ATCA

AUSTRALASIAN THERAPEUTIC COMMUNITIES ASSOCIATION

RESPONSE TO NATIONAL DRUG STRATEGY

February 2010

Response to

The National Drug Strategy Consultation

NDSconsultation@health.gov.au

National Drug Strategy Consultation
MDP 27
GPO Box 9848
Canberra ACT 2601

Australasian Therapeutic Communities Association

Associate Professor Lynne Magor-Blatch
A/g Executive Officer

atca@atca.com.au

1. Executive Summary

The Australasian Therapeutic Communities Association (ATCA) is the peak-body representing Therapeutic Communities across Australia and New Zealand. Therapeutic Communities (TCs) provide an evidence-based approach to alcohol and other drug treatment which is based on the use of the community as the prime vehicle for change. As such, TCs have a strong emphasis on both self-help and mutual help within a rehabilitation setting, supported by a range of psychosocial interventions.

The ATCA currently includes thirty-three members, which represent a total of 60 TCs operating across Australasia. These services employ more than 800 staff and treat over 5,000 people annually as well as providing additional critical services such as detoxification units, family support programs, child care facilities, exit housing and outreach services. As such, therapeutic communities work at all points of the treatment spectrum, from primary prevention and early intervention, to treatment and aftercare.

TCs have been found to work with a significantly more chaotic and complex group of clients than other treatment modalities. The TC does not generally represent the person's first treatment attempt. It is important to understand that all treatment modalities play a role in the overall treatment landscape and that 'one size does not fit all' when it comes to treatment for substance use.

The ATCA applauds and supports the Australian Government's commitment to the continuation of the National Drug Strategy.

Continued and increased emphasis needs to be given to early intervention and treatment strategies, recognizing that whilst reduction of supply is an important strategy, funding must also be provided and increased to address the treatment needs of the community. As some people move out of addiction, others are recruited in. The need to maintain a focus on harm reduction strategies, which includes facilitating access to treatment, continues to be a high priority.

With the release of the *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009),* the ATCA is well placed as a major provider of treatment services across the spectrum, from early intervention to treatment and aftercare, to contribute to this process and to work with Government and treatment services to ensure quality services are established and maintained.

The release of the *Standards and Support Package* has also been welcomed by the IGCD, particularly as a number of accreditation agencies are considering dropping the Alcohol, Tobacco and other Drugs (ATODS) modules from their standards packages. The ATCA is currently seeing increased interest in the use of the therapeutic community model, as residential services across Australasia embrace the concept and address issues of quality assurance within their programs. Additionally, many of our members are in the process of establishing new TCs as governments provide funding and release tenders for the establishment of new therapeutic communities.

Our member agencies are currently working with State and Territory governments to provide new services to Aboriginal and Torres Strait Islander peoples, to those who have co-occurring mental health and substance use disorders and to offenders within prison settings. This has meant that the 33 members of the ATCA are now operating 60 therapeutic communities, which constitutes a 46.5% growth in service delivery over the past three years.

The ATCA, as the peak body, is therefore ideally placed to broker change and to work with Government to ensure quality services are established and maintained.
The ATCA looks forward to a continued and developing relationship with the Australian Government to address this task.

The following response addresses the issues of concern in the continuation of the National Drug Strategy. In particular, the ATCA is concerned that services across governments and sectors are coordinated to provide the best opportunities for individuals and community experiencing the harms associated with substance use.

2. Recommendations

2.1. Drug-related harm

Recommendation 1: Comprehensive, multi-faceted prevention and treatment approaches should be adopted that acknowledge the complexity of human behaviour in relation to substance use and address the associated risk and protective factors.

2.2. Cross-sectoral approaches and the needs of the family

Recommendation 2: Substance prevention and intervention programs should target offspring of parents with substance use disorders. Children of alcohol and drug dependent parents are at the highest risk of any children for later drug use and other adolescent behavioral health and mental health problems. Research suggests that some children of substance abusers, like other children of dysfunctional parents, can develop special resilience skills with appropriate adult support.

Recommendation 3: Drug treatment services should consider the needs of the whole family, rather than just the identified substance user. This is particularly important where children are concerned. Providing opportunities for primary prevention and early intervention, and working with the whole family to address intergenerational issues of substance use will provide the best opportunities for vulnerable at-risk children.

The therapeutic community model provides evidence-based treatment for working with families, and particularly with vulnerable at-risk children.

Recommendation 4: Substance-using parents and their children need the support of all agencies across sectors and governments to work together to address the considerable and complex issues related to substance use. A coordinated cross-sectoral approach which includes health, justice departments, welfare, housing, education and child and family services should be established and maintained to provide the best opportunities for successful outcomes in working with families.

Recommendation 5: The National Drug Strategy should establish links with the Australasian Therapeutic Communities Association (ATCA) as the peak body working with more than 5,000 people annually to provide a range of evidence-based residential and support services for substance-using young people, adults and their children.

Therapeutic communities work with the most treatment-resistant and complex individuals who present with entrenched drug using histories and co-occurring disorders. One way of accessing this advice is through ATCA membership as a treatment and rehabilitation expert on the National Expert Advisory Committee (NEAP) to provide advice and assist with implementing and progressing national priorities.

2.3. Indigenous Australians

Recommendation 6: Interventions for all Australians should be matched to the needs of the individual. Therefore, treatment interventions are seen as a four-tiered approach:

1. Level 1: At base level, prevention, education and self-help.
2. Level 2: Short-term outpatient service.
3. Level 3: Long-term outpatient service, day programs and semi-residential service.
4. Level 4: Residential service, short-medium term, 24 hr coverage – to work with more complex clients. Aftercare and outreach services post-treatment.

Treatment approaches for Indigenous Australians should be targeted at the level of need. For those requiring Level 3 and Level 4 interventions, the Therapeutic Community Model of treatment, with its emphasis on family and community, provides an opportunity for further consideration.

Recommendation 7: While the *National Drug Strategy* should continue to address the needs of Indigenous Australians, the ATCA believes it is important that particular attention needs to be given to the continuing needs of Aboriginal and Torres Strait Islander communities through the *Aboriginal and Torres Strait Islander Complementary Action Plan.*

2.4. Workforce development

Recommendation 8: Over the next five years, attention needs to be focused on identifying, addressing and reducing the inequities in employment and workforce opportunities that exist between the NGO and the Government systems. In particular, the divide that exists in the remuneration provided to government staff in comparison with that of non-government staff, must be addressed and rectified. Additionally there is a need to look at the difference in the superannuation contribution and to consider the issue of transferability of other benefits, including long service leave entitlements.

To this end, it needs to be understood that the NGO sector will continue to lose valuable trained and experienced staff to the Government sector unless and until these inequities are addressed.

2.5. New technologies and online services

Recommendation 9: That the use of the internet, and particularly online counselling and chat rooms, be further implemented as a valuable means of disseminating information and providing treatment support and interventions.

2.6. Increased vulnerability: addressing risk factors in substance use and relapse

Recommendation 10: Attention needs to be given to the underlying causes of substance use and repeated relapse – lack of, or low, employment skills. This should be addressed by providing funding to AOD services to:

- Develop and build links with employers to understand and meet the skills needs of the local labour market.
- Facilitate links between local councils, employers, Australian Apprenticeship Access Program, Australian Apprenticeship Centres, Group Training Providers and Registered Training organisations to secure employment opportunities, apprenticeships and traineeships for job seekers.
- Develop and build links with educational bodies to facilitate appropriate training programs for job seekers who are in the process of completing their period of treatment and rehabilitation.
- Negotiate employment pathways with local businesses, tradespeople, councils and community organisations.

Additionally, inclusion of access to the Commonwealth Rehabilitation Service for people with an addiction must also be addressed. At present addiction is a precluded condition. Access to CRS training and employment services would greatly enhance the chances of securing employment.

2.7. Performance Measures

Recommendation 11: That attention be given to the resourcing needs of the AOD sector, and in particular the NGOs, to provide information and data against required performance measures.

Performance measures and reporting requirements should be developed across Government departments and agencies to ensure minimum duplication. This includes giving consideration to the ways in which reporting requirements can be coordinated across departments so that reporting formats and other requirements, including dates for reporting.

3. The Australasian Therapeutic Communities Association

The Australasian Therapeutic Communities Association (ATCA) is the peak-body representing Therapeutic Communities across Australia and New Zealand. Therapeutic Communities (TCs) provide an evidence-based approach to alcohol and other drug treatment which is based on the use of the community as the prime vehicle for change. As such, TCs have a strong emphasis on both self-help and mutual help within a rehabilitation setting, supported by a range of psychosocial interventions.

The ATCA currently includes thirty-three members, which represent a total of 60 TCs operating across Australasia. These services employ more than 800 staff and treat over 5,000 people annually as well as providing additional critical services such as detoxification units, family support programs, child care facilities, exit housing and outreach services. As such, therapeutic communities work at all points of the treatment spectrum, from primary prevention and early intervention, to treatment and aftercare.

Our member agencies vary in size from 10 to 100 beds. Residential program length also varies from several months to one and a half years, with most providing programs of between six and 12 months duration. Length of treatment is divided into stages, and typically includes an intensive residential treatment component followed by a transitional stage as clients move back into the community. TCs also vary in program structure and content, drawing on a wide range of approaches including 12 Step recovery models, systems theory, psychodynamic theory, cognitive behaviour therapy and social learning theory. A wide range of programs, both residential and non-residential, provide treatment options to suit individual needs.

4. Therapeutic communities (TCs) and substance use

The age of residents in therapeutic communities range from 15 to >50 years, although the majority of residents fall into the 18 to 30 age group. Reports from therapeutic communities in Australasia (Magor-Blatch & Pitts, 2009) indicate the majority of clients present with alcohol as the primary drug of concern, and Amphetamine-type Stimulant (ATS) use and cannabis as the secondary drugs of concern, and the primary illicit drugs of concern (Magor-Blatch & Pitts, 2009). This represents an important shift in therapeutic community treatment, since TCs were initially established during a period of significant opiate use and therefore have been seen primarily as treatment agencies working with illicit drug users.

TCs have been found to work with a significantly more chaotic and complex group of clients than other treatment modalities. Good outcomes from TC treatment are strongly related to treatment duration, which are most likely a result of benefits derived from the underlying treatment process. Clients who complete at least 90 days of treatment in a TC have significantly better outcomes on average than those who stay for shorter periods (NIDA, 2002). For individuals with many serious problems (e.g., polydrug use, co-occurring disorders, criminal involvement, mental health disorders, and low employment), research again suggests that outcomes are better for those who receive TC treatment for 90 days or more (Simpson, Joe & Brown, 1997).

TCs primarily work with individuals who have been unable to respond to outpatient services and who may be seeking abstinence within a harm minimisation context, rather than substitution as their primary goal. The TC does not generally represent the person's first treatment attempt. It is important to understand that all treatment modalities play a role in the overall treatment landscape and that 'one size does not fit all' when it comes to treatment for substance use.

Often people will have tried a number of approaches before seeking the relative restriction, but also the sense of security which a residential setting can provide. They may have used less intense approaches in the past and/or tried pharmacotherapy treatments. TCs tend to treat those with entrenched and more self-destructive dependence patterns and for whom the prognosis of recovery by less intensive methods is not good.

Results from a recent Australian study (The Methamphetamine Treatment Evaluation Study, MATES) (Cogger, McKetin, Ross, & Najman, 2008), involving 100 participants recruited from 15 Government and non-government services in Brisbane and the Gold Coast, supports the data collected by therapeutic communities, that TCs generally work with a group of people with longer drug using histories, more social disadvantage and more complex behaviours than other community-based AOD services (Magor-Blatch & Pitts, 2009).

Participants in the MATES research were drawn from three treatment modalities: 1) Withdrawal management (inpatient and outpatient) (n=29), 2) Residential rehabilitation (n=55), the majority of which were therapeutic communities, and 3) counselling (n=16). For all study participants, methamphetamine was the primary or secondary drug of concern; and there had been no inpatient meth/amphetamine treatment in the month prior to baseline questioning. All participants were interviewed on entry (at baseline), and at three and 12-months post-entry (Cogger, et al., 2008).

Results showed that participants from the TC sample were more likely to be using methamphetamine on five or more occasions per week than any other participants in the study. TC participants were also more likely to have exhibited clinically significant symptoms of psychosis in the month prior to treatment, and a significantly greater number of TC participants had met the DSM-IV criteria for panic disorder (Total sample= 31%, compared to Others = 14 % and the TC sample = 40%, $p<0.05$ cf. other treatment agencies) (personal communication/unpublished data) (Magor-Blatch & Pitts, 2009).

5. Cost effectiveness of therapeutic community treatment

For many, the TC is an alternative to lengthy imprisonment and as such the TC can be seen as a cost-effective option to prison. TCs offer the possibility for complete lifestyle change, and treatment frequently leads to the individual becoming a contributing member of society.

TC treatment costs need to be examined in the context of alternative treatment costs – including: hospitalisation, imprisonment, the cost to the community of the substance-user remaining in the community, the cost of police intervention, and the one-off cost of successful treatment versus on-going costs of maintenance approaches, as well as long term recidivism.

Almost all TCs are non-government agencies and are in part reliant on non-government funding. Any cost/benefit analysis should recognise that TCs are one of the few areas of drug and alcohol treatment where, to a degree, the 'user pays' principle has been implemented. Clients contribute to the financial cost of treatment in addition to their labour. This reduces costs as well as providing job skills training and increasing the therapeutic value of the treatment program.

Therapeutic Communities are diverse in terms of the range of programs offered; this is appropriate as each agency aims to be responsive to the particular needs of its client group. In general, programs aim to have enough structure to ensure a degree of order, security and clarity, while allowing room for residents to fail, make mistakes and learn from experience.

6. Drug-related harm

Australia's National Drug Strategy 2004–2009 is in its final year of implementation. The Strategy has been evaluated by independent experts under the auspices of the Ministerial Council on Drug Strategy (MCDS). The evaluation found that the Strategy and its three pillars of supply, demand and harm reduction are fundamentally sound and have been vital to the success of the Strategy in reducing the prevalence of, and harms from, drug use in Australia over a long period.

Nonetheless, significant harms from drug use continue to occur in Australia and new trends are emerging. What constitutes harmful substance use has been the subject of much debate. A traditional view has been that drug-related harm is mostly related to drug dependence. While those who are dependent on

substances generally experience a wide range of harms, it is now recognised that a wider perspective needs to be taken, and harm can be associated with a single episode of use or intoxication.

An even more narrow view is that harm is associated mostly with illicit substances. This is certainly not the case (Rickwood, Magor-Blatch, Mattick, Gruenert, et al., 2008). Likewise, the contexts within which alcohol and other drugs are consumed is often under-estimated and can confer greater risk for some; for example, public space and under-age on-premises consumption.

While the overall population use of most drugs has declined over the last decade or remained stable at low levels in recent years, there is some evidence to suggest that people who are using alcohol and other drugs are experiencing greater harms. Over the last decade more than 800,000 Australians aged 15 years and older were hospitalised for alcohol-attributable injury and disease (Pascal, Chikritzhs & Jones, 2009). Prescription and over the counter drugs are frequently associated with harmful use, and the use of performance enhancing drugs in sport is a growing issue. Overall, the harm associated with licit substances is considerably greater than that associated with illicit drugs.

Of the total social cost of drug abuse in 2004/05 of $55.2 billion, alcohol accounted for $15.3 billion (27.3 per cent of the unadjusted total), tobacco for $31.5 billion (56.2 per cent), and illicit drugs $8.2 billion (14.6 per cent). Alcohol and illicit drugs acting together accounted for another $1.1 billion (1.9 per cent) (Collins & Lapsley, 2008).

Harmful substance use is associated with problems beyond those experienced by the individual and poses considerable harm to the wider Australian community. For example, it is estimated that for every one person who drinks alcohol in large and/or frequent quantities, at least four other people are negatively affected (Rumbold & Hamilton, 1998). Harmful substance use can have a major impact on families through neglect, violence, separation, and financial and legal problems (Dietze, Laslatt, & Rumbold, 2004). It can affect work colleagues through absenteeism, loss of productivity, and work accidents, and the wider community through accidents and crime (Australian Bureau of Criminal Intelligence, 1998). Depending on the definitions used, up to 70% of crime is related to substance use (House of Representatives, 2003).

As substance use is such an entrenched part of western culture, it is essential to minimise its harmfulness. In Australia and across the western world, control of substance use has been attempted, historically, through laws regarding the legality or illegality of certain substances. Generally, this has been politically/ socially/ culturally/economically driven, and has had little to do with the level of use or possible harms that the substances themselves might cause (Lang, 2004).

Such prohibitionist approaches have been shown to have little long-term impact on the prevalence of substance use, and even less impact on the amount of harm associated with it. While effective prohibitions have resulted in temporary decreases in the use of targeted substances, their small gains have not been long-lasting and other consequences of prohibition have negated their impact (Lang, 2004). Consequently, little reduction in level of usage overall is achieved and other harms are introduced, including increased criminality of substance use and a lesser emphasis on the health-related harms.

Recommendation 1: Comprehensive, multi-faceted prevention and treatment approaches should be adopted that acknowledge the complexity of human behaviour in relation to substance use and address the associated risk and protective factors.

7. Cross-sectoral approaches

The ATCA strongly encourages and applauds action of governments in the coordination of efforts across governments and sectors to seek more comprehensive and effective solutions. Whole of government responses are particularly suitable for complex and longstanding policy issues as they focus on coordination and integration across different sectors. This is particularly important for tobacco, alcohol and other drug issues given their wide ranging impacts across law enforcement, health, licensing, local government, transport and other sectors. To this end, it is important to develop and maintain partnerships and linkages among law enforcement, health, education, community services, welfare, housing sectors, local governments, non-government organisations and academia to assist in ensuring a person-centred approach.

The ATCA is in a unique position to work with Government to encourage and support this process. Therapeutic communities in Australia are providing a range of services from primary prevention and early intervention to tertiary level treatment. Clients in our services include young people and adults, many of whom have the care and responsibility for children.

It is estimated there are 60,000 children in Australia with a parent in alcohol and other drug (AOD) treatment (Gruenert, Ratnam & Tsantefski, 2004). For children whose parents are not yet undertaking a treatment program, it is estimated that 13.2% or 231,705 children of 12 years and under are at risk of exposure to binge drinking in the household by at least one adult. Another 2.3% or 40,372 live in a household with at least one daily cannabis user, and 0.8%, or 14,042 live with an adult who uses methamphetamine on at least a monthly basis, and reports doing so in the home (Dawe, Atkinson, Frye, Evans, et al., 2007). Parental drug use can harm children from conception through to adulthood, with these children at greater risk of:

- Miscarriage, birth defects, withdrawal, delays & SIDS;
- Neglect and abuse (AOD in >50% child protection cases);
- Developing their own AOD problems; and
- Developing other psychological and behavioural problems (Gruenert, et al., 2004).

An increasing number of children are today affected by parental drug use and this has become a social problem requiring action on a number of levels. Increasingly, this is seen as “one of the most serious issues confronting the child welfare sector over the past 20 years” (Child and Family Welfare Association of Australia, 2002:9). Parental drug use, domestic violence and mental health issues are increasingly reported as contributing factors in the rise of notifications to child protection authorities (Families Australia, 2003; Patton, 2005; Saunders & Goddard, 1998).

The coexistence of these factors with other interpersonal and social difficulties also increases risk (Kroll & Taylor, 2003; Patton, 2005). There is, additionally, a significantly increased risk of violence in families where problematic substance use is present. This is clearly reflected in studies (Valleman, Bennett, Miller, Orford & Tod, 1993; Valleman & Orford, 1999). Additionally, for women accessing treatment services, domestic violence and mental health concerns are often combined as factors underlying substance use (Magor-Blatch, 2007).

Substance using parents may have a range of problems to manage. Behaviour may be characterised by inconsistency, irritability, lack of energy and impaired judgement. The result of this, together with the social context in which the family finds itself, and absence of family or friendship support systems, may set up a dynamic between parent and child which can result in increased risks of maltreatment (Barnard, 2005; Kroll & Taylor, 2003). These are the possible negative effects of parenting as an alcohol or drug dependent person (Magor-Blatch, 2007).

Parenting is often compromised by a lack of resources, stress, lack of respite or support, violence, poor mental health and poor modelling. While studies show that many of the chemical effects of drug use during pregnancy disappear in the early years of the child's life, at this point the family environment and parenting become more critical to outcomes (Barnard, 2003; Gruenert, et al., 2004). The diversity in parenting practices amongst drug using parents is marked particularly by low levels of confidence and high levels of guilt (Magor-Blatch, 2007).

Although many substance using parents are capable of providing adequate care in general, this can be punctuated by bursts of substance use which undermine the quality of care provided, leading to risky situations. Abandonment and neglect as a result of parental death from overdose, parental drug use or periods of absence due to imprisonment, have also combined to place additional stress on families and the child protection system (Drug Policy Expert Committee, 2000; Patton, 2005).

8. Effects on children of parental substance abuse

No less complex than the problems of substance abusing parents, are their children's needs. A large research literature exists from epidemiological, family, adoption and twin studies concerning the genetic and environmental risks that put these children at higher risk for a variety of problems (Kumpfer, 1999; Tarter & Messich, 1997). Whether because of in-utero exposure to stressors including tobacco, alcohol, or other drugs, or to genetic and environmental family risks, children of substance abusers are more frequently described by their parents as being hyperactive and as having difficult temperaments (Magor-Blatch, 2007).

McMahon and Luthar (1998) report in a review of developmental issues relating to children of substance abusers, that these children: (1) have poorer developmental outcomes (physical, intellectual, social and emotional) than other children, although generally in the low-normal range rather than severely impaired; and (2) are at risk of substance abuse themselves (Magor-Blatch, 2007).

There is mounting evidence of elevated risk for the development of substance use disorders at young ages as a result of familial and genetic factors. Merikangas and colleagues (1998) report an eight-fold increased risk of drug using disorders among relatives of 299 individuals with drug disorders. These findings were reinforced in a second generation study of the children of these drug dependent research subjects (Merikangas, et al., 1998). The strongest link was found between substance disorders in offspring (mean age 12 years) with parental substance abuse, although the link for psychopathology, particularly anxiety disorders, was similar. Risks of this magnitude place a family history of drug disorder as one of the most potent risk factors for the development of the child's development of drug disorders at an early age (Magor-Blatch, 2007).

Recommendation 2: Substance prevention and intervention programs should target offspring of parents with substance use disorders. Children of alcohol and drug dependent parents are at the highest risk of any children for later drug use and other adolescent behavioral health and mental health problems. Research suggests that some children of substance abusers, like other children of dysfunctional parents, can develop special resilience skills with appropriate adult support.

Therapeutic communities provide treatment for the whole family, with many including parents and children within the treatment program. Programs are supported by a multidisciplinary team, including Child and Family Psychologists and Family Support Workers. Targeted interventions, including play therapies, are included in programs.

It is our observation that substance-using parents show a genuine desire to change behaviours and to provide better opportunities for their children. Mostly, parents want to change, they want to become

more effective parents, to stop the cycle of drug abuse and to provide a better life for their children (Magor-Blatch, 2007).

However, parents need the support of agencies working together in an integrated manner to achieve this. This is one of the greatest challenges confronting the welfare system, particularly as many traditional boundaries exist between services. Alcohol and other drug services may be perceived as supporting the parent to maintain a parenting role with a child, who child protection services believe needs to be taken into care for their own protection. Child protection agencies may be perceived by drug using parents as punishing and adversarial, rather than genuinely assisting the family (Magor-Blatch, 2007).

However, concerns about children in these circumstances are well supported. Research indicates these children have often lived within a disruptive and dysfunctional family environment. They may have been the victims of abuse within or outside the family, and parental skills, family life and general child-rearing practices, such as discipline, boundary setting, consistency of care and reliability, may therefore be adversely affected (Gruenert, et al., 2004; Luthar, Merikangas & Rounsaville, 1993). However, while the needs of these vulnerable children must be considered of primary importance, the division between the rights of children and their parents is often indistinct (Effective Interventions Unit, 2002; Patton, 2005).

In most cases, the best way to support the child is to work with the parents. All children need opportunities to be "normal" - to play and to receive appropriate supervision, guidance, praise, predictable routines, meeting of material needs, stimulation, school routine, and support from family and friends. Older or traumatised children may also need their own support and counselling (Brook, Whiteman, Gordon & Brook, 1989; Gruenert, et al., 2004).

It is therefore important to consider treatment for substance use in the context of family treatment. Family support groups and the development of programs which build on alliances with family members need to be integrated into treatment from first contact (Westreich, Heitner, Cooper, Galanter, & Guedj, 1997). Therapeutic communities employ a number of interventions in working with parents and children, including family therapy, extending this to the wider family unit outside the program; cognitive behavioural therapy (CBT) and Solution-focused Therapy; parenting programs; individual and group counselling; work and education programs.

Recommendation 3: Drug treatment services should consider the needs of the whole family, rather than just the identified substance user. This is particularly important where children are concerned. Providing opportunities for primary prevention and early intervention, and working with the whole family to address intergenerational issues of substance use will provide the best opportunities for vulnerable at-risk children.

The therapeutic community model provides evidence-based treatment for working with families, and particularly with vulnerable at-risk children.

Recommendation 4: Substance-using parents and their children need the support of all agencies across sectors and governments to work together to address the considerable and complex issues related to substance use. A coordinated cross-sectoral approach which includes health, justice departments, welfare, housing, education and child and family services should be established and maintained to provide the best opportunities for successful outcomes in working with families.

Recommendation 5: The National Drug Strategy should establish links with the Australasian Therapeutic Communities Association (ATCA) as the peak body working with more than 5,000 people annually to provide a range of evidence-based residential and support services for substance-using young people, adults and their children.

Therapeutic communities work with the most treatment-resistant and complex individuals who present with entrenched drug using histories and co-occurring disorders. One way of accessing this advice is through ATCA membership as a treatment and rehabilitation expert on the National Expert Advisory Committee (NEAP) to provide advice and assist with implementing and progressing national priorities.

9. Indigenous Australians

Drug and alcohol misuse amongst Aboriginal and Torres Strait Islander people has had a devastating impact on the individual, their family and the community, with the incidences of violence, crime and ill health often becoming more serious as a result of alcohol and drug misuse. The combined use of drugs and alcohol and the breakdown of healthy relationships with family, friends and the community that it can cause, are of major concern to the community and therefore require a community response.

The Australian Institute of Health and Welfare (2007) *Statistics on drug use in Australia 2006* shows that in 2004–05, 16% of Aboriginal and Torres Strait Islander peoples drank at risky and high-risk levels in the last week prior to survey. Only twenty-four percent had not consumed alcohol in the past 12 months. Approximately half (52%) of Aboriginal and Torres Strait Islander peoples reported that they were current smokers, 23% had used marijuana/cannabis in the last 12 months and 28% had used an illicit substance in the last 12 months.

Cultural respect is the 'recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected' (Australian Health Ministers Advisory Council (AHMAC)). It incorporates the following principles endorsed by AHMAC and is consistent with the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, 2002* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2002:*

- An holistic approach to Aboriginal and Torres Strait Islander health;
- Health sector responsibility;
- Community control of Primary Health Care Services;
- Working together;
- Localised decision making;
- Promoting good health;
- Building the capacity of health services and communities; and
- Accountability for health outcomes.

Aboriginal people face interrelated physical, social, emotional, economic and environmental inequalities that contribute to, and exacerbate, AOD use. A range of wholistic approaches are required if any inroads are to be made in improving social and health outcomes for Aboriginal people. A whole-of-system approach across government and community organisations is imperative to ensure that program design and service delivery is effective and makes best use of available resources. This will require working across levels of government as well as with mainstream non-government agencies, Aboriginal organisations and individuals.

Aboriginal and Torres Strait Islander people experience higher rates of mental health disorders and social and emotional well-being problems than other Australians. They have reduced access to community based mental health care and other health care services, and particularly to care that is sensitive to their specific needs. Social and emotional well-being problems can result from grief; loss; trauma; abuse; violence;

substance misuse; physical health problems; child development problems; gender identity issues; child removals; incarceration; family breakdown; cultural dislocation; racism; and social disadvantage. Care is effective when multi-dimensional solutions are provided, which build on existing community strengths and capacity and include counselling and social support, and where necessary, provide support for family reunification.

Mental health problems may include crisis reactions, anxiety states, depression, post-traumatic stress, self harm, and psychosis. Treating mental ill health includes early intervention, treatment and monitoring, relapse prevention and access to specialist services, including rehabilitation and long term support. In order to effectively address the needs of Indigenous peoples, services need to be culturally appropriate and safe, and provide continuity of care across the life span.

Also of considerable concern, is the link between substance use and criminal offending. Indigenous offenders are more likely to be mandated through the criminal justice system to attend treatment than non-Indigenous offenders (71% compared with 31%) and often the more remote communities of Australia have limited access to counselling and other rehabilitation programs. Offenders in these communities may only have contact with police, the court and a community corrections officer or juvenile justice officer and/or community work order supervisor in relation to the matter for which they have come to court. In such circumstances, there has been a particular need to use court processes that support rehabilitation by promoting wellbeing. The development of therapeutic jurisprudence based projects sensitive to the needs of diverse communities in regional Western Australia have resulted from these concerns.

Being supported while in treatment through maintaining family contacts is an important component for people in their recovery process, especially within Aboriginal communities with strong kinship ties. Having personal contact with other Aboriginal people while in treatment and access to family by means of the telephone is also important. However, the main basis for involving family members is a recognition that substance abuse within a family and social system does not happen in isolation, and is a complicated mixture of social and interpersonal issues. This is not an excuse to blame the family, but to acknowledge that inevitably all members of the family and the community in which the person lives, become affected by the person's substance use. Therefore, it is important to include the family in the recovery process.

The family has often become the person's carer or the carer of the person's children. In many Aboriginal families, grandparents are raising grandchildren as whole generations have become affected by substance use. The family therefore needs support to understand and deal appropriately with the substance-using family member, and the whole family needs an opportunity to heal.

Extended families may have more understanding of their family member than anyone else. Their willingness to engage in the treatment process with their family member may help and strengthen the family and contribute to better treatment outcomes. Too often families try to work through issues in isolation – and this often leads to exhaustion, when families and friends may be tempted to give up. When they feel supported, they can become a vital force for positive change. With the increasing number of children living in families with substance use issues, it has become increasingly important to utilise the support the broader family and community can give.

However, it does need to be acknowledged that sometimes the family dynamics will make it extremely difficult for someone to recover, especially where there are generational issues of substance use and abuse. Family members may either intentionally or inadvertently maintain the person's substance use or make it difficult for them to change behaviours. In some cases, drugs and alcohol may be provided by a family member.

The Therapeutic Community Model provides an evidence based system of treatment that has a proven international research base. As a model, it has been utilised worldwide with Indigenous and non-indigenous communities since the 1950s and has been utilised within Australia since the early 1970s.

The Kimberley Custodial Plan: An Aboriginal Perspective - Stage two Report (2006) found the Therapeutic Community Model to be appropriate and "should inform the design and development" of services for Kimberley Aboriginal people.

Recommendation 6: Interventions for all Australians should be matched to the needs of the individual. Therefore, treatment interventions are seen as a four-tiered approach:

1. Level 1: At base level, prevention, education and self-help.
2. Level 2: Short-term outpatient service.
3. Level 3: Long-term outpatient service, day programs and semi-residential service.
4. Level 4: Residential service, short-medium term, 24 hr coverage – to work with more complex clients. Aftercare and outreach services post-treatment.

Treatment approaches for Indigenous Australians should be targeted at the level of need. For those requiring Level 3 and Level 4 interventions, the Therapeutic Community Model of treatment, with its emphasis on family and community, provides an opportunity for further consideration.

Recommendation 7: While the *National Drug Strategy* should continue to address the needs of Indigenous Australians, the ATCA believes it is important that the particular attention needs to be given to the continuing needs of Aboriginal and Torres Strait Islander communities through the *Aboriginal and Torres Strait Islander Complementary Action Plan.*

10. Workforce development

Workforce development, including the training and retention of staff within the Alcohol and other Drugs (AOD) sector is both important and imperative for the continuation of drug treatment and prevention services. The majority of service provision in the AOD sector is provided by non-government organisations (NGOs). However, people working within NGOs are poorly paid in comparison to their Government-employed counterparts, and do not typically receive the same range of benefits and opportunities.

The ATCA notes that over past decades non-government organisations have increasingly been involved or been asked to take the lead in the provision of services to support and treat people with substance use problems. Continuing to build the capacity of the NGO sector is therefore vital in further strengthening outcomes across the sector.

We also note and welcome the work that is progressing to strengthen the health service workforce through the implementation of the COAG Health Workforce Reform Package. It id hoped that as part of the Package, the establishment of a National Health Workforce Agency will provide more effective, streamlined and integrated clinical training arrangements and support workforce reform initiatives.

However, unless the employment inequities between the NGO and Government sectors are addressed, the NGOs will continue to lose trained and experienced staff to the Government sector, where they can receive a higher rate of pay and enhanced employment conditions.

The ATCA has recently released the *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009),* to ensure the integrity of the Therapeutic Community principle is maintained and continues to stand as a model of best practice in the treatment of substance misuse and co-occurring disorders.

The set of standards aim to:

- Identify and describe good TC practice which can be incorporated into a national quality framework
- Enable Therapeutic Communities to engage in service evaluation and quality improvement, using methods and values that reflect the TC philosophy
- Develop a common language which will facilitate effective relationships with all jurisdictions (national, state and territory)
- Provide a strong network of supportive relationships
- Promote best practice through shared learning and developing external links.

The *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009),* is also designed to support the workforce capacity within the AOD and co-occurring mental health sector and create an environment for sustaining the career paths of trained AOD workers within the NGO sector, including the valued practice of workers with 'lived' experience of the field. Therapeutic communities particularly value the experience of staff who are graduates of programs, and seek to incorporate learned knowledge and experience into their professional practice.

Recommendation 8: Over the next five years, attention needs to be focused on identifying, addressing and reducing the inequities in employment and workforce opportunities that exist between the NGO and the Government systems. In particular, the divide that exists in the remuneration provided to government staff in comparison with that of non-government staff, must be addressed and rectified. Additionally there is a need to look at the difference in the superannuation contribution and to consider the issue of transferability of other benefits, including long service leave entitlements.

To this end, it needs to be understood that the NGO sector will continue to lose valuable trained and experienced staff to the Government sector unless and until these inequities are addressed.

11. New technologies and online services

While the internet and new technologies provide a potential threat to the community through increased access to licit and illicit drug supplies, the potential for dissemination of information and messages on the harms from drugs, is enormous. Treatment is currently being delivered over the internet, with the potential to reach groups who would otherwise not have access. This includes people in remote and rural areas.

Many substance users are reluctant to attend traditional AOD services, and for many, their comparatively young ages and patterns of drug use make online options a real alternative to more traditional treatment (Magor-Blatch & Pitts, 2009). Computer-based therapy can be less confronting, and interactive interventions more engaging than face-to-face therapy for this difficult to engage group (Copeland & Martin, 2004).

There are different forms of computer-based therapy. These include posting a question, which is usually answered within a short space of time (e.g., two to four days). Examples of this include the Somazone site (Australian Drug Foundation: http://www.somazone.com.au). Other options include real-time chat services. This means that the client is able to make an appointment with a counsellor, and at the appointed time, both the client and the counsellor communicate at the same time, by typing. Chat software (like MSN) is used and counselling is between one client and one counsellor.

Kay-Lambkin (2008a) suggests that the benefits of motivational interviewing, contingency management and CBT strategies may be enhanced through the use of new technologies. Young people increasingly report the use of the internet to access education, support and health information, as well as for social interaction

(Australian Bureau of Statistics, 2005). While few controlled trials have examined the use of computerised treatments for mental health or AOD problems, Lynch and colleagues (2003) provide evidence to suggest that many drug users, and in particular, methamphetamine users, are supportive of accessing information via the internet.

Information provided by Drug Info Clearinghouse (Pennay & Lee, 2008) notes that unpublished data from an implementation trial of live online counselling in Australia shows that 700 people engaged in online counselling in the first eight months of operation. Of this number, approximately one-quarter were methamphetamine users. The majority were young (under 35 years of age) and chose to access the service anonymously (over 85%) outside of usual business hours.

Recommendation 9: That the use of the internet, and particularly online counselling and chat rooms, be further implemented as a valuable means of disseminating information and providing treatment support and interventions.

12. Increased vulnerability: addressing risk factors in substance use and relapse

Research has shown that the most effective treatment programs for substance dependency are those which include training in stress management and self-control, social and negotiation skills, job skills, and work habits. The most successful evaluated program for hospitalised, alcohol-dependent clients is the community reinforcement approach, which systematically trains clients in job and marital skills while arranging a work and home environment that sustains and rewards sobriety. This social and behavioural approach is more common in drug treatment, and particularly in therapeutic communities.

Employment appears frequently in the literature as an outcome criterion for substance users in treatment, and most clinicians subscribe to the belief that work plays an important role in recovery from dependency. Despite the importance attached to employment, many treatment modalities have not been shown to be effective in increasing client employment after treatment.

Many members of the ATCA are changing this through the introduction of accredited training programs for clients while they are undertaking rehabilitation within therapeutic community programs. Clients entering the TC are able to undertake training in accredited courses in a variety of training areas, including hospitality, business skills, hairdressing, building and horticulture.

Workskills and Job Training Programs assist in addressing one of the underlying causes of substance use and repeated relapse – lack of, or low, employment skills. This is part of a wholistic approach to drug treatment within TCs, which includes individual and group counselling, cognitive behavioural therapy, creative therapies, parenting skills, relapse prevention, stress management and relationship counselling.

TC residents are amongst the most marginalised, difficult and treatment resistant groups in the Australian AOD treatment community. TCs provide a unique model of treatment which includes education and life skills development as part of the rehabilitation process. When residents are ready to leave the TC these clients are job ready but have had few positive work experiences. This, combined with the stigma that goes with a history of addiction, means that these clients are usually considered unemployable.

The ATCA has provided Government with a proposal to establish Regional Job Creation Officers (through the Government's Jobs Fund) to work at a local and regional community level to assist in identifying the areas of skills development needed in the local and wider community, and to reflect these training opportunities within the TC.

Recommendation 10: Attention needs to be given to the underlying causes of substance use and repeated relapse – lack of, or low, employment skills. This should be addressed by providing funding to AOD services to:

- Develop and build links with employers to understand and meet the skills needs of the local labour market.
- Facilitate links between local councils, employers, Australian Apprenticeship Access Program, Australian Apprenticeship Centres, Group Training Providers and Registered Training organisations to secure employment opportunities, apprenticeships and traineeships for job seekers.
- Develop and build links with educational bodies to facilitate appropriate training programs for job seekers who are in the process of completing their period of treatment and rehabilitation.
- Negotiate employment pathways with local businesses, tradespeople, councils and community organisations.

Additionally, inclusion of access to the Commonwealth Rehabilitation Service for people with an addiction must also be addressed. At present addiction is a precluded condition. Access to CRS training and employment services would greatly enhance the chances of securing employment.

13. Performance Measures

Collecting data and evidence of treatment interventions and outcomes is considered important and desirable. However, it needs to be recognised that within the NGO sector, in particular, this comes at considerable cost to the organisation. The introduction and continued use of the *National Minimum Data Set* has provided a rich source of information and research data. However, for most NGOs this has meant diverting funding through staff time into data collection at the expense of treatment.

While it is important to develop and maintain high level, publicly reported performance measures under the National Drug Strategy to help improve transparency and accountability against the Strategy's objectives, adequate resourcing must be provided to services to enable them to undertake this task.
It is also important, given the considerable burden of reporting experienced by the sector, that performance measures and reporting requirements be developed across Government departments and agencies to ensure minimum duplication. This includes giving consideration to the ways in which reporting requirements can be coordinated across departments.

Recommendation 11: That attention be given to the resourcing needs of the AOD sector, and in particular the NGOs, to provide information and data against required performance measures.

Performance measures and reporting requirements should be developed across Government departments and agencies to ensure minimum duplication. This includes giving consideration to the ways in which reporting requirements can be coordinated across departments so that reporting formats and other requirements, including dates for reporting.

14. Conclusion

The ATCA applauds and supports the Australian Government's commitment to the continuation of the National Drug Strategy.

Continued and increased emphasis needs to be given to early intervention and treatment strategies, recognizing that whilst reduction of supply is an important strategy, funding must also be provided and increased to address the treatment needs of the community. As some people move out of addiction, others are recruited in. The need to maintain a focus on harm reduction strategies, which includes facilitating access to treatment, continues to be a high priority.

With the release of the *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package (2009),* the ATCA is well placed as a major provider of treatment services across the spectrum, from early intervention to treatment and aftercare, to contribute to this process and to work with Government and treatment services to ensure quality services are established and maintained.

The release of the *Standards and Support Package* has also been welcomed by the IGCD, particularly as a number of accreditation agencies are considering dropping the Alcohol, Tobacco and other Drugs (ATODS) modules from their standards packages. The ATCA is currently seeing increased interest in the use of the therapeutic community model, as residential services across Australasia embrace the concept and address issues of quality assurance within their programs. Additionally, many of our members are in the process of establishing new TCs as governments provide funding and release tenders for the establishment of new therapeutic communities.

Our member agencies are currently working with State and Territory governments to provide new services to Aboriginal and Torres Strait Islander peoples, to those who have co-occurring mental health and substance use disorders and to offenders within prison settings. This has meant that the 33 members of the ATCA are now operating 60 therapeutic communities, which constitutes a 46.5% growth in service delivery over the past three years.

The ATCA, as the peak body, is therefore ideally placed to broker change and to work with Government to ensure quality services are established and maintained.

The ATCA looks forward to a continued and developing relationship with the Australian Government to address this task.

References

Australian Bureau of Statistics (ABS). (2005). *Communications and information technology: use of information technology.* Publication No.1301.0. Canberra, Australia: Commonwealth of Australia

Australian Institute of Health and Welfare. (2002) 2001 National Drug Strategy Household Survey: State and Territory Supplement. Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare (AIHW). (2006). Alcohol and other drug treatment services in Australia 2004-05: Report on the National Minimum Data Set. *Drug Treatment Series No. 5.* AIHW cat. no. HSE 43. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW). (2007a). *2004 National Drug Strategy Household Survey: First Results.* Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW). (2007b). *Statistics on Drug use in Australia.* Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW). (2008). *2007 National Drug Strategy Household Survey: First Results.* Canberra: AIHW.

Australasian Therapeutic Communities Association (ATCA) (2009). *Australasian Alcohol and other Drug Therapeutic Communities Standards and Support Package.* ATCA, Melbourne.

Barnard, M. (2005). *Drugs in the Family: The impact on parents and siblings.* Joseph Rowntree Foundation, University of Glasgow.

Barnard, M.A., & McKeganey, N.P., (2004) The impact of parental problem drug use on children: what is the problem and what is being done to help? *Addiction 99,*552-559.

Brook, J., Whiteman, M., Gordon, A. & Brook, D.W. (1989). The role of older brothers in younger brothers' drug use viewed in the context of parent and peer influences. *The Journal of Genetic Psychology, 151*(1). 59-75.

Chikritzhs, T., Pascal, R. & Jones, P. (2004). Under-aged drinking among 14-17 year olds and related harms in Australia. National Alcohol Indicators, Bulletin No.7. Perth: National Drug Research Institute.

Child and Family Welfare Association of Australia. (2002). *A Time to Invest: in Australia's most disadvantaged children, young people, and their families.* The Child and Family Welfare Association of Australia, New South Wales.

Cogger, S., McKetin, R., Ross, J., & Najman, J. (2008). Methamphetamine Treatment Evaluation Study (MATES): Findings from the Brisbane Site. *Technical Report No. 295*, ISBN: 978-0-7334-2658-2. NDARC.

Collins, D.J and Lapsley, H.M. (2008) *The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004/05.*

Copeland, J. & Martin, G. (2004). Web-based interventions for substance use disorders: a qualitative review. *Journal of Substance Abuse Treatment; 26*(2):109-16.

Dawe, S., Atkinson, J., Frye, S., Evans, C., Best, D., Lynch, M., Moss, D., & Harnett, P. (2007). *Drug Use in the Family: Impacts and implications for children.* Australian National Council on Drugs.

Dietze, P., Laslatt, A., & Rumbold, G. (2004). The epidemiology of Australian drug use. In M. Hamilton, T. King & A. Ritter (Eds.), *Drug use in Australia: Preventing harm* (2nd Ed.) Melbourne: Oxford University Press, 1-16.

Drug Policy Expert Committee (2000), *Drugs: Responding to the Issues: Engaging the Community,* Victorian Government, Melbourne.

EIU (Effective Interventions Unit) (2002). *Supporting Families and Carers of Drug Users: A Review.* Edinburgh: Effective Interventions Unit, Scottish Executive.

Families Australia (2003). *Our Children, our concern, our responsibility,* Families Australia, ACT.

Gruenert S., Ratnam, S. & Tsantefski, M. (2004). *The Nobody's Clients Project.* Odyssey Institute of Studies, Odyssey House Victoria.

Kroll, B., & Taylor, A., (2003). *Parental substance abuse and child welfare.* London, Jessica Kingsley

Kay-Lambkin, F. (2008a). Technology and innovation in the psychosocial treatment of methamphetamine use, risk and dependence. *Drug and Alcohol review, 27*(3), 318-325.

Kumpfer, K.L. (1999). Selective prevention interventions: The Strengthening Families Program. In R. Ashery, E. Robertson & K.L. Kumpfer (Eds.) *Drug Abuse Prevention Through Family Interventions* Rockville, MD: National Institute on Drug Abuse.

Kumpfer, K.L., Walker, R., & Richardson (in press). Resilience in children of alcoholics. *Journal of Substance Use and Abuse*.

Lang, E. (2004). Drugs in society: A social history. In M. Hamilton, T. King & A. Ritter (Eds.), *Drug use in Australia: Preventing harm* (2nd Ed.) Melbourne: Oxford University Press, 1-16.

Luthar, S., Merikangas, K. & Rounsaville, B. (1993). Parental psychopathology and disorders in offspring – a study of relatives of drug users. *The Journal of Nervous and Mental Disease, 181*(6). 351-357.

Lynch, M., Kemp, R., Krenske, L., Conroy, A., & Webster, J. (2003). *Patterns of methamphetamine use: initial findings from the amphetamines in Queensland research project.* Brisbane, Queensland: Crime and Misconduct Commission, Queensland Government.

McMahon, T., & Luthar, S. (1998). Bridging the gap for children as their parents enter substance abuse treatment. In R. Hampton, V. Senatore & T. Gullotta (Eds.), *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives*. Thousand Oaks, CA: Sage.

Magor-Blatch, L.E. (2007). Families and Substance Use: Building a Resource for Recovery, *Communities, Children and Families Australia,* Volume 3, Number 1, 34-44.

Magor-Blatch, L.E. & Pitts, J.A. (2009). *Amphetamine-type Stimulant Use Treatment Protocol: An Intervention developed for the use of staff and clinicians with ATS clients of Therapeutic Communities.* Odyssey House McGrath Foundation.

Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M., Fenton, B., Zhang, H., O'Malley, S., & Rounsaville, B.J., (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, 55:973-979.

National Health and Medical Research Council (NHMRC) 2007, *Australian alcohol guidelines for low-risk drinking: draft for public consultation.*

Pascal, R., Chikritzhs, T., & Jones, P. (2009). *Trends in estimated alcohol-attributable deaths and hospitalisations in Australia, 1996-2005*. National Alcohol Indicators, Bulletin No.12. Perth: National Drug Research Institute, Curtin University of Technology.

Patton, N. (2005). *Towards and Understanding of Parental Drug Use and its Effects on Children's Welfare,* Masters Thesis, Department of Social Work, Monash University.

Pennay, A. & Lee, N. (2008). *Prevention and early intervention of methamphetamine-related harm.* Issues Paper. Number 6. Drug Info Clearinghouse.

Rickwood, D., Magor-Blatch, L., Mattick, R., Gruenert, S., Zavrou, N., & Akers, A. (2008). *Substance use: A Position Statement prepared for The Australian Psychological Society.*

Rumbold, G., & Hamilton, M. (19980. Addressing drug problems: The case for harm minimisation. In M. Hamilton, A. Kellehear, & G. Rumbold (Eds.), *Drug use in Australia: A harm minimisation approach* Melbourne: Oxford University Press.

Saunders, B.J. & Goddard, C.R. (1998). *A Critique of Structured Risk Assessment Procedures: Instruments of Abuse?* Child Abuse and Family Violence Research Unit, Monash University, Melbourne.

Tarter, R., Blackson, T., Martin, C., Loeber, R., & Moss, H. (1993). Characteristics and correlates of child discipline practices in substance abuse and normal families. *American Journal on Addictions*, 2(1):18-25.

Valleman, R., Bennett, G., Miller, T., Orford, J. & Tod, A. (1993). The families of problem drug users: a study of 50 close relatives. *Addiction, 88*(9). 1281-1289.

Valleman, R. & Orford, J. (1999). *Risk and Resilience: Adults who were the children of problem drinkers.* Reading: Harwood.

Victorian Alcohol and Drug Association (VAADA) (2002). *The Victorian Alcohol and Drug Sector's Perspective on Alcohol Excise and Taxation: A submission to the Senate Economic Legislation Committee*

Westreich, L., Heitner, C., Cooper, M., Galanter, M. & Guedj, P. (1997). Perceived Social Support and Treatment Retention on an Inpatient Addiction Treatment Unit. *The American Journal of Addictions, 6*(2). 144-149.