A new blueprint for alcohol and other drug treatment services 2009-2013
Client-centred, service-focused
Minister’s foreword

I am pleased to present A new blueprint for alcohol and other drug treatment services, 2009–2013, a client-centred and service-focused framework that will guide the Victorian Government’s reform priorities and investment decisions for alcohol and other drug services over the next five years.

We want a Victorian alcohol and other drug treatment system that prevents and reduces the harms to individuals, families and communities caused by alcohol and other drug misuse. We want a system that provides high quality, evidence-based, integrated services. We want to ensure people get the help they need to get their lives back on track so they can participate fully in the Victorian community.

The Victorian Government also wants to ensure that, consistent with its new mental health strategy, we intervene earlier to protect the health, development and wellbeing of children and young people. We need a system that builds resilient families to prevent the harms that are often associated with substance use and mental health issues passing from one generation to the next.

To achieve this we need focused treatment services that work in close partnership with other harm reduction, prevention, health, welfare and employment services to reconnect clients with their families and their communities on their journey from addiction to recovery. Finally, we need a service system that recognises that children and families of people receiving drug and alcohol services are also clients.

The Victorian alcohol and other drug treatment sector has an impressive track record of collaborative work and there are excellent examples of partnership initiatives that are helping to rebuild lives. This blueprint will build on that good practice.

The significant resources available for alcohol and other drug treatment should be used where they will have the most effective long-term benefit for clients and that means the latest evidence of what works to help people to reduce or cease substance use must inform our clinical practice.

The Victorian Government believes that the needs of clients, their families and communities should be at the heart of this new framework and I am pleased that Restoring the balance - Victoria’s alcohol action plan 2008–2013 provides an additional $14 million over the next four years to support key blueprint initiatives.

Our service models should be flexible enough to adapt and innovate to meet changing needs, and workforce development initiatives should build the sector’s capability and promote excellence. Work has already begun on reshaping withdrawal services with a new extended care model under development in Geelong. Pilot initiatives such as this will help to build and reshape our service system for the future.

Importantly, for clients and their families, the pathways into, through and beyond treatment should be clear and seamless.

This document commences our commitment to reform. I look forward to working with you in partnership to deliver an alcohol and other drug service system that is truly client-centred and service-focused.

The Hon Lisa Neville MP
Minister for Mental Health
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An agenda for change: executive summary

A new blueprint for alcohol and other drug treatment services, 2009–2013 establishes a client-centred and service-focused reform agenda for Victoria’s alcohol and other drug treatment service system.

Driving the need for change are the shifting patterns of harmful alcohol and other drug use in the community. Alcohol, cannabis and amphetamines are now the main drugs being used by people seeking treatment. Multiple health issues, the most prevalent being mental health problems, affect a substantial proportion of our clients. Families are increasingly seeking our help and young people are identifying a range of other health, welfare, housing, education and employment needs that impact upon the success of their treatment programs.

Reviews undertaken in 2003 and 2004 found that the existing alcohol and other drug treatment system is fragmented with variable connections to the other welfare, health and employment systems required to support clients with complex needs. Rapid growth in the service system in the late 1990s and the early part of this decade may have exacerbated this fragmentation with agencies struggling to deliver a wide range of programs and initiatives.

The blueprint addresses changes in the operating environment for services and takes account of existing good practice and evidence gathered in part through consultations conducted following the launch of the blueprint discussion paper in 2007. It will sit alongside and complement other related government initiatives including Restoring the balance - Victoria’s alcohol action plan 2008–2013, the forthcoming amphetamine-type (ATS) substances and related drugs strategy, the whole-of-government alcohol and drug prevention strategy and the new mental health strategy.

A number of initiatives contained in Restoring the balance - Victoria’s alcohol action plan 2008–2013 will seed the blueprint’s reforms and support key initiatives over the next four years. These include:

- $1.9 million to provide improved treatment options and stronger support for young people and their families through access to specialised family therapeutic interventions
- $2.7 million for a new model of medium-intensity community-based rehabilitation support for people leaving withdrawal programs who require extra support
- $4.5 million to develop and support online and telephone screening and self-help resources for people at risk of harm from drinking
- $2 million to provide addiction medicine specialist support to GPs delivering shared care arrangements to clients with complex support needs
- $3 million for a targeted community awareness campaign on the risks and harms of excessive alcohol consumption.

The blueprint establishes a client-centred and service-focused approach across the service system to deliver better treatment outcomes in six priority areas. Key actions for each priority area are highlighted in the following table:
**Key Actions**

**Young people**
- New strategies to support culturally sensitive treatments for Indigenous people and people from CALD backgrounds
- $1.9 million to improve access to family therapeutic interventions for young people and their families
- Stronger therapeutic frameworks to better support long-term behaviour change
- Train other workforces in alcohol and other drug issues to encourage earlier intervention with at-risk young people
- Develop stronger links between youth treatment services, housing, employment and training programs
- Ensure transition protocols support older clients in the move from youth-specific to adult treatment services

**Children and families**
- Ensure all services incorporate family inclusive practices so that children of our clients are our clients too
- $1.9 million to improve access to family therapeutic interventions for young people and their families
- Enhance screening tools, referral systems and practice guidelines to intervene earlier with at-risk families
- Training to improve the skills of our workforce to work more effectively with families and family members
- Earlier intervention through cross-program initiatives with family services to prevent intergenerational harms
- Worker rotation opportunities with mental health, child protection, housing and Child First services

**Clients**
- New strategies to support culturally sensitive treatments for Indigenous people and people from CALD backgrounds
- Joint-up responses for clients with multiple needs through better collaboration with other service systems
- Strengthen client engagement by implementation of a client charter of rights and responsibilities
- Develop specialist forensic services to help clients achieve longer-term behavioural change
- Raise awareness about harms of alcohol misuse among at-risk CALD and Indigenous groups
- Improve information and advice for clients and families through telephone helpline services and websites

**Clients and families**
- Ensure routine dual diagnosis screening for all young people entering treatment
- Integrate responses by collecting or co-delivering treatment interventions with other services for young people
- Train other workforces in alcohol and other drug issues to encourage earlier intervention with at-risk young people
- Develop stronger links between youth treatment services, housing, employment and training programs
- Ensure transition protocols support older clients in the move from youth-specific to adult treatment services
## Key Actions

### Prevention
- $4.5 million to develop and support screening and self-help tools for people at risk of alcohol-related harms
- Stronger support and training resources for GPs to intervene earlier
- Better partnering with local government to enhance community responses to prevention
- Develop a Victorian whole-of-government prevention strategy
- $3 million for a targeted community awareness campaign about risks and harms of alcohol misuse
- Undertake prevention research to identify best practice

### Improving access
- Develop the model for a centralised treatment access register
- Review Victoria’s pharmacotherapy model and role of addiction medicine
- Reconfigure residential withdrawal services to build strong links to GPs, hospitals and addiction specialists
- $2 million for addiction medicine specialists to support GPs caring for complex clients
- Improve support and access to treatment and health services for NSP and pharmacotherapy clients
- Stronger support for collaborations with health, housing, employment and other welfare services

### Excellence and quality
- Redvelop funding and reporting systems to promote service flexibility and innovation
- $2.7 million for a new medium-intensity rehabilitation support program
- Reconfigure counselling programs to improve client outcomes
- A new quality framework, improved professional development & clinical practice guidelines to build clinical skills
- Improve research dissemination and translation of evidence into practice
- Develop data linkage systems to inform policy
Introduction

This blueprint outlines the Victorian Government’s vision for the alcohol and other drug service system. It provides a coherent client-centred and service-focused framework for the future development and delivery of alcohol and other drug treatment services and identifies the key issues, principles and priority actions required to improve our responses to people who have substance use problems, and to better support their families and communities.

It builds on our system’s strengths and seeks to address the key challenges of system integration and clients with increasingly complex needs. The principles laid out in this blueprint will guide our resource priorities and policy choices over the next five years.

The document has been informed by feedback from clients, service providers and other stakeholders. Ongoing dialogue and collaboration will ensure the plan delivers better outcomes for clients, their families and communities through real improvements in our services, systems, and workforce.

Client and service strengths

Over a hundred community agencies and local government services deliver alcohol and other drug treatment services, advice, support and information to assist people who experience substance misuse problems. More than 26,000 Victorians access this system every year. Hundreds of pharmacies and general practitioners (GPs) provide pharmacotherapy treatment to more than 11,000 people on any given day. Needle and syringe programs (NSP) and other health protection services operate across the state working with injecting drug users to reduce the risk of transmission of blood-borne viruses, and connecting clients with other health services and treatment.

We have a comprehensive youth treatment program that helps young people most at risk of developing serious substance use dependence and those already experiencing significant harms through a network of outreach, residential and community-based treatment services.

We have a good track record in partnership and collaborative work with a range of other health and welfare providers including hospitals, mental health services, corrections programs, housing, disability and family services. Cross-government initiatives like school-based drug education and the community strengthening initiatives stemming from A Fairer Victoria (the government’s social policy action plan) help tackle disadvantage and reduce the risk factors that can lead to alcohol and other drug misuse.

Our treatment and health protection services sit within a comprehensive policy framework that underpins the Victorian Government’s overall drug strategy. New initiatives under Restoring the balance – Victoria’s alcohol action plan 2008–2013 and a forthcoming ATS and related drugs strategy will guide treatment responses for clients using these substances. A new mental health strategy for Victoria will improve early intervention and promote mental health system reforms, assisting our clients who struggle with mental health issues. These initiatives offer new opportunities to reshape and integrate our systems to be more responsive to the diverse needs of our clients.

Client and service challenges

The current treatment system was established over a decade ago and there have been a range of subsequent initiatives expanding the scope of what is delivered and models of service delivery. However, this has also created complexity for clients in moving between different treatment types and services.

Our system is not always readily understood by prospective clients, their families or by other services. The pathways into, through and beyond our treatment system could be clearer.

Clients and their families should know their options, their rights and responsibilities. Treatment delivery should be client-centred to better enable people to cease or reduce their harmful substance use.
The children of parents in treatment are also our clients. The intergenerational harms caused by substance misuse damage children, families and communities. We need to work more closely with child and family services to intervene earlier where children and young people are at risk of harm and encourage parents to get help and support with their parenting.

Substance misuse is both a cause and a symptom of other social, health and economic disadvantages. Partnering with other services and systems is therefore vital to delivering more holistic responses for clients. The resources available for treatment can also be more effectively applied through better service integration.

Some groups and individuals are more vulnerable than others. Our service system needs to reach out to these people and persevere with the most marginalised groups to effect positive and lasting behaviour change.

Among the most vulnerable are young people and those with co-occurring physical and mental health issues. Effectively addressing the needs of these clients requires closer collaboration with relevant health and welfare services to ensure that we intervene earlier and that people don’t fall between the gaps.

Philosophical diversity is both a strength and a weakness in the system. Robust interventions must be evidence-based and grounded in a quality framework. The focus of treatment, as distinct from other interventions, should be on changing behaviour to assist people to cease or reduce their substance use in the longer term. This has a key preventative impact, reducing the health inequalities and chronic illness often associated with longer term substance misuse.

Many of our services are innovative and flexible in their responses to clients but some of our systems, service models and frameworks have not kept pace. Bureaucratic requirements can be streamlined in concert with improved professionalism and a strong commitment to centring work on achieving behaviour change and positive outcomes for clients.

The alcohol and other drug service system

The blueprint promotes an integrated service system that delivers prevention, early intervention, treatment, harm reduction and recovery responses. It recognises that individual pathways through the service system are not necessarily linear and that a range of interventions may be required at different stages of a person’s journey towards and beyond recovery. The blueprint therefore sets out a framework for reform that supports the continuum of interventions and responses.

The model at Figure 1 provides an overview of the types of interventions available to Victorians experiencing substance use harms. It illustrates the importance of prevention, early intervention and harm reduction at all stages of risk and harm. The model also indicates the partnerships that can improve both early intervention responses and the quality and sustainability of treatment outcomes for clients.

The vision

This blueprint sets out our plan for the future. It places improved outcomes for clients, their families and their communities at the centre of that plan. Quality, evidence-based treatments and interventions are our tools for helping people to tackle their harmful substance use. Strong collaborations and partnerships help connect our clients to the wider range of health and welfare services they might need to successfully reintegrate into society. Our vision reflects Victoria’s harm minimisation approach.

The vision for alcohol and other drug services and interventions is:

To prevent and reduce the harms to individuals, families and communities associated with alcohol and other drug misuse by providing appropriate, timely, high quality and integrated services that help people to address their substance use issues and participate fully in the social and economic life of the Victorian community.
Client and service principles

The following are the principles that will guide the future development of the Victorian alcohol and other drug service system within six priority areas.

Client-centred:

1. **Clients: The alcohol and other drug treatment system should be client-centred**
   A client-centred system is one that acknowledges clients and their family, social and cultural connections. Effective treatment recognises the things that are important to clients and utilises their family and cultural connections to support them in achieving lasting behaviour change and linking them with the other services and support they require.

2. **Children and families: Interventions must reduce the harmful impact of alcohol and other drug use on children and families**
   The children and families of our clients are also our clients. The principles and agency responsibilities incorporated in the *Children Youth and Families Act 1995* (CYFA) that prioritise the needs of children and promote child safety and wellbeing frame our treatment interventions. Treatment services have an important responsibility to identify parents in their services, to collaborate with child and family services to support parents and their children to break the cycle of intergenerational substance abuse and to recognise and respond to a client’s family context and prioritise the best interest of the child.

3. **Young people: Interventions and responses for young people should be early, holistic and evidence-based**
   A quality youth alcohol and other drug treatment system delivers interventions that are evidence-based and grounded in a therapeutic framework. Interventions should occur as early as possible and be delivered where a young person first presents for help. Treatment should assist young people to cease or reduce their substance use, reconnect them with their families and communities and ensure they are linked with other health, welfare, employment and training services to get their lives back on track.

Service-focused:

1. **Prevention: Prevention and early intervention should be prioritised across the system**
   Prevention is multidimensional, operating across the continuum of prevention, early intervention, harm reduction, treatment, relapse prevention and recovery. Opportunities to prevent and address harmful substance use can be taken up in other health, education and welfare systems. Earlier intervention can be achieved through improved linkages and raised awareness within these other systems. Treatment delivers prevention outcomes by reducing and preventing the long-term harms associated with extended alcohol and other drug misuse.

2. **Improving access: Access to treatment should be seamless with ‘no wrong door’**
   The alcohol and other drug treatment system operates a ‘no wrong door’ philosophy for people with multiple or co-occurring needs. A person’s substance use issues need to be addressed in partnership with the other services they require. Clients with multiple needs should get access to appropriate services, care and treatment so that they can achieve better long-term health and treatment outcomes.

3. **Excellence and quality: Services must be high quality, evidence-based and effective in assisting clients to cease or reduce harmful alcohol and other drug use**
   The treatment system needs to be diverse, delivering timely, quality, evidence-based treatment and interventions to clients through a skilled and flexible workforce. Improved quality, consistency of services and enhanced responsiveness will deliver improved client outcomes.
Reviewing progress

This document outlines the key actions that will be undertaken to achieve these changes. Detailed implementation processes and strategies will be developed for each action item in consultation with consumers, the sector and other key stakeholders. The Department of Human Services’ Mental Health and Drugs Division will monitor the progress of actions attached to the blueprint. Summary reports will be provided to the Minister for Mental Health.
Figure 1: Victoria's alcohol and other drug service system and example interventions

Stage of disease continuum
- Controlled chronic condition
- Recovering/Stabilising
- Indicated prevention
- Prevent harm and relapse
- Established condition
- At risk
- Experimental
- Secondary prevention
- Prevent uptake and harm
- Pre-experimental
- Well population

Stage of substance use continuum
- At high risk
- Regular
- Indicated prevention
- Prevent harm and progression to regular use
- Established condition
- Established condition

Level of prevention
- Primary prevention
- Prevent uptake and harm
- Secondary prevention
- Prevent harm and progression to dependence
- Indicated prevention
- Prevent harm and complications
- At risk
- Experimental
- Pre-experimental

Prevention objective
- Promotion of healthy behaviours and environments across life course

Types of interventions
- Universal/targeted approaches
- Whole-of-government strategy
- Whole-of-government prevention strategy
- Improved access to self-help tools
- Alcohol-targeted awareness-raising campaign
- Stronger support and training for GPs
- Whole-of-government intervention strategy

Sectors and collaborative partners
- Primary health
- Public health
- Other sectors
- Hospitals
- Police
- Other sectors
- Primary health
- Community care and general welfare services provided through other sectors
- Increased self-management
- Broader partnerships

Examples of interventions proposed in blueprint
- Strong, continuing support and links to treatment services
- Address bio-psychosocial issues
- Intensive therapeutic interventions
- Single-session interventions
- Stress management
- Group sessions
- Skills and relapse prevention
- Holistic, multi-tiered interventions

Substance use is a chronic and relapsing condition. An individual's pathway is not necessarily linear.
Client-centred principle 1: Clients

The alcohol and other drug treatment system should be client-centred

Introduction

…the needs of people who use drugs are often complex and multifaceted. Consequently there is a need for coordinated and collaborative effort on the part of a diverse range of service providers and stakeholders with different backgrounds and perspectives.

A client-centred system is one that acknowledges clients as people enmeshed within their family, social, economic and cultural connections. Effective treatment recognises the things that are important to clients and uses their family and cultural connections to engage and support them in their treatment journey towards ceasing or reducing their harmful substance use.

Key changes

- New strategies to support culturally sensitive treatment for Indigenous people and people from CALD backgrounds
- Joined up responses for clients with multiple needs
- Strengthened client engagement through a client charter of rights and responsibilities
- Stronger specialist forensic services helping clients achieve longer-term behavioural change
What we know

Indigenous people

- Almost 2,000 courses of treatment were delivered to over a thousand clients by Indigenous-specific alcohol and other drug treatment services in 2006–07.
- In 2006–07 nearly 2,000 clients (approximately 7 per cent of all clients) of alcohol and other drug services identified as being of Aboriginal and/or Torres Strait Islander origin.
- While Indigenous people are less likely to drink than other Australians, those who do drink often do so at risky or high-risk levels. In 2004–05, 16 per cent of Indigenous Victorians aged 18 years and over had risky or high-risk levels of alcohol consumption, similar to the national Indigenous average of 16.5 per cent.

Culturally and linguistically diverse people

- Clients from a Vietnamese/South East Asian background form the second largest group in youth alcohol and other drug treatment services after Australian-born clients.
- An Australian Drug Foundation report published in June 2006 identified Horn of Africa refugee communities as ‘at risk’ of developing serious problems with alcohol and other drugs.

People with multiple needs and co-occurring conditions

As the baby boomers move into old age the state will also see its first wave of elderly people with first hand experience of illicit drug use. We have little idea what impact this will have on health resources.

(Peninsula Drug and Alcohol Program)

- Over 17 per cent of clients using treatment services in 2006–07 were aged 45 years or over. This group is more likely to have used alcohol and other drugs for longer periods creating greater likelihood of having a range of other physical and mental health problems including chronic illnesses such as diabetes, liver, kidney and heart disease, cognitive impairment and dual diagnosis.
- ABI clients form 2 per cent of those in treatment but ABI is under-diagnosed with estimates of up to 15 per cent of those in treatment having a cognitive impairment.
- Alcohol and other drug issues are over represented among clients of other service systems. Over 30 per cent of treatment clients have accessed mental health services and it is estimated that more than 50 per cent of mental health clients have comorbid substance use issues.
- Comorbid substance use disorder and mental illness is common among offenders in custody. Around 66 per cent of females and 50 per cent of males in custody with a substance use disorder also have a mental health disorder.
- A 2001 youth justice study reported that 43 per cent of youths believed a member of their family had a problem with drug misuse.
- Eighty per cent of prisoners have substance use problems and 63 per cent had substance use issues relating to the circumstances of their offence.
Client involvement and information for families

- Consultations and written submissions received on the blueprint discussion paper indicated most organisations and agencies support the development of a sector-wide client charter of rights and responsibilities.
- Of the more than 26,000 clients engaged with the alcohol and other drug treatment service system in 2006-07, 7 per cent were spouses, parents, siblings, friends or children of drug users. There are many more clients who would want a family member involved in their treatment as a primary support person.
- Family Drug Help line provides advice and support to over 6,000 family members annually.

Where we are now

Treatment services should always be targeted at clients’ treatment needs, and the most effective way to assess client need is to keep clients engaged in development of the treatment service system.

(Victorian Alcohol and Drug Association)

Indigenous people

Many Indigenous clients use non-Indigenous-specific (or mainstream) treatment services. All services therefore need to ensure they are responsive to Indigenous clients. Indigenous people can also access Koori-specific treatment programs, recently enhanced through the new Koori Youth Alcohol and Drug Healing Service.

Stronger links need to be made between Indigenous-specific treatment providers and mainstream treatment providers to promote inter-agency collaboration, cross-referral and clients’ reconnection with their communities. Cross-cultural training and mentoring programs for staff in Indigenous and non-Indigenous-specific agencies will help to ensure culturally appropriate treatment.

Culturally and linguistically diverse (CALD) people

It can be difficult for people from a different cultural background to access alcohol and other drug treatment services. This may be due to fear of the shame and stigma of being found out in their own community or ‘unfamiliarity with the concepts of counselling and treatment’.4

The Multicultural DrugInfo website provides information about alcohol and other drug issues to CALD workers and communities. Training initiatives have improved service delivery to CALD communities. Many treatment providers have built strong partnerships with multicultural and ethno-specific community agencies and some have employed bilingual or multilingual staff.

The Australian Drug Foundation (ADF), with funding from the Victorian Government, has developed a prevention suite aimed at improving information for CALD communities about the health harms and treatment options for substance misuse issues.

These examples of good practice can be built upon so that alcohol and other drug services can effectively respond to refugee and new migrant communities as well as more established CALD communities. Cultural awareness training for staff, improved information about prevention, treatment and support in community languages and a partnership approach with multicultural and ethno-specific organisations will improve access to alcohol and other drug treatment among these groups.
People with multiple needs and co-occurring conditions

People’s multiple needs and co-occurring conditions should not be a barrier when accessing treatment. There are a number of priority groups with multiple needs including:

- ageing clients, particularly those with co-occurring physical and mental health issues
- clients with an acquired brain injury (ABI)
- dual diagnosis clients
- forensic clients.

The alcohol and other drug sector works closely with other health and welfare providers to ensure the range of client needs are properly addressed. There are many examples of excellent practice like the Dual Diagnosis Initiative (addressing substance use and mental health needs) that provide a benchmark for good practice across Australia.

Other health and welfare services are beginning to recognise the prevalence of substance misuse issues for their clients. Forging stronger links and improving coordination across sectors with stronger financial incentives that promote and support collaborative efforts will improve treatment options and support for these clients.

Client involvement and information for families

Victoria’s alcohol and other drug treatment sector plays a critical role in helping people with substance misuse issues get themselves back on track and live healthier, happier lives. But, by targeting the resources we have more carefully and better acknowledging the role of clients in their own recovery, we can do better.

The government introduced a new Victorian Charter of Human Rights and Responsibilities in 2006. The charter seeks to promote and protect the civil and political rights of Victorian citizens. From 1 January 2008, public authorities have legal obligations under the charter. The Department of Human Services is reviewing all existing guidelines and legislation to ensure compliance with the Victorian Charter of Human Rights and Responsibilities Act (2006).

The principles for human rights are founded on respect for the dignity and worth of each person. This means that we have to listen more closely to the experiences of clients in shaping our treatment responses and that a client’s family circumstances and their cultural, medical, social, economic, physical, and mental health needs should be taken into account at intake, assessment, in treatment and in post-treatment support.

We need to recognise the contribution of families to a client’s recovery and strengthen their capacity to provide support. Family Drug Help and its associated telephone helpline provide information, support groups and referral to treatment for family members. Family members can also access counselling services, parent/carer-support programs and a number of peer-support services. The system isn’t always easy to navigate and we can make it more user friendly. Telephone helplines and websites will be reviewed to improve information for clients and their families.

Developing a Victorian alcohol and other drug client charter of rights and responsibilities will ensure clients have the opportunity to participate in decisions that affect their treatment and better understand their own responsibilities when they enter a treatment program. Such a charter will complement the Victorian Charter of Human Rights and Responsibilities and will strengthen client engagement and participation to improve treatment outcomes.

Where we want to be

Both the culture of treatment services and the expectations of clients would inevitably change through… a partnership approach and, in turn, clients would be better informed and equipped to have input into structural and policy matters at service and systems level. (VIVAIDS)
Improved client and family engagement in treatment requires the following elements:

- A client’s family circumstances and their cultural, medical, social, economic, physical, and mental health needs are taken into account at intake, assessment, in treatment and in post-treatment support.

- All treatment services have respect, awareness and understanding of Indigenous culture and its implications for effectively engaging and working with Indigenous clients and their families. Mainstream treatment programs are culturally sensitive and accessible to Indigenous people.

- Non-Indigenous (mainstream) treatment agencies are engaged in local, regional and statewide collaborative partnerships with Indigenous-specific treatment services and other Indigenous services for the benefit of clients.

- All treatment services have an awareness, respect and understanding of the needs of CALD clients and services and treatment programs are culturally sensitive and accessible. Services build collaborative relationships with CALD communities and ethno-specific organisations including refugee and new migrant organisations to improve access to treatment. CALD communities have access to culturally sensitive education and information about alcohol and other drug issues.

- Better collaboration and stronger links exist between alcohol and other drug treatment services and other sectors (including family services, housing, mental health, corrections, disability and acute medical facilities) in order to be more responsive, and intervene earlier with clients with multiple needs.

- The needs of older clients are recognised and potentially complex co-occurring physical and mental health problems are identified with appropriate referral and linkage to other specialist health services.

- Clients with an ABI receive treatment that addresses their individual needs.

- Housing and family services programs have improved awareness of substance use and mental health issues for their clients and provide appropriate support and referral for clients with a dual diagnosis.

- Forensic clients receive high quality treatment interventions and ongoing care and support to assist them in ceasing or reducing their substance misuse.

- Clients and their families have access to timely and accurate information on the range of alcohol and other drug treatment options, interventions and services.

- A new client charter of rights and responsibilities encourages clients to participate in treatment development and planning and to better understand the role of treatment services and themselves in their own recovery.

- Treatment providers encourage and actively seek out client and family involvement in their services to improve engagement and long-term treatment outcomes and ensure parenting and child concerns are identified and addressed.

**How we are going to get there**

**Good-practice example**

The Victorian Dual Diagnosis Initiative was established to respond to increasing numbers of people experiencing both mental health and substance use problems. A specialist youth dual diagnosis service was established in 2002–03. Dual diagnosis teams now operate across the state, providing direct care to clients and advice to services about delivering quality dual diagnosis practices and training across both the mental health and alcohol and other drug workforces.

Cross-sector workforce training and co-delivery of services works to better identify, assess and treat people with a dual diagnosis. For people with a dual diagnosis, this initiative ensures there is “no wrong door”. If a person presents for treatment in the mental health system or to an alcohol and other drug service they, and their families, can get the help and support they need.
### Action plan for clients

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Key partners</th>
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| **Action 1: Improve access for Indigenous people to culturally appropriate information, support and treatment services.**  
  - Develop a Koori alcohol action plan as part of *Victoria’s alcohol action plan 2008–2013* in partnership with the Koori community.  
  - Non-Indigenous (mainstream) treatment services are available, accessible and responsive to the needs of Indigenous clients and funding and service agreements reflect this requirement.  
  - An Indigenous strategy for alcohol and other drug treatment services is developed that links with the Koori alcohol action plan incorporating:  
    - prevention, early intervention, treatment and harm reduction responses  
    - cross-cultural training for staff  
    - strategies and good-practice examples to improve Indigenous accessibility to mainstream services  
    - cross-agency rotations of Indigenous and non-Indigenous workers  
    - referral protocols and opportunities for other collaborative work. | 1.5–2 years | Koori services  
  Koori peak bodies  
  Koori coordinating agencies  
  Koori Human Services (Department of Human Services)  
  Other treatment agencies |
| **Action 2: Improve access for culturally and linguistically diverse (CALD) people to information, support and treatment services.**  
  - Health promotion information engages at-risk CALD groups and raises awareness about the risks associated with alcohol misuse, linking clients with treatment and support.  
  - Treatment services are available, accessible and responsive to the needs of CALD clients; funding and service agreements reflect this requirement.  
  - A multicultural strategy for alcohol and other drug treatment services is developed incorporating:  
    - prevention, early intervention, treatment and harm reduction approaches  
    - cultural awareness training  
    - strategies and good-practice examples to improve accessibility of services  
    - referral protocols and opportunities for collaborative work. | 1–2 years | CALD peak bodies  
  Local Government  
  Refugee and migrant services  
  Treatment agencies |
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<th>Action</th>
<th>Timeframe</th>
<th>Key partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action 3: Respond more effectively to clients with multiple needs and co-occurring conditions.</strong></td>
<td>1 - 3 years</td>
<td>State government agencies, Commonwealth government, Treatment agencies, Peak medical and health bodies, Victorian specialist agencies</td>
</tr>
<tr>
<td>• Research the issue of ageing clients including prevalence of medical complexity.</td>
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<tr>
<td>• Reconfigure residential withdrawal models to achieve better treatment outcomes for clients including those with co-occurring conditions.</td>
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<tr>
<td>• Ensure service models respond to the outcomes of research into the needs of ageing clients including those with acquired brain injuries, dual diagnosis and co-occurring conditions.</td>
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<tr>
<td>• Develop specialist forensic services to support longer term behaviour change by:</td>
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<tr>
<td>• providing better information, support and connection with treatment pre and post release</td>
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<tr>
<td>• reviewing forensic programs to ensure an outcomes focus, exploring alternative models of funding, developing stronger continuity of care for clients and improving forensic workforce skills</td>
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<tr>
<td>• improving access to after-hours treatment for youth and adult forensic clients.</td>
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<tr>
<td><strong>Action 4: Ensure access for clients and their families to a range of information and advice about alcohol and other drug issues, support and treatment options.</strong></td>
<td>1 - 2 years</td>
<td>Helpline services, Consumer/family advocacy groups</td>
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<tr>
<td>• Ensure access to information, support and treatment for clients and their families through helpline and website services.</td>
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<tr>
<td><strong>Action 5: Build stronger client and family involvement in service planning and development.</strong></td>
<td>1 - 2 years</td>
<td>Peak bodies, Treatment agencies</td>
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<tr>
<td>• Review the guidelines and legislation (including the Alcoholics and Drug Dependent Persons Act 1968) to better meet requirements of the Victorian Charter of Human Rights and Responsibilities and provide more effective responses for clients with multiple and complex needs.</td>
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<tr>
<td>• Develop and implement a client charter of rights and responsibilities in all funded service agencies to promote human rights, improve client participation and engagement in treatment and long-term treatment outcomes.</td>
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<tr>
<td>• Strengthen client and family input into service planning and development.</td>
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Client-centred principle 2: Children and families

*Interventions must reduce the harmful impact of alcohol and other drug use on children and families*

**Introduction**

*Evidence indicates that positive and healthy relationships in families are supportive and protective … against alcohol and other drug use.*

(Centacare Catholic Family Services, Mary of the Cross Centre)

Parental substance misuse can be a risk factor in the development, safety and stability of children. It can disrupt positive family functioning and parenting capacity. When combined with other issues, such as socioeconomic disadvantage, family breakdown or mental health problems, the risks to children can be significantly heightened. Of course, not all parents who misuse substances have diminished capacity to parent adequately or place their children at risk. Indeed, wanting to be a better parent is often the main reason parents engage in treatment.

Treatment services need to actively identify parents in their services and recognise and respond to the family context for their clients. Stronger family-centred practice and connecting parents and adolescents with other health, welfare and social support services helps to alleviate the risks associated with substance misuse in families and prevent intergenerational harms. For young people, strong family relationships and family engagement in the treatment process helps address substance misuse and prevents future harms.
What we know

Given that most of our clients access welfare services prior to health services, staff awareness (and) strategies to engage with a family member who may have an alcohol or other drug issue… would be of great assistance with appropriate referrals.

(AGEnDAS Anglicare Victoria – Knox)

Data on parents using Victoria’s alcohol and other drug treatment services is currently limited. Recent updates to the department’s information system have found that 12 per cent of clients are living with dependent children but this is significantly under reported as more than 50 per cent of clients did not state their living arrangements.

The main alcohol and other drug telephone helpline for families takes more than 6,000 calls every year, generally from family members of people with substance use problems seeking information, advice or referral to services.

In many instances, parents with substance use problems will not present first at an alcohol and other drug treatment agency. Over 50 per cent of parents referred to Child Protection had alcohol or other substance use issues and 23 per cent had mental health issues. Their children are likely to suffer long-term and cumulative harms, including a greater risk of developing similar problems into adulthood. Earlier intervention requires a more targeted approach.

Research shows that a family therapeutic intervention, if delivered at a crisis point in a young person’s life, improves the likelihood of positive, longer lasting outcomes. Family therapeutic interventions are effective because they can address the causes and symptoms of substance abuse while building the coping skills and social networks that will sustain positive behaviour change. Evaluations show that these types of interventions are more effective than traditional treatment models in bringing about long-term sustainable behaviour change, and are particularly effective in helping adolescents to complete their treatment. Consultations on the blueprint discussion paper highlighted family therapeutic skills and access to family therapists as a gap in the current system.

Research shows that:

- children and young people exposed to unsafe, abusive environments suffer long-term adverse health outcomes including higher rates of high-risk behaviours including harmful levels of alcohol and illicit drug use
- alcohol is involved in 25–50 per cent of episodes of family violence
- drug use by family members significantly increases the chances that other family members will use drugs and ‘…parental drinking patterns can be a predictor of frequent and heavy drinking in offspring’
- effective treatment interventions need to target parents’ capacity to seek and sustain support systems in their family and social networks
- family-centred therapeutic approaches can deliver positive longer term outcomes for young people engaged in alcohol and other drug treatment.

Where we are now

A family member’s drug use invariably impacts upon family life and the individual relationships that exist within it. There is a strong connection between healthy and positive relationships within a family and family members’ health and wellbeing. It is incumbent upon government and community to act to strengthen families. However, it is also important to note that drug abuse can strike any family for a variety of reasons. In this time of crisis and stress, all families need extra support and information.

(Centacare Catholic Family Services, Mary of the Cross Centre)
Strengthening families is a key part of the government’s agenda. The introduction of the CYFA recognises the importance of families in improving longer term outcomes for children and young people and of the responsibilities of agencies in this endeavour. Child FIRST partnerships have been established across the state to secure better-integrated service responses for vulnerable families. Alcohol and other drug treatment services already link with these partnerships but more can be done to secure a stronger child-centred approach in delivering alcohol and other drug treatment services to parents and in developing better referral pathways to intervene earlier and provide ongoing support for parents and their children.

The government funds a range of family-specific services for parents wanting to address their substance misuse issues while caring for their children and for family members seeking help in responding to substance misuse by a loved one. Services available include a dedicated helpline, counselling services, residential rehabilitation for parents and children, support groups, access to parenting programs and pre- and post-natal care support for mothers.

**Where we want to be**

> Problematic drug use often affects all members of the family. In many situations, it is important that the alcohol and other drug service be able to acknowledge the family as ‘the client’ even if the role and relationship with individual members differs.

(Yarra Drug and Health Forum)

Supporting at-risk children, families and young people requires the following elements:

- All alcohol and other drug treatment services recognise the potential vulnerability of children (including unborn children) with parents who are misusing substances, and respond to their needs.

- Childrens’ best interest and reducing the harms to children from their parents’ substance misuse become key principles in policy and practice for the Victorian alcohol and other drug treatment system and part of service delivery core business.

- Treatment services ensure that their staff always consider and address the potential impact of parental substance misuse on their clients’ parenting capacity and the consequent impact on childrens’ development and wellbeing.

- Better collaboration, stronger links and practice guidelines operate between alcohol and other drug treatment services, family services and other relevant agencies ensuring earlier intervention for vulnerable and at-risk families, children and adolescents.

- Clinicians and other workers in the alcohol and other drug treatment system have the skills and capability to respond to families, supporting and engaging them in addressing substance use issues as part of a core treatment response.

- Vulnerable families get earlier intervention and better-integrated responses to protect the health, development and wellbeing of children and adolescents.

- Treatment services are responsive to the needs of families and work with them to identify the assistance and support they need for strong family functioning and positive engagement in treatment.

- Treatment services operate family-inclusive practices, engaging families in the treatment of young people where appropriate and desired by the young person, and referring families and young people to specialist family therapeutic intervention services when appropriate.

- Treatment services offer information, advice and appropriate referral to family members seeking information about the treatment pathway and services available to their family member and themselves.
The children of people in treatment are our clients too.

Families can access appropriate information and get the right advice and referral when they need it.

Families are engaged to identify their specific needs and what assistance they require.

Agencies consider and respond to the potential impact of parental substance misuse upon their client’s children.

Treatment services are responsive to the needs of families.

Treatment services operate using family inclusive practices.

Research shows that 12% of clients using alcohol and other drug treatment services are living with dependent children, but this is significantly under reported as more than 50% of clients did not state their living arrangements.

Figure 2: Interventions must reduce the harmful impact of substance misuse on children and families
How we are going to get there

Good-practice examples

Families of alcohol and other drug (AOD) clients are often both in need of, and can contribute to the effectiveness of interventions delivered through the AOD service system.

(Salvation Army)

UnitingCare Moreland Hall Playgroup
The Intensive Playgroup operated by Moreland Hall caters for single women with young children. Many of the playgroup participants are engaged with alcohol and other drug treatment programs and most also have mental health problems ranging from depression and anxiety through to more severe mental health issues. Many of the attending children have been, or are, clients of Child Protection. Clinicians at the playgroup exchange information with relevant agencies with the consent of participants.

The Intensive Playgroup engages families who are not accessing mainstream services providing support, treatment and referral for children and their parents. Importantly it connects disengaged parents with parenting support, helps build their parenting skills and confidence and assists them in accessing a range of health and welfare services for themselves and their children.

Family Drug Help
Family Drug Help provides a statewide service for people concerned about a relative or friend using alcohol or other drugs. It provides information and support, including a 24-hour telephone helpline. Trained volunteers who have experienced alcohol and other drug issues in their own families staff the helpline. In 2007 Family Drug Help took nearly 6,000 calls from people seeking help for a family member with alcohol or other drug problems.

Family Drug Help also facilitates peer support groups for family and friends of people who use drugs. Family Drug Help has established 41 support groups in Victoria over the past few years.
**Action plan for children and families**

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<th>Action</th>
<th>Timeframe</th>
<th>Key partners</th>
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<tr>
<td><strong>Action 1: Prioritise the interests of children whose parents are engaged with alcohol and other drug treatment in accordance with the <em>Children, Youth and Families Act (CYFA) 2005</em>.</strong></td>
<td>1–2 years</td>
<td>Departmental regions, Treatment agencies, Peak bodies, Consumer/family advocacy groups</td>
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<tr>
<td>• Ensure funding and service agreements deliver the requirements of the CYFA.</td>
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<td>• Update the <em>Parenting support toolkit</em> to address CYFA requirements.</td>
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<td>• Ensure assessment and treatment planning includes consideration of family functioning and the wellbeing of any dependent children.</td>
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<td>• Disseminate information to all alcohol and other drug workers on their responsibilities under CYFA.</td>
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<td><strong>Action 2: Improve access to family therapeutic interventions for clients of treatment services and promote earlier intervention for at-risk parents presenting in other health and welfare services.</strong></td>
<td>2–3 years</td>
<td>State government-funded treatment and family service agencies, Community health agencies, Psychiatric and Disability Rehabilitation and Support Services</td>
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<tr>
<td>• Fund up to five specialist family therapeutic workers to deliver assessment, family-based counselling and ongoing case management to young people engaged in treatment programs and their families.</td>
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<td>• Enhance screening tools, referral protocols and inter-agency communication and practice guidelines between treatment and family service agencies to intervene earlier with at-risk families.</td>
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<td>• Support cross-sectoral outreach and collocated delivery to improve outcomes for vulnerable families.</td>
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<td>• Promote worker rotations between alcohol and other drug treatment services, mental health, child protection, family services and homelessness services.</td>
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<tr>
<td>• Deliver earlier alcohol and other drug intervention responses to people presenting at family services, Child FIRST, mental health, primary health and homelessness agencies.</td>
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<td><strong>Action 3: Improve information about the range of treatment options and support for families to improve early intervention.</strong></td>
<td>1–2 years</td>
<td>Departmental regions, Helpline-delivery agencies, Consumer/family advocacy groups</td>
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<tr>
<td>• Improve advice and support for families through helpline and support services.</td>
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<td>• Publicise available services for families with substance use issues in Child FIRST partnerships.</td>
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<tr>
<td><strong>Action 4: Improve clinical and workforce skills in engaging families in treatment.</strong></td>
<td>1–3 years</td>
<td>Treatment agencies, Peak bodies, Registered training organisations</td>
</tr>
<tr>
<td>• Train the alcohol and other drug treatment workforce and particularly the youth workforce in family-centred practice and engaging families when treating adolescents.</td>
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<tr>
<td>• Train the alcohol and other drug treatment workforce in identifying and screening for parenting skills and support requirements.</td>
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Client-centred principle 3: Young people

Interventions and responses for young people should be early, holistic and evidence-based

Introduction

For sustainable change to occur, alcohol and other drug treatment needs to be offered in conjunction with other interventions which create the potential for ‘all-of-life’ change, with each intervention supporting the success of others. (UnitingCare, Moreland Hall)

Developing brains are highly vulnerable to the adverse impacts of alcohol and other drug use. Early responses can help prevent the significant harms that can result from binge drinking, illicit drug use, and the inappropriate use of prescription drugs. Problematic alcohol and other drug use can be prevented, addressed earlier, and treated more effectively.

Many young people experiment with illicit drugs or alcohol. For a proportion of young people, using alcohol or other drugs will be normalised across their peer group, presenting challenges and opportunities for prevention messages from sources ‘trusted’ by young people themselves. Prevention begins in family, early learning, school and community experiences. It also operates in the treatment system and in other care systems, where earlier intervention can divert young people before their substance use becomes entrenched. In order to coordinate responses to young people who are most at risk the Victorian Government is developing the Vulnerable youth framework to support and encourage action in schools, communities and services across the range of service needs.

Our primary goal is to keep young people from needing to use the treatment system through effective prevention and early intervention efforts. Where young people need help in tackling substance use issues, we must intervene at the earliest opportunity and provide quality, evidence-based treatment and interventions that focus on reconnecting young people to their family, education and or employment and community to get them back on track as soon as possible.
What we know

- Australian data on patterns of alcohol consumption reveal that 37 per cent of males and 42 per cent of females aged 14–19 years drank in a way that put them at risk or high risk of short-term alcohol-related harm at least once in the past year. Even higher percentages of young people aged 20–29 years (65 per cent of males and 57 per cent of females) drink alcohol in this way.\(^{11}\)

- Mental health and substance use disorders account for 60–70 per cent of the burden of disease among 15–24 year olds.\(^{12}\)

- Seventy-three per cent of young homeless people have substance use problems and 22 per cent have problems with both harmful substance use and mental health.\(^{13}\)

- Young people whose lives lack structure and are characterised by chaotic and problematic alcohol and other drug use are often disengaged from family and community and are unlikely to present at mainstream services.

- Outreach services provide the opportunity to meet young people in settings in which they are comfortable. Clients of youth outreach services are predominantly aged 15–17 years (34 per cent) or 18–21 years (43 per cent). A smaller number are aged over 22 years (7 per cent). Youth outreach services provide information, support, advice and referral to nearly 3,000 young people every year.

- Alcohol and other drugs are linked to the offences of one in two juvenile justice clients (48 per cent), with 73 per cent of these clients using alcohol and 55 per cent using cannabis.\(^{14}\)

- Harmful substance use is a risk factor for youth crime, child abuse, family violence and poor mental health outcomes in young people.\(^{15}\)
Service provision for young people is more effective if it is delivered in an integrated way through partnership and collaborative approaches that address the needs of young people on a continuum covering prevention, early intervention, secondary intervention and tertiary intervention.16

Where we are now

The Victorian youth alcohol and other drug service system represented a pioneering initiative when it was established a decade ago. This was when heroin dominated the market and street corners were the preferred venue for drug deals. Since then, alcohol, cannabis and amphetamines have become more dominant drugs of concern and street-based drug markets have become less evident. Recently there has been a stronger focus on addressing risky alcohol consumption including binge drinking among young people.

Prevention and early intervention

The prevention challenge for alcohol is different. There is a broad cultural acceptance of drinking. It is important in socialising and celebrations and the modelling of behaviour among adults can reinforce risk taking among adolescents. Parents are also often a source of supply of alcohol to their children and other minors and may not be fully aware of their responsibilities and the risks of alcohol use for young people.

Workers and agencies have adjusted their practice to reflect changing patterns of alcohol and other drug use but we need to focus future efforts on intervening sooner and more effectively. We need better-integrated services for vulnerable young people. No one agency can expect to be all things to young people and substance misuse is often correlated with a wide range of health, mental health, housing, education, employment and welfare issues. These service systems can provide earlier responses to substance misuse with support from the specialist alcohol and other drug treatment system.

Preventive measures and early interventions to reduce initiation into drug use and escalation of use are key components of a continuum of services. Education and preventive approaches, such as those of the Victorian Drug and Alcohol Prevention Council, and early interventions in a range of health, education and social settings provide support to young people to get them back on track quickly. Involving workers from outside the alcohol and other drug treatment system to pick up substance use problems earlier is critical in engaging with young people before they are at serious risk.

Peer influence can help young people to make safer choices about how they socialise. Government prevention messages can sometimes be resisted particularly if they are seen as ‘scare tactics’ while peer networks are a trusted source of information about alcohol and other drug use and related harm. Effective prevention policies must incorporate peer-based components to ensure risks and harms are properly understood and to challenge the ways in which alcohol and other drug use is conceptualised within the peer group.

Families also have an important and very significant influence on young people. The roles and influences of partners and extended family can sometimes be overlooked in alcohol and other drug treatment programs. Families may need advice and information to understand the risks associated with the misuse of alcohol and the harms associated with illegal drugs. They may also need support in helping a young person to make positive changes and move forward with their lives. Families remain an important point of connection and attachment for young people and there is strong evidence of the improved long-term outcomes that can be achieved by re-connecting young people with their families, their school and their community. Service delivery models therefore need to engage young people and their families and address both current and future harmful behaviour.

While approaches and techniques can differ, both the adult and youth treatment service systems share the common objective of helping clients to cease or reduce their substance use. Engagement remains an important feature of the youth-specific treatment system. The evidence points to better outcomes for young people when they can connect with a significant adult. Outreach already operates at treatment sites, through teams collocated with other youth service providers and through out-posted workers. This delivery model can support earlier intervention by targeting those most at risk in the settings where they first appear.
Evidence-based treatment and interventions

Outreach workers deliver a range of responses and interventions but there is no agreed standard or consistent therapeutic basis to outreach work. This needs to be addressed. We need to find out what works best and ensure outreach workers have the skills to both engage young people and to provide evidence-based therapeutic interventions that improve the health and skills of young people and reconnect them with family, learning or employment and their local community. Research tracking treatment outcomes for young people would inform the future development of the suite of youth interventions.

Other youth-specific treatment models also need clarification. Previous reviews of youth withdrawal highlight the need for clearer service specifications and treatment criteria for youth withdrawal including those that cater for youth withdrawal clients who are aged over 18 years and eligible for treatment in adult withdrawal programs. Nearly 42 per cent of young people using youth-specific treatment services are aged over 18 years and 16 per cent are aged over 22 years. We need to consider where these older clients are best placed to achieve longer term behaviour change and provide clear pathways for the transition from youth to adult treatment services.

A small proportion of young people using youth withdrawal services need a more flexible or extended treatment program to achieve longer term behaviour change due to diagnosed developmental delay or the complexity of their presenting circumstances. The eligibility criteria for an extended stay model needs to be clarified and incorporated into the operation of withdrawal services to assist these more vulnerable young people to achieve real change in their substance using behaviour and to reconnect with their families and community.

Young people with multiple needs

Specialist dual diagnosis workers respond holistically to young people with comorbid mental health and alcohol and other drug issues. These teams also work to improve the capacity of both sectors to recognise and respond to young people with a dual diagnosis who present at their services. All young people entering alcohol and other drug treatment or mental health services need to be routinely screened for substance use and mental health issues as part of the intake and treatment planning process.

Successful referral of young homeless people to specialist dual diagnosis services is difficult and needs to be a priority. In order to address the policy challenge of improving integrated service provision for those young people who are most at risk the Victorian Government is developing the Vulnerable youth framework.

Young people in contact with the justice and correctional system would benefit from improved access to alcohol and other drug treatment services or interventions. They can access counselling and other brokered treatment services to divert them from correctional settings, but there is a growing demand for provision of after-hours treatment services, particularly for young people who have daytime employment or training commitments.
Figure 3: Interventions and responses for young people

- Early intervention in primary and community health settings
- Improved access for young clients with a dual diagnosis including homeless youth
- Stronger therapeutic framework for service delivery to support long-term behaviour change
- Collocation, co-delivery and integration of youth service responses to improve early intervention for at-risk groups
- Increased access to after-hours services for young forensic clients
- Stronger link between treatment and health protection services to promote earlier intervention
- A professional workforce able to respond effectively to the needs of young people and new or emerging needs

- Stronger client and family involvement in service planning and delivery
- Stronger support for vulnerable families through better-integrated responses
- Clients and their families have access to better information and advice about alcohol and other drug issues, support and treatment options
- Improved access to family therapeutic interventions

- Improved access to relevant and appropriate information for young people about alcohol and other drug use
- Family therapeutic interventions build skills in resisting negative peer pressure, build social networks and life skills to sustain recovery
- Prevention, education and early intervention is promoted in a wider range of community settings
Where we want to be

Multiple co-occurring problems are the norm among adolescents with substance abuse problems. This ... calls for the use of global (multidimensional) assessment ... and the use of integrated multi-agency, multidisciplinary service teams.17

(Dennis et al 2004)

Preventing and reducing the harms young people experience from the misuse of alcohol and other drugs requires the following elements:

• Youth alcohol and other drug treatment services provide holistic responses integrated with other youth services as part of the whole-of-government framework that is being developed to address the needs of vulnerable young people.

• All young people entering alcohol and other drug treatment services or mental health services are routinely screened for a dual diagnosis.

• Health, welfare and youth service providers offer comprehensive health and wellbeing screening and assessment to identify the range of assistance young people need including assistance with alcohol or other drug issues.

• Prevention and early intervention activities are expanded to ensure young people are informed of the harms and risks of alcohol and other drug use and are supported to address their substance use and to reconnect with their families, their schools (or other education providers) and their broader communities.

• *Restoring the balance - Victoria’s alcohol action plan 2008–2013* will continue to deliver a range of initiatives to address risky drinking and intoxication including specific actions targeting young people.

• Treatment agencies have strong links and partnerships with other services to provide clients with access to quality health, welfare, educational, employment, training and other support services.

• Youth housing transition hubs offer collocated services for homeless young people and access to dual diagnosis responses for those who need help for co-existing mental health and alcohol and other drug concerns.

• Workers in health protection services who provide information, advice and referral for young people are trained to identify opportunities for early intervention and, where appropriate, to link young people into treatment services.

• Access to culturally sensitive treatment and rehabilitation services for Indigenous young people is improved through providing a Koori youth healing service.

• Young people in new and emerging migrant and refugee communities have access to information, treatment and support through services that are skilled in engaging diverse communities.

• Further research into effective interventions that address harmful substance use by young people is promoted and disseminated to inform practice.
Clients of youth-specific treatment services should:

- receive an appropriate, evidence-based therapeutic response that reflects their support needs whether they initially present in the treatment system or another service system
- receive routine screening for dual diagnosis issues as part of intake and assessment procedures
- be supported in engaging and reconnecting with their families, their schools and their communities
- be supported to access the other health, education, employment and welfare services they require
- have access to youth outreach and youth withdrawal services that operate within an agreed therapeutic model that assists them to cease or reduce their alcohol and other drug use by delivering quality interventions focusing on longer term behaviour change
- be able to stay longer in treatment programs when required to improve their chances of treatment success and successful reconnection with family and community
- have access to after-hours forensic-brokered alcohol and other drug counselling when they are in employment or other training programs during the day
- be appropriately supported in their transition to adult treatment services and programs.

**How we are going to get there**

**Good-practice examples**

**Alcohol and drug youth consultants**

Substance misuse can be an issue for young people living in out-of-home care. Government-funded alcohol and drug youth consultants provide specialist support to these young people and to the services providing care for them.

This program improves the skills and knowledge of Child Protection workers and improves links with youth-specific treatment services. Consultants also provide accessible and flexible treatment for young people to help them get back on track.

**Koori Youth Healing Service**

Ngwala Willumbong and the Youth Substance Abuse Service work in partnership to operate the Victorian government-funded Koori Healing Service for Indigenous young people who require a residential healing service to address their problematic alcohol and other drug use. The service takes a whole-person approach to treatment with elements incorporating social, spiritual and community connectedness.
## Action plan for young people

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<th>Action</th>
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<th>Key partners</th>
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<tr>
<td><strong>Action 1: Improve prevention and earlier intervention responses and post-treatment reconnections.</strong></td>
<td>1–4 years</td>
<td>Departmental regions, Youth treatment agencies, Youth housing services, Community and mental health services, Other youth health, justice, education, employment and welfare services, Local government, Research institutions</td>
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<tr>
<td>• Provide young people with information about the harms associated with using cannabis through a targeted community awareness-raising campaign.</td>
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<td>• Collocate and co-deliver youth outreach and other youth alcohol and other drug treatment services with related youth, health and support services to promote integrated delivery and earlier intervention.</td>
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<td>• Ensure implementation of commitment to screen all clients of alcohol and other drug treatment agencies and mental health services for dual diagnosis issues at entry/intake.</td>
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<td>• Improve awareness and recognition of alcohol and other drug use issues and intervention skills among workers and agencies delivering other specialist and generalist services to young people.</td>
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<td><strong>Action 2: Develop a stronger therapeutic framework for all aspects of youth alcohol and other drug treatment service delivery to help young people cease or reduce their substance use and better support longer term behaviour change.</strong></td>
<td>3 years</td>
<td>Departmental regions, Youth treatment agencies, Research institutions</td>
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<tr>
<td>• Institute a therapeutic framework for youth outreach and youth withdrawal service types in collaboration with the sector and clinical youth experts based on best practice and evidence.</td>
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<td>• Establish transition protocols for older clients in youth-specific services and improve understanding of youth-appropriate practices in adult treatment services to ensure young people can move seamlessly to adult services.</td>
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<td>• Research longer term outcomes for young people undergoing alcohol and other drug interventions and treatments to establish the efficacy of different models and treatment interventions.</td>
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<td><strong>Action 3: Improve responses for young people with multiple needs.</strong></td>
<td>3 years</td>
<td>Youth treatment agencies, Youth housing services, State government agencies including the Office for Youth and Youth Justice, Forensic agencies, Commonwealth government</td>
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<td>• Deliver earlier intervention and improve access to treatment responses for homeless young people.</td>
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<td>• Assess demand for after-hours treatment services for youth forensic clients and develop a pilot program if demand warrants it.</td>
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<tr>
<td>• Develop and promote stronger links and referral between treatment services and employment and training services for vulnerable young people.</td>
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Service-focused principle 1: Prevention

Prevention and early intervention should be prioritised

Introduction

I wish I’d known about the damage cannabis can do…

(Client at consultation forum 2007)

People can find themselves needing help with alcohol and other drug problems for many reasons. This requires coordinated whole-of-government responses and better use of the opportunities for prevention and early intervention work in other service systems.

There are many locations and circumstances in which opportunistic or pre-planned interventions can make a difference in preventing or reducing the harms associated with substance misuse.

Effective prevention and early intervention addresses problematic behaviours before they become entrenched and empowers people to make the necessary changes that will improve their health and wellbeing.

Prevention

Continuum of responses

Coordinated across government

Multiple intervention settings

Evidence-based interventions

Key changes

$4.5 million for screening and self-help tools for people at risk of alcohol-related harms

Development of a Victorian Government prevention strategy

Better partnering with local government to enhance community responses to prevention

$3 million for a targeted community awareness campaign about the risks and harms of alcohol misuse
What we know

It is important to acknowledge the benefits to clients, organisations and the workforce of good networking.
(Yarra Drug and Health Forum)

• Brief interventions are ‘…as effective as more intensive interventions for heavy drinkers, more cost-effective due to their length and can be used in a wide variety of primary care settings to reach a large number of clients’.18 Similarly, there is growing evidence of the efficacy of brief interventions for cannabis and amphetamines users.19

• Brief interventions for harmful drinkers are twice as effective as interventions for heavy smokers (or comparable if nicotine replacement therapy is used).20

• Alcohol, cannabis and amphetamine users are typically reluctant to seek help. A 2001 analysis found that less than 30 per cent of those with alcohol dependence sought help for their problems and most of those who did saw their GP.21

• Mental health and related substance use disorders are the number one health issue affecting young Australians, and only one in four of these young people currently receive professional help.22

• GPs, psychologists and mental health professionals do not readily identify co-occurring alcohol or other substance misuse in young people with depression.

• Health care professionals need to be appropriately trained to detect such disorders promptly to ensure young people have access to effective, early intervention and to ameliorate the substantially negative impact of co-occurring disorders.23

Where we are now

…GPs are a regular first port of call for many with alcohol and drug issues. Research has indicated GPs are important as a contact point for family members concerned about another member’s alcohol and drug use.
(Family Drug Help)

Prevention and early intervention are already an important part of Victoria’s drug strategy but these approaches can be further strengthened. Cross-government initiatives like drug education programs in schools work with young people to prevent alcohol and other drug use problems from occurring. Community strengthening initiatives stemming from A Fairer Victoria reduce disadvantage and help to build protective factors in individuals, families and communities.

At the other end of the continuum, forensic programs help to reduce drug-related crimes and the associated harms caused to victims, offenders, their families and the community. Every contact through the alcohol and other drug treatment system is an opportunity to prevent relapse and reduce further harm.

Screening tools and early interventions can identify problems very early and support people to address their substance use in the wider context of their physical and mental health. There is growing recognition of the potential for utilising internet and telephone helpline services to address psychological and social problems. Over 1.6 million Victorians are now internet subscribers.24 Increasing access to the internet, advancing technology and reducing costs means that information can be quickly provided. In many instances people prefer the anonymity such contact affords. Often people can help themselves if they have ready access to accurate information and self-help resources.

Complementing self-help resources, a range of screening and brief intervention tools for use by health professionals are now available. However, these are not used extensively by GPs or other health and welfare workers. Some hospitals have trialled screening and brief intervention tools with promising results.
Restoring the balance – Victoria’s alcohol action plan 2008–2013 incorporates an early intervention program. This program will promote a more systematic approach to early intervention for alcohol problems in general practice, community health and other settings through stronger support and training resources to assist GPs to intervene earlier with people who are drinking at risky or harmful levels.

All these activities will be coordinated as part of an integrated prevention framework. The Government’s new Victorian Drug and Alcohol Prevention Council (VDAPC) brings together experts from a range of fields. They will advise government on best-practice approaches to prevention, the latest research and opportunities for developing community initiatives. The council will also assist in developing the whole-of-government alcohol and drug prevention strategy. These Victorian initiatives will be informed by the growing focus on broad preventative health at the national level, with the recent establishment of the Preventative Health Taskforce.

Where we want to be

To further the use of early intervention there is a need to equip a wide range of health, welfare and education professionals (not just AOD workers) and the community (families, peers, etc), who come into contact with young people with the skills and information to identify where there are emerging issues and problems and, then, to act appropriately.

(Australian Drug Foundation)

Harms from the inappropriate use of alcohol, the use of illicit drugs and the misuse of prescription drugs can be prevented and reduced if:

• there are multiple opportunities for engagement on alcohol and other drug issues in a variety of settings to improve prevention and early intervention responses
• people have opportunities to help themselves through better web-based information, telephone support and resources
• client access points for early intervention opportunities are more effectively identified with stronger support and resources for GPs
• models of good practice for early intervention and prevention are identified and promoted
• research, evidence and existing good practice informs the development of prevention and early intervention responses
• as new drug issues emerge, all levels of government, providers, schools (and other education providers) and the community work together to develop effective prevention, early intervention, treatment and harm reduction responses

• Restoring the balance – Victoria’s alcohol action plan 2008–2013 reflects a prevention and early intervention approach as a key focus for addressing alcohol harms and issues in the community
• the Victorian whole-of-government alcohol and drug prevention strategy supports prevention and early intervention initiatives within education, justice, health, community, employment and other welfare programs.
How we are going to get there

Good-practice example

Municipal drug strategies provide successful examples of close collaboration between the community and local government to produce tailored drug responses. Funded in five municipalities across Melbourne since 2001–02 to address the local impacts of alcohol and other drug use, these wide-ranging projects allow the community to have a voice in addressing local community prevention, early intervention and harm reduction concerns.

Action plan for prevention

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Key partners</th>
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</thead>
<tbody>
<tr>
<td><strong>Action 1: Promote opportunities for prevention and early intervention in primary health and other settings.</strong></td>
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<tr>
<td>• Develop an early intervention/shared care program with an initial focus on alcohol use, partnering with the Royal Australian College of General Practitioners, General Practice Victoria and other stakeholders.</td>
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<tr>
<td>• Develop online screening and self-help resources for people wanting to address their alcohol problems confidentially.</td>
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<tr>
<td>• Work with the Royal Australasian College of Physicians (RACP), the Victorian Addictions Inter-hospital Liaison Association (VAILA) and metro/rural hospitals to explore the use of brief interventions in hospital settings.</td>
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<tr>
<td>• Identify opportunities for integrated health and wellbeing screening, working with community health services.</td>
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<tr>
<td>• Engage with local government to develop prevention and early intervention responses in local communities including the development of:</td>
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<td></td>
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<tr>
<td>• a community resource for drug prevention</td>
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<tr>
<td>• local community guidelines for responding to public drug use.</td>
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</tbody>
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2 years |
| Treatment agencies |
| Peak bodies |
| Consumer groups |
| Peak medical, GP, pharmacy and health bodies |
| Hospitals |
| Community health agencies |
| Local government |
| Helpline services |

| **Action 2: Identify best practice models for prevention and early intervention.** |
| • Develop a research strategy for alcohol and other drug issues prioritising blueprint outcome areas. |
| • Develop an Indigenous drug prevention research action plan. |
| • Develop a prevention research action plan. |
| • Undertake and collaborate in ongoing research into early intervention and treatment needs of people using alcohol and amphetamine-type substances (ATS). |

1 year |
<p>| Treatment agencies |
| Peak bodies |
| Koori peak bodies |
| Research organisations |
| Universities |
| ATS Taskforce |
| Victorian Drug and Alcohol Prevention Council |</p>
<table>
<thead>
<tr>
<th>Action</th>
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<th>Key partners</th>
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</thead>
<tbody>
<tr>
<td><strong>Action 3:</strong> Promote coordinated early intervention and prevention</td>
<td>1–4 years</td>
<td>Victorian Drug and Alcohol Prevention Council</td>
</tr>
<tr>
<td>strategies across government and communities.</td>
<td></td>
<td>Victoria Police</td>
</tr>
<tr>
<td>• Implement *Restoring the balance - Victoria’s alcohol action plan</td>
<td></td>
<td>State government agencies</td>
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<tr>
<td>2008–2013*, including a targeted community awareness campaign on the</td>
<td></td>
<td>Peak bodies</td>
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<tr>
<td>risks and harms of excessive alcohol consumption.</td>
<td></td>
<td>Local government</td>
</tr>
<tr>
<td>• Develop and implement a Victorian whole-of-government alcohol and</td>
<td></td>
<td>Peak medical, GP, pharmacy and health bodies</td>
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<tr>
<td>drug prevention strategy.</td>
<td></td>
<td>Consumer groups</td>
</tr>
<tr>
<td>• Develop and implement an ATS and related drugs strategy.</td>
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</table>

* *Restoring the balance - Victoria’s alcohol action plan 2008–2013* refers to a targeted community awareness campaign to educate about the risks and harms of excessive alcohol consumption.
Service-focused principle 2: Improving access

Access to treatment should be seamless with ‘no wrong door’

Introduction

The recognition of the importance of flexible and co-ordinated service delivery across the alcohol and other drug, mental health, child and family services and other sectors is vital to any considered attempts at improving service provision and client outcomes.

(UnitingCare, Moreland Hall)

Every treatment intervention is an opportunity to bring about long-term, positive change in a person’s life. Seeking help is often triggered by a crisis and motivation to enter treatment can be fragile.

The ‘no wrong door’ approach recognises that timely access to the right treatment is critical regardless of whether a person presents for alcohol and other drug treatment; at an NSP; or at a mental health, primary health, hospital, family or housing services facility.
What we know

…drug problems are multi-factorial and therefore the response to them must be multi-sectorial.

(Australian Drug Foundation)

• Recorded waiting times for residential services in the Alcohol and Drug Information System (ADIS) for quarter 3 of 2007–08 is an average of 6.9 days with recorded residential rehabilitation waiting times of 22.8 days and residential withdrawal waiting times of 5.8 days.

• In 2005–06, more than 20,000 bed days in Victoria’s public hospital system were utilised by people in a state of withdrawal while being treated for other medical and mental health conditions. Withdrawal adds to the complexity of treatment with an average bed day per separation of 7.6 days. There is an opportunity to strengthen prevention initiatives through the hospital system.

• The 2005–06 Victorian Admitted Episodes Dataset (VAED) in public hospitals shows over 3,000 separations where patients were withdrawing from alcohol or other drugs. The average stay per patient for withdrawal was 3.7 bed days.

• There are more than 5,000 GPs in Victoria but only 200 GPs treat the 11,000 clients requiring access to pharmacotherapies on any given day.

• Of 200 GPs involved in pharmacotherapy prescribing, just over 70 manage 8,000 (or 72 per cent) of pharmacotherapy clients. Of these, six GP prescribers account for 20 per cent of Victorian pharmacotherapy clients.

• One-third of Victorian pharmacies offer access to supervised dosing for pharmacotherapy.

• Research and modelling indicates that for every $1 spent on pharmacotherapy treatment, it repays $4 to $5 to the community in savings on health care and crime costs.

• NSPs located in growth corridors are reporting growing demand for their services indicating potential downstream need for treatment services.

• Nearly 13 per cent of all NSP client contacts are with people aged 20 years or under.

• NSPs recorded more than 300,000 contacts with injecting drug users during 2006–07. A recent survey of NSPs by Anex found that alcohol and other drug treatment, primary care, housing and crisis intervention services were some of the more common client referrals made.

Where we are now

Developments in the understanding of the treatment of addictions demonstrate that the role of Addiction Medicine and other key specialists including psychiatrists and general practitioners who work in the addictions field is crucial and requires greater consideration in the planning for a vision for the future of the drug and alcohol service system in Victoria.

(Australasian Chapter of Addiction Medicine)
Victoria has led the way in improving treatment outcomes for clients with multiple and co-occurring needs. Programs such as the Victorian Dual Diagnosis Initiative ensure there is ‘no wrong door’ for entry into alcohol and other drug and mental health treatment services. But more can be done to improve pathways into and through treatment.

A treatment access register for residential services could improve coordination between treatment services, increase the timeliness of access for clients, improve client information about treatment options and help people get their lives back on track sooner.

Stronger links between hospital addiction medicine specialists, GPs and treatment services, especially withdrawal and continuing care, will improve care and treatment outcomes for people with complex medical needs.

New funding made available under Restoring the balance – Victoria’s alcohol action plan 2008–2013 will support the provision of specialist advice to GPs and withdrawal services in managing clients with complex health and medical needs.

In 2007 the Commonwealth Minister for Health and Ageing approved a proposal to fully recognise addiction medicine as a specialist field. The Australian Medical Council is now assessing the suitability of the Australian Chapter of Addiction Medicine’s training program as the next step in this recognition process. These developments require urgent consideration to ensure that existing initiatives supporting a Chair of Addiction Medicine at St Vincent’s Hospital and funding for registrar rotations in addiction medicine can be built upon.

The department will convene a forum with RACP, the Royal Australian College of General Practitioners (RACGP), the Australasian Chapter of Addiction Medicine, General Practice Victoria (GPV), VAILA and other relevant stakeholders to discuss the potential implications and opportunities arising from these changes, and to plan accordingly.

A comprehensive evaluation of the current community based pharmacotherapy model [is needed] to ensure it can continue to be improved to be accessible, flexible and appropriate for clients.

(Maribyrnong City Council)

Pharmacotherapy in Victoria is provided by GPs, pharmacists and a number of specialist pharmacotherapy services (SPS) and treats over 11,000 clients on any given day. Pharmacotherapy clients are generally healthier than clients still using illegal drugs, are more involved in employment and social networks and are less likely to be engaging in criminal activity. It is an integral step towards a life free of addiction for many opiate users and a pathway into other treatment and recovery.

Although the pharmacotherapy system provides a service to a large number of clients, it is overly reliant on a relatively small number of GPs. Funding provided under Restoring the balance – Victoria’s alcohol action plan 2008–2013 will support and encourage GPs to continue their important work and to promote improved utilisation of pharmacotherapies for clients with alcohol problems by providing additional addiction medicine capacity and support.

We also need to think more creatively about how we use existing services to improve outcomes for our clients. For example, an NSP is a pathway to treatment for some of the most marginalised injecting drug users. NSPs and related services like the Mobile Overdose Response Service and mobile drug safety workers could be used more effectively to intervene earlier with clients who are at higher risk of harm. A review of the current pharmacotherapy model and the role of addiction medicine considering issues such as access to GPs and pharmacies is needed.
Where we want to be

Harm reduction services have the potential to be more than the first point of contact and referral to drug treatment. They can also act as frontline (primary and secondary) prevention as well as early intervention services for a range of issues. There is potential for these services to be a central hub and gateway for the spectrum of people who use drugs to a range of services and interventions.

Improving access to treatment and helping clients to achieve better long-term health and treatment outcomes requires the following elements:

• Clients needing residential treatment for alcohol and other drug concerns can access timely services and are supported while waiting for entry.
• Client screening takes account of complex medical needs and service responses are holistic and integrated with other health and welfare service providers.
• The service system draws on addiction medicine and other medical expertise to respond to the needs of clients with co-occurring medical conditions.
• The prescribing and dispensing of pharmacotherapies, including alcohol pharmacotherapies, is widely available across Victoria through well-trained and supported professional staff in client-friendly settings.
• There is improved support for GPs engaged in shared care arrangements for alcohol and other drug clients with treatment providers.
• Seamless service delivery provides clearer pathways into and through the system. Processes are more transparent, delivering an improved continuum of care between different treatment service types and reduced rates of client dropout.
• There are stronger links between health protection and treatment services. Clients of NSPs and other health protection services are supported to enter and engage with treatment.
• Changing demand is met through more accessible and responsive services and improved policy development and service planning.

How we are going to get there

Good-practice example

Primary health services for injecting drug users were established in five heroin ‘hotspots’ around Melbourne in 2001–02 including St Kilda, Melbourne, Dandenong, Yarra and Maribyrnong. These provided treatment to over 3,000 clients in 2005–06.

Evaluations found that primary health services provide a holistic model of health care through a range of health and welfare staff. Importantly, clients who engaged with the primary health services had stronger continuity of care, with their access facilitated to a range of other mainstream services including alcohol and other drug treatment.
## Action plan to improve access

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<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Key partners</th>
</tr>
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</table>
| **Action 1: Improve pathways to treatment.**                           | 3–4 years | Treatment agencies  
  Peak bodies  
  Consumer groups  
  Helpline-delivery agencies  
  Peak medical, pharmacy and health bodies  
  Victorian specialist agencies/services  
  Community health agencies  
  Primary Care Partnerships  
  Forensic agencies                                                 |
| • Develop a model for a centralised treatment-access register for residential services to improve treatment engagement, reduce dropout and utilise treatment resources more effectively. Assess the potential for a similar system for non-residential services. |           |             |
| • Investigate mechanisms/systems to improve the efficiency of intake, pre-treatment support, assessment, service coordination and referral. |           |             |
| • Review Victoria’s pharmacotherapy model and the role of addiction medicine focusing on primary health connections and access to GPs. |           |             |
| • Redirect pharmacotherapy regional outreach workers (PROW) to improve GP and pharmacy engagement in the pharmacotherapy program. |           |             |
| • Promote alcohol and other drug training opportunities for pharmacist and GP clinic staff. |           |             |
| • Promote the take-up of secondary NSPs in growth corridor areas and in superclinics. |           |             |
| **Action 2: Address clients’ complex medical conditions and co-occurring health needs.** | 3 years   | Treatment agencies  
  Peak bodies  
  Consumer groups  
  Helpline-delivery agencies  
  Peak medical, GP and other health bodies  
  Victorian specialist agencies/services  
  Community health agencies  
  Hospitals                                                      |
| • Reconfigure residential withdrawal services to enhance links and build partnerships with GPs, hospitals and addiction medicine specialists to improve outcomes for clients with complex medical conditions and co-occurring health needs. |           |             |
| • Develop stronger GP support systems (particularly for rural GPs) through addiction medicine specialists, the Drug and Alcohol Clinical Advisory Service (DACAS), specialist pharmacotherapy clinics and community health services to support improved shared care treatment models. |           |             |
| • Research the role of hospitals in treating withdrawal patients. |           |             |
| • Improve transition arrangements for patients between hospitals and community treatment services. |           |             |
| • Promote improved recognition of addiction medicine in university studies. |           |             |
| • Convene a forum to investigate the impacts of formal recognition of addiction medicine as a speciality and options for improving responses to clients with medically complex and co-occurring conditions. |           |             |
| • Promote priority access to dental treatment for alcohol and other drug clients |           |             |
### Action 3: Build stronger links between treatment and health protection services.

- Build NSP, mobile drug safety worker and Mobile Overdose Response Service capacity to formally engage, counsel and refer people to treatment and other health services.
- Enhance links between mental health services and primary NSPs.
- Improve access to training opportunities for health protection workers.
- Improve awareness of health protection services and pharmacotherapy treatment options among treatment services and other health and welfare services.

<table>
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<tr>
<th>Timeframe</th>
<th>Key partners</th>
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<tr>
<td>1–2 years</td>
<td>Health protection services&lt;br&gt;Pearl bodies&lt;br&gt;Consumer groups&lt;br&gt;State government agencies</td>
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### Action 4: Respond to new and emerging needs.

- Develop stronger connections to counselling services via NSPs/pharmacies in growth corridors.
- Partner with RACGP, GPV, VAILA, VAADA and the Department of Human Services General Practitioner Policy Group to develop service linkage protocols.
- Prioritise new resources and training activities for GPs, health protection workers, practice nurses and generalist counsellors in community health centres delivering services in growth corridors and rural areas.

<table>
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<tr>
<th>Timeframe</th>
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<tr>
<td>3 years</td>
<td>Health protection services&lt;br&gt;Pearl bodies&lt;br&gt;Consumer groups&lt;br&gt;Pearl medical, pharmacy and health bodies&lt;br&gt;Victorian specialist agencies/services&lt;br&gt;Community health agencies&lt;br&gt;Local government</td>
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Service-focused principle 3: Excellence and quality

Services must be high quality, evidence-based and effective in assisting clients to cease or reduce harmful alcohol and other drug use

Introduction

The focus of alcohol and other drug treatment should always be on achieving behavioural change and skill acquisition.

(UnitingCare, Moreland Hall)

Systems, services and workforces need to continually adapt and innovate to respond to multiple and changing client needs. Clients should have access to treatment that is based on the latest available evidence of what works. Enhanced flexibility and stronger therapeutic frameworks grounded in clinical practice guidelines will ensure our service models and workforces deliver high quality, evidence-based treatment that improves outcomes for clients.

Excellence and quality

Evidence-based treatment

Skilled and flexible workforce

Effective data systems

Consistent quality standards

Key changes

Redeveloped funding and reporting systems to promote service flexibility and innovation

$2.7 million for a new medium-intensity rehabilitation program

Reconfigured counselling program to improve client outcomes

A new quality framework, improved professional development and clinical practice guidelines to build workforce skills
What we know

Systems

• Sector consultations highlighted concerns over current episode-of-care (EOC) targets limiting flexibility and service capacity to undertake the more intensive work required with an increasing number of high-risk and multiple needs clients.

• Current performance targets may create perverse incentives for agencies to achieve outcomes by prematurely closing an EOC. This creates poor data quality that understates the degree and breadth of client needs.

Services

• Sector consultations highlighted a need for greater flexibility in the duration of withdrawal stays. This was noted as being particularly important for a small number of very high need clients with multiple issues and co-occurring conditions who need a lengthened period of support to build connections, develop life skills and encourage linkages to longer term services to prevent relapse.

• The growing number of clients with multiple needs requiring more complex case management and support has been attributed to increasing poly-drug use and a greater prevalence of clients with comorbid conditions and related social problems. A gap has been identified in current residential service models where higher levels of support and longer stays are required in some instances to prevent relapse and promote longer term positive treatment outcomes.

• A service system review conducted in 2003–04 identified mixed application of evidence-based practice across the sector and called for stronger counselling services.

Workforce

• A 2006 qualification review found that 64 per cent of respondents (workers in the alcohol and drug field) now met the Minimum Qualification Standard of Certificate Level IV.

• Half of the workforce has worked in the alcohol and other drug sector for more than five years, while almost a quarter (23 per cent) has been in the sector for less than two years.

• There is increasing evidence that the development, training and implementation of clinical practice guidelines can lead to improvements in both the process and the outcomes of care.25

Where we are now

The review of service delivery specifications is timely and will provide an opportunity to factor in much of the current creative work that the sector has conducted as an aside to service delivery.

(Eastern Drug and Alcohol Service)

Systems

Our performance measurement systems tell a story about people’s achievements in treatment, demonstrating their success in ceasing or reducing their drug use. Importantly they also provide information to the public about how alcohol and other drug treatment resources are spent.

However, there is some concern within the sector that performance measurement targets (EOC) for some service types may inhibit innovation and reduce flexibility when responding to clients with multiple needs and their families. Data also need to be used more effectively to identify emerging trends or issues.
Services

Funding has been secured under *Restoring the balance - Victoria’s alcohol action plan 2008–2013* to help develop and implement a new medium-intensity community-based rehabilitation model. Funding of $2.7 million over four years will provide an additional 110 episodes of rehabilitation care every year to support clients as they transition back into the community following withdrawal. This new service will fill the gap between withdrawal and alcohol and drug supported accommodation programs by catering for clients with higher support needs.

Some service specifications and standards have not been reviewed since they were originally established over 10 years ago, meaning that they can unintentionally inhibit innovation and create system gaps and limitations. Specifications and standards for the core service types will be revised to incorporate evidence-based and innovative new practice that reflect changes in client need and will improve treatment outcomes.

Within the current specifications there are challenges for some service types including:

- residential withdrawal – responding to higher support needs of some clients before they are stabilised and able to transition to other, longer term treatment support
- alcohol and other drug supported accommodation (ADSA) services – responding to higher support needs of some ADSA clients within the current model
- counselling, consultancy and continuing care (CCCC) services – securing long-term behaviour change in clients through evidence-based therapeutic interventions, responding to families and managing the increasing complexity of casework for clients with multiple needs, and meeting the needs of those with a chronic and relapsing condition.

The diversity of service models and philosophies for alcohol and other drug treatment in Victoria has led to innovative practice including one of Australia’s strongest treatment networks for young people with substance use issues.

A clear quality framework for Victoria’s diverse treatment system will help to define the dimensions of quality and outline key quality standards to ensure that regardless of differing philosophies or service delivery models, clients receive quality, evidence-based therapeutic treatment that focuses on aiming for, and sustaining, long-term behaviour change.

Workforce

*Workforce development should focus on retaining experienced staff as well as providing essential skill-based training such as core competencies and advanced skills in AOD treatment as well as core and advanced dual diagnosis skills, supervision and frontline management.*

(UnitingCare, Moreland Hall)

Building the capacity of the workforce is a key strategy for developing more effective treatment responses and improving client outcomes. A range of initiatives have been undertaken over the past few years including:

- the *Workforce development strategy* (2004–06) instituted a Minimum Qualification Standard (MQS) for alcohol and other drug workers
- nearly all treatment agencies being accredited through the Quality Improvement Council
- client input to treatment and health protection services and systems being supported and promoted through the Association of Participating Service Users (APSU), the Victorian Drug Users Organisation (VIVAIDS) and Anex.

The alcohol and other drug workforce should have access to continuing professional development to build their capacity and strengthen their clinical capabilities. Other health and welfare workforces need to recognise and understand substance use issues for their clients to improve prevention and early intervention responses and to promote joined-up responses to clients with multiple needs. Clinical practice guidelines should be reviewed and redeveloped to take account of the latest evidence.
Where we want to be

Systems
Supporting flexibility, innovation and quality within the treatment system requires the following elements:

- Data recording and performance measurement systems must deliver accurate and timely information and focus on what clients achieve as a result of their engagement in treatment.
- Data gathered through performance management systems are used to better inform service practice and to inform policy improvements that benefit clients.
- EOC targets provide accountability for government expenditure but incorporate flexibility to take account of the multiple needs of clients and innovative service responses for the most vulnerable clients and their families.
- Core standards and specifications for alcohol and other drug agencies promote innovative, flexible and evidence-based treatment interventions to work towards longer term behaviour change among clients.
- The treatment sector operates within a quality framework that defines the dimensions of quality and key quality standards.

Services
Assisting clients of alcohol and other drug treatment services to achieve better health and treatment outcomes requires the following elements:

- The therapeutic basis of treatment interventions is clearly defined, regularly updated to take account of new and emerging evidence through published clinical practice guidelines and translated into practice by the treatment sector.
- Clients in residential withdrawal programs with higher support needs and presenting issues (such as poly-drug use) can stay longer if required to stabilise their withdrawal prior to transitioning to longer term treatment.
- Clients exiting withdrawal programs and requiring additional support that makes them less suitable for alcohol and drug supported accommodation programs can access medium-intensity community rehabilitation that helps them to stabilise, build connections and engage with longer term treatment support to prevent relapse.
- Clients are supported in engaging and reconnecting with their families and their communities. Clients have the skills to access the other health and welfare services they need.

Workforce
A skilled and flexible workforce that supports improved client outcomes requires the following elements:

- The alcohol and other drug workforce have the clinical skills and expertise to deliver quality, evidence-based interventions that assist in achieving longer term behaviour change in clients.
- The alcohol and other drug workforce works collaboratively with other sectors, professions and programs, adopting a multidisciplinary approach to address a client’s treatment and support needs.
- Mainstream and other specialist health and welfare services have a good understanding of substance use issues, are able to intervene earlier with those at risk and provide integrated responses to assist alcohol and other drug clients to reconnect to family and community.
How we are going to get there

Good-practice examples

The *Victorian alcohol and other drugs workforce development strategy* introduced a Victorian alcohol and other drugs MQS. The MQS set a recommended minimum educational qualification (Certificate IV in alcohol and other drugs work) for specialist alcohol and other drug workers. For the first time, a significant proportion of the workforce attained specialist alcohol and other drug skills. This has created a foundation of strengthened practitioner skill that can be built upon in future workforce strategies.

Action plan for excellence and quality

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<tr>
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<tbody>
<tr>
<td><strong>Action 1: Improve service flexibility and capacity for innovation to improve treatment outcomes for clients.</strong></td>
<td>3 years</td>
<td>Departmental regions, Treatment agencies, Peak bodies</td>
</tr>
<tr>
<td>• Refine performance measurement systems to better account for clients with multiple needs and co-occurring conditions.</td>
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<tr>
<td>• Revise all service standards and specifications to take account of current best, and evidence-based, practice.</td>
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<tr>
<td>• Improve data gathering to better capture client outcomes and achievements.</td>
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<tr>
<td>• Improve data analysis to better identify emerging issues and any service gaps.</td>
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<td>• Develop data linkage systems to inform policy development and ensure the needs of clients with multiple needs are better identified and met.</td>
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<tr>
<td>Action</td>
<td>Timeframe</td>
<td>Key partners</td>
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<tr>
<td>Action 2: Develop a stronger therapeutic framework for all aspects of service delivery, introduce new service models and reshape existing treatment models to better support longer term behaviour change for this chronic and relapsing condition.</td>
<td>3 years</td>
<td>Departmental regions, Peak bodies, State government agencies, Treatment agencies, Community health agencies, Commonwealth government</td>
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<tr>
<td>- Implement a new medium-intensity rehabilitation model to support clients exiting withdrawal services to fill the gap in alcohol and other drug supported accommodation programs for clients with higher support needs.</td>
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<tr>
<td>- Pilot extended-stay withdrawal programs for clients with complex presentations and higher support needs.</td>
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<tr>
<td>- Redevelop the counselling, consultancy and continuing care (CCCC) service type (including CCCC, post-withdrawal linkage, mobile drug safety workers and mobile overdose response workers) to improve therapeutic outcomes, build treatment pathways and improve client connections through two streams:</td>
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<tr>
<td>• counselling/secondary consultation with a stronger focus on therapeutic interventions including family engagement and group work</td>
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<tr>
<td>• casework with a focus on treatment pathways and cross-sector linkages and connections.</td>
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<tr>
<td>Action 3: Establish a stronger evidence base and clear quality standards for delivering treatment services.</td>
<td>2–3 years</td>
<td>Treatment agencies, Peak bodies, Consumer groups, Registered training organisations, Research institutions</td>
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<tr>
<td>- Implement the quality framework outlining key quality standards for the sector.</td>
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<tr>
<td>- Build a stronger evidence base for what works in treatment through improved research, dissemination and translation of evidence into practice, supported by a research strategy linked to the quality framework and the workforce development strategy.</td>
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<tr>
<td>- Review and redevelop clinical practice guidelines to take account of the latest evidence and ensure these are incorporated in the quality framework and workforce development strategy.</td>
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</tbody>
</table>
**Action 4:** Further develop the clinical skills and capacity of the alcohol and other drug workforce.

- Implement a new workforce development strategy focusing on training and professional development in:
  - clinical supervision
  - advanced therapeutic interventions
  - family-based therapeutic interventions
  - case management skills
  - clinical mentoring support.
- Promote cross-sectoral training and opportunities for workforce rotation initiatives to build skills and awareness of alcohol and other drug issues in related sectors for earlier intervention and prevention and better collaborative work across sectors.
- Promote the incorporation of dual diagnosis and addiction medicine in relevant university degree courses.

<table>
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<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Key partners</th>
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<tbody>
<tr>
<td>Action 4: Further develop the clinical skills and capacity of the alcohol and other drug workforce.</td>
<td>4 years</td>
<td>Treatment agencies, Other health, youth and family service agencies, Peak bodies, Consumer groups, Registered training organisations, State government agencies, Local government, Commonwealth government</td>
</tr>
</tbody>
</table>
References

1. ABS 2006, National Aboriginal and Torres Strait Islander Health Survey 2004-05, ABS cat. no. 4715.0, Australian Bureau of Statistics, Canberra.


11. Turning Point Alcohol and Drug Centre 2006, Victorian alcohol statistics handbook, Volume 8: Alcohol use and related harm among young people across Victorian local government areas. Turning Point Alcohol and Drug Centre, Melbourne.


