Protecting Victoria's Vulnerable Children Inquiry

April 2011

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well-being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

The Victorian Alcohol and Drug Association

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA's purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

VAADA's consultation process

As the peak body on alcohol and other drug issues in Victoria, VAADA has undertaken consultation with the Victorian AOD sector on to determine their views on issues raised in this inquiry. We have also referred to previous surveys undertaken by VAADA's Sector Development Project in 2010.

VAADA wishes to acknowledge that this submission is based on a diverse range of opinions from across our membership. We extend our thanks to those VAADA members, as well as to the VAADA Board, who have generously given of their time and professional insight during its development.

While some comments may not reflect the individual opinions of all those who have provided input, there is powerful consensus on the key issues and priorities outlined in VAADA's submission. Any differences in opinion among the Victorian AOD sector have been represented to the greatest extent possible. However, the final analysis in this submission represents the views of VAADA.

Summary of Recommendations

VAADA makes the following recommendations:

1. That new screening tools be developed to enable comprehensive assessment of a client's family.

2. That training be provided to the AOD treatment sector workforce to enable them to undertake family inclusive practice.

3. That funding be provided for the development, piloting and roll out of family inclusive practice to address current service limitations in the area.

4. That AOD agencies that participate in family inclusive practice be provided with appropriate resources to make modifications to their office space to facilitate the attendance of families and children.

5. That the data collection system (ADIS) be revised and updated with more efficient and expedient data inputting processes, so that it has capacity to record further information on the family structure of presenting clients to enable family inclusive practice without an increase in the administrative burden on AOD workers.

6. The development of screening and assessment tools to ensure that relevant information on the client's family is captured and that appropriate resources are provided to account for the burden of administering these tools.

7. That a protocol or set of protocols be developed between the AOD sector and Child Protection outlining strategies and necessary processes to successfully roll out family inclusive practice throughout the AOD sector and integrate this with Child Protection and other relevant sectors.

8. That the Victorian Government undertake strategic planning and consultation with Child Protection and the AOD sector with a view to the development of integrated collaborative services. Such services should be evidence informed and be piloted and evaluated prior to full implementation.

9. That AOD agencies be properly resourced to be able to fund staff to undertake appropriate training, networking exercises and evidenced informed models of service delivery.

10. That Court staff including the judiciary receive training in AOD issues so they can make more informed decisions in relation to clients with children.

11. That training be provided to AOD staff in the areas of Court process and Child Protection, as well as in areas relevant to family inclusive practice such as contending with the complexities of working with clients, their children and addressing the underlying AOD issues.

12. That the Victorian Government consult with the AOD sector in developing policies outlining processes of collaboration between Child Protection, the Courts and the AOD sector.

13. That the Victorian Government consult widely with the AOD treatment sector and consumers in the development of policies relating to child protection and ensure that any new policies are supported by the delivery of appropriate capacity building, workforce development and a commensurate increase in resources.

14. That the AOD treatment sector be consulted regarding further involvement in the child protection system, with a view to clarifying its role, developing protocols and outlining the resource implications, and development of enhanced program activity.

Introduction

VAADA welcomes the opportunity to contribute to the 'Protecting Victoria's Vulnerable Children Inquiry' (the Inquiry). This inquiry is highly relevant to our sector, as both Child Protection and the Victorian Alcohol and Other Drug (AOD) treatment sector have significant relationships with their client bases. The AOD sector has a great opportunity to make a significant contribution to the prevention of child abuse and neglect, and in early intervention within vulnerable families and ease the burden on the child protection system.

The decisions and practices of Child Protection can have a significant impact upon the wellbeing of our clients and we therefore submit that primacy should be given to the development of an integrated service approach which enables a clear means of communication between both sectors and supports a collaborative approach where the wisdom from both sectors can be shared in a manner which minimises the harm and risk for all parties involved. There are a number of implications and resourcing issues which need to be addressed to develop an integrated model of service delivery which are canvassed in this submission.

The AOD treatment sector is supportive of the notion of 'the best interests of the child' and that this should supersede all other considerations. We do, however, believe that this can be interpreted differently depending on one's experience and expectations. Further, the treatment approaches supported by the current funding model focus on delivering treatment to individuals, which can impact upon the capacity of the AOD sector to prioritise the best interests of the child. This submission supports the necessary system and resourcing changes to better reflect an environment whereby family inclusive practice is realised and the 'best interests' principle can be better upheld.

Although there is limited data on causality regarding substance use and child abuse, key research indicates that 31 per cent of parents involved in child abuse had experienced issues with alcohol (ANCD: 2006:4). This scenario becomes significantly more complex when viewed within the context of long term abuse, whereby 70 per cent of those parents who had had issues with alcohol and been involved in child abuse were themselves victims of family violence (ANCD 2006:4). Thus, it is highly relevant for VAADA to provide input into this inquiry.

We will be responding to three of the eight Terms of Reference (TOR) listed in the Inquiry. These are:

- Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services, This should include consideration of ways to strengthen the capability of those organisations involved;
- The interaction of departments and agencies, the courts and service providers and how they can better work together to support at-risk families and children; and

- The appropriate roles and responsibilities of government and non-government organisations in relation to Victoria's child protection policy and systems.

TOR 1: Strategies to enhance early identification of, and intervention targeted at, children and families at risk including the role of adult, universal and primary services. This should include consideration of ways to strengthen the capability of those organisations involved.

Family Inclusive Practice

VAADA is of the view that there is a need to increase the capacity of the AOD treatment sector to provide more family inclusive practices for their clients. Key evidence supports this approach (see Martin, Lewis, Josiah-Martin and Sinnott 2010, Bamberg, Toumbourou and Marks 2008, French, Zavala, McCollister, Waldron, Turner and Ozechowski 2008, Copello, Templeton and Velleman 2006 and McComish, Greenberg, Ager, Essenmacher, Orgain, Bacik 2003), with models of service delivery that aim to address the needs of individuals, their family members and specifically their dependent requiring increased attention to ensure they are family sensitive. Within the context of this treatment type, the definition of family can be quite broad, including siblings, grandparents and friends as well as immediate family members.

Family inclusive practice is relevant to this Inquiry as it requires the clinician to be aware of the presence and role of family in a client's life and strengthen referral pathways as appropriate (Turning Point 2004:3, 9). It involves working not only to address the needs of the client, but also their families.

Family inclusive practice enables the clinician to take a wider view of the challenges evident with the presenting client, and to view these challenges within the context of the family structure. It provides opportunities for collaborative practice with other sectors, facilitating the development of communication and referral pathways to enable the best result for the client and family. Building the capacity of the AOD treatment sector to more fully participate in this space will increase the likelihood of identifying and subsequently responding to AOD related harm within the family and ensuring that the response is measured and appropriate. It will also provide an additional resource to Child Protection workers and demonstrate how the specialist AOD service system can assist through expert advice and input.

A further benefit of this practice is its preventative capacity. AOD clinicians will be able to not only assist the their clients with AOD issues, but also take proactive preventative action, in collaboration with other professionals if necessary, to protect the family and mitigate harms which may have been engendered by AOD use within the family milieu. This speaks to the relationship between AOD dependence and a history of victimisation of family violence (which was noted above), with the potential to prevent the inherited adverse family practices consistent with child abuse or neglect.

Although the AOD treatment sector is keen to be able to meaningfully participate there are currently a number of barriers which impact upon sector capacity. A consultation held with the sector to help inform this submission identified the following issues:

- Current structure of AOD treatment services;
- Reporting and recording data screening and assessment; and
- Lack of protocols and formal instruments promoting integrated and family inclusive practice.

VAADA believes that the government must take the lead role in developing a culture of integrated family inclusive practice within the AOD sector and must ensure that the necessary processes and considerations for implementation are rolled out equitably throughout the state.

Current structure of AOD treatment services

The current matrix of AOD treatment services tend to be focussed on the individual. This is in part related to inefficiencies in the data collection system and also to the funding model which is applied to AOD treatment. Most AOD treatment agencies are funded based on Episodes of Care (EOC), whereby agencies procure funding based on each completed EOC. The EOC model creates challenges in embracing change in service delivery methods and also limits the amount of time a clinician can spend with a client (VAADA Survey 2010). Family inclusive practice is likely to involve interaction with other family members which is likely to take more time and therefore may strain agency capacity and operations. This will be particularly telling for smaller agencies, and thus impact upon their capacity to engage in family inclusive practice.

Family inclusive practice, involving interaction and working with children, will require resources beyond increased service capacity. The organisations themselves will need to be redesigned to cater for a greater mix of individuals, including children. Practically speaking, this will engender significant tangible infrastructural modifications. It will also necessitate the introduction of new training programs on models of service delivery and screening tools, as the current emphasis on the individual does not generally bring about the need, nor provide capacity to sensitively ask 'questions about buying heroin and looking after children' (Sector Consultation 2011). Family inclusive practice would require expertise in engaging in such dialogues and ethical dilemmas.

Recommendation 1: VAADA recommends that new screening tools be developed to enable comprehensive assessment of a client's family.

Recommendation 2: VAADA recommends that training be provided to the AOD treatment sector workforce to enable them to undertake family inclusive practice.

Recommendation 3: VAADA recommends that funding be provided for the development, piloting and roll out of family inclusive practice to address current service limitations in the area

Recommendation 4: VAADA recommends that AOD agencies that participate in family inclusive practice be provided with appropriate resources to make modifications to their office space to facilitate the attendance of families and children.

Reporting and recording data, screening and assessment

The Victorian AOD treatment sector is currently using the Alcohol and Drug Information Service (ADIS), a reporting system which is over a decade old, to record data for the Department of Health (DH). Service providers have indicated that this does not have the capacity to appropriately record instances of family inclusive practice and does not support the retention of information beyond whether the client presenting has children. Service providers indicated that the current assessment tool does not account for 'out of home care, the number of children, the health status of the children or their relationship to the client' (Sector Consultation 2011).

The Victorian Auditor-General recently release an extensive and critical review of the AOD treatment sector, entitled *Managing Drug and Alcohol Prevention and Treatment Services* (The VAGO report 2011) which highlighted system failures in the data collection systems. The VAGO report noted the following issues for service providers regarding ADIS:

- 'data reported by ADIS on their performance is often inaccurate
- They cannot obtain their own information from the system for further analysis
- They consider that the data is not sufficient on its own for adequate service planning
- The data does not **fully represent the work undertaken by service providers**, limiting the department's ability to measure the performance of the service system.' (Victorian Auditor-General 2011:31) (Our emphasis)

The AOD treatment sector receives funding based on Episodes Of Care, which must be entered into ADIS. A service provider aptly noted that 'it is difficult to build a case for more resources to undertake family inclusive practice when the data system does not allow such practice to be recorded' (Sector Consultation 2011). This underscores the issues impeding the development of an integrated and family inclusive practice as the complexities in developing a case for an improved and flexible service type is restricted by the out dated reporting process.

VAADA supports the VAGO report's recommendation that DH must 'prioritise the replacement of its data collection system' (Victorian Auditor-General 2011:38).

Recommendation 5: VAADA recommends that the data collection system (ADIS) be revised and updated with more efficient and expedient data inputting processes, so that it has capacity to

record further information on the family structure of presenting clients to enable family inclusive practice without an increase in the administrative burden on AOD workers.

Service providers were also conscious of the time spent on undertaking administrative duties, and noted that the significant administrative impost from wide array of assessment forms requiring completion can be prohibitive to good practice. There is concern from the AOD treatment sector in simply tacking on additional assessment forms enabling the reporting of family related information, in that it will impact upon the time available for the provision of treatment.

However, in stating this, the AOD sector is keenly aware of the importance of assessment forms and the screening process as a whole in identifying familial issues with clients and developing an understanding of the specific dynamics at play within their family.

Recommendation 6: VAADA recommends the development of screening and assessment tools to ensure that relevant information on the client's family is captured and that appropriate resources are provided to account for the burden of administering these tools.

Lack of protocols and formal instruments promoting integrated and family inclusive practice

There are some significant, although not insurmountable, challenges regarding collaboration and integrated service delivery facing the AOD sector with Child Protection. These challenges include the ethical conflicts and complexities inherent in issues relating to the method of treatment and interventions adopted by AOD clinicians as well as privacy and confidentially. For instance, individuals presenting to AOD treatment agencies may be unwilling to participate in treatment if they felt that they could not trust the treating clinician; moreover, clinicians may experience structural barriers to garner adequate supports if they become aware of potential risk of harm to children of clients, especially if reporting these issues has the potential to negatively impact adversely on the alcohol or other drug treatment episode.

Work with the VAADA Sector Development project throughout 2010 and 2011 has highlighted a range of issues associated with AOD worker awareness and understanding of their responsibilities under the *Children Youth and Families Act* (2005). These complexities can be accentuated by the limited understanding of the technical aspects of the relevant legislation while Child Protection authorities will utilise, by way of reference to the law, moral arguments to garner information about AOD clients. An inherent conflict arises due to a lack of understanding of the law and a sense that AOD clinicians maybe breaching their ethical responsibilities to their clients. Further, AOD treatment clinicians are also aware of the low level of regard in which many AOD clients are held, and the often punitive responses exercised in lieu of access to appropriate treatment.

AOD service providers indicated that there may be conceptual differences on the impact of substance use as a measure of the quality of parenting. In essence a significant proportion of the dialogue appears to be focussed on the substance use per se, rather than how any substance use impacts on the parent's capacities to meet the safety and wellbeing needs of children. Child Protection personnel have indicated that urinalysis is a common tool used by staff as a determining measure of ones fitness to care for children in the absence of other corroborating evidence (Sector Consultation 2011). This runs contrary to AOD treatment experience, whereby one's capacity to parent is not solely measured through the consumption of alcohol and drugs, but rather how the consumption of these substances impact on the capacity of the person to parent effectively. There is a need to provide Child Protection with a clear sense of the experience and views of the AOD treatment sector.

A survey of 72 Victorian AOD agencies undertaken in 2010 identified perceived barriers to implementing family inclusive practices, including:

- Difficulty effectively engaging family members;
- Conflict of desires between client/consumer and family/carer;
- Lack of worker confidence that can include limited knowledge (clinical or of available services);
- Confidentiality and information sharing with families of clients;
- Confidentially and privacy concerns about sharing information with other services;
- Limited organisation capacity including resources, staff skills and time, competitive remuneration for up skilling; and
- Organisational and service system cultures (VAADA Survey 2010).

These barriers need to be dismantled and appropriate protocols need to be developed in consultation with all relevant stakeholders (including AOD clients). These protocols, highlighting the best interests of the child, need to take into account the experience of AOD clinicians to ensure that decisions made which impact upon the family are made with reference to the greatest wealth of experience possible. These protocols, led by the Victorian Government, would be contextualised to each specific region to ensure their relevancy and usage. These protocols should include:

- A time lined plan, outlining requisite resources, to enact organisational and system change to ensure that family inclusive and integrative practice can be implemented;
- A clear means of communication;
- A clear decision making process outlining the various roles of workers;
- A strategic plan for up skilling workers; and
- A clear process on dealing with issues related to confidentiality and privacy.

VAADA understands that there are protocols being developed at DH to update the previous protocols which were developed in 2002. We understand that there have been delays in this process; nonetheless, we are keen to see how these updated protocols will translate at a practice level upon release and the investment of resources which will support the implementation of these protocols

Recommendation 7: VAADA recommends that a protocol or set of protocols be developed between the AOD sector and Child Protection outlining strategies and necessary processes to successfully roll out family inclusive practice throughout the AOD sector and integrate this with Child Protection and other relevant sectors.

TOR: The interaction of departments and agencies, the courts and service providers and how they can better work together to support at-risk families and children.

The causes of family violence do not occur in isolation to the myriad of social determinants of disadvantage and therefore, an integrated approach to child protection should be adopted, in order to ensure the best interests of the child are maintained through an informed and collaborative approach. Practically speaking, this means servicing the community with a multidisciplinary team which has access to information and expertise from the full gamut of services and sectors. It also means the requisite sectors working together with a clear understanding of their specific roles and responsibilities.

The AOD sector would be keen to engage with Child Protection to develop joint initiatives in order to provide a more holistic service catering to the needs of the family as a whole. Such an initiative would require significant planning and resourcing, and the development of various protocols (see discussion above). There is a growing body of local and international research on the efficacy of various family inclusive programs which could be considered in the development of an integrated service jointly administered by the Child Protection and the AOD sector. Such a program would need to be piloted and subsequently evaluated.

A service provider indicated that the 'Working Together Strategy' was fairly effective in bringing together mental health, education and the AOD sectors (Sector Consultation 2011). It may be worthwhile revisiting that strategy in the development of integrated services (see http://www.health.vic.gov.au/mentalhealth/archive/publications/wts.pdf)

Recommendation 8: VAADA recommends that the Victorian Government undertake strategic planning and consultation with Child Protection and the AOD sector with a view to the development of integrated collaborative services. Such services should be evidence informed and be piloted and evaluated prior to full implementation.

Networking

AOD service providers indicated that there is a need for the sector to be adequately resourced to enable staff to attend networking activities, professional training, and meetings as AOD agencies generally do not have capacity to have staff attend events or meetings outside of the sector due to client demand (Sector Consultation 2011). Service providers have commented that the outcome for child protection clients depends on the experience of the child protection worker, and moreover, any contacts AOD workers have established who may provide them with advice. Some AOD workers have indicated that they have developed effective mutually beneficial relationships with a Child Protection worker, however, upon the worker changing employment, any informal processes are dissolved. Given the high turnover of Child Protection staff, it is currently untenable to implement consistent and effective processes through informal means. This means that although networking processes are important, and both Child Protection and the AOD sector should be resourced and provided with time to meet and discuss relevant issues, there is a need for a 'top down and bottom up' approach which provides a more solid foundation than the 'ad hoc' staff relationships and which helps cement protocols and working relationships between systems helping mitigate against the impact of staff movements, as discussed in the previous section.

Recommendation 9: VAADA recommends that AOD agencies be properly resourced to be able to fund staff to undertake appropriate training, networking exercises and evidenced informed models of service delivery.

Training

AOD service providers also indicated that involvement in Court processes can be cumbersome and time consuming and generally is not accounted for in the EOC funding requirements. Further, many AOD clinicians are not experts in navigating the legal system and this can be a barrier to ensuring the needs of families are met. This is compounded by the observations of some AOD service providers, who indicated that their clients often do not receive adequate legal advice and at times AOD clinicians are forced into a position where they are advocating for their client, even to their own lawyers (Sector Consultation 2011). Thus, there is a need for the delivery of training to AOD workers in the areas of Court process and the Child Protection system. Allowances for the resourcing issues in attending this training must be acknowledged and funded. The benefits in delivering training, other than to increase of knowledge, include the opportunities to build relationships and network between sectors.

Given the complexities of AOD issues and clients appearing in Court, there would be value in sharing insights and knowledge gained from this intensive work which occurs with these clients with Court personnel. The purpose of which is reduce the escalation of harm to individuals and their children

and ensure that Child Protection workers and Court staff take AOD issues into account in their practice.

The provision of training to AOD workers will enable them to more aptly navigate the child protection and other related service sectors. Additional areas of training required by staff, associated to the development of family inclusive practice, include working at the interface between client needs, children's needs and underlying AOD issues.

Recommendation 10: VAADA recommend that Court staff including the judiciary receive training in AOD issues so they can make more informed decisions in relation to clients with children.

Recommendation 11: VAADA recommends that training be provided to AOD staff in the areas of Court process and Child Protection, as well as in areas relevant to family inclusive practice such as contending with the complexities of working with clients, their children and addressing the underlying AOD issues.

TOR 3: The appropriate roles and responsibilities of government and non-government organisations in relation to Victoria's child protection policy and systems.

VAADA believes that there is a need for the Victorian Government to seek wide input into the development of child protection related policy. However, it must be enforced and supported with appropriate training, together with the bolstering the capacity of the workforce to undertake this type of work, to be effective.

AOD service providers listed a number of concerns regarding the processes and expectations levelled at young people who have been removed by Child Protection, which demonstrate the absence of AOD consultation in the determination of Child Protection cases. For example, AOD service providers indicated that removing a child from a family with substance use issues is likely to exacerbate these issues, as the parent(s) will react negatively due to the removal of their child. Further, regarding the welfare of a child who has been using substances, it is unrealistic to assume that a child who has been removed is likely to cease using drugs. As asserted earlier, the reliance on urinalysis to determine one's fitness for parenting is potentially harmful as substance use alone does not necessarily result in child abuse (Sector Consultation 2011). The AOD treatment sector has the experience to provide a high level of expertise and advice in matters relating to child protection and would welcome the opportunity to advise in appropriate cases, but require a significant increase in resources to be able to appropriate work with Child Protection, as well as introducing family inclusive practices into the current suite of AOD treatment modalities.

The AOD sector universally expressed concern regarding any expectation that they would play an intermediary role between Child Protection and the parents (as clients of an AOD treatment service) without the delivery of further resources and training. An intermediary role would also present some

ethical challenges, being that AOD clinicians would need to be well versed in confidentiality and privacy and would need to ensure that the client is fully aware of their rights. Moreover, there is concern that an intermediary role may be interpreted by the clients as a quasi-policing role, which would impair the effectiveness of AOD treatment by potentially undermining the therapeutic alliance that clinicians develop with service users.

The challenges inherent in the lack of resourcing ties into the limited capacity of the current AOD workforce to respond to Child Protection issues. Bereft of training and resources, the AOD sector does not have capacity to fully engage with Child Protection.

Recommendation 12: VAADA recommends that the Victorian Government consult with the AOD sector in developing policies outlining processes of collaboration between Child Protection, the Courts and the AOD sector.

Recommendation 13: VAADA recommends that the Victorian Government consult widely with the AOD treatment sector and consumers in the development of policies relating to child protection and ensure that any new policies are supported by the delivery of appropriate capacity building, workforce development and a commensurate increase in resources.

Recommendation 14: VAADA recommends that the AOD treatment sector be consulted regarding further involvement in the child protection system, with a view to clarifying its role, developing protocols and outlining the resource implications, and development of enhanced program activity.

References:

Bamberg, J.H., Toumbourou, J.W. and Marks, R 2008 'Including the siblings of youth substance abusers in a parent-focused intervention: a pilot test of the BEST Plus program', *Journal of Psychoactive Drugs*, 40:3, 281-91.

Copello, A., Templeton, L and Velleman R. 2006 'Family interventions for drug and alcohol misuse: is there a best practice?' *Current Opinion in Psychiatry* 19:3, 271-6.

Dawe, S., Frye, S., Best, D., Lynch, M., Atkinson, J., Evans, C. and Harriett, P. 2007 *Drug use in the family: Impacts and implications for children, Australian National Council on Drugs,* Canberra accessed 27 April 2011

http://www.ancd.org.au/images/PDF/Researchpapers/rp13_drug_use_in_family.pdf?phpMyAdmin=rGQ2XkOOsKjMp24r2sFwuVc5ibb

French, M.T., Zavala, S.K., McCollister, K.E., Waldron, H.B, Turner, C.W. and Ozechowski T.J. 2008 'Cost-effectiveness analysis of four interventions for adolescents with a substance use disorder', *Journal of Substance Abuse Treatment* 34:3, 272-81.

Martin, T., Lewis, T., Josiah-Martin, J. and Sinnott, T 2010 'Client family-member participation is associated with improved residential treatment program completion at an international drug and alcohol treatment centre', *Journal of Groups in Addiction & Recovery* 5:1, 34-44

McComish, J., Greenberg, R., Ager, J., Essenmacher, L., Orgain, L., Bacik, W. 2003 'Family-focussed substance abuyse treatment: a program evaluation', Journal of Psychoactive Drugs 35:3, 321-31.

Patterson, J. and Clapp, C. 2004 *Clinical Treatment Guidelines for Alcohol and Drug Clinicians No 11: Working with Families*, Turning Point Alcohol and Drug Centre Inc. Victoria.

Victorian Auditor-General (2011) *Managing Drug and Alcohol Prevention and Treatment Services*, Melbourne