



Alcohol and Other Drug Action Plan

2009 to 2013

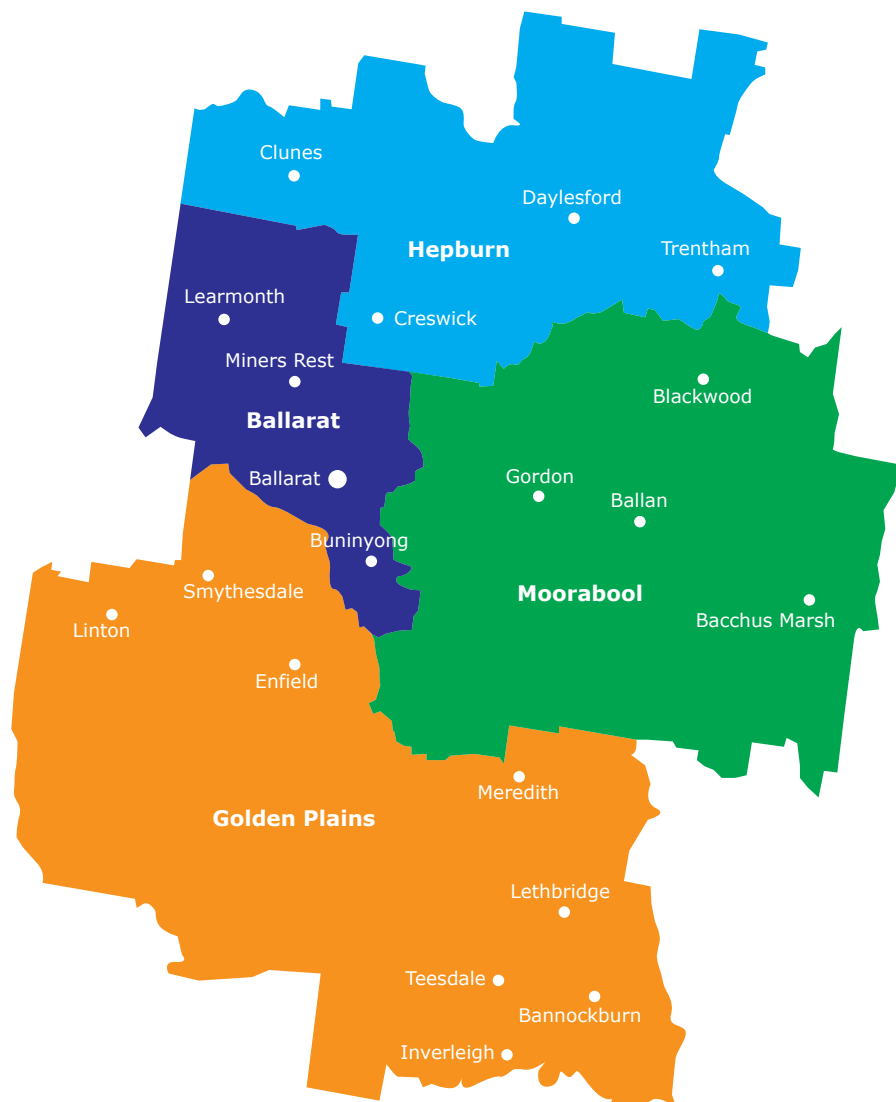


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Glossary of Terms

Table A: Glossary of Terms – Acronyms

ABI	Acquired Brain Injury
AOD	Alcohol and Other Drugs
CAFY	Community Action for Youth
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
CREDIT	Court Referral and Evaluation for Drug Intervention and Treatment
CSO	Community Service Organisation
EBP	Evidence Based Practice
ED	Emergency Department
HARP	Hospital Admission Risk Program – Chronic Care Management
HP	Health Promotion
IHP	Integrated Health Promotion
LGA	Local Government Area
MH	Mental Health
MOU	Memorandum of Understanding
PCP	Primary Care Partnership
PD	Professional Development
PDRSS	Psychiatric Disability Rehabilitation Support Services
PMHT	Primary Mental Health Team
RYAN	Regional Youth Affairs Network
SAAP	Supported Accommodation Assistance Program
SCADE	School, Community Approaches to Drug Education
SSMART ASSK	Surviving Substance Misuse and Alcohol Risk Taking and Alcohol Substance Survival Knowledge
TEN	Teacher Education Network
YAC	Youth Advisory Council
YSAAP	Youth Supported Accommodation Assistance Program
YSAS	Youth Substance Abuse Service

Table B: Glossary of Terms – Organisations

ABS	Australian Bureau of Statistics
ACU	Australian Catholic University
ADF	Australian Drug Foundation
ADIN	Australian Drug Information Network
AER	Alcohol Education and Rehabilitation Foundation
BADAC	Ballarat and District Aboriginal Cooperative
BCHC	Ballarat Community Health Centre
BDDGP	Ballarat and District Division of General Practice
BHS	Ballarat Health Services
BHSPS	Ballarat Health Services Psychiatric Services
BSSH	School of Behavioural and Social Sciences and Humanities, UB
CAFS	Child and Family Services Ballarat
CASA	Centre Against Sexual Assault
CHPCP	Central Highlands Primary Care Partnership
CHRP	Centre for Health Research and Practice (University of Ballarat)
CHSA	Central Highlands Sports Assembly
DHS	Department of Human Services
DEECD	Department of Education and Early Childhood Development
DJHS	Djerriwarrh Health Services
DoHA	Department of Health and Ageing (Commonwealth)
DPCD	Department of Planning and Community Development
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GFPS Exec	Grampians Family and Placement Services Executive
HHS	Hepburn Health Service
HMSS	School of Human Movement and Sports Sciences, UB
MCDS	Ministerial Council on Drug Strategy
NLGDAAC	National Local Government Drug and Alcohol Advisory Committee
NHSDA	National Household Survey on Drug Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SJoG	St John of God Ballarat Private Hospital
UB	University of Ballarat
UBSA	University of Ballarat Student Association
UCare	Uniting Care Ballarat
VHA	Victorian Healthcare Association Ltd
WHG	Women's Health Grampians
WHO	World Health Organisation
YIN	Youth Initiatives Network (Hepburn Shire)

Executive Summary

Ballarat Community Health Centre (BCHC) received funding from the Department of Human Services (DHS) to auspice the development of a Central Highlands Alcohol and Drug (AOD) Action Plan during 2008. A Steering Group was established which has included representatives from funded AOD agencies within the Central Highlands area. This Steering Group guided the project and the consultation phases.

This AOD Action Plan has been developed with a focus on young people and early intervention and prevention. However, the scope of the Action Plan has been defined broadly to include young people and their families. As a result of this broad interpretation, many issues have been raised during the consultation process and have been included in this AOD Action Plan.

A summary of some of the relevant legislation, policies and discussion papers has been included to provide context for this AOD Action Plan. There are several recent National discussion papers, two of which include ***Australia: The Healthiest Country by 2020***, and ***Preventing Alcohol-Related Harm in Australia*** (which provides the basis for the National Binge Drinking Strategy). The National Local Government Drug and Alcohol Advisory Committee (NLGDAAC) has recently developed recommendations that include a new approach to planning opportunities within local government, in order to reduce alcohol-related harms in the community through land use and planning mechanisms. In addition, the Doran Report was released in July 2008 by the Alcohol Education and Rehabilitation Foundation (AER) and reviewed cost effective interventions to reduce alcohol-related harms.

Victoria's Alcohol Action Plan 2008-2013 was released in May 2008, and includes four key initiatives. The first initiative focuses on restoring the balance for families, with more support in mainstream health services to help people reduce drinking early, and providing the best quality care for more serious alcohol use problems. The second initiative focuses on restoring the balance within our culture, with sustained community awareness efforts to change community attitudes and encourage a safe and sensible approach to alcohol use. The third initiative focuses on restoring the balance for the community, with properly enforced controls on the sale and marketing of alcohol, and preventing and reducing the consequences of excessive alcohol use such as alcohol-fuelled violence. The fourth initiative involves restoring the balance in partnership, with an emphasis on working with the Commonwealth and State governments to address alcohol-related issues on a national level.

Summaries of other relevant policy areas that are included in this Action Plan include Youth and Homelessness, Family and Children and Integrated Health Promotions Policies and Plans.

This AOD Action Plan has also included a brief overview of some of the relevant literature and evidence in the AOD area. This includes the social model of health, as well as some of the risk and protective factors for drug, tobacco and alcohol use. A summary of some of the effective interventions are also included to provide context for this Action Plan. Selected summary data regarding alcohol, tobacco and drug use for communities and local government areas within the Central Highlands area has also been included.

The policy, literature and evidence regarding AOD use and effective interventions provide important background information to the development of an AOD Action Plan for the Central Highlands area. This background information provides context, which has been enhanced with an extensive consultation process across a wide range of stakeholders. This consultation process occurred between September and December 2008. The key themes that emerged from the consultation process have formed the basis for this Action Plan. Twelve key priority areas have been identified, as follows:

1. Health Promotion
2. Community Development and Community Safety
3. University Students and Student Associations
4. Role of Councils
5. Family Support and Child Protection
6. Housing
7. Transport
8. Relationship with Police, Courts and Forensic Clients
9. Dual Diagnosis ABI/AOD Clients
10. Dual Diagnosis AOD/MH Clients
11. AOD Treatment Services for Individuals
12. Professional Development

Each of the 12 key priority areas has identified initiatives for implementation during 2009-2013. Those for 2009 are summarised here (refer to pages 35-63 for details of all proposed initiatives).

1. Health Promotion
 - 1.1. Promote community awareness of impacts and risks of AOD and binge drinking
 - 1.2. Promote Prevention and Early Intervention
 - 1.3. Increase awareness of impacts and risks of tobacco use
 - 1.4. Develop consistency in understanding evidence based practice (EBP) across health and education sectors.
2. Community Development/Attitudes and Community Safety
 - 2.6. Coordinate social marketing re City Safe programs.
3. University Students and Student Associations
 - 3.1 All student unions to provide and promote alcohol free activities.
 - 3.2 Student unions to be actively engaged in providing safe partying environments and safe transport options.
4. Role of Councils
 - 4.1. Respond to evidence that there is increased alcohol use where there is increased availability of alcohol
 - 4.2. Harm minimisation strategies to be supported through Liquor Accords
5. Family Support and Child Protection
 - 5.1 Improve relationships between Grampians Family and Placement Service (GFPS) organisations with services for AOD, disability and MH
 - 5.2 Improve understanding of the AOD, Disability and MH sectors in relation to the Childrens, Youth and Families Act and Statewide outcomes for children.

6. Housing
 - 6.1. Increase availability of safe, suitable and affordable housing, including transition housing, for youth and general community
7. Transport
 - 7.1. Increase availability and use of public transport across all ages
 - 7.2. Reduce Drink Driving
 - 7.3. Increase availability of appropriate transport for detox clients into services
8. Relationship with Police, Courts and Forensic Clients
 - 8.1. Support closer community links with police
 - 8.6. Increase police referrals to AOD services following arrest rather than in preparation for court appearance
9. Dual diagnosis AOD/ABI clients
 - 9.1. Consistent assessment that captures AOD/ABI clients
10. Dual diagnosis AOD/MH clients
 - 10.1. Implement consistent assessment for AOD/MH clients
 - 10.3. Clear referral pathways to ensure access to all appropriate services for clients with complex needs (multiple diagnoses)
 - 10.4. Establish consistent understanding of BHSPS services for AOD clients
 - 10.5. Participate in the Grampians AOD/MH Dual Diagnosis project
11. AOD Treatment Services for Individuals
 - 11.4. Improve access to neuropsychological assessment prior to admission to Rehab
 - 11.6. Improve access to information that is readily available about AOD services that do exist
 - 11.9. Evaluation of current service provision
12. Professional Development
 - 12.2. Increase awareness by generic workers re available AOD services, including after hours availability
 - 12.3. Increase skills for generic workers as they support clients waiting for AOD services
 - 12.6. Improve links with AOD Youth Outreach workers in local networks
 - 12.7. Increase skills and awareness of AOD workers re Child FIRST and referral procedures

These priority initiatives and other actions will be implemented under the guidance of a Central Highlands AOD Plan Implementation Committee. Four Working Groups are suggested, in the areas of Education and Health Promotion, Community Development, MHAOD Treatment Services and Professional Development. It is anticipated that these Working Groups will be established in 2009.

1. Project Brief

Develop and implement a 5 year drug and alcohol action plan for the Central Highlands, designed to provide appropriate evidence based health promotion and treatment services to young people and their families. The plan is expected to take into account and build upon existing plans. Specific Deliverables identified in the Action Plan Brief:

1. Undertake background research to identify the local alcohol and drug related needs and issues of communities in the Central Highlands, including current alcohol and drug usage patterns and service gaps;
2. Identify the relevant literature, evidence base, and policy environment for tackling alcohol and drug abuse and misuse (this was expected to include a broad approach which considered the social model of health, and risk and protective factors for young people and their families);
3. Review, measure progress and build upon the work of existing plans, strategies and projects;
4. Establish a working group to oversee the project and to improve service coordination, linkages between agencies and to develop local responses to issues or concerns which arise;
5. Develop a 5 year plan to address the identified alcohol and drug related community needs, including identification of appropriate health promotion strategies and treatment interventions for young people and their families, as well as facilitating appropriate education, service and system changes;
6. Develop a work program within the plan which documents negotiated agreement on responsibility for action plan strategies beyond the employment of the project officer;
7. The work program will include health promotion and treatment strategies, service development needs, workforce development and agency capacity building plans, and budget estimates;
8. Undertake initial implementation of the 5 year plan in conjunction with relevant stakeholders; and
9. Develop resource packages for human service staff, parents, teachers, and other community members.

Phase I

Phase I involved the initial consultation process and the development of the Central Highlands AOD Action Plan. This included the specific deliverables 1-5 identified in the Action Plan Brief above, and was completed between July and December 2008. The consultation process and methodology is summarised in Section 4.

Phase II

Phase II involves the implementation of Actions that were developed through Phase I. It is anticipated that this will commence in 2009 following the appointment of a Project Officer. The Project Officer will facilitate the AOD Action Plan under the guidance of the AOD Action Plan Implementation Committee, and will address the specific deliverables 6-9 identified in the Action Plan Brief above.

2. Policies, Literature and Evidence

2.1 Policy Summary

2.1.1 Victorian State Government Policy Frameworks

- ***Growing Victoria Together*** is the Government's vision for Victoria to 2010 and beyond. It establishes the policy parameters within which the Government has released separate economic, social and environmental policy goals and action plans for the state.
- ***A Fairer Victoria - Creating Opportunity and Addressing Disadvantage*** is the Government's social policy action plan. *Growing Victoria Together* and *A Fairer Victoria* guide all aspects of the Department of Human Services (DHS) operations and they inform human services planning at all levels. The DHS mission is to enhance and protect the health and wellbeing of all Victorians with particular emphasis on vulnerable groups and those most in need.
- ***The Victorian Indigenous Affairs Framework*** guides Victoria's efforts in improving outcomes for Indigenous children. The framework emphasises the importance of positive support for Indigenous parents, positive environments for their young children, and positive recognition of Indigenous culture.
- The Victorian ***Charter of Human Rights and Responsibilities*** imposes obligations on public authorities to act in a way that is compatible with the rights in the Charter and to take account of these rights when making decisions. These obligations commenced on 1 January 2008. Under the Charter, public authorities include public officials (e.g. departmental staff, Ministers, Local Government and Victoria Police) and entities established by statute that have functions of a public nature (such as public hospitals). It does not apply to private businesses or non government organisations except when and to the extent that they may be exercising functions of a public nature on behalf of the state or a public authority.

2.1.2 Alcohol and Other Drugs - Background

- The **National Drug Strategy 2004-2009** provides a vision and direction for Governments and non-government organisations in developing strategies and allocating resources for the prevention and reduction of the harmful effects of substance use in Australia. Substance use areas include tobacco and alcohol use, as well as illicit drug use. The objectives of the National Drug Strategy contribute to reducing drug use and supply, and preventing and minimising harm caused by licit drugs, illicit drugs and other substances.
- The ***Victorian Drug Policy and Services: An Overview*** was released in 2004 and provides the policy context that aims to promote and protect the health and wellbeing of all Victorians by reducing death, disease and social harm caused by the use and misuse of licit and illicit drugs. The policy outlines trends, treatment and initiatives for alcohol, tobacco, party drugs, cannabis, heroin, volatile substance abuse and medication abuse. It details the treatment options and prevention services and also specific target groups including: culturally and linguistically diverse communities, Indigenous population, dual diagnosis initiative, alcohol and drug youth consultants initiative, Acquired Brain Injury (ABI) program, homeless people with drug and alcohol problems, women, family services and forensic programs.

- The **Victorian Drug Strategy 2006-2009** includes a focus on alcohol, tobacco and other drug use with a strategy that promotes four related objectives: reducing supply, reducing demand, improving access to services and reducing harm. Reducing supply draws on law enforcement and diversion approaches to reduce the supply of drugs and drug-related crime and recidivism. Reducing demand for drugs involves prevention strategies, including education about the harms arising from drug use or misuse and reducing exposure to drugs. Improving access to services recognises the need for effective and relevant drug responses to be integrated with other services and support systems to provide better access to under-represented groups, and those with complex needs. Reducing harm involves reducing harmful drug use as far as possible and, at the same time, reducing problematic drug use overall.
- The **Dual Diagnosis: Key Directions and Priorities for Service Development** policy was released in 2007 and aims to improve outcomes for people with both mental health and alcohol and drug problems. The prevalence and complexity of dual diagnosis requires an integrated approach to assessment and treatment delivered as 'core business' within specialist mental health and alcohol and other drug services.
- In 2006, the **Victorian Drugs and Crime Prevention Committee** completed an **Inquiry into Strategies to Reduce Harmful Alcohol Consumption**. The final report incorporates 165 recommendations, and acknowledges the significance and complexities of the change in culture that is required, including health, social and economic interventions across a range of policy areas. This culture should ensure that there is support for the responsible use of alcohol, responsible supply of alcohol and appropriate sanctions against practices that lead to alcohol-related harm.

2.1.3 Alcohol and Other Drugs – Recent Developments 2008

Commonwealth

- The **Australia: The Healthiest Country by 2020** discussion paper has been developed in 2008 by the National Preventative Health Taskforce to focus on three key initial preventative health priority areas: obesity, tobacco and alcohol use. Targets established include reducing the prevalence of daily smoking to 9% or less, and reducing the prevalence of harmful drinking for all Australians by 30%. This is discussed in more depth in Section 4 (State and National Action Plans).
- **Preventing Alcohol-related Harm in Australia** was also developed in 2008 by the Alcohol Working Group of the National Preventative Health Taskforce. This paper reviewed a range of interventions, including regulating physical availability, taxation and pricing, drink-driving counter-measures, treatment and early intervention, altering the drinking context, regulating promotion, and education and persuasion. This paper also summarised recent developments in Australia, including the National Binge Drinking Strategy, the Council of Australian Governments (COAG) Binge Drinking Agreement, the work of the Ministerial Council on Drug Strategy (MCDS) and the Northern Territory Initiative and other Aboriginal and Torres Strait Islander specific initiatives. This is discussed in more depth in Section 4 (State and National Action Plans).
- **Local government action on alcohol: Using planning opportunities to**

reduce alcohol-related harm was prepared for the National Local Government Drug and Alcohol Advisory Committee (NLGDAAC) in 2008. It provides a review of the potential of local governments to reduce alcohol-related harms in the community through land use and planning mechanisms. This report suggests that better land use and planning, including licensing regulation controls at the local government level, is a significant lever for enhancing the primary prevention of alcohol-related harms. This includes opportunities to embed alcohol management in local planning to aid liquor outlet assessment and to make the best use of licensing controls.

- The **Doran Report** was released in July 2008 by the Alcohol Education and Rehabilitation Foundation (AER) and reviewed cost effective interventions to reduce alcohol-related harms. Seven strategies were identified (in order of decreasing cost-effectiveness), and included volumetric taxation, advertising bans, increasing the minimum legal drinking age to 21 years, brief interventions, licensing control, drink driving mass media campaigns, random breath testing and residential treatment + Naltrexone.

Victoria

- **Victoria's Alcohol Action Plan 2008-2013** was released in May 2008. This is discussed in more depth in Section 4 (State and National Action Plans).
- **A New Blueprint for Alcohol and Other Drug Treatment Services 2009-2013** was released in 2008, and establishes a reform agenda for Victoria's AOD service system. This strategy focuses on a client-centred and service-focused approach across the service system to deliver better treatment outcomes in six priority areas. These priority areas include clients, children and families, young people, prevention, improving access and excellence and quality.
- **Shaping the Future: The Victorian Alcohol and Other Drug Quality Framework 2008** was released in April 2008 and comprises six core standards: Consumer Focus, Evidence-based Practice, Continuous Quality Improvement (CQI), Corporate and Clinical Governance, Workforce Development, and Partnerships. The framework applies to all DHS-funded AOD services, including forensic services, needle and syringe programs, Indigenous and mainstream AOD services.
- The **Alcohol and Other Drug Withdrawal: Clinical Standards Project** has been developed in response to the changing patterns of alcohol and drug use in the community and a need for evidence-based resources. This project is funded through the Victorian DHS, with a draft report released in November 2008, and training to be available from February 2009.

2.1.4 Youth and Homelessness

- The **Vulnerable Youth Framework Discussion Paper** was prepared by the Victorian DHS, Department of Education and Early Childhood Development (DEECD) and the Department of Planning and Community Development (DPCD) in August 2008 and was released to provide feedback into the final Vulnerable Youth Framework. The framework has five focus areas: prevention and early identification; engagement in education, training and employment; local planning for youth services; tailored responses for particular groups; and effective services, capable people.
- **The State of Victoria's Young People** was developed jointly by the Victorian DEECD and DPCD in 2008. The findings in this report support suggestions that there has been an increase in the proportion of young people who drink

at levels that put them at risk of short term harm. Data reported from the Victorian Population Health Survey (2005) indicates that the prevalence of drinking alcohol at least weekly at ‘risky’ or ‘high-risk’ levels is greater among young people aged 18-24 than among other (adult) age groups. Measures to address alcohol misuse include the Good Sports Program, implementation of drug education in primary and secondary schools, harm minimization strategies for Schoolies Week and the Alcohol and Workplace Initiative.

- **Which Way Home? A New Approach to Homelessness** was a consultation paper released in May 2008 by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Suggested targets for reducing homelessness include decreasing the number of people moving from public housing and private rental to crisis accommodation services, increasing the number of women and children remaining in their own home following domestic and family violence, decreasing the number of people seeking crisis accommodation who first experienced homelessness as children and increasing the percentage of children who remain in school, education or training after being in crisis accommodation.

2.1.5 Family and Children

- The **Children, Youth and Families Act 2005** listed State AOD treatment services as “service agencies” under the Act. This allows for some special considerations regarding information sharing and referral procedures from Child FIRST programs.
- The **Child Wellbeing and Safety Act 2005** established Principles for Children that include service providers giving the highest priority to promotion and protection of a child’s safety, health, development education and wellbeing. AOD issues are identified as significant in 30-40% of families referred to Child FIRST and family services.
- The Victorian DHS **Sector Development Plan 2006** focuses on the needs of individual children, young people and families, and includes a commitment to improving the outcomes for those who access the services. This plan articulates that positive outcomes for vulnerable children, young people and families in Victoria will be achieved through a collaborative service system of skilled and sustainable community service organisations working in robust partnerships with other services, government and the wider community. It is predicted that AOD issues will increase in families referred to family services and child protection over the next 10 years.

2.1.6 Integrated Health Promotion

- **Integrated Health Promotion** has been identified by DHS as a key strategic direction. Integrated health promotion has three main foundations which include building effective partnerships, using a mix of interventions and a common planning framework, and working effectively across a broad range of sectors. The guiding principles for integrated health promotion include:
 - Addressing the broader determinants of health,
 - Basing activities on the best available data and evidence,
 - Acting to reduce social inequities and injustice,
 - Emphasising active consumer and community participation,
 - Empowering individuals and communities,
 - Explicitly considering difference in gender and culture, and
 - Working in collaboration

- The Central Highlands Primary Care Partnership (PCP) **Community Health Plan** promotes and supports best practice health promotion in partnerships with member agencies and other stakeholders to improve the health and wellbeing of the Central Highlands catchment area. Four priority areas have been identified, and include Physical Activity; Food, Nutrition and Healthy Weight, incorporating Oral Health; Mental Wellbeing and Social Connectedness; and Minimising Smoking, Alcohol and Drug use. The two Neighbourhood Renewal sites at Wendouree and Delacombe have been identified as priority settings for health promotion practice.
- Health Promotion Plans have been developed by several organisations within the Central Highlands area, some of which include BCHC, Ballarat Health Services (BHS) Hepburn Health Services (HHS), Djerriwarrh Health Service (DJHS) and Women's Health Grampians (WHG).

2.2 Literature Summary

An in-depth analysis of the available literature is outside the scope of this project. However, an overview of some of the key literature themes provides an important context for the development of an AOD Action Plan for the Central Highlands. As identified in the project brief, this literature review provides background information regarding the social model of health, and risk and protective factors for young people and their families. Specific areas included are:

1. Social Model of Health
2. Drug Use
3. Tobacco Use
4. Alcohol Use
5. Risk Factors – high and low risk groups
6. Effective Interventions

2.2.1 Social Model of Health

The World Health Organisation (WHO, 1946) defines health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"¹. The social model of health is based on the concept that an individual's health is determined by factors both in, and outside, his/her direct control. The social model of health includes social and environmental determinants in addition to biological and medical factors. The Victorian Healthcare Association (VHA, 2008) summarises three key areas that support a social model of health: health promotion, a coordinated "whole of government" approach to public health policy, and community participation. The VHA, include the following suggestions in summarising the challenges for implementation of the social model of health:

- *Act as a resource to the local community by providing expertise, resources and support for identification and discussion of local health issues.*
- *Use a community development approach to develop strategies to address issues, including supporting active participation of the community in decision making from the start, identifying issues and agreeing on strategies.*
- *Educate clinical staff and management in acute, sub-acute and community sectors about the Social Model of Health, and encourage thinking in terms of illness prevention as much as curative interventions.*
- *Support the acute environment to prevent the need for hospitalisation through the development of demand management programs for people with chronic and complex conditions by substituting community based and/or preventive services aimed at addressing underlying causes and risk factors.*

¹ Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100) and entered into force on 7 April 1948.

To address the challenges of implementing the social model of health, identification of key factors affecting the incidences of concern allows for a more targeted, and therefore more effective approach to initiatives that produce effective outcomes. Once an understanding of the specific factors affecting a community are understood, health service providers can engage in more focused campaigns, identify what priorities are relevant to their clients, and can act as a centre of expertise for the community in which they operate.

2.2.2 Drug Use

Olsson, Coffey, Toumbourou, Bond, Thomas and Patton (2003) analysed data from the Victorian Adolescent Health and Wellbeing Survey in 2003 and found that poor family functioning showed minimal association with level of cannabis use at both year nine and 11 school levels. However, permissive parental attitudes towards drug use and delinquency was found to have positive relationship to cannabis use in year nine students. The authors suggested interventions could focus on strengthening the parent-child relationship and promoting less permissive attitudes to drug use.

Wright, Bobashev, and Folsom (2007) reviewed data from the 1999 National Household survey on Drug Abuse (NHSDA) survey, and analysed youth marijuana use and the relative roles of the individual, households and neighbourhoods. The results indicated that for marijuana use in the past year, the role of the individual is the most prominent. When continuous rather than dichotomous constructs are used, the results for relative roles are unchanged.

Specific data regarding drug use is presented in Section 2.3 below.

2.2.3 Tobacco Use

Pampel and Aguilar (2008) reviewed changes in youth smoking patterns between 1976 and 2002 using a time series analysis. Results indicated a positive relationship between increases in cigarette prices and reduction in youth smoking. Results also indicated that higher marijuana initiation (or use) is associated with greater cigarette smoking during most of the time period.

Specific data regarding tobacco use is presented in Section 2.3 below.

2.2.4 Alcohol Use

Nelson (2008) studied similarities between youth and adult alcohol behaviours. Five key outcomes were reported, including (1) a positive relationship between youth and adult alcohol behaviours, (2) variation in taxes across states has no negative effect on youth alcohol behaviours, (3) higher outlet densities positively effect behaviours by young adults and adults but does not affect youth, (4) several regulatory variables have a negative effective on drinking prevalence and bingeing by youth and young adults, and (5) attendance at sports events does not increase drinking prevalence or bingeing.

A longitudinal study (Schier, Botvin, Griffin & Diaz, 2000) of 740 middle school youth investigated self esteem and adolescent alcohol use. The results indicated an initial simplified model with an inverse relationship between changes in self-esteem and alcohol use over time. When covariates were included, high initial levels of self esteem fostered increased alcohol use when compared to low initial levels of self esteem. Youth with poor competence skills advanced more rapidly in alcohol use and declined more gradually in self esteem. Poor social skills accelerated the rate of decline in self esteem. The authors concluded that self esteem is part of a dynamic set of etiological forces that instigate early stage alcohol use.

Little research has been conducted studying the influence of Australian drinking age laws, however, one study found that alcohol use in Australian youth rises steadily as the legal purchasing age of 18 approaches (White, Hill, & Effendi, 2003). Data from the National Drug Research Institute found that 82% of alcohol consumption by 14-17 year olds in Australia was at levels that posed risk of acute or chronic harm (Chikritzhs, Pascal & Jones, 2004).

Specific data regarding alcohol use is included in Section 2.3 below.

2.2.5 Risk Factors: Importance of Differential Strategies for High Risk and Low Risk Groups

Risk factors include attitudes and behaviours associated with the higher use of alcohol, other drugs or tobacco. Research indicates that interventions are more effective when they are targeted specifically to high or low risk groups so that different strategies can be implemented that meet the needs of each group. If interventions are not targeted to high and low risk groups, low risk individuals in a population contribute the highest burden by being in the majority. This creates what is known as the “Prevention Paradox”, which can have significant policy implications and can potentially serve to marginalise smaller groups of individuals with the highest risk behaviours (Stockwell, Toumbouru, Letcher, Sanson & Bond, 2004). Rossow and Romelsjo (2006) examined subpopulations with different drinking patterns to review the extent of the prevention paradox across the groups. These authors found empirical support for the existence of the prevention paradox. When the high risk groups were separated according to frequency of intoxication rather than annual volume of consumption, it was found that acute alcohol problems may be more common in subpopulations where intoxication is a common part of the drinking pattern.

The evidence indicates that the most effective strategies for prevention of adolescent alcohol and other drug problems is through a risk-focused approach, which identifies and separates high risk factors so that they can be effectively addressed. Risk factors have been found to be stable over time, in spite of changing norms. Interventions that include an increased number of risk factors can be used to target individuals with a greater likelihood of drug abuse (Hawkins, Catalano & Miller, 1992).

There is also a direct link between the availability of alcohol and other drugs and increased consumption. Effective methods in reducing consumption can be positively linked to taxation, laws to limit who can purchase, and regulations on how these products are sold (Hawkins et al. 1992). These authors also suggest that there are a number of individual and interpersonal factors that increase risk for the use of alcohol and other drugs. The individual factors include issues such as sensation seeking and

low harm avoidance which have been found to positively predict early onset alcoholism and poor impulse control that can lead to alcohol and other drug use and abuse. In addition, early and persistent problem behaviour in individuals, academic failure and low degree of commitment to school can increase risk. Interpersonal factors that increase risk include:

- Family factors
 - Family alcohol and drug behaviour and attitudes
 - Poor and inconsistent family management practices
 - Family conflict
 - Low bonding to family
- Peer interaction
 - Peer rejection in elementary grades
 - Peers and group influence
 - Associating with drug-using peers
- Social Issues
 - Alienation and rebelliousness
 - Attitudes favourable to drug use
 - Early onset of drug use

To illustrate the risk impact of peer groups and friends for use of tobacco, alcohol and other drugs, Urberg, Degirmencioglu and Pilgrim (1997) conducted a short term longitudinal study (n=1028) with school children in grades six, eight and ten. The results of the study found that influence came from a child's closest friend for initiation of cigarette and alcohol use, that use by friendship groups predicted transition to current cigarette use, and that use by a close friend predicted transition to current alcohol use. In addition, use by both group and close friends predicted adolescents drinking to intoxication. The study found no difference in the amount of influence between stable and unstable close friendships or friendship groups. A longitudinal study conducted by Schofield, Lynagh, and Mishra (2003) on youth culture and smoking tested four theoretical models to predict smoking, and found that the strength of identification to the peer group was the best predictor of smoking in youths.

Mental health is an area that can adversely affect the use and abuse of alcohol and other substances. Schier et al. (2000) studied the possible connections between mental health disorders in youth and alcohol use. The study found that youth with poor competence skills abused alcohol more rapidly and had a gradual decline in self esteem. Poor social skills accelerated the rate of decline in self esteem. The key findings of this study concluded that self esteem is part of a dynamic set of etiological forces that instigate early stage alcohol use. Butler, Fearon, Atkinson, and Parker (2007) developed a model of interactive risk after studying 85 youths referred for court ordered mental health assessments. The results found that factors such as parent-child alienation had strong associations with aggressive and/or delinquent behaviours.

An NHSDA report (Substance Abuse and Mental Health Services Administration, 1999) found that those in the age group 18-25 years who experienced a Major Depressive Episode (MDE) were more likely to have initiated alcohol use in the past year than those who did not. In addition, among young adults in this age group, those who experienced a past year MDE were twice as likely to have initiated use of any illicit drug in the past year as those who had not experienced an MDE in the past year.

Baron (1999) studied street youths and substance abuse and found that exposure to parental substance abuse and long term homelessness increases the risk of alcohol and illicit drug use. This study also found that job histories, depression and peers using drug and alcohol are linked to licit and illicit drug use as well as alcohol use. In addition, the results of the study found that self blame for unemployment increases the use of alcohol. Salmelainen (1995), cited in the Australian Institute of Criminology (AIC) report (2007), reported a large body of research that demonstrated the link between lifestyle and an increased likelihood of reoffending. The situational lifestyle factors that are most consistently demonstrated within the Australian context include unemployment, limited or low level education, poor residential location, a history of mental health problems, family instability and serious prolonged drug use. Any of these situational lifestyle factors were important in differentiating between high and low volume juvenile offenders.

Neighbourhood disorganisation that includes high population density, high residential mobility, lack of natural surveillance of public places, physical deterioration and low levels of attachment to the neighbourhood have been targeted as risk factors in alcohol and other drug use (Hawkins et al., 1992).

2.2.6 Effective Interventions

A relationship between risk and protective factors is critical in targeting intervention strategies. The literature regarding effective interventions has been separated here to discuss interventions within families, schools and communities.

Principles of Harm Minimisation

Harm minimisation strategies tend to be prominent in Australia, but little attention has been paid to the whether a change in behaviour occurs as a result of these policies (Toumbourou, et al., 2004). Ritter and Cameron (2005, p 5) summarised the key factors that form the basis of a harm minimisation approach, suggesting principles which include:

- “That the primary goal is reducing harm rather than drug use per se;
- That it is build on evidence-based analysis (strategies need to demonstrate, on balance of probabilities, a net reduction in harm);
- That there is acceptance that drugs are a part of society, and will never be eliminated;
- That harm reduction should provide a comprehensive public health framework;
- That priority is placed on immediate (and achievable) goals; and that
- Pragmatism and humanistic values underpin harm reduction”.

MacCoun and Reuter (2001), cited in Ritter and Cameron (2005, p7), have developed a model to conceptualise types of harm. The model describes three types of harm, including categories, bearers and sources of harm. Categories of harm include “health, social and economic functioning, safety and public order and criminal justice”. Bearers of harm include “users, dealers, intimates, employers, neighbourhood and society”. Finally, the sources of harm include “use, illegal status and enforcement”. This model provides a framework to separate the categories of harm, and therefore it allows for specific targeting and prioritisation of interventions and policy directions.

Interventions related to Risk and Protective Factors – Families and Schools

Hawkins et al. (1992) found that prevention approaches targeting risk factors including early childhood, family support and programs for parents of children and adolescents were effective interventions. Crosnoe et al. (2002) discussed the need for protective interventions in family relationships after findings that both family and school factors reduced adolescent delinquency. The results from the study also showed that school factors were more consistently protective and that sources of protection differed by gender.

Programs within schools have been investigated in a number of studies examining the risk of drug, alcohol, and tobacco use associated with peer groups. Many authors have linked peer group interactions and influence as key risks for youth (Hawkins et al. 1992; Schofield, Lynagh, & Mishra, 2003; Baron, 1999; McBride, Farrington, Midford, Meuleners & Phillips, 2004). Hawkins et al. (1992) suggest several social influence resistance strategies in schools including classroom-based interventions early in school, academic achievement promotion, organisational changes in schools, and comprehensive risk-focused programs. McBride, et al. (2004) report that follow-up interventions are an important factor in maintaining an effective outcome. A study of alcohol behaviour in transition following high school indicates that early intervention and education in secondary school is an important factor in decreasing alcohol-related harms (Toumbourou, Williams, Whilte, Snow, Munro & Schofield, 2004).

Jessor, Van Den Bos, Vanderryn, and Costa (1995) reviewed the relationship between psychosocial protective factors and alcohol and drug abuse in students in years seven, eight and nine. The findings of this longitudinal study indicated that there was a significant inverse relationship between protection and problem behaviour, with protection moderating the risk of problem behaviour. Hawkins et al. (1992) found that preventions in the form of social competence skill training and involvement in alternative activities were effective interventions for individuals.

The Resilient Families Program (Spence & Shortt, 2007) examined the impact of family factors relative to other influences on the development of adolescent alcohol use in the first year of secondary school. They also examined the feasibility of preventing adolescent alcohol use through the moderation of different family factors. The sample was drawn from 24 schools in Melbourne, and participants were allocated to a control group or an intervention group. The results concluded that education related outcomes were beneficial, but there was no effect in reducing student alcohol use in year eight students. The results also indicated that there was a significant amount of alcohol use in year seven students, and suggested that intervention could effectively occur earlier. The authors also suggested that more significant results may become apparent over a longer time period.

Ollson et al. (2003) suggested interventions targeting strengthening parent children relationships and promoting less permissive parent attitudes to drug use. A study of high risk youth examined the role of parents in drug prevention (St. Pierre, Mark, Kaltreider & Aiken, 1997). The results of this study indicated that parent involvement proved effective in the increased refusal by youth to alcohol, marijuana, and tobacco. Youths not in the prevention program reported a decreased ability to refuse these substances and an increase in favourable attitudes towards marijuana use. Spoth, Redmond, and Shin (2001) evaluated two family-based brief interventions for substance use by adolescents in school in the US, with pretest data collected in

grade 6, and follow up in grade 10. The specific interventions included the Iowa Strengthening Families Program and Preparing for the Drug Free Years Program. The results indicated significant impacts of the brief interventions in both programs, and concluded that family based brief interventions had the potential to decrease alcohol use in adolescents.

An Australian Institute of Family Studies (AIFS, 2004) report reviewed the research and interventions regarding the impact of parenting factors on adolescent alcohol use. Findings indicated that many young people had experimented with alcohol by the age of 14 -15 years, with a high proportion of young people obtaining alcohol from parents. Evidence suggested that delaying the onset of alcohol use indicated reduced levels of consumption as adults. The authors suggested a model of parenting influences on adolescent alcohol use, which included “parental monitoring, parental norms for adolescent use, and parental behaviour management skills all have direct links to adolescent alcohol use. Parent-adolescent relationship quality has an overall effect on these parenting behaviours, as well as direct connections to alcohol use” (p xiii). The report identified six conclusions (p xv):

1. “Parents should be provided with information concerning the advantages of delaying the age at which young people begin using alcohol.
2. Parents should be provided with educative guidelines on the influence of parental attitudes and norms on adolescent alcohol use, as well as guidance in managing the social pressure they feel to allow their adolescents to consume alcohol.
3. Once adolescents have commenced alcohol use, parents should be provided with educative guidelines which enable them to guide their adolescents in responsible alcohol use.
4. Parent education and family intervention programs should be supported in Australia to assist parents to gain skills for encouraging their adolescents to delay initiation to alcohol use and to adopt less harmful patterns of use. Intervention and prevention programs should receive best practice evaluations.
5. Given that broader social norms exert a considerable influence on adolescent alcohol use, strategies to reduce favourable cultural attitudes towards under-age alcohol consumption will be needed to support parental efforts.
6. More Australian research is needed to promote understanding of the developmental processes and pathways to adolescent alcohol use. In particular, research on the development of adolescent alcohol use in Indigenous communities is seriously lacking.”

Interventions related to Risk and Protective Factors – Individuals

Ritter and Cameron (2005, p i) completed a systematic review of harm reduction. Harm reduction was defined as “policies and interventions that focus on reducing the harms associated with drug use, not the amount of drug used”. Interventions reviewed included needle syringe programs (NSP), supervised injecting facilities, non-injecting routes of administration, outreach, HIV education, information and testing, overdose prevention interventions and legal frameworks. The review concluded that there was a significant evidence base for the effectiveness of NSP and outreach programs. The other interventions did not have a sufficiently extensive evidence base to develop strong conclusions.

Research has found that brief hospital interventions were found to be effective for individuals who have attended hospital emergency department services with issues related to AOD use. These brief interventions incorporated a comprehensive

assessment with structured feedback to the individuals about their current drug and alcohol situation, including discussions about personal responsibility, alternative strategies, and empathy and advice to the patient (Prodromidis, Abrams, Field, Scafidi & Rahdert, 1994).

Swan, Sciacchiato and Berends (2008) reviewed the effectiveness of brief interventions in primary care settings in Victoria. The authors reported that the uptake of these interventions into these settings was generally poor. They suggested that good practice for brief interventions included “client assessment, engagement, timely and goal-oriented intervention. The provision of written information, consideration for the stages of change and the development of linkages were also noted. Enablers of good practice included workforce training, identification of champions to promote BI delivery, organisational support, and the linking of BIs to assessment processes” (p xi).

Saitz, Horton, Sullivan, Moskowitz and Samuel (2003) also found that online screening and brief hospital intervention was an effective strategy for university students abusing alcohol. One month after completion of the screening and brief intervention, 15% of men and 33% of women no longer reported unhealthy use of alcohol.

Tevyaw and Monti (2004) reported on the positive use of “motivational enhancement intervention”, a method that can be used by clinicians, counsellors, and treatment providers to deliver an individual intervention following a negative alcohol or drug event. There is some evidence that these interventions are effective and can be used positively with youth, as the strategy is focused on avoiding argumentation and confrontation. Internet-based interventions are also highlighted (Tevyaw & Monti, 2004) as potentially effective for youth.

Interventions related to Risk and Protective Factors - Communities

Community interventions cover areas such as the roles of pubs and clubs, the role of the police and licensing authorities, the usefulness of health promotion campaigns, and the role of community-based organisations. An action research study exploring the role of pubs and clubs in intervention and prevention found that licensed venues can be an important setting to reduce alcohol-related harms within the community (Mallick, 2007). In the key findings of this study, partnerships with agencies such as the police or liquor licensing agencies are critical. Promotion and use of resource kits and educational signage in bar areas providing information about standard drinks and other alcohol related advice is seen as a key intervention technique. The importance of responsible service of alcohol training (RSA) for all staff and codes of conduct for security and crowd control was emphasised. Another important strategy to reduce alcohol and drug related harms was the availability of drinking water. Further suggestions arising from the research was a training course related to the use of drugs in a style similar to RSA for licensed venue staff and more educational material in venues about drug use.

The use of police and licensing agencies in preventing and mitigating the effects of alcohol, other drug, and tobacco use is highlighted by studies that show that manipulation of supply and enforcement strategies do have a positive effect on use of substances (Hawkins et al. 1992; Mallick, 2007). The use of public health campaigns, media, and advertising around the use of alcohol, other drugs, and tobacco was suggested by several authors (Hawkins et al. 1992; Wakefield, Flay,

Nichter & Giovino, 2003; Mallick, 2007). Wakefield et al. (2003) studied 492 youths between 12 and 14 viewing three different types of tobacco cessation advertisements.

The findings showed that pharmaceutical advertisements were more positively linked to impressions of the ease of cessation than advertisements like Quitline. Hawkins et al. (1992) discussed changing social norms and public health campaigns, education programs, and advertising campaigns impacting positively on prevention of alcohol and drug use.

In keeping with the social model of health advocated by the World Health Organisation, the need for community interventions cannot be understated. Hawkins et al. (1992) discussed detachment from community as a risk factor in alcohol and other drug abuse and suggested community health interventions and public health campaigns as effective intervention strategies. Wright et al. (2007) found that community disorganisation was a small contributing factor in adolescent drug use. Holder, Saltz, Grube, Voas, Gruenewald and Treno (1997) reported on a community trial that resulted in a 10% reduction in alcohol-related auto crashes across three communities. The same study reported that in the intervention communities, there was a 30% reduction in the number of retail outlets selling alcohol to underage buyers compared to 12% in control communities. Community-based interventions can begin to change public opinion about the use of alcohol, other drugs and tobacco within the community, which will in turn affect use of these substances. Foxcroft, Ireland, Lister-Sharp, Lowe and Breen (2003) recommend that policy-makers consider the potential benefits of community interventions for all age groups, not just youth, following a systematic review of psychosocial and educational interventions for young people.

2.3 Data Summary

2.3.1 Alcohol Use – Key Data Findings

Key findings of the **Victorian Youth Alcohol and Drug Survey 2004** showed a slight increase in occasional episodes of drinking at more extreme levels. For instance, since 2002, more young people aged 16-24 years (up from 35% in 2002 to 45% in 2004) reported that during a 12 month period there was at least one instance of drinking until they couldn't remember what happened. When reviewing the data by age group, the proportion of 22-24 year old young people reporting 'drinking until they couldn't remember what happened' at least once in the last 12 months increased from 31% in 2002 to 43% in 2004.

More young people (73%, up from 71% in 2003) reported at least one occasion where they drank alcohol with the specific intention of getting drunk; 54% of young people reported consuming 11 or more standard drinks in a day on at least one occasion (up from 52% in 2003) and 36% reported consuming 20 or more standard drinks in a day at least once (up from 31% in 2003). In addition, 47% of males (compared to 44% in 2003) and 27% of females (compared to 21% in 2003) reported at least one occasion during the previous 12 months when they had consumed 20 or more standard drinks in a day.

An analysis of regional Victoria compared to metropolitan Melbourne found that more young people living in regional areas drank at levels that put them at high risk of short-term harm. Specifically, 72% of young people from regional areas (compared with 68% from metropolitan areas) drank at least once in the last 12 months at levels that put them at high risk of short-term harm. In addition, 17% of young people in regional areas (compared with 13% of young people living in metropolitan areas) consumed 20 plus drinks in one day, monthly or more frequently. This was particularly apparent for males in regional areas.

One in five young people reported feeling afraid of someone under the influence of alcohol. Behaviours by males under the influence of alcohol include verbal abuse, stealing and causing property damage.

The findings from the **National Drug Strategy Survey (2004)** found that males across all age groups were more likely than females to drink alcohol on a daily basis, and that a greater number of females from all age groups had drunk less alcohol on a weekly basis compared to males. These differences were greater in teenagers. When reviewing the alcohol drinking status between the ages of 12-15, it was found that two in three (67%) of 12-15 year olds had not consumed a full serve of alcohol. Males in the 12-19 year age group were more likely to have consumed alcohol on a daily basis than females.

When reviewing the risk of harm in the long term due to alcohol consumption, persons in the 20–29 year group were the most likely to put themselves at risk (engaged in "risky" or "high risk" levels of alcohol consumption). When reviewed by gender and age, females in age groups 14–19 and 40–49 were more likely to put themselves at long term risk (engaged in "risky" or "high risk" levels of alcohol consumption) compared to males. Males were more likely to drive a motor vehicle while under the influence of alcohol compared to any other activity (e.g. operating a boat, other machinery, verbally or physically abusing someone, going swimming or going to work) or when using other drugs.

The **Australian secondary school students' use of alcohol in 2005** report includes data based on a national survey on the use of alcohol by secondary students. The findings indicated that use of alcohol increased as age increased.

Nationally, 86% of students had tried alcohol by age 14. By age 17, 70% of students had consumed alcohol in the month prior to the survey. Spirits were the most common types of drinks consumed by all ages. Parents were the most common source of alcohol among students who reported drinking in the past week.

The **Victorian Alcohol Statistics Handbook (Volume 8)** has reviewed alcohol-related assaults, and it was found that there is a significantly higher rate of alcohol-related assault of residents aged 0 – 17 in the Grampians region (7.54 per 10,000) compared to Victoria (6.10 per 10,000). Ballarat has the highest rate in the Central Highlands. Ballarat also has the highest rate of assault for residents aged 18 – 24, which is significantly higher than the Victorian rate (35.89 compared to 28.59). Overall, the Grampians region has a higher rate of assaults and incidents than Victoria. However hospital admissions are slightly lower than the Victorian rate. When reviewing alcohol related problems amongst young people, the Ballarat licensed venues were more likely to have alcohol related problems than any other LGA in the Central Highlands.

The findings from the **National Minimum Data Set (NMDS) 2006-2007** have reported that, in Victoria, the median age of persons receiving treatment for their own drug use was 31 years. The median age for people seeking treatment in relation to someone else's drug use was also 31 years. Alcohol was the most common principal drug of concern in closed treatment episodes (42%). Counselling was the most common form of treatment provided (49% of episodes), followed by withdrawal management detoxification (23%), and support and case management only (13%).

When reviewing this data in terms of the client profile, 94% of closed treatment episodes involved clients seeking treatment for their own drug use. The overall proportions of male and female clients were 64% and 36% respectively, which was consistent with the National figures. When figures were broken down by client age group, 31% of closed treatment episodes were for clients aged 20-29 years, followed by 28% for clients aged in the 30-39 years. When reviewing the data regarding the 'principal drug of concern', alcohol was identified as the most common, increasing from 35% to 42% between 2001-02 and 2006-07.

2.3.2 Tobacco Use

The **National Drug Strategy Survey (NDSS) 2004** reported a summary of Tobacco smoking status for all persons over 14 years between 1993 and 2007. This survey found that one in ten teenagers smoked tobacco in 2007, and that female teenagers were more likely to smoke than male teenagers. Overall, males are more likely to smoke than females, and smoking rates were highest in the age group of 20–29 years. When reviewing the smoking status for 12-19 year olds, females were more likely to have smoked than males. Smoking rates for females in the 16-17 year age group were nearly double their male counterparts, and 18–19 year olds have a higher rate of smokers than other age groups.

Within the Central Highlands, the **Generation Next: The Youth Have Spoken (2007)** report prepared by the City of Ballarat indicated that 80% of Ballarat's Youth responded "No" to having smoked cigarettes, with 12% indicating they do smoke and 7% indicating they "sometimes" smoke.

2.3.3 Drug Use

As noted above, the findings from the **NMDS (2006-2007)** have reported that, in Victoria, alcohol was the most common principal drug of concern in closed treatment episodes (42%). This was followed by cannabis (24%), which had increased from 22% in 2001-2002. The proportion of closed treatment episodes related to heroin decreased from 25% in 2001-2002 to 14% in 2006-2007.

The **NDSS (2004)** reported a summary of use of illicit drug status for all persons over 14 years between 1993 and 2007. The survey found that 2.3 million people aged 14+ years had recently used an illicit drug, with the greater portion being males. Males in the 20–29 year old age group were the highest in regard to using an illicit drug, and 285,400 teenagers had recently used an illicit drug. Generally, males were more likely than females to have recently used an illicit drug, however, in the 14–19 year old age group, females were more likely to have recently used an illicit drug.

When reviewing the data for specific drug use, the survey found that 18-19 year olds were the most common age group to have used Ecstasy recently. This age cohort was also the highest for any use of illicit drugs. Cannabis was rated as the most recently used illicit drug for the 16–17 and 18–19 age groups.

When reviewing the supply of illicit drugs, friends or acquaintances were rated highest as the source of supply for Cannabis, Tranquilisers, Methadone, Meth/Amphetamines, Cocaine, Hallucinogens and Ecstasy. Heroin was noted to be mainly supplied by a Dealer, and shops were rated highly as the source of supply for inhalants and analgesics. Steroids were most likely to be obtained by “other” methods.

The **Technical Paper “Use of multiple causes of death data for identifying injury and mortality” (AIHW, 2007)** has reviewed causes of death through drug use, based on the 2002 ABS mortality data. This report summarised data regarding poisoning by narcotics and psychodysleptics (hallucinogens) for selected groups. The results indicated that 15% of deaths (n=17) were from heroin, 34% (n=39) from opioids (codeine/morphine), 28% (n=32) from Methadone, 4% (n=5) from Cocaine, 12% (n=14) from other and unspecified narcotics and 6% (n=7) from Cannabis (derivatives).

Within the Central Highlands, the **Generation Next: The Youth Have Spoken (2007)** report prepared by the City of Ballarat indicated that 20% of Ballarat’s Youth responded to the survey as having taken an illegal drug. Marijuana was rated as the most frequently used, and Speed and Ecstasy were rated 2nd and 3rd highest respectively.

A review of the **Summary of Offences data** regarding drug use within the Central Highlands area indicates that Golden Plains had an increase of 52.2% in the number of drug offences recorded between 2005/2006 and 2006/2007. Hepburn increased 187.2%, Moorabool 187.8% and Ballarat increased 220.4% in the same period. This represents the data only, and has no discussion of whether this represents an increase in incidence, number of people identified or possible changes in conviction rates. Further analysis of this data would be beneficial.

2.3.4 Attitudes

The **National Drug Strategy Survey (2007)** found that support for banning smoking in pubs/clubs increased greatly between 2004 and 2007, and there was also an increase in support for tobacco measures. There was little change in support in regards to increasing taxes of any nature to stop smoking. There was greater support for law enforcement restriction methods compared to increasing taxes and banning alcohol completely. Females were more likely to support “Restricting late night trading of alcohol” compared to males.

The **Victorian Youth Alcohol and Drug Survey (2004)** surveyed attitudes towards alcohol, cannabis and other illicit drugs. The survey found that there was a slight increase in attitudes towards alcohol as “not wrong at all”, and a slight increase in Cannabis to be “very wrong”. There was a slight decrease in Cannabis to be “a little bit wrong” and “not wrong at all”, and a slight increase in illicit drugs to be “very wrong”.

The **Generation Next: The Youth Have Spoken (2007)** report indicated that the three most important issues for youth within Ballarat relate to drugs, alcohol and safety. Smoking was ranked 10th. The results indicated that 84% of Ballarat’s youth responded to the survey as having tried alcohol, 41.5% responded to having consumed alcohol monthly with 26% responding that they had consumed alcohol weekly.

3. Consultation Process and Methodology

3.1 Initial Consultant Appointment and Establishment of the Steering Group.

Ballarat Community Health Centre (BCHC) advertised the Drug and Alcohol Action Plan project as an Expression of Interest, and invited either potential Project Officers or interested Consultants to apply. Lynne Gleeson (Springtech Services Pty Ltd) was appointed to undertake the initial development of the Action Plan component of the project (Phase I of the Project Brief).

The Steering Group developed Terms of Reference for the Drug and Alcohol Action Plan project. Representatives were selected from organisations who receive funding for the provision of AOD services within the Central Highlands area. The membership is as follows:

BCHC representatives

BCHC Chief Executive Officer

BCHC AOD Team Leader

BCHC Health Promotion Team Leader

BCHC Mental Health Team Leader

DHS representatives – Grampians Regional Office

Manager, Primary Health

Alcohol and Drug Program Services Advisor

AOD Funded Agency representatives

Hepburn Health Service

Ballarat Health Service Psychiatric Services

Djerriwarrh Health Service

Uniting Care

Ballarat and District Aboriginal Cooperative

City of Ballarat

Project Consultant

Springtech Services

Lynne Gleeson (Springtech Services) reported directly to Robyn Reeves (CEO, BCHC). The Steering Group held meetings on a regular basis to inform and guide the project.

3.2 Review of the Policies, Literature and Evidence

Data was collected for the review of policies, literature and evidence from a range of sources, including State and Commonwealth policy and discussion documents and available literature. Many of the literature and data sources came from specialist alcohol and drug service providers, with a full list of sources included in the Reference list in Appendix 1. The data summary was focused on the LGAs within the Central Highlands area, including the City of Ballarat, and the Shires of Golden Plains, Hepburn and Moorabool.

3.3 Consultation Strategies and Scope

The consultation process included four separate phases.

The first consultation phase included the initial exploration of issues and themes through focus groups developed in collaboration with Steering Group members and held in each of the LGAs. These were conducted to identify key issues that were specific for each LGA, and to identify common issues that were across all LGAs in the Central Highlands area.

The second consultation phase included a stakeholder forum held in Ballarat on 23 October, 2008. This forum was intended to confirm issues identified through the initial focus group process, and to identify any gaps that had not been included. It was also intended to identify potential actions and strategies that could be implemented as part of the Action Plan implementation phase.

The third consultation phase included emailing all participants from the first and second consultation rounds in November 2008 with a draft of the Action Plan consultation themes and strategies. This was to request a review of the revised issues and actions, as well as requesting participants to identify themselves as potential lead stakeholders for relevant themes.

The fourth consultation phase included a one day feedback session where participants were invited to have feedback into the final Action Plan. This was conducted on 16 December, 2008.

A list of all participants is included in Appendix 2.

4. National and State AOD Action Plans

4.1 National

The following tables have been reproduced (in partial form) from the **Australia: The Healthiest Country by 2020** discussion paper. Table 1 has reproduced the key Initiatives and Strategies for Tobacco Control. Table 2 has reproduced the key Initiatives and Strategies for achieving change in alcohol-related harm. These initiatives and strategies are currently in the consultation phase and will therefore be reviewed. However, they do provide important context for current discussions and future policy directions.

Table 1: Ways to Work Together to Achieve Tobacco Control

Initiative	Actions
Ensure that cigarettes become significantly more expensive	1.1 Increase duty and prevent evasion of duty in order to increase the cost of tobacco products
Further regulate supply of tobacco products and exposure to tobacco smoke	2.1 Eliminate all remaining forms of promotion of tobacco including by banning displays at point of sale and ensuring plain packaging 2.2 States and territories tighten and enforce legislation to protect against exposure to second hand smoking 2.3 States and territories tighten and enforce legislation to eliminate sales to minors 2.4 States and territories license retailers, with no license available for sales through vending machines, internet, at hospitality and other social venues 2.5 Tobacco use becomes a 'classifiable element' in movies and video games 2.6 Improve consumer information through larger warnings, prohibition of misleading labeling, brand names and product characteristics; establish a national system to more regularly warn smokers 2.7 Legislate to ensure full reporting and governmental controls over all tobacco product constituents, additives, emissions and other aspects of manufacture and design
Increase the frequency reach and intensity of public education campaigns	3.1 Develop and fund effective media advertising and public education campaigns at levels of reach needed to reduce smoking
Ensure all smokers in contact with health services are given encouragement and support to quit	4.1 Develop and disseminate information and implement sustainable training programs for health workers for both pre-service training and continuing professional development 4.2 Increase availability of Quitline service for pregnant women, for those who need interpreters and those living in remote areas of Australia 4.3 Subsidise nicotine replacement therapy through Quitline or PBS

Ensure access to information, treatment and services for people in highly disadvantaged groups	<p>5.1 Fund media advertising and other programs and services tailored for Indigenous people</p> <p>5.2 Ensure availability and accessibility of nicotine replacement therapy for indigenous people</p> <p>5.3 Fund indigenous health organisations and workers to raise awareness of smoking and promote smokefree polices in local communities and services</p> <p>5.4 Fund research to evaluate innovative strategies to reduce smoking in indigenous communities</p> <p>5.5 Ensure all state-funded human services agencies and correctional facilities are smoke-free. Identify smoking status of clients and refer to cessation supports.</p>
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Source: Australia: Discussion Paper: *The Healthiest Country by 2020* (pages 24-27).

Table 2: Ways to Work Together to Achieve Change in Alcohol-Related Harm

Initiative	Actions
Reshape consumer demand towards low-risk drinking	<p>1.1 Develop adequately funded and effective social marketing and public education campaigns to prevent misuse and reduce alcohol-related harm, including targeted approaches and local complementary initiatives for different population groups</p>
Reshape supply towards lower-risk products	<p>2.1 Review the taxation system to stimulate the production and consumption of low-alcohol products</p> <p>2.2 Develop a staged approach to restrict alcohol advertising</p> <p>2.3 Remove tax deductibility for advertising, and develop a staged approach to restrict alcohol advertising</p>
Improve public safety	<p>3.1 Enforce legislation on responsible serving of alcohol, through intelligence-led policing programs that focus on drinking establishments</p>
Close the gap for disadvantaged communities	<p>4.1 Commission research on effective strategies to address social determinants of alcohol consumption in Indigenous and low-income communities</p>
Strengthen, skill and support primary health care to help people in making healthy choices	<p>5.1 Develop and disseminate information and training packages (with a focus on screening, effective brief interventions and appropriate referral pathways for health and welfare workers)</p>
Improve maternal and child health	<p>6.1 Pregnant women receive screening, advice and targeted programs from trained health professionals in ante natal clinics</p> <p>6.2 Individuals at risk from harmful drinking are identified and supported in changing their drinking behaviour</p>
Build the evidence base	<p>7.1 Model safer patterns of alcohol consumption in different communities from changes to alcohol taxation arrangements and understanding of the impact of different types of alcohol outlets and their density on hospitalisation, violence and crime rates</p> <p>7.2 Collect and analyse nationally consistent data about alcohol outlet density and alcohol-related health and safety outcomes with a view to regulate alcohol outlet density.</p>

Source: Australia: Discussion Paper: *The Healthiest Country by 2020* (pages 39-40).

4.2 Victoria

Victoria's Alcohol Action Plan 2008-2013: Restoring the Balance was released in May 2008. The summary of actions is reproduced here.

Table 3: Summary of Key Themes from Victoria's Alcohol Action Plan 2008-2013

	Initiative	Actions
Restoring the balance for families	<p>More support in mainstream health services to help people reduce their drinking early</p> <p>Providing the best quality care for more serious alcohol use problems</p>	<p>1.1 Establish an early alcohol intervention program</p> <p>1.2 Produce information for CALD communities</p> <p>1.3 Develop a Koori alcohol plan</p> <p>1.4 Implement the Blueprint for AOD services</p> <p>1.5 Respond more effectively to clients with co-occurring mental illness</p> <p>1.6 Extend shared-care models and promote primary care settings</p> <p>1.7 Introduce extended stay withdrawal programs</p> <p>1.8 Introduce family therapeutic interventions</p> <p>1.9 Develop a community corrections alcohol program</p> <p>1.10 Introduce new legislation to provide for involuntary detention</p>
Restoring the balance within our culture	Sustained community awareness to change community attitudes and encourage a safe and sensible approach to alcohol use	<p>2.1 Develop a community awareness campaign</p> <p>2.2 Support the distribution and uptake of the revised <i>Australian alcohol guidelines for low-risk drinking</i></p> <p>2.3 Introduce more effective AOD education in Victorian schools</p> <p>2.4 Support the Good Sports Program</p> <p>2.5 Introduce warnings on alcoholic energy drinks</p>

Table 3: Summary of Key Themes from Victoria's Alcohol Action Plan 2008-2013 (continued)

	Initiative	Actions
Restoring the balance for our community	<p>Properly enforced controls on the sale and marketing of alcohol</p> <p>Preventing and reducing the consequences of excessive alcohol use such as alcohol-fuelled violence</p>	<p>3.1. Enhance enforcement of the <i>Liquor Control Reform Act 1998</i></p> <p>3.2. Review liquor licensing fees</p> <p>3.3. Review obligations of managers and employees of licensed premises</p> <p>3.4. Consider introducing underage operatives</p> <p>3.5. Review compliance with the Voluntary Water Guidelines</p> <p>3.6. Develop an assault reduction strategy</p> <p>3.7. Introduce late-hour entry restrictions</p> <p>3.8. Freeze issuing of late-night liquor licenses</p> <p>3.9. Implement new security camera regulations</p> <p>3.10. Review patron numbers in high-risk venues</p> <p>3.11. Amend the Victorian Planning Provisions</p> <p>3.12. Consider a new rehabilitation system for high-risk drink-driving offenders</p> <p>3.13. Extend the zero blood alcohol concentration limit for young drivers</p> <p>3.14. Conduct the Safe Streets public safety research and pilot evaluation</p>
Restoring the balance in partnership	Working with the Commonwealth and other State and territory governments to address alcohol-related issues on a national level	<p>4.1. Conduct research into alcohol product packaging and labelling</p> <p>4.2. Reduce young people's exposure to alcohol advertising</p> <p>4.3. Explore actions to address secondary supply</p> <p>4.4. Review the alcohol content in ready-to-drink products</p> <p>4.5. Support including alcohol in the National Illicit Drug Strategy Drug Diversion Initiative</p> <p>4.6. Enhance alcohol diversion programs for young people</p>

Source: Victoria's Alcohol Action Plan 2008-2013 (page 7).

5. Selected Local Government Plans

Table 4 below provides a list of selected local government plans for the Councils within the Central Highlands AOD Action Plan area. This list is not intended to be inclusive of all Council Plans, and it is acknowledged that this list will change as plans are updated through Council processes. This summary is intended to provide some basis for developing links between the Central Highlands AOD Action Plan and other related local government plans.

Table 4: List of Selected Local Government Plans

	Relevant Plan to link with Central Highlands AOD Action Plan
City of Ballarat	Health and Wellbeing Plan 2007-2009
	Ballarat Youth Strategy 2009-2014
	Community Safety Action Plan 2008-2013 (includes City Safe)
	Disability Action Plan 2006
	Ballarat Municipal Early Years Plan May 2005
	Best Start Action Plan 2004
Shire of Golden Plains	Municipal Public Health Plan 2006-2008
	Early Years Plan 2009-2012
	Maternal and Child Health Services Action Plan 2006-2010
	Health Promotion Plan 2007-2010
	G21 Integrated Community Transport Plan 2009-2013
	Disability Action Plan 2006-2010
	Community Development Strategy 2007-2011
	Youth Development Plan 2007-2011
Shire of Hepburn	Municipal Public Health Plan 2005-2008
	Hepburn Social Plan 2005-2015
	Youth Policy 2008
	Access and Inclusion Plan 2005-2015
	Municipal Early Years Plan 2008
Shire of Moorabool	Local Area Plan 2007
	Recreation and Open Space Strategy 2007
	Municipal Early Years Plan 2006-2009
	Disability Access and Inclusion Plan 2005-2007

6. Key Actions

Please note that the themes presented from the consultation process represent participant perceptions. They are not intended to be inclusive of all agencies or programs within the service system, but simply capture the views of participants in this consultation process at this point in time. The outcomes from the consultation process have been used as one method of informing the Actions that have been developed. Key linkages are selected agencies that have indicated an interest in participating in a facilitating role.

BCHC has an oversight role in monitoring the implementation of this Action Plan. This will be enhanced through the establishment of an AOD Implementation Committee to monitor the activity of several Working Groups which have specific responsibilities.

As noted in the Action Plan Project Brief (Section 1), the implementation phase will commence in 2009 following the appointment of a Project Officer. The Project Officer will facilitate the AOD Action Plan under the guidance of the AOD Action Plan Implementation Committee, and will address the specific deliverables 6-9 identified in the Action Plan Project Brief.

Four Working Groups have been suggested to implement this Action Plan. It is proposed that the Working Groups provide a specific function and report through the AOD Action Plan Implementation Committee. A key method of communicating with the AOD field will be through the establishment of the AOD Network. The four Working Groups are suggested as follows:

1. Education and Health Promotion
2. Community Development
3. MHAOD Treatment Services
4. Professional Development

Key Priority Area: Health Promotion (Population Focus)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
1.1	Promote community awareness of impacts and risks of AOD and binge drinking	<p>Develop and promote interventions to address community attitudes and acceptance of binge drinking</p> <p>Increase awareness of the link between unwanted activity and alcohol, including family violence, sexual activity and assaults</p> <p>Coordinate HP Activity across health services as appropriate</p> <p>Coordinate and engage high profile speakers at events eg. Paul Dillon, Dave Hughes</p>	<p>Project Worker to collate and maintain list of locally available current resources</p> <p>Project Worker to facilitate coordinated HP activity as appropriate</p> <p>Additional funding to develop resources as need is identified</p>	<p>Integrated HP Activity reports across health services</p> <p>List of locally available current resources which are readily accessible</p>	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>Health Services, BCHC, Councils, Strengthening Generations CORE Group, SSMART Network</p>	2009
1.2	Promote Prevention and Early Intervention	<p>Support for evaluation of the SSMART AASK program</p> <p>Support continued implementation of the SSMART AASK program if evaluation outcomes support this</p> <p>Implement recommendations from SSMART Answers Conference Report 2007</p> <p>Support the ongoing implementation of specific AOD initiatives within the Strengthening Generations program</p> <p>Develop series of newspaper articles on AOD</p>	<p>Commitment of ongoing resources for the SSMART AASK program by using the evaluation results</p> <p>Additional funding for project when and where possible and appropriate</p> <p>Media willingness to print</p>	<p>Completed SSMART AASK evaluation</p> <p>Continued implementation of SSMART AASK program if appropriate</p> <p>Implementation of recommendations from SSMART Answers Conference</p> <p>Continued implementation of AOD objectives from Strengthening Generations program</p> <p>Regular publishing of newspaper articles re AOD</p>	<p>SSMART Network</p> <p>AOD Network</p> <p>Health Services/ Schools Strengthening Generations CORE Group</p>	2009

Key Priority Area: Health Promotion (Population Focus) (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
1.3	Provide accurate information to parents re education of young people about safe home based alcohol use	<p>Promote awareness of Safe Partying options</p> <p>Promote awareness of existing resources e.g. DEECD online resources for parents and “Party Safe” resources from Police</p> <p>Interventions to increase awareness that majority of parents do not give alcohol to underage persons</p> <p>Promote programs that develop increased resilience for young people</p>	<p>Project Worker to facilitate awareness of available resources</p> <p>Project Worker to facilitate coordinated HP activity as appropriate</p>	<p>Accurate information for parents readily available and accessible through a range of service providers</p> <p>Integrated HP Activity reports across health services</p>	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>Health Services, BCHC, Councils, DEECD, Police, UCare</p>	2011
1.4	Increase coordination between AOD information sessions and other Health Promotion activities	<p>Coordinate and share resources that are available for AOD HP e.g. Education re party scene AOD use</p> <p>Create opportunities to coordinate and engage high profile speakers at events eg. Paul Dillon, Dave Hughes</p>	<p>Project Worker to facilitate awareness of available resources</p> <p>Project Worker to facilitate coordinated HP activity as appropriate</p>	<p>High profile speakers are engaged in coordinated events</p> <p>Integrated HP Activity reports across health services</p>	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>Health Services, BCHC, Councils, Strengthening Generations CORE Group, SSMART Network</p>	2010
1.5	Increase awareness of impacts and risks of tobacco use	Promote availability of, and access to, QUIT and other programs	<p>Project Worker to facilitate awareness of available programs</p> <p>Project Worker to facilitate coordinated HP activity as appropriate</p>	Integrated HP Activity reports across health services	<p>Education/HP Working Group</p> <p>Health Services, BCHC, Councils</p>	2009

Key Priority Area: Health Promotion (Population Focus) (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
1.6	Increase awareness of, and coordination between, Smoking Cessation programs	Joint marketing approaches Develop closer collaboration across BHS and BCHC Smoking Cessation programs Development of baseline data measures	Project Worker to facilitate awareness of available programs Project Worker to facilitate coordinated HP activity as appropriate BHS and BCHC staff to coordinate marketing and development of indicators	Establish integrated HP Activity reports across health services Baseline data measures established Joint marketing approaches established	Education/HP Working Group Health Services, BCHC, BHS	2010
1.7	Improve links with CHSA and Leisure Networks (Geelong) to include AOD issues in education re sports management and events	Work with CHSA and Leisure Networks to support clubs in developing a range of fund raising activities that do not include alcohol Support for local sporting clubs as “champions” on safe and innovative AOD programs/activities	Project Worker to facilitate links between CHSA, Leisure Networks and AOD Network	Links established between CHSA and Leisure Networks with the AOD Network re AOD issues in sports clubs Number and range of alcohol free sports events	Education/HP Working Group AOD Network Councils, CHSA, Leisure Networks, DPCD	2010
1.8	Extend Health Promotion AOD and tobacco initiatives into workplaces	Deliver QUIT and AOD programs within workplaces as negotiated	Project Worker to facilitate coordinated HP activity as appropriate Capacity for staff to deliver programs	Establish integrated HP Activity reports across health services re tobacco initiatives	Education/HP Working Group Health Services, BCHC	2010

Key Priority Area: Health Promotion (Population Focus) (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
1.9	Develop consistency in understanding evidence based practice (EBP) across health and education sectors	Participation in SSMART AASK evaluation currently being undertaken through CHRP at UB Establish process between health and education sectors to develop a shared understanding of EBP and identify appropriate resources	Additional funding to support ongoing facilitation as need is identified	Completion of evaluation through CHRP Consistent understanding of evidence based practice between the two sectors and appropriate resources identified	Education/HP Working Group AOD Network UB (CHRP), DEECD, Strengthening Generations CORE Group, BCHC, Health Services	2009

Key Priority Area: Health Promotion (Schools Focus)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
1.10	Develop increased capacity for resilience among young people engaged in schools	<p>Develop or promote programs incorporating resilience into programs within schools</p> <p>Develop or promote programs that focus on harm minimisation approaches</p> <p>Engage with youth to identify the most effective messages and how to send these</p>	<p>Capacity to deliver schools based programs that support resilience and harm minimisation approaches within an EBP framework</p> <p>Financial support for peer education and to showcase programs developed by youth</p>	<p>A number and range of programs incorporated into schools</p> <p>A number and range of peer education and showcasing events</p>	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>DEECD Schools, Strengthening Generations CORE Group, BCHC, Health Services</p>	2010
1.11	Promote awareness of impacts and risks of tobacco use in schools	Use of Smoke Free Schools resource in Primary and Secondary schools	Capacity to deliver existing resources	A number of schools with implementation of program	<p>Education/HP Working Group</p> <p>DEECD, Schools, Health Services, BCHC, Councils</p>	2010

Key Priority Area: Health Promotion (Schools Focus) (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
1.12	Increase awareness of AOD and tobacco issues among parents	<p>Education to parents to focus on primary rather than secondary schools</p> <p>Focus on transition times e.g. Year 7 nights through School Nursing and welfare, parents and friends at schools</p> <p>Implement a series of age appropriate AOD HP activities before Year 7</p> <p>Dissemination of AOD HP resources into schools to support parents</p> <p>Increase awareness of depth and breadth of existing resources available through DEECD website</p> <p>Develop closer collaboration between health and education sectors to deliver consistent AOD messages into schools</p> <p>Lobby to implement consistent parent education programs</p>	Project Worker to facilitate close collaboration between DEECD and AOD agencies to develop coordinated approach to AOD and tobacco HP for parents	Accurate and consistent information for parents readily available and accessible through all primary and secondary schools	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>DEECD Schools, Strengthening Generations CORE Group, BCHC, Health Services</p>	2010
1.13	Increase availability of, and access to, appropriate resources that can be included in school newsletters	Increase awareness of approved DEECD resources that are already in schools and are available through the DEECD website	Project Worker to facilitate close collaboration between DEECD and AOD agencies	Links between AOD agencies, DEECD and schools to promote awareness of available resources	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>DEECD, AOD Services, Strengthening Generations, Councils</p>	2010

Key Priority Area: Community Development/Attitudes and Community Safety

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
2.1	Increase awareness of AOD issues and impacts in community development initiatives	<p>Provide programs which have flexible community development strategies</p> <p>Encourage coordinated efforts across organisations to promote further media coverage</p> <p>Promote awareness during Drug Action Week</p> <p>Work with community groups re awareness of issues</p> <p>Integration of messages across range of community groups</p> <p>Increase awareness of public safety re safe use of syringes and needle stick injuries</p>	<p>Service Coordination</p> <p>Local data re risks, harms and impacts of AOD use</p> <p>Project Worker to support prevention messages using local data</p>	<p>Obtain funding for additional resources when and where possible</p> <p>Integrated HP Activity reports across health services</p> <p>Baseline data measures established</p> <p>Joint marketing approaches established with media and community groups</p>	<p>Community Development Working Group</p> <p>AOD Network</p> <p>AOD Services BCHC, UCare, Councils, Strengthening Generations CORE Group, CHSA</p>	Ongoing
2.2	Increase awareness of AOD issues within communities to encourage social connectedness initiatives	<p>Encourage Business development in social connectedness initiatives</p> <p>Councils to integrate messages re AOD with social connectedness initiatives</p> <p>Councils to work with community groups to support social connectedness initiatives</p>	<p>Links with Business</p> <p>Project Worker to facilitate AOD messages with Community Development workers within Councils</p>	<p>Increased community support for AOD issues and initiatives through social connectedness</p>	<p>Community Development Working Group</p> <p>Commerce and Business groups, CBallarat, Ballarat Cares</p>	2011

Key Priority Area: Community Development/Attitudes and Community Safety (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
2.3	Increase youth participation in a range of options that do not include AOD	<p>Advocate for a range of options for youth</p> <p>Work with a range of community stakeholders to develop options</p> <p>Promote social leadership</p>	<p>Support for Councils to develop locations for youth meeting places</p> <p>Support for community groups to develop activities or locations for youth</p>	<p>Funding for additional resources when and where possible</p> <p>Provide an appealing mix of underage activities that do not include alcohol and support access to these events</p> <p>Provide safe entertainment venues</p> <p>Opportunities to engage youth in social leadership activities</p>	<p>Community Development Working Group</p> <p>Health Services, Councils , BCHC CAFS, YSAAP agencies, UCare BADAC, Schools DEECD, RYANs CAFYs, YINs, YACs</p>	2010
2.4	Increase engagement with youth who may not be in schools	<p>Support for generic youth workers</p> <p>Establish links between AOD and homelessness programs</p> <p>Work with local business to support investing in youth</p>	<p>Funding for generic youth workers</p> <p>Project Worker to facilitate development and implementation of protocols between AOD and YSAAP programs</p> <p>Project Worker to establish links with local businesses</p>	<p>Improved access to services and supports</p> <p>Strong connections established between AOD and YSAAP programs</p> <p>Local business involvement with programs that support youth</p>	<p>Community Development Working Group</p> <p>Health Services Councils, BCHC CAFS, YSAAP agencies, UCare BADAC, RYANs CAFYs, YINs, YACs</p>	2010

Key Priority Area: Community Development/Attitudes and Community Safety (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
2.5	Develop increased capacity for resilience among young people who are not engaged in schools	<p>Develop or promote programs incorporating resilience</p> <p>Develop or promote programs that focus on harm minimisation approaches</p> <p>Engage with youth to identify the most effective messages and how to send these</p>	<p>Capacity to deliver programs that support resilience and harm minimisation approaches within an EBP framework</p> <p>Financial support for peer education and to showcase programs developed by youth</p>	<p>A number and range of programs available for youth who are not engaged in schools</p> <p>A number and range of peer education and showcasing events</p>	<p>Education/HP Working Group</p> <p>AOD Network</p> <p>Strengthening Generations CORE Group, BCHC, Health Services</p>	2010
2.6	Coordinate social marketing re City Safe programs	Encourage coordinated efforts to promote further social marketing	Incorporate into existing Council funding cycle	Greater awareness of City Safe programs	<p>Community Development Working Group</p> <p>AOD Network City of Ballarat</p>	2009
2.7	Strategically align Central Highlands AOD Action Plan with other existing Action Plans	<p>To link with Council Plans where appropriate (see Table 4)</p> <p>Share information across stakeholders re what other areas are doing in related areas</p>	Project Worker to facilitate collaboration between relevant stakeholders	<p>Links between AOD Action Plan and Council Plans and review process</p> <p>Clear communication across stakeholders</p>	<p>Community Development Working Group</p> <p>AOD Network</p> <p>Councils</p>	2011

Key Priority Area: University Students and Student Associations

Key stakeholders include Individuals and Families; Communities, Higher Education providers, Schools and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
3.1	Increase input into university curriculum re AOD and MH issues	Develop closer links between university and health services staff	Project Worker to facilitate links between University staff and Health Services staff	AOD and MH expertise incorporated into university curriculum Number and range of collaborative projects between university and health and education sector partners re AOD and MH	Professional Development Working Group AOD Network Specifically UB Mt Helen (Nursing, Education, HMSS and BSSH); TAFE (Community Services) and ACU (Nursing & Midwifery, Education) Other Undergraduate and Postgraduate programs	2010
3.2	Increase engagement with university student communities in developing programs re awareness of risks and impacts of AOD	Engage students in process to discuss issues and solutions Identify existing and develop new resources to increase awareness of impacts and risks Investigate university and student union activities that may encourage or increase AOD use	Project Worker to work collaboratively with university student services staff to engage with student communities Project Worker to facilitate collation of prior work done in collaboration between AOD agencies and universities Information about communications that are used to deliver marketing messages to student communities	Established process to engage with student communities re AOD on an ongoing basis Number and range of HP activities within the University environment Applications for additional funding to support HP programs Increased student awareness of issues and resources in university communities	Education/HP Working Group AOD Agencies UB and ACU, UB and ACU Student Unions, UB and ACU students School of Forestry (Creswick), University of Melbourne Rural Clinical School ACU (social justice and community engagement, Students, Learning and Teaching Department)	2010

Key Priority Area: University Students and Student Associations (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
3.3	All student unions to provide and promote alcohol free activities	<p>Address conflicts of interest between UBSA (Mt Helen) and Ballarat alcohol venues</p> <p>Support student unions to provide and promote alcohol free activities for Ballarat Cup Day and O Weeks (both UB and ACU)</p> <p>Support student unions to provide and promote ongoing alcohol free activities</p>	<p>Commitment from UB to address conflicts of interest with UBSA (Mt Helen)</p> <p>Capacity from AOD services to support student unions in the development of alternative activities</p>	<p>Declared conflict of interest from any student union representatives</p> <p>Number and range of alcohol free events provided by student unions</p>	<p>Education/HP Working Group</p> <p>UB and ACU</p> <p>UBSA (Mt Helen)</p> <p>ACU Student Association</p>	2009
3.4	Student unions to be actively engaged in providing safe partying environments and safe transport options	<p>Support alternatives to Wednesday night activities for UB students</p> <p>Courtesy bus transport to be provided both to and from Ballarat venues on Wed night</p>	<p>Project Worker to liaise with UBSA (Mt Helen, TAFE) and ACU Student Association</p> <p>Funding</p>	<p>Student unions and associations to promote safe partying environments</p> <p>Safe transport options provided both to and from Ballarat venues</p>	<p>Community Development Working Group</p> <p>UB and ACU</p> <p>UBSA (Mt Helen)</p> <p>ACU Student Association</p>	2009
3.5	Increase support for students who are moving to Ballarat, including International students	<p>Promote awareness of alcohol free events on campus and in Ballarat</p> <p>Develop and promote awareness of risks and impacts of AOD</p>	<p>Funding</p> <p>Capacity from universities transition committees and AOD services</p>	Coordinated social marketing campaigns across UB and ACU	<p>Community Development Working Group</p> <p>UB and ACU, UBSA and ACU Student Association, ACU Learning and Teaching Department, University transition committees, AOD services</p>	2010

Key Priority Area: Role of Councils

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
4.1	Respond to evidence that there is increased alcohol use where there is increased availability of alcohol	Promote availability of free water in licensed venues Increase targeted interventions to reduce availability and consumption of alcohol in major population centres	Planning permit considerations Project Worker to facilitate links with licensed venues	Free water available at all times in licensed venues Councils to reduce availability of alcohol through planning permit regulations in major population centres	Community Development Working Group Councils: Ballarat, Golden Plains, Moorabool, Hepburn	2009
4.2	Harm minimisation strategies to be supported through Liquor Accords	Centralise late night venues to single precinct to enable more effective delivery of policing and other services.	Project Worker to link with Police, licensees, Council re Liquor Accord initiatives	Continuation of Liquor Accord within Ballarat Development and implementation of Liquor Accords in other areas as required: Bacchus Marsh, Daylesford, Creswick	Community Development Working Group AOD Network Councils: Ballarat, Golden Plains, Moorabool, Hepburn Police	2009
4.3	Increase interventions to control the number of liquor outlets across Ballarat	Leverage land use planning to control placement and number of outlets and opportunities for sale of alcohol	Data from Turning Point re number of liquor outlets Support from City of Ballarat Council and staff	Active reduction in number and availability of liquor outlets	Community Development Working Group City of Ballarat	2012
4.4	Provide alternative entertainment in central precinct	Review land use planning within central precinct area – support for planning to use the space in a different way	Coordination between planning permit from Council and liquor license from Police	Establishment of alternative entertainment in central precinct	Community Development Working Group City of Ballarat	2012

Key Priority Area: Family Support and Child Protection

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
5.1	Increase awareness of services to support families who have a carer role	Coordinate and promote awareness by carers of all ages and health and education professionals of existing programs and their availability	Project Worker to facilitate joint marketing initiatives	Greater awareness by families that have a carer role of services and programs that may be beneficial.	AOD Network GFPS Exec, Health Services, Child Protection, CAFS, BCHC	2010
5.2	Improve relationships between Grampians Family and Placement Service (GFPS) organisations with services for AOD, disability and MH	Develop and implement a regional MOU setting out mutual understanding and responsibilities Utilize expertise from each service system in working with children and families	Capacity from GFPS, AOD, MH and Disability organisations to form a working group	Draft a regional MOU to set priorities for regional initiatives with each service system To establish one significant initiative in conjunction with AOD, MH and Disability services that shares resources to achieve a regional outcome	AOD Implementation Committee GFPS Exec, Health Services, Child Protection, CAFS, BCHC, DEECD	2009
5.3	Improve understanding of the AOD, Disability and MH sectors in relation to the Childrens, Youth and Families Act and Statewide outcomes for children	Meetings and forums with DHS and agencies with AOD, Disability and MH Services	Capacity from DHS, AOD, MH and Disability organisations to plan and attend meetings	Establish a shared understanding between sectors	Professional Development Working Group AOD Network GFPS Exec, Health Services, DHS Child Protection, CAFS, DHS Disability	2009

Key Priority Area: Housing

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
6.1	Increase availability of safe, suitable and affordable housing, including transition housing, for youth and general community	Bring key stakeholders (LGAs and key organisations) together to discuss coordinated approaches to lobbying for appropriate housing	Capacity from Councils, SAAP and DHS Housing Project Worker to facilitate links between stakeholders and AOD services	Increased availability of safe, affordable and suitable housing for all target groups	Community Development Working Group AOD Network	2009
6.2	Increase availability of safe, affordable housing that is accessible to the target group, including dual diagnosis clients	Develop strategic approach to housing Establish strong relationships between community development and planning to meet needs of identified groups Coordinated advocacy between different levels of government Reduce the occurrence and impacts of individuals who come in and “trash” housing			Councils: Ballarat, Golden Plains, Moorabool, Hepburn DHS Housing BCHC, UCare, SAAP funded agencies	2012

Key Priority Area: Transport

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
7.1	Increase availability and use of public transport across all ages	Lobby for increased and improved transport availability Promote safe transport options, including taxis Coordinate with transport providers to support access to, and from, activities Provide increased transport options for clients immediately after treatment eg. Develop options to address transport difficulties	Relationships with appropriate governments departments City Safe Taxi Rank Project Worker to coordinate activities	Designated Driver program “Stay with Mates” program Alcohol-free drinks for drivers Options available to address transport difficulties	Community Development Working Group Councils: Ballarat, Golden Plains, Moorabool, Hepburn Health Services BCHC UCare	2009
7.2	Reduce drink driving	Encourage young people to stay with friends overnight on Saturday and return on Sunday Develop “Stay with Mates” program Promote “Alcohol-free drinks for drivers” programs				
7.3	Increase availability of appropriate transport for detox clients into services	Client needs to be stable prior to transport Range of transport options to be available Lobby for appropriate transport for detox clients to services outside the region, particularly at realistic times				

Key Priority Area: Relationship with Police, Courts and Forensic Clients

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
8.1	Support closer community links with police	Explore/extend existing successful examples of education and apply to drug diversion programs (e.g. Bacchus Marsh referral/diversion program, "Alcohol: What's the Harm" program in Ballarat)	Networks in each LGA area Staff capacity to support active engagement Project Worker to facilitate links with Police	Participation of AOD services in local Networks Police Referrals	Community Development Working Group AOD Services Moorabool Police	2009
8.2	Increase use of Cautioning Programs (Alcohol or Drugs)	Increase publicity and marketing Link drug cautions in a similar way to alcohol program for teens	Project Worker to facilitate links with Police, Corrections and other stakeholders	Police Referrals Drug cautions implemented	Community Development Working Group Police, Health Services, Corrections, DoJ	2011
8.3	Increase utilization of drug diversion programs	Expand to cautionary programs including adults and teens	Project Worker to facilitate links with Police, Corrections and other stakeholders	Police Referrals Increased awareness of Drug diversion appointment line	Community Development Working Group Health Services, BCHC, Councils, Police, CREDIT, Corrections, DoJ	2010

Key Priority Area: Relationship with Police, Courts and Forensic Clients (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
8.4	Increase awareness of consequences for arrest for alcohol e.g. compulsory assistance	Education re CREDIT/Bail program and support for referrals Information re availability forensic services	Increased resources for the CREDIT/Bail program when and where possible	Police Referrals CREDIT Referrals	Community Development Working Group Health Services, BCHC, Councils, Police, CREDIT, Corrections, DoJ	2010
8.5	Increase referrals between AOD services and Family Violence and Child Protection interventions	Develop stronger links between family violence and child protection services, police units and AOD/MH services	Project Worker to identify existing MOUs and protocols	Increased referrals to, and from, AOD services Police Referrals	AOD Implementation Committee GFPS Exec, Police Health Services, DHS Child Protection, Family Violence services	2010
8.6	Increase police referrals to AOD services as first option, in lieu of penalty or criminal sanctions.	Develop protocols for early referral to AOD services	Project Worker to identify existing MOUs and protocols	Increased referrals to AOD services Police Referrals CREDIT Referrals	Community Development Working Group Health Services, BCHC, Councils, Police, CREDIT, Corrections, DoJ	2009
8.7	Develop closer relationship with the court system as an avenue to bridge the gap between judicial and therapeutic services	Evaluation of links between court system and therapeutic services Implement additional protocols as appropriate	Project Worker to identify existing MOUs and protocols	Closer relationship between judicial system and therapeutic services	AOD Implementation Committee Health Services, BCHC, Councils, Police, CREDIT, Corrections, DoJ	2010

Key Priority Area: Dual diagnosis AOD/ABI clients

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
9.1	Consistent assessment that captures AOD/ABI clients	Develop screening tool to identify AOD/ABI issues Trial screening tool	Capacity to develop and trial screening tool Accurate indicative screening tool	Collaborative Screening tool that captures AOD/ABI clients	MHAOD Working Group BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, BADAC	2009
9.2	Increase recognition of clients with multiple diagnoses which may include AOD/MH/ABI/ Intellectual Disability	Develop indicative screening tool for AOD/MH/ABI/ Intellectual Disability Trial screening tool Develop consistent protocols for service coordination Develop a collaborative service network that implements service protocols	Capacity to develop and trial screening tool Accurate indicative screening tool	Collaborative screening tool that captures multiple diagnosis issues	MHAOD Working Group BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, HARP, BADAC	2010
9.3	Accurate data about ABI/AOD dual diagnosis clients	Develop accurate reporting and data collection re AOD/ABI clients Develop common reporting template to be used across the AOD Network for a 1 year trial	Capacity to develop and trial data collection and reporting template	Accurate reporting and data collection template	MHAOD Working Group BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, HARP, BADAC	2010

Key Priority Area: Dual diagnosis AOD/ABI clients (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
9.4	Reduce delay in neuropsychological assessment for prioritised clients	Lobby for increased resources to be available for prioritized clients Establish agreed process between neuropsychology services and referring agencies	Funding for additional neuropsychological assessments	Agreed process in place for prioritised clients	MHAOD Working Group BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, HARP, BADAC, Health Services	2011
9.5	Develop and implement process for neuropsychological assessment prior to admission to Rehab and after detox	Build assessment into the discharge process following detox, when the person is able to participate Lobby for improved collaboration between detox, rehab and neuropsych assessments	Funding for additional neuropsychological assessments	Agreed process in place	MHAOD Working Group BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, HARP, BADAC	2011
9.6	Implement recommendations from 2008 Evaluation of BHS AOD/ABI Case Management Services in rural regions (for Grampians region)	Recommendations developed and ready for implementation Implement recommendations as appropriate	Capacity for AOD services to participate	Recommendations implemented	MHAOD Working Group	2011

Key Priority Area: Dual diagnosis MH/AOD clients

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
10.1	Implement consistent assessment for AOD/MH clients	<p>Screening tool for dual diagnosis has been developed and is currently being piloted</p> <p>Implement accurate indicative screening tool after pilot testing</p> <p>Establish and implement protocols for consistent assessment</p>	Capacity for AOD and MH agencies	All MH and AOD services using consistent assessment	<p>MHAOD Working Group</p> <p>BHS ABI Clinic, BHSPS, UCare, GCHC, DHS Disability, BCHC</p>	2009
10.2	Increase recognition of clients with multiple diagnoses which may include AOD/ MH/ABI/ Intellectual Disability (same as 9.2 above)	<p>Develop indicative screening tool for AOD/MH/ABI/ Intellectual Disability</p> <p>Trial screening tool</p> <p>Develop consistent protocols for service coordination</p> <p>Develop a collaborative service network that implements service protocols</p>	<p>Capacity to develop and trial screening tool</p> <p>Accurate indicative screening tool</p>	Collaborative screening tool that captures multiple diagnosis issues	<p>MHAOD Working Group</p> <p>BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, HARP, BADAC</p>	2010

Key Priority Area: Dual diagnosis MH/AOD clients (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
10.3	Clear referral pathways to ensure access to all appropriate services for clients with complex needs (multiple diagnoses)	Define and develop clear referral/clinical pathways following administration of indicative screening tool (See 10.1 and 10.2) GPs to be aware of the range of referral options available (including PDRSS, BHSPS, AOD services, Medicare, private health care professionals and Mental Health Nurse Incentive Program)	Project officer to facilitate	All funded MH and AOD services would use agreed referral pathways Clear information and access to available services Documented pathways and information available	MHAOD Working Group All funded MH and AOD services Health Services, UCare, BHS Psych Services, BCHC, HARP BDDGP, BADAC	2009
10.4	Establish consistent understanding of BHSPS services for AOD clients	Develop an agreed understanding of role and practice of BHSPS with AOD clients Consistent protocols to be developed and implemented	Project officer to facilitate	Consistent implementation of protocols	MHAOD Working Group BHSPS All funded MH and AOD services	2009
10.5	Participate in the Grampians AOD/MH Dual Diagnosis project	Dual diagnosis project to develop treatment capacity, consistent data collection and tools and agency responsibilities AOD and MH agency participation and collaboration in the UCare Dual Diagnosis project	Project officer to facilitate	Implementation of consistent data collection and recommendations from the project	MHAOD Working Group All funded MH and AOD services UCare	2009

Key Priority Area: Dual diagnosis MH/AOD clients (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
10.6	Smoking Cessation programs specifically for AOD/MH clients	Recognise the relationship between smoking and MH issues Develop specific programs/resources re smoking cessation for MH/AOD clients, e.g. schizophrenia specific programs	AOD and MH agency capacity	Smoking Cessation program for MH/AOD Dual Diagnosis clients	Education/HP Working Group Health Services, BHSPS, BCHC, HARP BDDGP, BADAC	2010
10.7	Alcohol, tobacco and other drugs education programs for clients with recognised AOD/MH issues	Develop specific HP interventions for MH clients which include tobacco use, nutrition and healthy lifestyles Adopt existing programs where available Implement appropriate HP interventions	AOD and MH agency capacity	Specific HP interventions available for dual diagnosis clients re alcohol, tobacco and other drugs	Education/HP Working Group Health Services, UCare, BHSPS, BCHC, HARP, BDDGP, BADAC	2010
10.8	Consistent implementation of clinical practice guidelines for dual diagnosis clients	Promote consistent implementation of clinical practice guidelines for dual diagnosis across BHS and BHSPS Guidelines could be available to other Health Services	Capacity from BHS and BHSPS	Review by BHS re implementation of clinical practice guidelines to be completed	MHAOD Working Group BHS Pop Health Cttee, BHSPS, Health Services	2010

Key Priority Area: AOD Treatment Services for Individuals

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
11.1	Improve access to voluntary adult detox beds in Central Highlands	Develop coordinated data from multiple agencies to indicate detox and rehab needs	Data	Baseline data from AOD agencies in Central Highlands	MHAOD Working Group AOD Network	2011
11.2	Improve access to rehab beds in Central Highlands	Explore options for a Central Highlands model that coordinates detox and rehab beds Support for an Addictions Physician to be available in Ballarat	Collate data related to outcomes for clients from the Central Highlands, including data comparing metropolitan with regional areas		BHS (Pop Health Cttee) and HHS, BHSPS, BCHC, HARP, BDDGP, BADAC, UCare Tabor House	2011
11.3	Improve access to consistent seamless care between detox and rehab	Develop coordinated data from multiple agencies to indicate detox and rehab pathways Admission into Rehab to be timed with detox where possible Good coordination by AOD workers between detox and rehab Development and implementation of protocols to support systemic seamless care	Data Collate data related to pathways for clients Project Worker to coordinate	Baseline data from AOD agencies in Central Highlands	MHAOD Working Group AOD Network BHS Pop Health Cttee, HHS AOD services BHSPS, BCHC, HARP BDDGP, BADAC Health Services, UCare Tabor House	2011

Key Priority Area: AOD Treatment Services for Individuals (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
11.4	Improve access to neuropsychological assessment prior to admission to Rehab	Assessment to occur after detox and prior to rehab Incorporate into the discharge process after detox Lobby for increased resources to be available for prioritized clients	Project Worker to coordinate Funding for additional neuropsychological assessments	Agreed process in place for prioritised clients	MHAOD Working Group AOD Network BHS ABI Clinic BHSPS, UCare, GCHC, DHS Disability BCHC, HARP, BADAC, Health Services	2009
11.5	Improve access to options for detox services	Increase availability of home based withdrawal services Increase awareness of home based withdrawal services Establish coordinated baseline data from AOD agencies in Central Highlands	Funding Data	Increased awareness of home based withdrawal services Increased referrals to home based services when appropriate	MHAOD Working Group AOD Network Health Services, HHS, BCHC, HARP, BDDGP, UCare Tabor House	2010
11.6	Improve access to information that is readily available about AOD services that do exist	Develop resources that provide clear and coordinated information for GPs and other providers from websites and AOD agencies	Resources re AOD services that do exist to be readily available online from all key linkage partners	AOD Network to promote awareness of existing resources and their availability Development of coordinated information for Central Highlands AOD agencies	MHAOD Working Group AOD Services, BHSPS, BCHC, HARP, BDDGP, BADAC, UCare Tabor House, Councils, DEECD	2009

Key Priority Area: AOD Treatment Services for Individuals (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
11.7	Increase numbers of prescribing GPs	Encourage GPs to upskill and want to prescribe good opioid substitution therapy Liaison with those who can prescribe/treat Eg. GPs and Pharmacists and PMHT	DHS Pharmacotherapy Officer	Baseline data re number of prescribing GPs Increased number of prescribing GPs	MHAOD Working Group BDDGP, Health Services, DHS Pharmacotherapy Officer	2010
11.8	Improve consistent implementation of clinical practice guidelines for alcohol withdrawal in acute settings and blood alcohol estimation in ED Services	Promote consistent implementation of clinical practice guidelines across Acute and ED Services at BHS Guidelines could be available to other Health Services	Capacity from BHS and BHSPS	Review by BHS re implementation of clinical practice guidelines to be completed	MHAOD Working Group BHS Pop Health Cttee, BHSPS, Health Services	2010
11.9	Evaluation of current service provision	Review waiting list times, effectiveness, range of available services and service levels (include treatment, counselling, diversion and home based withdrawal programs)	Surveys and data collection from AOD agencies	Evaluation report	MHAOD Working Group All AOD Agencies	2009

Key Priority Area: Professional Development

Key stakeholders include Individuals and Families; Communities, Schools and Workplaces; Health Services; Industry and Commonwealth, State and Local Governments.

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
12.1	Provide PD for GPs supporting complex and dual diagnosis clients	Local GPs to attend for specialised training in AOD issues	Funding for training and to support GP attendance	Numbers of GPs attending specialized training to identify AOD issues Increased knowledge for GP's to support complex and dual diagnosis clients	PD Working Group BDDGP	2011
12.2	Increase awareness by generic workers re available AOD services, including after hours availability	Resources to be developed and disseminated re availability of local services and referral processes Liaise specifically with Golden Plains Council to clarify and coordinate AOD services from Ballarat and Geelong	Project worker to coordinate Funding for dissemination	Greater awareness of AOD services available for generic workers	PD Working Group AOD Network Health Services, Councils, BCHC, BDDGP, UCare, AOD services	2009
12.3	Increase skills for generic workers as they support clients waiting for AOD services	Provide PD opportunities/training Strengthen links between stakeholders on an ongoing basis	Project worker to coordinate Stakeholder identification	Generic workers are trained to support AOD clients awaiting services Stronger links between stakeholders	PD Working Group AOD Network Health Services, Councils, BCHC, BDDGP, UCare, AOD services	2009

Key Priority Area: Professional Development (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
12.4	Increase skills for clinicians who are working with multiple diagnosis AOD/ABI/MH/ Intellectual Disability clients	Provide PD opportunities Clinicians to attend for specialised training in multiple diagnosis issues		Clinicians who are more skilled in working with multiple diagnosis clients Resources to support Clinicians	PD Working Group Health Services BHSPS, BCHC, HARP BDDGP, UCare, UB	2011
12.5	Increase skills for clinicians re AOD and MH clients who present to Emergency and Acute services	Provide PD opportunities Clinicians to attend for specialised training in dual diagnosis issues	Project Worker to coordinate with BHS Dual Diagnosis clinician and consultant in Grampians Dual Diagnosis project (UCare)	Clinicians who are more skilled in working with clients presenting to Emergency and Acute Services	PD Working Group Health Services BHSPS, BCHC, HARP BDDGP, UCare, UB	2011
12.6	Improve links with AOD Youth Outreach workers in local networks	Develop closer relationships with AOD Youth Outreach workers	Project Worker to coordinate	AOD Youth Outreach workers participating in local networks to improve service coordination	PD Working Group Moorabool Golden Plains Health Services BCHC	2009
12.7	Increase skills and awareness of AOD workers re Child FIRST and referral procedures	Provide PD opportunities Develop protocols with family services and child protection workers re AOD services and establish referral pathways	Project worker to identify existing or develop protocols with family services and child protection workers	Greater awareness and skills of AOD workers More streamlined referral procedures	PD Working Group Family Services Alliances, Child Protection, Child First, AOD Services	2009

Key Priority Area: Professional Development (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
12.8	Increase skills for teachers to manage absenteeism and bullying	Provide PD opportunities Teacher Education Network (TEN) sessions in bullying and absenteeism	Working Group to liaise with DEECD Capacity from teachers to attend TEN training	Delivery of TEN training to teachers in bullying and absenteeism Increased skills for teachers in managing these issues	PD Working Group DEECD, Health Services/Councils Strengthening Generations CORE Group	2010
12.9	Increase skills for teachers with concerns about delivery of AOD information into classes	Provide PD opportunities Teacher Education Network (TEN) AOD sessions Promote effective Drug Education within Schools by classroom teachers Link training and education packages to current practice and legislative requirements	Working Group to liaise with DEECD Capacity from teachers to attend TEN training	Delivery of TEN training to teachers re AOD issues Promotion of effective Alcohol and Drug Education within Schools by classroom teachers Training and information packages to be linked to current practice and legislative requirements	PD Working Group DEECD, Health Services/Councils Strengthening Generations CORE Group	2010
12.10	Increase skills of licensed venue staff in relation to drug awareness	Explore opportunities for a drug awareness training course similar to RSA Review need for this program within Central Highlands and explore options with Turning Point	Working Group to conduct needs analysis for drug awareness training	Development and Implementation of drug awareness training course if review supports identified need	PD Working Group	2010

Key Priority Area: Professional Development (continued)

	Initiatives (What do we want to achieve?)	Actions (How can we address the issue?)	Resources (What do we need to be able to address it?)	Outcomes	Key Linkages	End Date
12.11	Increase awareness of the impacts of AOD abuse on families, including the safety and well-being of children	Provide PD opportunities for AOD, family violence, child protection and family support workers	Working Group to coordinate	Greater awareness of issues around AOD in families and with children	PD Working Group AOD Network GFPS Exec, Health Services, Child Protection, CAFS, BCHC, DEECD, Schools	2010
12.12	Increase AOD and MH clinicians skills in each area	AOD and MH Clinicians to have dual qualifications	Working Group to coordinate Quality AOD, MH and Dual Diagnosis Cert IV programs available in Ballarat	Increase in skilled dual diagnosis clinicians operating in the Ballarat area	PD Working Group All funded MH and AOD services UB (TAFE)	2012

7. Identification of Priority Areas - 2009

Priorities have been identified by each of the key priority areas discussed above and have a timeline for implementation in 2009. These can be summarised as follows:

1. Health Promotion
 - 1.1. Promote community awareness of impacts and risks of AOD and binge drinking
 - 1.2. Promote Prevention and Early Intervention
 - 1.5. Increase awareness of impacts and risks of tobacco use
 - 1.9. Develop consistency in understanding evidence based practice (EBP) across health and education sectors
2. Community Development/Attitudes and Community Safety
 - 2.6. Coordinate social marketing re City Safe programs
3. University Students and Student Associations
 - 3.3. All student unions to provide and promote alcohol free activities
 - 3.4. Student unions to be actively engaged in providing safe partying environments and safe transport options
4. Role of Councils
 - 4.1. Respond to evidence that there is increased alcohol use where there is increased availability of alcohol
 - 4.2. Harm minimisation strategies to be supported through Liquor Accords
5. Family Support and Child Protection
 - 5.2. Improve relationships between Grampians Family and Placement Service (GFPS) organisations with services for AOD, Disability and MH
 - 5.3. Improve understanding of the AOD, Disability and MH sectors in relation to the Childrens, Youth and Families Act and Statewide outcomes for children.
6. Housing
 - 6.1. Increase availability of safe, suitable and affordable housing, including transition housing, for youth and general community
7. Transport
 - 7.1. Increase availability and use of public transport across all ages
 - 7.2. Reduce Drink Driving
 - 7.3. Increase availability of appropriate transport for detox clients into services
8. Relationship with Police, Courts and Forensic Clients
 - 8.1. Support closer community links with police
 - 8.6. Increase police referrals to AOD services as first option, in lieu of penalty or criminal sanctions.
9. Dual diagnosis AOD/ABI clients
 - 9.1. Consistent assessment that captures AOD/ABI clients

10. Dual diagnosis AOD/MH clients
 - 10.1. Implement consistent assessment for AOD/MH clients
 - 10.3. Clear referral pathways to ensure access to all appropriate services for clients with complex needs (multiple diagnoses)
 - 10.4. Establish consistent understanding of BHSPS services for AOD clients
 - 10.5. Participate in the Grampians AOD/MH Dual Diagnosis project

11. AOD Treatment Services for Individuals
 - 11.4. Improve access to neuropsychological assessment prior to admission to Rehab
 - 11.6. Improve access to information that is readily available about AOD services that do exist
 - 11.9. Evaluation of current service provision

12. Professional Development
 - 12.2. Increase awareness by generic workers re available AOD services, including after hours availability
 - 12.3. Increase skills for generic workers as they support clients waiting for AOD services
 - 12.6. Improve links with AOD Youth Outreach workers in local networks
 - 12.7. Increase skills and awareness of AOD workers re Child FIRST and referral procedures

Appendix 1 - References

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Appendix 2 – Consultation Participant List

Steering Group membership

Robyn	Reeves	Chief Executive Officer, BCHC
Allan	Murphy	Health Promotion Team Leader, BCHC
Marilyn	Gale	Mental Health Team Leader, BCHC
Ray	Beacham	AOD Team Leader, BCHC
Jeff	Cuell	Ballarat and District Aboriginal Cooperative
Judy	Gregurke	Djerriwarrh Health Service
Joy	Nichols	Ballarat Health Services Psychiatric Services
Maureen	Gleeson	Manager, Community Health, Hepburn Health Service
Carolyn	Barrie	Manager, Health and Wellbeing, City of Ballarat
Sue	Adam	Manager, AOD Services, Uniting Care Ballarat
Allison	Doodt	Department of Human Services (DHS) Grampians Region
Judith	Perrin	Department of Human Services (DHS) Grampians Region

Participants in Consultation Process

Gail	Trembath	BCHC AOD Team
Tania	Rigby	BCHC Counselling and Youth Support Team
Brett	Vallance	BCHC AOD Team
Margaret	Morison	BCHC AOD Team
Marie	DeGrazia	BCHC AOD Team
Suzanne	Powell	BCHC AOD Team
Jodie	Downey	City of Ballarat
Peter	Appleton	City of Ballarat
Cassie	Lindsey	City of Ballarat
Amanda	Collins	City of Ballarat
Anthony	Harrington	Ballarat Health Services Psychiatric Services
Maureen	McPhail	BHS ABI Service
John	Perham	Moorabool Shire Council
Jaclyn	Reriti	Golden Plains Shire
Clare	Beacham	Golden Plains Shire
Mary	Shone	BDDGP
Kelvin	Wilson	Centacare Ballarat
Barb	Taylor	Department of Human Services (DHS)
Susila	Naidu	Highlands Local Learning and Employment Network
Kim	Harris	Ballarat Magistrates Court
Ian	Davies	Ballarat Police
Jeannie	King	University of Ballarat
Jo	Rix	Australian Catholic University
Jemma	Fardy	Ballarat Community Correctional Services
Ela	Oki	Djerriwarrh Health Service
Melanie	Stones	DEECD
Maureen	Waddington	SJOG
Sue	Renn	DEECD

David	Johnson	Regional Coordinator Position for Forensic Clients
Andrew	Netherway	School Nursing, Daylesford
Kevin	Zibell	Child and Family Services Ballarat
Maree	McCorquodale	Hepburn Health Service
Simon	Holmes	Hepburn Health Service
Rae	Hough	CAFS Ballarat (Daylesford)
Jim	Ross	Police Bacchus Marsh
Ashley	Heenan	Community Safety Officer, City of Ballarat
Peter	Pinney	Hepburn Health Service – Team Leader, Counselling
Maree	McCorquodale	Hepburn Health Service - AOD Withdrawal Nurse
Simon	Holmes	Hepburn Health Service AOD Youth Outreach
Rae	Hough	CAFS Daylesford
Craig	Fletcher	Councillor, City of Ballarat
Jen	Pollard	Health and Wellbeing, City of Ballarat
Brendan	Murphy	Department of Corrections
Jim	Burrows	University of Ballarat
Sally	Boddenham	Health and Wellbeing, City of Ballarat
Trevor	Halmacek	Community Development, Golden Plains Shire
Aleisha	Harling	Youth and Recreation, Golden Plains Shire
Yuko	Ishido	Youth and Recreation, Golden Plains Shire
Bennita	Hough	CHNurse – Dereel, BDNH
Pauline	Hammond	Health and Wellbeing, Haddon, Golden Plains Shire
Gail	Smith	CH Nurse – Bannockburn, Golden Plains Shire
Linda	Govan	Ballarat Health Services – HARP
Nathan	Broome	Ballarat Health Services – HARP
Irene	Padarcic	BCHC Health Promotion Team (School Focussed Youth)
Patty	Kinnersly	Women's Health Grampians
Ally	Parnaby	Hepburn Health Service
Brian	Dunn	Hepburn Shire