Whole of Government AOD Strategy

Response to AOD Sector Consultation

September 21st, 2011

Overarching questions

1. How should prevention, early intervention, treatment, education, regulation and law enforcement activities be tailored to take into account the following (please provide ideas for some, all or others)?

• Age and stage of life

In keeping with emerging research and consistent observations across the health and community service sectors, Moreland Hall has noted a growing demand for treatment services by people aged over 50 years, particularly in relation to alcohol use. Typically, these presentations are characterised by chronic poor health in multiple areas, entrenched unemployment, family breakdown and social isolation.

The risks associated with over-use of prescription medication amongst older people will also require special attention, both in relation to overdose risk (as evidenced in the recent Turning Point report on ambulance overdose attendances in 2009/10) and long-term health impacts. While the complications arising from combining alcohol with prescription medication are well recognised within the AOD and broader health sectors, we appear to be witnessing the emergence of a new target group (i.e. those developing dependence on opiate-based analgesics) who would be unlikely to identify as AOD-dependent but who will require significant levels of future support.

The lack of AOD services specifically catering to the needs of older people will become more apparent as the population continues to age. The growth in numbers of older people experiencing harms relating to overmedication and/or long-term alcohol use will place a particular burden on our health and community services.

Planning needs to be done on how AOD treatment services will be integrated within aged-care settings and gerontology services. It appears logical that (as is currently underway for mental health and family services) these will be the next areas to be targeted for improved approaches to co-ordinated care with AOD treatment services. It is clear that age will need to become a standard criterion when considering complexity of clients' needs.

- **Different settings, including country Victoria**

Moreland Hall has extensive experience in delivering treatment and education services across a range of different settings, including in Victorian regional and rural areas. Two of the major challenges we have observed in these areas are ensuring the sustainability of services that are locally available and overcoming logistical access barriers to those that are not.

Moreland Hall has developed strong service linkages within the Rural Hume region to support referral of young people into the agency's youth residential withdrawal service. These partnerships have been demonstrated to provide effective service co-ordination between Moreland Hall and regional service providers. However, logistical difficulties – primarily associated with client and workers' travel to and from Melbourne for assessment and treatment – remain a significant obstacle to further improvement of service co-ordination.

After having been responsible for the regional delivery of the 'Cautious with Cannabis' and 'FOCiS' diversion programs for several years, local service providers are typically reporting that there is insufficient demand within their community to sustain continued face-to-face delivery. Whilst Moreland Hall's Melbourne-based programs continue to be in high demand, the delivery of these programs in regional areas is placing an unreasonable burden on already overstretched local service providers.

Moreland Hall proposes that increasing use of online approaches to service planning and delivery will provide one solution to treatment accessibility for people in rural and regional Victoria. The agency is about to commence the development of a pilot project utilising remote videoconferencing for a range of activities including:

- Clinical assessment;
- Participation in group programs;
- Case management conferences;
- Family 'visits' with clients engaged with residential programs;
- Treatment blogs and other forms of consumer feedback.

The agency's Registered Training Organisation (RTO) has already demonstrated the effectiveness of it's blended approach of face-to-face and online delivery for competency training and is well-placed to continue its development of a range of self-directed therapeutic and educational online interventions for clients.

In keeping with this approach, and the service model for the above videoconferencing project, Moreland Hall proposes the expansion of partnerships between rural/regional service providers and larger metropolitan services with the capacity to develop and maintain high quality online interventions. There is an increasing body of evidence supporting the effectiveness of online delivery for early interventions and more intensive therapeutic work. However, such interventions require significant expertise to develop and maintain, and are premised upon appropriate accessibility (suitable ICT, broadband connection speed etc.) for end users.

By utilising rural/regional services as a local access point (with services provided with appropriate ICT infrastructure and technical support), interventions can be centrally maintained by services with appropriate levels of expertise. This would free up local service providers to focus their limited resources on more intensive interventions with those people requiring more individualised treatment.

- **Culturally and linguistically diverse communities**

There is a clear need for the Victorian AOD sector to be more engaged with CALD communities to increase community understanding of key issues (such as the nature of dependence and the western concept of mental health) and awareness of available treatment and support services.

Moreland Hall's own experience (most recently, in partnership with the Foundation House: the Victorian Foundation for Survivors of Torture) has shown the benefits of taking a community development approach to working with CALD community groups. AOD treatment services (and their underlying approach) need to be explained in the context of different cultural understandings of AOD use, dependence and recovery. Interventions need to provide appropriate responses to community issues and provide practical benefits that are readily identifiable by community members. Treatment providers need to work in partnership with target community networks and recognise community resources that can be integrated within treatment planning and delivery to promote recovery.

This process requires the development (and ongoing maintenance) of strong relationships between service providers and key community stakeholders. The importance of personal relationships between service provider staff and community stakeholders in building community trust cannot be understated. This process can be a time and resource-intensive process, particularly during the development phase. Any initiatives targeting CALD communities need to have appropriate time frames and will need suitable sustainability plans to ensure that relationships are not lost once project funding ceases. They must also be appropriately targeted at one or two key communities, rather than trying to cover many communities at once. It is not enough simply to translate existing materials into community languages. Interventions need to be in-depth and focussed on sustainable processes, not shallow interactions to promote resources that will, without sufficient community engagement, remain largely unused.

- **Aboriginal and Torres Strait Islander Victorians**

As with CALD communities, providing AOD treatment services with ATSI communities requires a strong emphasis on partnerships, consultation, trust-building and building strong relationships with key stakeholders. Gaining acceptance within ATSI communities as an ethical and culturally appropriate service takes time and requires ongoing commitment to the maintenance of effective service linkages.

Moreland Hall's success to date in gaining acceptance within ATSI service networks and community fora has required a sustained commitment to maintaining appropriate consultation processes that do not fit well with typical project funding frameworks. The development of our *Yarnin About Yarndi* resource kit is a good example of a project that was pursued well after Departmental funding for a cultural adaptation of the *Cautious with Cannabis* program had expired. The resources required were far greater than initially projected, but the outcome was far superior and our insistence on following appropriate consultation processes has resulted in a high degree of community ownership of the resource. As a result, community networks are now more interested in ongoing collaboration with Moreland Hall. In September this year, our CEO and Koori Alcohol and Other Drug Worker were invited by network members to present our current activities to the Aboriginal Strategic Governance Group for the North and West Metro Region.

Yarndi also provides a good example of appropriate interventions by AOD treatment services, namely those that focus on supporting local service providers to work within their own communities and help to build the capacity of mainstream services to engage with ATSI clients in culturally appropriate ways.

Yarndi is an example that should be built upon. One obvious step would be the expansion of the resource to include alcohol-specific content.

- **Disadvantaged populations**

The key to effective engagement and supporting sustained treatment outcomes with disadvantaged populations is the adoption of a holistic approach to their typically complex and interrelated needs. It is important to recognises that AOD use within target groups may be far from the primary causal factor of disadvantage, but that it can exacerbate existing burdens or stigma. For AOD treatment to

be effective, it must be co-ordinated with appropriate responses in other areas to support recovery in a truly holistic sense.

What will also be required with disadvantaged populations is a clearer provision of AOD treatment services within a chronic health model, with a focus on ongoing, regular support, as opposed to the current episodic approach.

A good example of this type of approach is the State Government's response to Bushfire-affected communities. The mobilisation of multiple resources that was effectively case-managed by experienced staff made a significant impact within those communities, including a co-ordinated approach to the impacts of a history of trauma. While it would be impractical to expect the expansion of this level of services to a broader population group, it is worth considering for target risk groups experiencing particularly entrenched disadvantage.

One example of possible applications of this approach is the current expansion of Moreland Hall's Intensive Playgroup program to provide engagement with families identified by Family Services or Maternal and Child Health Nurses as being at risk of experiencing AOD-related harms. The development of this capacity for early interventions with vulnerable families provides a potentially powerful vehicle for extending the reach of treatment providers beyond acute harms and take on a more preventative role.

• People with multiple and complex, or forensic needs

As mentioned above, the need for holistic approaches to multiple and complex needs (including involvement with the justice system) is well recognised. As with other disadvantaged populations, forensic clients require an integrated response that recognises the interrelation between the causal factors of their offending and their AOD use.

Moreland Hall is an established provider of community and prison-based forensic treatment and has extensive experience in responding to the particular challenges faced by forensic clients. There is a clear need for an improved understanding of the roles that AOD treatment can (and cannot) play in promoting individual recovery and reducing future recidivism. AOD treatment is not simply a box to be ticked within legal proceedings or forensic case management. Moreland Hall has found that the best outcomes are achieved when Magistrates, Community Corrections Officers and other relevant stakeholders have an appropriate awareness of the treatment process and how it can best be integrated with other supports and interventions.

An example of this is the work Moreland Hall has done with Magistrates and elders at Victoria's Adult and Children's Koori Courts. The training provided to these court officials was recognised by participants and making a significant contribution to improving their capacity to engage in therapeutic jurisprudence and make better use of the AOD treatment resources available within their communities.

Moreland Hall is also recognised as a leader in the development of innovative services for clients with multiple and complex needs, including Dual Diagnosis. Since 2001, the agency has implemented a range of responses designed to improve the planning and effectiveness of AOD treatment episodes for people who are not well-served by the standard delivery model. Chief among these is Intensive Support Services program that provides a more intensive, case management approach of longer duration than a standard counselling episode.

The model has proven to be an effective model for providing significant and durable outcomes for people who require a more co-ordinated and holistic approach to their AOD treatment and other support needs. It is a model that should be more widely adopted for services working with people with multiple and complex needs. The model would also provide a vehicle for encouraging all funded AOD treatment providers to engage with this client group, rather than referring 'difficult' clients on to other services.

• The needs of hard-to-reach groups

Strategies for engaging with traditionally hard-to-reach groups (e.g. CALD communities) have been outlined above. As with all clinical work, the key to engagement with such groups is the establishment of respectful and effective relationships and the perception of benefit resulting from subsequent interactions.

One hard-to-reach group that Moreland Hall is placing increasing emphasis on is Pre-Contemplative or Contemplative users, of both licit and illicit substances. This has required the development of appropriate engagement and communication strategies. For example, the agency's *Bluebelly* website (www.bluebelly.org.au) targets Pre-Contemplative amphetamine-type substance (ATS) users and focuses entirely on harm reduction information (provided by site users and moderators). By definition, Pre-Contemplative users will always be unlikely to seek out AOD treatment information or contact with treatment services.

It is incumbent on the AOD sector to reach out to this group (rather than relying on social marketing campaigns) to establish direct contact and provide audience-appropriate interventions that encourage shifts in attitudes and behaviour relating to AOD use. Available evidence suggests that hyperbolic, fear-based marketing campaigns will work with a small proportion but are not, on balance, an effective harm reduction strategy. Government and the AOD sector need to provide a more co-ordinated, consistent and evidence-based message on the potential harms associated with AOD use. Such an approach will provide a far greater opportunity to promote informed community responses to AOD issues and reduce the level of stigma associated with AOD use and AOD treatment services. It will also improve the perceived credibility of Government messages on emerging issues (e.g. 'analogue' drugs) amongst those groups most likely to be affected by them.

Moreland Hall's unfunded *Alcohol: Considering Change?* program was originally developed in response to expressed community concern about alcohol-related harms. Intended to build on media coverage of binge-drinking by young people, the program sought to provide a new pathway into treatment services for those Contemplative alcohol users who would not previously have considered seeking specialist support. Now operating for three years, the program has become a *de facto* Diversion program, with Magistrates from across the Metropolitan region referring people facing alcohol-related charges.

• The experiences of consumers, families and carers.

While there have been encouraging recent initiatives to cater to the needs of families and carers of people participating in AOD treatment and promote consumer participation within the AOD sector, there is still much that needs to be done. Although the development of sustainable consumer participation approaches throughout the sector will take time to establish and embed within individual providers' culture, there is a broad range of possible strategies for incorporating people's lived experience into treatment planning, implementation and review:

- Expand opportunities for sectoral research into consumer experiences (and treatment outcomes – see below).
- Recognise the role families have in supporting recovery and increase the capacity of treatment providers to include family members and carers in treatment planning, delivery and review.
- Establish Family Inclusive Practice as core business for AOD treatment providers, as has been done more widely for Dual Diagnosis practice. Support capacity building with funded competency training.
- Improve the availability of services for family members and carers, such as the Action for Recovery Course (ARC) delivered by Moreland Hall in partnership with Family Drug Help.
- Treatment services should support broader pathways to recovery e.g. via study, training, volunteering, employment. Improve partnerships with relevant education, training and employment service providers for a more integrated approach.

Moreland Hall's Intensive Playgroup program has been recognised as an effective model for engaging with children affected by parents' AOD use and is one that could be expanded to other services. The agency's introduction of a Family Counsellor role is also demonstrating the powerful benefits for AOD treatment that can be gained by strengthening family relationships within the context of an individual's recovery.

2. Can you provide examples of approaches which have effectively prevented or delayed the onset of drug and alcohol use, or which have reduced the misuse and early use of alcohol and drugs in the community?

As mentioned above, Moreland Hall's Intensive Playgroup program provides an effective model for expanding AOD treatment services into mainstream primary health settings. In addition to the prevention of future harms relating to children's development, future AOD use and related issues, the Playgroup model is providing a good example of the value of engaging with at-risk families at an early stage to prevent the onset or escalation of AOD-related harms for parents and children.

While an early-childhood, developmental focus is ultimately likely to produce the most sustainable outcomes, there are a range of other initiatives that can play a clear preventative role. Harm Reduction initiatives designed to provide young people with authoritative and practical information relating to AOD use have been shown to be successful in improving young people's awareness of related issues and reducing risks associated with experimental and occasional use. Moreland Hall resources such as *Mind Your Head* (AOD use and mental health) booklets or the *Duggy's Krew* series of animations have proven to be effective tools for engaging young people in discussions of potential risks associated with AOD use and developing strategies to avoid them.

Additionally, Diversion Programs such as *Cautious with Cannabis* and *FOCiS* provide an effective mechanism for reducing the possible escalation of AOD use (and related harms) amongst those coming into contact with the legal system for the first time.

One example of prevention that has successfully engaged with the broader population on alcohol has been Hello Sunday Morning (http://hellosundaymorning.com.au). It has been particularly effective in reaching young drinkers who would never have considered seeking specialist treatment and has built a positive model for supporting and reinforcing behavioural change. It also provides a potentially effective model for client engagement and collection of treatment outcomes data.

3. How can the following be more involved in preventing drug and alcohol misuse (please provide ideas for some or all)?

- **Individuals**
  - Be more aware of signs of potential misuse amongst friends and colleagues and aware of potential responses.

- **Parents/families**
  - Parents model appropriate behaviour for their children.
  - Parents have access to authoritative information and better understanding of issues relating to AOD use by young people.
  - Families able to discuss AOD use issues openly, with children provided with authoritative information.

- **Schools**
  - Increase capacity of school nurses/welfare workers/psychologists/chaplains to provide appropriate support (and referrals) for students affected by AOD misuse.
  - Improved linkages with specialist AOD treatment services.

- Integration of resources developed by AOD services within curricula, as has been done with Beyond Blue's *Kids Matters*.

- **Communities**
  - Improved awareness of AOD issues and reduced stigmatisation of people using AOD.
  - Improved support for at risk and vulnerable families.
  - Improved linkages with local AOD treatment services.

- **Local governments**
  - Improved awareness of the impacts of planning decisions (e.g. approval of housing developments without appropriate community infrastructure) on future AOD misuse and related community concerns.
  - Better support for specialist AOD treatment services.

- **Businesses**
  - Provision of employment opportunities for people in recovery
  - Better support for specialist AOD treatment services.

- **Liquor licensees**
  - More effective application of Responsible Service of Alcohol (RSA) requirements.
  - Avoiding promotions targeting binge drinking.

- **Health services**
  - Improved acceptance of people presenting with AOD issues.
  - Improved service partnerships with specialist AOD treatment providers.
  - Increased capacity for brief AOD interventions by primary health workers.

- **Police**
  - Improved partnerships with specialist AOD treatment services.
  - Development of local Diversion initiatives to direct young people into education and/or treatment services.

4. What changes could be made to the current treatment system to improve access and build stronger recovery pathways for people who have serious alcohol or drug issues?

- There needs to be a consistent improvement of the treatment system to respond holistically to clients' complex and interrelated needs. Moreland Hall's success with the development and implementation of its Catalyst non-residential rehabilitation program has been recognised by the program's external evaluators as being largely due to such an approach:

  > *The fact that the Catalyst program is capable of producing change in clients' behaviour, attitudes and wellbeing in a relatively short period of time may be attributed to a range of factors including the intensive nature of the program, the holistic approach, the mix of theoretical and experiential learning, and the opportunity to integrate this learning through immediate in vivo application of newly acquired skills and knowledge.* (Caraniche, 2011)

- There are currently no funded prevention programs for alcohol. *Cautious with Cannabis* (Cannabis) and *FOCiS* (other illicit) are effective, but there is no corresponding statewide program for alcohol. Moreland Hall has been delivering its *Alcohol: Considering Change?* program as a *de facto* alcohol diversion program for over three years with no funding. There is clearly a need for alcohol diversion as program currently receives referrals from

Magistrate's Courts across the Melbourne Metro region. The program has received over 100 court referrals in the past year.

- Moreland Hall could develop an online version of the Drug Driver program. There are currently only a very limited number of agencies delivering the program and both are in the metro region. Online delivery would dramatically improve regional accessibility.
- Moreland Hall could provide online delivery of *Cautious with Cannabis* and *FOCiS*. Programs are currently delivered in person by local service staff, who report that demand for the programs is not strong enough to ensure their viability.
- Movement to evidence-based rather than ideology-based services. At present, some services reject clients on proven, efficacious treatment (such as opiod replacement therapy) because they are not compatible with their beliefs systems and/or eligibility criteria. Requiring individuals to place themselves at increased risk of relapse and potential overdose in order to be accepted into a treatment program is unacceptable.
- Abandonment of no smoking policy (and it's deterrent effect) for inpatient services. The no smoking policy is driving clients from services to smoking compatible units, creating an uneven and unsustainable load distribution.
- All major metropolitan and regional hospitals to offer AOD services. Acute AOD issues are health issues yet not all hospitals, including some major metropolitan hospitals, have appropriate services (and/or allocated beds) in place to deal with them.
- Provide safer injection facilities at major injecting drug use sites across Melbourne metropolitan area and regional centers. There is more than enough evidence now to support their introduction in Victoria (see Moreland Hall's position paper on the proposed introduction of a Medically Supervised Injecting Centre in Melbourne: http://bit.ly/msicpositionpapers).
- Separate methadone and buprenorphine prescription and allow all GPs to prescribe the latter. The new Suboxone film preparation should make it even safer (in terms of minimizing opportunities for diversion of medication), so why not allow all GPs to prescribe it?
- Streamline the SMT permit process by making it online. The current fax based service is antiquated and onerous.
- Expansion of non drug means of addressing anxiety and depression, because effective alternatives like CBT are now first line interventions and will assist in avoiding a lot of the problems that have come with benzodiazepine prescription.
- Abandon episodes of care model allowing flexibility to meet client needs (eg alcohol v benzodiazepine or methadone withdrawal). This method is now antiquated and a hindrance to provision of adequate treatment to all people with drug related issues.
- Therapeutic communities be encouraged to take and remain on opiate replacement therapies (ORT). Currently therapeutic communities and ORT are considered to be incompatible. This incompatibility forces service providers and clients into less than ideal, compromised, often dangerous and unworkable scenarios. If we could change this, the evidence would suggest that the effectiveness of therapeutic communities would be increased.
- Distribution of naloxone to NSP users. Overseas experience clearly demonstrates the life saving benefits of this approach.

- Acute health services (particularly hospitals) need to be more willing to admit people for whom AOD use forms part of their presenting issues. Too often, health services (and many other service providers) see AOD use as disqualifying people from eligibility for their services. Too often, the message conveyed to people seeking their services is that their AOD use is something that must be dealt with separately, before they would be eligible for other services. This misunderstanding of the role of AOD use in complex presentations needs to be tackled systematically and the stigmatization of people who use AOD must be addressed at a social and sectoral level.

5. How can different agencies – including specialist alcohol and drug treatment, police, hospitals, schools, child protection services, housing, liquor licensing, the criminal justice system, planning, tourism and transport – work more closely in partnership to prevent the misuse of alcohol and drugs, and the harms associated with alcohol and drug misuse, and to help people overcome their alcohol and drug problems?

- Hospitals need to make themselves more accepting of people presenting with AOD issues as part of their broader health concerns. The main factor behind the establishment of the new Hepatitis C Clinic at Moreland Hall was the realisation that AOD users were not using hospital-based services. People are too frequently turned away by acute health services because of their AOD use. This must change.
- Co location of mental health and AOD services so they can work together, compliment one another, rather than current system which sees issues as separate and hinders referral, treatment and care
- Unification of AOD services so they are no longer competitors. The current system does not encourage collaboration between service providers or across the AOD sector.
- Unified service access model/ criteria, as opposed to the current system where each provider has its own criteria, times and routine, making the system very difficult to navigate.
- Adoption of a single assessment procedure to streamline entry to and referral across Victorian AOD services. The current system, where each service sees the need to conduct its own assessment, requires the client to wait for each process, hindering service accessibility.

6. How can our research and evidence base be improved to inform an assessment of the outcomes of the strategy and priorities for future action?

- Develop better quality data collection systems that can provide an accurate picture of what activity is actually occurring within funded AOD services.
- Fund evaluation of services beyond simple episode reporting.
- Build service providers' capacity to undertake meaningful evaluation of their programs and undertake longitudinal studies of treatment outcomes.
- Identify and document examples of leading practice across different service types.

More specific questions

DEMAND REDUCTION – Preventing the uptake and/or delaying the onset of use of drugs; reducing the misuse and early use of alcohol and drugs in the community; and supporting people to recover from dependence and reintegrate with the community.

1. **How can we promote cultural change in the community concerning drinking and intoxication, including across a wide range of settings such as workplaces, post-secondary education and training and sport?**

- As has been done with smoking, focus on health messages.
- Increase awareness of the impacts beyond the individual drinker (violence, road toll etc)

2. What can be done to delay the use of alcohol and reduce underage alcohol consumption?

- Education initiatives to support informed decision-making by young people and provide practical supports e.g. drink refusal skills.

3. How can we reduce the number of people drinking at risky levels?

Young people

- informed decision-making and understanding of harm-reduction strategies
- reduce alcohol advertising

Adults

- health campaigns
- reduce availability
- tax reform

4. What should be the role of health practitioners, community organisations, liquor outlets and educators in influencing demand?

- See response to overarching question 3.

5. What are the failures in the current range of demand prevention programs?

- Social marketing campaigns targeting young people are generally ineffective. 'Scare' campaigns appeal to parents and legislators, but do not engage with young peoples' attitudes or result in change. Costs of these campaigns far outweigh their benefits (not including political benefits) – funds would be more effectively spent on treatment programs.

- Pricing can be effective in reducing demand but tax reform needs to be comprehensive (e.g. volumetric taxation), not just targeting individual beverage types.

6. What further support is required to help offenders with drug addiction in custodial settings and postrelease?

- Improved availability of treatment programs whilst in prison (including opiate pharmacotherapies, Liver Clinics and NSP programs).
- Provision of basic supports i.e. accommodation and training/employment upon release.

7. What can be done to better respond to the health needs of people who have a mental illness and misuse alcohol and drugs?

- Continue to expand Dual Diagnosis capacity within AOD and Mental Health sectors.
- Expand capacity to provide appropriate case-management for Dual Diagnosis clients.

8. How can alcohol and drug treatment services better respond to, and support the needs of children when treating their parents?

- Establish Family Inclusive Practice as core business across all service types, as has been done by Moreland Hall.
- Work more in partnership with Child Protection and Family Services.

9. How should prevention activities address the specific needs of Victorian Aboriginal and Torres Strait Islander people?

- Focus on building resilience within communities, support community members to provide appropriate services and develop effective referral pathways into treatment.
- Recognise culture as a strength and incorporate cultural factors into recovery planning.

10. How can we improve health literacy and educate young people and adults about the risks associated with drugs and alcohol?

- See above response to question no. 5.

SUPPLY REDUCTION – Reducing the supply of illegal drugs and controlling and managing the supply of alcohol and other legal drugs.

12. How can we foster a culture of personal responsibility around alcohol use?

- Include as part of a broader civic responsibility campaign. It should be embedded in more general pro-social behaviours.
- Continue to educate the community about the impacts on others of individuals' drinking.

13. Are there effective ways of encouraging greater access to, and consumption of, lower alcohol content beverages?

- Pricing/taxation (see above response to question no. 5)

14. Given the liquor licensing reforms underway are there other opportunities in this area to reduce the harm caused by excessive alcohol consumption?

- Introduce measures to limit the hours and availability of alcohol. The free market approach to alcohol sales has resulted in wide ranging harms to the user and society and it needs to be more strictly controlled.

15. There is a growing new population of people addicted to painkillers. What can be done to control the misuse of prescription drugs?

- Reschedule alprazolam to schedule 8, as was done with Rohypnol. The cases are very similar and the same strategy may be equally as effective.
- Consider rescheduling all benzodiazepines to schedule 8. Making them harder to prescribe and enabling closer monitoring may help reign in some of the problems these drugs are creating.
- Establish a real time monitoring system for benzodiazepine and analgesic prescriptions so pharmacists and doctors can more readily identify potential abuse/ dependence/ doctor shopping.
- Instigate an automatic review process for repeat benzodiazepine and analgesic prescriptions so doctors can be encouraged to think about writing the next script.

16. What should be the role of GPs and pharmacists in helping ensure that prescription medication is accessed appropriately – what are the opportunities?

- Encourage doctors to write scripts for and pharmacists to dispense the amount of drug needed, not the amount manufacturers put in packs. Clients often end up with more medication than they need. The drugs can then be taken inappropriately, sold, diverted or abuse. This occurs simply because that's how they are packaged. If the GP specified the exact number required these harms could be avoided and better medicine would be practiced.

17. How should the government and the police develop effective responses to emerging synthetic/analogue drugs?

- Need to promote informed public responses (rather than hyperbolic fear-based approaches) to emerging user groups e.g. 'analogue' drugs.
- Focus on public health (rather than legislative) response.

18. What more can be done to tackle crime and disorder associated with alcohol and drug use?

- Fund more treatment services, not more prisons.

- Provide increased levels of support for prisoners post-release to help prevent scenarios (e.g. homelessness, unemployment) in which recidivism becomes increasingly likely and individuals are at far greater risk of AOD-related harms (e.g. overdose).

HARM REDUCTION – The reduction of the adverse health, social and economic consequences of the use of alcohol and drugs, for community safety and amenity, families and individuals.

19. How can we support and encourage people to drink responsibly?

- Emphasise the public health argument (see above)

20. Are there practical improvements that can be made to the design and management of licensed premises to reduce the risks of specific harms to the health and safety of patrons?

- Reducing hours of operation for licensed premises (particularly late opening hours)
- While the recent 'lockout' initiative was a failure, it would still be worth revisiting options for reducing the potential harms associated with late night drinking in entertainment precincts e.g. transferring to plastics and/or reducing the availability of alcohol (in favour of water or other non-alcoholic options) for the last two hours of operation.

21. What are some examples of local community projects that have succeeded in reducing harms such as alcohol and drug fuelled anti-social behaviour?

- Many music festivals (e.g. the Big Day Out) take a rigorous approach to proof-of-age requirements for alcohol purchases, promote free water and avoid the use of glass.

22. How can we take a more holistic approach to ensure alcohol and drug issues are assessed and tackled in conjunction with other issues people face, such as child protection, mental health, offending behaviours, general health, employment and housing?

- Reduced silos within/across govt. Departments.

- Enhance case management approach to encompass holistic needs

23. How can we build the skills of relevant workforces (such as alcohol and drug, police, corrections, health, welfare, emergency services, teachers and hospitality) to better identify and respond to people with alcohol and drug problems?

- Include AOD training as mandatory within relevant qualifications.

- Fund Moreland Hall's proposed Vocational Graduate Diploma in AOD and Mental Health.

- Promote wider reciprocal rotation program across govt funded services.

- Moreland Hall's experience with capacity-building projects with teachers has shown that they unlikely to produce sustainable benefits. Regardless of the amount of specialist professional development opportunities provided, teachers tend to see AOD as another issue they don't have time to think about and don't feel confident discussing in depth with their students. Our experience would suggest that more benefit to be gained in working with school nurses/welfare workers etc to develop their capacity to provide consistent, evidence-based responses.

24. Are current treatment services meeting the needs of people seeking treatment and how could they be improved?

- Key concerns about the current service system include:
    - Ongoing risks to injecting drug users and local residents in communities where high levels of public injecting occur. Recent moves to expand NSP services are welcome, but there is a clear need for the introduction of a Medically Supervised Injecting Centre in Melbourne, in keeping with the UnitingCare-run centre in Sydney;
    - The Episode of Care (EoC) model serves, in many cases, as an obstacle to the provision of integrated and continuous care for clients, particularly those with complex needs. The model effectively distorts the nature of treatment provided (towards a shallow, short-term focus) and how it is reported (the recent VAGO report noted the significant discrepancies in EoC data).
    - The current system provides little-to-no capacity to provide follow-up with clients once their EoC is complete.
    - The current system is too fragmented and difficult to navigate, even by health professionals. It is too difficult for individuals or workers in other sectors to determine appropriate access points and too easy for individuals to 'slip through the cracks' once they manage to enter treatment.
    - There is too much variability in the quality of services provided across the AOD sector and inconsistencies in non-geographical eligibility criteria for clients. Too often, clients are excluded from particular Government-funded services for ideological reasons or because they are considered 'too complex'. This is unacceptable.
    - Client's legitimate choices about their treatment goals are too often disregarded, particularly in relation to abstinence-based approaches. Such approaches can place clients at greater risk and unnecessarily prevent them from completing their treatment with a service when retaining them within the service would clearly be in their best interests.
    - There are too few options for clients to choose from to provide ongoing support to their recovery. Once clients have completed a rehabilitation program, the main options for them are abstinence-based self-help groups. While these groups are an essential support for many people, they are not a suitable option for many.

- Recommended improvements include:
    - Introduction of at least one Medically Supervised Injecting Centre in Melbourne;
    - Replacement of the Episode of Care model that focuses more on complexity of client needs and enables a greater capacity for ongoing support for people in recovery and the collection of follow-up outcomes data.
    - Increase capacity for ongoing case management of clients (rather than episodes) and establish standard follow-up structures to capture longitudinal outcomes data and provide opportunities to support re-engagement with treatment where required.
    - Intake processes need to be streamlined and treatment pathways should be clearly and consistently communicated to the public. Senior intake workers should be allocated to follow individual clients throughout their treatment to ensure they receive holistic and integrated responses to their particular needs.
    - All Government-funded services should operate under a consistent set of best practice principles, with consistent eligibility criteria. No service should be able to reject a client because they are 'too difficult' (with the exception of clients experiencing acute psychosis who present an immediate risk to their own and/or others' safety).
    - All Government-funded services should respect client's choices in relation to their treatment goals. While it is a legitimate goal (and one that all clients should be encouraged to consider) no client should be forced to adopt abstinence or be punished for lapsing. As Moreland Hall's experience with its *Catalyst* program has shown, supporting clients to re-engage with their treatment following a lapse has significant benefits for the individuals concerned and provides genuine examples of perseverance for their peers.

- New support options should be introduced to support recovery, including peer support groups such as Moreland Hall's *Momentum* program for former *Catalyst* clients.

25. What approaches foster partnerships between agencies, to reduce the adverse health, social and economic consequences of the use of alcohol and drugs? This could span settings and approaches including specialist alcohol and drug treatment, police, courts, child protection, housing, road safety, local community amenities, and workplace health.

- Perception of common concern and/or mutual benefit
- Strength of relationships amongst key stakeholders
- Availability of resources to support collaboration

26. How can workplace occupational health and safety approaches be improved to respond to alcohol and drug issues?

- AOD treatment to be included in worker supervision/performance management/return to work structures, but employers need to take responsibility and show commitment to process, not just box-ticking. Tokenistic approaches by employers will achieve little.

- AOD misuse can be given greater prominence in return-to-work planning following workplace injuries.