

|  |
| --- |
| Alcohol and other drugs program guidelines  Part 2: program and service specifications |

|  |
| --- |
| Acknowledgements  The Department of Health and Human Services gratefully acknowledges the contribution made by service providers of alcohol and other drug treatment services to the development of these guidelines; in particular the members of the Alcohol and other Drug Sector Reference Group. If you would like to provide feedback on how these guidelines can be improved, please [email the Drug Policy and Reform unit](mailto:AOD.enquiries@dhhs.vic.gov.au) <AOD.enquiries@dhhs.vic.gov.au>. |
| To receive this publication in an accessible format phone 9096 6000, using the National Relay Service 13 36 77 if required, or [email the Drug Policy and Reform unit](mailto:AOD.enquiries@dhhs.vic.gov.au) <AOD.enquiries@dhhs.vic.gov.au>.  Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.  © State of Victoria, Department of Health and Human Services, April 2018.  Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.  Available at [Alcohol & other drugs](https://www2.health.vic.gov.au/alcohol-and-drugs/) <https://www2.health.vic.gov.au/alcohol-and-drugs>. |
|  |

Contents

[1 Purpose of the guidelines 5](#_Toc523740858)

[1.1 This document 5](#_Toc523740859)

[2 Prevention and early intervention 6](#_Toc523740860)

[2.1 Information and support 6](#_Toc523740861)

[2.2 Family support 7](#_Toc523740862)

[3 Harm reduction 7](#_Toc523740863)

[3.1 Education and awareness 8](#_Toc523740864)

[3.2 Overdose prevention and response training 8](#_Toc523740865)

[3.3 The Victorian needle and syringe program 9](#_Toc523740866)

[3.4 Peer support 9](#_Toc523740867)

[3.5 Outreach and engagement 10](#_Toc523740868)

[3.6 Tailored facilities with trained staff 10](#_Toc523740869)

[4 The treatment system 10](#_Toc523740870)

[4.1 DirectLine – statewide screening and referral service 11](#_Toc523740871)

[4.2 Catchment-based intake 12](#_Toc523740872)

[4.3 Assessment 16](#_Toc523740873)

[4.4 Counselling 19](#_Toc523740874)

[4.5 Care and recovery coordination 21](#_Toc523740875)

[4.6 Non-residential withdrawal 23](#_Toc523740876)

[4.7 Residential withdrawal 25](#_Toc523740877)

[4.8 Therapeutic day rehabilitation 28](#_Toc523740878)

[4.9 Residential rehabilitation 29](#_Toc523740879)

[4.10 Specialist dual diagnosis residential rehabilitation 31](#_Toc523740880)

[4.11 Subacute withdrawal and intensive stabilisation 32](#_Toc523740881)

[4.12 Pharmacotherapy 33](#_Toc523740882)

[5 Population-specific service systems 36](#_Toc523740883)

[5.1 Youth AOD services 36](#_Toc523740884)

[5.2 Aboriginal AOD services 43](#_Toc523740885)

[5.3 Forensic AOD treatment services 47](#_Toc523740886)

[6 Additional support 50](#_Toc523740887)

[6.1 Drug and alcohol clinical advisory service 50](#_Toc523740888)

[6.2 AOD Pathways service 50](#_Toc523740889)

[6.3 Statewide neuropsychology service 50](#_Toc523740890)

[6.4 Specialist alcohol and other drugs consultancy service 51](#_Toc523740891)

[6.5 The Victorian dual diagnosis initiative 51](#_Toc523740892)

[6.6 Women's AOD service 52](#_Toc523740893)

[6.7 Mother and baby residential withdrawal unit 52](#_Toc523740894)

[6.8 Reconnexion 52](#_Toc523740895)

[6.9 Medically supervised injecting room 52](#_Toc523740896)

[6.10 Compulsory drug withdrawal 53](#_Toc523740897)

[7 Sector planning, support and capacity building 55](#_Toc523740898)

[7.1 Catchment-based planning 55](#_Toc523740899)

[7.2 AOD emergency department initiative 56](#_Toc523740900)

[7.3 Research 56](#_Toc523740901)

[7.4 Peak and advocacy organisations 57](#_Toc523740902)

# Purpose of the guidelines

These guidelines provide information for funded agencies about the alcohol and other drugs (AOD) programs and services funded by the Victorian Department of Health and Human Services (the department).

The guidelines are divided into three sections.

**Part 1: overview** outlines the broad approach the department takes in relation to prevention, harm reduction and treatment.

**Part 2: program and service specifications** outlines the service specifications for particular programs and services.

[**Part 3**](#_PART_3:_Reporting,)**: quality, reporting and performance management** outlines key regulation and reporting requirements.

## This document

This document provides agencies with an understanding of the purpose, aims, target groups and key service requirements for Victorian Government-funded AOD services and programs.

These guidelines are designed to be used in conjunction with other key documents that outline the range of responsibilities and requirements that apply to funded organisations, including policy and funding guidelines, service agreements and legislative and regulatory requirements.

# Prevention and early intervention

The Victorian Government provides funding for a range of programs and services that aim to prevent or reduce the harm associated with AOD use.

## Information and support

### DrugInfo

The Alcohol & Drug Foundation’s (ADF) Drug Facts service provides easy access to information about AOD, including the prevention of related harms, with a range of free resources and publications accessible via the Drug Facts website, an SMS service and a telephone and email information line.

Drug Facts also delivers seminars and forums relating to AOD use to a wide range of audiences, provides resources to help parents have conversations with their children about AOD use, and hosts an email alert service for people who require responsive information in preventing AOD-related harm.

In addition, Drug Facts provides a specialist library service for people working or studying in AOD-related work settings, and contributes to peer-reviewed published research on prevention, public health, and AOD.

The ADF encourages professionals and members of the general community to use the service as their first port of call when looking for AOD information.

For more information refer to [ADF Drug Facts](http://www.adf.org.au/drug-facts) <www. adf.org.au/drug-facts> or contact 1300 85 85 84.

### SayWhen

SayWhen is an online screening and self-management tool for people who would like to check whether they are drinking alcohol at harmful levels and learn strategies to reduce their drinking, particularly in peer situations. SayWhen helps people learn the circumstances in which they are likely to misuse alcohol, and develop their own strategies for managing peer pressure. SayWhen is available through the Better Health Channel.

For more information refer to [SayWhen](http://mapi.betterhealth.vic.gov.au/saywhen). <http://mapi.betterhealth.vic.gov.au/saywhen>.

### Ready2Change

Ready2Change is an early intervention web and telephone-based drug support service run by Turning Point. It is a structured telephone intervention that provides support to people with AOD or gambling issues and motivates long-lasting change.

Ready2Change helps people assess, develop and self-manage their own strategies to reduce harmful drug use.

This program can provide support to individuals who have difficulties accessing face-to-face services due to time constraints, geography, employment, stigma and other barriers.

For more information visit the [Turning Point website](http://www.turningpoint.org.au) <www.turningpoint.org.au> or contact DirectLine 1800 888 236.

### Youth Drug and Alcohol Advice Service

YoDAA is Victoria’s specialist youth AOD advice service. It provides young people and families, carers, schools and professionals helping young people with AOD-related issues with information, tools, advice and support.

Further information about YoDAA’s interface with other youth-specific AOD services is set out in this document under Population-specific service systems.

For more information, visit the [YoDAA website](http://www.yodaa.org.au/) <http://www.yodaa.org.au/> or contact the advice line on 1800 458 685.

## Family support

Family members, including the dependent children of a person who is a client of an AOD treatment service, are eligible for focused support. A variety of support is available, including information, advice, referral, brief interventions and single session therapies, counselling, peer support and education programs.

The Victorian Government’s *Ice Action Plan* has provided for greater responsiveness to families of people with drug and alcohol issues through significant investment in family drug support services and education.

### Family Drug Help

Family Drug Help, a program of the Self Help Addiction Resource Centre (SHARC), provides services that aim to strengthen the physical and mental health of families impacted by someone’s alcohol or drug use, and support the family’s ability to cope with their individual situations. Family Drug Help provides a 24-hour helpline, and access to information and referral to support groups and family counselling. For further information on SHARC, see *Peak and advocacy organisations* in this document.

### Alcohol and other drug support services for families

Family drug support services are available through selected community health providers across Victoria. Providers deliver programs that are flexible and meet local population need and demand. Activities include peer support, group-based support, support for young people whose parents are affected by drugs, targeted support for siblings, grandparents, culturally and linguistically diverse communities (CALD) and Aboriginal people, individual support (such as counselling) and information sessions.

### Family drug education

The department funds family drug education workshops through a consortium of Turning Point, SHARC and The Bouverie Centre. Their education program Breakthrough: ice education for families, helps Victorians to recognise when a family member has a problem with ice, encourage the affected person to get treatment and support them through their recovery. For workshop dates and more information call 1800 ICE ADVICE (1800 423 238) or refer to [Breakthrough ice education for families](https://www.breakthroughforfamilies.com/). <https://www.breakthroughforfamilies.com>.

### Additional support

Intake services can provide brief interventions and single session therapy to families and significant others, and also refer to counselling services, as required. Referrals to family and generalist supports or group and peer-based programs and forums may be appropriate for some people.

For more information see *Catchment-based intake – family support* in this document.

# Harm reduction

The Victorian Government is committed to reducing the harm associated with AOD use. Harm reduction strategies are evidence-based public health approaches designed to reduce the negative consequences of ongoing AOD use.

## Education and awareness

The Victorian Government funds a number of agencies to provide targeted information, education and awareness around safer drug use. Providing drug users, peer workers and other harm reduction workers with access to information and training better equips them to manage and respond to problematic drug use.

Providing a range of educational material and information specifically tailored to illicit drug users can help reduce fatal overdoses and risky drug taking behaviours that result in significant harm for individuals and the wider community.

It is important that these messages are distributed widely, and are particularly accessible at needle and syringe program outlets, health services and through peer networks and other support services.

### Prevent Alcohol and Risk-related Trauma in Youth program

The Prevent Alcohol and Risk-related Trauma in Youth (PARTY) program is a full-day, in-hospital education program that aims to reduce risky AOD-taking behaviour among secondary school students by helping them to understand risks, choice and consequences. Delivered at the Royal Melbourne and The Alfred hospitals, the PARTY program covers the trauma, injury and poor health that can result from risk-taking behaviour and poor decision making, including AOD misuse. As part of the program, students are given first-hand experience in established trauma centres, hear from senior staff about what AOD can do to the body and brain, and have the opportunity to talk to patients and families that have been impacted by injuries resulting from risky behaviour.

The PARTY program at The Alfred has been expanded beyond a school-based education initiative to also reach young repeat offenders, navy trainees and youth in regional areas through their various outreach programs.

For more information on PARTY at The Alfred contact (03) 9076 8888 or refer to the [PARTY website](http://www.partyalfred.org.au/) <http://www.partyalfred.org.au/>.

For more information on PARTY at the Royal Melbourne Hospital contact (03) 9342 4294 or visit the [PARTY website](https://www.thermh.org.au/patients-visitors/services-clinics/trauma-care/party-program) <https://www.thermh.org.au/patients-visitors/services-clinics/trauma-care/party-program>.

## Overdose prevention and response training

Many fatal opioid overdoses are preventable. Victoria strongly supports efforts to ensure wide accessibility of naloxone, a lifesaving medication that can reverse the effects of an opioid overdose and allow time for an ambulance to attend.

Expanded distribution of naloxone to community members likely to witness overdose is recommended by the World Health Organization and has been found to safely and successfully reverse opioid overdoses in a range of settings.

In addition, the Victorian Government funds training for families, friends and front-line workers on how to safely use the drug to reverse the effects of an opioid overdose. Training for front-line workers focuses on needle and syringe program workers, drug outreach workers, other primary and community health workers. Overdose prevention and response training informs families, friends and front-line workers about how to connect individuals who have experienced overdose with AOD treatment services.

Specific programs aimed at naloxone training include:

* the Community Overdose Prevention and Education (COPE) initiative increases awareness of the availability and use of naloxone to general practitioners (GPs), pharmacists, other health workers, drug users and their families
  + the Drug Overdose Prevention Education (DOPE) program educates drug users who are the most likely to be present in the event of an overdose in overdose response, including naloxone administration.

## The Victorian needle and syringe program

The Victorian needle and syringe program (NSP) is a major public health initiative primarily intended to minimise the spread of blood-borne viruses (BBV) (i.e. HIV/AIDS, hepatitis B and C) among injecting drug users and into the wider community.

NSPs provide injecting drug users with sterile injecting equipment, sharps disposal containers, a range of sexual health products, as well as information, education and support.

NSPs can be stand-alone services with funded staff, or programs that operate within existing organisations such as community health services, hospitals, councils, AOD treatment agencies, youth organisations, and pharmacies.

NSP services may also be delivered through outreach services, including foot patrols and mobile NSPs and secure dispensing units.

More information about the NSP is available on the department’s website, [Needle and Syringe Program](https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-prevention-harm-reduction/needle-and-syringe-program). <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/aod-prevention-harm-reduction/needle-and-syringe-program>.

## Peer support

### Overview

Peer-based support programs are highly effective for communicating health promotion and harm reduction messaging to specific population groups, such as young people, injecting drug users or cultural groups.

Peer workers are an integral part of Victoria’s harm reduction response. They are trained and supported to educate their peers on safer ways to use drugs or reduce the negative consequences of their drug use. Peer workers can also model positive change as defined by the service user, rather than the service. Generally, people are very receptive to receiving harm reduction education from their peers and are more likely to take that advice on-board.

Peer education programs are also particularly effective in getting harm reduction messages to people who might be hard to reach or are disconnected from mainstream health services. They able to draw on their local knowledge and experience of drug use to identify those at risk of overdosing. Their support includes education and information on how to reduce the risk of drug-related harm, access to sterile injecting equipment and other tools to reduce the risk of overdose.

Peer workers also provide strategic consumer insight to policy and program development, and can assist in the development of new initiatives.

Harm Reduction Victoria, SHARC and the Association of Participating Service Users (APSU) are funded by the department to deliver a range of peer-based programs. In addition, most AOD activities require service providers to incorporate peer workers or peer support elements in their service models.

### Peer work

A peer workerwithin the AOD treatment sectoris a person, stable in their own recovery, who uses his or her lived experience of drug and alcohol issues, plus skills learned in formal training, to support a client’s change processes and recovery. This means a peer worker will have experienced drug and alcohol use and associated issues, but have also transitioned onto a path of recovery.

For further information, please see *Part 3: Attachment 8*, which provides further information about peer work and the peer workforce in the AOD Treatment Sector.

## Outreach and engagement

A number of services provide outreach and community engagement as part of their response to problematic drug use in their community.

Mobile drug safety workers and overdose response workers support NSP outlets and emergency services in dealing with overdose, providing education on harm reduction and treatment pathways for drug users.

Harm reduction outreach programs proactively engage with vulnerable people experiencing harm from AOD who are not engaged with mainstream health, social support or AOD treatment services. Often these vulnerable people are homeless with minimal social support. Outreach workers provide sterile injecting equipment, information, education and referral to a range of health and social services.

These programs often operate in areas where there are high levels of drug use, particularly injecting drug use. They can provide crisis overdose response, overdose prevention workshops, education, client assessments, short-term case management and to support access to a range of social and health services.

## Tailored facilities with trained staff

The Victorian Government funds dedicated facilities in areas of high drug use where users can access clean equipment, information, support and referral to treatment – including dedicated spaces that can be used by drug users.

Specialist AOD primary health services were established in 2000-01 in five metropolitan Melbourne drug use hotspots to provide a ‘one-stop-shop’ for vulnerable people including street-based injecting drug users and at-risk youth.

These services incorporate in-house healthcare services and case management, harm reduction education, and information about drug use and related health issues. Primary health services also provide advice and information via linkage and referral to other appropriate services and outreach.

# The treatment system

A broad spectrum of community-based and residential treatment options are available to people experiencing harms related to AOD use including:

* statewide screening and referral
* catchment-based intake
* assessment
* counselling
* care and recovery coordination
* non-residential withdrawal
* residential withdrawal
* therapeutic day rehabilitation
* residential rehabilitation
* specialist dual diagnosis residential rehabilitation
* subacute withdrawal and intensive stabilisation
  + pharmacotherapy.
  + The following section outlines the service specifications for each.

## DirectLine – statewide screening and referral service

DirectLine is a statewide telephone and online service which supports people seeking AOD information, advice or referral. Most clients identified as non-dependent users are offered telephone and online supports, including information and advice, brief interventions, worker-facilitated and self-guided supports, and referrals to non-AOD services. Clients identified as likely to require treatment for AOD related risk, harm or dependence are referred to catchment-based intake services. DirectLine offers information, advice and brief interventions before, during and after treatment and operates 24 hours a day, seven days a week.

### Purpose

To provide a statewide centralised point of access to the AOD service system offering around the clock access to confidential advice and support.

### Target group

DirectLine provides services for all Victorians, including metropolitan, rural and regional populations of primary AOD users, their families, friends, carers, and the wider community.

### Key service requirements

DirectLine:

* operates 24 hours a day, seven days a week
* provides online and telephone screening and facilitated referral to catchment-based intake services
* refers people who do not require AOD treatment services out of the system and to other health and human services as appropriate
* manages the bed vacancy register (BVR) in collaboration with catchment-based intake services and AOD treatment services
  + enhances access for people from rural and regional areas and those unable or unwilling to attend face-to-face services.

### Sector interface

DirectLine provides facilitated referrals for clients by linking them into a three-way telephone call with the appropriate catchment-based intake service. The DirectLine counsellor ensures that clients are handed over to a catchment-based intake service prior to leaving the call, where possible, and provides an introduction based on the initial telephone contact. Where the DirectLine counsellor is not able to speak with an intake worker in the appropriate catchment, with the client’s consent DirectLine emails the service with information about the caller. This email includes contact details and preferences regarding next business day contact by the service.

#### Communication

DirectLine should be kept informed about any issues impacting on client flow to intake and treatment services.

#### After-hours support

Where an after-hours response is not in place at catchment-based intake services, DirectLine will accept diverted phone calls. DirectLine counsellors can provide immediate support and information to callers seeking information and advice out-of-hours, and provide advice about accessing local services during business hours.

#### Drug Diversion Appointment Line

DirectLine manages the Drug Diversion Appointment Line (DDAL) from Victoria Police. Low-risk clients receive a structured telephone intervention at DirectLine while substance dependent or at risk clients are referred to the relevant catchment-based intake service to access a ‘DDAL intervention’ and further support. This may include referral for assessment and treatment if required. For further DDAL information, please see Part 2: Heading [4.2.5.6 Diversion](#_Diversion).

#### Victoria Police e-Referral system

The Victoria Police e-Referral system (VPeR) is a statewide IT referral system that enables police members to refer persons in need of support to services in the course of their day-to-day duties. Referrals relating to AOD are directed to DirectLine.

When a referral is made through VPeR to DirectLine, one outbound telephone follow-up attempt is made to the subject of the referral. Where that person is able to be contacted – information, advice, a brief intervention and, where appropriate, referral to treatment services are provided. If that person is unable to be contacted, a single SMS with DirectLine contact details is sent.

## Catchment-based intake

The catchment-based intake function provides local knowledge to support client pathways to all Victorian AOD services, inclusive of youth, adult, residential and non-residential, Aboriginal, state and commonwealth-funded AOD services. Intake services assist people to navigate the AOD service system and engage proactively with treatment providers on behalf of, and in partnership with, AOD clients and their families.

Catchment-based intake services work closely with the statewide screening and referral service and other treatment providers to facilitate client intake, triage, and referral to treatment, including the use of brief interventions and bridging support as required. Intake services also support families and significant others of people with AOD issues.

Person-centred treatment is a governing principle in the delivery of intake services. Clients may choose to seek intake services outside their residential catchment. Access to AOD services is not limited by catchment boundaries.

While the Australian Community Support Organisation (ACSO’s) Community Offenders Advice and Treatment Services (COATS) program undertakes the majority of intake services for forensic clients, catchment based intake may receive referrals for court based diversion programs clients such as the Court Integrated Services Program (CISP), Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) program and the Assessment and Referral Court List (ARC List). These clients are then referred on to assessment and treatment services as required and COATS are notified of the referral.

For further information, see *Forensic programs and services* in this document.

### Purpose

Catchment-based intake services are the critical entry points into the Victorian AOD service system and they support the movement of existing AOD clients through the system.

In each catchment, the intake service determines and prioritises client access for Victorian Government-funded AOD treatment services.

Catchment-based intake services improve equity of access to treatment by prioritising vulnerable and at-risk clients. People entering the treatment system go through intake and are triaged according to risk and need.

Prioritisation and referrals are made according to client’s needs and service availability, rather than being based on relationships between service providers.

Intake services use clinical judgement, supported by the department-endorsed standardised intake tool, to identify a person’s level of risk and need and to determine appropriate treatment pathways.

### Target group

Intake providers offer services to people aged 16 years and older. Young people aged up to 25 years are offered the choice to attend a youth AOD service, as appropriate. There is no upper age limit in place for AOD services.

Intake services also support families and significant others of people with AOD issues.

### Key service requirements

Catchment-based intake services undertake the following activities.

* Identify and respond to the clinical AOD treatment and support needs of all clients and their families (including dependent children) with appropriate approaches to CALD, Aboriginal, LGBTI, dual diagnosis, homeless and some forensic clients.
* Deliver timely, high-quality, culturally safe intake and triage for people seeking AOD treatment. This is done using clinical judgement, supported by the department-endorsed intake tool.
* Support a consistent catchment-wide approach to accessing treatment that allows intake services to improve equity, by prioritising clients according to need.
* Maintain records of client flow across the entire catchment, within relevant legislative obligations, in order to understand service capacity in the catchment and inform pattern and volume of referral from intake to treatment and support services. Local protocols and agreements between intake providers and other AOD providers will support this process.
* Provide brief interventions in the form of education and advice that aims to achieve a short-term reduction in harm associated with AOD use. This may include crisis intervention, harm reduction measures, relapse prevention planning, and support for co-occurring issues, such as mental health.
* Provide bridging support in the form of regular contact which aims to support client engagement, retention, motivation and stability while clients wait for assessment and treatment.
* Be based in location/s that is/are easy to access, operate Monday to Friday during standard business hours, and demonstrate capacity for after-hours responsiveness.
* Deliver intake and triage via face-to-face, telephone and online modes, as well as on an outreach basis as required.
* Receive client referrals from the statewide screening and referral service, and other health/human services/support services, including child protection.
* Work with other catchment-based intake services, the statewide screening and referral service, the Australian Community Support Organisation (ACSO) and the BVR to coordinate referrals into the residential system.
* Establish strong relationships with all AOD providers and other service providers (including mental health, child protection and family services) in the catchment to support smooth referral pathways and maintain local knowledge of the range of AOD treatment and support options available to clients.
* Maintain knowledge of a variety of relevant local and statewide health and human service support options such as services specialising in dual diagnosis, homelessness and family violence.
* Refer clients to their treatment destination or other support services as required.
* Refer ‘complex’ and residential AOD clients to care and recovery coordination and liaise with the provider of that function to initiate longer-term care planning for eligible clients. This may also include ensuring the client is appropriately connected to further treatment and support post-withdrawal.
* For clients not receiving care and recovery coordination, and who have completed an initial course of treatment (e.g. non-residential withdrawal), the intake service may refer the client for a subsequent course of treatment.
* Promote the service to other health/human/support services, including GPs and justice services, so they know where to refer their clients if they have AOD issues.
* Provide advice to assist families in their support role, and engage family members in the intake process where appropriate.
* Provide, with the appropriate consent, information in relation to a client (including client summaries) to the original referral source, as well as to the services the client has been linked with. For example, this may include notifying a client’s GP of the treatment service and treatment type they have been referred to.
* Prioritise people with significant issues regarding risk and complexity, including people subject to or discharged from involuntary detention and treatment under the *Severe Substance Dependence Treatment Act 2010* (SSDTA) and people on family reunification orders under the *Children, Youth and Families Act 2005* (where there is an alcohol condition).
  + Work closely with St Vincent's Health to ensure that clients who are detained and treated for compulsory AOD withdrawal under the SSDTA programare engaged with care and recovery coordination prior to discharge from the treatment centre.

### Funding model and accountability

This function is funded through an activity-based model. Payment is made on the basis of a standard fixed price. A different price is set for each mode of contact. For further information about pricing please refer to the *Funding and Policy Guidelines* available at <<https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>>

The provider is expected to report activity to the department on a regular basis. Other measures may be developed as part of the performance management framework for AOD treatment services.

The standard fixed price is indicative only and service providers should not determine the length of a course of treatment or the number of contacts provided based on the price of an average product.

The department will not pay for additional activity beyond the agreed activity.

### Additional information

#### ‘Walk-ins’

‘Walk-in’ intakes should only be completed by treatment providers in exceptional circumstances. It is expected that local services will work together to agree on options for facilitating access to intake services for clients that present directly to treatment services in person or via phone.

Flexibility remains for treatment providers to conduct direct intake or deliver a brief intervention for clients or family members requiring an immediate face-to-face service where urgent need exists. Where intake is conducted by treatment providers, services should ensure that this information is shared with the catchment-based intake provider to enable capacity monitoring and support client movement through the AOD service system. This allows the catchment-based intake service to continue to support the equitable prioritisation of clients to AOD treatment based on risk and need.

#### Using department endorsed tools

Practitioners providing intake are required to use the department-endorsed intake tool. The intake tool, combined with clinical judgement is used to identify and respond to client’s treatment and support needs. This work should occur with the support of clinical supervision.

The intake tool and accompanying Victorian AOD clinician guide can be found on the department’s website, [Intake process and tools](https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treatment). <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treatment>

#### Varying a client’s standard and complex status

A person’s level of life issues and personal circumstances, influenced by housing, employment and psychological distress, influence eligibility for ‘standard’ and ‘complex’ courses of treatment. Complexity is indicated at intake, and confirmed at assessment. Changes in client circumstances and wellbeing may influence a client’s complexity status. Changes in client circumstances and wellbeing may change a client’s eligibility for standard and complex treatments. In these cases, counselling, non-residential withdrawal and care and recovery coordination providers may vary a client’s standard or complex status.

When this occurs, providers advise catchment-based intake providers of the change in status to assist in monitoring capacity. Catchment-based intake services are to acknowledge variation notifications.

#### Clinical governance of clients on waitlists

Intake providers retain clinical responsibility for a client referred to another service's waitlist until the receiving service accepts the client's transfer of care, or delivers any intervention or any activity to that client. From this point, the clinical governance responsibility for a client on a waitlist is shared between the referring and the receiving services. Shared responsibility continues until the receiving service begins any assessment or treatment activity, at which point the clinical governance responsibility becomes the responsibility of the treatment service.

Clear expectations of clinical responsibility will be underpinned by clear communication processes between referring and receiving services.

Clinical governance is a clinical rather than operational issue and is managed by services in the context of their own clinical governance and risk management strategies.

#### Family support

Services should be responsive to the needs of families and significant others of people with an AOD issue, even when the person is not yet engaged in treatment. Depending on the needs of families and significant others, referrals may be made to family and generalist supports or group and peer-based programs and forums where these are available. If appropriate, intake providers can provide brief interventions or single session therapy for families and significant others and refer to counselling services where this need is identified. Referrals to family and generalist supports or group and peer-based programs and forums may be appropriate for some people.

#### Diversion

Catchment based intake services are required to accept DDAL referrals and provide 'DDAL interventions' to DDAL clients. DDAL interventions may be delivered via face-to-face or phone and can be delivered via two separate or back to back sessions. All intake services are expected to regularly advise Turning Point of their available appointment times and ensure they have additional capacity available during festival periods.

The intensity of the DDAL intervention session will be influenced by the client’s substance use severity and life complexity. DDAL clients who are identified as needing AOD treatment beyond the DDAL requirement should be referred on for assessment and treatment as required.

Catchment-based intake services are required to submit Treatment Compliance Advice (TCA) forms to ACSO for all DDAL clients on completion of the intervention. ACSO will provide this information to Victoria Police to advise whether the client has met the conditions of the diversion.

Catchment-based intake services are also required to provide support to other ‘informal’ pre-charge or pre-sentencing forensic diversion clients. These include people who present to the catchment-based intake service who are not on a formal diversion order, but who are seeking treatment to address their AOD-related offending behaviour. This may include people referred by Victoria Police, courts, solicitors, legal aid and drink/drug drive providers.

For all ‘Formal’ diversion clients who are required to attend an AOD service to meet the conditions of their diversion plan, as ordered by a magistrate or court program, they may be referred for assessment and treatment by ACSO-COATS.

For further information see Part 3: Heading 5.1.1 Intake and assessment for forensic diversion clients.

#### Intake and assessment for forensic clients

ACSO’s Community Offenders Advice and Treatment Services (COATS) program undertakes the majority of forensic intake and assessment services for forensic clients. This is the case for clients referred through Community Corrections and the Adult Parole Board. For further information, see *Forensic programs and services* in this document.

## Assessment

Assessment providers work closely with catchment-based intake services, the statewide screening and referral service, and other treatment providers to facilitate comprehensive assessment and treatment planning for voluntary clients.

The assessment function supports client pathways to all Victorian services, inclusive of youth, adult, residential and non-residential, Aboriginal, state and commonwealth-funded AOD services. Person-centred treatment is a governing principle in the delivery of assessment services.

Assessment is conducted by treatment providers to enable therapeutic treatment relationships to begin at the point of assessment. Where possible, the assessment should be conducted by a clinician who is appropriate for the client’s ongoing treatment to reduce ‘extra steps’ in a client’s treatment journey.

While ACSO’s Community Offenders Advice and Treatment Services (COATS) program undertakes the majority of assessments for forensic clients, AOD providers may receive referrals for court based diversion programs clients such as the Court Integrated Services Program (CISP), Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) program and the Assessment and Referral Court List (ARC List). On occasion AOD providers may also undertake an assessment a Drug Diversion Appointment Line (DDAL) client.

Assessments may also be provided to ‘informal’ or ‘other’ diversion forensic clients who may have legal matters of a non-criminal nature pending of which their drug or alcohol use is related or a concern. These referrals may come from the courts, solicitors, legal aid and drink / drug drive providers.

These clients are then referred for treatment services as required and COATS are notified of the referral.

For further information, see *Forensic programs and services* in this document.

### Purpose

Assessment is used as to determine the level and type of treatment and support required by presenting clients. Those providing assessment use the department-endorsed comprehensive assessment tool and clinical judgement. This work should occur with the support of clinical supervision.

Assessment ensures that a client’s comprehensive treatment needs are adequately understood so that they can access the services most suitable to their needs. Optional assessment modules provide a detailed understanding of particular strengths, issues or experiences that may have been flagged intake or assessment, or that may require further consideration.

Practitioners providing assessment develop an initial treatment plan for all clients that forms part of a package of referral information provided to services engaged in the client’s treatment pathway.

### Target group

Assessment is provided to clients seeking treatment and support to address the causes of their AOD-related risk, harm, dependence or related issues. Assessment providers offer services to people aged 16 years and older. Young people aged up to 25 years are offered the choice to attend a youth AOD service, as appropriate. There is no upper age limit in place for AOD services.

### Key service requirements

Assessment providers are required to accept all referrals from catchment-based intake services.

Assessment providers undertake the following activities.

* Identify and respond to the clinical AOD treatment and support needs of all clients and their families (including dependent children) with appropriate approaches to CALD, Aboriginal, LGBTI, dual diagnosis, homeless and forensic clients.
* Deliver timely, high-quality, culturally safe assessment for people seeking AOD treatment. This is supported by use of the department-endorsed tool, thus reducing the need for repeat assessments and providing immediacy of response.
* Provide brief interventions in the form of education and advice that aims to achieve a short-term reduction in harm associated with AOD use. This may include crisis intervention, harm reduction measures, relapse prevention planning, and support for co-occurring issues, such as mental health.
* Provide bridging support in the form of regular contact which aims to support client engagement, retention, motivation and stability while clients wait for treatment.
* Develop initial treatment plans that accompany clients to their treatment destination.
* Refer clients for appropriate treatment and support, considering the full potential needs of each client (including the range of services available from other providers).
* Work with catchment-based intake services to understand service demand, capacity, availability and issues affecting specific cohorts such as people who are involved with the child protection system.
* Be based in location/s that is/are easy to access, operate Monday to Friday during standard business hours, and demonstrate capacity for after-hours responsiveness.
* Deliver assessment services via face-to-face, telephone and online modes, as well as on an outreach basis as required.
* Receive client referrals from catchment-based intake services, the statewide screening and referral service and other health/human services/support services, including child protection.
* Refer ‘complex’ and residential AOD clients to care and recovery coordination and liaise with the provider of that function to initiate longer term care planning for eligible clients. This may also include ensuring the client is appropriately connected to further treatment and support post withdrawal.
* For clients not receiving care and recovery coordination, and who have completed an initial course of treatment (e.g. non-residential withdrawal) the assessment provider may refer the client for a subsequent course of treatment.
* Work with the catchment-based intake services, ACSO, the statewide screening and referral service and the BVR to coordinate catchment-based referrals into the residential system.
* Collaborate closely with intake services to facilitate information transfer about client movement and advise local catchment-based intake service of the movement of clients into and out of their services, within their relevant legislative obligations.
* Work with catchment-based intake services to deliver a seamless experience for clients. For example, this could include providing information about assessment availability to intake services to enable live assessment appointment booking.
* Promote the intake service to other health/human/support services, including GPs and justice services, so they know where to refer their clients if they have AOD issues.
* Provide advice to assist families in their support role.
* Provide, with the appropriate consent, information in relation to a client (including client summaries), to the original referral source, intake service as well as to the services the client has been linked with.
  + Prioritise people with significant issues regarding risk and complexity, including people subject to or discharged from involuntary detention and treatment under the SSDTA.

### Funding model and accountability

This function is funded through an activity-based model. Payment is made on the basis of a standard fixed price. For further information about pricing please refer to the *Funding and Policy Guidelines* available at <<https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>>

The provider is expected to report activity to the department on a regular basis. Other measures may be developed as part of the performance measurement framework for AOD treatment services.

The standard fixed price is indicative only and service providers should not determine the number of contacts provided based on the price of an average product.

The department will not pay for additional activity beyond the agreed activity.

### Additional information

#### ‘Walk-ins’

‘Walk-in’ assessments not referred from intake should only be completed by assessment and treatment providers in exceptional circumstances. It is expected that local services will work together to agree on options for facilitating access to assessment services for clients that present directly to treatment services in person or via phone.

Flexibility remains for assessment and treatment providers to conduct an assessment not referred from intake or deliver a brief intervention for clients or family members requiring an immediate face-to-face service where urgent need exists. Where assessment is conducted in this way, services should ensure that this information is shared with the catchment-based intake provider to enable capacity monitoring and support client movement through the AOD service system. This allows the catchment-based intake service to continue to support the equitable prioritisation of clients to AOD treatment based on risk and need.

#### Using department endorsed tools

Practitioners providing assessment are required to use the department-endorsed comprehensive assessment tool. The assessment tool, combined with clinical judgement is used to identify and respond to a client’s treatment and support needs. This work should occur with the support of clinical supervision.

The comprehensive assessment tool and accompanying Victorian AOD clinician guide can be found on the department’s website: <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treatment>

#### Comprehensive assessment and initial treatment plan

Comprehensive assessment continues to consider the full potential needs of each client (not just the services available within the treatment provider conducting the assessment).

Information collected at intake, the comprehensive assessment, the identified treatment needs and the client’s own preferences inform the development of the initial treatment plan.

Assessment services should engage family members in the development of the initial treatment plan as appropriate.

#### Treatment pathways

There may be cases where a client requires (or prefers) ongoing treatment to be delivered by a provider who is not their assessment provider. In order to refer a client appropriately, assessment providers should work with the client and catchment-based intake services to understand the range of treatment options available to meet the client’s needs.

Treatment providers should work closely with catchment-based intake services to understand the capacity of services to which they refer clients, to inform the pattern and volume of referral.

Clients seeking additional AOD treatment beyond a current course of treatment are not required to return to the catchment-based intake service. In most cases, the existing treatment provider can facilitate access to further treatment, update the treatment plan and inform the catchment-based intake service of the client’s allocation to a new course of treatment or episode of care. This referral activity is built into the funding product of the existing treatment provider (e.g. course of counselling, withdrawal or care and recovery coordination).

Clients may be referred for re-assessment if a significant change in need or life complexity suggests that this is warranted.

#### Diversion

ACSO COATS receives direct referrals for court based diversion programs clients such as the Court Integrated Services Program (CISP), Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) program and the Assessment and Referral Court List (ARC List)

ACSO will then refer these clients on to assessment and treatment services as required and notify catchment intake services of the referral.

## Counselling

AOD counselling services are provided by a range of health professionals including counsellors, social workers, psychologists, GPs, consultant physicians and psychiatrists. At completion of counselling treatment, clients leave with an exit plan or continue to work with the care and recovery coordination function for further supported referral.

Different modes of counselling include face-to-face, online and telephone consultations for individuals and families, as well as group counselling and day programs.

### Purpose

Counselling supports positive behavioural change in people by providing evidence-based therapeutic individual, group and family counselling interventions.

### Target group

Counselling is available from community-based treatment services for adults and young people aged 16 years and above and, when appropriate, their families, either as individuals or in groups.

### Key service requirements

The key features of the counselling stream include:

* the delivery of evidence-based, therapeutic individual, group and family counselling interventions
* a focus on recovery-oriented care
* priority access for ‘complex’ clients and those transitioning to and from bed-based services
  + the use of new technologies as an adjunct to counselling.

All funded counselling services must meet the following service requirements.

* Operate during standard business hours and demonstrate capacity for after-hours service.
* Deliver therapeutic counselling interventions of varying duration and intensity to individuals, families and groups.
* Liaise with care and recovery coordination regarding care planning, referrals and progress and to prevent duplication of service as required.
* In collaboration with the client and their family, build, if appropriate, on the client’s initial treatment plan to:
  + - determine details of the type of counselling interventions required to address the therapeutic needs of the person, building on the plan provided at assessment
    - deliver evidence-based psychosocial interventions including but not limited to brief interventions, cognitive behavioural therapies, community reinforcement therapy, contingency management, motivational enhancement therapy, social behavioural therapy and group work
    - undertake exit planning.
* Work flexibly to meet people’s varying needs, including on an outreach basis as appropriate.
* Provide secondary consultation where required. This may include providing information and support to respond to needs for clients involved with child protection and other human services.
* Make follow-up contact with standard clients at three and 12 months post-treatment exit to:
  + - track progress of recovery post-treatment
    - support re-engagement with AOD treatment services or other supports, where appropriate.
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.
* Support priority access and fast-tracking of people identified with significant issues regarding risk and complexity. People discharged from compulsory detention and withdrawal treatment under the SSDTA are a priority group for access and treatment. Other priority groups include people with at-risk dependent children, homeless clients, Aboriginal clients, clients with an acquired brain injury (ABI) or mental illness, justice/forensic clients, clients transitioning to and from residential services, and clients who require treatment as part of an order under the Children, Youth and Families Act, to assist in reunification with their children.

Funding model and accountability

This function is funded through an activity-based model.

* + Payment is made on the basis of a standard fixed price. Counselling clients are classified as standard or complex according to their substance severity and life complexity. For further pricing information, please refer to the [*Funding and Policy Guidelines*](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines)<https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

Duration can range from a brief intervention/single session to extended periods of one-to-one engagement or group work. Where counselling is delivered through group programs, the following activity lines are used as an initial guide depending on the duration and intensity of the group program:

* Brief intervention – for each client that has participated in a group program pre-commencement or as an alternative to treatment or with an average duration of 12 hours, a course can be recorded. This could include clients participating in a group program around treatment readiness or relapse prevention.
* Standard counselling – for each client that has participated in a group program with an average duration of 15 hours, a course can be recorded.
  + Complex counselling – for each client that has participated in a group program with an average duration of 50 hours, a course can be recorded. Work undertaken as part of therapeutic day programs is recorded under a separate function.

There is scope for reclassifying between standard and complex should a client’s clinical requirements change significantly during the treatment episode, or to source another additional treatment activity in some instances.

The provider is expected to report activity to the department on a regular basis. Other measures may be developed as part of the performance measurement framework for AOD treatment services.

The standard fixed price is indicative only and service providers should not determine the length of a course of treatment or the number of contacts provided based on the price of an average product.

The department will not pay for additional activity beyond the agreed targets.

## Care and recovery coordination

This stream includes coordinating treatment planning and goal setting, and supported referral to services. Care and recovery coordination is an additional individualised and flexible support that supplements other AOD treatment services over a longer period. The duration and intensity of the service varies depending on a person’s need. Care and recovery coordination is available before, during and after a client's treatment for up to 12 months.

### Purpose

Care and recovery coordination seeks to support integrated treatment and care pathways for the highest-need/risk clients within AOD treatment services, who require a coordinated care response by, at a minimum:

* coordinating treatment planning and care in accordance with recovery goals
* supporting clients’ access to other health, human and support services
  + supporting meaningful involvement by the client and their family in care coordination and goal setting to maximise opportunities for meaningful social and economic participation.

### Target group

This service is designed for people with the highest need or who are at the greatest risk.

People are referred for care and recovery coordination when the catchment-based intake service or the assessment provider indicates that the client requires a complex intervention. Referrals may also be made through other treatment streams offered by treatment providers, for example, withdrawal services. People eligible for care and recovery coordination typically present with behaviours or conditions that:

* place the individual at high risk to self, to staff or the community
* are identified at assessment as requiring a long-term supportive service, often requiring residential treatment
  + are clients of, or recently discharged from, compulsory withdrawal treatment under the SSDTA.

### Key service requirements

Care and recovery coordination includes the following activities.

* Deliver care coordination to the highest-need/risk clients who present with characteristics of complexity.
* Deliver pre-care support to complex clients on waiting lists via multiple modalities (for example, telephone, face-to-face, online).
* Deliver care coordination throughout a client’s AOD treatment pathway, and post-exit for up to 12 months from commencement of treatment.
* Create and sustain strong interagency connections and more integrated service responses to meet the holistic needs of clients. To facilitate interagency connections, common service coordination tools such as the Service Coordination Tool Template tools are used where appropriate.
* Dedicate capacity to respond to the needs of Aboriginal clients.
* Demonstrate capacity to respond to other priority groups as relevant to each catchment.
* Use peer support as an important and valid service response for clients as relevant to local need.
  + Coordinate homeless-specific service responses for clients as relevant to local need.

Care and recovery coordination operates on a catchment basis, with flexibility to service multiple sites, via face-to-face and telephone modalities, at a minimum. It delivers services to clients 52 weeks a year, Monday–Friday during standard business hours and has capacity for after-hours service. This function is focused on responding to urgent client needs.

All funded care and recovery coordination services must meet the following service requirements.

* Receive eligible client referrals from catchment-based intake services and assessment providers.
* Work with clients, their families and other key services (including catchment-based intake services and assessment providers) to develop care and recovery plans that:
  + - are informed by the comprehensive assessment and initial treatment plan
    - identify a clear treatment pathway where multiple interventions are required
    - identify service coordination activities
    - set out specific, measurable, achievable, realistic and time-bound goals so that treatment and recovery can be tracked and regularly reviewed
    - identify and provide information and services to address the associated needs of families and dependent children.
* Be responsive to the individual treatment needs of clients, including variations in the intensity and duration of treatment (e.g. intense treatment over a short period, less intense over a longer period).
* Provide clients with supported referral to other AOD treatment services as required.
* Liaise with AOD treatment services regarding the person’s progress against treatment goals.
* Deliver information, advice and brief interventions such as motivational interviewing or group work and relapse prevention to clients, as required.
* Facilitate access to other health and human services support that the client may require.
* Lead care coordination or provide support where the person has an existing care coordination worker (for example, a forensic or department worker including mental health and community support service workers), to ensure continuity of care for the person, by:
  + - preparing the client for their next phase of treatment or care
    - onward referral, liaison, case conferencing or collaborative work with other service providers, including those beyond the AOD sector, to meet the needs of the client
    - identifying and linking clients to peer workers, volunteers and broader community supports
    - advocating on behalf of clients, where necessary.
* Undertake discharge planning, recording goals/outcomes achieved and post-treatment goals.
* Deliver assertive follow-up of care and recovery coordination clients at three and 12 months post-treatment exit to:
  + - track progress of recovery post-treatment
    - support re-engagement with AOD treatment or other supports, where appropriate.
* Care and recovery coordination providers incorporate activities tailored to specific priority populations and as such, involve significant outreach and interagency collaboration.
* Create and sustain strong interagency connections with, for example, local ACCHOs, prescribing GPs, dispensing pharmacies, housing workers, and homelessness support, child protection, family services, debt/financial counselling, employment services, ABI support services and community health services.
* Work closely with the provider of compulsory withdrawal treatment under the SSDTA to:
  + - prioritise access to care and recovery coordination for clients detained for compulsory withdrawal treatment under the SSDTA
    - ensure care and recovery coordination is available prior to and following discharge from compulsory withdrawal treatment.
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.

### Funding model and accountability

This function is funded through an activity-based model. Payment is made on the basis of a standard fixed price. For further information about pricing please refer to the [*Funding and Policy Guidelines*](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines)*.* <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

The price is set for a course of coordination of up to 12 months duration. The price of an average course of care and recovery coordination is indicative only, and service providers should not determine a client’s length of treatment based on the price of an average course of treatment. Clinical need may warrant additional treatment courses to also be provided.

The provider is expected to report activity to the department on a regular basis and participate in any evaluation as required. Other measures may be developed as part of the performance measurement framework for AOD treatment services.

The department will not pay for additional activity beyond the agreed targets.

## Non-residential withdrawal

Non-residential withdrawal involves a clinical withdrawal assessment, withdrawal treatment and referral and information provision via face-to-face and telephone, at a minimum. Non-residential withdrawal services are located in each of the catchments. Non-residential withdrawal is available in a variety of settings and may be provided in coordination with medical services such as hospitals, GPs and addiction medicine specialists. The service model may differ from catchment to catchment and is responsive to local need.

The Third Edition of the *Alcohol and other Drug Withdrawal Guidelines* are available on the [Turning Point website](https://www.turningpoint.org.au/treatment/clinicians/withdrawal-guidelines%3e). <https://www.turningpoint.org.au/treatment/clinicians/withdrawal-guidelines>

### Purpose

Non-residential withdrawal supports people to safely achieve neuroadaptation reversal or stabilisation through an abrupt cessation or gradual reducing regime.

Non-residential withdrawal seeks to:

* cease or reduce substance use to a level that restores a person’s health and wellbeing in the short-term
* provide a firm foundation for a person’s longer-term improved health and wellbeing
* provide a step-up or step-down response for clients requiring stabilisation, including pre- or post-residential withdrawal treatment
  + form part of an integrated and coordinated care pathway by linking complex clients with the care and recovery coordination function.

### Target group

Non-residential withdrawal may be suitable for:

* low to medium-risk clients aged 16 and over with an AOD dependence
* clients with a level of stability in their lives exhibited by supportive friends or family, or stable housing
* clients accessing shared care arrangements with rural hospitals
  + higher-risk clients requiring non-residential treatment, including targeted step-down withdrawal support following residential withdrawal treatment.

Where a person is assessed as needing non-residential withdrawal, they are referred for this service. Prioritisation of access to non-residential withdrawal is based on level of acuity and need, including psychosocial need.

There are a number of clients whose AOD use requires a residential withdrawal response, but whose concurrent mental health issues or behavioural problems make it difficult for them to successfully engage in a residential withdrawal setting. These clients may be assessed as suitable for non-residential withdrawal as part of their stepped care pathway. In such cases continual risk assessment is a critical component of treatment.

Non-residential services also provide step-down support to clients discharged from residential withdrawal services, especially those for whom the duration of the withdrawal syndrome goes beyond the duration of their residential admission. For example, clients experiencing protracted withdrawal from methamphetamine or benzodiazepines may require further treatment support available through non-residential withdrawal.

### Key service requirements

All funded non-residential withdrawal services must meet the following service requirements.

* Operate Monday–Friday during standard business hours and ensure after-hours support where required.
* Build on the treatment plan or residential withdrawal discharge plan to determine the clinical components of the withdrawal treatment required, engaging and involving clients and families as appropriate.
* Deliver clinical withdrawal assessment, withdrawal treatment, referral and information via face-to-face and telephone modalities.
* Provide access to a medical practitioner, including GPs or addiction medicine specialists to provide generalist and specialist medical support during and post-withdrawal, as required.
* Provide access to appropriate nursing care, including withdrawal nurses, AOD nurse practitioners, nurse practitioners, mental health nurses and practice nurses, as required.
* Use evidence-based withdrawal management, pharmacotherapies and behavioural therapies, symptomatic medications and supportive care consistent with best practice.
* Link clients to further AOD treatment, and refer to other health/human services support services, as required.
* Link with care and recovery coordination services to ensure that continuity of care is maintained for clients along their entire treatment and care pathway, as well as deliver post-withdrawal care that addresses psychological, social and behavioural problems associated with substance dependence as required.
* Work with the catchment-based intake service, the assessment provider and care and recovery coordination to manage the period between when a client is assessed as requiring non-residential withdrawal and their entry into treatment.
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.
* Work with the provider of compulsory withdrawal treatment under the SSDTA to support the discharge of clients from a drug treatment order into voluntary withdrawal treatment (St Vincent’s Health).
* Actively include family and/or significant others in withdrawal treatment process by assisting clients to develop better connection with the family and the community – this includes preparing the family and/or significant others for the process of AOD withdrawal as well as including them as is appropriate in the withdrawal process and discharge plan.
  + Ensure medical/clinical oversight is in place during a person’s withdrawal.

Non-residential withdrawal treatment is not a stand-alone treatment. Rather, it is one step towards commencing sustained behaviour change. Post-withdrawal treatment such as counselling, rehabilitation and maintenance pharmacotherapy can support longer-term behavioural change.

The main pathway into non-residential withdrawal treatment is through catchment-based intake, assessment and same-service referral (i.e. from another stream within the same AOD treatment service). Intake and comprehensive assessment information travels with clients to their new treatment provider. Non-residential withdrawal providers should work with the catchment-based intake service, assessment provider and the care and recovery coordination function to ensure clients are linked to further AOD treatment such as counselling and/or other health, human services and support services, as required.

People that have been subject to involuntary detention and treatment under the SSDTA are a priority group for access and treatment. Other priority groups include people with at-risk dependent children, homeless clients, Aboriginal clients, clients with an ABI or mental illness and justice/forensic clients.

Funding model and accountability

This function is funded through an activity-based model. Payment is made on the basis of a standard fixed price. There are two prices for non-residential withdrawal, based on whether a client has been assessed as standard or complex. For further information about pricing please refer to the [*Funding and Policy Guidelines*](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines)*.* <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

The two prices are based on the average number of contacts required for a course of non-residential withdrawal across the client population. The model has been designed this way to give providers the flexibility to respond to a spectrum of client need.

There is scope for reclassifying between standard and complex should a client’s clinical requirements change significantly during the treatment episode, or to source another additional treatment activity in some instances.

The provider is expected to report activity to the department on a regular basis. Other measures may be developed as part of the AOD performance measurement framework.

The department will not pay for additional activity beyond the agreed activity and targets.

## Residential withdrawal

Residential withdrawal services support clients to safely withdraw from AOD dependence, in a supervised residential or hospital facility.

The Third Edition of the *Alcohol and other Drug Withdrawal Guidelines* are available online on the Turning Point website. <<https://www.turningpoint.org.au/treatment/clinicians/withdrawal-guidelines>>

### Purpose

The primary purpose of community residential drug withdrawal is to achieve effective neuroadaptation reversal from alcohol and other drugs of dependence. Withdrawal is not a stand-alone program but rather one step contributing to longer-term behaviour change.

### Target group

Residential withdrawal may be appropriate for people with complex needs, including medically complex withdrawal symptoms and other life, family and accommodation circumstances. The following populations may be better suited to residential withdrawal treatment options:

* clients who require 24-hour supportive care and medical supervision to withdraw
* clients with psychological or social crises requiring a high level of support
* clients requiring pharmacotherapy and medical care for acute withdrawal symptoms and non-acute illnesses
* clients assessed as ‘complex’ with a moderate to high AOD dependence, poly drug use, or a history of previous unsuccessful withdrawal attempts
  + clients whose family or accommodation circumstances are less stable, such as clients lacking supportive friends or family, or stable housing.

### Key service requirements

All funded AOD community residential withdrawal services must meet the following service requirements.

Access

Accessible, timely and targeted intervention enhances the likelihood of positive outcomes. Accessibility encompasses responsiveness to geographic, cultural, age, gender, individual and family circumstances. It also relies on a strong consumer focus, encompassing consumer involvement in the planning and review of treatment and service accessibility. To be accessible, services must:

* provide a respectful and caring approach that responds to individual and family circumstances taking into account geographic, cultural, family, age and gender circumstances
  + encourage and consider consumer feedback across key aspects of service planning and delivery.

#### Preparation

Preparing individuals for the withdrawal process includes informing them about the facility, program, withdrawal process and expectations. This also includes initial screening for suitability for the service and the needs of each individual. Support strategies should be in place while individuals await admission. Preparation contributes to building rapport between individuals and treatment staff, which in turn leads to improved engagement and better outcomes. Preparation includes telephone and face-to-face interactions.

Services must:

* ensure that individuals understand the treatment process and purpose and are provided with sufficient information about withdrawal and are enabled to make a considered and informed decision about engaging in this treatment
* ensure that individuals requiring a different AOD/health service are actively assisted to make this link through referral processes such as written referral and/or arranged telephone appointments
  + develop with the individual, a plan that seeks to address their needs whilst awaiting admission and during treatment. Support is provided to individuals before, during and after withdrawal.

#### Assessment

Clients referred from catchment-based intake services or other treatment services will have already completed a comprehensive assessment and initial treatment plan. This pre-existing information forms the basis of any additional withdrawal-specific assessment.

Services must:

* complete a structured and comprehensive medical and psychosocial assessment that leads to a sound treatment plan. The assessment process includes:
  + - full medical assessment by a medical officer prior to and as part of the admission process
    - comprehensive psychosocial assessment by qualified and experienced staff that are competent and capable AOD practitioners
    - observation and recording of physical indicators and symptoms prior to admission
    - full documentation of the assessment process and outcomes.

#### 24-hour structured supervision, support and care

Supportive care delivers medical and psychosocial treatment interventions within a calm and appropriate environment. Appropriate structures and supervision are important components of safe and comfortable withdrawal. Medical and medication support are also key elements. A well-developed clinical governance framework is critically important.

Services must:

* provide 24-hour supportive care, in a safe environment, staffed by well-qualified, experienced and trained individuals who are competent and capable AOD practitioners
* ensure the availability of a well-qualified and experienced senior clinician to oversee the treatment program and provide staff supervision and support
* ensure that regular, consistent and well-documented observations of physical, medical and psychological well-being are undertaken by appropriately skilled staff – this includes careful monitoring of the course of withdrawal
* ensure that medical and mental health responses are readily available to address problems that may arise in the course of withdrawal
* use evidence-based treatment approaches
* provide, at the direction of the medical officer, appropriate medication as required – this should be undertaken in accordance with protocols for the safe use and administration of medication
  + ensure that an appropriate level of nursing and medical coverage is reflected in the staffing profile – all services are required to provide 24 hours a day, seven days a week nursing cover, in addition to appropriate medical officer access and have well-articulated linkages with a hospital network.

#### Care coordination, planning and linkage

Effective coordination of client care, comprehensive treatment planning and the development of strong linkages with other AOD, health, family and forensic services helps to facilitate successful treatment outcomes. All services are responsible for ensuring that client treatment pathways are developed and that other service linkage is made.

Services must:

* provide care coordination and case management services for clients, including:
  + - the development of an individual treatment plan (ITP) or individual recovery plan in partnership with the client, comprising regular, consistent and documented monitoring of the course of withdrawal
    - the development of a discharge plan, which ensures appropriate linkages and referrals are made to post-withdrawal services
* ensure that the linkages identified in the client’s treatment plan are in place prior to discharge
* work with catchment-based intake services, care and recovery coordination providers and other treatment services to ensure clients are linked to ongoing care after withdrawal, where possible
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with
  + facilitate travel arrangements for clients into withdrawal treatment and upon discharge from the withdrawal service as appropriate.

#### Structured programs

The provision of structured programs is integral to an effective residential withdrawal intervention. Structured programs aim to engage individuals in a healthier lifestyle. They also provide group and individual therapy to assist clients with issues such as anxiety, depression, anger, parenting, grief and loss. Structured programs therefore meet social, physical and psychological aspects of the withdrawal experience. They value and include the family and/or significant others and seek to strengthen linkages with post-withdrawal services.

Services must:

* provide a structured program that includes an emphasis on social activity, physical well-being, self-care and complementary therapies
* facilitate recuperation through a restful and calm environment, provision of a nutritious diet, and by encouraging healthy sleeping patterns
* provide a program of structured group work and individual support aimed towards encouraging behaviour change
* provide an opportunity for individuals to engage in appropriate physical exercise, living skills and social activities
* actively include family and/or significant others in the withdrawal treatment process by assisting clients to develop better connection with the family and the community – this includes preparing the family and/or significant others for the process of AOD withdrawal as well as including them as far as is appropriate in the withdrawal process and discharge plan
  + facilitate access to smoking cessation support for all clients.

#### Hospital-based withdrawal services

Withdrawing from AOD can cause acute symptoms that range from mild to severe. Symptoms vary depending on the type of drug used, length of dependence, the individual’s physical and psychological wellbeing and the method of withdrawal chosen.

If severe medical or mental health issues co-occur with the client’s AOD use, or if complex medical withdrawal is anticipated, hospital inpatient withdrawal may be required. Hospital-based withdrawal is generally considered appropriate for those with a confirmed or suspected history of delirium tremens, seizures, severe medical or psychiatric co-morbidities or a high suicide risk.

In a hospital-based withdrawal setting, a client will receive medical support and supervision 24 hours a day, along with intensive psychiatric support, as required.

More broadly, addiction medicine teams and the Victorian Addiction Inter-hospital Liaison Association (VAILA) treat patients present with AOD-related health issues, assist with withdrawal, develop post-withdrawal plans, and enable colleagues in the acute sector to more effectively manage patients with addictions.

Withdrawal in a hospital setting is predominantly funded separately through the department’s health service programs public hospital budget, although there are a range of rural models that incorporate direct AOD treatment funding to enable supported access to dedicated beds.

### Funding model and accountability

Payment is made on the basis of a standard fixed price. For further information about pricing please refer to the [*Funding and Policy Guidelines.*](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines)<https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

Service providers are expected to adjust the duration and intensity of the treatment response to meet the complexity of the client’s presentation. This may mean that some clients stay longer than others, based on their need, but that the average length of stay of the cohort is expected to be around six to seven days.

## Therapeutic day rehabilitation

Therapeutic day rehabilitation is a non-residential intensive structured therapeutic program. Therapeutic day rehabilitation occurs over a period of weeks, and includes counselling and program elements designed to build life skills and promote general wellbeing. The key difference between therapeutic day rehabilitation and traditional bed-based rehabilitation services is that people do not live on site but rather live at home while participating in daytime activities, so that connections with family, friends and community can be maintained throughout the rehabilitation period.

### Purpose

Therapeutic day rehabilitation programs deliver targeted interventions to address psychosocial causes of AOD dependence though evidence-based treatment, with the aim of sustainable recovery.

### Target group

Therapeutic day rehabilitation services are aimed at supporting people who are at risk of harm as a result of their AOD problem. Therapeutic day rehabilitation is suitable for clients who require more intensive support than individual counselling, particularly those for whom the ability to maintain links with home, family and friends are part of achieving sustainable recovery. For example, clients who have access to family support and stable housing, or who have dependent children, may find a community-based rehabilitation option well suited to their needs.

Withdrawal, stabilisation of use, or pharmacotherapy treatment prior to admission may be required in order for the client to be able to commit, participate in and benefit from the program. In some cases, it may be appropriate for clients to transition from residential rehabilitation into therapeutic day rehabilitation.

### Key service requirements

All funded therapeutic day rehabilitation services must meet the following service requirements.

* Provide counselling and/or cognitive behavioural therapies and related therapies such as relapse prevention, mindfulness, mood management, motivational enhancement, narrative therapy, coping skills and family counselling.
* Provide a mix of individual and group counselling, self-help and peer support.
* Provide holistic treatment that promotes life skills that support clients to achieve sustainable recovery.
* Support reintegration into the community and re-engagement with recreation and activities. For example, this could include training in financial management, employment skills, exercise and nutrition.
* Provide responsive models of service delivery that are suitable for a wide range of drug types, including the particular needs of clients recovering from methamphetamine use.
* Provide a structure that reflects the needs of the client group. The hours of operation may vary, as can modes of service delivery, provided the integrity of the structured program and the client experience is maintained.
* Work with catchment-based intake services and treatment services to support client pathways to treatment.
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.
  + People who have been subject to compulsory detention and treatment under the SSDTA are a priority group for access and treatment. Other priority groups include people with at-risk dependent children, Aboriginal clients, and justice/forensic clients.

### Funding model and accountability

This function is funded through an activity-based model. Payment is made on the basis of a standard fixed price. For further information about pricing please refer to the [*Funding and Policy Guidelines*](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines)*.* <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

The provider is expected to report activity to the department on a regular basis and participate in any evaluation as required. Other measures may be developed as part of the performance measurement framework for AOD treatment services.

The department will not pay for additional activity beyond the agreed activity.

## Residential rehabilitation

Residential rehabilitation provides a structured and therapeutic environment for people to address issues related to their AOD use.

In Victoria, residential rehabilitation services deliver a mix of evidence-based treatment interventions that vary in duration and intensity. Services typically deliver individual and group counselling and life skills with an emphasis on self-help and mutual support to support reintegration into community living.

Delivered as a statewide service, clients may access residential rehabilitation services from anywhere in Victoria.

### Purpose

Residential rehabilitation services provide 24-hour supervision by suitably qualified staff in a residential treatment program of an average of three months duration. All residential rehabilitation providers will:

* deliver high quality residential rehabilitation services for people affected by AOD misuse
  + deliver transition support to clients entering or leaving the residential rehabilitation service.

### Target group

Residential rehabilitation may be suitable for:

* clients who have experienced substance dependence and/or harm
* clients seeking to address the issues related to their AOD use
* clients at high risk of harm from AOD misuse impacted by multiple life complexities, such as mental illness, homelessness, family violence
* clients requiring a sustained period of structured tertiary intervention in a therapeutic environment
* clients whose home setting or social circumstances are not supportive of non-residential rehabilitation options
  + clients who are assessed as treatment-ready at admission (i.e. AOD-free, stabilised on pharmacotherapy treatment or undertaking slow-stream pharmacotherapy withdrawal treatment).

Individuals will typically be referred for residential rehabilitation following a comprehensive assessment. Clients may be referred from intake and assessment or AOD treatment services.

Prioritisation of access to residential rehabilitation will be based on level of need, including psychosocial need.

Some residential rehabilitation services provide services specific to certain populations including women, youth, and Aboriginal clients.

Priority access to residential rehabilitation services will be delivered to clients discharged from compulsory residential withdrawal under the SSDTA.

Information about the availability of Victorian residential rehabilitation beds is found on the [DirectLine website.](http://bvr.directline.org.au/) <bvr.directline.org.au>. This site is accessible to AOD treatment providers.

### Key service requirements

All funded residential rehabilitation services must meet the following service requirements.

* Build on the comprehensive assessment and treatment plan to determine the clinical and psychosocial components of the treatment required, engaging and involving clients and families, as appropriate.
* Deliver treatment and support, referral and transition support (face-to-face, phone).
* Provide a range of treatment interventions that support behavioural change, social and life skills development and relapse prevention including counselling and therapeutic group work.
* Utilise a model of care that incorporates evidence-based interventions and management approaches.
* Utilise symptomatic medications, pharmacotherapies and supportive care consistent with best practice and evidence-based guidelines, as required.
* Provide recovery-focused case management for clients including a negotiated ITP with a community reintegration component.
* Provide access to a medical practitioner, including GPs or addiction medicine specialists, to provide generalist and specialist medical support during residential rehabilitation treatment, as required.
* Provide access to appropriate nursing and psychological care, as required.
* Facilitate client access to other services appropriate to their health and welfare needs, including providers of non-residential AOD treatment and support, mental health treatment and support, housing services, vocational training and employment skills.
* Deliver community re-integration support including referral into safe and appropriate accommodation where necessary.
* Cultivate effective and productive relationships and referrals pathways with relevant agencies, in particular AOD providers, addiction medicine specialists, mental health providers and other community-based health/human services/support services.
* Work with other AOD services to provide bridging support pre- and post-treatment to assist in client transition into and out of the residential rehabilitation setting.
* Provide appropriate referral to services for carers and families of those affected by AOD use.
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.
  + Operate seven days per week, 24 hours a day.

### Pathways in and out

Residential rehabilitation treatment is an important step towards positive and lasting behaviour change. Planning for and supporting a person’s intake and discharge from residential rehabilitation supports their journey towards positive living.

Pathways into residential rehabilitation treatment include catchment-based intake and same-service referral (i.e. from another stream within the same AOD service) or referral from another AOD service (including Aboriginal Community Controlled Health Organisations/ACCHOs). Comprehensive intake and assessment information should accompany clients to their new treatment provider.

Residential rehabilitation services are responsible for ensuring clients are linked to further community-based treatment and/or supports which respond to their level of need. This might include individual or group counselling, telephone and/or online supports through services such as DirectLine, or connections established with a GP and/or other health and support services.

Pre- and post-discharge from residential rehabilitation services, bridging supports should be provided to clients transitioning to community-based treatment and support services.

### Funding model and accountability

Payment for residential rehabilitation treatment is made on the basis of a standard fixed price. For further information about pricing please refer to the [*Funding and Policy Guidelines*](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines)*.* <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

Service providers are expected to adjust the duration and intensity of the treatment response to meet the complexity of the client’s presentation. This may mean that some clients stay longer than others, based on their need, but that the average length of stay of the cohort is expected to be around three to four months.

The provider is expected to report activity to the department on a regular basis and participate in any evaluation as required. Other measures may be developed as part of the performance measurement framework for AOD treatment services.

## Specialist dual diagnosis residential rehabilitation

While all residential rehabilitation services provide dual diagnosis support, specialist dual diagnosis residential rehabilitation is available for clients experiencing a higher severity of mental health symptoms combined with AOD dependence.

Specialist dual diagnosis residential rehabilitation services deliver targeted interventions to address the multiple complexities faced by clients with co-occurring AOD and mental health needs (dual diagnosis).

This service seeks to address the needs of people with dual diagnosis who are not well accommodated in standard AOD residential rehabilitation services. Key components of the program include engagement and stabilisation, high levels of integration of mental health and AOD treatment, and assertive aftercare and relapse prevention support.

Referral into the program is similar to referral pathways for standard residential rehabilitation. People will typically be referred into this service via existing AOD and mental health services, because people suitable for this service will most likely have contact with the service system through AOD catchment-based intake, mental health intake or AOD and mental health treatment services. People may also be referred through primary care or other community services or may self-refer.

In assessing eligibility, the service provider’s focus is on symptoms’ severity rather than specific mental health conditions or diagnoses. The service provider will undertake an admission assessment prior to accepting a referral.

## Subacute withdrawal and intensive stabilisation

Sub-acute withdrawal and intensive stabilisation is a residential service focussed on clients with medically complex withdrawal needs and socially complex rehabilitation needs. Such patients are commonly unsuitable for withdrawal in a community setting due to a range of medical co-morbidities. Purely acute settings are also unsuitable for the withdrawal of such clients as they commonly do not offer the required range of specialist AOD inputs. The integrated intensive stabilisation offers such clients a focussed period of residential therapy, stabilising their social circumstances and behaviours post-withdrawal to ensure that they are able to successfully participate in counselling, rehabilitation or other services in the future. Intensive stabilisation provides a stay of approximately 28 days dependent on client needs.

### Purpose

Sub-acute withdrawal and intensive stabilisation services offer 24 hour supervision by suitably qualified staff, including medical professionals. Such services have two key purposes:

To enable withdrawal for medically complex clients in a place of safety with suitable supporting infrastructure.

To provide intensive stabilisation of complex clients who are unable to access conventional therapeutic services due to the complexity of their needs.

### Target group

The majority of clients are expected to access both the sub-acute withdrawal and intensive stabilisation components of the service.

#### Sub-acute withdrawal:

Patients with a DSM 5/ICD10 diagnosis of severe substance use disorder or dependence, whose management is outside the scope of current community residential withdrawal. The criteria for admission to the subacute beds are as follows:

* alcohol and other drug dependence complicated by:
  + - comorbid medical conditions or complications such as:
    - injection-related infection (e.g., endocarditis or sepsis, requiring high dose antibiotic therapy),
    - infectious diseases such as HIV, Hep A, B or C,
    - chronic illnesses such as cirrhosis of the liver,
    - comorbid psychiatric conditions such as mood disorders (e.g. depression, anxiety), stabilised psychotic illnesses, acquired brain injuries, or personality disorders, (excluding acute psychosis and suicidal behaviour)
    - a history of withdrawal seizures, and/or
    - malnutrition requiring parenteral care.
* dependence on high doses of painkiller opioids needing stabilisation or substitution with high dose methadone or buprenorphine (a service offering that is likely to be in even greater demand following the introduction of SafeScript).
* dependence on novel psychoactive and synthetic drugs including cannabis like substances, methamphetamine and GHB.
* transfer from high dose methadone (or other opioids) to buprenorphine.
* high dose and unstable illicit benzodiazepine use.

#### Intensive stabilisation

The model is indicated for patients requiring a period of stabilisation following acute detoxification, such as for the management of:

* Opioid pharmacotherapy commenced or resumed as part of a care plan,
* Dose reductions as part of withdrawal of drugs of dependence (such as benzodiazepines or opioid analgesics),
* Recovery from significant or complex withdrawal (i.e., patients with medical comorbidities such as unstable diabetes, chronic liver disease, pancreatitis),
* Poor nutrition and fatigue requiring supplementation (e.g., under-nutrition of long-term alcohol or methamphetamine use).

### Key service requirements

* Sub-acute withdrawal and intensive stabilisation services must meet the following key requirements:
* 24/7 general medical cover for sub-acute withdrawal clients.
* In-hours medical cover for intensive stabilisation clients.
* Ability to take direct, state-wide referrals from an acute setting.
* Access to acute pharmacy and imaging support as clinically indicated.
* Provision of group based psycho-educational components that utilises elements of Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT)
* Provision of individual counselling and life skills training.
* Provision of ongoing aftercare programme, commonly through telephone liaison

### Funding model and accountability

This function is funded through an activity-based model. Payment is made on the basis of a standard fixed price. For further information about pricing please refer to the Funding and Policy Guidelines available at <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

The provider is expected to report activity to the department on a regular basis and participate in any evaluation as required. Other measures may be developed as part of the performance measurement framework for AOD treatment services.

The department will not pay for additional activity beyond the agreed activity.

## Pharmacotherapy

Pharmacotherapy is the use of substitution medication, such as methadone or buprenorphine, to assist in the treatment of opioid addiction. Pharmacotherapy treatment is well-proven in clinical trials, demonstrating improvements in health, social and occupational functioning across a wide range of people. Pharmacotherapy can help improve a person’s stability, reduce related offending behaviour and reduce blood-borne virus transmission

The Victorian pharmacotherapy system includes community-based pharmacotherapy providers such as general practitioners, nurse practitioners and pharmacists. General practitioners and nurse practitioners (with a notation for a category in which the prescribing of buprenorphine/naloxone is authorised) are able to prescribe Suboxone (buprenorphine and naloxone) for up to five patients without undergoing formal training.

The Victorian policy for prescribing and dispensing of pharmacotherapies is explained in the *Policy for maintenance pharmacotherapy for opioid dependence* (2016). The policy outlines safe and effective practice related to the prescribing of pharmacotherapies and the appropriate dispensing of pharmacotherapies by pharmacies.

Justice Health pays pharmacotherapy dispensing fees for clients being released from prison for a period of four weeks post-release. The department subsidises pharmacotherapy dispensing fees for clients under 19 years.

### Pharmacotherapy area-based networks

In 2013-14, five pharmacotherapy area-based networks (PABNs) were established throughout the state to ensure a more localised approach in connecting care, driving best practice and improving pharmacotherapy client outcomes. Each of the five networks contributes to assisting community-based pharmacotherapy providers to implement a more integrated and cohesive service to improve client outcomes. PABNs provide links to specialist support and community-based providers and mainstream the treatment of opioid dependence in general practice to reduce burden on specialist services.

The networks undertake the following functions.

* Develop a strategic approach to addressing the need for pharmacotherapy services in the area.
* Identify and analyse gaps in service provision in their area and provide local solutions.
* Partner with other services in the area (such as hospitals, health services, specialist pharmacotherapy services, GPs, pharmacists, other AOD services) to form partnerships to facilitate an integrated assessment, treatment referral pathways, intervention, ongoing support and wrap around support and mentoring to pharmacotherapy providers.
* Facilitate ongoing support and mentoring for pharmacotherapy treatment providers to strengthen the community-based system.
* Provide and distribute advice regarding best-practice and emerging issues relating to pharmacotherapy.
* Attract and retain pharmacotherapy providers to the area to relieve pressure to existing services.
* Facilitate access to ongoing training for pharmacotherapy providers.
  + Provide access for complex clients to addiction medicine specialists.

Further information about PABNs is available via Information on the [Victorian Pharmacotherapy Area-Based Networks](file:///C:\Users\cwal1610\AppData\Local\Temp\notes7A2C6A\www2.health.vic.gov.au\about\publications\factsheets\information-on-victorian-pharmacotherapy-area-based-networks). <www2.health.vic.gov.au/about/publications/factsheets/information-on-victorian-pharmacotherapy-area-based-networks>.

### Specialist pharmacotherapy services

Specialist pharmacotherapy services provide a consultative service to community-based pharmacotherapy prescribers seeking expert opinion about the management of patients with complex issues. Prescribers may also refer complex clients to receive secondary consultations at these services. Five specialist pharmacotherapy services are located through metropolitan Melbourne, however the service is open to all eligible Victorians.

#### Purpose

To support pharmacotherapy providers to provide services to clients with complex psychosocial needs and drug dependencies.

#### Target group

The target client group is adults and young people on a program whose needs cannot be met solely by their regular pharmacotherapy prescriber. These include clients with:

* unstable psychiatric conditions, including psychosis, depression and personality disorders
* high-risk patterns of substance abuse including significant alcohol, methamphetamine and poly drug use
* challenging behaviours unable to be managed in other community settings
* chronic pain disorders who are abusing licit and illicit opioids
  + serious medical conditions such as HIV and hepatitis C.

#### Key service requirements

The services include the following functions.

* Provide secondary consultation, opinion and advice to medical practitioners with complex pharmacotherapy clients.
* Provide addiction-focused medical care, pharmacotherapy prescribing and stabilisation for complex clients.
* Support addiction-focused medical care with comprehensive psychosocial assessment, collaborative treatment planning, and specialist counselling.
* Identify pathways from specialist services back into GP prescribers and community-based AOD services.
* Facilitate clients’ access to relevant health, welfare and recovery services where appropriate.
* Deliver a service that is sensitive to the impact of AOD use on clients’ families, carers and communities.
* Provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.

### Pharmacotherapy Regional Outreach Worker program

Pharmacotherapy Regional Outreach Workers (PROWs), employed generally by health services, operate in regional and rural Victoria. PROWs provide support to pharmacotherapy providers and clients to obtain the best outcome for the client.

#### Purpose

PROWs improve client access to pharmacotherapy by supporting general practitioners to recruit and retain opiate dependent persons in treatment and assist effective withdrawal.

#### Target group

PROWs may be suitable:

* to support prescribers and dispensers of opioid pharmacotherapies
* for clients using pharmacotherapies
  + for families of clients undertaking the program.

#### Key service requirements

PROWs undertake the following functions.

* Improve client access to, and the effectiveness of, drug substitute pharmacotherapies by supporting and enhancing the role of general practitioners to encourage, recruit and retain opiate dependent persons in treatment and effective treatment completion.
* Engage AOD treatment services, GPs and Primary Health Networks (PHNs) in local or sub-regional strategies for enhancing the use of the variety of substitute pharmacotherapies based on the needs of the local community.
* Operate responsively with regard to medical or technological advances in pharmacotherapy.
* Provide an outreach service to GPs and pharmacists providing information and advice and facilitating the referral of clients to drug treatment services.
* Cultivate shared care protocols through providing family sensitive treatment information and referral between GPs and AOD services.
* Improve engagement of GPs and pharmacists in delivering pharmacotherapy for people with opioid dependence.
  + Provide information and referral for pharmacotherapy clients into a wide range of health and welfare services.
  + Support and work collaboratively with the local PABN.

### Slow-stream pharmacotherapy reduction at residential rehabilitation

Slow-stream pharmacotherapy reduction programs now operate in two residential rehabilitation centres, Windana Therapeutic Community and Odyssey House Therapeutic Community. Participation in the rehabilitation program is thought to reduce the subjective distress of pharmacotherapy reduction.

Slow reduction in a supportive treatment environment reduces the risk of relapse and overdose that may occur during opioid neuroadaptation reversal.

Slow-stream pharmacotherapy beds are allocated through the residential rehabilitation assessment process.

# Population-specific service systems

Population-specific AOD treatment services are available for cohorts with specific needs including youth, Aboriginal and forensic clients.

All services are expected to provide, with the appropriate consent, client summaries to the original referral source, intake service as well as to the services the client has been linked with.

## Youth AOD services

Youth AOD services help vulnerable young people up to the age of 25 years to address their AOD use issues and build resilience. This is achieved through a family-based approach, where appropriate, that is integrated with a range of other services including mental health, education, health, housing, child protection and family services.

Youth services accept referrals from catchment-based intake services as well as self-referrals and direct referrals from other services, including child protection, out-of-home care providers and youth justice providers. Further advice on accessing youth-specific services is available from DirectLine and YoDAA. Young people access services based on clinical judgement that includes an assessment of a young person’s developmental stage, AOD treatment needs and accessibility, and the young person’s preference. Older youth should be supported to transition from youth to adult services as appropriate.

### Statewide Youth AOD Advice service

YoDAA is Victoria’s specialist Youth Drug and Alcohol Advice Service. YoDAA offers anyone concerned about a young person’s substance use with access to youth AOD information, personalised advice and direct connection with appropriate services.

#### Purpose

To provide a simple method for anyone concerned about a young person’s substance use to access information, advice, support and direct connection with services where needed.

#### Target group

Recognising the multiple factors that influence a young person’s substance use, YoDAA targets all stakeholders in a young person’s health and wellbeing. These include:

* young people
* family and carers
* professionals who work with young people
* health services
  + schools.

YoDAA has a specialised and enhanced capacity to respond to carers and workers in the out-of-home care and child protection system.

#### Key service requirements

The service includes the following functions.

* Work within and between treatment services, in schools, hospitals, families and the wider community to provide developmentally appropriate and evidenced-based information to support a caller to determine a next step, including needs identification and harm reduction advice.
* Provide brief intervention and referral for young people to a youth AOD service.
* Support young people to navigate through the AOD system through pathways, information, resources and supported referral.
* Provide secondary consultation and resources. This may include providing information and support to respond to needs for clients involved with child protection and other human services.
* Provide AOD intervention advice including coaching for carers and non-professionals.
* Provide waitlist management support for funded youth AOD treatment services.
  + Provide assertive engagement of young people requiring assistance including those who face barriers to accessing treatment.

### Youth AOD day programs

Youth AOD day programs supports young people who are currently linked or involved in treatment with youth AOD treatment services by providing a post-treatment pathway for the client.

#### Purpose

To assist a person in developing life skills that aid in community living, and to provide continuity of care for young people who are engaged in AOD treatment.

#### Target group

Youth AOD day programs vary according to local client need but may be suitable for:

* any young person aged 14–21 years who may be either linked or involved in treatment with the AOD treatment sector
  + 12–14 year olds who are not involved in formal education and therefore do not have access to its support services.

#### Key service requirements

Funded youth AOD day programs must meet the following service requirements.

* Provide short-term life skills, vocational/employment and recreational-based programs to support young people who are currently engaged with a youth AOD treatment service in order to provide a client pathway to post-treatment.
* Provide support and assistance to access services which enhance the client’s capacity for sustained non-drug abusive community living, through relapse prevention, life skills acquisition, counselling, personal care activities and/or any other services appropriate to their health and welfare needs.
* Develop, in consultation with the relevant clinician, an ITP with the client.
  + Refer clients, carers and families affected by AOD use to appropriate support services.

### Youth AOD outreach services

An outreach service is a mobile treatment and support service that provides assessment, support and ongoing case coordination to young people with AOD problems, in their own or in a neutral environment. It also supports generalist agencies that work with young people, through information, education and training.

#### Target group

Young people up to the age of 25 years whose use of licit and illicit drugs causes significant physical, psychological and social harm.

#### Key service requirements

* Funded youth AOD outreach services must meet the following service requirements.
* Reduce the harm caused by AOD use.
* Encourage withdrawal and provide post-withdrawal support where appropriate.
* Provide assessment, support and case management on an outreach basis to young people in their own environment.
* Employ motivational strategies and evidence informed therapeutic interventions where required.
* Operate from a location accessible to young people, such as co-location in an existing youth service.
* Provide ongoing support to young people in an accessible, ‘open door’ capacity.
* Maximise flexibility in treatment and support services so that, where possible and appropriate, young people can maintain their current environment with minimal disruption to themselves or others.
* Provide support, information and resources to generalist agencies that work with young people.
* Build young people’s resilience and promote pro-social connections.
* Develop inter-service networks and linkages to ensure appropriate and coordinated ongoing case coordination and referral processes.
* Make and follow through supported referral.
  + Provide appropriate services for carers and families of those affected by AOD use.

#### Youth home-based withdrawal

Youth home-based withdrawal services are provided to young people where the withdrawal syndrome is of mild-to-moderate severity and the young person is able to be supported by a family member or friend at home. The service is provided by an experienced nurse in conjunction with a medical practitioner.

As well as support to manage drug withdrawal and coordinate care with GPs and other medical professionals, youth home-based withdrawal nurses also address the primary health, psychological and emotional wellbeing needs of young people and provide links to other health, welfare, educational, vocational and recreational services.

#### Target group

Young people up to the age of 25 years requiring withdrawal where the withdrawal syndrome is of mild-to-moderate severity and not complicated by significant illness or psychosocial problems, and where a support person is available and in the immediate vicinity during withdrawal.

#### Key service requirements

* Funded youth home-based withdrawal services must meet the following service requirements.
* Provide a home-based withdrawal service by an experienced nurse in conjunction with a medical practitioner.
* Provide an initial assessment and physical examination of the client.
* Provide information and support to the client and support person about the course of withdrawal, including information on how to deal with emergencies. The support person, whether a family member or not, must be present or available and in the immediate vicinity during withdrawal.
* Monitor the course of withdrawal in liaison with the medical practitioner concerning the need for pharmacotherapy and medical care.
* Provide an on-call, out-of-hours service to advise on and manage difficulties or queries that may arise during the course of withdrawal.
* Develop an individual treatment plan with the client.
* Facilitate links to other services for post-withdrawal support.
* Provide other appropriate services, where relevant, for carers and families of those affected by AOD use.

### AOD youth consultants

AOD youth consultants provide secondary consultation, support and advice to child protection clients and staff in out-of-home care residential facilities, adolescent community placement and secure welfare services.

#### Target group

Child protection clients and staff in out-of-home care residential facilities, adolescent community placement and secure welfare services.

#### Key service requirements

Funded AOD youth consultants undertake the following functions.

* Provide secondary consultation, specialist knowledge and support to the child protection case planning process and contribute to appropriate assessments, interventions and common practices, protocols and processes.
* Work closely with the department’s child protection, youth justice and AOD areas to support the achievement of priority objectives.
* Ensure strong linkages and coordinated service responses with the existing Secure Welfare Services Specialist AOD Treatment Worker.
* Support ongoing service delivery and implementation through the provision of advice and support to child protection and out-of-home care providers to ensure continuity of service and stability in the care experience.
* Support the child protection and out-of-home care sector in managing young people with substance abuse issues through collaboration, partnership, shared learning, and by providing practical guidance which supports the development of workable solutions, both within and between each service system and the department.
* Provide linkages into AOD treatment services.
  + Provide active monitoring and tracking of the target young people who may be moving between the child protection, out-of-home care and AOD treatment service systems.

### Youth residential withdrawal

Youth residential withdrawal services provide short-term intensive support, time out and drug withdrawal services to young people in a residential setting. This includes psychosocial, medical and pharmacological support, treatment and intervention in a safe, secure and drug-free environment on a 24-hour basis.

The average length of stay in the service is approximately ten days and is supported by pre- and post-support including assessment, active holding, community treatment planning, community reintegration and aftercare.

#### Purpose

The specific service aims and objectives for youth residential withdrawal services include the following.

* Provide intensive residential support, time out and drug withdrawal to young people whose use of AOD causes significant harm and who may be experiencing concurrent issues such as homelessness, serious health or psychiatric problems, psychosocial issues and physical safety issues.
* Provide services on a 24-hour basis, within the context of a holistic, multidisciplinary, psychosocial health framework, in an environment which is physically and emotionally safe, drug-free and community-based.
* Develop effective linkages with the range of service systems which impact on a young person’s life, in order to facilitate the provision of integrated and coordinated care and link the young person to a strong support network.
* Provide information and referral services to the young person’s family and significant others, and to involve family members in the treatment of the young person where appropriate.
  + Provide services to young people which cater for, and are appropriate to, their age, gender, cultural background or legal status.

#### Target group

The youth residential withdrawal services target young people aged 12–21 years, whose use of licit and illicit drugs causes significant physical, psychological and social harm. Clinical judgement and client choice will define whether young people up to age 25 years are considered developmentally appropriate for the youth residential withdrawal service, or would be more suited to a general adult residential withdrawal service.

These young people may also be experiencing concurrent issues such as family breakdown, homelessness, serious health or psychiatric problems, psychological issues, serous behavioural issues including offending, and physical safety issues.

Young people may require drug withdrawal and/or therapeutic respite care from situational pressures associated with harmful drug use. Services should be provided to these young people regardless of their age, gender, cultural background or legal status.

#### Key service requirements

Funded youth residential withdrawal services undertake the following functions.

* Provide psychosocial, medical, and pharmacological support, treatment and intervention in a safe, secure and drug-free environment to young people, aged 12–25 years, on a 24-hour basis, for the purpose of minimising harm associated with drug use and assisting with drug withdrawal.
* Address presenting physical and psychological issues associated with AOD use. Behavioural and social issues caused or compounded by AOD use and issues underlying use will be identified.
* Ensure that the assessment, including physical examination, and treatment of the client is youth, gender, and culturally sensitive and includes motivational approaches to the engagement and retention of young persons in the program.
* Improve awareness of harm reduction strategies within a developmentally appropriate framework and increase the capacity of the individual to maintain behaviour which reduces drug-related harm.
* Operate structured programs, including appropriate group activities, the content of which will be framed to ensure accessibility to young people.
* Program activities will develop drug-free recreational and social experiences, provide psycho-social support, skill development (including intra- and inter-personal and independent living skills) and facilitate educative processes such as harm reduction. Programs should incorporate behaviour management techniques to respond to challenging behaviours.
* Provide information and referral services for clients’ carers, families and significant others, and where appropriate, involve these significant others in the treatment of the young person.
* Ensure that procedures and programs take account of the needs of differing cohorts of young people including and take account of age, gender, cultural groups and vulnerability.
* Ensure that each client has an ITP based on assessment, identification of risk factors and the setting of goals and objectives to increase protective factors. This plan will be developed in consultation with the young person. The ITP relates to the EOC provided to the young person by this service, and should contain a discharge plan including links to a broader case plan for the client, where relevant.
* Be situated in a community-based house of domestic aspect, centrally located, preferably close to recreational facilities and easily accessible by public transport.
* Be located close to an acute hospital and a child and adolescent mental health service to ensure access to emergency back up and appropriate specialist treatment and support. Joint service provision arrangements will be established through formal protocols.
* Ensure the development of appropriate procedures for the referral, assessment, intake and exit of clients using the service. The service will also develop and implement clearly articulated policies which guide case practice. This will include protocols for critical incident response, violence, sexual assault and drug taking.
* Retain appropriate contact with the referring agency. Where the young person is already being case managed by a lead agency, the residential withdrawal service should contribute to case planning and the client’s discharge plan should be developed in conjunction with the primary case manager. If the young person is a statutory client through either child protection or youth justice, the service must liaise with the designated case manager.
* Facilitate processes for longer-term issues to be addressed through inter-service linkages, supported referral and discharge planning. Exit planning should focus on the development and enhancement of protective factors, such as the development of resources, skills and supportive social bonds to promote well-being.
  + Ensure that the service is effectively integrated with AOD service system and effective linkages and working relationships are developed with other service providers, including child protection and youth justice where relevant.

### Youth AOD supported accommodation program ­­– Wilum

The Youth Support and Advocacy Service (YSAS) Wilum AOD supported accommodation program supports young people who are in need of accommodation and wish to remain abstinent after completing AOD withdrawal.

Wilum operates in the inner north-west of Melbourne.

#### Purpose

To provide accommodation and a support program for young people to reintegrate with the wider community after completing AOD withdrawal.

#### Target group

Young people aged 16–20 years who, having completed AOD withdrawal, wish to remain drug-free and are in need of accommodation.

#### Key service requirements

The supported accommodation program includes the following functions..

* Provide accommodation for up to 12 months.
* Support young people to develop independent living skills, including goal setting and access to therapeutic groups.
* Encourage young people to reintegrated with the wider community through access to education and employment.
  + Develop effective linkages with the range of service systems which impact on a young person’s life, in order to facilitate the young person’s connection to a strong support network.

### Youth residential rehabilitation

Residential rehabilitation programs are offered to young people who have undergone an AOD withdrawal or treatment program and have not been successful in reducing or overcoming their AOD use problem and are not suited to attend an outpatient program. Clients include those who suffer the more severe consequences of harm associated with AOD use, such as criminal involvement or social disadvantage, and whose home setting or social circumstances are not supportive of non-residential treatment options.

#### Purpose

The primary purpose of the youth residential rehabilitation program is to provide the opportunity for young people to address their AOD problems and develop skills that enable them to re-enter the community.

#### Target group

The target age group for the service is young adults aged 16–21 years wishing to address their problematic AOD use and equip themselves with life skills that enable them to live independently in the community. It should be a matter of clinical judgement and client choice whether young people up to age 25 years are considered developmentally appropriate for the youth residential service, or would be more suited to a general adult residential rehabilitation service.

Referrals to the program may be from youth and adult AOD treatment services and other youth service providers.

#### Key service requirements

Funded youth residential rehabilitation services undertake the following functions.

* Provide an intensive rehabilitation program to clients of AOD services who have undergone an AOD withdrawal program or who require such treatment to manage their AOD use problems.
* Provide a range of treatment interventions, which includes behavioural treatment approaches, social and community living skills, training relevant to the young person’s needs, counselling, therapeutic group work and relapse prevention.
* Provide care coordination for clients including a negotiated ITP with a community reintegration component.
* Facilitate access and link the client to other services appropriate to their health and welfare needs including educational/vocational training and employment skills.
* Support the client (where appropriate) to return to their family home, or obtain safe, secure and affordable accommodation.
* Provide appropriate services for carers and families of those affected by AOD use.
* Establish and maintain strong professional links with other relevant agencies.
  + Enhance rehabilitation with a strong focus on counselling and integration including other community health, welfare and educational/vocational support services. The program should address long-term client needs through establishing referrals and support linkages to education, accommodation, vocational, health and other identified services.

## Aboriginal AOD services

The department works with Aboriginal people, organisations and communities, other parts of government and the Commonwealth to ensure access for Aboriginal people to a range of AOD treatment services.

The Aboriginal programs and service descriptions listed below may change from 2018-19. Consistent with the government policy on self-determination, the department is working with the Aboriginal community to implement the priorities of *Korin Korin Balit Djak - Aboriginal health, wellbeing and safety strategic plan, Balit Murrup - Aboriginal social and emotional wellbeing framework* and the *Aboriginal Governance and Accountability Framework*. Further information about these policies can be found in Part 3 of these guidelines.

### Aboriginal AOD workers

Aboriginal AOD workers work in a culturally informed way with Aboriginal individuals and families to address problematic AOD use. Aboriginal AOD workers provide services based on a harm reduction approach, including assessment, counselling, care coordination, group work including therapeutic cultural groups, health promotion, education, information, referral, advocacy and liaison services. Victorian Aboriginal AOD workers are based in a range of ACCHOs and Aboriginal Community Controlled Organisations (ACCOs).

#### Purpose

To provide Aboriginal people and families with a range of prevention, early intervention and group support services including counselling, brief intervention, referral to appropriate AOD services including withdrawal and rehabilitation treatment, care coordination and ongoing support.

#### Target group

Aboriginal people experiencing issues related to problematic AOD use and their families, friends and carers.

#### Key service requirements

Aboriginal AOD workers undertake the following functions.

* Provide structured assessments of AOD consumption, health and psychological factors.
* Increase awareness of AOD problems and their effects through participation in culturally sensitive and appropriate health promotion activities.
* Provide referral to counselling, withdrawal, post-withdrawal support and other funded treatment interventions (to streamline access to more intensive services where required, Aboriginal AOD workers may establish direct referral arrangements with mainstream AOD services).
* Ensure strong linkages with other health and welfare services in the community.
* Work with ACSO COATS and the appropriate courts to facilitate support and treatment for forensic clients.
* Provide other appropriate services, where relevant, for carers and families of those affected by AOD use.

### Aboriginal AOD clinical nursing program

The Aboriginal AOD clinical nursing program funds nursing positions that are integrated with AOD and Social and Emotional Wellbeing teams to provide appropriate treatment and support to clients and families. These teams provide holistic, culturally appropriate clinical care and support to clients throughout their AOD recovery pathway and link in with Aboriginal AOD workers.

#### Purpose

To provide Aboriginal people and families with a range of prevention and early intervention group support activities, counselling, brief intervention and referral to appropriate AOD withdrawal and residential rehabilitation services.

#### Target group

Aboriginal people experiencing issues related to problematic AOD use.

#### Key service requirements

The program includes the following functions.

* Provide structured assessments of AOD consumption, health and psychological factors.
* Increase awareness of AOD problems and their effects through participation in culturally sensitive and appropriate health promotion activities.
* Provide clinical assessment, planning and intervention, referral to counselling, withdrawal, residential rehabilitation, post-withdrawal support and other funded treatment interventions.
* Ensure strong linkages with other health and welfare services in the community.
  + Provide other appropriate services, where relevant, for carers and families of those affected by AOD use.

### **Bunjilwarra Aboriginal Youth AOD Healing Service**

The Bunjilwarra Aboriginal Youth AOD Healing Service is a purpose-built statewide 12-bed AOD residential rehabilitation and healing service. The service is managed by the Victorian Aboriginal Health Service (VAHS) in partnership with YSAS with the support of local Aboriginal and non-Aboriginal health services.

#### Purpose

Bunjilwarra offers Aboriginal youth a supportive environment to address their AOD issues, through active participation in therapeutic and structured programs designed to assist them to develop living skills, and to strengthen their cultural identity and spiritual wellbeing.

#### Target group

Aboriginal young people aged 16–25 years experiencing issues related to problematic AOD use.

#### Key service requirements

The service includes the following functions.

* Adopt a holistic approach that recognises physical, emotional and spiritual needs.
* Strengthen and build a young person’s understandings and connections to their individual Aboriginal community and culture.
* Operate in partnership and with the support of local Aboriginal and non-Aboriginal health services.
* Achieve effective transition, exit and after-care back into community.
  + Work with key service providers and established networks and relationships across the state, to plan and coordinate client transition and after-care.
  + For further clarification of key service requirements, please refer to the earlier youth residential rehabilitation section.

### Aboriginal community AOD resource service

The AOD resource service is Melbourne metropolitan-based and provides responsive support as an alternative to incarceration for Aboriginal persons who are found to be intoxicated or drug-affected in public.

#### Purpose

The service provides support for Aboriginal people who come into contact with Victoria Police for public intoxication.

#### Target group

The primary target for this service is Aboriginal people who are AOD affected. The service can support up to six clients at a time.

#### Key service requirements

The AOD resource service undertakes the following functions.

* Respond to referrals from Victoria Police and the Victorian Aboriginal Legal Service.
* Undertake a risk assessment to determine client safety and suitability for the service.
* Provide short-term AOD support. The length of stay for clients varies with the maximum time being two days.
  + Link clients to Aboriginal and mainstream AOD, homelessness and welfare services as appropriate.

### Aboriginal AOD diversion workers in mainstream AOD services

Aboriginal AOD diversion workers provide culturally safe support and referral service for Aboriginal forensic clients referred from the courts into AOD treatment.

#### Purpose

Aboriginal AOD diversion workers operate in mainstream AOD services located near Koori courts. Their role is to provide a link between the Koori court, the Aboriginal community and the AOD treatment service system, and provide a service tailored to the needs of offenders appearing before the Koori court.

#### Target group

Clients appearing before the Koori court.

#### Key service requirements

The service includes the following functions.

* Provide structured assessments of AOD consumption, health and psychological factors.
* Increase awareness of AOD problems and their effects through delivery of culturally sensitive and appropriate health promotion activities.
* Work with the ACSO COATS and the appropriate courts to facilitate support and treatment.
* Provide referral to counselling, withdrawal, post-withdrawal support and other funded treatment interventions.
* Ensure strong linkages with other health and welfare services in the general community.
  + Ensure access to treatment services by assisting with arrangements for the care of children whose parents are participating in this program.

### Mainstream AOD treatment services – access for Aboriginal people

All AOD services are expected to provide friendly, welcoming and culturally safe environments for Aboriginal people, and also provide service models that meet the needs of Aboriginal people.

#### Client pathways

Aboriginal-specific services provided by ACCHOs and ACCOs accept referrals from catchment-based intake services, as well as self-referrals and direct referrals from other services or through DirectLine.

Aboriginal people can also choose to access mainstream services through catchment-based AOD intake services.

A designated Aboriginal care and recovery coordination function must be available in each catchment. The function encompasses a diversionary and generalist service response for Aboriginal clients, as required.

#### Prioritisation

All mainstream AOD treatment services are expected to prioritise access for Aboriginal people. Where people with a similar level of need are assessed as requiring AOD treatment services, priority is given to Aboriginal people.

For further information, please see *Part 1: overview – prioritisation*.

Price loading

A 30 per cent loading is applied for work with Aboriginal clients. For further information, please see *Part 3: quality, reporting and performance management – Drug Treatment Activity Unit (DTAU) loadings*.

### **Sector partnerships** – Aboriginal metropolitan ice partnership

The Aboriginal metropolitan ice partnership is an initiative across four metropolitan areas to help improve access to services for Aboriginal people affected by methamphetamine and other drugs. Working in partnership, selected Aboriginal-controlled community organisations and mainstream AOD service providers will provide assertive outreach and treatment, as well as help to streamline access to more intensive services where required.

#### Purpose

The initiative aims to build sector capacity to specifically work with ice-affected Aboriginal individuals and families and provide learnings about approaches and practices that can be embedded into the AOD service system to provide better responses to those in the Aboriginal community affected by ice.

#### Target group

Aboriginal people experiencing issues related to problematic ice, alcohol and other drug use, and their families and carers.

#### Key service requirements

The Aboriginal metropolitan ice partnerships include the following functions.

* Provide intensive Aboriginal culturally responsive support, clinical services, and holistic wrap around care to improve the health and wellbeing of those impacted by ice and AOD issues.
* Provide education, counselling and support to individuals, families (both individual and group work) and community members to build their capacity and resilience to manage ice and AOD-related issues.
* Build the capacity of mainstream AOD services to provide culturally responsive care for Aboriginal people.
* Strengthen the capacity of ACCHO/ACCOs to provide effective treatment and support for ice and AOD issues.
* Strengthen partnerships and referral pathways between ACCHO/ACCOs and mainstream AOD services.
* Develop evidence and best practice around effective approaches and practices.
  + Contribute to a broader understanding of the patterns of ice and AOD use.

## Forensic AOD treatment services

The department funds the assessment and treatment for all community-based forensic clients across the state. Forensic AOD treatment is part of the broader AOD treatment system and includes specific targeted programs, as well as access to general community treatment.

### Purpose

AOD treatment for forensic clients is aimed at reducing the harms associated with AOD misuse, including the offending-related behaviour.

### Target group

Forensic treatment programs and services are provided to people with AOD use issues who have had contact with the justice system. The majority of forensic clients are mandated to attend treatment as a condition of a judicial order

### Key service requirements

#### Forensic intake and assessment service

ACSO is funded by the department through their COATS program a range of functions relating to the treatment of community based offenders as below:

* intake and screening;
* assessment;
* treatment planning;
* bridging
* administration of forensic brokerage funding on behalf of the department
* reconciliation and demand monitoring of all forensic treatment
* ACSO undertakes the majority of intake and assessment service delivery to forensic clients.

In July 2018 a new Forensic Assessment Tool was released as a key component of the new Forensic Alcohol and other Drugs Treatment Service Delivery Model publicly released on 20 July 2018.

The new tool helps to better identify an individual’s risk of substance related harm and the relationship to their risk of re-offending. This will be used by ACSO COATS in assessing forensic clients. More detailed information on the tool in Penelope is also available on the ACSO website at <<http://coats.acso.org.au/>>.

AOD providers who undertake assessments for forensic ‘diversion’ clients referred from courts or court support programs such as the Court Integrated Services Program (CISP), will continue to use the voluntary AOD intake and assessment tool including Module 12 (Forensic) available at <<https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treat>>.

#### Treatment services

Forensic AOD treatment is a core function for all funded adult, youth and specialist AOD services across Victoria. All funded services are required to:

* consider all forensic referrals from COATS, justice agencies, and other AOD treatment providers - refusal to treat a forensic client is only by exception and COATS must be notified
* provide appropriate treatment to the client based on the treatment plan developed by COATS
* provide forensic reports for the court, where required
* submit Treatment Completion Advice (TCA’s) to COATS at the conclusion of treatment

Lead agencies in each of the consortiums are expected to proactively manage capacity to take referrals for forensic clients as a priority.

Forensic clients are often mandated to attend AOD treatment, and can be found to be in breach of a judicial order if they do not access treatment promptly.

### Forensic-specific programs

Forensic clients are referred to the full range of treatment services including counselling, withdrawal, care and recovery coordination, rehabilitation and youth and Aboriginal-specific services.

In addition there are a range of forensic-specific programs and initiatives that are particularly targeted at addressing AOD use in relation to offending behaviour.

For further information on forensic-specific programs, please refer to the department’s website, [Forensic Services](file:///C:\Users\cwal1610\AppData\Local\Temp\notes7A2C6A\www2.health.vic.gov.au\alcohol-and-drugs\aod-treatment-services\forensic-aod-services). <www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/forensic-aod-services>.

For more information about ACSO COATS, refer to the [COATS website](http://coats.acso.org.au/) <http://coats.acso.org.au>.

### Group programs

#### Choices Program

‘Choices’ is an AOD group education program for low risk offenders sentenced to a community based order. ‘Choices’ aims to:

* Increase awareness of the relationship between AOD use and offending
* Identify the range of potential harms associated with alcohol and different types of drugs and methods
* of use
* Understand the short and long term effects of use on physical and mental health
* Identify the drivers and patterns of use and the interrelationships with other issues
* Improve knowledge of concepts of cravings, tolerance, dependence and withdrawal
* Understand the stages of change and how to plan for changing behaviour
* Develop strategies to identify levels of risk and reduce impacts and consequences
* Identify strategies and interventions for self-monitoring and relapse prevention.

#### KickStart Program

KickStart is a criminogenic AOD group program based on the principle of Cognitive Behavioural Therapy (CBT) and Risk, Needs, Responsivity (RNR) for offender treatment.  
  
The program is designed to improve participants’ understanding of the relationship between their substance use and offending; learn the skills to facilitate change and prevent return to previous behaviours; and develop achievable self-management plans.  
  
Eligible participants must have a community based sentence, usually a Community Corrections Order with an AOD condition. They must be assessed by Corrections with a medium to high risk of re-offending; as well as moderate to high risk of AOD harm. Each group program is structured and closed to ensure consistency throughout their engagement.   
  
There is a 42 hour group ('G42') for those with a high risk of re-offending, and a 24 hour group ('G24') for those with a medium risk of re-offending. Both run over an 8 week time frame.   
  
Those found 'unsuitable' for the group at induction with the service provider (e.g. those with significant cognitive impairment) will be diverted to the corresponding structured individual counselling program based on KickStart content. The high risk offenders go to the 15 session structured individual counselling ('IC15'), and the medium risk offenders go to the 8 session structured individual counselling ('IC8').   
  
The KickStart program is being piloted to 30 June 2019 in Abbotsford, Broadmeadows, Ringwood, Footscray and Dandenong.

### Diversion programs

#### Drug Diversion Appointment Line

DirectLine manages the Drug Diversion Appointment Line (DDAL) from Victoria Police. Low-risk clients receive a structured telephone intervention at DirectLine while substance dependent or at risk clients are referred to the relevant catchment-based intake service to access a ‘DDAL intervention’ and further support. This may include referral for assessment and treatment if required.

Catchment based intake services are required to accept DDAL referrals and provide 'DDAL interventions' to DDAL clients. DDAL interventions may be delivered via face-to-face or phone and can be delivered via 2 separate or back to back sessions. All intake services are expected to regularly advise Turning Point of their available appointment times and ensure they have additional capacity available during festival periods.

The intensity of the DDAL intervention session will be influenced by the client’s substance use severity and life complexity. DDAL clients who are identified as needing AOD treatment beyond the DDAL requirement should be referred on for assessment and treatment as required.

Catchment-based intake services are required to submit Treatment Compliance Advice (TCA) forms to ACSO for all DDAL clients on completion of the intervention. ACSO will provide this information to Victoria Police to advise whether the client has met the conditions of the diversion.

#### Police cautions and diversion programs

People apprehended by the police for use or possession of an illicit drug other than cannabis may be offered a ‘drug diversion caution’ on the condition that they undertake a clinical drug assessment and attend at least one session of any prescribed drug treatment. Diversion is often directed to first time offenders. It can occur pre-charge or can be court-based.

‘Cautious with Cannabis’ is for anyone who has received a Cannabis Caution from the Police or anyone who has concerns about their cannabis use (family and friends welcome). The 2.5 hour education programs assist participants to:

* Identify and reduce drug-related harms
* Reduce and stop drug use
* Access ongoing treatment and support

The ‘Methamphetamines Personal Education Program’ is a 3 hour education program designed for people who have been placed on a diversion program or for people concerned about their methamphetamine use.

The program incorporates the use of a range of strategies designed to engage participants, and provides an opportunity for participants to reflect on the impact of Methamphetamine use on their lives and those people around them. Participants are supported to develop strategies associated with various stages of behaviour change, including harm reduction, planning for change, getting through withdrawal and relapse prevention.

The First Offender’s Court Intervention Service (FOCis) is a 2.5-hour compulsory drug education program for first offenders sentenced to the program by the Magistrates’ Court of Victoria.

#### Victoria Police e-Referral system

The Victoria Police e-Referral system (VPeR) is a statewide IT referral system that enables police members to refer persons in need of support to services in the course of their day-to-day duties. Referrals relating to AOD are directed to DirectLine.

When a referral is made through VPeR to DirectLine, one outbound telephone follow-up attempt is made to the subject of the referral. Where that person is able to be contacted – information, advice, a brief intervention and, where appropriate, referral to treatment services are provided. If that person is unable to be contacted, a single SMS with DirectLine contact details is sent.

#### Forensic targets

Specific forensic treatment targets apply. For more details please see *Part 3: quality, reporting and performance management – forensic targets*.

# Additional support

## Drug and alcohol clinical advisory service

The Drug and alcohol clinical advisory service (DACAS) is a specialist 24-hour telephone consultancy service that assists health and welfare professionals throughout Victoria to respond effectively to individuals with alcohol or other drug use problems.

All calls are answered by experienced DirectLine clinicians. Calls that require specialist medical advice are referred to DACAS consultants who are addiction medicine or addiction psychiatry specialists.

DACAS provides assistance with drug and alcohol issues including assessment, medical management of withdrawal syndromes, substitution pharmacotherapy and other prescribing issues, medical and nursing management of intoxication and toxicity, management of medical and psychiatric complications associated with drug and alcohol use, drug interactions and pain management.

For further information visit [DACAS](http://www.dacas.org.au) <www.dacas.org.au/> or phone 1800 812 804.

## AOD Pathways service

AOD Pathways provides short term intensive support to individuals and families who have experienced difficulty in accessing treatment due to levels of complexity and multiple needs. The specialist team assists with navigation, advocacy, support and referral for individuals and their families.

It is not intended that this service will duplicate catchment based intake services but provide extra support to those who may not otherwise be able to engage in treatment.

AOD Pathways is a statewide phone based service delivered by Eastern Health Turning Point. Referrals may be made by individuals, family members or carers and health professionals by calling 1800 319 619.

## Statewide neuropsychology service

The statewide neuropsychology service provides clinical neuropsychology assessments primarily to forensic clients with suspected or diagnosed brain injury, who also have co-occurring AOD use disorders. The service also offers secondary consultations to AOD workers and corrections workers to assist in the understanding and management of these clients.

The service has a dual clinical and educational role, and articulates an evidence-based model of care for cognitively impaired clients who present with multiple comorbid diagnoses, including behavioural disturbance and alcohol and substance use disorders. The service provides regional training in the form of seminars and workshops to AOD and criminal justice services across Victoria. Additionally, it develops training materials to assist in the assessment and management of these clients, and accommodates postgraduate neuropsychology student placements.

The service is delivered by Turning Point.

## Specialist alcohol and other drugs consultancy service

The statewide Specialist Alcohol and other Drug Consultancy Service was initiated in response to a gap in service provision regarding a lack of services that medical professionals could refer their alcohol and other drugs clients to for specialist treatment and care.

Once referred to the service by their regular health-care provider, clients are triaged and provided with an initial face-to-face appointment with a specialist addiction physician or psychiatrist.

Following this initial appointment, a comprehensive treatment plan is provided to the referrer so that the client may progress their recovery as soon as possible.

The Specialist Alcohol and other Drug Consultancy Service model is a medical one, with psychological, nursing and other clinician support on hand to obtain the best outcome for clients. Telemedicine consultations have continued to be a small but significant and expanding form of consultation for rural and regional clients or for those who cannot attend appointments face-to-face.

The service is delivered by Turning Point.

## The Victorian dual diagnosis initiative

There is a range of State and Commonwealth funding allocated to enhance the capacity of AOD treatment services and mental health services to respond to clients with concurrent mental health and drug issues. As dual diagnosis is prevalent, staff should be trained in dual diagnosis and provided with appropriate education and learning opportunities.

The Victorian dual diagnosis initiative’s (VDDI) structure includes four metropolitan agencies with links to workers embedded in each rural region. AOD treatment services are supported by the VDDI which provides training and consultation services and has some direct service provision responsibilities to clients.

For more information on dual diagnosis and responding to client needs, please see the department’s website, [dual diagnosis](https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis). <www2.health.vic.gov.au/mental-health/practice-and-service-quality/specialist-responses/dual-diagnosis>.

### Purpose

The VDDI supports the development of better treatment practices and collaborative relationships between AOD treatment and mental health services. The key activities of the VDDI are:

* the development of local networks
  + training, consultation and modelling of good practice through direct clinical intervention and shared care arrangements.

### Target group

Mental health and AOD treatment workers who require support to respond to clients with concurrent AOD and mental health issues, and people who are experiencing issues related to concurrent AOD and mental health issues.

### Key service requirements

The initiative includes the following functions.

* Develop co-operative working relationships between mental health and AOD treatment services within the relevant area service catchment. This should particularly address areas of access, assessment and the development of effective treatment planning.
* Provide training and consultation to all community mental health and AOD treatment services within the catchment with a strong focus on building capacity within the services to respond more effectively to people with a dual diagnosis.
  + Provide direct service to clients with a serious mental illness and substance use problems with a focus on developing and modelling good practice. This may be by providing a limited direct service and intensive support/consultation to case managers on specific cases.

## Women's AOD service

The Royal Women’s AOD service (WADS) is a statewide AOD service providing specialist clinical services to pregnant women and their infants. The service also offers training and secondary consultations to health professionals in acute and primary health services and the community sector. This includes a 24-hour on-call medical service.

WADS provides medical care, counselling and assessment and support services to women affected by complex substance use and alcohol dependence, and assessment and care of infants exposed to AOD during pregnancy. WADS use a multidisciplinary team approach to advance the health and wellbeing and the medical needs of women and their infants.

WADS provide specialist services for pregnant women with ongoing AOD issues, offering a multidisciplinary approach to improve the health and well-being of pregnant women and infants.

## Mother and baby residential withdrawal unit

The mother and baby residential withdrawal unit is a statewide community residential AOD withdrawal service for mothers with babies operating at UnitingCare ReGen’s Curran Place site in Ivanhoe.

The four-bed unit delivers a tailored AOD withdrawal service to mothers with children aged up to 12 months. Clients engage in program activities operating at the adjoining Curran Place adult withdrawal unit.

## Reconnexion

Reconnexion, delivered by EACH, provides specialised services and programs to address the challenges of anxiety, depression and benzodiazepine dependency and related conditions. Services include counselling, secondary consultation, group programs, telephone support and information and community education.

Further information can be found online at [Reconnexion](http://www.reconnexion.org.au). <http://www.reconnexion.org.au/>

## Medically supervised injecting room

The Victorian Government has commenced the trial of a medically supervised injecting room (MSIR) in North Richmond.

The MSIR is a place where adults can inject drugs in a supervised health setting. The MSIR will also provide a gateway for people who inject drugs (PWID) to access other health services, as well as a pathway to treatment and rehabilitation.

Clients requiring services like mental health support, wound care and blood testing will be able to access them through the MSIR, and North Richmond Community Health (NRCH), or be referred to external health and support services, such as drug treatment or mental health support.

The primary purpose of the centre is to provide a safer setting for people to inject drugs, consistent with the objects outlined in Part IIA of the *Drugs, Poisons and Controlled Substances Act 2017* (the Act):

to reduce the number of deaths and harm from drug overdoses

to provide a gateway to health and social assistance, including drug treatment, health care and counselling

to reduce drug overdose related ambulance attendances and emergency department presentations

to reduce the number of discarded needles and syringes and the incidence of drug injecting in public places

to improve the amenity of the neighbourhood for residents and traders in the vicinity of the MSIR

to assist in reducing the spread of blood borne diseases, including but not limited to HIV and Hepatitis C.

### Key service requirements

The service will:

* provide PWID with access to sterile injecting equipment, safe syringe disposal options, and sexual health products
* provide a safer setting to inject in a medically supervised environment, considering privacy and safety
* provide crisis overdose response, and support for addressing medical needs such as wound care, abscesses, blood-borne virus treatment, and assessments
* support access to a range of health and social support services, including drug treatment, health care, mental health care and counselling
* allow for relevant harm reduction, treatment and support services to in-reach or collocate at the service
* offer service responses of varying duration and intensity dependent on client needs and preferences
* provide education and information to reduce the risk of drug-related harm
* provide education and tools to reduce the risk of overdose, and overdose deaths
* engage with the local community to improve understanding of the MSIR
* identify and respond to the harm reduction and support needs of clients and their families with appropriate approaches to culturally and linguistically diverse, Aboriginal, Lesbian, Gay, Bisexual, Trans and gender diverse and Intersex (LGBTI) people, dual diagnosis, homeless and forensic clients.
* maintain records within relevant legislative obligations to understand client needs, drug trends, service delivery and inform the pattern and volume of referrals
* participate in the evaluation of the service
  + provide brief interventions in the form of education and advice that aims to achieve a short-term reduction in harm associated with alcohol and other drug use. This may include crisis intervention, harm reduction measures, relapse prevention planning, and support for co-occurring issues, such as mental health.

## Compulsory drug withdrawal

The Severe Substance Dependence Treatment Act (SSDTA) provides for a brief period of detention and compulsory withdrawal treatment of people with severe substance dependence in a treatment centre. Only Victorians with the most severe substance dependence who urgently require treatment to save their life or prevent serious damage to their health will fulfil the criteria to be detailed and treated under this Act. Detention and treatment under this program is limited to a maximum of 14 days, and must always be an option of last resort.

### Purpose

Compulsory treatment under the SSDTA gives a person access to medically assisted withdrawal, time to recover, and the capacity to make decisions about their substance use, health, welfare and safety, and the opportunity to engage in voluntary treatment.

### Target group

To be eligible for treatment under the SSDTA, detention must be the only means by which treatment can be provided for a person, and there must be no less restrictive means reasonably available to enable the person’s treatment. Without intervention, these severely dependent people are likely to become permanently disabled or die. The Magistrates’ Court is required to make an order for the person to be detained and treated. The current treatment provider is St Vincent’s Hospital in Fitzroy, Melbourne.

### Key service requirements

St Vincent’s Hospital delivers the program which includes the following functions.

* operate the service under the requirements of the SSDTA, in accordance with residential withdrawal specifications for complex clients.
  + prior to discharging a client, work with local care and recovery coordination providers to support client access to voluntary AOD treatment and other support services (if clients choose to accept this service).
* Clients subject to compulsory treatment under the SSDTA have priority access to voluntary AOD treatment and support services following discharge from compulsory treatment.

For further information on the program*,* please see the department’s website, [Severe Substance Treatment Act](https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/severe-substance-treatment-act-ssdta). <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/severe-substance-treatment-act-ssdta>.

# Sector planning, support and capacity building

The department funds a range of services and organisations to provide support to the AOD treatment sector. This includes funding a catchment-based planning function, research, peak bodies and specific capacity building and workforce development activities.

## Catchment-based planning

The department funds a catchment-based planning function, undertaken by a single provider in each catchment. Services delivering this function are also the provider of at least one other AOD treatment stream in the service catchment/s. This function involves the engagement of a qualified and experienced planner.

### Purpose

This planning function assists AOD treatment providers operating in a given catchment to develop an evidence-based catchment plan which identifies critical service gaps and pressures and strategies to improve responsiveness to client and community need and population diversity, including disadvantaged population groups. Each plan provides the basis for improved cross-sector service coordination and by doing this achieve a more planned, joined-up approach to the needs of clients.

### Target group

Catchment planners support providers of all AOD treatment services within a catchment to efficiently participate in relevant service coordination and planning platforms managed by, for example, PHNs, public health services and local governments. All AOD service providers in a given catchment are required to actively participate in the development of an annual catchment-wide plan, as a condition of funding.

### Key service requirements

Catchment-based planners undertake the following functions.

* Gather and analyse relevant health and population data to identify and understand the distinct and diverse needs of people with AOD problems living in the service catchment
  + - this specifically includes people facing significant disadvantage and discrimination such as those who are homeless or at risk of homelessness, Aboriginal people, CALD and refugee populations, people with a dual diagnosis or disability, people with issues related to family violence and at-risk dependent children.
* Develop and regularly review a catchment-based AOD plan which identifies current and projected service gaps and pressures, and develop cohesive strategies to improve responsiveness to community need and population diversity.
* Work on behalf of, and in collaboration with, other AOD treatment providers in the catchment and other stakeholders including the department
  + - catchment-based planning processes must engage all AOD treatment services within the catchment.
* Engage with relevant agencies and planning structures (for example, PHNs and local governments through municipal health and wellbeing plans) and participate in discussions and planning to:
  + - identify and develop shared strategies to address systemic barriers to access and deliver a more coordinated response to the needs of people with AOD problems at the system level across the catchment
    - ensure the needs of people with an AOD problem in the catchment are taken into account in other local planning activity.
* Ensure the views of clients and their families inform the development and review of the catchment-based AOD plan and are represented in other relevant planning forums by creating or engaging in existing catchment level processes and opportunities.
  + Hold regular meetings with local/regional department representatives and other relevant government representatives regarding the development, review and implementation of the catchment plan.

The plan is based on analysis of relevant health and population data, supplemented by targeted consultation as required. It is expected to deliver:

* a single common catchment-based AOD plan developed in collaboration with funded AOD treatment services in the catchment and other key stakeholders, including clients and their families
* active involvement with relevant planning structures and processes to influence and jointly plan for the needs of clients and their family at the catchment level
  + advice on current and emerging trends at the local (catchment) level.

#### Funding model and accountability

This function is block-funded in each catchment. The funding provided is inclusive of salary, on-costs and corporate support costs. It is expected that this function involves the engagement of a qualified and experienced planner.

The provider is expected to provide an updated catchment-based plan on an annual basis.

For further information, please see *Part 3: Attachment 5*, which further details key data and information inputs, provides program governance advice and lists AOD providers of the planning function by catchment.

## AOD emergency department initiative

The department provides funding to 27 emergency departments (EDs) to assist in managing AOD related presentations. The investment aims to support EDs to improve their response by managing risky behaviours, responding to co-morbid mental health concerns, improving access to treatment, and increasing staff confidence in responding to patients with problematic substance use.

The initiative promotes and supports a flexible and consistent approach in program design to respond to the unique needs of EDs in metropolitan and regional Victoria. The initiative works within a continuous improvement framework to enable EDs to share best practice in managing AOD presentations.

## Research

The department supports evidence-based research to drive better outcomes for people affected by AOD use and that strengthens policy, regulatory and service responses to harm associated with AOD use in Victoria.

Research contributes to policy, practice, service design and delivery by:

* providing early surveillance on changing AOD trends
* improving knowledge on the influences of changing AOD use patterns and influences over life span
* providing measures of the prevalence of AOD use
* improving understanding of early intervention strategies and approaches to integration of AOD treatment and primary care
* improving understanding of influences of service demand and access
  + improving access and retention in treatment of specific population groups.

### Early warning systems

The department has a range or sources of information on emerging AOD use trends and harms.

#### AODstats and Ambo-AODstats

The department provides funding to publish statistics describing major patterns of AOD use and associated harms in Victoria. In 2014, these hard copy handbook volumes were redeveloped into an online interactive map in order to improve timeliness and usefulness of the data. AODstats and Ambo-AODstats are found on the Victorian AOD interactive statistics and mapping webpage. They provide information on the harms related to alcohol, illicit and pharmaceutical drug use in Victoria.

The data which underpin these pages were obtained from numerous sources, ranging from government departments to AOD treatment agencies. The information provides a convenient statistical and epidemiological resource for policy planners, service providers, catchment planners, health professionals and other key stakeholders. The data and maps build on and update information previously provided in text format, deliver the most recent data available and provide a monitoring tool for AOD trends.

#### Wastewater analysis

Estimating the use of AOD in the community is important for health and emergency services responses. Chemists can now quantify a variety of AOD in wastewater. Wastewater analysis provides reliable chemical data on the use of drugs of major concern to the community such as alcohol, methamphetamine, cocaine and MDMA. Wastewater analysis is population-based, and so has less ethical issues than other sampling methods. It does not provide information about any individual person’s AOD consumption, or frequency of use.

## Peak and advocacy organisations

### The Victorian Alcohol and Drug Association Inc.

The Victorian Alcohol and Drug Association (VAADA) is a peak organisation for the AOD sector, and aims to reduce the harms associated with AOD use within the Victorian community. VAADA’s membership includes people working in the AOD field, and individuals who have an interest in minimising the harms caused by AOD.

VAADA’s purpose is to ensure that the issues for people experiencing the harms associated with AOD use and the organisations that support them are well represented in policy and program development and public discussion

VAADA provides advice to the department to inform policy development and advocates for changes to the service system. VAADA also represents member’s issues, provides leadership, keeps members informed and supports evidence-based practice in the sector.

### Victorian Aboriginal Community Controlled Health Organisation Inc.

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is the peak body for Aboriginal Health. VACCHO is the leading advocate for the health of Aboriginal people in Victoria and a peak organisation to its membership.

VACCHO is an Aboriginal community organisation that represents 100 per cent of ACCHOs in Victoria. VACCHO’s purpose is to build the capacity of its membership and to advocate for issues on their behalf.

VACCHO provides advice to the department to inform policy development and shape how health services are developed and delivered for the Aboriginal Community. VACCHO also provides a strong support network, education and training, workforce development opportunities, undertakes research and advocacy, and provides resources for the sector and the community.

### Harm Reduction Victoria

Harm Reduction Victoria (HRVic) is a peer-based organisation that provides education, practical support, information and advocacy to users of illicit drugs, their friends, and allies. Funded primarily by the department, HRVic seeks to improve the way people who use drugs are treated in the broader community as well as by medical, community and government services. Department-funded HRVic harm reduction initiatives include the DOPE naloxone training program (see *Harm reduction - overdose prevention and response training* in this document), and DanceWize, which aims to reduce AOD-related harm at Victorian dance parties, festivals and nightclubs through peer education.

### Penington Institute

Penington Institute is a not-for-profit organisation advancing health and community safety by connecting substance use research to practical action. Funded by the department, Penington Institute aims to: enhance awareness of the health, social and economic drivers of drug-related harm; promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use; build and share knowledge to empower individuals, families and the community to take charge of substance use issues and; better equip front-line workers to respond effectively to the needs of those with problematic drug use. Penington Institute provides the community overdose prevention and education program, COPE (see *Harm reduction - overdose prevention and response training* in this document).

### Self Help Addiction Resource Centre

SHARC, a community-based organisation, promotes self-help and peer-led approaches to recovery from severe AOD-related issues.

SHARC aims to provide opportunities for individuals, families and communities affected by addiction and related problems to recover and achieve meaningful, satisfying and contributing lives.

SHARC provides a confidential telephone helpline, web-based information services, community-based training programs and support groups, peer-based residential programs, a consumer advocacy service for treatment service users, and training for health and welfare workers.

SHARC is a leader in Peer Workforce Development, providing training for peer workers and organisational readiness for treatment services. SHARC delivers Peer Workers supervision in groups and individually, as well as consulting to the AOD and Mental Health sectors as experts in Peer Work.

#### Association of Participating Service Users

APSU is a Victorian consumer representative body at SHARC. APSU draws guidance and direction from an advisory committee made up mostly of consumers. APSU’s membership is free and both consumers and service providers are encouraged to join.

APSU’s purpose is to increase consumer participation in AOD treatment services, policy development and implementation, and increase service user-run programs and activities.

APSU works to ensure the opinions, ideas, and experiences of people who use AOD services contribute to policy, research, service provision and professional development. .

APSU has conducted research, developed practical guides to consumer participation and disseminated written information materials and newsletters to the Victorian AOD Sector.