

*Towards a New Blueprint for Alcohol and Other Drug Treatment Services:
A Discussion Paper*

How to Make a Submission

Alcohol and Other Drug (AOD) Sector partners are invited to contribute their views on the proposed future direction of Victoria's Alcohol and Other Drug Treatment Services as outlined in the Blueprint Discussion Paper.

Proposed objectives and priority actions are summarized below for your consideration. Key questions have been listed to assist you with your submission. You may wish to focus your submission on a particular aspect of the discussion paper and you may address all, some or parts of proposals according to your interests. Additional general comments on the overall strategic objectives are welcome.

Submissions may be made publicly available on the DHS website. Please mark your submission 'confidential' if you do not want your submission to be published.

Submissions can be forwarded as a word or PDF document using one of the three options below. (Note: the website does not provide facilities for the uploading of submissions online.).

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Please submit your feedback by **18 May 2007**

Additional copies of the Blueprint discussion paper and submission guidelines can be found at <http://www.health.vic.gov.au/drugservices/pubs>

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Submission Title Page

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Submissions will be considered as available for discussion and publication unless you indicate otherwise.

Confidential: Yes

No

Vision

To ensure Victorians with alcohol and other drug issues have access to appropriate, timely, effective and quality alcohol and other drug treatment services and interventions to reduce the harms caused to individuals, families and communities.

Objectives

1. A client-centred system
2. Improved accessibility
3. Improved quality
4. Promote prevention & early intervention
5. Stronger partnerships & linkages

Key questions for you to consider when preparing your submission:

1. *What are the potential advantages or benefits of this priority action?*
2. *What are the potential challenges or risks of this priority action?*
3. *What factors would need to be considered in the development or implementation of this priority action?*
4. *How would this priority action impact on your agency?*
5. *Should this priority action be pursued further?*

General comments on the overall direction of the Blueprint Discussion Paper

VAADA thanks DHS Drugs Policy and Services Branch for the opportunity to comment on their Blueprint discussion paper. VAADA recognises that the Blueprint represents an attempt by DHS to improve the existing AOD treatment services sector. We welcome this work, and appreciate the effort that DPSB has put into consulting with the AOD sector while drafting the Blueprint.

VAADA recognises that the Blueprint is designed to improve the efficiency and capacity of the service system within current funding constraints. We acknowledge that all public resources should be used efficiently, and commend the work of the Drug Strategy Group in determining how public monies might best be utilised in improving services for users of alcohol and other drugs.

However, VAADA believes that there is a need for better whole of government coordination of financial contribution to the AOD sector. Many aspects of the current service system will not be sufficiently improved unless more resources are dedicated to improving them. Although participants at all but one of the Blueprint consultations that VAADA attended were specifically advised that there would be no further funding for services under the Blueprint, participants continued to raise the need for better resources. At various forums, sector workers have indicated that

- AOD treatment workers need to work without pay in order to treat clients adequately;
- Clients are being sent for treatment to other states because the Victorian system is under capacity;
- Clients are being turned away from services because the system is under capacity; and
- Clients are failing to access services because waiting lists are too long.

In the advent of any future funding being directed to the AOD treatment system, we believe that the following areas should receive targeted resourcing:

- Intake systems aimed at helping with waitlist management
- Developing services with Indigenous and CALD communities
- Growth corridors and response to population changes

Nevertheless, VAADA also acknowledges the efforts made by DPSB in drafting the Blueprint, and the limitations they have had to work in. We believe that many of the strategies suggested in the Blueprint discussion paper represent positive ways of improving the current treatment service system design. In this submission, VAADA hopes to highlight suggested ways of improving service system design within the constraints of the current funding model.

Priority Area 1: Responding to the Needs of Young People

Please refer to the questions listed above when considering the priority actions listed below.

For more information on this section, please refer to pages 13-25 of the Blueprint Discussion Paper.

- a) A new quality framework for treatment services incorporating a client charter of rights and responsibilities.

Please see response to priority action 2.a

- b) Improve client input into service planning and delivery.

Please see response to priority action 2.a.

- c) Youth residential withdrawal service specifications reviewed to take account of client needs.

(No response)

- d) Develop a stronger therapeutic framework for Youth Outreach service type.

VAADA acknowledges DHS concerns that outreach is an under-utilised mode of treatment delivery. We also believe that having a stronger therapeutic framework to youth outreach services could well improve some client outcomes.

However, we are concerned that there was not much support for introducing a therapeutic framework for youth outreach services expressed at the Blueprint Regional Consultations. It appears that demand for a stronger therapeutic framework in AOD youth outreach services is primarily arising from outside the AOD sector. **VAADA recommends that a stronger therapeutic framework is not generally introduced into youth outreach services until a model of the framework is more clearly outlined following appropriate consultation with the sector. Further, the model should**

- **Clearly be shown to improve client outcomes; and**
- **Include a rationale for how it improves client outcome.**

VAADA notes that strengthening the therapeutic focus of outreach may lead to outreach workers being required to keep more detailed records of clients' behaviour. We also note that in many outreach situations it will be very difficult to obtain informed consent from clients regarding the obtaining and storing of information. **VAADA recommends that any therapeutically oriented form of youth outreach include strong guidelines**

- **Advising treatment workers that the minimum necessary amount of personal information should be requested from clients**
- **On obtaining informed consent from clients regarding obtaining and storing client information**
- **On the appropriateness of applying therapeutic interventions in any given case**

We also recommend that DHS bear in mind that should youth outreach workers be required to deliver therapeutic outreach, they will need remuneration at the similar levels to CCCC workers.

Those AOD treatment workers who expressed support for strongly therapeutic youth outreach services also said that they were already engaged in this sort of work. VAADA additionally recommends that any exploration of models of therapeutic youth outreach explore existing models of therapeutic outreach as well.

Please see also response to priority action 3.b.

- e) Development of clearer criteria and transition/service transfer arrangements for older clients of youth-specific services.

VAADA strongly supports the development of clearer criteria and transition arrangements for older clients of youth services. We recommend that the following factors be borne in mind during the development of any new criteria and arrangements:

- That some older clients of youth services have an 'emotional age' younger than their chronological age. We recommend that special guidelines be developed for identifying and arranging treatment for such clients, taking full account of the rights and needs of these clients.
- That clients are reported as frequently dropping out of treatment during the transition from youth to adult services. The high attrition rate is often attributed to the decrease in levels of client support and management between youth and adult services. **VAADA recommends that a thorough investigation be conducted into the causes of client drop out on transition from youth to adult services; that a report of this investigation, including recommendations, be produced; and that changes be made to youth and/or adult services on the basis of these recommendations.**
- VAADA also considers that not all youth clients will need to access adult services after treatment in the youth system. VAADA recommends that the investigation into the causes of client drop out take this into account.
- VAADA also considers that developmental delay may not be the only reason why some adults could be more appropriately treated within youth-focused services. For instance, some clients with ABIs may benefit from similar services as youth clients. VAADA recommends that DHS consider the possibility of services based around a more nuanced assessment of developmental level.

Until this investigation is conducted, as an interim measure VAADA recommends the creation of positions for transitional case managers who can help support clients during the transition from youth to adult services.

- f) Workforce development initiatives to improve case management skills and confidence in responding to family issues during treatment.

Please see response to priority action 2.g, regarding workforce development initiatives across the sector.

- g) Exploration of early intervention and integrated delivery opportunities with other services that deliver programs for vulnerable young people.

VAADA supports the emphasis of the Blueprint discussion paper on both early intervention and integrated delivery of youth services. We recommend that the following factors be taken into account when exploring potential program types in this area:

- That AOD treatment providers may not at present be the most appropriate people to undertake prevention work. VAADA suggests that DHS consider the possibility of developing training in AOD-related health promotion and prevention, and including this work within AOD workforce development strategies at a later time. Resourcing for developing and implementing this training could be located within general health or health promotion funding streams.
- That vulnerable young people can be stigmatised by contact with treatment services, and can consequently become socially isolated. We therefore recommend that any targeting of young people under 'indicated prevention' programs balance the need to protect young people from risk, the need to protect young people from stigmatisation, and the need to protect the rights of young people.
- That prevention and early intervention programs (which run into each other) work better when conducted within communities, in collaboration with members of the community.
- That creative, innovative solutions be found for intervening early, and that early interventions are developed in response to the characteristics and needs of the specific community and/or social groups being targeted.

h) Develop referral protocols with family service agencies to improve access to family therapies.

VAADA supports families having better access to family therapies, and believes that strengthening referral protocols between family and 'mainstream' services will help do this. However, VAADA notes that at present there are few family-specific services in Victoria. We suggest that DHS consider investing new resources in improvement of AOD services for families.

VAADA also believes that the rights and needs of drug users' families always need to be balanced against the rights and needs of drug users. We recommend that the choice about whether a drug user accesses family-based therapies remains with drug users.

VAADA notes that the needs of families and their treatment preferences may vary across different cultural communities. We recommend that cultural-specific family treatment programs be developed for members of CALD and Indigenous communities, with strong referral protocols both with generalist agencies and to mainstream agencies.

We recommend that DHS consider establishing a referral service for CALD-specific agencies, which could also perform referral services for family-focused services based in CALD communities.

VAADA also emphasises the need for workers within mainstream family services to be able to access cultural awareness training.

i) Build stronger links with employment and training services and initiatives to improve connectedness of young people.

VAADA strongly endorses the strengthening of linkages between youth treatment services and employment and training services. Connection to employment and training can prevent young people from using alcohol and other drugs in a way that results in social isolation; and can also help reconnect young people who misuse alcohol and other drugs to their communities.

Promoting involvement in employment or training could form part of 'indicated prevention' programs, while connecting young people to employment and training could constitute part of treatment (or possibly harm reduction) programs. **VAADA recommends:**

- **In the first instance, that DHS provide better resourcing to AOD treatment agencies to help them support linkages with employment and training agencies.**
- **That DHS develop a referral services for youth AOD agencies that helps support linkages with employment and training programs**
- **That involvement in employment and/or training programs be associated with treatment outcomes for some young people, as appropriate.** For some young people, reconnection to their community – as measured by involvement in training and/or employment – may be an appropriate treatment aim.

Further to this, VAADA notes that partnerships with employment and training represent a weak point across the AOD sector, not just in youth services. **VAADA recommends that**

- j) Identify resources required to build effective partnerships and linkages for clients and review performance measurement systems.

Please see response to priority action 2.f and responses under Section 3.

- k) Develop Whole of Government Alcohol and Drug Abuse Prevention Strategy that incorporates prevention work with Indigenous and CALD communities.

Whole of Government AOD Strategy

VAADA strongly supports the development of a Whole of Government Alcohol and Drug Strategy. Alcohol and drug misuse can have harmful consequences in multiple areas of life; the work of various government departments relates to these diverse areas. However, **VAADA is concerned that currently the Whole of Government Alcohol and Drug Strategy does not refer to any real, concerted strategy across government to deal with the harms associated with misuse of alcohol and other drugs.**

VAADA also believes that while the work of some government departments might best be focused on prevention of AOD misuse, prevention strategies would work best if planned in association with planning of treatment and harm reduction services. Therefore, **we recommend the establishment of a Whole of Government Alcohol and Drug Strategy, in preference to a Whole of Government Alcohol and Drug Abuse Prevention Strategy.**

As an aside, VAADA notes that should the strategy go forward as a prevention strategy, it might be more appropriate for the strategy to be called the 'Whole of Government Alcohol and Drug **Misuse** Prevention Strategy'.

VAADA notes that any Whole of Government AOD strategy must take into account:

- The links between problematic AOD use and a host of social and economic disadvantages
- The links between problematic AOD use and a host of medical problems
- A host of strategies of strategies that combine to form a harm minimisation approach: prevention, harm reduction, demand reduction, supply reduction, treatment, brief interventions, law enforcement
- The links between these different elements of a harm minimisation approach
- A range of systemic issues mitigating against the individual who has the problem (eg hospital and medical treatment access, treatment waiting lists, policy limitations, and so on).

Work with Indigenous and CALD communities

VAADA believes that any Whole of Government Alcohol and Drug Strategy should address prevention work with Indigenous and CALD communities. However, we also believe that there are pressing AOD-related issues in both CALD and Indigenous communities. Not all are directly related to prevention. Further, VAADA does not believe it is in the direct interests of CALD and Indigenous clients to delay work until a Whole of Government AOD Strategy is formulated. We therefore recommend that DHS consider developing specific, targeted projects to address AOD issues in Indigenous and CALD communities.

With regards to Indigenous communities, VAADA recommends

- That an AOD action plan for Indigenous communities be developed in consultation with Indigenous communities and the AOD sector, identifying areas for attention, and planning where to focus resources and actions.
- That any AOD action plan for Indigenous communities focus on strengthening
 - General capacity to respond to clients within Koori-specific services, by
 - Developing a flexible funding pool for innovative programs
 - Developing a referral service for secondary consults for Koori-specific agencies. This referral service could have a role in developing training related to services for Koori clients
 - Developing services or elements of services that can involve family and community groups in treatment planning
 - Establishing an expert reference group that has capacity to issue reports
 - Building a network involving Koori-specific and network agencies that meets regularly
 - Capacity to respond to Koori clients within mainstream services, by
 - Offering access to cultural awareness and linguistic training for staff
 - Strengthening referral protocols with Koori-specific agencies
 - Building networks
- That research into treatment efficacy among Koori people be extended and better disseminated. Members of Koori communities should actively participate in all stages of the planning and execution of this research.

With regards to CALD communities, VAADA recommends

- Given the proportion of people from CALD communities currently accessing the AOD treatment system, that at some level CALD services become part of every agency's work
- That there be a focus on prevention within emerging CALD communities, to prevent AOD-related problems within these communities, and to prevent emerging communities from becoming ghettoised.
- That ethno-specific prevention, harm reduction, treatment, and law enforcement AOD strategies be developed for use with CALD communities, prior to development of the Whole of Government Alcohol and Drug Abuse Prevention Strategy
- That AOD strategies be developed in collaboration with members of CALD communities
- That all treatment staff at mainstream AOD agencies be offered access to training in cultural awareness
- That AOD treatment services which are often accessed by members of CALD communities should employ workers with relevant linguistic skills, or have a consultant interpreter. Other AOD agencies, without bilingual workers, should develop strong referral protocols with these agencies
- That a referral service for secondary consults for CALD-specific agencies be developed.
- That forums to discuss issues arising around AOD misuse and CALD communities, attended by staff from both mainstream and ethno-specific agencies, be supported by DHS
- That ADIS be amended to give a better indication of how strongly clients who speak English as a first language might be involved in CALD communities – for instance, at

- present a client with a single grandparent from a CALD background and a client with two parents with English as a second language would appear identical on an ADIS assessment.
- That research into AOD issues and CALD communities be better disseminated across the AOD sector, as part of the Victorian AOD research strategy
 - That AOD prevention strategies targeting CALD communities consider working within CALD communities, ideally by collaborating with respected members of those communities

Other emerging communities

VAADA is concerned that the Blueprint discussion paper does not discuss emerging communities other than emerging CALD communities. There is currently strong population growth in the outer metro regions of Melbourne. These new communities are often planned without regard for demand for health and welfare services, and are usually remote from existing health and welfare services.

In light of this, **VAADA recommends**

- **That any AOD treatment strategy take account of population growth corridors in Victoria**
- **That a needs assessment for AOD treatment services in these emerging communities be conducted**
- **That the findings from this needs assessment exercise inform the planning of AOD treatment services in Victoria**

l) Establish an AOD research strategy for Victoria that identifies ways to better disseminate contemporary Australian research across the field.

Please see response to priority action 2.i.

m) Develop a comprehensive Brief Interventions Strategy for application in primary health services, hospitals and the AOD treatment sector.

Please see response to priority action 2.m.

n) Identify existing good practice and opportunities to build stronger links between AOD treatment services and harm reduction services.

Please see responses to priority actions 2.b and 3.a.

o) Improve access to youth-related AOD training opportunities for harm reduction workers delivering information, advice and referral to young people.

Please see response to priority action 3.a.

p) Develop and conduct amphetamines and cannabis media campaigns to improve community awareness of harms and risks associated with these drugs and help and support available for individuals and families.

VAADA has some significant reservations in relation to this issue. Firstly, VAADA is concerned that there is not enough evidence supporting the value of public media campaigns in reducing demand for illicit drugs. Secondly, we are concerned that there is not enough evidence to support the creation of campaigns that focus specifically on amphetamines or cannabis.

VAADA advises that caution is exercised during the planning of any proposed media campaigns, specifically in ensuring that scarce funding is not shifted from areas where it is needed to campaigns that will almost certainly be ineffective.

Should the Victorian Government proceed with its plans to conduct public media campaigns, **VAADA recommends that the following factors be taken into account:**

- **That any media campaigns designed to reduce demand are targeted at those who are likely to take up use of amphetamines and/or cannabis.**
- **That any media campaigns take into account the diversity among users and potential users of amphetamines and/or cannabis.**
- **That any media campaigns are carefully pitched to avoid stigmatising users of amphetamines and/or cannabis.**
- **That any media campaigns designed to reduce demand also be directed at those in a position to help correct structural problems that lead to use of amphetamines and/or cannabis.** For example, a campaign could be directed at employers in the hospitality and transportation industries.
- **That media campaigns focus on educating potential users about reducing harms associated with the use of amphetamines and/or cannabis.**
- **That media comment from the Victorian Police accord with current data in relation to amphetamines, and is consistent with DPSB and/or VicHealth messages; and that the messages from different departments within VicPol present a consistent message to the public.**

Priority Area 2: Improving Interventions & Services for Adults and Young People

Key questions:

Please refer to these questions when considering the priority actions listed below.

1. *What are the potential advantages or benefits of this priority action?*
2. *What are the potential challenges or risks of this priority action?*
3. *What factors would need to be considered in the development or implementation of this priority action?*
4. *How would this priority action impact on your agency?*
5. *Should this priority action be pursued further?*

For more information on this section, please refer to pages 26-41 of the Blueprint Discussion Paper.

- a) New quality framework for treatment services incorporating a client charter of rights and responsibilities and improved client input into service planning and delivery.

VAADA expresses caution with regards to imposing a new quality framework on AOD treatment agencies. Our membership reports that the bureaucratic burden on treatment agencies associated with accreditation is already high, and imposition of a new quality framework would simply force treatment agencies to shift labour from treatment to administrative tasks.

Further, our membership reports that there does not appear to be any clear rationale for imposing a new quality framework on AOD treatment agencies. Almost all of the quality standards outlined in the new quality framework are already covered by existing accreditation frameworks. VAADA is also concerned that the new quality framework is being developed without any review of the existing CQI quality/accreditation framework.

If DHS requires more consistency in accreditation across the AOD treatment system, VAADA recommends that any one of three alternatives be followed instead of imposing a new quality framework on AOD treatment agencies on top of the existing accreditation frameworks:

- That DHS narrow down the proposed quality framework so that only those standards not currently covered by existing accreditation frameworks (such as the requirement that treatment programs must accord with the research evidence base) be included within the new quality framework;
- That DHS impose the new quality framework, but remove treatment agencies' requirement to accord with the CQI framework; or
- That DHS not impose the new quality framework on AOD treatment agencies.

VAADA recommends that DHS conduct a review of CQI before developing a new quality framework for AOD treatment agencies, or taking any of the above courses of action.

If development of the new quality framework goes ahead, VAADA considers that it must include scope for development of new policy initiatives. At present, the Victorian AOD sector does not have a coherent or unified policy strategy, although such strategies are operational in other Australian and international jurisdictions, and have been implemented in Victoria in the past. The lack of such a unified policy strategy in Victoria has meant that treatment and harm

reduction programs proved to be successful in other jurisdictions – such as medically supervised injecting rooms – have not been introduced here.

Additionally, VAADA commends the continuing strong client focus of the proposed quality framework. VAADA is concerned, however, that an independent entity to receive, review and investigate service user complaints is not attached to the new Charter. VAADA considers that any move to protect clients' rights is empty without an independent review mechanism that can:

- Assess clients' complaints about service;
- Mediate disputes between clients and services;
- Provide support and advocacy services for clients; and
- Produce reports on structural problems within the AOD service system.

Ideally such a mechanism should be fully independent of DHS or the service system. Accordingly, **VAADA recommends that a formal and fully independent review mechanism be established and attached to the Charter of users' rights and responsibilities. This mechanism would need to be**

- **Adequately resourced, and**
- **Adequately advertised to clients.**

This review mechanism could be formulating following an assessment of the effectiveness and appropriateness of adopting the different complaints mechanism models used in the mental health, disability, and housing sectors. It could also be appropriate to consider locating this mechanism as a function of the Health Services Commissioner.

VAADA welcomes increased client input into service planning and delivery. Such an approach should help sharpen the approach agencies take and better reflect the needs of the consumer. AOD treatment services should always be targeted at clients' treatment needs, and the most effective way to assess client need is to keep clients engaged in development of the treatment service system. **VAADA recommends that mechanisms be developed for ongoing client input into service system development.** We advise that client input occur across the service system, from hospital to health centre and other community-based agencies, not only within youth services.

Additionally, VAADA believes that any future quality framework for the AOD treatment system must take account of the experience and expertise of AOD service providers. Any new quality framework for the AOD treatment service system would ideally be developed and implemented in full consultation with AOD service providers. **We recommend that this principle of broad-based consultations informs development of the new AOD treatment sector quality framework.** The success of the processes followed and outcomes of the West Australian quality framework is indicative of what can be achieved in this area.

VAADA acknowledges that any new quality framework should take account of both best practice and innovative new programs developed by AOD treatment services. Please see further responses to priority action 2.b and 2.c.

b) Promote service innovation and flexibility to respond to the needs of clients.

VAADA strongly endorses promotion of service innovation and flexibility in responding to the needs of clients. However, we note that at present AOD treatment service agencies across all regions of Victoria are compelled to invent innovative/flexible service programs because current funding models do not allow service providers to adequately respond to client need within their funding agreements. While we believe that ongoing innovation and flexibility within the treatment system is valuable, and while we acknowledge that the innovations of service

providers are the best they can do in their circumstances, we do not believe that the innovations currently being made are necessarily the best possible programs for meeting the needs of clients.

Ideally, ongoing funding would be allocated to developing research into the needs of clients and how best to respond to them. In light of this, **VAADA recommends that the proposed AOD research strategy for Victoria include provision for exploring innovative and flexible treatments for users of drug and alcohol.**

Additionally, **VAADA recommends**

- **That, prior to the rolling out innovative programs, an assessment must be made**
 - **Of whether or not the program is likely to address client need effectively**
 - **Of how moving resources from an agency's core services to innovative programs might affect client demand on other agencies**
- **That safeguards for clients in innovative programs be put in place.**
- **That an innovative programs funding pool should be established to promote innovative projects in the sector.**
- **That successful innovative programs developed by AOD treatment agencies be publicised across the sector.**

Please see also response to priority action 2.g (recommendations regarding flexible funding).

- c) Core standards and specifications for service delivery to be reviewed and updated taking account of evidence based research and best practice.

VAADA supports ongoing review and update of the core standards and specifications for service delivery. While we fully endorse standards and specifications being based on evidence-based research and best practice, we also believe that standards and specifications must receive support from the AOD treatment sector. It is also not clear whether the AOD treatment sector has enough evidence-based research on which to base core standards and service specifications. Accordingly, **VAADA recommends that any new core standards and specifications for service delivery be derived from thorough consultation with the AOD treatment sector.**

We also recommend that any AOD research strategy continue research into the effectiveness of existing service types.

Please also see responses to priority actions 2.a, 2.b, 2.d and 2.g.

- d) Recognition of the importance of case management in service delivery in quality frameworks, service specifications and performance measurement.

VAADA agrees that AOD treatment agencies currently undertake much casework with clients, and that most of this work is not currently acknowledged within our present quality frameworks, service specifications, and performance measurement systems.

The upcoming Blueprint will be based on a client-centred model of prevention, harm minimisation and treatment. On the basis of views expressed at the Regional Blueprint Consultations and in the course of VAADA's consultations, VAADA believes that casework is, under the current funding model, crucial to ensuring that clients stay within treatment services for an adequate amount of time, and thus improving outcomes. **Ideally, better resourcing would be given to AOD treatment agencies to allow them to employ staff to either better**

address client needs and thereby reduce the need for casework, or to perform casework functions.

VAADA also recommends that DHS take into account the fact that, without better resourcing, focusing on casework will compel AOD treatment workers to spend less time treating clients. We believe that including a casework standard within the new quality framework cannot be considered a long-term solution to the problem of sector-wide under-resourcing, and may possibly exacerbate this problem.

If, and only if, a casework standard is introduced into the new quality framework, VAADA supports recognition of case management in AOD treatment service specifications. During the Regional Blueprint Consultations, however, much confusion arose about what the term 'case management' actually meant. Confusion also arose concerning what service types involved case management-type work. Accordingly, **VAADA recommends that before 'case management' is incorporated into AOD treatment service specifications, DHS should**

- **Fully explore models of case management and casework;**
- **Provide a clear definition of 'case management' and/or 'casework' to use in service specifications; and**
- **Determine which treatment service types should involve case management/casework, and to what level.**

VAADA recommends that DHS conducts this investigation in full collaboration with AOD treatment service providers.

VAADA considers it to be a necessary consequence of the above that case management/casework be recognised within AOD treatment service performance measures. If case management/casework is recognised within service specifications but not within performance measurement targets, then AOD treatment staff will be required to do work for which they are unaccountable, and for which they are not adequately remunerated. Therefore, **VAADA recommends that, if case management (or its equivalent) is recognised within service performance measures, case management (or its equivalent) be recognised within performance measurement targets.**

Please also see responses to priority actions 2.a, 2.d and 2.g.

- e) Current information and education provision for clients and families/carers to be reviewed and enhanced where possible.

VAADA supports improving access to information for clients and families/carers. We recommend that information about AOD treatment services, including support services for families, be promoted through workplaces and community institutions. Information about Directline could be included in this information.

VAADA broadly supports the seamless information and intake system envisioned within the Blueprint discussion paper. We therefore **tentatively** support enhancement of Directline by connecting it to a duty worker intake system, although **we recommend that Directline operates only as a referral point.** Directline might be most valuable in this context if used to support clients before they enter treatment services.

VAADA notes that development of a duty intake worker system

- May, by standardising intake systems, make intake processes more accountable to clients
- Would ideally help AOD treatment services and DHS keep better track of waiting lists and unmet need

- Would ideally give DHS a better idea of what waiting lists and service capacity exist, and what capacity may be required.

Further, VAADA notes that if clients and families are able to access information about intake systems through Directline, this could

- Improve information to clients and families
- Improve access to services by streamlining and creating a single entry point
- Help ensure seamless service for clients and families, particularly if clients were able to make appointments for assessment through Directline
- Help make the best of scarce resources by using an 'AOD treatment marketing budget' in marketing the single entry point (eg, Directline), rather than a host of different agencies
- Provide valuable data about treatment service system demand and supply. We recommend that collected data be publicly accessible and that this system be open and transparent

VAADA also notes that the duty intake worker system presents several potential problems:

- The duty worker intake system is not economical in the case of smaller agencies. **If a solution for smaller agencies cannot be found, then plans to develop a duty worker intake system will need to be abandoned.** Implementing it in larger agencies alone would create inconsistencies, and possible inequities, across the sector.
- AOD agencies will not be able to shift workers from treatment services to staff the duty intake worker system. **VAADA advises that funding will need to be found to develop, implement and maintain any standardised duty intake worker system.**
- VAADA also notes that the creation of a seamless information-and-intake system may entail the creation of after-hours services. We recommend that this be borne in mind during development of any duty worker intake system.
- **VAADA recommends that, in the case of any duty worker intake system being established, DHS should provide full support to AOD treatment agencies during implementation of the duty worker intake system.**

Although VAADA acknowledges that the duty intake workers system could not work in the case of smaller agencies, **VAADA does not endorse the establishment of a regional duty worker intake system.** Our concerns about a proposed regional duty worker intake system include

- Questions as to where the regional duty worker intake function would be located. We consider that locating the duty intake worker in either regional DHS offices or in nominated AOD agencies would be problematic.
- The regional duty worker intake function would need to be located separately from agencies. Clients would then need to have contact with several staff before accessing treatment – which is believed to make clients more likely to drop out of treatment.

In general, VAADA believes that co-ordination of system-wide improvements might be negatively affected if the improvements are fragmented into regional activities.

At this point, VAADA considers that a different solution should be found for making intake processes consistent across smaller agencies. Perhaps three different systems could be developed for consistent intake across small, medium and large agencies, respectively.

- f) Review performance measurement systems in collaboration with VAADA and other stakeholders including options for regional service targets.

VAADA welcomes the opportunity to work with DHS in reviewing performance measurement systems. At present the AOD treatment system performance measurement system fails to

capture a large amount of the work performed by AOD treatment agencies. Consequently, this work cannot officially be measured against any performance standard, and it technically goes unpaid. **VAADA recommends that the current AOD treatment system performance measurement system be reviewed and revised.**

Further, we recommend that the following factors be taken into account during revision of the AOD treatment performance measurement system:

- **The types of work AOD treatment staff currently undertake that are not already counted by ADIS – for example, case management/casework;** VAADA considers that it is preferable to introduce case management/casework to the AOD treatment system via revision of the performance measurement system than via a quality framework.
- **The types of work AOD treatment staff believe should be included under a revised performance measurement system;**
- **The types of work clients believe should be included under a revised performance measurement system;**
- **That both clients and service providers will need to be consulted in the process of reviewing the performance measurement system;**
- **That the contents of any AOD treatment performance measurement system must reflect the contents of the AOD treatment core standards and service specifications;**
- **That an alternative methodology to ADIS may be required to assess revised performance measurement targets;**
- **That an alternative unit of measurement to the Episode of Care may be required to assess revised performance measurement targets.**

VAADA considers that it is too early to support regional service targets, for the following reasons:

- Given the diversity between Victoria's regions, it may be too difficult to devise a methodology for setting appropriate and fair regional targets.
- It is not in line with the reporting requirements of other Victorian health and welfare sectors.
- It is not clear how regional performance targets would benefit either clients or service providers.
- Any information that would become available to DHS under regional performance measurement reporting requirements can already be accessed through ADIS.

g) A refreshed Workforce Development Strategy to improve the skills and competencies of workers in responding more effectively to the needs of AOD clients.

VAADA acknowledges the importance of continuing to develop the AOD treatment workforce so that workers will respond better to clients' needs. **VAADA recommends the establishment of a Workforce Development Unit or sector development unit, ideally within VAADA.**

VAADA has some concerns with aspects of the future Workforce Development Strategy:

- Firstly, VAADA is concerned that an emphasis on workforce development may lead to resources being shifted to training from other areas within the AOD treatment system where they cannot be spared. **We recommend that this be taken into account during drafting of the Workforce Development Strategy.**
- Secondly, several of the Regional Blueprint Consultations revealed that AOD services are often taking on clients who would probably best be seen by services dedicated to working in other health and welfare sectors. This is contributing to the overloading of the system reported by AOD treatment workers. VAADA is concerned that the workforce development strategy may be aimed at developing AOD staff to help clients who would better be dealt

with by other services. Given that AOD treatment workers already report that they are unable to meet demand, **VAADA recommends that any new Workforce Development Strategy should explicitly take into account the current lack of capacity within the treatment system to meet demand for services.**

- Thirdly, VAADA shares concerns expressed during the Regional Blueprint Consultations that, within the current design of the AOD treatment system, developing the AOD treatment workforce will lead to highly trained workers leaving the AOD treatment system. AOD workers are currently paid less than equivalent workers in other sectors of the health and welfare fields, and they have no clear path for career advancement. This occurs in part because the sector employs workers of mixed professional levels. VAADA notes that DHS wishes to raise and standardise professional standards among the AOD treatment workforce. However, should AOD workers be required to adhere to a higher professional standard of training, they will at some future point in time need to be remunerated at a professional level – which will necessitate better funding for staffing purposes.

VAADA believes it is in the interest of both AOD treatment system workers and AOD treatment system clients for workers to be better trained. We also believe, however, that insisting that AOD treatment workers be better qualified without allocating more resources to AOD agencies for staffing purposes will lead either to staff leaving for better paid work (exacerbating the current high rate of staff turnover within the sector), or to managers skimping on other costs to pay for labour. **We recommend that this be taken into account during drafting of the Workforce Development Strategy.**

- Fourthly, while VAADA believes that the Workforce Development Strategy rightly focuses on the skills indicated in the Blueprint discussion paper – namely responding to clients' needs, working with families, and case management – we note that at present there are no methods of measuring workers' performance in these areas. This is of particular concern given that the Workforce Develop Strategy focuses on areas where workers interact with potentially vulnerable stakeholders such as clients and families. Consequently, **VAADA recommends that any new training or work requirements of AOD treatment workers by the upcoming Workforce Development Strategy be linked to clear and relevant performance measurement targets.**

Further to this, as funding for AOD agencies is tied to performance measurement targets via ADIS, VAADA is concerned that the new Workforce Development Strategy will require AOD treatment workers to perform work that is uncounted and unpaid. Given that new funding cannot be allocated to AOD services under the Blueprint, **VAADA recommends that flexible funding be allocated to AOD treatment agencies to allow them to implement any new Workforce Development Strategy.**

Any such flexible funding could also be used by agencies to develop innovative new programs (see further response to priority action 2.b). Accordingly, **VAADA recommends that DHS, in collaboration with VAADA, investigate models of flexible funding and implement a system by which AOD treatment agencies can access flexible funding.**

Given that the AOD treatment system will not receive new resourcing under the Blueprint, it is advisable that DHS look at ways in which workforce development can be delivered more economically. VAADA believes that the current diversity among AOD Registered Training Organisations is valuable, as AOD clients require diversity in treatment philosophies and modalities. However, training might be more economically delivered if the RTOs were unified through a 'sector development and training' forum; this forum would give RTOs a chance to liaise, and could also act as a clearinghouse through which information about training and development could be discussed and accessed. Therefore, **VAADA recommends that with DHS support VAADA establish an AOD treatment Sector Development and Training Unit to coordinate RTOs, and to collate and disseminate information about sector training opportunities.**

- h) Ensure AOD workforces have access to cross-cultural training to improve service accessibility for Indigenous and CALD clients and ensure the sector is able to respond appropriately to emerging refugee and new migrant communities.

VAADA supports this priority action area, but believes that much more work needs to be done to establish links between mainstream, Indigenous and CALD agencies to ensure access of Indigenous and CALD clients to services. In addition to cross-cultural training being provided to AOD services, **VAADA recommends**

- **That better support and resourcing be given to Indigenous- and CALD-specific services**
- **That a referral services agency be established to support links between CALD, Indigenous, and mainstream agencies**
- **That more information be made available within Indigenous and CALD communities about accessibility and specifications of treatment and harm reduction services.**
- **That networks between mainstream, Indigenous, and CALD agencies be further developed, enhanced and supported by DHS**

- i) Establish an AOD research strategy for Victoria.

VAADA strongly supports better dissemination of research findings across the AOD treatment sector. However, we recommend that any review of how to improve dissemination of research findings across the sector must include investigation of the barriers to disseminating research.

Further, **VAADA recommends that a strategy for better dissemination of AOD research should include ways of making AOD research available and accessible to clients so that they may make informed decisions about their treatment.**

In order to promote 'ownership' of AOD research among the Victorian AOD treatment sector, we suggest that AOD treatment agencies be encouraged to participate in research activities. Accordingly, **VAADA recommends that any existing funding pool for AOD research be expanded and made accessible to a broader range of agencies.**

Additionally, while we acknowledge that much research (notably on CALD communities) has not been adequately disseminated across the field, we are also aware that there are still gaps in the AOD evidence base. **VAADA therefore recommends that the AOD research strategy should identify gaps in current research, and devise strategies for filling those gaps, in addition to determining how research should be disseminated.**

Please also see responses to priority actions 2.b, 2.c and 2.i.

- j) Explore options for a central residential vacancy management system and regional intake networks to ensure clients receive timely assessment and matching to appropriate services.

VAADA broadly supports the establishment of a centralised residential vacancy management system, with some qualifications. We believe that a centralised intake system

- Could possibly help clients locate treatment places more quickly than under the present system

- May help fill beds that are vacated suddenly
- Would assist in establishing a mechanism for assessing unmet demand and supply issues in the treatment system

However, we note the following reservations concerning adoption of a central intake system:

- Some service providers, particularly in rural areas, have expressed concerns that clients will be compelled to take the next available bed, no matter how distant it is from their home.
- Concerns have been expressed that clients will be compelled to take the next available placement, even if that placement occurs in an agency with treatment programs contrary to clients' needs.
- Accordingly, **VAADA recommends that clients not be removed from any centralised intake waiting list if they refuse a placement on reasonable grounds, including**
 - **Extreme geographical distance/transportation problems**
 - **Incompatibility between client's needs and service philosophy and/or treatment program**
 - **Lack of relevant cultural or linguistic expertise in placement agency**
- Some service providers, again particularly in rural areas, have expressed concerns that the referral pathways they have built up with local service providers will be lost or ignored if a centralised intake system is established.
- Accordingly, **VAADA recommends**
 - **that DHS fully explores a range of models for implementing a centralised intake system prior to implementation;**
 - **that AOD treatment service providers and clients are thoroughly consulted during this process; and**
 - **that the value of existing informal referral pathways be taken into account.**
 - **that the intake system include a mechanism to feed localised knowledge into centralised systems.**

Some service providers have also expressed concerns that a centralised intake system will remove their ability to refuse clients whom they see as posing a risk to staff or other clients. While we are wary of endorsing exclusion of clients from services, we acknowledge that some clients can disrupt other clients' progress in treatment. Except in exceptional circumstances, one client's needs should not override the needs of many clients. Additionally, even in a client-focused system where the principle of meeting clients' needs overrides the principle of protecting workers' safety, the safety of AOD treatment staff should still be ensured to the maximum extent possible.

Given the above, **VAADA recommends that the centralised intake system include a mechanism for reviewing agencies' requests for clients to be excluded from placement in an agency. Appropriate policies would need to be developed, and any mechanism which is established should at least**

- Be able to receive requests that a client not be placed with an agency
- Have the capacity to expedite requests
- Assess requests on the basis of (a) meeting clients' needs; and (b) protecting staff safety
- Have strong evidentiary requirements for requests
- Be able to mediate for a client to be placed within an agency
- Have an attached complaints mechanism to receive complaints from both agencies and clients
- Be auspiced under the same agency as the centralised intake system

Further, VAADA recommends that, where a client is placed in an agency contrary to a request from that agency, DHS provide workplace supports to staff within that agency.

- k) Review options to build a more diverse pharmacotherapy system in Victoria to improve access to services for clients and access to training and information about pharmacotherapy for AOD agencies and other health and welfare services.

Although VAADA understands the significance of what has been achieved over the years in Victoria with regard to opioid substitution therapies, we believe that the current Victorian system has some significant failings largely around prescriber- and provider-related issues. One perspective of this problem is that demand and supply are in great disequilibrium. Given the stress the current system finds itself in, it is imperative that a range of alternative approaches be tried, even if in pilot form.

VAADA fully supports access to information about pharmacotherapy for AOD agencies and other health and welfare services. Further to this, however, **VAADA recommends that access to pharmacotherapies be extended.** Extension of the program could see a range of positive social outcomes, including reduced deaths, reduced imprisonment rates, reduced crime, stabilisation for drug using individuals, and so on.

VAADA's membership has indicated that there are significant barriers to accessing pharmacotherapies in Victoria. These include:

- There simply are too few dispensers of pharmacotherapies in Victoria. The scarcity of pharmacotherapy dispensers affects clients as pharmacotherapy dispensers tend to be concentrated in certain areas, with clients in other areas – particularly rural and outer metro areas. Potential clients living in these areas are often dissuaded from taking up treatment because of transportation and time issues.
- The scarcity of pharmacotherapy dispensers also presents serious workforce issues for AOD service providers, as dispensers become overloaded with clients. This exacerbates low levels of recruitment, as the high workloads of dispensers discourage other GPs and pharmacists from dispensing.
- Clients on pharmacotherapies are often on lower incomes or in receipt of Centrelink payments. Dispensing fees for pharmacotherapies can therefore represent a significant proportion of clients' income, making pharmacotherapies effectively unaffordable for some clients.
- Clients may drop out of pharmacotherapy programs for a number of reasons. Currently, there is no provision for continuity of care for Victorians who drop out of pharmacotherapy programs, and so these clients may fail to re-access treatment.

VAADA is concerned that none of these problems with the current Victorian pharmacotherapy system will be corrected without more resources to extend services. Therefore, **VAADA recommends that the Victorian government consider extending funding to pharmacotherapy programs.**

VAADA notes, however, that this is not likely to happen within the current funding regime for AOD treatment services. Accordingly, **VAADA recommends that DHS consider a range of dispensing models that do not rely on the traditional pharmacist figure**, including:

- the nurse practitioner dispenser model, possibly based on the community health nurse practitioner model
- a mobile pharmacotherapy model, based on currently existing mobile health services, which could incorporate recording technologies used in mobile child immunisation programs
- a brief interventions model (see further response to priority action 2.m)
- combining pharmacotherapy with other treatment types, particularly counselling

- l) Ensure services have access to up-to-date training, support and information to respond effectively to emerging drug types.

VAADA recognises that there are different patterns of use and different environmental risks associated with use of different drugs – and that accordingly different harms arise from the use of different drugs. However, currently it is unclear whether responding to clients on a ‘drug-by-drug’ basis is effective. **VAADA therefore recommends that research be conducted to assess whether it is appropriate to respond to clients on the basis of drug(s) used.**

It may be appropriate for treatment service workers to respond to clients on the basis of drug(s) used. If so, and if treatment workers are consequently required to increase capacity by responding to emerging drug types, then capacity to respond to emerging drug types becomes a workforce development issue. Consideration must then be given to the factors outlined in the response to priority action 2.g.

- m) Develop a comprehensive Brief Interventions Strategy for application in primary health services, hospitals and the AOD treatment sector.

VAADA considers that a Brief Interventions Strategy (BIS) represents an essential part of any new strategy for helping improve efficiency within the AOD treatment sector. We believe that brief interventions offer an opportunity both to enhance existing interventions and to help fill gaps in the service system. **VAADA welcomes the opportunity to work with DHS and others in developing a Brief Interventions Strategy for the AOD treatment sector.**

Brief interventions present an opportunity to improve efficiency of AOD treatment services without new funding. It is not clear, however, whether or not the existing EOC-based funding structure is appropriate to use of brief interventions. **VAADA recommends that work on a Brief Interventions Strategy should consider**

- **Whether it is appropriate to fund brief intervention-type services under an EOC-based funding model**
- **If the EOC model is appropriate, what modifications might need to be made to the EOC-based funding model were it to be applied to brief interventions**
- **If the EOC model is inappropriate, what other model of funding could be applied to work involving brief interventions.**

VAADA considers that a BIS would work best if combined with a strategy for flexible funding for AOD treatment agencies, either on a permanent basis or until a better funding structure for brief interventions is determined. Accordingly, **VAADA recommends that work on a Brief Interventions Strategy be complemented by work on a Flexible Funding Strategy for the AOD treatment sector.**

During the Regional Blueprint Consultations, confusion was expressed about what the term ‘brief interventions’ actually meant. It emerged that ‘brief interventions’ could take two forms:

- Opportunistic interventions, often but not exclusively undertaken by workers outside the AOD treatment sector; and
- Brief courses of treatment, which could occur within several different treatment types

VAADA believes that, however they are eventually defined, both these types of brief interventions could be valuable additions to the AOD treatment repertoire.

- Opportunistic interventions may

- Help identify clients who might not otherwise be attracted to the AOD treatment system
- Offer the opportunity to intervene with clients before they develop dependent alcohol or drug use
- Help in the development of linkages between AOD treatment services and other health and welfare services, particularly GPs and hospital-based services
- Represent a non-stigmatic means of intervening with youth clients and clients from CALD communities
- Provide a means of educating clients about the risks of alcohol and other drugs
- Brief courses of treatment may
 - Allow greater numbers of clients to access treatment
 - Be a more appropriate response to the treatment needs of some clients
 - Make better use of the resources of AOD treatment agencies
 - Present an opportunity to strengthen new casework initiatives

Although opportunistic interventions could present a means of preventing some clients from becoming alcohol- or drug-dependent, VAADA notes that opportunistic brief interventions also have the potential to be intrusive, paternalistic, and even offensive, as they will in most circumstances be applied to clients who have not sought treatment for AOD issues. In order to counteract this, **VAADA recommends that any Brief Interventions Strategy that recommends use of opportunistic interventions should include a complaints mechanism for clients specific to use of opportunistic interventions.**

Given that clients may not even be aware that they are being 'treated', creating an adequate complaints mechanism for opportunistic interventions presents serious challenges. **VAADA recommends that the form of this complaints mechanism should be thoroughly worked out before implementation of the Brief Interventions Strategy; and, if no adequate complaints mechanism can be developed, then use of opportunistic interventions should be excluded from the Brief Interventions Strategy.**

It should also be borne in mind that, given the potential intrusiveness of opportunistic interventions, potential deliverers of opportunistic interventions will need to be carefully trained to respect the rights of clients. Accordingly, **VAADA recommends that potential training strategies for deliverers of opportunistic interventions include**

- **Training in awareness of clients' rights**
- **Training in sensitivity to the needs of youth people**
- **Training in sensitivity to the needs of members of CALD communities**
- **Training in sensitivity to the needs of members of Koori communities**

While brief interventions are currently primarily performed via outreach, the two different types of brief intervention suggest possibilities for use in different treatment types and situations. For instance:

- Opportunistic interventions could be used
 - In hospitals and community health services in the course of other medical treatment
 - By GPs in the course of assessing patients
 - By workers in the homelessness sectors
 - By school nurses
 - By dental workers
 - By harm reduction workers
 - By outreach workers
- Brief courses of treatment could be used
 - As short courses of counselling
 - As a form of support for families of alcohol and drug users
 - As an interim or 'safety net' form of administering pharmacotherapy
 - Through internet services

Given all the above, **VAADA recommends that the Brief Interventions Strategy should**

- **Examine models of both types of brief intervention**
- **Develop clear definitions of each type of brief interventions**
- **Specify which treatment types could involve use of brief interventions**
- **Specify which sorts of agencies will apply brief interventions**
- **Develop a strong complaints mechanism to be attached to use of opportunistic interventions**
- **Recommend that training in brief interventions include thorough training in the rights and needs of various client groups**
- **Explore the educational opportunities presented by brief interventions**

n) Development of stronger links between AOD treatment services and harm reduction services with improved access to training opportunities for harm reduction services delivering information, advice and referral.

Please see response to priority action 3.a.

Priority Area 3: Building Partnership

Key questions:

Please refer to these questions when considering the priority actions listed below.

1. *What are the potential advantages or benefits of this priority action?*
2. *What are the potential challenges or risks of this priority action?*
3. *What factors would need to be considered in the development or implementation of this priority action?*
4. *How would this priority action impact on your agency?*
5. *Should this priority action be pursued further?*

For more information on this section, please refer to pages 42-51 of the Blueprint Discussion Paper.

- a) Development of stronger links between AOD treatment services and harm reduction services including community pharmacies and NSP services with improved access to training opportunities for harm reduction services delivering information, advice and referral.

VAADA welcomes initiatives to build stronger links between AOD treatment services and harm reduction services, and recommends that these linkages be developed across the AOD treatment sector, not just in youth services. **VAADA recommends that VAADA and ANEX be supported in forming a reference group that will**

- **Explore possibilities for improving referral protocols between treatment and harm reduction services.**
- **Explore possibilities of adopting a case management/casework model for clients requiring services from both treatment and harm reduction agencies.**
- **Identify areas of mutual concern where collaborative endeavours can be applied**
- **Explore strategic areas of mutual activity**

VAADA supports increased access to AOD treatment training for harm reduction services, and believes it presents the opportunity to address a gap in the training currently provided by the AOD RTOs. **VAADA recommends that DHS support VAADA (and possibly others) in establishing a clearinghouse with the tasks of**

- **Identifying AOD treatment training needs for harm reduction workers;**
- **Brokering projects for AOD treatment training for harm reduction workers to AOD RTOs;**
- **Disseminating information about AOD treatment training to harm reduction workers.**

Ideally, training would be provided to harm reduction workers on **how to deliver information about a wide range of health and welfare needs** – housing, employment, training, etc – to clients. VAADA acknowledges that youth and adult clients may have different needs in this regard, and recommends that this be taken into account during identification of AOD treatment training needs for harm reduction workers.

- b) Develop a comprehensive Brief Interventions Strategy for application in primary health services, hospitals and the AOD treatment sector.

VAADA recommends the formal recognition of VAILA by DHS through direct funding support. VAILA has an important role to play in bridging the gap between community-based treatment services and the experience of hospital-based treatment services.

VAADA also recommends that formal recognition be given to the Victorian Primary and Community Health Network by DHS. This network bridges the gap between community-based primary health facilities and treatment services.

Please also see response to priority area 2.m.

- c) Work with Divisions of General Practice and the Royal Australian College of GPs in the development of the Brief Interventions Strategy and to improve awareness of AOD issues and responding to alcohol and other substance use in the context of mental health initiatives.

Both VAILA and VPCHN should be asked to be involved in the development of such strategies.

Please also see response to priority area 2.m.

- d) Promote service innovation and existing good practice in hospitals to identify and respond to clients with AOD issues.

VAADA acknowledges the importance of good AOD-related practice in hospitals as part of any broad AOD strategy. Currently, a high proportion of hospital admissions are drug- and/or alcohol-related; many AOD clients are treated within hospitals, or are referred from hospitals to other treatment services. In order to strengthen links between hospitals and community-based AOD treatment services, and to promote good AOD-related practice in hospitals, **VAADA recommends**

- **That access to training on the special needs of clients with AOD-related disorders or AOD co-morbid conditions be available to all hospital-based medical staff**
- **That access to training on how to deal with AOD-related disorders or AOD co-morbid conditions be available to all hospital-based medical staff**
 - **This training could be developed and delivered by AOD treatment agencies**
- **That hospital staff in intake or triage departments be required to undergo training in identifying AOD involvement in admissions**
- **That VAILA be formally recognised by DHS through direct funding support. VAILA has an important role to play in bridging the gap between community-based treatment services and hospital-based treatment services.**
- **That formal opportunities for networking between hospital staff and community-based AOD treatment staff, such as VAILA, be supported by DHS**
- **That referral protocols between hospitals and the community-based AOD treatment sector be strengthened**

Please see response to priority action 2.b for general comments on promotion of service innovation.

Please see responses to priority actions 2.b and 2.c for general comments on promotion of best practice in AOD treatment.

- e) Pilot treatment models for forensic clients that secure long-term behaviour change and explore funding models that promote after hours access to treatment for forensic clients in full time employment.

VAADA broadly supports piloting treatment models for forensic clients that secure long-term behaviour change. However, this support is subject to several qualifications:

- **That any pilot programs fully take into account the human rights of forensic clients.**
- **That forensic clients only be required to participate in these pilot programs as part of their sentencing requirements.**
- **That if these programs prove successful in securing long-term behaviour change, that the possibility of their being extended to all AOD clients be explored.**

VAADA also recommends that pilot treatment programs should incorporate post-release provision of methadone, on a fully subsidised basis, and for an indefinite length of treatment.

Additionally, VAADA endorses the extension of after-hours treatment services to forensic clients, but **recommends that after-hours treatment services be accessible to all clients.**

- f) Explore partnering opportunities with other program areas such as Office for Children and Primary Health to improve family and community connections, access to mainstream health and dental services, encourage take-up of secondary NSPs and other services to better address client needs.

VAADA considers that partnering opportunities with other program areas should be explored as part of a concerted Whole-of-Government Alcohol and Drug Strategy. **VAADA reiterates that any whole-of-government alcohol and drug strategy must be developed as a coordinated approach among the relevant areas of government.**

VAADA welcomes better partnerships and linkages with the Office for Children, the Department for Victorian Communities, the Department for Education and Training, and Primary Health services. However, **VAADA emphasises that developing linkages and partnerships with other sectors requires resourcing; and that, given the lack of expanded funding to the AOD sector, any strategy for developing inter-sectoral linkages must take into account the fact that resources will be diverted from other services to develop new linkages.**

VAADA believes that the purposes of developing better linkages and partnerships between agencies and departments in different sectors are

- To address client needs more effectively; and
- To improve efficiency within both the AOD treatment system and the health and welfare sectors more widely.

However, VAADA believes that the first of these two principles clearly overrides the second. **We recommend that caution be exercised to ensure that clients' needs are always addressed by the most appropriate agency.**

Several important potential partners in drug treatment issues are not mentioned in the Blueprint discussion papers:

- Victorian Police
- Office for Youth
- Local government authorities

VAADA recommends that DHS consider Victorian Police, the Office for Youth, local government authorities, and other relevant bodies as potential partners in a whole-of-government AOD strategy, in addition to those partners named in the Blueprint discussion paper.

- g) Strengthen links with the Department for Victorian Communities and the Department for Education and Training.

Please see response to priority action 3.f.

- h) Review workforce development programs and performance measurement systems to ensure recognition of the roles of case management and partnership building.

Please see responses to priority actions 2.d, 2.f and 2.g.

End submission