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| Alcohol and other drugs program guidelinesPart 3: quality, reporting and performance management |
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| To receive this publication in an accessible format phone 9096 6000, using the National Relay Service 13 36 77 if required, or email the Drug Policy and Reform unit <AOD.enquiries@dhhs.vic.gov.au>.Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Department of Health and Human Services, April 2018.Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.Available at [Alcohol & other drugs](https://www2.health.vic.gov.au/alcohol-and-drugs/) <https://www2.health.vic.gov.au/alcohol-and-drugs>. |
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# Purpose of the guidelines

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

The guidelines are divided into three sections:

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

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

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

## This document

This document provides agencies with an understanding of the quality, performance and reporting requirements for AOD services.

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

# Introduction

The department is responsible for ensuring that quality government-funded AOD services and programs are delivered to the Victorian community. Service specifications exist for all Victorian funded AOD treatment streams and describe the objectives and functions of each treatment stream. These requirements are outlined in Part 2: program and service specifications.

The department plans, develops policy, funds and regulates government funded AOD services. In general terms, funded organisations delivering AOD services are expected to:

* deliver the volume of services for which departmental funding is provided
* deliver quality services consistent with prescribed standards and guidelines
* deliver services that are accessible, inclusive and responsive to the diversity of the Victorian community
* provide agreed data and reporting to meet accountability and planning requirements
	+ work with the department to develop new approaches to service delivery.

The prescribed standards are set out in the *Policy and funding guidelines*, available on the [department’s website](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Cpolicy-and-funding-guidelines) <www2.health.vic.gov.au/about/policy-and-funding-guidelines>.

# Quality and policy

## Service agreements

Funded AOD services are governed by a service agreement which details the contractual arrangement between the department and the organisation receiving funding to deliver the service. Large health service providers, including hospitals, develop an agreed Statement of Priorities every year which articulates key areas of focus.

Service agreements establish minimum and mandatory requirements such as service delivery specifications and arrangements, quality, risk management, performance, funding and other matters. They also oblige funded organisations to comply with relevant legislative requirements and the department’s policies.

The service agreement and related schedules provide the legal and mandatory compliance requirements for department funding, such as maintenance of health service accreditation, incident reporting, insurance and financial records.

The board of an organisation is primarily responsible for ensuring that the terms and conditions of the agreement and its associated policies are met, and has oversight for clinical governance and quality.

Victorian services contracted to deliver direct client care must comply with a range of departmental policies. The *Alcohol and other drug treatment principles* and the *Victorian alcohol and other drug client charter* are two such policies.

## Standards and accreditation

AOD treatment services are required to support consistently high quality and safe services, including compliance with relevant accreditation and standards. Organisations that receive funding for the delivery of AOD treatment services are expected to adhere to any quality framework or policy initiative adopted by the department.

It is compulsory for all funded providers to comply with the department’s requirements regarding accreditation. Currently, this requires agencies to be, or able to be, accredited within existing generic accreditation frameworks by an entity that is certified by the International Society for Quality Health Care or the Joint Accreditation System of Australia and New Zealand.

### Forensic treatment providers

AOD treatment services that assess or provide treatment to forensic clients must nominate a Clinical Supervisor within their organisation who is accredited with the department. This individual is responsible for overseeing clinical standards and governance in relation to forensic clients managed within their organisation.

### Forensic assessments

All AOD clinicians who conduct assessments for forensic clients must be accredited by the department.

Those seeking forensic accreditation must apply through the department. Application forms can be obtained online, please refer to the [ACSO COATS Training and Accreditation page](http://coats.acso.org.au/training-accreditation/) <http://coats.acso.org.au/training-accreditation/>.

Any changes to accreditation requirements will be communicated by the department.

Australian Community Support Organisation (ACSO) Community Offenders Advice and Treatment Services (COATS) uses the Forensic Assessment Tool that was released as a key component of the Forensic AOD Treatment Service Delivery Model. The tool helps to identify an individual’s risk of substance related harm and the relationship to their risk of re-offending

### Safety and quality

The department considers safety and quality critical to the successful delivery of AOD treatment. AOD treatment services will take into account the following core quality principles when considering strategies and approaches for the delivery of a safe, quality service. These principles underpin the *Australian safety and quality framework for health care*:

* principle 1: person-centred
* principle 2: driven by information
	+ principle 3: organised for safety and quality.

### Incident reporting

Funded organisations are expected to have sound incident management processes in place that comply with legislative and departmental requirements. This should include response, management, reporting and review policies and procedures. Information obtained from incident reporting should be used to inform continuous improvement and drive quality improvement within an organisation.

Funded organisations are further required to comply with the department‘s procedures for incident reporting as a condition of funding. Following the introduction of the Critical Incident Management System (CIMS), there are now different departmental incident reporting requirements in place for providers of AOD treatment services depending on what type of funded organisation they are.

All non-government organisations (NGOs) delivering AOD treatment services are required to use CIMS. This assists organisations to manage incidents internally and report incidents to the department. For further information please refer to [CIMS](http://providers.dhhs.vic.gov.au/cims). <http://providers.dhhs.vic.gov.au/cims>.

Community Health Services and Health Services providers delivering AOD treatment services must continue to adhere to the *Health Incident Reporting Instruction (2013*). Category 1 and 2 incidents related to the delivery of AOD treatment services must be reported to the appropriate operational division via the Incident Report Form, unless an organisation has another established process in place to report incidents to the department.

### Operational capability

AOD treatment services are required to have the organisational capability necessary to support the efficient and effective provision of AOD treatment services in the range of areas set out below.

#### Continuous quality improvement

Funded services should embed a comprehensive system of continuous quality improvement, promoting best practice and regular review of structures, systems, processes and practice, to improve services and consumer outcomes. Services should have comprehensive, accessible, relevant, and accurate policies and procedures to guide decision-making that are regularly reviewed and updated.

#### Consortium membership

Changes to consortium membership are subject to departmental endorsement. Consortium leads must ensure that all proposed changes are communicated to the department in a timely manner. This ensures the department can respond to any issues that proposed membership changes may create, and that it is aware of all providers delivering AOD treatment services in Victoria. It is the consortium leads' responsibility to ensure that all members comply with service agreement requirements.

#### Workforce

AOD treatment services must assemble, manage and sustain a competent and capable workforce with the necessary knowledge, attitudes and skills across the range of services, roles and functions they deliver. Services should be adequately and appropriately staffed and have workforce policies and organisational approaches to develop individuals and their knowledge base to support maximum service effectiveness.

Services are responsible for identifying the professional development and workplace support needs of their workforce and for providing a program of learning and professional development for staff which reflects the transformational requirements of an AOD treatment program. They are also expected to have in place effective strategies to recruit and retain suitably qualified staff and to support ongoing workforce development.

Services should undertake these responsibilities cognisant of the *Victorian Alcohol and other drugs workforce strategy 2018 - 2022*. Building on the 2004 *Minimum Qualification Strategy*, the new strategy sets the direction for workforce development and planning for Victoria’s alcohol and other drug treatment sector. For further information please refer to the department’s website[, Alcohol and other drug workforce](https://www2.health.vic.gov.au/alcohol-and-drugs/alcohol-and-other-drug-workforce/aod-workforce-policy). <https://www2.health.vic.gov.au/alcohol-and-drugs/alcohol-and-other-drug-workforce/aod-workforce-policy>.

Agencies will need to identify how their workforce development plans will facilitate delivery of client centred, outcome-focused models in ways that respond to contemporary policy directions such as the *Victorian AOD treatment principles.*

#### Consumer participation

The lived experiences of AOD consumers and their families are embedded at all levels of the AOD treatment system. Services should work with service users, consumer representative organisations and peak bodies to understand the client/consumer experience and implement strategies for continuous improvement. Funded services should work towards sustainable partnerships that support the development and delivery of programs that result in improved outcomes for consumers.

Funded services should recognise and respond to consumer rights and responsibilities, actively encourage genuine and meaningful consumer participation, and use consumer feedback in the planning, development and delivery of services, programs and interventions. Services are developed and delivered in a respectful and sensitive manner with regard for different cultural backgrounds, diverse ages and stages in life and different family circumstances.

#### Clinical governance

Funded AOD services are governed and managed to maximise efficiency, transparency and effectiveness and to ensure accountability. Services must have mechanisms to ensure good clinical governance. Clinical governance is a system by which managing bodies (e.g. Boards and Executive Committees), managers, clinicians and staff share responsibility and accountability for quality of care, continuous improvement, minimising risks and fostering an environment of excellence in care for clients and their families.

#### Evidence-based practice

AOD services ensure that programs and interventions work within, and contribute to, developing the evidence base for AOD treatment. Services have continuity of care as a central feature encompassing greater connectedness, communication and coordination. Services have comprehensive program policies, procedures and practices that are evidence-based and canvass all aspects of the treatment pathway from first contact to exit.

#### Insurance

In accordance with the service agreement terms and conditions, all providers will be required to indemnify the department against a claim by any person for loss of or damage to property, death or personal injury or other financial loss, caused by the negligence of or breach of statutory duty by the service provider.

A significant majority of service providers that enter into a departmental service agreement are covered under the Community Service Organisations Insurance arranged and funded by the department’s insurance programs. The insurer is the Victorian Managed Insurance Authority (VMIA).

Details of the insurance cover provided, including the respective insurance manuals, can be accessed via the [Funded Agency Channel](http://www.dhs.vic.gov.au/funded-agency-channe) (FAC) <http://www.dhs.vic.gov.au/funded-agency-channel>.

Providersthat are not eligible for cover under departmental insurance programs are required to arrange appropriate insurance.This will include cover for Public and Products Liability as well as for Professional Indemnity insurance.

#### Other requirements

AOD treatment servicesare required to understand and abide by directions articulated in a range of Victorian Government policies, frameworks and procedures and legislative requirements.

## Reporting and compliance

### Service Agreement Compliance Certification (SACC)

Organisations are accountable for the appropriate use of funding, and for the delivery of the services specified in the Service agreement.

#### Service Agreement Compliance Certification (SACC)

Most organisations funded through a service agreement will be required to submit an annual Service Agreement Compliance Certification (SACC).

The SACC contains questions relating to:

* Financial Management, that the organisation has used funding as outlined in their Service agreement, is financial viable, has prepared its financial reports and any audit reports and maintains an asset register.
* Risk Management, that risks are managed in accordance with the Australian/New Zealand Risk Management Standard.
* Staff safety screening, referee checks, police checks, and if relevant Working with Children Checks have been completed.
* Privacy and Data Protection, that the organisation’s practices and systems that do not contravene the *Privacy and Data Protection Act 2014* and the *Health Records Act 2001*, to protect personal and health information.

The SACC must be submitted to the department three months after the organisation’s financial operating period, or seven days after the organisation’s Annual General Meeting.

**Does the SACC apply to my organisation?**

The SACC form is mandatory for organisations that are funded by the Department of Health and Human Services.

The SACC form is not required for:

* Organisations that only receive funding under a Short Form Common Funding Agreement
	+ Hospitals when they already complete financial reports to the Department Health and Human Services on a monthly basis; complete a Risk Management Attestation/Certification and are scrutinised by the Health Services Commissioner in relation to their compliance with the Health Records Act and the Privacy and Data Protection Act; and where they currently manage staff file sampling as part of accreditation processes and other compliance requirements, including the Australian Health Practitioner Regulations

Please refer to the [Guidelines for the Service agreement compliance certification (SACC)](https://fac.dhhs.vic.gov.au/guidelines-service-agreement-compliance-certification-form) for more information <https://fac.dhhs.vic.gov.au/guidelines-service-agreement-compliance-certification-form>

Further information about service agreement requirements more broadly can be found in the [Service agreement information kit:](http://fac.dhhs.vic.gov.au/service-agreement-information-kit) <http://fac.dhhs.vic.gov.au/service-agreement-information-kit>

### Reporting service delivery

Services are accountable for the appropriate use of funding and for the delivery of services specified in the service agreement. To ensure accountability, services are required to regularly report on the services they are funded to deliver through data collections and other reporting. This allows the AOD treatment service and the department to periodically review progress and achievement of agreed targets and performance measures and ensure accountability.

The department aggregates data received from AOD treatment services to assess the performance of each provider and the AOD treatment program, to produce reports to inform performance monitoring, service planning and policy development, and to meet national reporting requirements.

From October 2018, all services delivering AOD treatment activities are required to report data through systems that are compliant with the Victorian Alcohol and other Drug Collection (VADC).

Service providers are bound by the legislative requirements of the *Privacy and Data Protection Act 2014,* the *Health Records Act 2001* and the *Information Privacy Act 2000*.

For further information on reporting requirements for AOD services, visit the [department’s website](https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/reporting-for-aod-services) <https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/reporting-for-aod-services >.

Information about the VADC can be found at <<https://www2.health.vic.gov.au/alcohol-and-drugs/funding-and-reporting-aod-services/data-collection>>.

# Funding

The Victorian AOD services operate under a mixed-funding model.

* The majority of adult non-residential services have been funded through Activity-based funding (ABF) since September 2014.
* Adult residential services and Aboriginal and youth-specific services are funded on the basis of an episode of care (EOC).
* Other AOD treatment grants such as research, local initiatives and pharmacotherapy programs are funded on the basis of a block grant.
	+ Funding for AOD prevention and control activities is based on block grants and submissions.

Funding provided to service providers is indexed consistent with the government’s annual determination for community service organisations.

## Activity-based funding

ABF is similar to the way governments monitor, manage and administer the funding of healthcare provided by public hospitals. ABF allows accurate and transparent allocation of funding to community health services based on the activity they perform. This requires an ability to define, classify, count, cost and fund activity in a consistent manner.

ABF is based on three principles:

* Classification – grouping activity that uses a similar amount of resources into clinical meaningful classes.
* Counting – applying the same rules and units to measure the amount of activity that occurs.
	+ Costing – measuring in dollars the amount of resources used to provide each output in the classified group.

Adult community-based AOD services have experienced the phased implementation of ABF since the 2014 changes to the service system. The community-based adult non-residential AOD treatment funding model is a flexible, primarily activity-based system based on the following functions:

* Intake
* Assessment
* Care and recovery coordination
* Counselling
* Non-residential withdrawal
* Catchment-based planning (block-funded)
	+ Therapeutic day rehabilitation

Each function is comprised of one or more products. Each product has a counting unit, as illustrated in Figure 1, which will be the basis for funding and accountability. Table 1 provides a description of the products.

## Episode of care funding

Adult residential services (such as residential withdrawal and residential rehabilitation), Aboriginal and youth-specific services and some non-residential services are currently funded on the basis of an episode of care (EOC).

An EOC is a completed course of treatment undertaken by a client under the care of an AOD worker, which achieves at least one significant treatment goal.

The model acknowledges that not all courses of treatment will result in a significant treatment goal being achieved, and this is taken into account in both unit prices set and targets expected. Unit prices may be calculated based on:

* an equivalent full-time worker (38 hours per week)
* a residential service whose outputs are separations per bed per annum based on average lengths of stay
* a service where a team of workers may be involved in order to deliver the required EOC
	+ other services.

The department is planning to transition all services currently funded on an EOC basis to ABF in the coming years. This process will begin with the transition of all residential services, currently planned for 1 July 2019.

Figure : adult non-residential AOD funding model

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### Sub-products

The following additional activity lines exist within the functions:

* Bridging support (at same Drug Treatment Activity Unit, or DTAU, as an intake contact) – regular contact which aims to support client engagement, retention, motivation and stability while clients wait for assessment and treatment.
* Brief interventions (at same DTAU as a comprehensive assessment) – education and advice that aims to achieve a short-term reduction in harm associated with AOD use. This may include crisis intervention, harm reduction measures, relapse prevention planning, and support for co-occurring issues, such as mental health.
* Single sessions (and same DTAU as a comprehensive assessment) – single session therapy, work or consultations undertake with family members or significant others
	+ Family sessions (at same DTAU as standard counselling) – course of counselling provided to family members/significant others.

Table : adult non-residential AOD product descriptions

| Product | Description  |
| --- | --- |
| **Intake and referral**  | On average, 20 minutes of client contact time will be undertaken for a face-to-face and telephone courses of referral and on average, 15 minutes of client contact time will be undertaken for an internet course of referral. As this is an average, some clients may require more time, while others will require less, however the same price will always be paid. |
| **Comprehensive assessment and initial treatment plan**  | On average, 3.5 hours of multi-disciplinary input should be allocated to the completion of comprehensive assessment and initial treatment plan. This includes a total of 60 minutes for care coordination activity which is incorporated into the funding product. Provision should be made for brief interventions, education and support for clients, family members and carers. As this is an average, some clients may require more time, while others will require less, however the same price will always be paid. |
| **Care and recovery coordination**  | On average, a course will incorporate 15 hours of client-related coordination, funded based on the delivery of completed courses of care and recovery coordination. A completed course of care and recovery coordination will be funded at 2.222 DTAU. As this is an average, some clients may require more hours, while others will require less, however the same price will always be paid. The comprehensive assessment and care plan includes a total of 60 minutes for care and recovery co-ordination.To allow flexibility, there is no time limit on the duration of a course of care and recovery coordination. It is envisaged that a case manager will have the capacity to manage up to a maximum of 7 cases per day (Monday – Friday). |
| **Counselling** | Standard counselling is funded based on the delivery of completed courses of counselling. A completed course of standard counselling is funded at 0.910 DTAU, incorporating on average, 4 contacts.Complex counselling is funded based on the delivery of completed courses of counselling. A completed course of complex counselling is funded at 3.414 DTAU, incorporating on average, 15 contacts. On average, a contact would include 45 minutes of client contact time. To allow flexibility, there is no time limit on the duration of a course of counselling. |
| **Non-residential withdrawal**  | Standard non-residential withdrawal is funded based on the delivery of completed courses of non-residential withdrawal at 0.849 DTAU, incorporating on average, 4 contacts.Complex non-residential withdrawal is funded based on the delivery of completed courses of non-residential withdrawal at 2.124 DTAU, incorporating on average, 10 contacts.On average, a contact would include 45 minutes of client contact time. To allow flexibility, there is no time limit on the duration of a course of non-residential withdrawal. |
| **Therapeutic day rehabilitation** | On average, a course will incorporate 150–180 hours of client contact time at 11.000 DTAU. |

## AOD outputs and outcomes

Funded organisations should use the Funded Agency Channel to determine their targets for AOD drug services, and note that these represent the minimum deliverables expected for the funding provided. Funded organisations may consequently report higher levels of service delivery. Health services’ Statements of Priorities include AOD services activity targets for successful courses of treatment for both residential and community-based services.

### Complexity

To ensure that complex and high need clients are provided with care that meets their needs, separate ‘standard’ and ‘complex’ products apply to the counselling and withdrawal treatment streams.

Complexity is determined through the administration of a comprehensive assessment, which is conducted as part of the assessment function, or by ACSO in the case of referral through the courts. Service providers only receive the ‘complex’ price for those clients assessed as complex through that assessment process.

Service providers are expected to adjust the duration and intensity of the treatment response to meet the complexity of the client’s presentation. There is scope for reclassifying between standard and complex should a client’s clinical requirements change significantly during the treatment episode.

The ‘standard’ and ‘complex’ prices represent average prices for these client groups, and are based on the average number of contacts required for a course of treatment across the client population. It is expected that some clients may cost more and some less, but the overall cost will average out.

The price of an average course of treatment is indicative only, and service providers should not determine a client’s length of treatment-based on the price of a course of treatment. Clinical need may warrant additional treatment courses to also be provided.

## Price

The unit price for the delivery of products above (with the exception of the catchment-based planning function) is indicated in Table 3 below. All prices are intended to cover direct costs, fixed costs and overheads.

The application of the funding model is facilitated through the use of a Drug Treatment Activity Unit (DTAU). All activities (classified as ‘products’) are funded as a defined multiple of DTAUs, for which there is a single price as illustrated below.

Any pricing changes will be made by amending the value of the underpinning DTAU from year to year. Each funded activity has a price that is calculated by multiplying the DTAU price by an activity weighting. The DTAU price and activity loadings are found in the current Policy and Funding Guidelines. Please refer to the [Policy and Funding Guidelines](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines) for more detail. <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>.

Whilst the DTAU pricing has been derived from an average length of a course of treatment across the entire client group, there is no set number of contacts, sessions or hours that equate to a course of treatment being completed for an individual client. Agencies should provide as much treatment as is required for each client and are expected to adjust the duration and intensity of treatment response to meet the complexity of the client’s presentation.

### DTAU loadings

All adult community-based services are expected to prioritise access for Aboriginal people and a 30 per cent DTAU loading is applied for work with Aboriginal clients.

There is a 15 per cent forensic loading applicable to identified (non-Aboriginal) forensic clients, in recognition of the additional costs associated with service delivery to this client group. For further information see *Reconciling forensic activity* in this document*.*

Clients that are both Aboriginal people and forensic clients will receive the 30 per cent loading only.

### Funding for catchment-based planning function

The catchment-based planning function is block-funded. A single provider in each catchment is annually funded to develop the catchment plan in collaboration with all other service providers.

For more information about catchment-based planning, see *Attachment 5* in this document.

# Targets

Service delivery targets form a part of service agreements. Payment is made to providers in advance on the basis of agreed DTAU and EOC targets. These targets are derived directly from the funding that each provider receives from the department.

Departmental area staff are responsible for monitoring and responding to service provider performance against targets. While non-achievement of targets does not necessarily reflect underperformance, divisional area staff are expected to engage with service providers when targets are not achieved to identify causes and potential solutions. Processes for responding to performance issues are outlined in detail in the AOD performance management framework.

## Targets for activity-based funding

Providers are required to achieve their overall DTAU target, and 80 per cent against the target for each individual activity. As outlined in Section 5.1.1, this allows for service providers to be flexible in the activities they deliver in response to demand. Note that for non-forensic clients, the department will not pay for activity delivered above agreed targets.

As outlined in Section 4.4, different activity types have different DTAU weightings, and there are additional loadings for services delivered to Aboriginal and forensic client groups. This means that the number of courses that service providers will be required to deliver to achieve their targets will differ depending on what they deliver, and to whom they deliver it. Delivering more services to Aboriginal and forensic clients will mean that service providers achieve their targets more quickly.

### Flexibility

An important feature of the funding model for adult non-residential AOD treatment services is that it allows providers to adjust the mix of treatment types delivered in line with client needs. This allows providers to adapt more flexibly over time as changes in AOD use patterns and other local factors arise.

This flexibility is achieved by requiring service providers and consortia to achieve:

* 80 per cent of their DTAU targets in any individual activity stream
	+ 100 per cent of their total DTAU targets.

This means that service providers and consortia are able to move 20 per cent of their DTAUs between activity streams to respond to demand, provided they are achieving their overall DTAU target.

For providers that are part of a consortium, this flexibility occurs at the consortium level. Consortium lead providers should monitor each member provider’s DTAU utilisation in each funded activity stream to ensure that the consortium is delivering an appropriate mix of services across the catchment. Table 2 provides several scenarios of service provider delivery against targets. Note that in these scenarios, only Consortium A has appropriately used the flexibility and achieved all of its targets.

Table : DTAU delivery scenarios

| Consortium and activity | Target: minimum (80%) | Target: Full (100%) | Actuals: DTAUs delivered | Actuals: % of target achieved  | Target achieved |
| --- | --- | --- | --- | --- | --- |
| Consortium A: Care and recovery coordination | 80 | 100 | 110 | 110% | Yes |
| Consortium A: Counselling | 80 | 100 | 130 | 130% | Yes |
| Consortium A: Non-residential withdrawal | 80 | 100 | 85 | 85% | Yes |
| **Consortium A: Total DTAU target** |  | **300** | **325** | **108%** | **Yes** |
|   |  |  |  |  |  |
| Consortium B: Care and recovery coordination | 80 | 100 | 110 | 110% | Yes |
| Consortium B: Counselling | 80 | 100 | 160 | 160% | Yes |
| Consortium B: Non-residential withdrawal | 80 | 100 | 40 | 40% | No |
| **Consortium B:** **Total DTAU target** |  | **300** | **310** | **103%** | **Yes** |
|   |  |  |  |  |  |
| Consortium C: Care and recovery coordination | 80 | 100 | 85 | 85% | Yes |
| Consortium C: Counselling | 80 | 100 | 90 | 90% | Yes |
| Consortium C: Non-residential withdrawal | 80 | 100 | 85 | 85% | Yes |
| **Consortium C:** **Total DTAU target** |  | **300** | **260** | **87%** | **No** |

As Table 2 shows, Consortium A has achieved both 80 per cent of its DTAU targets in each activity stream, as well as its overall DTAU target. It has therefore achieved all of its targets. However, Consortium B has not achieved 80 per cent of its non-residential withdrawal target even though it has achieved its overall target. This means that it has not achieved all of its targets. Similarly, while Consortium C has achieved 80 per cent of its targets in each of its activity streams, it has not achieved its overall target, and therefore also has not achieved all of its targets.

If service providers or consortia are consistently underperforming against a particular activity stream while also achieving their overall target, they can seek to have some of their funding transferred between activity streams permanently. To do this, service providers should present a strong evidence base to their departmental area office demonstrating that the reason for the proposed funding transfer is demand rather than performance issues.

Like any ABF model, it is anticipated that adjustments to the model will be required over time. A process of periodic review of the funding model will occur, with scope to adapt relative prices across the different treatment streams if analysis of data and sector feedback indicates adjustments may be required. This also provides capacity for the model to be adapted over time to accommodate sector changes, including those related to changing AOD use patterns and/or innovations in service models.

## Targets for episode of care funding

Different activity types have different unit prices, and therefore EOC targets are held against individual activity types. Unlike activity-based funding, there is no flexibility to transfer targets between activity types on a short-term basis. There are no additional loadings for services delivered to forensic or Aboriginal clients.

## Forensic targets

### Intake and assessment for forensic diversion clients

In order to meet the forensic target, catchment-based intake providers are expected to deliver 10 per cent of all intake DTAUs to forensic clients. If an intake provider has achieved their overall DTAU target as well as their forensic target, fee for service payments may be available for any additional DTAUs delivered to forensic clients. See Section 5.1.3 for more details.

The majority of forensic clients are referred to ACSO COATS from Community Correctional Services. ACSO COATS undertakes intake and assessment and referral into the forensic AOD treatment system.

Catchment-based intake services, and some youth and Aboriginal services, also provide intake, assessment and brief intervention services for forensic clients. This is mostly for diversion clients, which include referrals from Victoria Police or Victorian courts.

Diversion clients may also include those that are not formally diverted from the justice system, but who have legal matters related to their AOD use pending and are seeking to address their AOD issues. These clients still attract forensic loading and will be reconciled against an agency’s forensic targets as long as a Treatment Completion Advice (TCA) form is submitted to COATS within 6 months from the date of treatment commencement. If a TCA is outstanding after this time, the agency must seek a variation with COATS to let them know the client is still engaged in the course of treatment.

DTAU for diversion clients is calculated at the standard forensic comprehensive assessment and initial treatment plan price.

### Treatment for forensic clients – adult non-residential treatment services

In order to meet the forensic target, consortia are expected to deliver 20 per cent of adult non-residential AOD DTAUs to forensic clients. If a consortium has achieved their overall DTAU target as well as their forensic target, fee for service payments may be available for any additional DTAUs delivered to forensic clients. See Section 5.1.3 for more details.

### Fee for service arrangements

ACSO will pay additional ‘fees for service’ to consortia if they deliver additional services to forensic clients after they have achieved both their overall and forensic activity targets across all catchments in which they deliver services. ACSO pays fees to service providers or consortium leads upon receipt of treatment completion advices (TCA) related to the additional activities. To receive fee for service payments in a financial quarter the following two conditions must be met:

* The consortium or provider must exceed its overall targets for all activity types that it delivers.
	+ The consortium or provider must exceed its forensic DTAU or EOC target (i.e. minimum of 10 per cent for intake or 20 per cent for adult non-residential treatment).

This arrangement supports providers to meet demand for forensic services, thereby enabling forensic clients to meet the requirements of their court order. Fees are provided to the consortia lead or service provider based on the forensic unit price for the particular activity.

Table 3 outlines how the fee for service policy works in practice for consortia with DTAU targets.

Table : Fee for service eligibility examples

| Consortium | DTAU targets:overall target(incl. forensic target) | DTAU targets: forensic target | DTAUs delivered:overall | DTAUs delivered:to forensic clients | Eligibility for fee for service payment | Forensic DTAU attracting FFS |
| --- | --- | --- | --- | --- | --- | --- |
| Consortium A | 10 | 2 | 14 | 4 | Yes – exceeded both overall and forensic targets | 2 |
| Consortium B | 10 | 2 | 15 | 10 | Yes – exceeded both overall and forensic targets | 5 |
| Consortium C | 10 | 2 | 10 | 7 | No – did not exceed overall target  | 0 |
| Consortium D | 10 | 2 | 15 | 2 | No – did not exceed forensic target | 0 |

All four consortia in the above example had an overall target to deliver 10 DTAUs during a quarter. Only Consortium A and B are eligible for fee for services because they met both conditions listed above.

A consortium is not eligible for fee for service for additional activities delivered to mainstream clients.

Please note that fee for service payments are only paid on a consortium basis. That is, even if an individual agency within a consortium achieves both its overall and forensic targets, it is not eligible to receive fee for service payments. Instead, fee for service payments will only be paid to the agency’s consortium when the consortium as a whole is eligible.

### Reconciling forensic activity

COATS reconcile all forensic activity against each consortium’s forensic funding via the submission of TCA forms from agencies. Treatment agencies must complete a TCA payment form, via ACSO’s client management system. This enables COATS to monitor activity and broker payment to treatment agencies where required.

All adult non-residential treatment provided for forensic clients, including intake, and assessment, attract a 15 per cent loading in recognition of the additional costs associated with service delivery for this client group.

This loading incorporates elements such as the additional administrative requirements, greater difficulty in contacting clients and higher proportions of ‘no-shows’. This means that the price for each product is 15 per cent higher for a forensic client and each service provided accounts for 15 per cent more DTAU per unit of activity.

Agencies are able submit for partial payments of ¼, ½, ¾ for clients who do not complete the treatment ordered. However, there is no reconciliation or payment made for non-attendance.

A treatment episode and associated TCA is ‘opened’ when the treatment agency accepts a treatment appointment. TCAs must be opened within four weeks. A TCA payment form remains open for six months from the date of treatment commencement. After this time, an agency forfeits payment for the episode of treatment. For further detail, please refer to [ACSO COATS Finance](http://coats.acso.org.au/finance/) <http://coats.acso.org.au/finance/>.

# Performance management framework

Performance management is an important part of ensuring that public funds are used as effectively as possible to deliver the best outcomes for clients and the broader Victorian community. It enables both funded providers and the department to monitor and better understand service and system performance, identify opportunities and risks, and drive improvement. Data collected through performance management informs responses to emerging issues and helps funded providers and the department target key areas for attention.

A new performance management framework has been developed for Victorian Government-funded AOD treatment services. The framework outlines how the department will measure the performance of agencies, and the indicators and data sources that will be used. It provides clarity and consistency in how services will be held accountable for their performance. This includes defining the roles and responsibilities of services and outlining performance measurement domains and indicators.

The framework complements the service agreement agencies have with the department. The service agreement, minimum service delivery targets and related schedules remain binding. The framework builds on these policies by outlining specific measures for AOD service delivery. For services funded through a service agreement, performance monitoring arrangements set out in the Funded Organisation Performance Monitoring Framework (FOPMF) also apply.

# Attachments

## Attachment 1: catchments

Delivery arrangements and responsibilities for AOD treatment services are organised on a catchment basis across Victoria.

Service providers in each catchment will work collaboratively with the catchment-based intake service and with a common plan which will identify critical service gaps and development needs within the catchment. The catchment-based intake service will also maintain a close working relationship with the statewide screening and referral service, DirectLine.

Catchments are not intended to restrict client choice and it is expected that some clients may choose to access services in a different catchment to where they live.

No limit will be placed on the proportion of clients that providers may treat from outside their catchment, but the primary accountability of providers will be to meet the needs of their own catchment.

The way in which different service elements are organised by each provider should ensure a streamlined experience for clients and optimal efficiency in delivery.

All service providers operating in a given catchment will be:

* required to work collaboratively with other AOD treatment services (including pharmacotherapy providers) in the catchment and adjoining catchments where relevant, in order to establish and sustain well integrated local delivery systems
* accountable for delivering tangible outcomes that matter for clients and their families and improve the client’s experience of care. This will include a demonstrated commitment to involve clients and their families in treatment planning, providing information to make informed choices and working with clients to identify their treatment and recovery goals
	+ required to support clients through referral and shared care planning with other AOD treatment provider/s in the service catchment, Aboriginal Community Controlled Health Organisations (ACCHOs), community, clinical and community-based mental health services, primary health care, human services, the justice system and other services and stakeholders in the local delivery environment to achieve improved service outcomes for the client group.

Figure : rural and regional AOD catchments



Figure : metropolitan AOD catchments



Catchments were established to improve collaboration, planning and service coordination between AOD services and other health and welfare services, and to reduce system fragmentation.

Service providers in each catchment work collaboratively under a common plan that identifies critical service gaps and development needs at the local level.

Catchments are not intended to restrict client choice and it is expected that some clients may choose to access services in a different catchment to where they live.

More information about catchments can be found by searching for “treatment catchments” in reports and fact sheets on the department’s website, [Alcohol & other drugs](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Calcohol-and-drugs) <www2.health.vic.gov.au/alcohol-and-drugs>.

### Catchment boundary alignment

The department operates across the state from within 17 local areas. The department is in the process of changing the AOD catchment boundaries to align with the areas to ensure AOD planning and service delivery is integrated across other health and human services delivery, including the establishment of Support and Safety Hubs in response to recommendations from the Royal Commission into Family Violence.

For the majority of existing AOD catchments there will be no boundary change, and only a name change from the existing catchment to the area will be required. However, some existing catchments, particularly those in the inner-north and west metropolitan areas, the Bayside and Mornington Peninsula area, rural western Victoria and Gippsland will be reconfigured to the department areas.

These changes may mean that a service provider agreement will now refer to one or more department areas, when currently it only refers to one catchment. Note that this does not mean that services are required to expand or contract the current geographic area they service. It simply references the department areas they provide services within.

The department will work closely with service providers, particularly those most significantly affected, to ensure a smooth transition to the new arrangements that are expected to take effect from 1 July 2019.

## Attachment 2: legislative and policy context

### Introduction

Service providers are required to understand and abide by directions articulated in a range of government policies, frameworks and procedures as well as a range of legislative requirements. Key policies, frameworks and legislation relevant to the provision of AOD treatment services are detailed in this document.

Please note this information is provided as a guide only and does not constitute an exhaustive list of all government legislation, policies, frameworks and procedures that are applicable to the delivery of AOD treatment services.

### Legislative context

#### Drugs, Poisons and Controlled Substances Act 1981

Drugs and poisons are strictly regulated through the Drugs, Poisons and Controlled Substances Act(the Drugs Act). The Drugs Act covers prescription and pharmacy-only drugs, drugs of dependence and many household, industrial and agricultural chemicals. Controls are set down in the Drugs Act and in *Drugs, Poisons and Controlled Substances Regulations 2006*. Further information is available from:

Drugs and Poisons Regulation
From 10:00 am to 4:00 pm, Monday to Friday (except for public holidays)
**Telephone Number:** 1300 364 545
Fax: 1300 360 830

For more information please refer to the [Drugs and Poisons Act:](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Calcohol-and-drugs%5Caod-policy-research-legislation%5Caod-legislation%5Cdrugs-and-poisons-ac) <www2.health.vic.gov.au/alcohol-and-drugs/aod-policy-research-legislation/aod-legislation/drugs-and-poisons-act>.

#### Severe Substance Dependence Treatment Act 2010

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

For more information about compulsory drug withdrawal under the SSDTA, see *Part 2: program and service specifications – additional clinical support*.

#### Victorian Charter of Human Rights and Responsibilities Act 2006

The Victorian Charter of Human Rights and Responsibilities Act (the charter) is a Victorian law that sets out the basic rights, freedoms and responsibilities of all people in Victoria. It describes the relationship between government and the people it serves. The charter requires public authorities, such as Victorian state and local government departments and agencies, and people delivering services on behalf of government, to act in a manner consistent with the human rights outlined in the [Charter](http://www.humanrightscommission.vic.gov.au/the-charter) <www.humanrightscommission.vic.gov.au/the-charter>. The charter specifies twenty fundamental basic human rights, including but not limited to: the right to be treated equally, to be safe from violence and abuse, to be part of a family and to have our privacy respected.

#### The Mental Health Act 2014

The Victorian Mental Health Act (theMH Act) provides a legislative framework for the assessment, treatment and protection of people who have mental illness in Victoria. The MH Act provides for people to receive assessment and treatment in the least restrictive way possible, with the least possible restrictions on human rights and human dignity. The MH Act:

* introduced a supported decision-making model that gives patients a voice in their assessment, treatment and recovery
* focused on minimising the duration of compulsory treatment and ensuring that treatment is provided in the least restrictive and least intrusive manner possible
	+ established robust safeguards and oversights to protect the rights, dignity and autonomy of people with mental illness, including establishing a new mental health tribunal and a mental health complaints commissioner.

Although primarily concerned with individuals requiring compulsory mental health treatment, the new legislation and the practice and culture changes being promoted as part of its implementation are an important consideration for AOD treatment providers. AOD treatment providers need to be familiar with the provisions of the new legislation as they apply to their clients and the services they deliver.

AOD treatment providers will support some people on community treatment orders as well as those who may require compulsory inpatient treatment. Providers of AOD treatment services will be expected to work with clinical and community-based mental health support services to be alert to the particular issues that might arise for clients.

For further information on the updated MH Act, refer to the [Mental Health Act 2014](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cmental-health%5Cpractice-and-service-quality%5Cmental-health-act-2014) <www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014>.

#### Victorian Disability Act 2006

The [*Disability Act*](http://www.legislation.vic.gov.au/)and the [*Disability Regulations 2007*](http://www.legislation.vic.gov.au/) provides for a stronger whole-of-government, whole-of-community response to the rights and needs of people with a disability, and a framework for the provision of high quality services and supports for people with a disability.

The *Disability Act* sets out principles for people with a disability and for disability service providers. Disability service providers are the department and organisations that are [registered](http://www.dhs.vic.gov.au/for-service-providers/disability/service-quality-and-improvement/disability-act-2006-for-service-provider/quality-services/related-resources-holder6/register-of-disability-service-providers-list) under the *Disability Act* to provide disability services. The *Disability Act* requires that people with a disability be given information that explains their rights. For example, when a person starts to use a disability service, the disability service provider must give them information about the services to be provided and their rights under the *Disability Act.*

Refer to the [Disability Act](http://www.dhs.vic.gov.au/for-individuals/disability/your-rights/disability-act-2006) for further information <www.dhs.vic.gov.au/for-individuals/disability/your-rights/disability-act-2006>.

#### Disability Discrimination Act 1992

Under the Disability Discrimination Act*,* it is unlawful to discriminate against a person on the basis of their disability including physical, intellectual, psychiatric, sensory, neurological or learning disabilities; physical disfigurement; disorders, illness or diseases that affect thought processes, perceptions of reality, emotions or judgment, or results in disturbed behaviours; presence in body of organisms causing disease or illness (e.g. HIV). The Disability Discrimination Act applies to activities including employment; education; access to premises; accommodation; buying or selling land; clubs; sport; administration of Commonwealth laws and programs; provision of goods; and services and facilities.

For further information on disability discrimination protections, refer to the [Brief Guide to the disability Discrimination Act](http://www.humanrights.gov.au/our-work/disability-rights/guides/brief-guide-disability-discrimination-act) <www.humanrights.gov.au/our-work/disability-rights/guides/brief-guide-disability-discrimination-act>.

#### Health Complaints Act 2016

In April 2016, the Parliament passed the Health Complaints Act. Under the legislation, the existing Health Services Commissioner will be replaced by a new watchdog, the Health Complaints Commissioner. The new Commissioner will have greater power to take action against dangerous and unethical health providers who are not registered under national health practitioner regulation law.
In a major change, the Health Complaints Act will allow anyone to make a complaint, rather than just the person who received the health service. The Commissioner will also have the power to investigate a matter that could have been the subject of a complaint even when no complaint is lodged, for example, if the media have uncovered a provider making false or harmful claims.

Under the new Health Complaints Act (as under the previous Act), it will be possible for complaints to be made about any AOD health service provider in Victoria. This includes:

* public and private AOD health service providers
* registered and unregistered health service practitioners
	+ individual practitioners and health service organisations.

The Commissioner will be able to receive complaints about registered health service providers who are from one of the 14 health professions registered under the Health Practitioner Regulation National Law (Victoria) 2009 (the National Law) who can use a protected title, e.g. doctor, dentist, physiotherapist, midwife etc. Serious matters related to the conduct, competence or health of registered health practitioners will continue to be referred to Australian Health Practitioner Regulation Agency.

The Commissioner will also receive complaints about ‘unregistered health service providers’. This is a very broad group and will include for example (but not be limited to) allied health assistants, counsellors and psychotherapists, art therapists, nutritionists, homeopaths, paramedics, assistants in nursing, and massage therapists.

For further information refer to the [Health Complaints Act Factsheet](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Cpublications%5Cfactsheets%5Cfactsheet-health-complaints-act-2016). <www2.health.vic.gov.au/about/publications/factsheets/factsheet-health-complaints-act-2016>.

#### Children, Youth and Families Act 2005 *–* Amendments

Amendments to the Children, Youth and Families Act have come into effect that address harmful delays in decision-making for children who cannot live with their families due to abuse and neglect.

The new family reunification order sets a time limit of 12 months for family reunification to occur, before reunification will no longer be pursued. In some circumstances this may be extended to 24 months. If family reunification has not been achieved within this timeframe, permanent alternative care arrangements are made.

Parents whose children are subject to a family reunification order may be subject to order conditions which require them to attend AOD assessment and treatment, among other services.

Ensuring timely access to services for these families will be critical as it is important that parents have the opportunity to address issues in a timely manner to improve the likelihood of reunification with their children. This is reflected in these guidelines in the status of parents in this cohort as clients who require priority access to treatment.

Additional funding is allocated towards treatment services to help parents meet the requirements of family reunification legislation.

Intake providers and service providers are expected to actively engage with clients in this treatment stream to support their early and ongoing access to treatment, as well as to maintain strong relationships with child protection to inform them if there are concerns about a client’s treatment progress.

#### Children, Youth and Families Act 2005 *–* Child Protection Protocol

The Child Protection Protocol defines the respective roles and responsibilities of Child Protection, the Department of Education, licensed children’s services and Victorian schools in working together the protect children and young people from abuse and neglect. The protocol also provides information about mandatory reporting under the *Children, Youth and Families Act. Professionals prescribed as mandatory reporters include registered medical practitioners (including psychiatrists) and nurses.*

Please refer to the website [Obligations to protect children](https://www.education.vic.gov.au/childhood/providers/regulation/Pages/protectionprotocol.aspx) for further information <https://www.education.vic.gov.au/childhood/providers/regulation/Pages/protectionprotocol.aspx>

#### Victorian Health Records Act 2001

The Health Records Act created a framework to protect the privacy of individuals' health information. It regulates the collection and handling of health information. The Health Records Act:

* gives individuals a legally enforceable right of access to health information about them that is contained in records held in Victoria by the private sector
	+ establishes Health Privacy Principles (HPPs) that will apply to health information collected and handled in Victoria by the Victorian public sector and the private sector.

The access regime and the HPPs are designed to protect privacy and promote patient autonomy, while also ensuring safe and effective service delivery, and the continued improvement of health services. The HPPs generally apply to all personal information collected in providing a health, AOD, mental health, disability, aged care or palliative care service; and all health information held by other organisations.

For further information on health records, visit the department’s website, [Health Records Act](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Clegislation%5Chealth-records-act) <www2.health.vic.gov.au/about/legislation/health-records-act>.

#### Carers Recognition Act 2012

The Carers Recognition Act formally recognises and values the role of carers and the importance of care relationships in the Victorian community. The Carers Recognition Act includes a set of principles about the significance of care relationships, and specifies obligations for state government agencies, local councils, and other organisations that interact with people in care relationships.

The Carers Recognition Act defines a carer as someone who provides care to another person, and includes carers under the age of 18. Carers can provide care for a person who: has a disability; has a mental illness; has an ongoing medical condition; or is an older person with care needs. Care relationships also include those situations where a person is being cared for in a foster, kinship or permanent care arrangement.

The provisions in the Carers Recognition Act build on and expand the *Victorian charter supporting people in care relationships* which came into effect in 2010. The charter has been updated to reflect the new Carers Recognition Act.

Please refer to the department’s website, [Working with consumers and carers for more information](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cmental-health%5Cworking-with-consumers-and-carers) <www2.health.vic.gov.au/mental-health/working-with-consumers-and-carers>.

#### Family Violence Protection Amendment Act 2017

The *Family Violence Protection Amendment (Information Sharing) Act 2017* prescribed certain organisations to comply with the Family Violence Information Sharing Scheme (the scheme). The scheme is designed to enable safe information sharing between professionals in a timely and effective manner to assist with preventing or reducing family violence.

From 26 February 2018, community based child protection practitioners located within Support and Safety Hubs (Hubs), and workers delegated to represent the child protection program on Risk Assessment and Management Panels (RAMPs) will be required to comply with the scheme.

From September 2018, AOD services will be prescribed to comply with the scheme.

Please refer to the [Family Violence Information Sharing Scheme](https://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.htm) for more information <https://www.vic.gov.au/familyviolence/family-safety-victoria/information-sharing-and-risk-management.html>

#### Occupational Health and Safety Act 2004

The Occupational Health and Safety Act is the cornerstone of legislative and administrative measures to improve occupational health and safety in Victoria. The Occupational Health and Safety Actsets out the key principles, duties and rights in relation to occupational health and safety. The general nature of the duties imposed by the Occupational Health and Safety Actmeans that they cover a very wide variety of circumstances, do not readily date and provide considerable flexibility for a duty holder to determine what needs to be done to comply.

For further information on occupational health and safety, refer to the [Worksafe website](http://www.worksafe.vic.gov.au/laws-and-regulations/occupational-health-and-safety). <www.worksafe.vic.gov.au/laws-and-regulations/occupational-health-and-safety>.

#### Equal Opportunity Act 2010

The objectives of the Equal Opportunity Act are to encourage the identification and elimination of discrimination, sexual harassment and victimisation and their causes, and to promote and facilitate the progressive realisation of equality. It is against the law under the Equal Opportunity Act to discriminate against a person based on their [personal characteristics](http://www.humanrightscommission.vic.gov.au/index.php/types-of-discrimination). It is also against the law to [sexually harass](http://www.humanrightscommission.vic.gov.au/index.php/types-of-discrimination/sexual-harassment) someone or to victimise them for speaking up about their rights, making a complaint, helping someone else make a complaint or refusing to do something that would be contrary to the Equal Opportunity Act.

Please refer to the [Equal Opportunity Act](http://www.humanrightscommission.vic.gov.au/the-law/equal-opportunity-act) for more information <www.humanrightscommission.vic.gov.au/the-law/equal-opportunity-act>.

#### Privacy and Data Protection Act 2014

The Privacy and Data Protection Act (the PDPA) sets a standard for the protection of the privacy of personal information by the Victorian public sector, using [Information Privacy Principles](http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/information-privacy-principles) (IPPs). The objectives of the PDPA are to:

* provide for responsible collection and handling of personal information in the Victorian public sector
* provide remedies for interferences with the information privacy of an individual
* establish a protective data security regime for the Victorian public sector
* establish a regime for monitoring and assuring public sector data security
	+ establish the Commissioner for Privacy and Data Protection.

Under the PDPA, State Government organisations, local councils and private sector organisations acting as contracted service providers to the Victorian Government are all bound to protect the privacy of people’s personal information. ‘Personal information’ means recorded information which can identify someone. The Privacy and Data Protection Commissioner administers the PDPA.

With limited exemptions, all Victorian Government agencies, statutory bodies and local councils must comply with the IPPs. The principles cover collection, use and disclosure, data quality, data security, openness, access and correction, unique identifiers, anonymity, trans-border data flows, and sensitive information.

For further information on privacy and data protection, refer to the [Office of the Victorian Information Commissioner](http://www.cpdp.vic.gov.au/menu-privacy/privacy-laws-and-standards/privacy-and-data-protection-act-2014) <www.cpdp.vic.gov.au/menu-privacy/privacy-laws-and-standards/privacy-and-data-protection-act-2014>

#### Competition and Consumer Act 2010

The Competition and Consumer Act replaced the *Trade Practices Act 1979.* The purpose of the Competition and Consumer Actis to promote fair and efficient competition within markets and to provide protection to consumers. To achieve this, rights and obligations are conferred to businesses in their dealings with each other, and on their dealings with consumers.

### Victorian policies and frameworks

#### Victorian public health and wellbeing plan 2015–19

The *Victorian public health and wellbeing plan 2015–19* outlines the government's key priorities over the next four years to improve the health and wellbeing of Victorians. The plan articulates the government's vision for a Victoria free of the avoidable burden of disease and injury, so that all Victorians can enjoy the highest attainable standards of health, wellbeing, and participation at every age. Healthy living is encouraged from early years and throughout life, as many chronic disease and injuries are preventable. Reducing harmful AOD use is a key health and wellbeing priority in the plan.

The [*Victorian public health and wellbeing plan*](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Chealth-strategies%5Cpublic-health-wellbeing-plan) is available on the department’s website. <www2.health.vic.gov.au/about/health-strategies/public-health-wellbeing-plan>.

#### Health 2040: advancing health access and care

*Health 2040* presents a clear vision for the health and wellbeing of Victorians and for the Victorian healthcare system, built around three pillars:

* Better health: focused on prevention, early intervention, community engagement and people's self-management to maximise the health and wellbeing of all Victorians.
* Better access: focused on reducing waiting times and delivering equal access to care via statewide service planning, targeted investment, and unlocking innovation.
	+ Better care: focused on people's experience of care, improving quality and safety, ensuring accountability for achieving the best health outcomes, and supporting the workforce to deliver the best care.

[*Health 2040*](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Cpublications%5Cpoliciesandguidelines%5CHealth-2040-advancing-health-access-and-care) is available on the department’s website <www2.health.vic.gov.au/about/publications/policiesandguidelines/Health-2040-advancing-health-access-and-care>.

#### Victorian clinical governance policy framework

Good clinical governance ensures that the governing body, managers, clinicians and their staff are responsible and accountable for the safety and quality of care they provide. The Victorian clinical governance policy framework consists of four domains of quality and safety, and provides the key principles on which good clinical governance is based.

This framework is the department’s policy on clinical governance. For public health services, compliance with the framework is mandated in the policy and funding guidelines that underpin Statements of priorities and Health service agreements. It is a requirement for all public health services to review their local clinical governance policies against the framework. Health services should report compliance against the framework through their annual Quality of care report.

A guidebook and toolkit is available on the department’s website to assist in the review of relevant roles and responsibilities of key stakeholders in the framework. Please refer to the [Clinical Governance Policy](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Chospitals-and-health-services%5Cquality-safety-service%5Cclinical-risk-management%5Cclinical-governance-policy) <www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-risk-management/clinical-governance-policy>.

**7.2.4.4 Child Safe Standards**

The Child Safe Standards are compulsory for all Victorian organisations that provide services or facilities for children, including those that are funded and/or regulated by the State Government and those that are not.

The standards are designed to drive cultural change in organisations, so that protecting children from abuse is embedded in the everyday thinking and practice of leaders, staff and volunteers.

Further information on the seven [Child Safe Standards](https://providers.dhhs.vic.gov.au/child-safe-standards) and resources to support compliance with the standards are available at the department’s website < <https://providers.dhhs.vic.gov.au/child-safe-standards>>

#### Delivering for diversity – cultural diversity plan 2016–19

The Victorian Government launched *Delivering for diversity* in March 2016. The framework aims to embed cultural diversity in all the department's services, programs and policies. This framework builds on the department’s efforts to improve services for culturally and linguistically diverse communities (CALD). These communities include those with a long-established presence in Victoria, as well as recently arrived migrants, refugees and asylum seekers.

The [*Cultural diversity plan*](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Cpublications%5Cpoliciesandguidelines%5Cdhhs-delivering-for-diversity-cultural-diversity-plan-2016-19) is available from [the de](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/dhhs-delivering-for-diversity-cultural-diversity-plan-2016-19)partment’s website <www2.health.vic.gov.au/about/publications/policiesandguidelines/dhhs-delivering-for-diversity-cultural-diversity-plan-2016-19>.

#### Korin Korin Balit Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027

Korin Korin Balit-Djak means ‘Growing very strong’ in the Woi wurrung language. It provides an overarching framework for action to improve the health, wellbeing and safety of Aboriginal Victorians.

The plan details how the department will work with Aboriginal communities, community organisations, other government departments and mainstream service providers - now and into the future - to improve the health, wellbeing and safety of Aboriginal people in Victoria.

Korin Korin Balit-Djak covers five domains:

* Aboriginal community leadership
* prioritising Aboriginal culture and community
* system reform across the health and human services sector
* safe, secure, strong families and individuals
* physically, socially and emotionally healthy Aboriginal communities.

For further information please refer to [Korin Korin Balit-Djak website](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak): <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/korin-korin-balit-djak>

**7.2.4.6 Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027**

*Balit Murrup* means 'strong spirit' in the Woi-wurrung language. It recognises that to reduce the growing mental health gap, we need new and different solutions to address what has been described in as entrenched mental health crises. The vision of Balit Murrup is to support Victorian Aboriginal people, families and communities to achieve and sustain the highest attainable standard of social emotional wellbeing and mental health.

Balit Murrup's objective is to reduce the health gap attributed to suicide, mental illness and psychological distress between Aboriginal Victorians and the general population.

Balit Murrup includes four domains:

· Improving access to culturally responsive services

· Supporting resilience, healing and trauma recovery

· Building a strong, skilled and supported workforce

· Integrated and seamless service delivery.

For more information please Balit Murrup is available from the department’s website: <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/balit-murrup-aboriginal-social-emotional-wellbeing-framework-2017-2027>>

**7.2.4.7 Aboriginal Governance and Accountability Framework**

The Aboriginal Governance and Accountability Framework supports the department’s commitment to self-determination and ensures Aboriginal voices drive decisions around the health, wellbeing and safety of Aboriginal Victorians through better partnership and joint decision-making between Aboriginal communities, government and agencies.

This framework also provides an opportunity for the transparent monitoring of accountability of outcomes for Aboriginal Victorians and informs governance, monitoring and accountability to Korin Korin Balit-Djak.

The [Aboriginal Governance and Accountability Framework](https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/governance-accountability) is available from the department’s website: <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/governance-accountability>

#### Ending family violence: Victoria’s plan for change

Victoria’s 10-year family violence plan *Ending family violence: Victoria’s plan for change* details how the government will deliver the 227 recommendations made by Australia’s first Royal Commission into Family Violence and build a new system that supports families and strengthens victims' protection from perpetrators. The plan is focused on outcomes and a service system that is united, integrated and joined-up, including family support, legal, housing, financial support, mental health and AOD services.

[*Ending family violence: Victoria’s plan for change*](http://www.vic.gov.au/familyviolence)is available from the Government’s website <http://www.vic.gov.au/familyviolence>.

#### Victoria’s 10-year mental health plan

The aim of Victoria’s 10-year mental health plan is to guide investment and drive better mental health outcomes for Victorians. Recognising that nearly half of all Victorians will experience mental illness in their lifetime, the plan focuses on greater efforts in prevention, and providing better integrated services and support for the most vulnerable people in the community. Actions addressed will include working with people with mental illness, their families and carers, other experts and across government to identify better responses to mental illness co-occurring with harmful AOD use. The plan also outlines the government’s approach to work directly with people with a mental illness, their families and carers to co-produce and improve services.

The [*10-year mental health plan*](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Cabout%5Cpublications%5Cpoliciesandguidelines%5Cvictorias-10-year-mental-health-plan%3E)is available from the department’s website <www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan>.

#### Rainbow e.Quality guide for LGBTI inclusive practice

The Victorian Government *Rainbow e.Quality guide* is an online lesbian, gay, bisexual, trans and intersex (LGBTI) communities inclusive practice guide for health and community services. The guide was developed to assist mainstream health and community service agencies to identify and adopt inclusive practices and become more responsive to the health and wellbeing needs of LGBTI individuals and communities.

The [*Rainbow e.Quality guide*](file:///C%3A%5CUsers%5Ccwal1610%5CAppData%5CLocal%5CTemp%5Cnotes7A2C6A%5Cwww2.health.vic.gov.au%5Crainbowequality)is available from the department’s website <www2.health.vic.gov.au/rainbowequality>.

#### Absolutely everyone: state disability plan 2017–20

*Absolutely everyone* is the state disability plan for the whole of the Victorian Government. The plan focuses on key areas to drive change such as adopting a universal design approach, changing attitudes, increasing access to affordable housing, public transport, schools and jobs. It seeks to ensure that people with a disability are able to make the most of the National Disability Insurance Scheme (NDIS) through a series of actions. These include working with communities to identify and address barriers to participation.

[*Absolutely everyone*](http://www.statedisabilityplan.vic.gov.au) is available from the Government’s website <www.statedisabilityplan.vic.gov.au>.

#### Victorian Government information technology strategy 2016–20

The Victorian Government ICT Strategy provides high-level direction on the design and use of information and technology to deliver better government policy, services and outcomes for Victorians. Please refer to the [Information Technology Strategy](http://www.enterprisesolutions.vic.gov.au/) for more information <www.enterprisesolutions.vic.gov.au/>.

#### Victorian service coordination practice manual 2012

The purpose of the practice manual and associated resources is to assist service providers across health and human services sectors to consistently implement service coordination. The manual is designed to define practices which support service coordination and provide the basis for monitoring, benchmarking and continuous improvement of service coordination across Victoria. A range of government-funded and broader health and community sectors and service providers have been progressively implementing use of the manual since 2001 to achieve improved outcomes for their consumers.

The [Victorian service coordination practice manual](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-service-coordination-practice-manual-2012) is available from the department’s website <www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-service-coordination-practice-manual-2012>.

#### Can I ask...? An alcohol and other drug clinician’s guide to addressing family and domestic violence

This resource explores the relationship between AOD use and family and domestic violence. This guide provides AOD workers and organisations with an introduction to family and domestic violence, and identifies how the sector can better support clients who have co-occurring AOD and family violence issues, and minimise associated harms experienced by their children. It is a reference document to assist in worker’s training and development, and to support organisations to consider their family violence practice, policy and procedures.

These guidelines are available from [The National Centre for Education and Training on Addiction](http://www.nceta.flinders.edu.au/workforce/projects_and_research/family-centred-practice-alcohol-and-other-drug-field) website <www.nceta.flinders.edu.au/workforce/projects\_and\_research/family-centred-practice-alcohol-and-other-drug-field>.

### Clinical policies and guidelines

#### Alcohol and other drug withdrawal guidelines (2018)

The revised *AOD withdrawal guidelines* are a guide for anyone involved in the care of clients undertaking substance withdrawal, including nursing and medical staff, AOD clinicians and other health professionals. The guide includes a description of withdrawal principles and pathways for clients in AOD treatment, and describes treatment options for withdrawal from alcohol, benzodiazepines, opioids, cannabis, psychostimulants and tobacco. Special needs client groups are covered in detail, including a chapter on management of substance addiction in those with co-occurring mental illness.

The practice guidelines inform best practice AOD withdrawal care for clinicians and provide an overview for those interested in understanding and structuring effective AOD treatment models. For more information please refer to the [Withdrawal Guidelines](https://www.turningpoint.org.au/treatment/clinicians/withdrawal-guidelines) online <https://www.turningpoint.org.au/treatment/clinicians/withdrawal-guidelines>

#### Clinical treatment guidelines

A Clinical Treatment Guidelines series was developed by Eastern Health Turning Point, including the [*Clinical treatment guidelines for methamphetamine dependence and treatment (2007)*](https://www2.health.vic.gov.au/about/publications/researchandreports/clinical-treatment-guidelines-for-methamphetamine-dependence-and-treatment-2007)which can be found on the department’s website: <https://www2.health.vic.gov.au/about/publications/researchandreports/clinical-treatment-guidelines-for-methamphetamine-dependence-and-treatment-2007>

Also included in the series were:

* Key principles and practices
* Motivational interviewing
* Relapse prevention
* Reducing harm for clients who continue to use drugs
* Controlled drug use interventions
* Effective weed control (working with cannabis users)
* Working with polydrug users
* Assertive follow-up
* Prescribing for drug withdrawal
* Managing difficult and complex behaviours
* Working with families
* Smoking cessation (working with clients to quit)
* Youth alcohol and drug outreach
* Methamphetamine dependence and treatment
* Case management in alcohol and other drug settings.

#### Policy for maintenance pharmacotherapy for opioid dependence (2016)

Victoria's Policy for maintenance pharmacotherapy for opioid dependence was revised and was made effective from 1 September 2016. There is significant focus in the revised Policy on pharmacotherapy take-away doses, which can be fatal if diverted, shared or ingested incorrectly.

Pharmacotherapy providers are encouraged read the revised policy and understand that the tightened guidelines deliver stronger, clearer, safer and additional advice on the provision of pharmacotherapies throughout Victoria.

The [Policy for maintenance pharmacotherapy for opioid](https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/maintenance-pharmacotherapy-aod) dependence can be found on the department’s website: <https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/maintenance-pharmacotherapy-aod>

##

## Attachment 3: acronyms and glossary

### Acronyms

The following abbreviations are found in parts 1–3 of the program guidelines.

**ABF** Activity-based funding

**ABI** Acquired brain injury

**ACCHO** Aboriginal Community Controlled Health Organisation

**ACCO** Aboriginal Community Controlled Organisation

**ACHS** Australian Council of Healthcare Standards

**ACR** Australian Coordinating Registry

**ACSO**  Australian Community Support Organisation

**ADF** Australian Drug Foundation

**AIDS** Acquired immune deficiency syndrome

**AIFRS** Australian Equivalents to International Financial Reporting Standards

**AOD**  Alcohol and other drugs

**APSU**  Association of Participating Service Users

**BBV**  Blood-borne virus

**BVR** Bed Vacancy Register

**CALD**  Cultural and linguistic diversity

**CHI** Commission for Hospital Improvement

**CIMS** Client incident management system

**CISP** Court Integrated Services Program

**COATS**  Community Offenders Advice and Treatment Services

**COPE** Community Overdose Prevention and Education initiative

**CREDIT** Court Referral and Evaluation for Drug Intervention and Treatment program

**DACAS** Drug and Alcohol Clinical Advisory Service

**DDAL** Drug Diversion Appointment Line

**DOPE**  Drug Overdose Prevention Education program

**DTAU** Drug Treatment Activity Unit

**EOC** Episode of care

**FAC** Funded Agency Channel

**FaMDAS** Frankston and Mornington Drug and Alcohol Services

**FAR** Financial Accountability Requirement

**FOCis** First Offender’s Court Intervention Service

**FOPMF**  Funded Organisation Performance Monitoring Framework

**GP** General Practitioner

**HIV** Human immunodeficiency virus

**HPP**  Health Privacy Principles

**HRVic**  Harm Reduction Victoria

**ICT** Information and communications technology

**IM** Information management

**IPP** [Information Privacy Principles](http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/information-privacy-principles)

**IRP** Individual recovery plan

**ITP** Individual treatment plan

**LEAP** Victoria Police Law Enforcement Assistance Program

**LGBTI** Lesbian, gay, bisexual, trans and intersex community

**MDMA** Methylenedioxy-methamphetamine (ecstasy)

**MHCSS** Mental Health Community Support Services

**MSIR** Medically Supervised Injecting Room

**NDIS**  National Disability Insurance Scheme

**NDSHS** National Drug Strategy Household Survey

**NSP** The Victorian Needle and Syringe Program

**PABN** Pharmacotherapy area-based network

**PAMS** Pharmacotherapy Advocacy, Mediation and Support service

**PARTY** Prevent Alcohol and Risk Related Trauma in Youth Program

**PDPA** Privacy and Data Protection Act

**PHN** Primary Health Network

**PROW** Pharmacotherapy Regional Outreach Worker

**RNDB** VicRoads Road Network Database

**RSA** Responsible service of alcohol training and alcohol management standards

**SACS** Social and Community Services award

**SECADA** South Eastern Consortium of Alcohol and Drug Agencies

**SHARC**  Self Help Addiction Resource Centre

**SSDTA** The *Severe Substance Dependence Treatment Act 2010*

**SURe** Substance Use Recovery consortium

**TCA** Treatment Compliance Advice

**VAADA**  Victorian Alcohol and Drug Association

**VAC** Victorian Aids Council

**VACCHO** Victorian Aboriginal Community Controlled Health Organisation

**VADDS**  Victorian Association of Drink and Drug Driver Services

**VAED** Victorian Hospital Admitted Episodes Data

**VAHS** Victorian Aboriginal Health Service

**VAILA** Victorian Addiction Inter-hospital Liaison Association

**VDDI** Victorian Dual Diagnosis Initiative

**VEMD** Victorian Emergency Minimum Dataset

**VMIA** Victorian Managed Insurance Authority

**WADS** Royal Women’s AOD Service

**YoDAA**  Youth Drug and Alcohol Advice Service

**YSAS** Youth Support and Advocacy Service

### Glossary

**Alcohol and other drug (AOD) problem** –a general term that refers to a pattern of harmful behaviour involving the misuse or overuse of substances for mood-altering purposes which change how a person behaves or feels.

**AOD treatment services** – services and functions funded by the State of Victoria as part of the AOD treatment services program.

**Assessment** – in the AOD treatment system, the assessment function delivers standardised, good practice comprehensive assessment and treatment planning to identify and prioritise a person’s treatment and referral needs. This activity includes brief interventions and bridging support, where appropriate.

**Bridging support** – a form of regular contact which aims to support client engagement, retention, motivation and stability while clients wait for assessment and treatment.

**Brief intervention** – education and advice that aims to achieve a short-term reduction in harm associated with AOD use. This may include crisis intervention, harm reduction measures, relapse prevention planning, and support for co-occurring issues, such as mental health.

**Care and recovery coordination** – a function that facilitates more seamless and integrated treatment pathways for complex clients, and their families, and improves access to other services and support systems in the community.

**Carer** – a person caring for a person with an AOD problem. This may include a family member, partner, dependent child, friend or other person who has a significant role in the life of the person. The role of carer may not necessarily be a static or permanent one but may vary over time according to the needs of the person and the carer. Paid carers such as professional staff in services, attendant carers or residential workers are not included in this definition.

**Case management** – the coordination of services by a professional for the assessment, planning and implementation of care to meet an individual’s needs. The underlying tasks of case management include: assessment of need; care planning; implementation; monitoring; and regular review.

**Catchment** – a geographical area with boundaries.

**Catchment-based intake** – the function that provides the main pathway into localised treatment in each catchment. These services deliver standardised good-practice triage, to identify a person’s need for, and prioritise their referral to, specialist alcohol and other drug treatment and other services. This activity includes brief interventions and bridging support, where appropriate, up until the point of a client's assessment.

**Catchment-based planning** – a function to develop an evidence-based catchment plan which identifies critical service gaps and pressures, and strategies to improve responsiveness to client and community need and population diversity, including disadvantaged population groups. Each plan will provide the basis for improved cross-sector service coordination and by doing this achieve a more planned, joined-up approach to the needs of clients.

**Client** – a user or potential user of an AOD treatment service.

**Client-facing support** – support provided directly to a client either on a one-on-one basis or in a group setting.

**Clinical governance** – the medical oversight and accountability structures that ensure high standards of care, transparent responsibility for client outcomes, and continuous service improvement.

**Client summaries –**information provided in connection with the further treatment of a client, with client consent and within relevant legislative obligations. For example, a client summary provided with a client referral from a catchment-based intake service to an assessment provider may include information on the treatment needs and preferences of a client. A client summary provided by a treatment service to a client’s GP on their completion of a course of treatment may include information about a client’s progress or their achievement of significant treatment goals.

**Complexity** – a person’s level of life issues and personal circumstances, influenced by housing, employment and psychological distress. Complexity is indicated at intake, and confirmed at assessment. Changes in client circumstances and wellbeing may influence a client’s complexity status and eligibility for ‘standard’ and ‘complex’ courses of treatment.

**Complex client** – a client screened as complex through the administration of the common screening process described above. Screening and clinical judgement identifies a client’s needs and their eligibility for standard and complex treatments, which are priced differently. Complex clients are prioritised for assessment and may receive additional supports such as Care and Recovery Coordination as appropriate.

**Complex course of treatment –** separate ‘standard’ and ‘complex’ products apply to the counselling and withdrawal treatment streams. Service providers receive a higher ‘complex’ price for treatment provided to those clients screened as complex through the process described above. There is scope for reclassifying between standard and complex should a client’s clinical requirements change significantly during the treatment episode.

**Consortia** – a legal entity consisting of a combination of agencies.

**Counselling** – face-to-face, online and telephone treatment and support for individuals and families, as well as group counselling and day programs. Counselling is classified as standard or complex and duration can range from a single session to extended periods of one-to-one engagement or group work. Clinical assessment and review is an ongoing process throughout the service period.

**Cultural and linguistic diversity (CALD)** – the range of different cultures and language groups represented in the population who identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home.

**Cultural competence** – a set of congruent behaviours, attitudes and policies that come together in a system or agency or among professionals that enable that system, agency or those professionals to work effectively in cross-cultural situations.

**Cultural responsiveness** – the capacity to respond to the healthcare issues of diverse communities.

**Drug treatment activity unit (DTAU)** – a single price common counting tool. The price of all funded activities will be expressed as a multiple of this unit price.

**Dual diagnosis** – one or more diagnosed mental health problems occurring at the same time as problematic AOD use.

**Eligible person** – a person eligible to receive AOD treatment and support through AOD treatment services.

**Episode of care (EOC)** – a completed course of treatment undertaken by a client under the care of an AOD worker, which achieves at least one significant treatment goal.

**Family** – includes a family member, partner, or dependent child/children that have a significant role in the life of the client.

**Family counselling/session** – a course of counselling provided to family members/significant others and receives the same DTAU as Standard Counselling.

**FOI Act** – the *Freedom of Information Act 1982* (Vic).

**Forensic brokerage –** ACSO facilitates referrals for clients from a range of justice services, by arranging and purchasing assessments and treatment from specialist AOD treatment services for forensic clients.

**Harm reduction** – approaches aim to reduce the negative consequences associated with AOD use and reduce other related risk factors.

**Incident reporting** – reporting of incidents and adverse events that may occur in the delivery of AOD treatment services. A range of incident reporting requirements are in place across the department. These reporting requirements vary depending on the type of incident and the services involved, which in some instances are underpinned by legislation or national agreements.

**Individual recovery plan (IRP)** – are completed with a client using a service measured by the use of DTAU funding.

**Individual treatment plan (ITP)** – are completed with a client to document a planned treatment approach and outcomes to be achieved.

**Information management (IM)** – the collection, storage and use of information from one or more sources and the distribution of that information to one or more audiences. It includes both electronic and physical information.

**Information and communications technology (ICT)** – the integration of telecommunications (telephone lines, wireless networks, internet and other communication mediums), computers, software, storage and audio-visual systems which enable users to access, store, transmit, and manipulate information.

**Information system** –the technical infrastructure and human resources that support the collection, storage, processing, transmission and dissemination of information required by all or some part of an agency to support the delivery of services.

**Intake** –in the AOD treatment system, the intake function delivers standardised good-practice triage to identify a person’s need for, and prioritise their referral to, specialist alcohol and other drug treatment and other services. This activity includes brief interventions and bridging support, where appropriate, up until the point of a client's assessment.

**Legal entity** – a service provider or individual with legal status established under:

* *Associations Incorporation Act 2009* (Vic)
* *Co-operatives Act 1996* (Vic)
* *Corporations Act 2001* (Commonwealth)
* *Health Services Act 1988* (Vic)
* An Individual Act of Parliament
* Natural person (a person at least 18 years of age, with a mental capacity to understand the agreement, not under any order or bankrupt)
	+ *Trustee Act 1985* (Vic).

**Lesbian, gay, bisexual, trans and intersex** **community (LGBTI)** – an acronym that refers to people who have diverse sexual orientation, sex or gender identity. The acronym includes other sexuality, sex and gender non-conforming people, regardless of their term of self-identification.

**Measures** – a defined collectable unit which enables organisations to track and assess progress against indicators.

**Mental health community support services** (**MHCSS) –** the new name for Victoria’s community mental health services formerly known as Psychiatric Disability Rehabilitation and Support Services.

**Naloxone –** a lifesaving medication that can reverse the effects of an opioid overdose. On 1 February 2016 Naloxone was listed as a Schedule 3 medication (over the counter drug). This means that individuals no longer need a doctor’s prescription in order to access the medication. The department funds several overdose prevention programs that train people who are likely to be present in the event of an opioid overdose to administer naloxone.

**Neuroadaptation –** the process where person’s body and brain has adapted to the presence of a drug in the body and now requires it to continue to function normally. Heavy alcohol or other drug use can lead to this tolerance and dependence on a substance. People with neuroadaptation to AOD can experience uncomfortable or life-threatening symptoms when they stop using the drug/s of dependence.

**Neuroadaptation reversal –** the process of undoing the significant changes in person’s body and brain that have occurred support the constant presence of drugs or alcohol in the body. This process is often referred to as withdrawal or detox. During neuroadaptation reversal, a person will feel uncomfortable and may have painful symptoms.

**Non-facing client support** – support/activities undertaking on behalf of an individual client/group of clients that is not provided directly to an individual client/group of clients.

**Non-residential withdrawal** – supporting people to safely achieve neuroadaptation reversal through an abrupt cessation or gradual reducing regime. It includes a clinical withdrawal assessment, withdrawal treatment in the person’s home or at an AOD service, and referral and information provision via face-to-face and telephone modalities.

**Program and service advisor** – a person employed by the department to manage funding agreements at the divisional level.

**Recovery** – the concept of building a meaningful and satisfying life as defined by the person, whether or not they experience any ongoing or recurring symptoms or difficulties. Recovery is a personal journey, unique to each individual.

**Recovery-oriented treatment** – treatment that acknowledges that a person’s path to recovery is individual and unique, and informed by their strengths and hopes, preferences, needs, experiences, values and cultural background.

**Safety** – a state in which risk has been reduced to an acceptable level.

**Service provider** – an entity funded by the department to deliver services.

**Service volume** – the quantum of service (expressed as an agreed standard unit).

**Standards** – general statements against which organisations can audit their performance. The Australian Council of Healthcare Standards (ACHS) defines standards as “a statement of the level of performance to be achieved” (ACHS 2006).

**State** – the Crown in right of the State of Victoria (and includes the department).

**Statewide intake** – a function that provides a 24/7 statewide telephone and online service to facilitate entry into the AOD treatment system, screen and refer people into or out of AOD treatment, provide information and advice, and link people to other appropriate services.

**Stepped care** – clients can move seamlessly between services in response to higher or lower levels of risk and acuity.

**Service integration** – a health and human service system where there are good connections between services. Integrated services help achieve better outcomes for clients by facilitating timely and appropriate referrals for clients across their treatment journey.

**System fragmentation** – the absence or underdevelopment of connections between specialist AOD treatment services, and other health and human services. A fragmented service system reduces the likelihood that clients will be matched with services that best meet their needs in a timely way. It is the opposite of service integration.

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# Attachment 5: catchment-based planning function overview (March 2015)

## Definitions

**Catchment** – a geographical area with boundaries. AOD services are delivered across service catchments. In metropolitan Melbourne, there are a total of nine catchments. The non-metropolitan area is divided into a total of seven catchments.

**Health inequalities** – differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates related to physical health between people with a severe mental illness and the general population. Health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned.

**Health promotion** – defined by the World Health Organisation (2005) in the Bangkok Charter for Health Promotion in a Globalised World as ‘the process of enabling people to increase control over their health and its determinants, and thereby improve their health.’ The primary means of health promotion occurs through the development of public policy that addresses the prerequisites of health such as income, housing, food security and employment.

**Alcohol and other drug (AOD)** **services** – early intervention and tertiary treatment services and functions funded by the State of Victoria as part of the AOD Services program.

**Population health** – the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire population. Population health seeks to step beyond the individual-level focus of mainstream medicine and public health by addressing a broad range of factors that impact health on a population-level.

**Primary prevention** – the goal of primary prevention is to protect people from developing an AOD-related problem or experiencing an accident or injury. Examples of primary prevention include informing people about the effects and the harms associated with the use of AOD, changing laws and regulations that govern sales of alcohol and tobacco, providing positive role modelling of AOD use, helping people to reduce stress in their lives, and developing safe environments that reduce the risk of AOD use.

**Recovery** – an approach based on strengths and hopes which celebrates and builds on people’s resilience and their own resources. This can include their skills, physical and mental health, relationships, housing situation and values, beliefs and attitudes.

A recovery approach recognises people for who they are, in the context of their achievements, their family and friends and their community. A recovery approach connects people to the other supports and systems they need to build their resilience and resources. A recovery approach recognises that a person’s recovery journey is their own and extends throughout and beyond the time they spend in formal treatment.

Recovery sits within a framework of harm minimisation that recognises people come to treatment through many different paths and their goals and their journey to recovery and wellbeing are individual and unique.

**Social determinants of health** – the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between geographical areas and population groups.

## Introduction

This overview document specifies the purpose, scope and operational requirements of the AOD catchment-based planning function. It builds on information previously provided in the former Department of Health’s service specifications for the delivery of the catchment-based planning function. For service specifications for the delivery of selected AOD treatment services in Victoria, see<[www.health.vic.gov.au/aod/pubs/index.htm](file:///%5C%5CN060%5CGROUP%5CDrug%20Policy%20and%20Services%5CDesign%20%26%20Development%5CGuidelines%5C2017%20Guidelines%20review%5Cwww.health.vic.gov.au%5Caod%5Cpubs%5Cindex.htm)>.

Catchment-based planning will be undertaken by a single provider on behalf of, and in partnership with all AOD services operating in the catchment and a range of stakeholders, including the department. For Victorian AOD catchment maps, see <[www.health.vic.gov.au/aod/pubs/index.htm](file:///%5C%5CN060%5CGROUP%5CDrug%20Policy%20and%20Services%5CDesign%20%26%20Development%5CGuidelines%5C2017%20Guidelines%20review%5Cwww.health.vic.gov.au%5Caod%5Cpubs%5Cindex.htm)>.

The primary purpose of the planning function is to assist AOD providers operating in a given catchment to develop a regular common plan which will identify critical service gaps and pressures, and strategies to improve responsiveness to people with AOD issues (particularly people facing disadvantage), population diversity and broader community need. While the primary focus is on treatment services, it is anticipated that planning will also consider prevention and early intervention activities and initiatives in the region, in order to promote integrated approaches to service delivery.

The plan will also provide a basis for improved cross service coordination at the catchment level and by doing this achieve a more planned, joined-up approach to the needs of individual clients. Service coordination is expected across housing, mental health, gambling, primary health, justice, education and employment agencies.

It will also support providers of AOD services in a catchment to efficiently participate in relevant service coordination and planning platforms managed by, for example, Medical Locals / Primary Health Networks, Primary Care Partnerships, Public Health Services and Local Government Authorities.

Organisations funded to deliver the following AOD programs and functions in a given catchment should be actively involved in the development, implementation and review of the catchment-wide strategic plan. This includes:

* intake providers
* assessment providers
* counselling providers
* non-residential withdrawal providers
* care and recovery coordination providers
* residential AOD withdrawal providers
* residential rehabilitation providers
* Aboriginal services
* youth and adult AOD providers
	+ other Victorian Government-funded AOD program providers.

## Objectives

The objective of the catchment-based planning function is to:

* gather and analyse relevant health and population data to identify and understand the distinct and diverse needs of people with AOD problems living in the catchment, particularly those facing significant disadvantage and discrimination such as those who are homeless or at risk of homelessness, Aboriginal people, CALD and refugee populations and people with a dual diagnosis/disability
* on behalf of and in collaboration with other AOD treatment providers in the catchment and other stakeholders (including the department), develop, implement and regularly review a catchment-based AOD plan which will identify current and projected service gaps and pressures and develop cohesive strategies to improve responsiveness to community need and population diversity, within existing resources
* engage with relevant agencies and planning structures (for example, Primary Health Networks, Primary Care Partnerships, health promotion platforms and strategies, and Local Government through health and well-being plans) and participate in discussions and planning to:
	+ - identify and develop shared strategies to address systemic barriers to access and deliver a more coordinated response to the needs of people with AOD issues at the system level across the catchment
		- ensure the needs of people with an AOD issue in the catchment are taken into account in other local planning activity
		- build shared local understanding of AOD issues and responses
* ensure the views of clients and their families/significant others inform the development, implementation and review of the catchment plan and are represented in other relevant planning forums by creating or engaging in existing catchment level processes and opportunities
	+ engage through catchment-based planning processes with all AOD treatment services within the catchment, including those out of scope for recommissioning, Commonwealth funded, youth, adult and Aboriginal AOD services.

#### Out-of-scope

The following activities are out of scope for the funded AOD catchment planning function:

* conduct or commissioning of research, including translation research
* experience of care surveys (consumer and family)
* direct provision of AOD services
* primary prevention activities
* promotional events
	+ formal review of individual AOD providers’ service delivery and practice models.

#### Key features

The AOD planning function has the following key features:

* A three year catchment-based strategic plan developed and implemented in collaboration with, and on behalf of, funded AOD providers in the catchment, consumers and family and other key stakeholders.
* The strategic plan will be based on analysis of relevant health and population data and (expressed) AOD demand data, and other secondary data sources, supplemented by targeted consultation as required.
	+ Active involvement and collaboration with relevant local planning structures and processes to influence and jointly plan for the needs of people with AOD issues and their families and significant others at the catchment level.

AOD providers of the catchment planning function who have been funded for this function in multiple adjoining catchments may produce a region-wide strategic plan. Such plans must however incorporate catchment-specific analyses and strategies to ensure the unique features and needs of the catchment are fully accounted for.

#### Funding model

As at 2018, the AOD catchment planning function is funded on a block basis at $59,001 per annum per catchment.

#### Key data and information inputs

A range of data and information inputs have been identified to inform the development of the strategic plan. Useful sources may include, but are not limited to:

* demographic data
* index of Relative Socio-Economic Disadvantage (a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area)
* AODstats data <[www.aodstats.org.au/](http://www.aodstats.org.au/)>. This Victorian AOD interactive statistics and mapping webpage includes seven unit record datasets and two aggregated datasets:
	+ - Victorian emergency department presentations data from the Victorian Emergency Minimum Dataset (VEMD)
		- Victorian hospital admissions data from the Victorian Hospital Admitted Episodes Data (VAED)
		- AOD-related ambulance attendances from the Turning Point Ambo project
		- AOD treatment services data
		- Victorian mortality data from the Australian Coordinating Registry (ACR)
		- Serious road injuries from the VicRoads Road Network Database (RNDB)
		- Aggregated assault and family incident data derived from the Victoria Police Law Enforcement Assistance Program data (LEAP)
		- Workforce data
		- DirectLine counselling, information and referral service data
		- Periodic release of AOD consumption – National Drug Strategy Household Survey (NDSHS)
* other population health data, with a specific focus on AOD use
* catchment-wide service mapping and input from organisations that have readily available information/data on AOD related issues, vulnerable population groups and service utilisation.
* aggregated AOD Intake and Assessment Service output data on expressed service demand.
* catchment-level AOD outcome data (where available)
* secondary information sources such as surveys and research
* the identification and analysis of knowledge gaps and data/information gathering through consultation and liaison with relevant community groups and agencies (for example local health and community planning structures, consumers and families, Aboriginal-specific organisations, refugee groups, gambling groups, mental health groups and migrant resource/information centres)
* other sources as relevant.

#### Guiding framework

The planning framework for the AOD catchment planning function should be guided by the following, at a minimum:

* **Determinants of health and their interactions** – the plan should seek to identify and address the factors and conditions which directly impact on AOD, wellbeing and social and economic outcomes for people with AOD issues.
* **Address health inequalities –** the plan should take into account social, economic, geographical, legal and cultural influences that impact on AOD use and create inequality. Evidence shows that people who are most disadvantaged should be targeted to reduce these inequalities. The plan may therefore 1) identify priority at-risk or high needs populations in relation to AOD, and 2) identify and consider underserviced population groups and the reasons why.
* **Human rights principles** **of non-discrimination, equality and empowerment** – the plan should consider the possible impact on the human rights of all those directly and indirectly affected by the development and implementation of the AOD strategic plan. The human rights that belong to all people in Victoria, without discrimination, are set out in Part 2 of the *Charter of Human Rights and Responsibilities Act 2006.*
* **Driven by evidence –** the plan should use robust evidence, information and analysis to understand service demand, identify service gaps and help drive improvements in service delivery and responsiveness.
* **Continuum of need** – the plan should identify critical service gaps across the spectrum of prevention of AOD misuse to tertiary interventions (including early intervention to reduce the burden of disability). The plan may identify, consistent with a focus on the determinants of health, the range of health and community services and strategies required to provide a more comprehensive spectrum of service responses and interventions for people with AOD issues.
* **Strategic focus** – the plan should include a strategic mix of strategies across the continuum of need that address population needs and diversity, with a focus on high priority /at risk groups.
* **Consumer, family and significant other engagement** –the formulation, implementation and review of the plan should be informed by the views of consumers, families and significant others. Governance structures and processes should thus be designed in a manner that reflects such engagement.
* **Collaboration across sectors and levels** – the plan should activelyengage with sectors and groups with a stake in AOD outcomes, for example, housing, corrections, education, gambling, Aboriginal health, community services and Child Protection services.
	+ **Demonstrate accountability for health outcomes** – the plan should be collaboratively reviewed annuallyagainst agreed milestones and planned outcomes by its key stakeholders.

#### Program governance

As a minimum, providers of the catchment planning function are required to establish and maintain appropriate governance structures and processes that actively support the involvement of core stakeholders in the formulation, review and implementation of the strategic plan. These stakeholders may include, but are not limited to:

* relevant AOD providers in the catchment
* consumers, family and significant other representatives
* major health services in the catchment
	+ a representative of the department divisional office (ex-officio basis).

The AOD strategic plan should be endorsed by these core stakeholders.

The organisations leading the AOD catchment planning function should also ensure their governance/planning structures and processes, including communication and consultation processes, actively support the participation of relevant local health and human services providers as well as organisations and entities involved in health and community planning in the catchment, such as, but not limited to:

* Public Health Services
* Local Government Authorities
* Primary Care Partnerships
* Primary Health Networks
	+ Mental Health Alliances or equivalent

A representative from the department divisional office will participate on governance structures established for the planning function on an ex-officio basis.

#### Monitoring and reporting requirements

AOD providers delivering the catchment planning function will meet quarterly or as agreed with department divisional staff and other relevant departmental officials as part of monitoring and reporting requirements for this function. Providers may also be required to deliver a brief written report outlining activities undertaken and accounting for expenditure of funding for the preceding period.

The department may also convene forums with all providers of the AOD catchment planning function to discuss data and systemic issues.

It is anticipated that the AOD strategic plans will be made publically available. This includes being published on agreed websites.

#### AOD catchment planning providers

The organisations funded to lead the development of the catchment-based AOD strategic plan and associated activities are detailed below.

Table : AOD providers of the planning function by catchment

| Catchment | AOD provider |
| --- | --- |
| **Bayside** | Bayside Integrated Services |
| **South East Melbourne** | South Eastern Consortium of AOD Agencies (SECADA) |
| **Frankston-Mornington Peninsula** | Frankston and Mornington Drug and Alcohol Services (FaMDAS) |
| **Inner North Melbourne** | Uniting Care ReGen - Odyssey House |
| **North Melbourne** | Uniting Care ReGen - Odyssey House |
| **North West Melbourne** | Odyssey House - Uniting Care ReGen |
| **South West Melbourne** | Odyssey House - Uniting Care ReGen |
| **Inner East Melbourne** | Substance Use Recovery (SURe) Consortium |
| **Eastern Melbourne** | SURe Consortium |
| **Gippsland** | Latrobe Community Health Service |
| **Goulburn Valley** | Goulburn Valley AOD Services |
| **Hume** | Gateway Health |
| **Grampians** | Grampians AOD Consortium |
| **Loddon Mallee** | Bendigo Community Health Services |
| **Great South Coast** | Great South Coast Drug and Alcohol Treatment Services Consortium |
| **Barwon** | Stepping Up |

#### Implementation schedule for development of strategic plan

An indicative time frame for the development, implementation and collaborative review of the catchment-based strategic plans is described below. Due to the expected impact of catchment boundary alignment in some areas, timeframes for strategic plans and reporting are different for areas affected or unaffected by catchment boundary alignment that will take effect from 1 July 2019.

Table : indicative timeframe for AOD catchments in areas with minimal impact from catchment boundary alignment.

These AOD catchments include: Barwon, Goulburn Valley, Ovens Murray/Hume, Inner East Melbourne, Eastern Melbourne and South Eastern Melbourne.

| Activity | Indicative timeframe |
| --- | --- |
| **Three year strategic plan (including implementation plan) produced and released** | 1 December 2015 |
| **Implementation period** | December 2015 – December 2018 |
| **Annual formal review processes completed and completion of the annual plan**  | December 2016, 2017 and 2018 |
| **Development of new three year plan**  | Draft – by 1 November 2018 |
| **Three year strategic plan (including implementation plan) produced and released** | Final document – 1 December 2018 |
| **Implementation period**  | December 2018 – December 2021 |
| **Annual formal review process and completion of the annual plan**  | December 2019, 2020 and 2021 |

Table : indicative timeframe for AOD catchments in areas affected by catchment boundary alignment.

These AOD catchments include: Great South Coast, Grampians, Bayside, Frankston-Mornington Peninsula, Gippsland, Inner North Melbourne, North Melbourne, North Western Melbourne, South Western Melbourne and Loddon Mallee.

| Activity | Indicative timeframe |
| --- | --- |
| **Three year strategic plan (including implementation plan) produced and released** | 1 December 2015 |
| **Implementation period** | December 2015 – December 2018 |
| **Annual formal review processes completed and completion of the annual plan**  | December 2016, 2017 and 2018 |
| **One year extension for strategic plan to be produced and released** | Final document – 1 December 2018 |
| **Implementation period**  | December 2018 – December 2019 |
| **All new areas: development of new two year plan**  | Draft – by 1 November 2019 |
| **Two year strategic plan (including implementation plan) produced and released** | Final document – 1 December 2019 |
| **Implementation period**  | December 2019 – December 2021 |
| **Annual formal review process and completion of the annual plan**  | December 2020 and 2021 |

## Attachment 6: Key contacts

The DirectLine service finder is also accessible at <[www.directline.org.au/service-finder](file:///%5C%5CN060%5CGROUP%5CDrug%20Policy%20and%20Services%5CDesign%20%26%20Development%5CGuidelines%5C2017%20Guidelines%20review%5Cwww.directline.org.au%5Cservice-finder)>.

Table : key contacts

| Provider / consortium  | Contact | Local government area | Catchment |
| --- | --- | --- | --- |
| Bayside Integrated Services | 1800 229 2639690 9778 | Cities of: Port Phillip, City of Glen Eira, Bayside, Stonnington, Kingston | Bayside |
| South Eastern Consortium of AOD Agencies (SECADA)  | 1800 142 536 | Cities of: Greater Dandenong, Casey, Cardinia Shire | South East Melbourne |
| Frankston and Mornington Drug and Alcohol Services (FaMDAS) | 1300 665 781 | City of FrankstonMornington Peninsula Shire  | Frankston-Mornington Peninsula |
| Eastern Health Turning Point AOD Consortium | 1800 778 278 | Cities of: Boroondara, Manningham, Whitehorse, Monash | Inner East |
| EACH SURE Consortium | 1300 007 873 | Cities of: Knox, Maroondah Shire of Yarra Ranges | Eastern Melbourne |
| UnitingCare ReGen and Odyssey House Victoria: | 1800 700 514 | Cities of: Moreland, Moonee Valley, Melbourne, Yarra  | Inner NorthNorth MelbourneNorth West MelbourneSouth West Melbourne |
| North and West Metro Alcohol and Other Drug Service |  | Cities of: Whittlesea, Darebin, Banyule Shire of Nillumbik |
|  |  | Cities of: Brimbank, Hume, Maribyrnong, Melton  |
|  |  | Cities of: Hobsons Bay, Wyndham |
| Barwon AOD Consortium | 1300 094 187Colac area:1300 763 254  | City of Greater GeelongShires of Colac-Otway, Surf CoastBorough of Queenscliff | Barwon |
| ACSO | 1300 022 760 | Shires of: Bass Coast, South Gippsland, Baw Baw, Wellington, East GippslandCity of LaTrobe | Gippsland  |
|  | 1300 022 760 | Rural Cities of: Wodonga, Wangaratta, BenallaShires of: Indigo, Towong, Mansfield, Alpine | Hume  |
|  | 1300 022 760 | Shires of: Moira, Strathbogie, Mitchell, MurrindindiCity of Greater Shepparton | Goulburn Valley |
|  | 1300 022 760 | Shires of: Moorabool, Golden Plains, Pyrenees, North Grampians, West Wimmera, Hindmarsh, Yarriambiack, HepburnRural Cities of: Ararat, HorshamCity of Ballarat | Grampians |
|  | 1300 022 760 | Rural Cities of: Mildura, Swan Hill Greater City of BendigoShires of: Buloke, Gannawarra, Loddon, Campaspe, Central Goldfields, Mount Alexander, Macedon Ranges |  Loddon-Mallee |
|  | 1300 022 760 | Shires of: Glenelg, Southern Grampians, Moyne, CorangamiteCity of Warrnambool | Great South Coast |

Table : Other important statewide contacts

| Service | Contact | Provider |
| --- | --- | --- |
| DirectLine | 1800 888 236 | Eastern Health Turning Point |
| Youth Drug & Alcohol Advice (YoDAA)  | 1800 458 685 | Youth Support and Advocacy Service (YSAS) |
| Family Drug Help | 1300 660 068 | Self Help Addiction Resource Centre (SHARC) |
| AOD Pathways  | 1800 319 619 | Eastern Health Turning Point |

## Attachment 7: statement of outcomes

Table 9 provides a summary of the indicative types of outcomes that the Victorian Government is seeking to achieve for people with an alcohol and drug problem through the delivery of accessible, efficient, effective and responsive alcohol and drug treatment services.

It also illustrates the type of benefits that clients should expect as a result of receiving this treatment, acknowledging that alcohol and drug treatment providers alone will not be able to achieve all of these outcomes.

Please note this information is illustrative only. The department reserves the right to amend anyaspect of this statement of outcomes.

Table a: Indicative outcomes and benefits to client to which AOD treatment services are expected to contribute – effectiveness

| Indicative outcome | Ways benefit might be measured |
| --- | --- |
| AOD-taking behaviours of clients stabilised, improved or ceased  | Reduced frequency and/or level of AOD use. Increased protective behaviours associated with AOD use. |
| Improved quality of life status  | Client reports better/greater satisfaction with living conditions. |
| Improved social connectedness/reduced social isolation | Family or significant other are positively engaged with the client and are part of the support system provided to the client.Improved quality of personal relationships. Improved safety and wellbeing of dependent children.Client participates in mainstream social and recreational activities that are meaningful to them. |
| Improved physical health | Client reports fewer or less severe physical health symptoms.Improved engagement with primary health for prevention and/or management of chronic health problems. Reduction in preventable illness, key health risks and chronic disease (for example obesity, diabetes, smoking).Reduction in co-occurring health problems (including mental health issues). |
| Clients’ capacity for engagement in AOD treatment services and decision making about their own treatment planning improved | Clients have the skills, knowledge and confidence they need to make informed choices about the type of treatment and ongoing support they need.Clients articulate recovery oriented treatment goals.Self-management capacity. |
| Contribution to improved long-term housing security | Reduction in number of clients experiencing repeated or chronic homelessness.Timely access to appropriate and affordable stable housing.Maintenance of stable tenancy. |
| Contribution to improved economic participation | Engagement by clients in schooling/ vocational training opportunities of their choosing.Improved employment participation. |
| Client engagement with health, human services and other key social supports | Improved engagement with primary health for prevention and/or management of chronic health problems. Improved engagement with human services and social supports (e.g. housing, community services).  |
| Reduced involvement with the justice system | Reduction in the number of clients that come into contact with the justice system and the frequency of contact by individual clients. |
| Improved involvement of families in support provided to the client | Families have the skills, knowledge and confidence they need to support the person they care for.Active, respectful involvement of family in decisions related to the provision of support. |

Table 9b: Indicative outcomes and benefits to client to which AOD treatment services are expected to contribute - efficiency and sustainability

| Indicative outcome | Ways benefit might be measured |
| --- | --- |
| Services are cost efficient  | Services delivered within specified prices. |

Table 9c: Indicative outcomes and benefits to client to which AOD treatment services are expected to contribute – responsiveness

| Indicative outcome | Ways benefit might be measured |
| --- | --- |
| Responsiveness to population diversity | Services are culturally safe.Services effectively engage and respond to diversity.Services effectively engage and respond to individuals/groups known to experience significant disadvantage, particularly:Aboriginal people, their families and the community people experiencing or at risk of homelessnesspeople with a dual diagnosis/disabilitypeople with criminal justice involvement people with CALD backgrounds. |
| Improved responsiveness to family members including children and significant others | Family members provided with timely information, referral and advice to support. |
| Improved responsiveness to dependent children of clients | Dependent children identified and needs recognised in client care and support.Dependent vulnerable children referred to appropriate supports.Clients more confident in managing parenting responsibilities. |

Table 9d: Indicative outcomes and benefits to client to which AOD treatment services are expected to contribute – accessibility

| Indicative outcome | Ways benefit might be measured |
| --- | --- |
| AOD treatment services are easy to find and access  | Referral agencies, clients, and family members find it easy to locate AOD treatment services.Services are able to accept new clients on referral within a timely manner. |
| People who are most in need are prioritised for access | People with high-level AOD problems receive priority access and support in a timely manner. |
| The AOD treatment services system is easy to navigate | Clients do not have to retell their full histories multiple times.Complex clients are actively supported through their treatment. |
| People have reasonable access to AOD treatment services no matter where they live | People living in rural Victoria have reasonable access to AOD treatment services.More people and services are accessing treatment via centralised screening and catchment-based intake units.More people are accessing online screening and self-directed treatment options through the centralised screening and referral service. |

Table 9e: Indicative outcomes and benefits to client to which AOD treatment services are expected to contribute – continuity

| Indicative outcome | Ways benefit might be measured |
| --- | --- |
| Pathways between AOD treatment streams, including intake and assessment, are well established and support continuity of care | No gaps exist in the AOD treatment pathway for clients because:coordination at the statewide, catchment-based, service and client level is effective and supports continuity of care for clientscoordination and referral pathways between intake and AOD treatment services are effective and support continuity of care for clients. |
| Pathways to and from local human services and other social support services are well established and support continuity of care | AOD treatment services and human services/social support services collaborate and plan together to achieve improved outcomes and continuity of care for shared clients.Well established and effective referral pathways exist between AOD treatment services and human services/social support services e.g. no gaps exist between elements of the treatment and support pathway. |

Table 9f: Indicative outcomes and benefits to client to which AOD treatment services are expected to contribute – safety

| Indicative outcome | Ways benefit might be measured |
| --- | --- |
| Client safety | Number of critical incidents involving clients.  |
| Family safety | Number of critical incidents involving families and dependent children. |
| Worker safety | Number of critical incidents involving workers.  |

## Attachment 8: Peer work and the peer workforce in the AOD treatment sector

### Peer Work and the Peer Workforce in the AOD Treatment Sector

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

Peer Workers provide non-clinical assistance; they share their personal experiences in a way that inspires hope and role models recovery. Peer Workers are complementary to and work collaboratively with multi-disciplinary teams to provide support in line with the organisational frameworks.

NB: A peer worker within the sector responsible for supporting the holistic health of people who use drugs such as NSP sites or primary health care support for this cohort also uses their lived experience and formal training to support their clients, however may not identify as being in recovery. For the purpose of these guidelines, we will refer to peer workforce as being in the treatment sector.

Peer Support is what peer workers offer to others who have similar experiences by facilitating authentic connections, offering mutual support and sharing personal experiences in a way that inspires hope and role models possibility.

The most common, evidence based, Peer Work role is direct, in the form of one on one; or in a group setting. There is also online support and telephone support available in limited form from peer workers. Peer workers also engage in a wide range of activities and work in individual and systemic advocacy; as consultants and advisers; health promotion; education; group development and facilitation or to undertake research. Specialist peer work roles may be created for different population groups, culturally and linguistically diverse communities, and forensic patients.

### Purpose

Peer workers support clients at all stages of the treatment process through connection, mutual support and identification. Peer Workers provide support and deliver psychosocial and educational activities to inspire hope, reduce risk of overdose and relapse and keep clients engaged in the treatment process. They work within multi-disciplinary teams and provide an extra dimension of relationship to support the client journey.

**Key features of peer work include:**

* + 1. Initiating and developing relationships with clients. The relationship between the peer worker and the peer is the foundation on which peer support is created. This encompasses:
			- * Understanding connection, practicing interpersonal skills, having knowledge about change and attitudes consistent with a recovery orientation.
				* Providing the mutual support, validating client’s experiences and feelings.
				* Reaching out to engage client’s across the whole continuum of the treatment and recovery process
				* Sharing lived experiences as a way of identification, encouragement, role modelling and inspiring hope
				* Supporting clients to acquire the resources, services, and supports they need to enhance their recovery.
		2. Peer work is often present under the activity of Delivering Care and Recovery Coordination activities.
			- * Delivering a range of client engagement activities that will aid clients to navigate treatment
				* Providing bridging support and brief interventions for clients waiting to enter treatment or between treatment programs
				* Supporting clients to engage with other community supports such as mutual aid groups, community programs, families, medical practitioners and other service providers.
				* Establishing peer led groups to manage risk of relapse for those clients waiting to enter treatment
				* Delivering harm reduction and relapse prevention strategies including education and training around relapse and overdose
		3. Participating in quality improvement, service development and other improvement activities - offering additional, unique, lived experience that complements and enriches the existing workforce in the AOD sector.

#### Key service requirements for agencies to introduce, develop, support and sustain Peer Workers and the Peer Workforce

Peer work has been recognised as an integral part of quality service delivery, resulting in many organisations formalising and integrating designated peer worker roles. Peer workers are an emerging and evolving workforce and there is growing interest in the value of the peer workforce in AOD. Agencies need a clear understanding of the planning, development and support requirements, to ensure they introduce a peer workforce that is sustainable and working to an evidence base.

**Key features of agency responsibility include:**

##### Planning

Adequate pre-implementation planning, including acquisition of the skills and resources to support and manage peer workers. Including:

* Agency readiness training and preparation for the introduction of the discipline within organisations. For management and staff this includes acquiring a high-level understanding of the role, what makes it effective, and knowledge of the model and/or values-base underpinning peer work.
* Peer work is reflected in organisational systems e.g. endorsed by committees of management, expressed in Mission and Vision statements, reflected in organisational charts and introduced to clients through promotional activities – posters, pamphlets and forums.
* Role and position descriptions developed in collaboration with management and lived experience practitioners using language consistent with recovery orientation, peer work values, principles and guidelines.
* Ensuring organisational policies and procedures are consistent with, and reflect, the role.

##### Development and support

The provision of an established professional development framework for the peer workers to ensure quality, consistency and sustainability of peer work. Including:

* Quality, standardised AOD Peer Worker training to build core skills and provide a sound knowledge base of the peer work discipline.
* Ongoing professional development opportunities in the domain of peer work.
* Provision of regular supervision specific to the peer work discipline (from a skilled lived experience practitioner) ensuring that the peer workforce is meaningfully supported in their role and encourage to continuously develop both personally and professionally.
* Support for peer workers to attend peer worker networks, forums and communities of practice to serve as a professional development function and an ongoing mechanism for networking, development and discipline specific information exchange.
* Regular performance appraisals linked to the discipline of peer work, and the requirements of the job description that note strengths and achievements for the peer workers.

##### Sustainability

Organisations need to maintain a commitment to resourcing the peer workforce both internally and within the treatment sector. This means that:

* Organisations continue to build upon and share resources to enhance peer support activities – between agencies and across the sector.
* Organisations continue to emphasise, retain, and value the distinctiveness of the peer work role.
* Evaluation of peer activities are facilitated, documented and outcomes are distributed to staff, consumers and the wider sector.
* Continued education of staff and the sector about the role of the peer workforce is ongoing and regularly reiterated e.g. via recruitment, training, staff meetings and internal/external communications.