favoured one above the other (usually).

27.8% of respondents only provided Very Brief interventions. 25% of respondents preferred either Extended or Very Brief interventions respectively, while 16.7% provided both equally. 2.8% of respondents either provided Extended Brief Interventions only, or had not provided a Brief Intervention before.

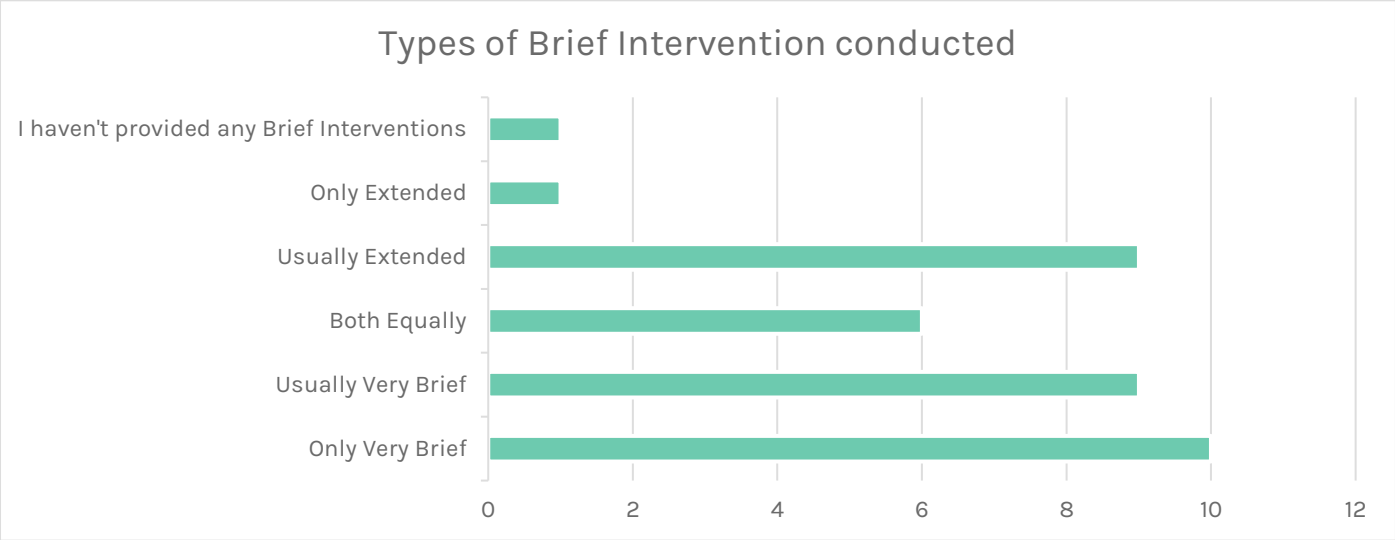

Figure 5 - Types of Brief Interventions conducted

Taken together, the majority of respondents (53%) show a preference towards Very Brief Interventions, compared to a little under a third (28%) preferring Extended Brief Interventions and fewer than a quarter (19%) showing no preference between the two models.

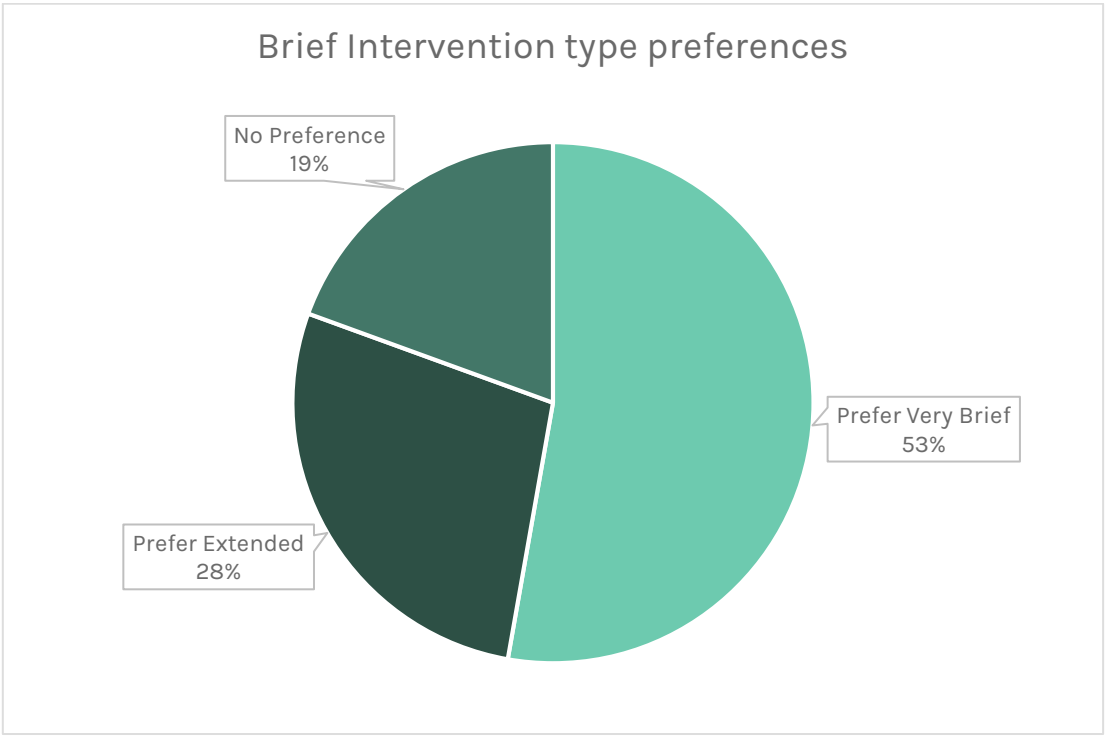

Figure 6 - Brief Intervention Type Preferences

Attitudes

Respondents were asked to provide an open-ended response to the question, "*What do you think are the potential benefits of providing AOD Brief Interventions to your clients*?".

32 of 45 responders provided an answer to the question, and responses were varied in length and content. Responses were roughly assigned to categories according to their content, with each category representing common theme of perceived benefits to providing Brief Interventions. These categories included Efficacy of Brief Interventions, Rapport Building, Harm Minimisation, Capacity Building and Compatibility with Other Interventions, a Beginning Step, Awareness Raising (Information Provision), Responsiveness (Time Effectiveness), Appropriateness, Providing Referral Opportunities, and Cost Efficacy.

The most common themes were the ability of Brief Interventions to Increase the Capacity or Empower Clients (13%), the Responsiveness or 'Quickness' of Brief Interventions (11%), the ability to provide Harm Minimisation (11%) and the Effectiveness and Evidence Base for Brief Interventions (11%). Respondents also commonly cited that Brief Interventions provided a 'first step', that they were appropriate and made good use of short interactions, and that Brief Interventions could help fill gaps in other services. A list of responses is available in Appendix B.

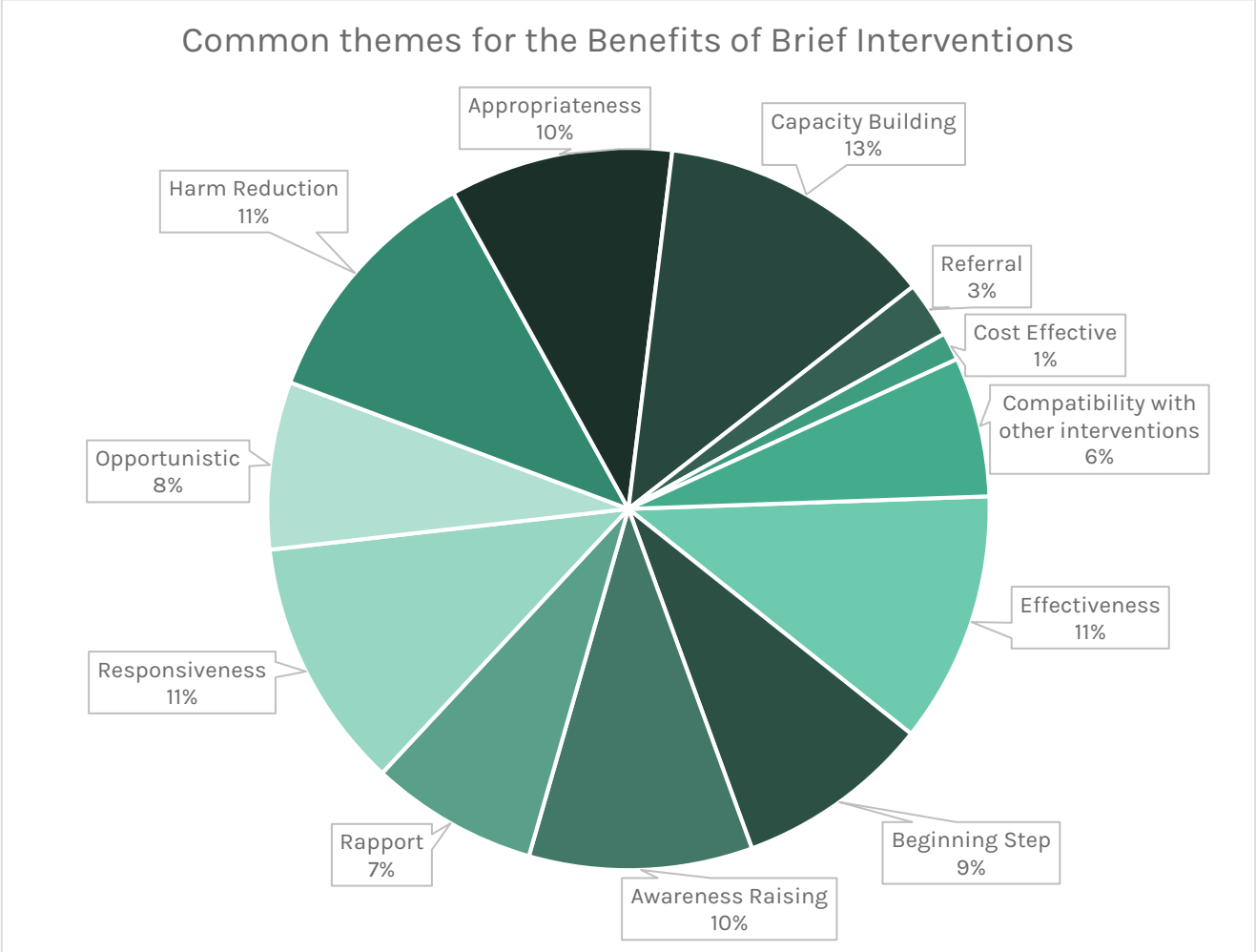

Figure 7 - Reported benefits of Brief interventions

Settings

Respondents were provided a list of settings in which a brief intervention might be performed, and asked to select all that apply. Outreach settings were most commonly reported (12%) followed by Community Organisations (10%), Other (10%), General Practice Clinics (9%) and Youth Settings (9%). No responses were recorded for Migrant and CALD settings, Disability settings, Private Organisations, or Specialist Medical Clinics. Of the Other settings specified, most identified Schools (6 responses), Child and Family Centres (1 response), Sporting clubs (1 response) and the provision of brief interventions over the phone (1 response).

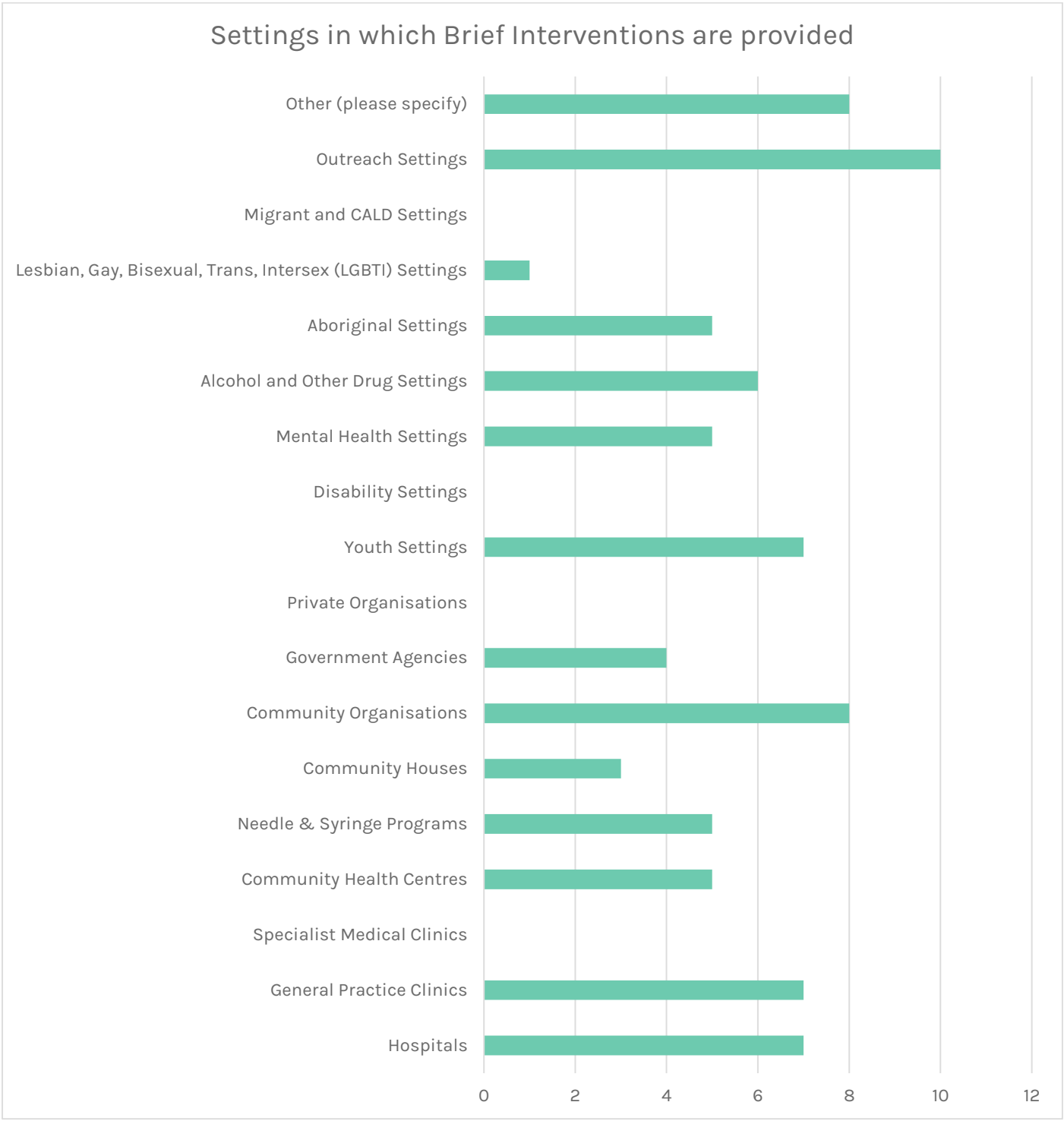

Figure 8 - Settings in which Brief Interventiosn are conducted

Content

Based on existing research and models such as *Alcohol and Other Drug Brief Interventions in Primary Care*, Turning Point Alcohol and Drug Centre 2008, respondents were provided a list of activities commonly present in Brief Interventions and asked to select as many as they have experience using.

The two most commonly cited activities when providing brief interventions were Building rapport and Engagement (11%) and Discussing Harm Reduction Strategies (10%), closely followed by Providing Written Information (9%), and Discussing Treatment Options (9%).

Considering the Stages of Change (8%), Providing Advice (8%), and Setting Participant Goals (8%) were next most common, as well as Warm and Cold referrals (7% respectively) and Motivational Interviewing (7%). Other activities provided during a Brief Intervention were reported at 5% or less, suggesting that the aforementioned activities are the top 10 most common components of Brief Interventions.

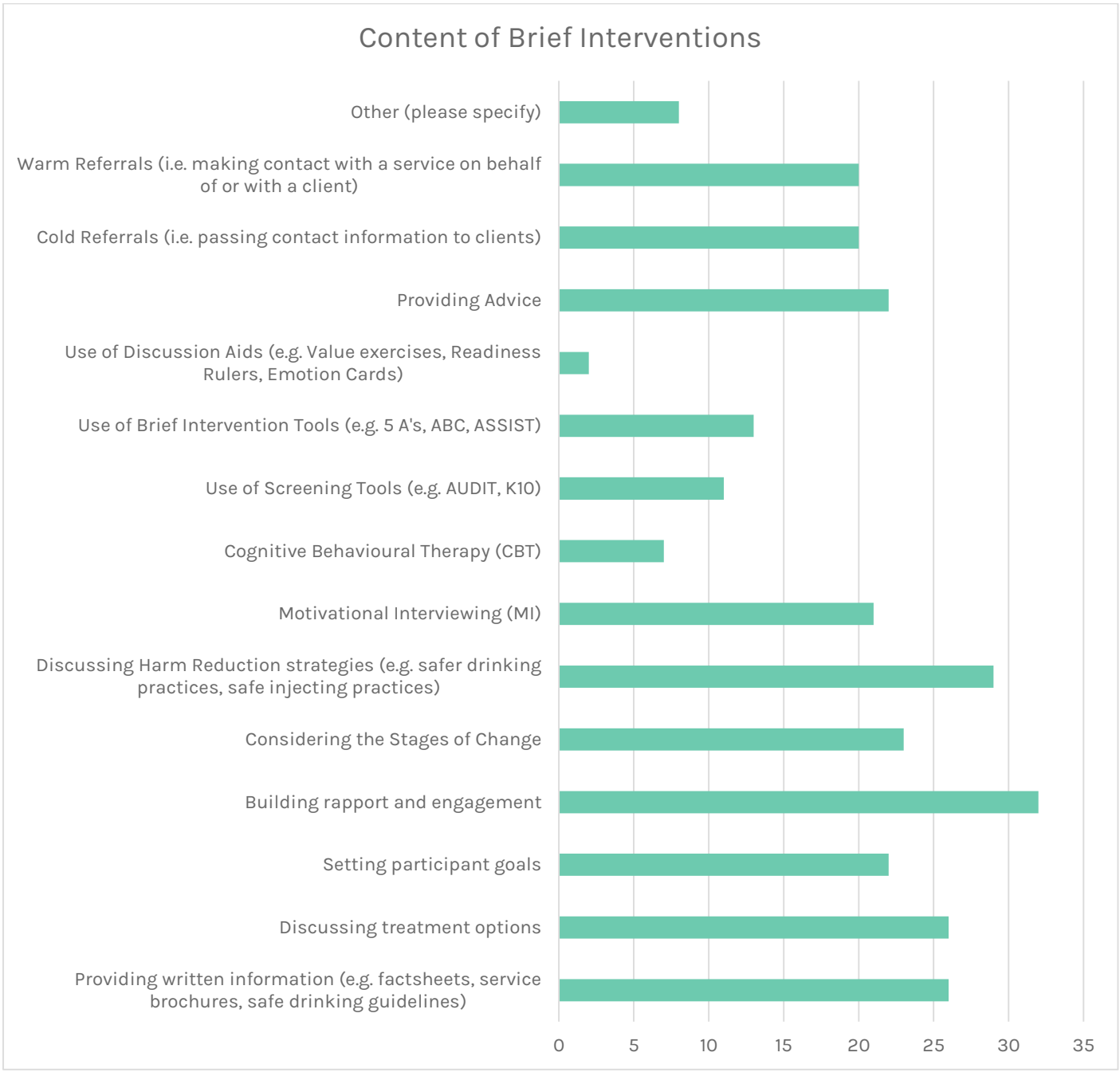

Figure 9 - Most frequently reported content in Brief Interventions

Most common Brief Intervention content types
Building Rapport and Engagement
Discussing Harm Reduction Strategies
Providing Written Information
Discussing Treatment Options
Considering the Stages of Change
Providing Advice
Setting Participant Goals
Warm (Facilitated) Referrals
Cold (Client-driven) Referrals
Motivational Interviewing

Table 4 - Ten most common Brief Intervention content types

Least commonly reported were Other (3%), Cognitive Behavioural Therapy (3%) and the use of Discussion Aids (1%). Participants were not asked to give a reason for their selections and the reasons behind these activities being poorly represented can be speculated upon but are at this time unknown.

Participants were asked to specify when selecting 'Other'. Generally these responses added additional detail that may fit into existing categories, but these have not been reflected in the main data at this time.

'Other' responses for Brief Intervention Content
"Health education and promotion class and school activities"
"Transporting, Attending, Advocating with parents at Client Intervention Sessions with AOD workers, GP's, Child Health and Parenting Nurses, Family Support Workers, School Social Workers, Psychologists and Psychiatrists."
"Educating sporting clubs to refer at risk clients or AOD users to 3rd party treatment organisations"
"Safer injecting, screening for BBVs, treatment for Hep C"
"It depends on the client"
"Collaboratively working with Aboriginal Health Workers"
"Would like to do MI or CBT but don't feel I have the training"

Table 5 - Brief Intervention Content Open-Ended Responses

Reasons

Reasons for providing Brief Interventions were fairly evenly distributed, with the most common reasons being Something Mentioned in Discussion (14%), Direct Question from Client (13%), Related Health Issue (12%) or Open Discussion about Substance Use Habits (12%).

Very few respondents reported initiating a brief intervention if a client returned from a long absence (3%). Of the Other (2%) responses, the answers typically confirmed or clarified an existing reason ("Client Directed", "Most often open discussion", "HEADSSS assessment" "Upon engagement… or when specific need arises…").

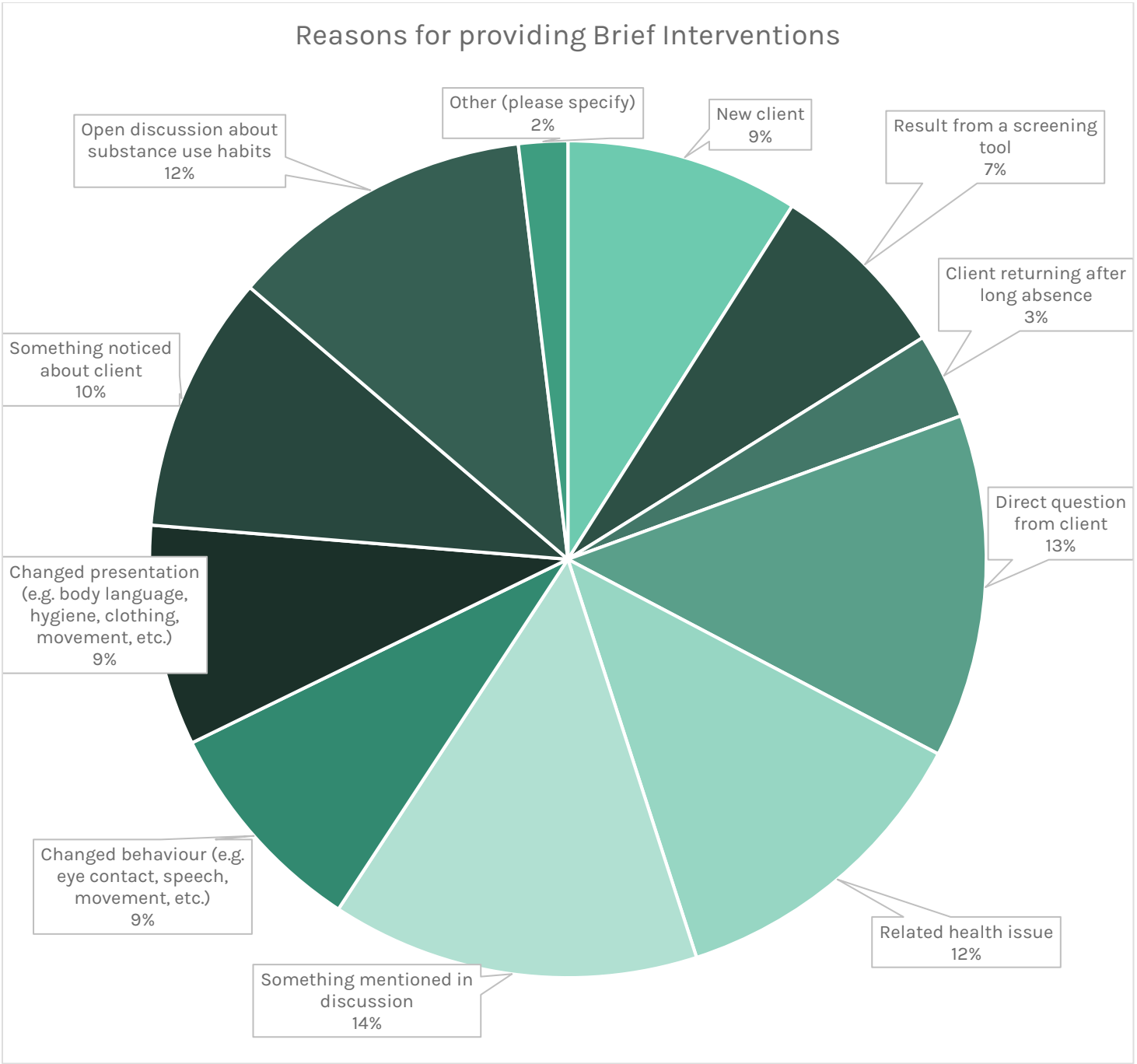

Figure 10 - Reasons for providing Brief Interventions

Commonly Used Tools

The most commonly used Screening and Brief Intervention tools reported are the HEADDS Adolescent Health Check (13%) and ABC for Smoking Cessation (13%), the Kessler Psychological Distress Scale K10 (11%) and the Alcohol Use Disorders Identification Test AUDIT (9%). The remaining tools listed represented no more than 6% of responses, with the exception of Other (Figure 11), suggesting that aside from these four tools, workers providing Brief Interventions may self-select tools according to their own preferences, exposure, or workplace policy.

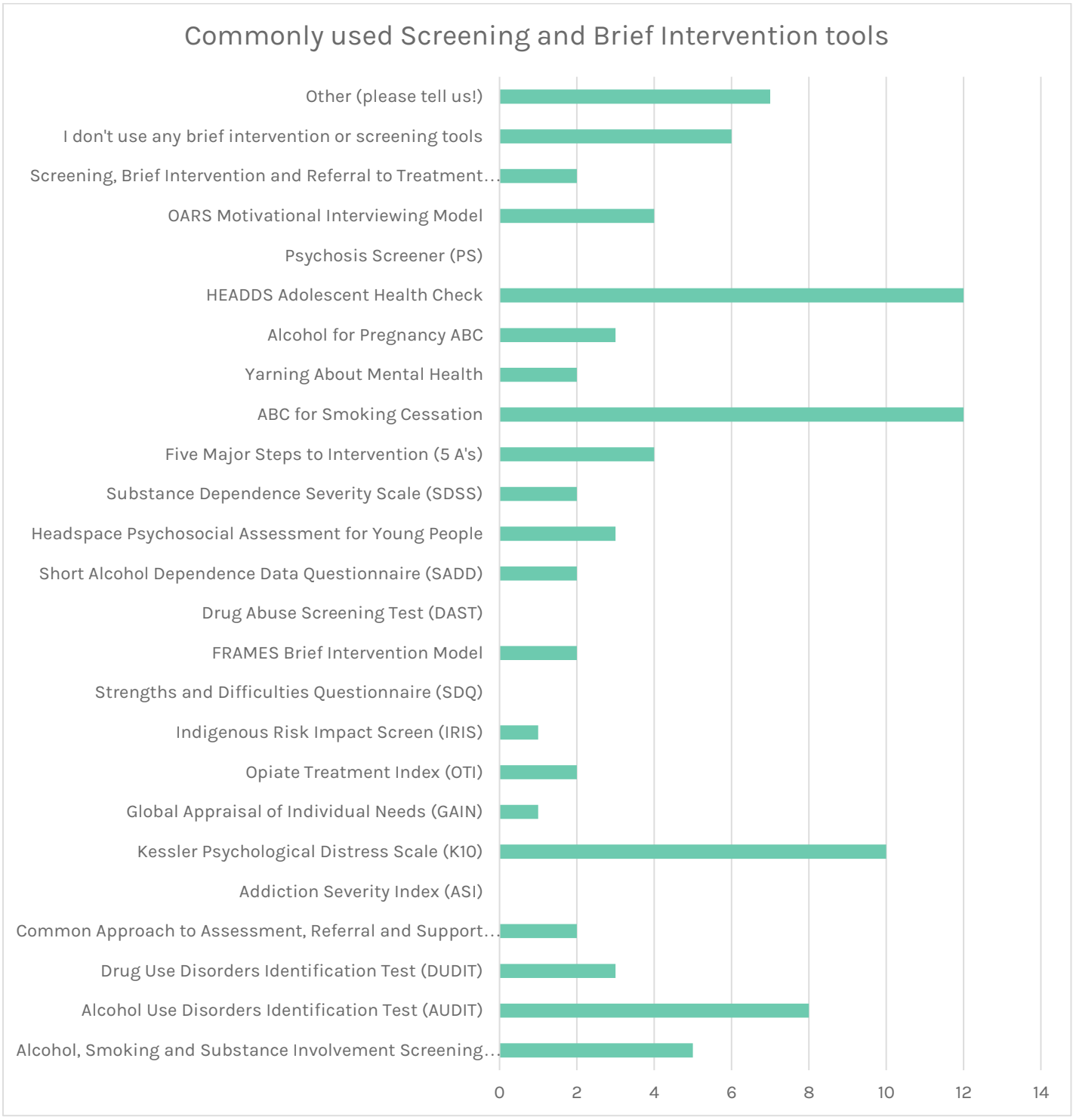

Figure 11 - Commonly used Brief Intervention and Screening Tools

Other reported tools

When asked to clarify their 'other' responses, the majority of respondents chose not to list or describe other tools. Of those that did, additional tools included 'Direct Confidential Client Disclosure', 'DASS', 'Audit-C', 'Drinkmeter', 'Grassessment', 'Psycheck', 'MSE' and 'Ask the Questions'. Some respondents additional chose to clarify how some tools were used or to confirm that they had not heard of the tools listed.

'Other' responses for Brief Intervention and Screening Tools
The above tools are used with extended contact in my role they are not used in brief intervention settings
Direct Confidential Client Disclosure
Nil
DASS, AUDIT C - many of these tools above I'd use more in an assessment rather than a shorter brief intervention. Also use online screening tools such as drinkmeter, Grassessment (when NCPIC was up and running) and Say When websites
Pyscheck
Ask the questions - haven't heard of many of the above tools
MSE, history

Table 6 - 'Other' Brief Intervention and Screening Tools Open-Ended Responses

Barriers

Barriers to providing Brief Interventions were a mixture of worker and client-based barriers. The top three responses were Lack of Access to Brief Intervention Training (12%), Time Constraints (10%), Competing Client Health Priorities (10%), followed by the Client's position in the Stages of Change (6%), Lack of Confidence (6%), Being unsure of what tools exist (6%) and Challenging Client Behaviours (6%).

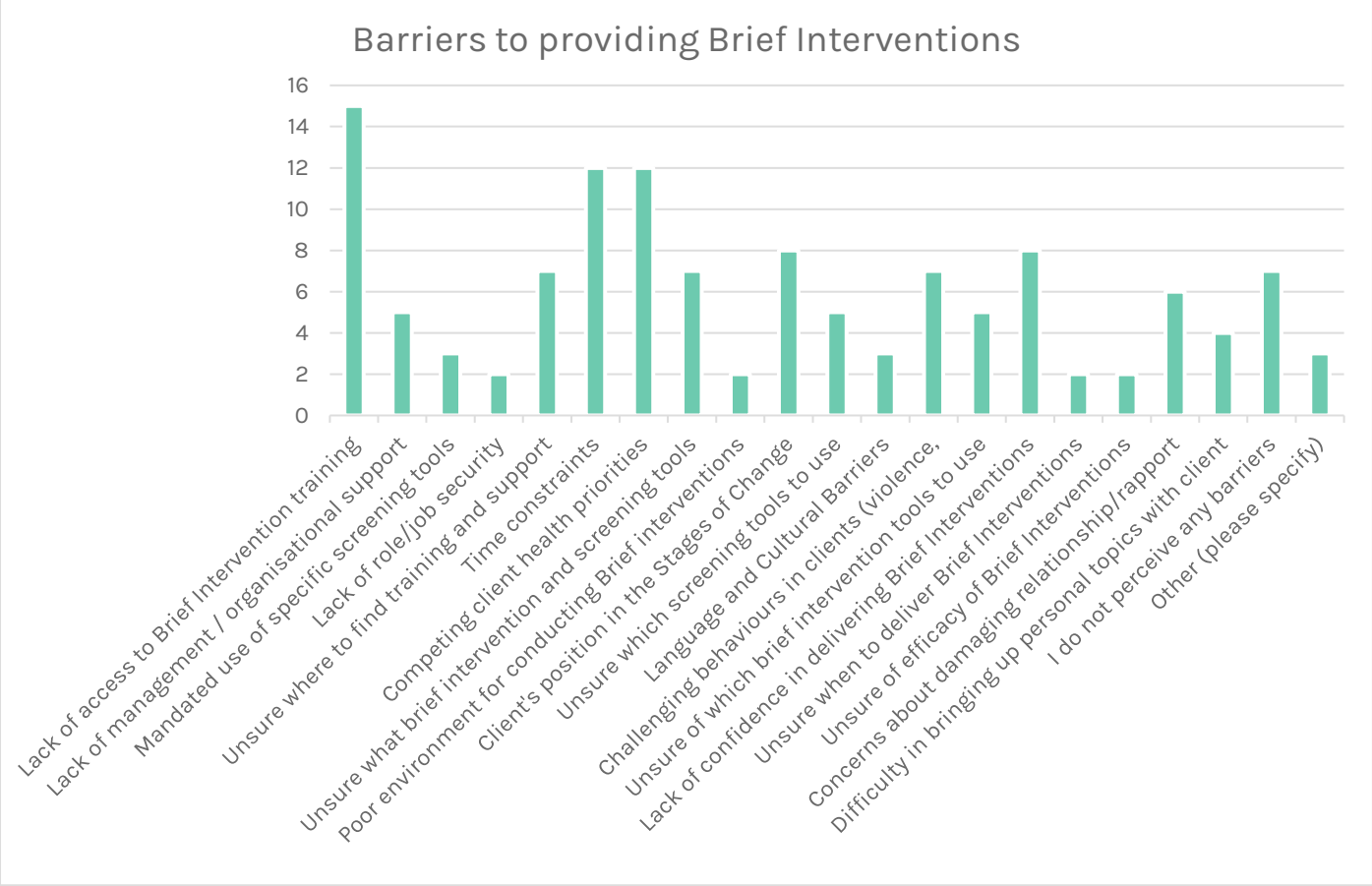

Figure 12 - Barriers to providing Brief Interventions

Respondents also cited being Unsure of where to finding training and Support, Unsure of which tools to use, and concerns about damaging rapport as the next most common barriers. While relatively few respondents chose Language and Cultural Barriers (2%), Lack of Management/organisation Support (4%), Mandated use of Specific Tools (2%), Lack of job security (2%) and being unsure of the Efficacy of Brief Interventions (2%), no concern listed had zero responses suggesting that these barriers, while uncommon, should still be considered. Interestingly, 6% of respondents did not perceive any barriers to their provision of Brief Interventions. Three respondents provided clarification for their 'other' selection, as shown in Table 7.

'Other' responses for Brief Intervention Barriers
"Not a defined AOD service, will refer on to other specialist service if client presentation is chronic substance abuse."
"Outside of rthe scope of GS staff involvement with clients - primary prevention rather than secondary or tertiary involvement"
"Minimal free/cheap to access services with long waiting periods mean that patient is very often lost to follow up or loses motivation."

Table 7 - Brief Intervention Barriers Open-Ended Responses

Summary

The majority of respondents to this survey were Cisgender Women, holding Community Services, School Health Nurse or General Practitioner type jobs with an average of 10.7 years of experience. Two thirds of respondents had received at least one incidence of Brief Intervention training. The most common settings in which Brief Interventions were provided were Outreach, within Community Organisations, General Practice Clinics and Youth settings. Attitudes towards Brief Interventions were positive, with the most commonly reported perceived benefits to providing them cited as the ability of Brief Interventions to increase the capacity of clients and to provide harm minimisation, as well as their effectiveness and responsiveness.

Just over half of all respondents showed a preference for providing Very Brief Interventions, with just over a quarter of all respondents only providing this type. Within the Brief Interventions provided, ten activities were identified as most common, with the top activities being the building of rapport and engagement, the discussion of harm minimisation strategies, provision of written information and discussing treatment options. Brief Interventions were prompted most often by something mentioned in discussion, a direct question from a client, discussion about substance use habits or about a related health issue. While some common Brief Intervention and Screening tools were identified, including more well-known tools such as HEADDS, ABC for Smoking Cessation, K10 and Audit, the responses were scattered across the list provided, suggesting that individual or organisational choice plays a role in the tools used by workers.

The three most cited barriers to providing Brief Interventions were Lack of access to Brief Intervention training, Time Constrains, and Competing Client Health Priorities. It is worth noting that none of the barriers listed for participants to choose from had zero responses, indicating that these less common barriers should nonetheless be taken into account.

The data collected in this survey will be used to inform the creation of the Tasmanian Alcohol and Other Drug Brief Intervention Framework, a strategic document which may help to address some of the barriers noted by the respondents by providing reinforcement of knowledge and access to a variety of brief intervention and screening tools. Despite two thirds of respondents having received training, responses indicated a general sense of lack of confidence or forgotten skills which suggests the need for more frequent, highly marketed Brief Intervention training for a variety of workers.

A repeated survey with wider reach and/or a more targeted participant group may provide a more accurate sample of the Tasmanian workforce and their use and understanding of Brief Interventions, as well as their training and support needs.

Appendix A – Question List

Question Text	Answer Options
Q1. What is your gender?	(Cis) Woman (Cis) Man (Trans) Woman (Trans) Man Non-Binary Prefer not to answer Other (please specify)
Q2. What is your job title?	Open-Ended Response
Q3. What organisation(s) do you work for?	Open-Ended Response
Q4. How many years of experience do you have working with AOD clients?	Number Entry
Q5. What are your qualifications? (e.g. any Certificates, Degrees, specific experience, etc.)	Open-Ended Response
Q6. Have you ever received training in Brief Interventions?	No Yes (please specify)
Q7. What do you think are the potential benefits of providing AOD brief interventions to your clients?	Open-Ended Response
Q8. Generally, do you deliver Very Brief (less than 25mins, simple) or Extended (more than 25mins, involved) Brief Interventions?	Only Very Brief Usually Very Brief Both Equally Usually Extended Only Extended I haven't provided any Brief Interventions
Q9. In what setting(s) do you provide Brief Interventions? (Tick all that apply)	Hospitals General Practice Clinics Specialist Medical Clinics Community Health Centres Needle & Syringe Programs Community Houses Community Organisations Government Agencies Private Organisations Youth Settings Disability Settings Mental Health Settings Alcohol and Other Drug Settings Aboriginal Settings Lesbian, Gay, Bisexual, Trans, Intersex (LGBTI) Settings Migrant and CALD Settings Outreach Settings Other (please specify)
Q10. When delivering, what do your AOD Brief interventions tend to involve? (Tick all that apply)	Providing written information (e.g. factsheets, service brochures, safe drinking guidelines) Discussing treatment options Setting participant goals Building rapport and engagement Considering the Stages of Change Discussing Harm Reduction strategies (e.g. safer drinking practices, safe injecting practices) Motivational Interviewing (MI)

	Cognitive Behavioural Therapy (CBT) Use of Screening Tools (e.g. AUDIT, K10) Use of Brief Intervention Tools (e.g. 5 A's, ABC, ASSIST) Use of Discussion Aids (e.g. Value exercises, Readiness Rulers, Emotion Cards) Providing Advice Cold Referrals (i.e. passing contact information to clients) Warm Referrals (i.e. making contact with a service on behalf of or with a client) Other (please specify)
Q11. What would prompt you to deliver an AOD Brief Intervention? (Tick all that apply)	New client Result from a screening tool Client returning after long absence Direct question from client Related health issue Something mentioned in discussion Changed behaviour (e.g. eye contact, speech, movement, etc.) Changed presentation (e.g. body language, hygiene, clothing, movement, etc.) Something noticed about client Open discussion about substance use habits Other (please specify)
Q12. What AOD Brief Intervention and Screening tools do you use? Include any tools you have adapted for your own use. (Tick all that apply)	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) Alcohol Use Disorders Identification Test (AUDIT) Drug Use Disorders Identification Test (DUDIT) Common Approach to Assessment, Referral and Support (CAARS) Addiction Severity Index (ASI) Kessler Psychological Distress Scale (K10) Global Appraisal of Individual Needs (GAIN) Opiate Treatment Index (OTI) Indigenous Risk Impact Screen (IRIS) Strengths and Difficulties Questionnaire (SDQ) FRAMES Brief Intervention Model Drug Abuse Screening Test (DAST) Short Alcohol Dependence Data Questionnaire (SADD) Headspace Psychosocial Assessment for Young People Substance Dependence Severity Scale (SDSS) Five Major Steps to Intervention (5 A's) ABC for Smoking Cessation Yarning About Mental Health Alcohol for Pregnancy ABC

	HEADDS Adolescent Health Check Psychosis Screener (PS) OARS Motivational Interviewing Model Screening, Brief Intervention and Referral to Treatment (SBIRT) I don't use any brief intervention or screening tools Other (please tell us!)
Q13. Are there any barriers that impact your capacity to deliver an AOD Brief Intervention? (Tick all that apply)	Lack of access to Brief Intervention training Lack of management / organisational support Mandated use of specific screening tools Lack of role/job security Unsure where to find training and support Time constraints Competing client health priorities Unsure what brief intervention and screening tools exist Poor environment for conducting Brief interventions Client's position in the Stages of Change Unsure which screening tools to use Language and Cultural Barriers Challenging behaviours in clients (violence, intoxication, etc) Unsure of which brief intervention tools to use Lack of confidence in delivering Brief Interventions Unsure when to deliver Brief Interventions Unsure of efficacy of Brief Interventions Concerns about damaging relationship/rapport Difficulty in bringing up personal topics with client I do not perceive any barriers Other (please specify)
Q14. I would be willing to answer further questions about my response to this survey and my details are below.	Contact Details

Appendix B – Open-Ended Responses to Benefits of BI

What do you think are the potential benefits of providing AOD brief interventions to your clients?
Provision of brief interventions provides : - Rapport building opportunities - Opportunities for harm reduction information - Opportunities for ambiguity exploration - Service and treatment options discussion
Timely, appropriate information that suites the clients situation and circumstance and enables capacity building for change
Make the most of a potentially short interaction which may be the only available opportunity
To plant the seed.
giving them stategies
Opportunistic conversations They feel less threatened & overloaded by using brief interventions.
Immediate response to client issues
It is a start. Provides clients with options and thus choices.
I think it's the highest quality method, the most effective and easily the most cost efficient practice
Increased awareness to clients of their substance use/misuse and provision of evidence based, best practice intervention methods/supports to empower opportunities for increased client decision making options.
Small behavioural changes and potential reduction in frequency of drug use. Useful as part of larger interventions and holistic primary prevention approach
Immediate and responsive to client needs Can increase interest in longer term treatment
Every opportunity to discuss AOD and their potential harm on health, along with the message about stopping and the benefits that gives, should be taken. It just might be the time that someone listens, is ready, and acts on your advice.
They get heard and issues can start to be addressed
fwr rgwn rgubjubf
establish rapport sharing information
It is a common issue with the clients I work with & are often not severe enough to refer to alcohol and drug services. It works as successful preventative work
Expeditious Tailored Awareness raising Informative Facilitating/supporting referral
Allows clients to find out specific information without having to be too overwhelmed with a long session with a worker.
I am able to talk about keeping them safe in the present while also exploring the discrepancy between what they are doing now and what they would like to be doing in the future. This can inspire hope and motivation to change, which is when I give them the tools to make this change themselves.
Building rapport so they feel comfortable sharing with you and returning for a possible second appointment.
Risk Management and Harm minimisation
Doing what I can to save sending off referrals which may not be picked up for weeks/months, and delivering something with someone that already has rapport with me
Realising the risks and cost involved
supporting them in making informed decisions
Positive

Provide opportunistic information
Evidence based intervention for patients depending upon willingness to change
most effecient intervention
It is evidence based - offers something to patients which is known to be effective. AOD issues play out in many ways across patients' lives - it is important to address AOD issues within the context of the person's life.
Time Effectiveness
Interventions in a space they feel safe in, with a familiar practitioner
Keeping them out of hospital system, hopefully changing their behaviours, saving a family unit or a life (ultruistic perhaps)
Can result in positive change or plan the seed for change
Risk assessment, motivational interviewing, education, assessing readiness to quit
I'm easily accessible and can be opportunistic. It aids rapport too for ongoing follow up.