Alcohol and Other Drugs Catchment Plan 2018-2020

Inner Eastern Melbourne

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List of acronyms

AAFG	Action on Alcohol Flagship Group
ACSO	Australian Community Support Organisation
AOD	Alcohol and other drugs
CALD	Culturally and linguistically diverse
CRAF	Common Risk Assessment Framework
CRC	Care and recovery coordination
DHHS	Department of Health and Human Services
ECADS	Eastern Consortium of Alcohol and Drug Services
EMPHN	Eastern Melbourne Primary Health Network
EMR	Eastern Metropolitan Region
EMHSCA	EMR Mental Health Service Coordination Alliance
EMR RFVP	EMR Regional Family Violence Partnership
IEM	Inner Eastern Melbourne
LGA	Local government area
MIC	Migrant Information Centre
NDIS	National Disability Insurance Scheme
NDSHS	National Drug Strategy Household Survey
OEM	Outer Eastern Melbourne
OEPCP	Outer East Primary Care Partnership
SHARC	Self Help Addiction Resource Centre
SURe	Substance Use Recovery
VAADA	Victorian Alcohol and Drug Association
YoDAA	Youth Drug and Alcohol Advice
YSAS	Youth Support + Advocacy Service

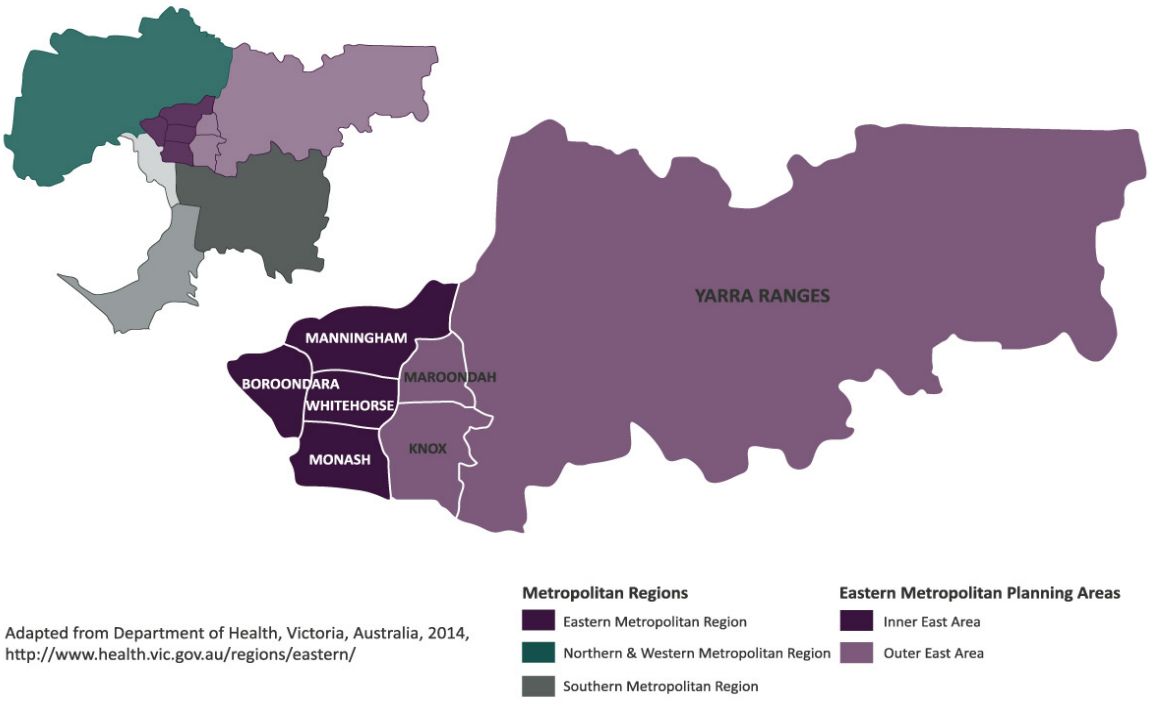
Background

Alcohol and other drugs (AOD) catchment-based planning in Inner Eastern Melbourne

The primary purpose of the catchment-based planning function is to assist alcohol and other drugs (AOD) service providers operating within a catchment to develop an agreed, catchment-based strategic plan that will aim to improve responsiveness to people with AOD issues, particularly those at significant risk of greater disadvantage.

Since late 2014, EACH has been funded to carry out catchment planning for AOD services (and previously Mental Health Community Support Services until 2017) across the entire Eastern Metropolitan Region (EMR – Figure 1), which includes both Inner Eastern Melbourne (IEM; local government areas of Boroondara, Manningham, Monash and Whitehorse) and the Outer Eastern Melbourne (OEM; local government areas of Knox, Maroondah and Yarra Ranges). This provides a unique opportunity to plan system improvements across the region. This catchment plans focuses specifically on the Inner East catchment.

Figure 1: Map of the Eastern Metropolitan Region of Melbourne, Victoria, and its local government areas



Milestones to 2018

The first EMR Integrated Mental Health and Alcohol and Other Drugs Catchment Plan 2016-2018 was prepared and endorsed in 2015. This plan identified four priority areas for targeted action over 2016-2018, to improve the responsiveness of regional service to client groups experiencing additional vulnerability: those experiencing family violence (victims and perpetrators), service users with dependent children, Aboriginal and Torres Strait Islanders, and young people.

Outcomes from this first round of catchment planning are summarised in Appendix 1.

The '*Strengthening the AOD system*' project

In early 2018, the Department of Health and Human Services (DHHS) Inner and Outer Eastern Melbourne provided one-off funding to the Outer East Primary Care Partnership (OEPCP) to lead a '*Strengthening the AOD Service System for Improved Client Experience'* project. The purpose of this project is to identify and implement system changes to address issues identified in a review commissioned by DHHS into a critical incident in 2017 and respond to underutilisation of some new activities funded through the 2014 AOD reform. This review raised important issues regarding the coordination of care across the EMR service system, the management of transitions between services and duty of care issues. A brief summary of the project aims and key stakeholders can be found here: https://oepcp.org.au/wp-content/uploads/AODProject_Overview_Updated-Aug-2018.pdf

Relationship to this catchment plan

For the 2018-2020 AOD catchment planning cycle, the Eastern Metro DHHS branch requested that the Catchment-based planning function assist and contribute to the *Strengthening the AOD system* project (to be referred herein as 'the project'). The remainder of this document will focus on providing an overview of the background and methodology for this project, its four priority areas for improvement, and relevant demographic and socio-economic features of the Inner Eastern Melbourne catchment that impact on the design and delivery of this project. Work currently being undertaken or planned as part of this project is detailed.

A small project team meets regularly to provide oversight for this project. The project team includes membership from the Outer East Primary Care Partnership, the Catchment Planning team from EACH and the DHHS Inner and Outer Eastern Melbourne.

Stakeholder consultation and emerging themes

To identify areas for service system improvement, extensive consultation was first undertaken as part of the project. This consultation included:

- **Stakeholder interviews** with managers from state-funded community based AOD services across Inner Eastern and Outer Eastern Melbourne. This included agencies in the two consortiums providing services across the areas, the Eastern Consortium of Alcohol and Drug Services (ECADS; auspice: Eastern Health) and Substance Use Recovery (SURe; auspice: EACH). Residential rehabilitation services, forensic services (ACSO) and youth services (YSAS), operating in the region, were also invited to participate in the consultations. Interviews focused on:
    - Level of confidence that clients can find and be linked into an appropriate service in a timely manner;
    - Sharing of client and service information across agencies in the catchment;
    - Views on why some treatment streams are oversubscribed/ undersubscribed;
    - Integration of care with other service providers;
    - Barriers to engagement and strategies for maximising engagement;
    - Key challenges in day to day work.

An external consultant undertook the interviews and produced a content and thematic analysis of the data. This report was provided to all key stakeholders for review and is available here: https://oepcp.org.au/wp-content/uploads/AOD-stakeholder-summary-report-FINAL.pdf

- **Consumer and carer engagement** to gain insights from people with lived experience. To do so, the project team consulted with members of the EMR's Dual Diagnosis Consumer and Carer Advisory Committee, hosted a consumer workshop and conducted a number of phone interviews. A summary of the issues identified can be found in Appendix 2. Service providers were also consulted for their insights into client experience during a workshop held in May 2018.

The key themes that emerged from both stakeholder and consumer and carer interviews were arranged under the following headings:

- **Promotion and awareness of services in the region:** Feedback suggested there needs to be an improved systematic approach to raising awareness about services and treatment options across the Inner Eastern Melbourne and Outer Eastern Melbourne areas.
- **Intake/referrals:** Centralised intake now occurs for each area. However, there is concern about equal distribution of referrals to all agencies in the areas.
- **Residential withdrawal and residential rehabilitation:** Accessing rehabilitation services was a concern in relation to admission criteria and wait times.
- **Information sharing:** Exploring this issue related to communication between the multiple agencies involved in a person's care as well as discharge planning.
- **Forensic clients:** There are a number of challenges related to engaging with and responding to the needs of forensic clients.
- **Care and recovery coordination:** Agencies are still working through the best model of care to integrate care and recovery coordination into their process.
- **The consortia:** Challenges were identified in terms of communication and collaboration, both within and across consortia.
- **Workforce and resourcing:** These were important concerns for service delivery staff due to the complex nature of clients and concerns about under resourcing and workforce issues.

These themes were subsequently utilised to inform a prioritisation workshop with regional key stakeholders in May 2018.

Priority areas for system improvements

During the May 2018 workshop, key stakeholders discussed the themes identified as part of consultation, and chose to prioritise four of them for further in-depth investigation, and to target action for system improvement. These four priority areas are:

1. Care and recovery coordination (CRC);
2. Workforce;
3. Service Awareness and Access;
4. Information Sharing and Discharge Planning.

In addition, at this workshop, service providers engaged in a client journey mapping exercise. Participants were asked to identify rewarding and challenging aspects of their work along a hypothetical client journey. This process highlighted areas of concern from both client and clinician viewpoints in regards to access, workforce, and discharge planning. A summary of the outcomes from this workshop can be found online[1] and in Appendix 3.

This catchment plan

Strengthening the AOD system is a long-term project. While there are four priority areas examined in detail in this plan, the remaining areas that were highlighted as concerning during stakeholder feedback will also be addressed during the work of this project.

This catchment plan provides a catchment overview, highlighting some key demographic and socio-economic features of the IEM and OEM. Each of the four identified priority areas are also explored with relevant data for consideration in developing system improvements. Work currently being undertaken across the region to reduce AOD risk is also identified. The initial project plan for working on the four priority areas is provided.

More information and updates on the project can be found here: https://oepcp.org.au/aod-project/#client

[1] https://oepcp.org.au/wp-content/uploads/AOD-May-Workshop-Summary.pdf

Key features of Inner Eastern Melbourne's demographic and population health profile

Online local government community profiles based on 2016 Census data from the Australian Bureau of Statistics (ABS), along with the *Social Health Atlas of Australia* have been used to provide a snapshot of the key demographic and population health features of the catchment.

Demographic indicators

An overview of key demographic indicators for the Inner Eastern Melbourne catchment is given in Table 1. Key trends are highlighted in this section.

Table 1: Demographic indicators for Inner Eastern Melbourne

Indicators	Boroondara	Manningham	Monash	Whitehorse	State
Area (km^2)	60.2	113.3	81.5	64.3	227,495
Total Population	167,232	116,260	182,618	162,080	5.95 mill
Ageing Index	93.1	131.9	108.6	103.8	85.4
Indigenous status (%)	0.20	0.19	0.23	0.23	0.86
Overseas born (%)	32.5	41.7	48.9%	40.1	30.3

Source: EMPHN Atlas 2018 for Boroondara, Manningham and Whitehorse; id.community profiles for Monash, based on 2016 Census data (ABS)

An ageing population

All LGAs in the catchment rate higher than state average for the ageing index[2]. In particular, Manningham (131.9), Monash (108.6) and Whitehorse (103.8) are well above the state average (85.4), meaning that their population tends to be older than elsewhere in the state.

While there is limited understanding about the prevalence and treatment of alcohol and drug use in older adults[3], findings from the recent 2016 National Drug Strategy Household Survey (NDSHS) showed an increase in some drug use in older populations. The recent Eastern Melbourne Primary Health Network (EMPHN) Atlas mapping process did not identify any AOD services that cater specifically for older adults. Further, in-depth analysis of current service users shows a low proportion of older adults seeking treatment across the region.

Aboriginal and Torres Strait Islanders and cultural diversity

Across all LGAs of the Inner East, the percentage of people stating being of Aboriginal and/or Torres Strait Islander heritage is lower than across the whole Victorian population.

In all LGAs of the catchment, the percentage of residents born overseas is greater than the state average, indicating that cultural diversity is high in these areas. Table 2 lists the top 10 countries of birth other than Australia for residents of the Inner East catchment. In particular, people born in China are present in all LGAs of the Inner East in proportions that are much greater than the state average. The diverse range of backgrounds in the region will need to be taken into consideration for future project works.

[2] Calculated as elder-child ratio: (population >64yrs) / (population 0-14yrs) per 100 persons
[3] https://adf.org.au/insights/ageing-with-alcohol/.

Table 2: Top 10 countries of birth (other than Australia) of residents in Inner Eastern Melbourne (% of whole population)

Country of Birth	Boroondara	Manningham	Monash	Whitehorse	State
China (excludes SARs and Taiwan)	6.6	9.3	12.5	11.5	2.7
United Kingdom	3.5	2.6	2.4	3.0	3.5
India	2.4	1.5	5.3	3.0	2.9
Hong Kong	1.1	2.6	1.4	1.5	0.4
Malaysia	2.0	3.3	3.3	2.7	0.8
Vietnam	1.2	0.9	1.5	1.5	1.4
New Zealand	1.6	0.9	1.1	1.2	1.6
Greece	1.0	2.4	2.4	1.0	0.8
Italy	0.9	2.7	1.4	0.9	1.2
Sri Lanka	0.7	0.6	3.6	1.3	0.9

Source: id.community profiles for Boroondara, Manningham, Monash, and Whitehorse, based on 2016 Census data (ABS)

Socioeconomic indicators

Salient socioeconomic indicators for Inner Eastern Melbourne are summarised in Table 3.

Table 3: Selected socioeconomic indicators for Inner Eastern Melbourne

Indicators	Boroondara	Manningham	Monash	Whitehorse	State
Single parent families with children aged less than 15 years (%)*	12.4	13.2	13.5	12.9	18.3
Needing Assistance (%)†	3.8	5.0	4.8	4.7	5.1
Early School Leavers (ASR per 100)*	11.9	19.6	18.5	18.4	26.0
Unemployment (%)*	3.9	5.8	3.8	5.9	5.8
Income (<$400/wk) (%)†	27.5	33.1	36.2	33.7	30.3

*Source: * PHIDU, 2018, Social Health Atlas of Australia – Data by Local Government Area; †id.community profiles for Boroondara, Manningham, Monash, and Whitehorse, based on 2016 Census data (ABS)*

Unemployment

Some areas within the catchment have slightly higher than state average unemployment rates, namely Manningham (5.9%) and Whitehorse (6.0%). Research has shown that unemployment can be a predictor of increased alcohol or drug taking behaviours[4]. This could be a consideration when working with clients in the region as to the provision of additional supports (such as employment support).

[4] Popovici, I., French, M.T. (2013), *Does unemployment lead to greater alcohol consumption?,* Ind Relat, 52(2): 444-466.

AOD services profile

State-funded community-based AOD services in the region are delivered by two consortia: Eastern Consortium of Alcohol and Drug Services (ECADS; auspice: Eastern Health) and Substance Use Recovery (SURe; auspice: EACH). SURe consortium partners are EACH and Anglicare Victoria. ECADS is a partnership between lead agency Turning Point Alcohol and Drug Centre (under Eastern Health auspice), Access Health and Community (H&C), Link Health and Community, Inspiro, the Self-Help Addiction Resource Centre (SHARC) and SalvoCare East.

Table 4 provides an overview of the types of services and activities provided by the various state-funded agencies across the region.

Table 4: Key state-funded AOD service providers and related activities in Inner Eastern Melbourne (IEM)

Organisation	Activities	Comments
EACH	Assessment, counselling, Care and Recovery Coordination (CRC), Non-Residential Withdrawal (NRW), youth outreach, residential rehabilitation	SURe consortia (lead, with Anglicare), Reconnexion (statewide benzodiazepine support services) reform initiatives - Family Reunification Order
	Adult Residential Rehabilitation (statewide)	Mooroolbark (12 beds); Healesville (11 beds)
	Youth Outreach	Eastern Drug and Alcohol Service (EDAS) consortia (lead, with Access H&C and Link H&C)
Eastern Health (Turning Point)	Intake (voluntary IEM), assessment, counselling, CRC, NRW	ECADS consortia (lead, with Inspiro, Salvocare, SHARC, Access H&C and Link H&C) and reform initiatives - Risk of Overdose, FV Advisor (Phase 2), Group interventions for forensic clients (Kickstart)
	Adult Residential Withdrawal (statewide)	Box Hill – community withdrawal (4 beds), stabilization and assessment (8 beds) and sub-acute withdrawal (8 beds).
	Specialist Pharmacotherapy Service (SPS) (methadone and buprenorphine)	Assessment and short-term management of complex opioid dependent clients including those with persisting pain and addiction.
	AOD nursing and medical team - Addiction medicine consultation and liaison services	Provide in-hospital consultation and liaison services for in the Emergency Department and across general hospital wards (Box Hill, Maroondah and Angliss Hospitals).
Salvocare Eastern	Adult Residential Rehabilitation (statewide)	The Bridge Program - The Basin (40 beds)
Anglicare	Youth Outreach	LYFT (Linking Youth and Families Together) Program
YSAS	Youth Outreach	AOD Youth Principle Practitioner and Youth Consultants (focus young people involved with Child Protection, Youth Justice, Out of Home Care) and Youth Workers
	Youth Residential Withdrawal (statewide)	Glen Iris (5 beds)
ACSO	Intake (forensic)	Across OEM and IEM
Ngwala	Aboriginal Community Controlled Organisation – Drug Services	2 AOD Workers
VACCA	Aboriginal Metro Ice Partnership	Partnership with Eastern Health – 1 AOD worker
Nillumbik Community Health Service	Mobile Drug Safety Worker Needle and Syringe Program outreach	

Strategic catchment planning priority areas

The four strategic catchment planning priority areas presented below are based on the four areas chosen by key stakeholders during the May 2018 workshop of the *Strengthening the AOD system* project.

Strategic priority area 1: Care and recovery coordination

The issue

Across both the Inner Eastern and Outer Eastern Melbourne catchments, there has been underutilisation of the Care and recovery coordination (CRC) service stream in recent years. Stakeholder feedback indicated that there were a number of reasons that made it difficult for agencies to meet CRC targets. These included:

- Lack of clarity around the role and eligibility of clients, given complexity of cases
- Difficulty in tracking and reporting CRC activity
- Overlap between Counselling and CRC service streams

> *For people with complex needs, **care and recovery coordination** is available to navigate treatment and provide support if they are waiting to access treatment. It also supports a person to plan for exit from treatment and to access other services that can assist with health and wellbeing needs such as housing, training, education and employment, or other support that can help prevent relapse.*
>
> Source: State of Victoria, Department of Health and Human Services, *Alcohol and other drugs program guidelines, Part 1: overview*, April 2018.

Service providers across the region use their CRC allocation flexibly in different ways and across various service types. It has been recognised that such operational differences create difficulties in promoting what this service stream does or does not offer, to both external sector stakeholders (e.g. homelessness services) and to clients directly.

Data to support and inform this priority area

Demographic data has been analysed for all AOD clients receiving support through the state-funded CRC service stream over the past three years (Table 5). More males than females access services in the catchment. Most clients are seeking CRC services for alcohol-related issues. Predominantly, clients using CRC are aged between 31 and 50 years.

Table 5: Demographic features (%) of current AOD clients in state-based CRC treatment services (2014-2017)

Characteristic	Inner Eastern Melbourne
Male	52.3
Female	47.7
Primary drug of use	
Alcohol	51.3
Amphetamines	23.5
Cannaboids and related drugs	8.1
Other	17.1
Aged 16-30 years	26.2
Aged 31-50 years	55.0
Aged 51+ years	24.8

Source: DHHS data. Data is not displayed by LGAs as the small number of clients would risk identification (n=298)

Work being undertaken

Since identifying CRC as an area of priority from stakeholder feedback, managers of the ECADS and SURe consortia jointly agreed that CRC should be the first area for agencies to work together on improving.

The project team is currently coordinating a series of action-oriented workshops to support agencies to identify and implement system level improvements to improve the utilisation of CRC as a treatment stream within AOD services. These monthly workshops use a "Plan, Do, Study, Act" quality improvement approach. The first of these workshops was held on 20th September 2018, with 13 key stakeholders from service organisations operating in the EMR. Agreement was reached regarding the following[5]:

- **Vision** – the group agreed to work together to:
    - Develop clarity of CRC roles across regions;
    - Build partnerships to strengthen and support CRC role;
    - Capture activity and record accurately in order to meet targets;
    - Create a model that provides best practice example of CRC.
- **Agreed strategies**:
    - Develop an understanding of current practice;
    - Work together to agree on best practice principles for CRC;
    - Identify organisational changes needed to support best practice principles;
    - Identify strategies for improving interface with other program areas;
    - Work together to build capacity of organisations.

This information was collated and used to inform a regional CRC work plan which can be found in Appendix 4.

[5] As documented in the following summary report: https://oepcp.org.au/wp-content/uploads/CRC-Workshop-1-Summary.docx, accessed on 23/10/2018.

Strategic priority area 2: Workforce

The issue

Stakeholder consultation raised concerns around the current state of the area's AOD workforce, including:

- Recent reform changes were highly disruptive, resulting in AOD workers either leaving the sector or those still in the system being severely fatigued;
- Difficulties in recruiting to positions;
- New integrated models in community health have resulted in AOD staff being supervised by people not skilled in the area of AOD; and
- The workforce is transitory due to the complexity of the work and poor remuneration. Consequently inexperienced clinicians are working with very complex clients.

This issue is not unique to the Inner East catchment. At a state-wide level, DHHS has committed $2.5 million over 12 months, to address immediate priorities of the Alcohol and other Drugs (AOD) Workforce Strategy, including:

- Attraction campaign
- Lived experience workforce
- Accredited training
- Forensic AOD workforce
- Addiction medicine capability
- Gathering recovery stories[6]

Data to support and inform the priority area

In 2017, the Victorian Alcohol and Drug Association (VAADA) facilitated a state-wide workforce survey on behalf of DHHS. The data from this survey provides a picture of workforce composition across catchments. However, it is not yet available. VAADA continues to advocate for this data to be made available to catchment based planners for use in development of regional catchment plans.

Work being undertaken

Possible areas for action were identified during the May 23rd workshop, including:

- Review mandatory minimum qualifications alongside the training that is offered to the sector
- Provide orientation for all workers
- Reciprocal rotations
- Recognition of prior learning
- Re/establish network meetings
- Develop an external supervision model

[6] State of Victoria, DHHS, *Alcohol and other drug sector – immediate workforce lift,* https://www2.health.vic.gov.au/-/media/health/files/collections/policies-and-guidelines/v/171109-vaada-comms---workforce-lift.pdf, accessed 01/10/2018.

- Review VAADA's work on models of outreach
- Showcase examples of where recovery has occurred.

Detailed planning for any of these proposed action areas has yet to occur. Workforce development will be incorporated within the other three priority areas. For instance, within the CRC workplan, organisational capacity building has been identified as a strategy. It is anticipated that work will commence on this in mid-2019. Workforce development activities will aim to leverage off relevant opportunities from the DHHS AOD Workforce Strategy.

Strategic priority area 3: Service Awareness and Access

The issue

Stakeholder consultation revealed a number of concerns about the awareness of services in the general community and the ease of access for those needing services. These included:

- Accessibility and promotion of each service on their own website
- General understanding in the community and from local GPs of treatment options available (concern people think only of residential rehabilitation as treatment option)
- Concern over the promotion of DirectLine as a centralised intake pathway
- Concern from clients and carers about service access

Data to support and inform the priority area

Referral sources

Table 6 indicates the specified referral source for clients entering state-based AOD services in the region. Service providers and consumers both indicated that often clients refer themselves for help with service providers they have used in the past. Self-referrals are more predominant across all LGAs of the Inner East than across the state. This could suggest that there is entrenchment in the system. This is something to be considered in planning future works regarding service awareness and access.

Consumer feedback also indicated issues with access and awareness of services. In particular, feedback indicated that new users believed residential rehabilitation was their only available course of treatment. A summary of the feedback can be found in Appendix 2.

Table 6: Top three referral source for state-based AOD clients (2016-2017) by LGA (% unique clients)

Referral source[7]	Boroondara	Manningham	Monash	Whitehorse	State
Self	39.2	37.7	45.1	31.8	30.0
Mandated (Office of Correction + ACSO)	33.7	48.0	31.6	32.3	52.4
Other AOD service (includes residential, non-residential and same service)	23.8	23.1	15.3	27.5	24.0

Source: DHHS AOD source data

DirectLine awareness

DirectLine is the main Alcohol and Drug advice line across the state. It is not stated as a referral source in Inner Eastern Melbourne client source data for the 2016/2017 financial year. The state average for clients referred from DirectLine is 0.2%. Similarly, General Practitioners (GPs) are also not stated as primary referral sources due to the low numbers in the source data.

New vs repeat clients

All LGAs in the catchment, except Manningham, have higher levels of new clients than the state average (Table 7). This suggests that the project may need to raise awareness of the system to potential first-time service users. Once again, feedback from service providers indicated an entrenchment in the system, and all LGAs, except Monash, indicated a higher number of repeat clients than the state average.

[7] Unique client totals (and associated percentages) can exceed 100%, as a client can have multiple courses of treatment during the quarter of different attributes, and is thus counted for each occurrence.

Table 7: Client type (new or repeat) for state-based AOD clients (2016-2017) by LGA (% unique clients)

Referral source[8]	Boroondara	Manningham	Monash	Whitehorse	State
New	40.1	34.4	45.0	37.9	34.7
Repeat	50.0	53.8	41.1	51.9	49.9

Source: DHHS AOD source data

Work being undertaken

Possible areas for action were identified during the May 23rd workshop, including:

- Developing and testing promotional material with different cohorts
- Look at Youth Drug and Alcohol Advice (YoDAA) as an example of best practice.

Detailed planning for any of these proposed action areas has yet to occur. It is anticipated that work for this priority area will commence in mid-2019. As discussed above, consumer feedback has indicated issues with service awareness. As a result we would envisage working closely with consumers to co-design and test solutions.

[8] Unique client totals (and associated percentages) can exceed 100%, as a client can have multiple courses of treatment during the quarter of different attributes, and is thus counted for each occurrence.

Strategic priority area 4: Information Sharing and Discharge Planning

The issue

While there was general agreement in stakeholder feedback that collaboration and sharing between service providers of the region was occurring, some persisting challenges were identified, including:

- Difficulty of managing dual diagnosis, particularly with the transition of some services to the NDIS
- Need for clients to repeat their story to multiple providers
- Risks associated with discharging a client who is homeless

It was agreed that improvements should be made in all these areas.

Data to support and inform the priority area

Stakeholders raised concerns around managing discharge (particularly from residential rehabilitation) when a client is homeless. Table 8 indicates that when homelessness is examined as a broad demographic characteristic across the catchment, this is a less frequently identified concern than on average across the state. However, the high percentage of clients with an "undetermined" homelessness status could also mean the number of people homeless could be greatly underestimated across the catchment.

Table 8: Homelessness status (%) of AOD service users (all treatment types) in Inner Eastern Melbourne 2016-17

Homelessness status	Boroondara	Manningham	Monash	Whitehorse	State
Homeless	4.3	4.0	3.7	1.8	6.1
Not homeless	42.8	42.7	38.7	51.4	49.7
Undetermined	64.2	63.7	67.9	55.4	60.2
	Residential rehabilitation clients ONLY – all Inner Eastern Melbourne				
Homeless	15.0				
Not homeless	74.1				
Undetermined	10.8				

When residential rehabilitation clients only are examined (Table 8), the proportion of Inner Eastern Melbourne clients stating they are homeless is concerning (15%). These values cannot be separated into LGAs due to the low number of cases.

As discharge planning was highlighted as an issue, it is interesting to note that the proportion of referral destinations documented as "undetermined" varied greatly across the catchment (Table 9). This confirms the service providers' perception around discharge practices being variable across the catchment.

Table 9: Referral destination on discharge for all state-based AOD clients (2016-2017) by LGA (% unique clients)

Referral destination	Boroondara	Manningham	Monash	Whitehorse	IEM	State
Undetermined	42.3	30.8	41.6	26.5	35.2	37.2
None	34.6	43.2	37.2	47.1	41.0	46.7
AOD service (same or other)	30.8	28.6	25.1	36.9	31.5	16.7
GP	9.6	16.1	8.8	11.8	11.3	8.3

When examining referrals out of residential rehabilitation (Table 10), it appears the recording of the destination is much clearer than across all treatment streams, with no "undetermined" referral destinations. Compared to the state average of 46.7% across all treatment types for no referral being given or noted, clients leaving residential rehabilitation have no referral in only 21.7% cases.

Table 10: Referral destination for AOD clients exiting state-based residential rehabilitation services over 2014-2017 period (% unique clients)

Referral destination	Inner Eastern Melbourne
AOD service –other	34.9
AOD service – same	19.9
None	21.7
GP	4.21

The period following departure from residential services is recognised as being associated with a heightened risk of relapse and overdose[9]. Therefore, it is likely that clients of residential rehabilitation services would benefit from improvements in discharge planning, in particular in regards to improving referral pathways.

Work being undertaken

Possible areas for action were identified during the May 23rd workshop, including:

- Client discharge paperwork to reflect Individual Recovery Plan (care team)
- Client accessing a residential service to have a CRC clinician pre/post/during admission to facilitate service transition
- Map residential services eligibility, admission processes and share this across the region and on websites, etc.
- Identify gaps in current services
- Develop communications for clients and referrers, including a short video to assist client preparation.

The project team will invite stakeholders to commence work in information sharing and discharge planning in February 2019. It has been selected as the next area of priority because of the synergies with some of the work taking place in CRC. This decision has been endorsed by managers of the two consortia and supported by members of the CRC working group. As with CRC, the project team will coordinate a series of action-orientated workshops to support agencies to identify and implement system level improvements in information sharing and discharge, utilising a Plan, Do, Study, Act (PDSA) approach. This will run simultaneously to the CRC workshops.

In these workshops there will be a particular focus on:

- reviewing who, when and how communication is provided at multiple points of a client's journey
- building supportive pathways and bridging supports for clients pre and post services particularly withdrawal and residential rehabilitation services

[9] Strang, J., McCambridge, J., Best, D., Beswick, T., Bearn, J., Rees, S., Gossop, M. (2003) *Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow-up study*, BMJ, 326(7396): 659-960.

Other work

We acknowledge that there are a number of disadvantaged population groups that need specialised service attention. To achieve system responsiveness improvements in the longer term and address these needs, we have chosen to focus this catchment plan on specific service improvements under the four strategic areas detailed above. We plan to build on these improvements and target specific population groups in future work. Addressing the needs of all of these groups is beyond the scope for this catchment plan. However, we acknowledge that there is already work being undertaken across the catchment to address the needs of diverse communities. Some of this work includes:

Action on Alcohol Flagship Group (AAFG) is a consortium of representatives from the seven local governments across IEM and OEM, community health agencies, Inner East and Outer East Primary Care Partnerships and the Dalgarno Institute. The partnership is committed to taking midstream and upstream action, to reduce the harmful impacts of alcohol in local communities.
The rolling action plan identifies a number of priority areas including:

- Advocacy work
- Changes to the local liquor licencing
- Local community actions.

Further information can be found here:
https://thewellresource.org.au/topics/alcohol-misuse/connect/emr-action-on-alcohol-flagship-group

The AAFG also received funding in 2018 from the Australian Drug Foundation (ADF) to become a Local Drug Action Team (LDAT). Initially the LDAT will focus on working in partnership with the Migrant Information Centre, EACH and other key stakeholders to support the Chin community reduce the harm they experience from alcohol misuse.

The **Migrant Information Centre (MIC)** supports culturally and linguistically diverse (CALD) people and their families, older people, people with disabilities and their carers, community groups and service providers in the Eastern Metropolitan Region of Melbourne to enhance their settlement and access to services and strengthen their participation within the community. Among other services, MIC provides Respectful Relations training to youth from CALD backgrounds which provides information around alcohol and drug use and family violence. The MIC has undertaken a community awareness program around alcohol and drinking after noting an increasing number of clients who migrated as refugees from Chin State in Myanmar (formerly Burma) requesting assistance due to drink driving charges (MIC 2012).

The **Eastern Melbourne Primary Health Network (EMPHN)** is undertaking a co-design process to develop a new AOD service model that will be commissioned by EMPHN in mid-2019. The co-design process is led by consultants 360Edge.

Where to next

A detailed plan for the '*Strengthening the AOD Service System for Improved Client Experience'* is being developed in more detail. At this stage, the summary project plan is available here: https://oepcp.org.au/wp-content/uploads/AOD-May-Workshop-Summary.pdf

Appendix 1: Eastern Metropolitan Region Mental Health and Alcohol and Drugs Action Plan 2017-2018

Progress summary, March 2018

Domain	Key actions	Progress	Outcome
1. Workforce capacity building and systems	Screening tools Building workforce capacity Peer leadership	▪ Input to development of new Alcohol & Other Drug (AOD) Intake and Assessment tools, available online.[10] ▪ Review of 18 mental health (MH) screening and assessment tools in use across the region. Recommendations made regarding improvements to mental health screening processes.[11] ▪ Workforce capacity and capability mapping exercise completed.[12] ▪ Eastern Peer Support Network supportive of increasing peer leadership amongst service users with dependent children and future work to be undertaken by Eastern Mental Health Service Coordination Alliance (EMHSCA) in this area. ▪ Further workforce capacity building will be undertaken by Regional Family Violence Partnership (RFVP) and the Specialist Family Violence Advisors (MH/AOD).	Complete
2. Cross-sectoral integration	Prepare for Support and Safety Hubs	▪ Ongoing monitoring, in collaboration with the RFVP, of the planned roll out of Support and Safety Hubs in our region.	Complete
3. Cross-sectoral collaboration	Review referral practices Secondary Consultation model Perpetrator accountability	▪ Secondary consultation activities currently undertaken across the region mapped as part of the Capability and Capacity Snapshot survey. ▪ EMHSCA producing document of referral pathways in the EMR (i.e. via Linkages, annual workshops and events, and committee work). ▪ Eastern Dual Diagnosis Service working with Integrated Family Services to develop secondary consultation model and distribute to EMHSCA for further collaborative development and endorsement. ▪ Enhancing coordination between MH, AOD and family violence services will continue through the Regional Family Violence Partnership (RFVP) and the Specialist Family Violence Advisors (MH/AOD) based at Eastern Domestic Violence Service. ▪ Mapping of services and programs undertaking men's behaviour change in the region was completed and results disseminated to MH and AOD service providers.	Complete

[10] https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treatment

[11] Available at hhttps://www.easternhealth.org.au/images/services/emhsca/Regional_Report_MH_Screening_Review.pdf

[12] Available at https://www.easternhealth.org.au/images/services/emhsca/Final_Report_-_Capability_and_Capacity_Snapshot.pdf

Appendix 2: Consumer Consultation

Outer East Primary Care Partnership

Strengthening the AOD service system for improved client experience

Client consultation summary

Background

To gain the lived experience of those using the local AOD system, a small scale round of direct consultation with clients was carried out between July-September 2018. The consultation aimed to gain perspectives from clients on their experience in locating, accessing, receiving and ceasing support and treatment from AOD services in the Eastern region.

Opportunities to be involved in the consultation were via a focus group or phone interview. Flyers were distributed via AOD services in the region. A semi structured discussion was held during the focus group and a standardised interview script was developed for the phone interviews.

11 clients participated in the consultation; 2 face to face via the focus group and 9 over the phone. Data collected from the focus group and the phone interviews were synthesised into descriptive themes.

Key Findings

Finding a service:

Entering the system for the first time most commonly occurred at a crisis point. For many clients, it was a family member or friend that took on the responsibility of trying to locate a service on their behalf. Some clients stated that the experience of finding and even accessing a service was difficult to remember. This was either due to the length of time that had passed since they first entered the service system or because their substance use had affected their memory.

Attempting to locate a service for the first time was usually via the internet and by using search terms such as “rehab” or “AOD treatment”. Quite often these search terms brought up results for private rehabilitation facilities. For the majority of clients this was not an appropriate option due to cost. Some clients stated that before they entered the system they were not aware about other service options such as counselling or withdrawal. For clients with a history of long term substance use these options were not readily available when they first sought help.

Word of mouth appeared to be another common and useful way for people to find out about different services. Most clients reported that they had heard of DirectLine but few could recall ever seeing DirectLine advertised on television as they had other helplines such as Gambler’s HelpLine or LifeLine.

For those clients with a recent history of incarceration the majority commented that there is not enough knowledge or support in prisons to connect clients with appropriate services in the community. One client talked about how even doing simple things, such as the grocery shopping, was overwhelming for him post release. Trying to find support for his substance use was simply too hard. The majority of these clients recommended that prisons required more education on what supports are available in the community.

Overall, clients commented that there needs to be more awareness about what treatment services are available for alcohol and drug issues. Treatment options such as rehab and AA/NA tend to be heavily portrayed in movies and in the media. This portrayal does appear to influence people’s preconceptions about what treatment is available for substance abuse.

Accessing a service:
For some clients finding and accessing a service was easier depending on who you know. Several commented that accessing a service is easier once you are in the system or if you have previously attended a service. The majority of clients stated they had experienced minimal waiting times for services. Some clients put this down to good luck and circumstance and having also had previous contact with services. For some clients it was because they had priority of service via the forensic system.

Where a wait time was associated with a service, there was a mixed response from clients as to whether or not they received contact from the service while on their wait list. Only a couple of clients said that they felt they had to tell their story multiple times when accessing services. Many of the clients spoke about accessing services via another worker or service which made the process a more seamless one for them.

Using a service:
Clients interviewed had experience in using a number of AOD services including counselling, residential rehabilitation and residential withdrawal. The majority of clients spoke very highly of the services they received and most stated they would recommend these services to others.

Clients valued services utilising a holistic approach, having consistency in workers and communication between services when multiple agencies were involved. “Trust” and “non-judgmental” were common phrases used by clients to describe what made their experience with services a highly positive one. The philosophy of the service and whether it matched their individual values was also noted as being important. Several clients stated they appreciated services utilising a family centred approach.

On the whole, clients spoke highly of the skill and expertise of workers in the sector. A couple of clients stated that they had contact with some staff who were fairly junior and may have lacked the skills required to deal with their complexity. A number of clients commented the most useful part of their treatment was having contact with a peer worker or those workers with a lived experience.

The majority of clients said that they had had a treatment plan with services. However, the majority also were unclear about whether information about their treatment was being shared between multiple services and/or with GP. This was despite clients stating that they wanted services to be ‘on the same page’. A couple of clients commented on feeling disempowered over decisions based on their withdrawal treatment and felt a lack of alternative options had been provided to them.

Some clients acknowledged that success of their treatment was based on their stage of readiness and how willing they were to make changes in their life. Some clients with a Corrections order stated that they found engaging with services difficult due to concerns about the repercussions of disclosing their substance use.

Leaving a service:
There was a mixed response in regards to the experience of leaving a service. Several clients stated that this is the area that requires the most improvement. Some clients stated that they have a tendency to just drop out of services at their own accord. This could be because they are either doing well or they have relapsed and no longer want to engage with services.

Several clients spoke about instances where they were not ready to cease treatment but they were discharged due to a cease in funding, completion of a treatment order or in a couple of cases the service just terminated contact. Several clients recommended that a transition period out of a service or from one service to another, rather than a complete discharge, be introduced as common practice. Furthermore, discharge should always take place with discussion and consultation.

For those clients who had had completed a residential rehabilitation or withdrawal program once again there was a mixed response here. Some clients stated they were provided with supports and contacts upon discharge, were others were not. Overall, clients seemed unsure if they had a discharge plan and whether a copy was provided to

their GP/other service. Some clients stated that periodic check-ups (eg. a phone call to touch base) after leaving a service was something that they had either found or would find extremely useful.

Several clients talked about the importance of services discussing with them, from the beginning, their understanding of services and treatment. This could help client's increase their understanding of what recovery is and reduce false expectations of treatment. It could also assist with people's coping mechanisms when they are dealing with lifestyle stressors or out of rehabilitation settings and back "in the real world".

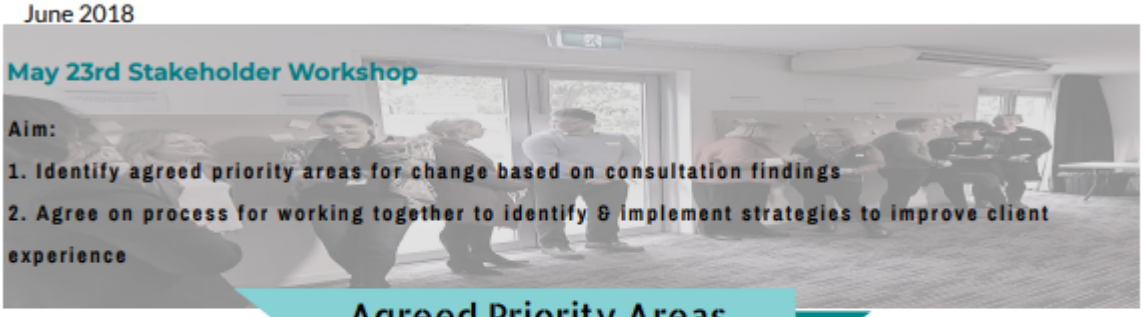
Conclusion:

The personal experiences shared by the clients who participated in this consultation provided a number of useful insights. They highlighted a number of positives aspects about the local AOD service system. These include a workforce that is perceived by most clients to be highly skilled and experts in their field, minimal waiting times for services and holistic approaches to treatment and support. The consultation also highlighted several areas where the sector could consider opportunities for improvement. These include increasing community awareness of the types and the availability of different treatment options and service supports, building the capacity of the corrections system (particularly prisons) so that they have an increased knowledge about services available in the community and the provision of support offered at discharge and post discharge. Areas where opportunity for improvement was highlighted were generally consistent with those raised during the sector stakeholder consultation earlier this year.

Appendix 3: Summary of outcomes from the stakeholder workshop on 23/05/2018

Strengthening the AOD service system for improved client experience

June 2018



May 23rd Stakeholder Workshop

Aim:

1. Identify agreed priority areas for change based on consultation findings

2. Agree on process for working together to identify & implement strategies to improve client experience

Agreed Priority Areas

Care & Recovery Coordination

What needs to change?

- Ability to meet & record targets
- A clear definition of the role of C&RC
- Better understanding of how different agencies offer C&RC

Possible actions

- Sharing of clients across consortiums to meet demand
- Education on role of C&RC and how different agencies offer C&RC
- Increase capacity to assess client suitability for C&RC utilising DHHS guidelines

Service Awareness & Access

What needs to change?

- Ensure promotional materials (eg., websites, social media, etc) meet the needs of clients, carers, GPs and other referrers
- Increase ease of access (state and local level intake systems)
- Change community perception that rehab is the only form of treatment for addiction

Possible actions

- Develop and test promotional material with different cohorts
- Look at YODA as an example of best practice.

Workforce

What needs to change?

- Increased strategies to build a highly skilled workforce
- Consistency in understanding risk when working within the AOD sector
- An understanding of the existing values &attitudes towards the client group

Possible actions

- Review mandatory minimums qualifications alongside the training that is offered to the sector
- Provide orientation for all workers
- Reciprocal rotations
- Recognition of prior learning
- Re/establish network meetings eg., ECADA
- Develop an external supervision model
- Review VAADA's work on models of outreach
- Showcase examples of where recovery has occurred

Information Sharing & Discharge Planning

What needs to change?

- Communication of discharge to treating clinician (not just GP) needs to happen at multiple points of client's journey
- Increase client support when accessing residential services
- Consistency, equity & transparency in the eligibility & admission processes for resi rehab admission
- Waitlist seen as a preparation period for clients to increase chances of completing a program

Possible actions

- Client discharge paperwork to reflect IRP (care team)
- Client accessing a resi service to have a C&RC clinician pre/post/during admission to facilitate service transition
- Map resi eligibility, admission processes & share this across the region & on websites etc
- Identify gaps in current services
- Develop comms for clients and referrers including a short video to assist client preparation

Appendix 4: Care & Recovery Coordination (CRC) Work Plan for 2018-19

Developing a CRC best practice model for the EMR Work Plan 2018-19				
Strategies	**Actions**	**Status / Deliverable**	**Timeline**	**Responsibility**
Develop an understanding of current practice in delivery of CRC	Members provide a description of the CRC model being provided within their agency	Completed	Sept- Oct 18	Agency Reps
	Different models of CRC delivery are documented - highlighting similarities and differences	Completed	Sept- Oct 18	Jean - OEPCP
	Members discuss and clarify how each agency is delivering CRC	Completed	Sept- Oct 18	Agency Reps
Success Indicator: All participating agencies have an understanding of how CRC is being provided across the region and can identify areas of consistency and differences in practice				
Work together to agree on best practice principles for CRC for the region	Identify and agree on best practice principles for CRC	In progress	Nov 18-Feb 19	Agency Reps
	Members review their current CRC model against agreed best practice principles	In progress	Nov 18-Feb 19	Agency Reps
Success Indicator: Best practice principles for delivery of CRC are defined and agencies can demonstrate changes needed to ensure their care model aligns with these principles				
Identify organisational changes required to support best practice principles	Members identify changes required to their CRC model to align with best practice principles	In progress	Nov 18-Jan 19	Agency Reps
	Members document what needs to change and how they will change their model, including a timeframe, for introducing changes	Not started	Nov 18-Jan 19	Agency Reps
	Members report on change process at workshops, sharing learning's and providing support to each other, to problem solve issues that may arise	Not started	Nov 18-Jan 19	Agency Reps
	Explore client and clinician experiences of changes implemented	Not started	Feb 19-April 19	Agency Reps
Success Indicator: Member agencies are providing CRC that is consistent with agreed best practice principles				
	Identify existing gaps in knowledge/skills across the region	In progress	Nov 18-Jan 19	Agency Reps

Developing a CRC best practice model for the EMR Work Plan 2018-19				
Strategies	**Actions**	**Status / Deliverable**	**Timeline**	**Responsibility**
Work together to build capacity of organisations	Identify strategies for addressing these gaps		Jan 19- Mar 19	Agency Reps
	Identify resources and processes required to implement the above strategies		Jan 19- Mar 19	Agency Reps
	identify opportunities for agencies to work collaboratively to provide CRC		Jan 19- Mar 19	Agency Reps
	Identify agreements and tools required to support collaborative approaches to CRC across the region		Jan 19- Mar 19	Agency Reps
	Explore client and clinician experiences of changes implemented		Jan19 – Mar 19	Agency Reps
	Document and develop case studies of how collaborative approaches to CRC have been implemented		Jan 19- Mar 19	Agency Reps
Success Indicator: Agencies have staff with the knowledge and skills required to refer/provide CRC across the region OR Collaborative approaches to CRC across the region can be demonstrated				
Identify strategies for improving interface with other program areas	Identify key program areas that agencies want to improve interface with e.g. residential rehabilitation, mental health, homelessness		Feb 19-April 19	Agency Reps
	Identify strategies for improvements such as the promotion and implementation of referral pathways		Feb 19-April 19	Agency Reps
	Document and develop case studies of how collaborative approaches to CRC have been implemented		Feb 19-April 19	Agency Reps
	Explore client and clinician experience of the strategies implemented		Feb 19-April 19	Agency Reps
Success Indicator: Increased interface with other program areas				