

# Eastern Metropolitan Region Mental Health and Alcohol and Drug Catchment Plan

Action Plan 2017-2018

Eastern Metropolitan Region Mental Health and  
Alcohol and Drug Planning Council

May 2017

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***Acknowledgement***

We begin by acknowledging the traditional custodians of the land on which we work, and we pay our respects to Elders past and present. We acknowledge the sorrow of the Stolen Generations and the impacts of colonisation on Aboriginal and Torres Strait Islander Peoples. We recognise the resilience, strength and pride of the Aboriginal community. We embrace diversity in all its forms, and respect everyone's strengths and contributions irrespective of gender, ethnicity, culture, religious beliefs, sexual orientation and political views.

## Acronyms

<b>ACCO</b>	Aboriginal Community Controlled Organisation	<b>IFS</b>	Integrated family services
<b>ACCHO</b>	Aboriginal Community Controlled Health Organisation	<b>LGA</b>	Local Government Area
<b>AOD</b>	Alcohol and Other Drug(s)	<b>LGBTI</b>	Lesbian, Gay, Bisexual, Transgender and Intersex
<b>BWAHS</b>	Boorndawan Willam Aboriginal Healing Service	<b>MH</b>	Mental Health
<b>CALD</b>	Culturally and Linguistically Diverse	<b>MHCSS</b>	Mental Health Community Support Services
<b>CCU</b>	Community Care Unit	<b>MMIGP</b>	Mullum Mullum Indigenous Gathering Place
<b>CRAF</b>	Common Risk Assessment Framework	<b>NACCHO</b>	National Aboriginal Community Controlled Health Organisation
<b>CYMHS</b>	Child and Youth Mental Health Service	<b>NDIS</b>	National Disability Insurance Scheme
<b>DDACL</b>	Dandenong and District Aborigines Co-Operative Limited	<b>OECYAP</b>	Outer East Child and Youth Area Partnership
<b>DDX</b>	Dual Diagnosis	<b>OEHCSA</b>	Outer East Health and Community Support Alliance
<b>DHHS</b>	Department of Health and Human Services	<b>PIR</b>	Partners in Recovery
<b>ECADS</b>	Eastern Consortium Alcohol & Drug Services	<b>PHN</b>	Primary Health Network
<b>ECASA</b>	Eastern Centre Against Sexual Assault	<b>RAP</b>	Reconciliation Action Plan
<b>EDVOS</b>	Eastern Domestic Violence Service	<b>SURe</b>	Substance Use Recovery program
<b>EFT</b>	Equivalent full-time	<b>TFER</b>	Together for Equality & Respect
<b>EMFVN</b>	Eastern Men's Family Violence Network	<b>VAADA</b>	Victorian Alcohol and Drug Association
<b>EMHSCA</b>	Eastern Mental Health Service Coordination Alliance	<b>VAHS</b>	Victorian Aboriginal Health Service
<b>EMPHN</b>	Eastern Melbourne Primary Health Network	<b>VACCA</b>	Victorian Aboriginal Child Care Agency
<b>EMR</b>	Eastern Metropolitan Region	<b>VACCHO</b>	Victorian Aboriginal Community Controlled Health Organisation
<b>EMRFVP</b>	EMR Family Violence Partnership	<b>VALS</b>	Victorian Aboriginal Legal Service
<b>FaPMI</b>	Families where a parent has a mental illness	<b>YAODEN</b>	Youth Alcohol and Other Drug Eastern Network
<b>FS</b>	Family Services	<b>YRR</b>	Youth Residential Rehabilitation
<b>FV</b>	Family Violence	<b>YSAS</b>	Youth Substance Abuse Service
<b>GP</b>	General Practitioner		
<b>HICSA</b>	Healesville Indigenous Community Services Association		

## Executive summary

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The Eastern Metropolitan Region Mental Health and Alcohol and Drug Planning Council (EMR Planning Council) was established in late 2014 to:

- Consider the health and wellbeing needs of service users of state-funded mental health community support services (MHCSS) and alcohol and other drugs (AOD) services
- Facilitate better integration across services, and
- Provide governance to the catchment-based planning function, based at EACH, to undertake a systems analysis and strategic planning process.

Following a focus in 2015 and early 2016 on conducting an extensive regional needs analysis, the Planning Council oversaw activity in 2016 which centred on developing a set of actions to improve regional service providers' capacity to meet the needs for service users, with a particular focus on the following four priority population groups:

- Those co-experiencing family violence
- Service users with dependent children
- Young people
- Aboriginal and Torres Strait Islanders (the term Aboriginal is also used in this report, which refers to both Aboriginal and Torres Strait Islander People).

The process for developing actions included:

- Analysis of relevant population health and service usage data across the region<sup>1</sup>.
- Consideration and alignment with statewide and local reviews, plans and strategies.
- Formulation of cross-sectoral working groups, which included consumer/carer representatives, for three of the priority areas: family violence; service users with dependent children; and young people.
- Coordination of action planning workshops for the family violence and service users with dependent children priority areas, based on rapid improvement methodology. During these workshops, themes and priorities for action were determined by stakeholders from various relevant sectors (e.g. mental health, AOD, family violence, family services, etc.).

The action plan put forward in this document is the result of this collaborative planning process, and proposes actions across three domains: workforce capacity building and systems, cross-sectoral integration and cross-sectoral collaboration. It is a plan which is set in a fluid policy and funding context, characterised by major drivers such as the upcoming roll-out of the National Disability Insurance Scheme (scheduled for November 2017 in the Eastern Region), cuts to the mental health community support services catchment planning funding, and strong recommendations from the Royal Commission into Family Violence around the role of mainstream services in ensuring that women and children live free of violence.

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<sup>1</sup> The local government areas of the Eastern Metropolitan Region (EMR) are: Boroondara, Manningham, Monash, Whitehorse, Knox, Maroondah and Yarra Ranges.



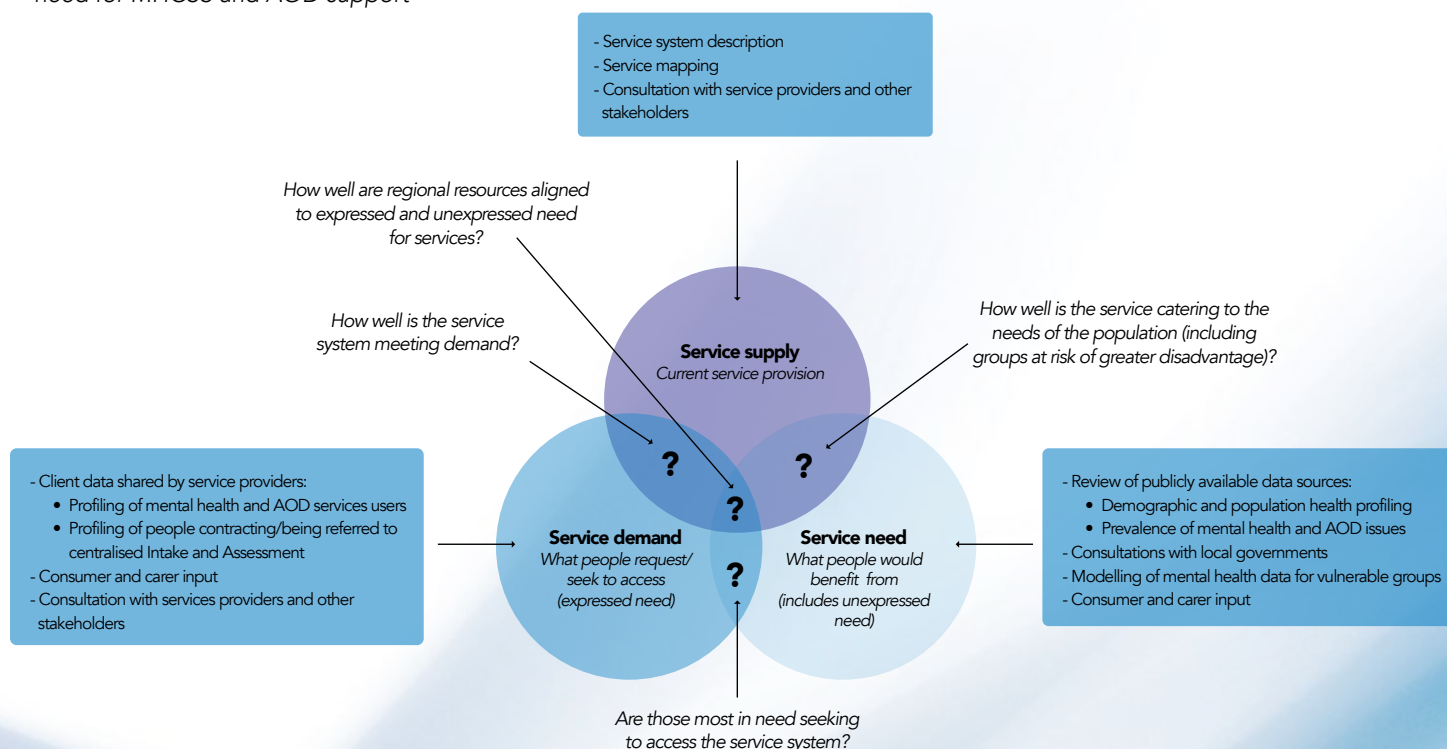
## Introduction and context

### *The Eastern Metropolitan Region catchment-based mental health and alcohol and other drugs planning function*

In 2014, catchment-based planning functions were established across all regions of Victoria during the reform and recommissioning processes for state-funded alcohol and other drugs (AOD) services and community-based services for people with psychiatric disability (previously known as Psychiatric Disability Rehabilitation and Support Services [PDRSS], then became Mental Health Community Support Services [MHCSS]). Catchment planning aims to improve the responsiveness of services to people with AOD issues and/or severe and persistent mental illness, particularly those who are at greater risk of disadvantage. Specifically, catchment-based planning serves to:

- Gather and analyse relevant health and population data to identify and understand the distinct and diverse needs of community members and their carers in the EMR with a psychiatric disability or requiring AOD services, particularly those facing significant disadvantage.
- Analyse data on MHCSS and AOD service supply, demand and unmet need to identify service gaps and pressures, and to monitor and analyse trends in expressed demand for MHCSS/AOD in the catchment (see Figure 1).

**Figure 1:** Types of information sought to understand the alignment of regional service system's supply, demand and need for MHCSS and AOD support

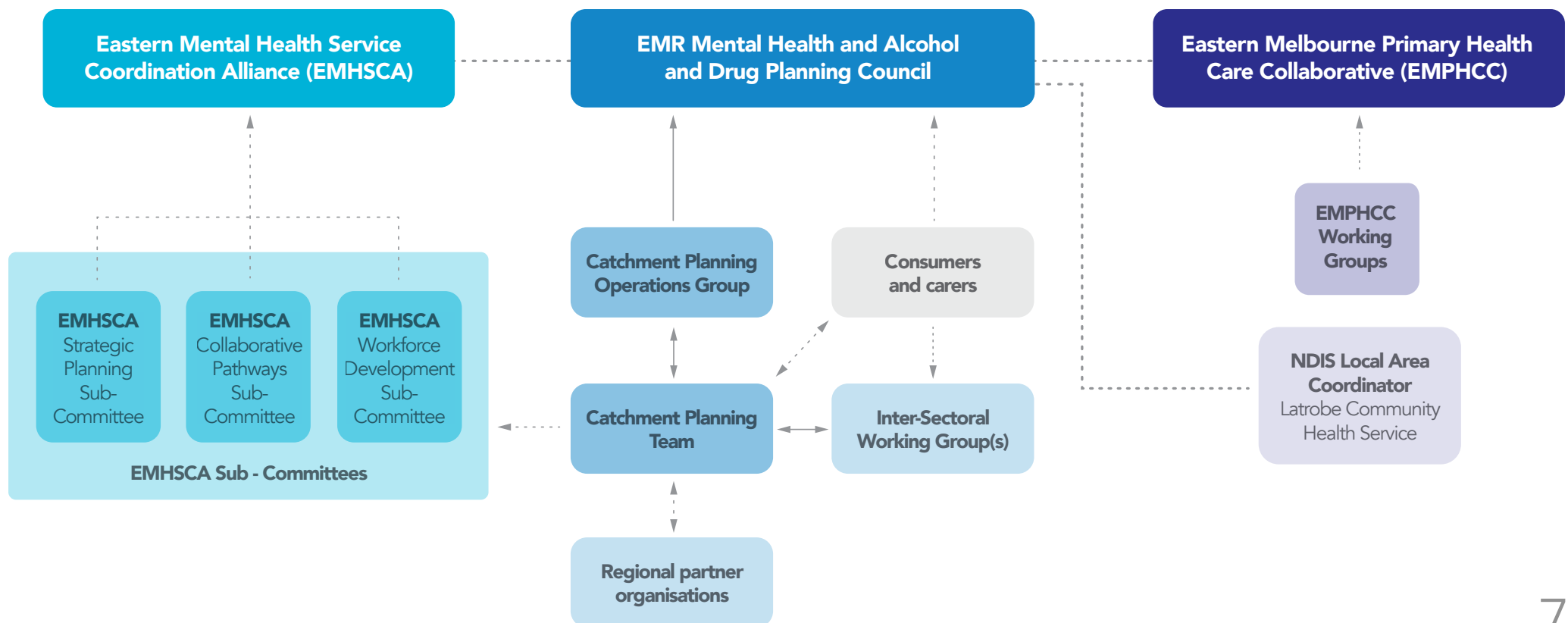


In December 2017, a letter was issued by the Department of Health and Human Services DHHS Central Office regarding the state-wide cessation of funding for the MHCSS catchment-based planning function, as of June 30th 2017. The rationale provided for this funding cut related to the MHCSS sector's upcoming transition to the National Disability Insurance Scheme (NDIS), and the introduction of NDIS Local

strategic leadership of the interface between the AOD, community-based mental health, acute mental health and disability sectors in the region.

Figure 2 below illustrates the governance structure overseeing catchment-based planning for 2017-2018. Unless otherwise stipulated, the findings and actions identified in this plan apply to both catchments (Inner and Outer East) and both sectors (mental health and AOD).

Figure 2: EMR catchment-based planning governance structure, 2017-2018



## Salient policy, strategy and service developments in 2015-2017

In late 2015 and early 2016, three reports were released which identified important post-reform systemic issues for both the AOD and MHCSS sectors, and proposed solutions that will likely impact on how these services are delivered across the EMR, moving forward. Key findings and recommendations which are relevant

to the Action Plan 2017-2018 can be found in Table 1. In particular, the centralised intake and assessment processes were strongly identified as needing refinement to remove barriers to access, especially for vulnerable clients.

**Table 1:** Issues and solutions proposed as part of independent reviews to strengthen the post-reform AOD and MHCSS service systems

Report	Systemic issues identified	Solutions proposed
<p><b>Independent Review of the New Arrangements for the Delivery of Mental Health Community Support Services and Drug Treatment Services</b></p> <p>Aspex Consulting, September 2015</p> <p><i>Applies to both AOD and MHCSS (unless stipulated otherwise)</i></p>	<ul style="list-style-type: none"> <li>• Phone-based intake and assessment creates barriers for clients, especially vulnerable clients</li> <li>• Insufficient focus on family involvement in intake and assessment</li> <li>• Concerns about the appropriateness of the screening tools and their excessive complexity</li> <li>• Perception of limited support being provided to clients who are waiting for service</li> <li>• Clients with co-occurring AOD misuse and mental illness have to complete two separate intake and assessment processes to access services</li> <li>• AOD only: separation of assessment and treatment roles viewed as problematic</li> <li>• MHCSS only: widespread un-winding of group activities and drop-in services</li> <li>• Lack of a funding structure for dual diagnosis clients</li> </ul>	<ul style="list-style-type: none"> <li>• Streamline the current screening tools</li> <li>• Support service model that increases proportion of supported referrals and outreach assessments, particularly for vulnerable client groups</li> <li>• Develop a common assessment template for dual diagnosis clients</li> <li>• AOD only: review resource for Care and Recover Coordination services for clients with multiple service needs</li> <li>• AOD only: fully devolve the assessment function to treatment service providers</li> <li>• Implement a new service category/stream and funding category focused on a 'brief intervention', which would be applicable to both clients and carers/family interventions</li> <li>• DHHS, in collaboration with the AOD and MHCSS sectors, to develop a workforce strategy</li> <li>• Develop an integrated funding model that blends drug treatment and MHCSS for dual diagnosis clients</li> <li>• Assess the suitability of resourcing for 'care, recovery and coordination' service and the scope for coordinated service models for clients with multiple service needs</li> </ul>



Report	Systemic issues identified	Solutions proposed
<p><b>DHHS Sector Forum: Adult Alcohol and Other Drug Community Based Service Provision Review</b></p> <p>Dr Heather Wellington, 22 April 2016</p> <p>AOD-specific</p>	<ul style="list-style-type: none"> <li>• AOD screening tool perceived as excessively structured and inflexible</li> <li>• Inconsistent quality of client assessments, generally and in relation to culturally and linguistically diverse (CALD) and Indigenous clients specifically</li> <li>• Lack of pathways for some client groups, including Indigenous clients</li> <li>• Inconsistent and potentially inadequate support for people on waiting lists</li> <li>• Poor connections and integration with the rest of the health care system</li> <li>• High burden of data collection on clinicians</li> </ul>	<ul style="list-style-type: none"> <li>• Redesign the screening tool, moving away from structured questions that are perceived as deskilling clinicians to a semi-structured tool that supports clinical discussion</li> <li>• Improve staff skills</li> <li>• Develop specific tools for young people, adults, dual diagnosis clients and families</li> <li>• Incorporate family violence into the screening tool</li> </ul>
<p><b>Regional Voices</b></p> <p>VAADA, February 2016</p> <p>AOD-specific</p>	<ul style="list-style-type: none"> <li>• AOD intake and assessment identified as a priority issue, due to process at initial contact and multiple steps needed to get to treatment, especially for complex clients</li> </ul>	<ul style="list-style-type: none"> <li>• Review eligibility and access to services via the screening process to ensure neither is a barrier for clients seeking AOD support</li> <li>• Facilitate access for complex clients: support engagement and flexible modes of service delivery (including outreach)</li> <li>• Brief intervention and family support should be included as treatment modality</li> <li>• Develop tailored models for youth services that address engagement and retention challenges with this cohort</li> <li>• Workforce development strategies should support collaborations, partnerships and linkage development amongst agencies</li> <li>• Reduce administration and bureaucracy to streamline service access and increase time spent on clinical work</li> <li>• Develop outcome measurement to demonstrate system effectiveness and inform sector planning and development</li> </ul>

Additional documents were released shortly before or after the finalisation of the high-level EMR Integrated mental health and alcohol and other drugs catchment plan 2016-2018 (December 2015). As these also critically shape the policy, strategy and funding context for

catchment-based planning, their specific relevance to the three main priority areas of catchment planning is summarised in Table 2 below.

**Table 2:** Mapping of salient reports, policies and strategies and their relevance to specific catchment-based planning priority areas

Document	Family violence	Service users with dependent children	Aboriginal and Torres Strait Islanders
<b>Independent Review of the New Arrangements for the Delivery of Mental Health Community Support Services and Drug Treatment Services</b> Aspex Consulting, September 2015		<p>Recommends adequate training/ information in relation to enhanced family involvement at intake and assessment</p> <p>Recommends implementing a new service category/stream focused on a 'brief intervention', which would be applicable to both clients and carers/family interventions</p>	<p>Recommends developing program guidelines to promote good practice for vulnerable clients with multiple service needs</p>
<b>Regional Voices report</b> Victorian Alcohol and Drug Association (VAADA), February 2016		<p>Recommend that family support be funded as a treatment modality</p>	
<b>Royal Commission into Family Violence: Summary and Recommendations</b> State of Victoria, March 2016	<p>Recommends that:</p> <ul style="list-style-type: none"> <li>• Common Risk Assessment Framework (CRAF) be reviewed and redeveloped</li> <li>• Risk Assessment and Management Panels (RAMPs) are rolled out (with mental health and AOD representation)</li> <li>• Development and establishment of Support and Safety Hubs</li> <li>• A workforce development and training strategy be developed for priority sectors, including mental health and AOD</li> <li>• Interventions for perpetrators be researched, trialled and evaluated</li> </ul>	<p>Recommends that priority funding is available for therapeutic interventions and counselling for children and young people who are victims of family violence.</p>	<p>Recommends that:</p> <ul style="list-style-type: none"> <li>• Invest in programs that provide 'wrap-around' support to parents and children, especially in the first five years of life</li> <li>• Continue to work in partnership with Aboriginal communities</li> </ul>

Document	Family violence	Service users with dependent children	Aboriginal and Torres Strait Islanders
<p><b>Victoria's 10 year mental health plan 2015-2025</b></p> <p>State of Victoria, November 2015</p>	<p>A key action includes reviewing how services respond to people experiencing trauma family violence and child sexual assault. Reference is made to 'The Roadmap for Reform: Strong Families, Safe Children'</p>	<p>Mental health services need to work more closely with:</p> <ul style="list-style-type: none"> <li>• School-based programs to build resilience and influence attitudes that support mental wellbeing of children and young people.</li> <li>• Social and community services to develop effective consumer and carer peer support practice models for children and young people, families and carers.</li> </ul>	<p>Key action includes: DHHS to develop an Aboriginal mental health and wellbeing framework with Aboriginal community controlled health organisations and communities.</p>
<p><b>Always was, always will be Koori</b></p> <p>Commission for Children and Young People Victoria, October 2016</p>	<p>Recommends that: Address family violence and intergenerational trauma through healing informed interventions.</p>	<p>Recommends that:</p> <ul style="list-style-type: none"> <li>• Services implement culturally competent methods for early identification of child's Aboriginality</li> <li>• Aboriginal disability support workers to work closely with the proposed Aboriginal child protection teams in each DHHS division.</li> </ul>	

Document	Family violence	Service users with dependent children	Aboriginal and Torres Strait Islanders
<b>Roadmap for Reform: Strong Families, Safe Children</b> State of Victoria, April 2016	Key actions include: <ul style="list-style-type: none"> <li>• Assist universal services to identify and respond to family violence (reference made to Royal Commission into Family Violence).</li> <li>• Implement recovery focussed interventions for children, youth and families</li> </ul>	Key actions include: <ul style="list-style-type: none"> <li>• Increase timely access to universal services for vulnerable children and their parents through flexible and integrated service responses.</li> <li>• Provision of strengths based, family-centred interventions</li> <li>• Implement a service navigation function</li> <li>• Improve information sharing and collaboration between child protection and specialist services to identify risks to children.</li> <li>• Publish a children and families research strategy and improve broader data and information sharing across the system</li> <li>• Develop a collective impact framework to improve planning and local decision making</li> </ul>	Key actions include: <ul style="list-style-type: none"> <li>• Build supportive and culturally strong communities and improving access to universal services</li> </ul>

Additional documents which primarily impact a single area are also listed under their relevant priority section.

### **National Disability Insurance Scheme (NDIS) roll-out**

Finally, it is also important to be cognisant of the eventual roll-out of the National Disability Insurance Scheme (NDIS) across the EMR, scheduled for November 1st 2017.

It is anticipated that most (~90%) MHCSS funding will transition to the NDIS. MHCSS providers are currently highly concerned with preparing their operations for this significant transition in funding and service

model to customer-centred packages. NDIS funding is also expected to be very lean, which will likely leave mental health organisations with limited overheads and capacity to engage in cross-sectoral collaboration, service coordination and regionally-driven workforce capacity building initiatives, such as those proposed in the draft Action Plan 2017-2018

## Action planning

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### *Priority areas for catchment-based planning in 2016-2018*

#### *Process of selection in 2015*

In November 2015, the Planning Council reviewed the evidence gathered to date on the region's AOD and mental health service system, and the residing population's needs for services and support. Through a facilitated deliberative process, the Council identified four priority areas (out of 10 proposed possibilities<sup>2</sup>) for catchment-based planning to concentrate on for the period 2016-2018. These areas were selected on the basis of the weight of evidence available both internationally and regionally that demonstrated their significant impact or connection with mental illness and/or AOD misuse, their alignment with broad national, state and regional policies and strategies, and opportunities to build on existing or upcoming regional work. These four areas were:

1. Family violence
2. Service users with dependent children
3. Young people
4. Aboriginal and Torres Strait Islander Peoples

#### *Progress achieved in 2016*

In 2016, the catchment-based planning function undertook further intensified and targeted cross-sectoral engagement, in order to gain a deeper understanding of current and upcoming work related to each priority area. This was a necessary step to ensure that the actions listed in this plan are aligned with and add value (rather than duplicate) to what is currently happening in the AOD, mental health and other relevant sectors (family violence, family services, etc.), are relevant to the regional context, and benefit from the buy-in associated with collaborative processes for identifying issues and solutions.

A diverse range of methods were used to create engagement with relevant regional stakeholders and develop the understanding of the regional situation under each priority area; these are outlined in Table 3. More detailed descriptions of each data collection or engagement method can be found in Appendix 1.

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<sup>2</sup> The proposed areas which were not prioritised at this stage for targeted work were homelessness, culturally and linguistically diverse communities, ice, older persons aged 65+, physical health and service system access and navigation.



**Table 3: Methods for data gathering and regional engagement implemented in 2016, to inform action planning**

Method	Family violence	Service users with dependent children	Young people	Aboriginal and Torres Strait Islanders
Client file review (n=110 for AOD; n=50 for MH; Aboriginal n=47)	X	X	X	X
Service provider survey	X	X	X	X
Service provider focus group			X	
Sector engagement and consultation	X	X	X	X
Workshop - Rapid improvement methodology	X	X		
Data review	X	X	X	X
Document review		X		X
Working Group meetings	X	X	X	

The process for identifying and validating proposed actions varied slightly for each priority area, and is explained below, under each area's specific section.

### *Decision-making in 2016-2017*

In December 2016, the Planning Council participated in a facilitated discussion to explore the implications of the roll-out of the NDIS in the EMR in late 2017, and began working through the endorsement of the various actions proposed under each of the four priority areas. This conversation continued in February 2017, when the proposed action plans for the four priority areas were combined into a single plan and condensed, in light of the announced reduction in funding and resourcing capacity for catchment-based planning. This resulted in negotiations around which regional platforms were best placed to carry out some of the work identified. As such, while young people remain a significant priority for the region, it was noted that the needs identified were being addressed in a range of existing key

partnerships, which involve similar senior stakeholders. In the interests of minimising duplication, it was agreed that other partnerships would manage the young people priority area. Information gathered in 2016 about this priority area is presented in Appendix 2.

### *Resourcing and role of the catchment-based planning team*

Actions proposed as part of the Action Plan 2017-2018 relate primarily to workforce capacity building and systems, cross-sectoral integration and cross-sectoral collaboration. Implementation now largely depends on appropriate commitment and resourcing by Planning Council members and service provision organisations.

As such, the focus of the catchment-based planning team for the period 2017-2018 will be redirected towards:

- Supporting the establishment of a combined working group (bringing together representatives from the 2016 working groups) to drive the implementation of actions endorsed by the Planning Council, and maintain ongoing secretariat support.
- Undertake discrete projects as required under the action plan, such as mapping exercises that will inform further action by regional partner organisations.
- Collaborate closely with the Eastern Mental Health Service Coordination Alliance (EMHSCA) and its sub-committees, to jointly facilitate the implementation of shared work priorities and maximise impact.
- Establish close linkages with the Eastern Melbourne Primary Health Care Collaborative (EMPHCC) and its relevant working groups, to participate in and influence regional discussions around service system pathways.

- Supporting AOD service providers in identifying actions to improve the service system in response to emerging regional and local needs.
- Ongoing gathering and analysis of data regarding regional population and community needs, and service gaps and pressures, with an AOD services focus.
- Initiate the establishment of a relationship with the EMR's NDIS Local Area Coordinator (LAC).

In the rest of this section, the combined action plan for catchment planning's three priority areas is outlined, preceded by key findings and observations which serve to situate the proposed actions within the regional context. Deliberately, much of the data detail has been located in appendices.

In line with catchment-based planning's three-year planning cycle, the main focus of this action plan is on the remainder of the 2015-2018 planning period. However, it is recognised that many proposed actions require a longer-term vision, and this is reflected where appropriate.

## Priority area 1: Family violence

### WHY WAS THIS SELECTED AS A PRIORITY AREA FOR ACTION IN 2016-2018?

Across Australia, approximately one in three women aged 15 years or over have experienced physical assault, one in five women have experienced sexual assault, and over half of all women have experienced at least one incident of physical or sexual violence in their lifetime<sup>3</sup>. Family violence is not limited to intimate partner violence, but also encompasses violence that might occur between family members, such as between siblings and across generations (e.g. parents as victims of violence by teenage or adult children). While family violence is predominantly perpetrated by men against women and children, it can also occur in same-sex relationships and against males at the hands of females. Family violence is not always physical in nature, and may also consist of threats, psychological and emotional abuse, financial control and purposeful social isolation.

The links between family violence, mental health (MH) and alcohol and other drugs (AOD) use are multiple and complex:

- Among Victorian women aged 15-44, violence against women is the leading contributor to death, disability and ill-health. Poor mental health outcomes, including depression and anxiety, accounts for the majority of this burden of disease (62%)<sup>1</sup>
- Intimate partner and sexual violence against women can lead to depression, post-traumatic stress disorder, sleep difficulties, eating disorders, emotional distress and suicide attempts
- Women who have experienced intimate partner violence are almost twice as likely to experience depression and problem drinking

- Sexual violence, particularly in childhood, has been associated with an increased risk of smoking and drug and alcohol misuse<sup>4</sup>
- A recent report from Victoria's Crime Statistics Agency (2016) showed that some form of definite alcohol use was flagged in 21.2% of family violence incidents recorded by police over a two-year period (2014-2015): 8.0% noted alcohol use by both victim and perpetrator, 1.7% noted alcohol use by the victim only, and 11.6% showed alcohol use by the perpetrator only. Interestingly, alcohol use by either or both parties tended to be associated with older perpetrator age. Perpetrators recorded as having used alcohol were also more likely to be male (82.9%). Perpetrator alcohol use was also associated with greater frequency of threats to harm or kill (victim, family member, children, pets), children being present and perpetrator history of mental illness/depression<sup>5</sup>
- Whilst not causal factors, evidence suggests that in individual cases of family violence, mental illness and AOD use are risk markers for increased severity and frequency. Still in relation to alcohol, the evidence shows that the severity and risk of injury is increased; women's rehabilitation from drug and alcohol problems is directly related to whether they are able to escape domestic violence; and that perpetrators use their substance use as a 'tactic of abuse' to increase fear and control<sup>6</sup>.

<sup>3</sup> Cox, P. (2015) Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey 2012, Horizons Research Report, Issue 1, Australia's National Research Organisation for Women's Safety (ANROWS), Sydney; and Woodlock, D., Healey, L., Howe, K., McGuire, M., Geddes, V. and Granek, S. (2014)

<sup>4</sup> <http://www.who.int/mediacentre/factsheets/fs239/en/>

<sup>5</sup> Sutherland, P., McDonald, C., Millsteed, M., In Brief No.7: Family violence, alcohol consumption and the likelihood of criminal offences, Crime Statistics Agency, December 2016, <https://www.crimestatistics.vic.gov.au/research-and-evaluation/publications/family-violence-alcohol-consumption-and-the-likelihood-of>

<sup>6</sup> Family Violence Royal Commission Witness Statement. Humphries, C WIT.0006.002.0001, July 16, 2015

## The bigger picture – what’s happening in this space at the national and state levels?

Tables 1 and 2 above detailed findings and recommendations from salient reports, which are relevant to the region’s work to improve the response to AOD and MHCSS service users who are impacted by family violence.

## The situation in the Eastern Metropolitan Region

### What do we know about family violence in the EMR?

As shown in Table 4 below, rates of recorded family incidents from Victoria Police indicate an increase in the reporting of family-related incidents across all local areas of the Eastern Metropolitan Region (EMR) over a five-year period (2011 to 2016). This mirrors the trend across the whole state of Victoria. This suggests that either family incidents are on the rise in the region, and/or that its reporting is increasing. Rates across all local government areas of the Outer East (Knox, Maroondah and Yarra Ranges) are markedly higher than in the Inner East (Boroondara, Manningham, Monash and Whitehorse).

**Table 4:** Rates of recorded family incidents, per 100,000 population, on a financial year basis (July-June)

Rates of family incidents, per 100,000 population					
Municipality	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Boroondara	309.3	343.3	373.2	366.2	470.4
Manningham	424.7	487.2	552.0	591.9	646.1
Monash	508.0	624.2	637.4	667.4	709.7
Whitehorse	435.0	510.6	554.9	620.9	635.1
Knox	883.0	1,028.0	950.5	1,048.9	1,117.6
Maroondah	657.3	803.0	882.3	890.4	1,056.9
Yarra Ranges	704.9	731.0	912.4	913.3	1,081.2
All of Victoria	886.7	1,056.0	1,116.4	1,194.1	1,288.7

### Results from client file review

Data on family violence is not currently being gathered on a systematic basis across mental health and AOD services in the EMR. Addressing this would enable us to gain a clear regional picture of the co-occurrence of family violence, mental illness and AOD concerns. In mid-2016, a client file review was conducted to provide an initial snapshot of family violence

identification and management by the region’s state-funded, community-based AOD and MHCSS service providers. Broadly, the audit revealed that:

- In both sectors, more females than males report currently experiencing or having experienced family violence in the past



- In the majority of cases, experience of family violence recorded in client files related to the past. AOD clients tended to have more current experience of family violence than MHCSS clients
- Few clients identified being perpetrators; in many cases, perpetrators also identified being victims of family violence, thereby suggesting very complex family situations
- Of all clients who identified experiencing family violence in either service sector, only about a third of clients were recorded as being referred on to other services, whether counselling, specialist family violence, or others.
- Respondents described their service response to people experiencing family violence as victims, or perpetrators, as consisting of the following:
  - o Part of core service response and external referrals (both AOD and MHCSS)
  - o Internal referrals (in addition to the above), for AOD services only
- AOD and MHCSS service providers share consumers experiencing family violence with a range of other organisations, including Eastern Domestic Violence Service (EDVOS), Eastern Legal Service, Legal Aid, respite services, child protection, Safe Steps, Eastern Centre Against Sexual Assault (ECASA), and Safe Futures.

Summary data can be found in Appendix 3.

### ***Results from service provider survey***

A survey was conducted in mid-2016 with a small sample of AOD and MHCSS service providers, in order to gain insights into their perceptions and experience of working with consumers with various co-occurring issues, including family violence. Salient findings include:

- Family violence was one of the most prominently identified co-occurring issues for clients of both AOD and MHCSS services, and for various groups of consumers, particularly young people, Aboriginal and Torres Strait Islanders, and service users with dependent children
- The majority of respondents from organisations in both the AOD and MHCSS sectors estimated making between one and five referrals per week to family violence-specific services, for both victims and perpetrators. This somewhat contrasts with the low frequency of referrals being evidenced in the case notes reviewed as part of the client file review, revealing either a mismatch between provider perception and the reality of referral practices, or under-recording of referral practices for family violence-related issues

### ***Primary Care Partnership skills audit for family violence***

In mid-2016, the Outer East Health and Community Support Alliance (OEHCSA, or Primary Care Partnership) carried out an online 'Identifying and Responding to Family Violence Needs Assessment Survey' across the EMR. Results from this survey have been filtered to look at the specific needs of respondents who identified working in either an AOD or mental health program. Findings from this skills audit which are relevant to this action plan are:

- About four out of five respondents from either AOD or MH programs stated that they screen women and/or children who access their services for family violence, whether routinely or on an ad hoc basis. More AOD respondents (42%) stated conducting routine family violence screening than MH respondents (23%). However, about half of these, in both sectors, stated that this was not done using a specific tool



- More AOD respondents (58%) than MH respondents (46%) were aware of their organisation having a policy to guide the identification and response to client disclosures of family violence
- Respondents from the AOD and MH sectors supported in similar proportions the range of organisational supports which could support their identification and response to family violence: professional development (70%), workplace policy and/or procedure (48%), supervision and support (39%), access to secondary consultation (45%), and clearly identified referral pathways (52%).  
The only point of difference between the two sectors related to the desire to see more support and leadership from senior management, identified by 48% of MH respondents compared to 25% for AOD respondents
- Only 40% and 50% of MH and AOD survey respondents, respectively, stated having attended family violence training in the past three years. All these respondents had received training on the CRAF. Close to two thirds (62%) of all respondents believed that they needed training and support in identifying and responding to family violence, marking a need for ongoing strategies to be in place.

### *What is currently happening in family violence regionally?*

The lead-up to and release of the Royal Commission into Family Violence in 2016 has created a groundswell of activity and commitment to the prevention of family violence across all of Victoria, and the EMR is no exception. Many governance structures and initiatives were already in existence in the region, and have thus become important platforms to enable collaborative action in this area.

The following regional governance or collaborative structures have relevance to the work proposed here:

- EMR Family Violence Partnership (EMRFVP)
- Together for Equality and Respect (TFER) Strategy
- EMR Social Issues Council
- Outer East Child and Youth Area Partnership (OECYAP)

## Action planning

### Process used to collaboratively identify actions

#### Family Violence Working Group

In early September 2016, a Family Violence Working Group was established to guide the development of this Action Plan, on behalf of the EMR Mental Health and Alcohol and Drug Planning Council. Its inter-sectoral membership (see full list in Appendix 4), co-led by Peter Ruzyla (EACH) and Jenny Jackson (EDVOS), met three times to shape the design of an Action Planning Workshop (see below for details) and ensure that the actions proposed in this plan are:

- Based on evidence of need in the region, as established through data collection and practitioner wisdom
- Congruent with the recommendations and proposed actions from the Royal Commission into Family Violence and other sector reform documents
- Aligned with the work of other regional initiatives, such as the EMR Family Violence Partnership

All members of the working group have reviewed this plan and have had input into its development.

#### Action Planning Workshop

On Friday 21 October 2016, a workshop was held to inform the development of this action plan. Specifically, it aimed to identify solutions and actions that would enable the EMR's AOD and MHCSS service sectors to:

1. Be responsive to the needs of victims of family violence
2. Work together with other sectors to optimise the safety of victims
3. Work collaboratively with other sectors to enhance perpetrator accountability

Attendees included representatives from the region's AOD, MHCSS, and family violence sectors, DHHS, OEHCSA, and consumers and carers. A full list of attendees can be found in Appendix 5. The structure of this workshop was based on rapid improvement methodology and facilitated by Eastern Health.

It brought participants together to reflect on:

- What's working well for service users with mental health and/or AOD concerns who are also experiencing family violence
- What's not working well
- Solutions and actions

A summary of discussion points from the day is found in Appendix 6. The solutions and actions proposed during the workshop were themed, then further discussed and refined by the Family Violence Working Group. The proposed actions generated as part of this process have been discussed by the Planning Council in December 2016 and February 2017, and where relevant and appropriate, combined with those of other priority areas (Table 6).

## Priority area 2: Service Users with Dependent Children

### WHY WAS THIS SELECTED AS A PRIORITY AREA FOR ACTION IN 2016-2018?

Children and young people can be vulnerable to neglect and harm if the capacity of parents and family to effectively care, protect and provide for their long term development and wellbeing is limited. This can be the case when stressors such as AOD misuse, and poor mental health in parents/guardians are present in the family environment. These factors can also contribute to a child's under-participation in key universal services, such as early childhood services and school, thereby entrenching disadvantage and leading to poorer developmental and educational outcomes<sup>7</sup>.

In addition, care of children is recognised as providing a significant protective factor in relation to parental wellbeing and recovery from poor mental health. Supporting parents, who are consumers of mental health and/or AOD services, to recover, is therefore essential to family wellbeing. Support for children of service users is also vitally important as a preventative strategy for both children and parents.

### *The bigger picture – what's happening in this space at the state level?*

In 2012, the Bouverie Centre was commissioned to develop a Client-Centred Framework for Involving Families, to specifically support and guide mental health and AOD services in working collaboratively with the families of an individual with mental illness and/or AOD concerns<sup>8</sup>. This framework assumes that while adult clients remain the focus of care, mental health

and AOD services must play an important role in assisting families, including where children may be vulnerable or may be taking on a carer role, in identifying and addressing their own needs.

Effective parenting, and parental support contributes to resilience and recovery. There is emerging evidence of the value of programs designed specifically to assist parents with mental health and substance abuse problems<sup>9</sup>. The links between parental mental health and/or AOD misuse and childhood and youth vulnerability, including children in out of home care, are well documented.

In recent times, there has been growing awareness that the carer role in such families can fall to children, and whether or not children are in a caring role, they can also develop deteriorating mental health as a result of family stress if not well supported.

Establishing effective family-focussed practice has been identified as requiring multiple enablers, from workforce capacity e.g. training, post-training support, and organisational supports and structures to systemic changes e.g. widespread use of efficient tools and protocols, flexible funding models, cross-sectoral collaboration and efficient referral pathways with family services<sup>10</sup>.

<sup>7</sup> [http://www.dhs.vic.gov.au/\\_\\_data/assets/pdf\\_file/0010/764281/Victorias\\_vulnerable\\_children\\_strategy.pdf](http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/764281/Victorias_vulnerable_children_strategy.pdf)

<sup>8</sup> From Individuals to Families; A Client centred Approach For Involving Families – The Bouverie Centre LaTrobe University 2012.

<sup>9</sup> Ibid

<sup>10</sup> Building capacity for cross-sectoral approaches to the care of families where a parent has a mental illness – Advances in Mental Health: Promotion, Prevention and Early Intervention 2015

The Independent Review of New Arrangements for the delivery of Mental Health Community Support Services and Drug Treatment Services by Aspex Consulting, commissioned by DHHS in 2015, identified a number of structural issues associated with the MHCSS and AOD post reform model. There was general support for priority of access, consistent screening tools and assessment. However, of relevance to this population group, issues identified include:

- Phone-based intake and assessment creates barriers for clients, especially vulnerable clients
- Insufficient focus on family involvement in intake and assessment (tools)
- Insufficient focus on clients with multiple service needs (tools, treatment response criteria)
- Capping of number of sessions - inflexible
- Insufficient funding flexibility to address inter-agency service coordination
- Capacity and capability of the workforce to meet expectations
- Lack of funding for dual diagnosis (or other) model

Relevant recommendations included:

- Streamlining the current screening tool
- Development of program guidelines in relation to vulnerable clients with multiple needs
- Ensuring there is adequate training in relation to carer and family involvement

The 2016 VAADA report, *Regional voices: The impact of alcohol and other drug sector reform in Victoria*, detailed provider feedback at regional consultations and relevant issues identified including:

- The difficulty at intake/assessment to engage with, identify and respond to complex issues (in addition to AOD clinical)
- Family support not recognised as a treatment type modality
- Workforce development needs to support collaboration

Eastern Health's FaPMI program recently participated in a cross-sectoral workforce development initiative called *Keeping Families and Children in Mind*, which aimed to build the capacity of various service sectors (including mental health and AOD) to deliver family-focused practice. Evaluation revealed that the successful development of such complex practice takes time, support and commitment from both workers and their organisations, cross-sectoral training and post training support<sup>11</sup>.

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<sup>11</sup> Goodyear, M., Obradovic, A., Allchin, B., Cuff, R., McCormick, F., Cosgriff, C. (2015) Building capacity for cross-sectorial approaches to the care of families where a parent has a mental illness, *Advances in Mental Health*, 13(2): 153-164.

## *The situation in the Eastern Metropolitan Region*

### **What do we know about service users with dependent children in the EMR?**

In addition to the plans and policies detailed earlier in Table 2 (page 10), it is important to consider alignment with the following plans and regional activity:

- Integrated Family Services Alliance – Inner East and Outer East Catchment Plan 2016-2017
- Families where a parent has a mental illness – A service development strategy 2017 (FaPMI)
- Outer East Child and Youth Area Partnership
- Taskforce 1000

The current EMR Integrated Family Services Catchment Plan identified mental health as a key priority. This includes professional development for family services staff, stronger engagement with the mental health sector and reviewing practice when working with mental health issues. Family services are currently looking at how to provide Mental Health First Aid training to all family services staff.

### **Family Services Statistics**

- In the Inner East, approximately 230 referrals are made to Integrated Family Services per quarter. Monash has the highest referral rate followed by Whitehorse then Boroondara and Manningham.
- Referrals from mental health services to Child Protection and Police have increased over time.
- In the Outer East, Integrated Family Services receive approximately 350 referrals per quarter. Yarra Ranges has the highest referral rate followed by Knox then Maroondah. The most common source of referrals are 'self-referrals', followed by referrals from Child Protection and then mental health services. Referrals from mental health services are highest in the Yarra Ranges and very low from Maroondah.

### **MHCSS and AOD Statistics**

Data from DHHS about the proportion of MHCSS and AOD consumers in each LGA who have dependent children indicates that 14% of AOD service users have dependent children living at home, and 0.6% of MHCSS service users have dependent children living at home. As the data is not compulsory to complete, 27% - 56% of family status is unknown.

### **Results from service provider survey**

As previously noted, a survey was conducted in mid-2016 with AOD and MCHSS services (SURE consortia, ECADS consortia, EACH – MHCSS Intake). Identified key issues regarding family responsiveness included:

- Cautiousness of clinicians to ask about parenting capacity – fear of client disengagement and fear of subpoena regarding child protection issues
- Providers' perception regarding extent of referrals to family services:
  - o All advise one to five referrals per week on average
  - o Internal and warm referrals into AOD/MH (by-passing Intake) may not record family service engagement occurring
  - o Advise that written information regarding support services (including family services) is given out in sessions but not necessarily recorded
- Tensions between AOD and Child Protection would benefit from improved collaboration
- More support programs required for carers in general, particularly children, would assist referral



The survey explored referrals occurring between EMR MHCSS and family services, and AOD and family services, however this has been difficult to determine by examining data captured due to variations in what is specified as a referral organisation.

Respondents from across EACH, Neami, Inspiro, Youth Substance Abuse Service (YSAS), Reconnexion, Anglicare, Prahran Mission, Link Health and Community and Access Health & Community identified the following top co-occurring conditions for service users with dependent children in their services:

- MHCSS service users with dependent children – AOD, housing, family violence, financial stress
- AOD service users with dependent children - family violence, mental health, Child Protection

#### ***Results from client file review***

A snapshot review of documents completed at Intake, Assessment and in case notes for MCHSS and AOD was undertaken to get a better picture of the identification, response and referral of service users with dependent children.

Initial screening processes in both sectors identify service users with dependent children, and throughout screening tools there are references to children and their safety. The client file review undertaken showed that identification of safety risk was subjective and varied. There was also minimal documentation regarding the mental wellbeing and specific needs of children where a parent has a mental illness or substance issues, with recorded information about identification, response and referrals relating primarily to safety risks. Furthermore, a few instances were noted where family violence trauma was identified for the consumer-parents, but no risk to the children was recorded. Further details on the findings of the client file review can be found in Appendix 3.

Based on these summary findings, there appears to be a need to improve the focus placed on children and parents and their specific needs, with respect to both safety and wellbeing, as part of MHCSS and AOD service provision.

## Action planning

### Process used to collaboratively identify actions

#### Service Users with Dependent Children Working Group

The Service Users with Dependent Children Working Group was established and met five times during 2016. Its inter-sectoral membership (see full list in Appendix 4) was co-led by Rebecca Johnson (Eastern Health) and Amanda Exley (Anglicare). The group's purpose was to discuss data, issues from the various sectors' perspectives, and to discuss current governance bodies, structures and initiatives that align with this priority group (including those detailed above).

Issues were identified by the working group (collated in Appendix 7), which informed the scope of the Action Planning Workshop.

#### Action Planning Workshop

On 3 November 2016, a workshop was held to inform the development of the action plan. Attendees included DHHS, Child Protection, consumers, MHCSS, AOD and family services. A full list of attendees can be found in Appendix 5. The objective of the workshop was to collaboratively develop a regional plan to ensure that state-funded MHCSS and AOD services in the EMR:

1. Are responsive to the needs of service users who are parents
2. Are responsive to the health, mental wellbeing and safety of children of service users
3. Collaborate with family services

The strengths, issues and themes identified by participants regarding implementing family-inclusive practice for people with mental health and/or AOD concerns are listed in Appendix 6.

Workshop participants identified a number of potential solutions. The working group refined these into goal statements and actions and have identified key stakeholders to be involved in the delivery. The proposed actions generated as part of this process are presented in Table 6.

*"When discussing children of MH and AOD service users within our community, it is paramount to consider their needs in context to the family unit. These children are no different to any other child whose parent is suffering an illness. To ensure the best interests of these children, one must first address the needs of the primary care giver. It often reminds me of the emergency safety plan demonstrated at the beginning of a flight - the adult must first place on their own oxygen mask so they are in the best position to be at the aid of all in their care. I believe this perspective is perfect when addressing reform of service users with dependent children".*

*Sian Pietsch – Consumer representative*

## Priority area 3: Aboriginal and Torres Strait Islander Peoples

### WHY WERE ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES SELECTED AS A PRIORITY AREA FOR ACTION IN 2016-2018?

The links between Aboriginal status, mental health and alcohol and other drugs concerns are multiple and complex:

- Compared to the non-Indigenous population, Aboriginal and Torres Strait Islander Peoples have consistently been found to have higher prevalence of psychological distress (anxiety and depression symptoms) particularly among adults (between 50% to three times higher)
- In 2013, Indigenous Australians were found to be more likely to abstain from drinking alcohol than non-Indigenous Australians (28% and 22%, respectively). However, among those who did drink, a higher proportion of Indigenous Australians drank at risky levels
- Recent reports suggest methamphetamine (ice) is replacing alcohol as the drug of choice in some Aboriginal and Torres Strait Islander communities (Harvey, 2015).<sup>12</sup> Ice is associated with increasing levels of violence, particularly domestic violence
- In 2013, Indigenous Australians were estimated to be 1.6 times more likely than non-Indigenous people to have used any illicit drug during the previous 12 month-period<sup>13</sup>
- Across Australia, age-standardised rates of suicide are on average nearly twice as high for Aboriginal

and Torres Strait Islander people than for non-Aboriginal people<sup>14</sup>

- Indigenous Australians are also more likely than the non-Indigenous population to experience co-occurring life stressors, which are often linked to mental health and/or AOD concerns, including gambling problems, involvement with the police, being a witness to or being a victim of abuse or violent crime, and family violence<sup>15</sup>
- Taskforce 1000 survey data for the East DHHS Division (2014-15), reviewed children who were identifying as having a mental health concern (n=45). Of those children, 71% were receiving treatment/ support, 11% placed in a mental health facility and 11.4% of children were using substances<sup>16</sup>.

There is increasing recognition that Aboriginal social, spiritual and cultural determinants of health are not well understood and hence affect the overall health and well-being of Aboriginal people<sup>17</sup>.

<sup>12</sup> Harvey A, McGregor A, Ice addiction overtaking alcohol as biggest problem facing Indigenous Australians, rehab expert says, ABC News (website), 1 April 2015. Online publication: <http://www.abc.net.au/news/2015-04-01/ice-addiction-overtaking-alcohol-biggest-problem-indigenous/6365926>

<sup>13</sup> <http://www.druginfo.adf.org.au/topics/aboriginal-and-torres-strait-islanders>

<sup>14</sup> [http://www.health.gov.au/internet/main/publishing.nsf/content/305B8A5E056763D6CA257BF0001A8DD3/\\$File/1.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/305B8A5E056763D6CA257BF0001A8DD3/$File/1.pdf)

<sup>15</sup> [http://www.healthinfonet.ecu.edu.au/uploads/resources/29415\\_29415.pdf](http://www.healthinfonet.ecu.edu.au/uploads/resources/29415_29415.pdf)

<sup>16</sup> Melbourne: Commission for Children and Young People (2016). Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria. <http://www.cyp.vic.gov.au/downloads/always-was-always-will-be-koori-children-inquiry-report-oct16.pdf>

<sup>17</sup> Behrendt, L., Jorgensen M., Vivian, A (2015). Self-Determination: Background Concepts Scoping paper prepared for the Victorian Department of Health and Human Services. University of Technology, Sydney.

## *The bigger picture – what's happening in this space at the national and state levels?*

It is increasingly being acknowledged and understood that Aboriginal culturally-specific governance is a crucial element for the realisation and achievement of self-determination goals, and that communities must be empowered to take control and deliver the services that they need <sup>18 19 20</sup>.

The peak body for Aboriginal health in Victoria is the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). It provides support to their community members, but to also engage, advise and influence government policy makers, funding bodies and other stakeholders and partners to consider how health services are developed and provided to the Aboriginal community<sup>21</sup>.

### **Policy, key planning and implementation directions**

A significant number of Victorian and Commonwealth government planning and implementation initiatives and frameworks are in place to drive and contribute to the improvement of the health and well-being of the Aboriginal community. Appendix 8 summarises key planning initiatives and report recommendations that are relevant to AOD and mental health work, to improve provider response and provision of effective services and programs with Aboriginal community members. Overall, it is important to note the following common themes and approaches across these multiple planning initiatives:

- The importance of strengthening self-determination, governance and empowerment of Aboriginal communities, through fostering community ownership and responsibility when designing, implementing and evaluating services and programs
- The health and wellbeing needs of Aboriginal and Torres Strait Islanders must be addressed across the lifecycle
- Improving Aboriginal people's access to mainstream services including mental health and other support services is planned to be achieved through:
  - o Understanding the importance of early life intervention and Aboriginal person's connection with their community
  - o Increasing mainstream service provider cultural competency and capability. Lack of awareness, understanding of and engagement with local Aboriginal communities can often lead to discrimination and racism
  - o Integrating culturally safe and appropriate service approaches that are responsive to the Aboriginal person's needs
  - o Investigating co-design of policy, services and programs with the Aboriginal consumers and community
  - o Improving service coordination and continuity of care between mainstream services and Aboriginal controlled health and community organisations
  - o Strengthening service provider healing-informed approaches, including intergenerational trauma

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<sup>18</sup> Behrendt, L., Jorgensen M., Vivian, A (2015). Self-Determination: Background Concepts Scoping paper prepared for the Victorian Department of Health and Human Services. University of Technology, Sydney.

<sup>19</sup> Michael Weightman (2013). The Role of Aboriginal Community Controlled Health Services in Indigenous Health. 4(1)Australian Medical Student Journal 49

<sup>20</sup> Patrick Sullivan (2007). Indigenous Governance: The Harvard Project, Australian Aboriginal Organisations and Cultural Subsidiarity. (Working Paper No 4/2007, Desert Knowledge CRC, 2007) 15

<sup>21</sup> <http://www.vaccho.org.au/>



- Increase and promote employment opportunities for Aboriginal and Torres Strait Islander Peoples
- Build and strengthen partnerships based on respect both within and between Aboriginal and Torres Strait Islander peoples and mainstream service providers
- Explore service system redesign opportunities that have the flexibility to deliver locally-based and culturally appropriate service delivery approaches to the Aboriginal community
- Improve the range and quality of research and evaluation activity to generate evidence to inform the development of culturally appropriate service model interventions and service delivery approaches

### *The situation in the Eastern Region*

#### *Structures and service provision to Aboriginal and Torres Strait Islanders in the EMR*

In the EMR, Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCOs) deliver a number

of health and wellbeing services and programs in their local community. Community members, as well as mainstream mental health and AOD providers commonly link up with the following ACCHOs and ACCOs (locations illustrated in Figure 3):

- Victorian Aboriginal Health Service (VAHS)
- Ngwala Willumbong Ltd
- Mullum Mullum Indigenous Gathering Place (MMIGP)
- Healesville Indigenous Community Services Association (HICSA)
- Victorian Aboriginal Child Care Agency (VACCA)
- Boorndawan Willam Aboriginal Healing Service (BWAHS)
- Victorian Aboriginal Legal Service (VALS)
- Dandenong and District Aborigines Co-Operative Limited (DDACL)

**Figure 3:** Geographical location of Aboriginal-specific services available to EMR residents





As can be observed from Figure 3, there is significant clustering of EMR Aboriginal-specific organisations and services in the Outer East. This potentially creates access difficulties for Aboriginal people living in the Inner East, as they would need to either travel to the Outer East or out-of-catchment to the inner city to find Aboriginal-specific services.

### What do we know about Aboriginal community members in the EMR?

Census data shows that 0.4% of the EMR's total population identify being of Aboriginal and/or Torres Strait Islander descent<sup>22</sup>. While they are mostly dispersed across the area, a greater concentration of this community group is evident in particular suburbs, as identified in Table 5.

Table 5: Number of EMR residents identifying as Aboriginal or Torres Strait Islanders (2011)

LGA	Catchment total	Suburbs with greatest number of Aboriginal people
Inner East	1,047	Glen Waverley, Mount Waverley, Mulgrave (all within Monash LGA)
Outer East	1,928	Healesville, Ferntree Gully, Boronia, Mooroolbark, Croydon
Whole EMR	2,975 (0.4%)	-

(Since this catchment plan was developed, more data was released in June 2017 regarding the region's Aboriginal and Torres Strait Islander population, based on the 2016 Census, which can be found at [www.abs.gov.au](http://www.abs.gov.au). Data from the 2011 Census was purposefully kept in this report, as this is what was available during the decision-making process).

In both catchments, and as in the rest of Australia, the Aboriginal population tends to have a younger age profile compared to the non-Aboriginal population<sup>23</sup>. Furthermore, it has been identified that:

- Aboriginal children are over-represented in the Eastern Region's Child Protection system, making up approximately 10% of open cases in early 2015
- Aboriginal children and young people are also over-represented in substantiated cases of child abuse and placements in out-of-home care in the EMR. Drivers for Aboriginal children coming into out-of-home care include family violence, parental substance misuse, mental health issues (parent and/or child), and disability (parent and/or child)<sup>24</sup>

Mental health and AOD misuse have repeatedly been identified as priorities for action as part of regional consultation processes with the Aboriginal and Torres Strait Islander community<sup>25</sup>.

### What do we know about Aboriginal community members in the EMR?

The survey of AOD and MHCSS service providers in 2016 suggests that, based on provider perception, key co-occurring issues for Aboriginal and Torres Strait Islander service users in the region are:

- For AOD service users: disconnection, forensic, social isolation, family breakdown, family violence, child protection involvement, mental health, and homelessness
- For mental health service users: AOD, homelessness, family violence, legal issues, cultural isolation, financial issues and ageing

<sup>22</sup> Department of Health and Human Services, 2014. Eastern Metro Region profile. [https://www2.health.vic.gov.au/getfile/?sc\\_itemid=%7b147E9B18-A7E1-489A-92F6-E61DCB78D21C%7d&title=Eastern%20Metro%20Region](https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b147E9B18-A7E1-489A-92F6-E61DCB78D21C%7d&title=Eastern%20Metro%20Region)

<sup>23</sup> ABS 2011 Census of Population and Housing.

<sup>24</sup> Melbourne: Commission for Children and Young People (2016). Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria. <http://www.cyp.vic.gov.au/downloads/always-was-always-will-be-koori-children-inquiry-report-oct16.pdf>

<sup>25</sup> DH, 2013. Report on the EMR Koolin Balit and Aboriginal Health Outer East Community Consultation Workshop (23 September 2013).

### *Aboriginal and Torres Strait Islander Peoples accessing EMR mental health and AOD mainstream services*

Given that they make up 0.4% of the EMR population, and their anticipated higher burden of mental illness and AOD concerns, Aboriginal and Torres Strait Islander Peoples appear to be relatively well represented in the region's mainstream mental health and AOD service user populations:

- Of the 5,771 AOD clients in the period July 2015-June 2016, approximately 3% identified being Aboriginal and/or Torres Strait Islander (4% Outer East, 3% Inner East)
- Of the 1,947 MHCSS clients in the same period, approximately 2% identified being Aboriginal and/or Torres Strait Islander (3% Outer East and 1% Inner East)

These figures are likely to be under-estimates, with non-disclosure of Aboriginal status a frequent phenomenon observed by mainstream services.

Below is a summarised snapshot of data (from the 2015-2016 period) and trends that describes the Aboriginal member profile and highlights the complexity of Aboriginal consumers accessing AOD and mental health services. Additional descriptive and summary data can be found in Appendix 9.

- Aboriginal people engaging with AOD services are often repeat consumers (66% repeat), whereas for MHCSS services they are mostly new consumers (78%)
- The Aboriginal consumer age profile is somewhat older for those engaging with MHCSS than with AOD

- Within the MHCSS cohort, 38% of Aboriginal consumers only identified their Indigenous status post intake, during service provision
- Prioritisation of Aboriginal consumers for service provision was relatively low within both service systems: 21% for AOD and 35% for MHCSS
- Primary drugs of concern identified for Aboriginal AOD consumers were alcohol (40%) and amphetamines (21%). Polydrug use was flagged for two thirds of AOD consumers
- For both AOD and MHCSS, self-referrals were the most frequent mode of contact with intake services. The second highest sources of referrals were from AOD and mental health services (for each opposite sector). For AOD services, a further 14% of referrals originated from forensic and child protection agencies; for MHCSS, 8% came from family and child protection services
- Nearly all consumers had identified co-morbidities (96% in MHCSS, 93% in AOD). Some of the most frequent co-occurring issues identified included unemployment and homelessness
- According to Aboriginal-specific client file review process, experience of family violence appears to be frequent in the service user population:
  - Twenty-one percent of female AOD consumers reported being victims, while 42% of male AOD consumers identified being perpetrators (either past or current)
  - Seventy percent of female MHCSS consumers reported being victims of family violence, while 43% of male consumers reported being perpetrators. In addition, 67% of male consumers reported experiencing family violence as victims in the past
  - Many AOD and MHCSS consumers experiencing family violence are also involved with the child protection system

## *Mainstream AOD and mental health service organisations, contributions to the health and wellbeing of Aboriginal and Torres Strait Islanders – review of Reconciliation Action Plans (RAPs) and Closing the Gap plans*

Responses collected as part of the 2016 AOD and MHCSS service provider survey suggest that referral activity from mainstream AOD and MHCSS services to Aboriginal-specific organisations occurs on a weekly basis, indicating that linkages are currently in place to a certain extent.

A document review of available Reconciliation Action Plans (RAPs) and Closing the Health Gap plans from four organisations that include mental health/AOD services was undertaken to understand what organisations are planning and/or implementing in regards to making change through their work. All RAP and Closing the Health Gap plans reviewed sat at an organisational strategic and/or operational level, with some AOD and mental health specific activity occurring.

There seems to be a lot of planning and implementation occurring in this space, with different levels of readiness and maturity. There is, however, limited evidence of evaluation activity occurring to inform effectiveness of process and outcomes. Key planning and implementation themes relate to:

- Engagement and partnership
- Organisational and sector development and learning
- Workforce development opportunities
- Systems and structures of service delivery

Examples of strategies under each of these themes are listed in Appendix 10.

Some organisations are also taking proactive steps in the development of service models and supportive initiatives and roles to increase Aboriginal connections with mainstream AOD and mental health services, including building and strengthening relationships with the Aboriginal community. Examples include:

- Co-location of AOD and mental health mainstream providers with ACCOs
- Implementation of the Care Coordination and Supplementary Services Program (CCSS Program) which aims to improve the health outcomes of Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary and follow-up care
- Co-design of health service hubs with ACCOs
- Organisational recruitment of Aboriginal-specific roles to support Aboriginal people when accessing AOD and/or mental health services. Key roles include:
  - o Aboriginal liaison/engagement coordinators and officer roles to build capacity of mental health and AOD mainstream services, including making links with the Aboriginal community, secondary consultation, care coordination, broader organisational capacity building
  - o Aboriginal health support roles established to work with Aboriginal people when they access a mental health and/or AOD service, including Aboriginal outreach workers
  - o Koolin Balit-funded roles in Aboriginal community organisations

## Action planning for 2017-2018

### *How can catchment-based planning make a difference and value add to current sector activity?*

Planning and delivery of mainstream AOD and mental health services that are inclusive of Aboriginal and Torres Strait Islander Peoples (youth, adults, families and communities) can be a complex, but rewarding task for many mainstream providers. There is also acknowledgement that a lot of great activity is already happening under this priority area, but unfortunately limited information is available regarding organisational intervention and activity outcomes to inform clear decisions and direction for future work.

Building on previous work achieved both cross-regionally and within organisations will be important, and as such, discussions and negotiations to share lessons learnt and align efforts should be sought, so there is an informed and coordinated approach taken when working with the Aboriginal community. In particular, ongoing meaningful and respectful engagement with the Aboriginal sector is critical for actions under this priority area to be successful. Agreed actions must not duplicate existing initiatives, but add value to current sector and community activity.

As mentioned in the Executive Summary, due to the high demand and burden of over consultation placed on few Aboriginal and Torres Strait Islander staff and organisations, it was not possible to form a formal working group. Semi-structured interviews and discussions with Aboriginal providers and community members has provided rich information about how to best work with Aboriginal people and community and revealed key themes. This information is available in Appendix 11. As a result, the need to include a specific focus on Aboriginal and Torres Strait Islander community needs has been reflected across all relevant actions in Table 6.

## Catchment action plan for 2017-2018

Table 6 below outlines the various actions proposed in order to improve the regional service response to people with mental health and/or AOD concerns who

are also Aboriginal and Torres Strait Islanders, parents with dependent children, and/or experiencing family violence.

**Table 6:** Action plan, 2017-2018

Domain	Action	Steps	Stakeholders
1. Workforce capacity building and systems	1.1. Amend the screening and assessment processes of MHCSS and AOD service providers in the Eastern Metropolitan Region (EMR) to enable the systematic identification of: <ul style="list-style-type: none"> <li>Family violence risk</li> <li>Service users with dependent children (SUDC)</li> </ul>	1.1.1. Provide regional and multidisciplinary input into Turning Point's state-wide review process of the Intake and Assessment tools for AOD services, to suggest questions and wording which would enhance the identification of: <ul style="list-style-type: none"> <li>Family violence (past and current victims and perpetrators) and risk and safety concerns, for both the primary victim and any dependent children</li> <li>Service users with dependent children, and associated parenting or child wellbeing needs</li> </ul>	<ul style="list-style-type: none"> <li>MHCSS and AOD service provision agencies and consortia</li> <li>Family services</li> <li>Family violence specialist agencies</li> </ul>
		1.1.2. Review the screening and assessment tools of all EMR-based MHCSS services, at all points of a service user's journey, to assess their usefulness in identifying: <ul style="list-style-type: none"> <li>Family violence (past and current victims and perpetrators) and risk and safety concerns, for both the primary victim and any dependent children</li> <li>Service users with dependent children, and associated parenting or child wellbeing needs</li> </ul>	<ul style="list-style-type: none"> <li>EMHSCA Strategic Planning Sub-committee</li> <li>MHCSS and AOD service provision agencies and consortia</li> <li>DHHS EMR</li> <li>Family services</li> <li>Family violence specialist agencies</li> </ul>
		1.1.3. Develop an enhanced screening process for AOD and MHCSS service providers across the EMR, and pilot the use of mandatory questions about: <ul style="list-style-type: none"> <li>Family violence harm and risk, and the presence of dependent children</li> <li>Parenting needs and wellbeing needs of children, including where family violence is not a factor</li> </ul>	<ul style="list-style-type: none"> <li>EMHSCA Strategic Planning Sub-committee</li> <li>MHCSS and AOD service provision agencies and consortia</li> <li>DHHS EMR</li> <li>Family services</li> <li>Family violence specialist agencies</li> <li>EMR Regional Family Violence Partnership (EMRFVP)</li> </ul>



Domain	Action	Steps	Stakeholders
		1.1.4. Formally evaluate the usefulness of the piloted amended screening tools, and use this information to advocate to central DHHS for changes to be made to state-wide tools and data collection	<ul style="list-style-type: none"> <li>• EMHSCA Strategic Planning Sub-committee</li> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• DHHS EMR</li> </ul>
	1.2. Build the capacity of the EMR AOD and MHCSS workforces to ensure they have the right skills and knowledge to enable timely and appropriate identification and response to: <ul style="list-style-type: none"> <li>• Family violence risk</li> <li>• Dependent children and their specific support needs</li> <li>• Parenting needs of service users with dependent children</li> <li>• Aboriginal and Torres Strait Islander cultural safety needs</li> </ul>	1.2.1. Compare and contrast the actions proposed by the Planning Council with EMHSCA's work plan	<ul style="list-style-type: none"> <li>• EMHSCA</li> </ul>
		1.2.2. Conduct a mapping exercise to understand the various types of capacity building activities (e.g. training, mentoring, etc.) that are happening across the region in AOD and MHCSS services, with regards to: <ul style="list-style-type: none"> <li>• Family violence risk</li> <li>• Dependent children and their specific support needs</li> <li>• Parenting needs of service users with dependent children</li> <li>• Aboriginal and Torres Strait Islander cultural safety needs</li> </ul>	<ul style="list-style-type: none"> <li>• Outer East Health &amp; Community Support Alliance (OEHCSEA)</li> <li>• EMHSCA Strategic Planning Sub-committee</li> <li>• DHHS EMR</li> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family violence specialist organisations</li> <li>• Eastern Men's Family Violence Network (EMFVN)</li> <li>• Family services</li> <li>• FaPMI (Families where a Parent has a Mental Illness) program</li> <li>• Taskforce 1000</li> </ul>
		1.2.3. Work with EMR AOD, MHCSS, family violence and family services providers across the EMR to develop an inter-sectoral workforce capacity building framework/strategy to strengthen the response to service users with co-occurring mental health, AOD, family violence and/or parenting and children's support <sup>26</sup> .	

<sup>26</sup> Topics for training would need to include (list not exhaustive and will be subject to refinement following additional consultation): recognising and responding to family violence risk (including risk assessment); supporting victims who are still living in the family violence environment; using the Common Risk Assessment Framework (CRAF), in its current form and upcoming revised format; case noting in the context of family violence and family breakdown; identifying and working with service users who are perpetrators of family violence (including accountability); parenting needs of adults with AOD and/or mental health concerns; identifying and supporting the needs of dependent children whose parent(s) have AOD and/or mental health concerns; family-focussed and inclusive practice; cultural awareness about Aboriginal and Torres Strait Islander people and communities; and cultural competency and safety when working with Aboriginal and Torres Strait Islander service users (identifying or not).

Domain	Action	Steps	Stakeholders
			<ul style="list-style-type: none"> <li>• Aboriginal and Torres Strait Islander-specific organisations</li> <li>• Outer East Child and Youth Area Partnership (OECYAP)</li> <li>• Integrated Family Services (IFS) Alliance</li> <li>• EMRFVP</li> </ul>
		1.2.4. Scope and review the packages and providers of family violence-related training, and family inclusive practice that are available across the EMR, with a view to identifying best value for a regional approach to consumers with mental health and substance use issues.	<ul style="list-style-type: none"> <li>• EMHSCA Workforce Capacity Building Sub-committee</li> <li>• DHHS EMR</li> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family violence specialist organisations</li> <li>• Family services</li> <li>• FaPMI</li> <li>• IFS Alliance</li> </ul>
	1.3. Increase peer leadership amongst service users who have dependent children (SUDC), including SUDC-specific peer positions and include carers, parents and children to increase co-design of services	1.3.1. Negotiate with the Eastern Health Peer Support Network to consider including this action under their 2017-2018 work plan	<ul style="list-style-type: none"> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family services</li> <li>• FaPMI</li> <li>• IFS Alliance</li> <li>• Eastern Health</li> </ul>
2. Cross-sectoral integration	2.1. Collaboratively define the interface between the MHCSS, AOD and family services sectors and the development and delivery of Support and Safety Hubs for family violence in the EMR	2.1.1. Initiate a regional discussion through a working group combining representatives from the 2016 Family Violence Working Group and Service Users with Dependent Children Working Group	<ul style="list-style-type: none"> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family violence services</li> <li>• EMFVN</li> <li>• Family services</li> </ul>

Domain	Action	Steps	Stakeholders
		2.1.2. Organise for an independent organisation or consultant to facilitate the development of a model for a collaborative, inter-agency approach to Support and Safety Hubs in the EMR (prior to the tender being released), which would include MHCSS, AOD and family violence / family services	<ul style="list-style-type: none"> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family violence services</li> <li>• EMFVN</li> <li>• Family services</li> <li>• EMRFVP</li> </ul>
3. Cross-sectoral collaboration	3.1. Review current referral practices between AOD and MHCSS sectors, and family violence and family services, to identify opportunities for improvement	3.1.1. Build on the work currently being carried out by the EMHSCA Collaborative Pathways Sub-Committee, to ensure that catchment-based planning's priority areas (family violence, SUDC and Aboriginal and Torres Strait Islanders) are considered	<ul style="list-style-type: none"> <li>• EMHSCA</li> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family violence specialist organisations</li> <li>• Family services</li> </ul>
		3.1.2. Enhance communication and referral pathways between AOD, mental health, family violence, men's behaviour change programs, family services, children's services, and any other sector which works with families in breakdown, family violence victims and/or perpetrators	<ul style="list-style-type: none"> <li>• EMHSCA</li> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Family violence specialist organisations</li> <li>• EMFVN</li> <li>• Family services</li> <li>• FaPMI</li> <li>• IFS Alliance</li> <li>• Aboriginal and Torres Strait Islander-specific organisations</li> <li>• Child Protection</li> </ul>
	3.2. Establish a secondary consultation model between AOD and MHCSS and family services and family violence services	3.2.1. Examine various models for secondary consultation programs (including the one implemented by the Eastern Dual Diagnosis Service), and identify opportunities for collaboration and resourcing	<ul style="list-style-type: none"> <li>• EMHSCA</li> <li>• Eastern Dual Diagnosis Service</li> <li>• DHHS EMR</li> </ul>

Domain	Action	Steps	Stakeholders
			<ul style="list-style-type: none"> <li>• MHCSS and AOD service provision agencies and consortia</li> </ul>
		3.2.2. Re-establish regional groups and processes for secondary consultation around family violence, family services, Aboriginal and Torres Strait Islanders, AOD and mental health	<ul style="list-style-type: none"> <li>• EMHSCA</li> <li>• MHCSS and AOD service provision agencies and consortia</li> <li>• Eastern Health</li> <li>• Family violence specialist organisations – e.g. EDVOS, ECASA</li> <li>• EMFVN</li> <li>• Family services</li> <li>• FaPMI</li> <li>• IFS Alliance</li> <li>• Aboriginal and Torres Strait Islander-specific organisations</li> </ul>
	3.3. Enhance perpetrator accountability across the EMR	3.3.1. Map services and programs across the EMR which work directly with perpetrators of family violence and share with MHCSS and AOD services in the EMR	<ul style="list-style-type: none"> <li>• EMFVN</li> <li>• MHCSS and AOD service provision agencies</li> <li>• Family violence specialist organisations</li> <li>• DHHS EMR</li> </ul>
	3.4. Further strengthen linkages between the Planning Council, MHCSS and AOD service providers and the Aboriginal community and its culturally-specific organisations, services and networks	3.4.1. Tap into existing Aboriginal-specific networks and community engagement structures, in order to collaborate with community around required actions to enhance the AOD and MHCSS service response for Aboriginal and Torres Strait Islanders in the EMR	<ul style="list-style-type: none"> <li>• DHHS EMR</li> <li>• MHCSS and AOD service provision agencies</li> <li>• Eastern Health</li> <li>• Planning Council</li> </ul>

## Appendix 1: Description of data collection methods used to inform action plans

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### *Client file review*

A random review of client files in MCHSS and AOD, analysing between 20 – 50 files in each program area beginning at Intake, through Assessment and Treatment, was conducted with a selection of organisations in the region to determine the process in relation to the consumer's journey. The review included assessing the screening and assessment tools and information recorded, and the practitioner's client file notes to assess identification, response and referral – in relation to family violence co-occurrence; Aboriginal service users; and service users with dependent children. A client journey mapping was conducted in relation to young people.

### *Service provider survey*

A survey was developed to obtain qualitative and quantitative data not collected by funding accountability mechanisms. Surveys requested details regarding programs, eligibility criteria, funding, location, hours of operation, equivalent full-time EFT, and service demand in order to get an understanding of supply in relation to demand. In addition, organisations were asked to respond to questions about consumer complexity such as referrals, collaboration and systemic issues.

### *Data reviews*

Data aggregation and dis-aggregation was requested from the Department of Health and Human Services in relation to MCHSS and AOD service users with dependent children, compared to others; young people, including in adult services; Aboriginal and Torres Strait

Islander consumers; and any service users identifying family violence in the data fields. Data was also sought from family services in the region and a range of public data sources relevant to mental health and alcohol & other drug issues.

### *Document reviews*

It was recognised that there is extensive work being undertaken in relation to MCHSS, AOD and state funded services in relation to the priority population groups. These were taken into account when considering the issues and potential actions and where local actions were occurring there were attempts to align with these to avoid duplication and strengthen effort.

### *Working Group meetings*

Working Groups were established across the four priority areas, with a Priority Lead nominated from within the Planning Council, representing MCHSS and AOD service expertise in the region, and a Co-Lead representing expertise from the priority population group sector, additional to MCHSS and AOD. The Priority Lead and Co-Lead determined the membership for the Working Groups to ensure a cross section of representation of stakeholders. Consumers/carers were also appointed to each priority area. The Working Groups met for different lengths of time commencing in August 2016, depending on availability of members. The Aboriginal Working group did not go ahead. The Catchment Planning team provided secretariat support to these Working Groups. Working Groups were tasked with determining the scope for action within MCHSS and AOD services and the objectives for the cross-sectoral Action Planning Workshops.



### *Action Planning Workshops*

The Catchment Planning team adopted rapid improvement methodology to expand on the work of Working Groups, bringing together representatives from government, primary health networks and primary care partnerships, planning bodies/partnerships and across sectors: mental health (community and acute); AOD; youth and family services; family violence sector; womens' health and Aboriginal services. Representation was across programs including intake, clinicians and leadership. The Action Planning Workshops presented data, set out key objectives, explored issues, practice, and solutions. These were then formulated into action areas and prioritised by relevant working groups.

### *Sector engagement and consultation*

Semi-structured interviews, individual and group discussions with AOD and mental health providers and priority group sectors was employed as a key mechanism throughout the planning process to ensure that issues, opportunities, pressures and gaps were well understood and considered a part of the planning and decision-making processes.

### *Service provider focus group*

A service provider focus group was conducted with AOD providers: SURE and ECADS Intake, to determine the process for referring young people into services and any service gaps, and also with EACH as a provider of residential rehabilitation to determine the process of access and referral for young people with mental health conditions, and any service gaps and any good practice initiatives.

## Appendix 2: Priority area - Young People

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### Introduction

#### *Why was this selected as a priority area for action in 2016-2018?*

Adolescence is a peak age of onset for many mental health disorders. Mental illness and substance use disorders account for 12% of Australia's Burden of Disease <sup>27</sup>.

In 2015, 14% of 4–17 year olds were assessed as having mental health disorders in the previous 12 months. Child and adolescent males (16%) were more likely than females (12%) to have experienced mental disorders in the previous 12 months. The prevalence of mental disorders was slightly higher for older females (13% for 12–17 year olds) than for younger females (11% for 4–11 year olds). However, the prevalence for males did not differ markedly with age. Most alcohol-related harms, namely emergency presentations, ambulance attendances, assaults during high alcohol hours and serious road injuries occur at higher rates in people aged 15-24 than in the general population of all LGAs of the EMR, sometimes up to threefold.

Rates of harm (emergency presentations, hospital admissions and ambulance attendances) associated with both illicit drug use and pharmaceutical drug misuse are also all higher in young people aged 15-24 years than in the general population in all LGAs of the EMR <sup>28</sup>.

In addition, catchment-based planning consultations during 2014 with key informants revealed that difficulties in finding youth-friendly General Practitioners (GPs), and the concentration of many youth-specific mental health and/or AOD services within selected hubs (e.g. Box Hill) of the catchment, can create barriers for young people to access mental health and/or AOD support within the region.

For the purposes of this priority area, young people are defined as those who are of secondary school age, between 12 to 18 years of age.

#### *The bigger picture – what's happening in this space at the state level?*

Catchment-based planning work regarding Young People aligns to the following key strategic documents:

- Victoria's 10 year Mental Health Plan (2015-2025)
- Reducing the alcohol and drug toll Victoria's plan 2013–2017
- Commission for Children and Young People Strategic Plan 2014-16
- Victoria's Vulnerable Children: Our Shared Responsibility Strategy 2013-22
- Balert Booron: The Victorian Plan for Aboriginal Children and Young People 2010 - 2020

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<sup>27</sup> Burden of Disease (2011)

<sup>28</sup> [www.aodstats.org.au](http://www.aodstats.org.au) EMR (2015)

## The situation in the Eastern Metropolitan Region

### What do we know about Young People in the EMR?

AOD services for young people in the EMR are predominantly provided by:

- YSAS – a partner in the SURE Consortia, providing AOD youth outreach and non-residential withdrawal services
- Link Addiction Recovery Service - a partner in the ECADS Consortia, providing AOD services for 12-21 year olds in the Inner Melbourne Catchment, and to young people and their families through the Youth Alcohol and Other Drug Eastern Network (YAODEN) of service providers.
- MHCSS services are provided across the EMR by EACH, Neami and Prahran Mission for 16-18 year olds in an adult service system model
- EACH and Neami provide Youth Residential Rehabilitation programs under the MHCSS funding

Table 7: Youth by AOD service type 2015-2016, DHHS

	Maroondah	Yarra Ranges	Knox	Boroondara	Manningham	Monash	Whitehorse
Planned Respite	55	47	47	31	34	42	60
Residential Rehabilitation	65	39	50	5	<5	<5	5
Individual Client Support Packages	316	278	234	218	121	197	339
Youth Residential Rehab. non-24 hour	9	8	21	18	<5	5	19

A greater number of young people access AOD services than community mental health, although eligible young people up to 25 years of age with a mental health condition can attend the Child & Youth Mental Health Service (CYMHS) provided by Eastern Health. There are instances of cross use of MHCSS and clinical mental health services e.g. CYMHS by clients. There is also anecdotal evidence, from community based providers (focus group 2016), that an increasing number of young people with complex and acute conditions are being serviced in community settings (both for mental health and AOD), as a result of demand exceeding supply in the acute setting. Youth up to 25 years of age can also access federally funded headspace services located in Knox and Hawthorn.

### Results from service provider survey

As previously mentioned, a survey was conducted with EMR AOD and MHCSS service providers to obtain qualitative data about young people accessing these service areas. Respondents identified that the top co-occurring conditions for young people in their services were:

- AOD – Mental health, Child Protection, family breakdown, housing
- MHCSS – AOD, housing, family violence

## *Results from MHCSS and AOD Service Provider Focus Group 2016*

In addition, a focus group of practitioners identified a range of issues relevant to young people's access to services and suggestions for improvement (see Appendix 6 for full details). Key themes arising included:

- Workforce capacity building (including in adult services)
- Collaboration and integration – with Federal and acute MH services, and across treatment areas
- Service gaps in EMR for young people

## *Action Planning*

### *Process used to collaboratively identify actions*

#### **Young People Working Group**

A cross-sectoral Working Group from AOD, Mental Health (Clinical and MHCSS), Youth and Family Services, Education and the Primary Health Network (membership list in Appendix 4) convened in October 2016, with two meetings to consider issues facing young people who are service users of MCHSS and AOD.

The scope was defined as:

- MHCSS and AOD services in EMR, post reform
- Identify gaps, pressures and needs
- Improve service system responsiveness to young people 12 – 18 years

#### **Key themes and issues**

Following analysis of local data including that obtained from service provider surveys and focus group themes, the Working Group built on the following identified issues and themed areas for action:

- Service Improvement – within adult MHCSS and AOD organisations to better support young people

- Staff Training (youth friendly; family focussed; Dual Diagnosis competent)
- Service Coordination/Case Management/Secondary Consultation – across MCHSS, AOD, clinical MH
- Data - need to record and capture consistent data in MHCSS and AOD specific to young people
- Pathways/Mapping - need to build on existing platforms and promote entry points to staff and other sectors
- MHCSS and AOD collaboration with other sectors supporting young people with mental health and substance issues
- MH/AOD service system - need for more programs for young people, and for service gaps to be filled in EMR to improve access

Working Group members identified initiatives that were occurring in the region, in relation to headspace planning and the Primary Health Network planning and commissioning of services, as per their needs analysis. The Working Group was mindful of the need to collaborate and avoid duplication, and work in partnership particularly given the predominant role of headspace in the provision of community based mental health services for young people. Discussion also occurred in relation to: service improvements in AOD for young people with family focussed programs; efforts to improve coordination and colocation with Headspace; and the advent of YAODEN to improve allocation. There was a recognition that the voice of young people was important to be heard regarding the provision of services and in any planning.

## Proposed Actions

The draft Action Plan in Table 8 below was formulated around the recognised need for:

- Engagement with service users supported by their practitioners and service organisations

- To participate in proposed forums led by partners, where the identified issues specific to MHCSS and AOD could be considered and addressed in the next 12 months.

*Table 8: Proposed actions for the young people priority area*

Domain	Goals	Action	Key Stakeholders
Community engagement, consultation and co-design	Develop a deep engagement process/activity with young people who are current/recent service users, support workers and parents to seek their experiences/suggestions to improve MHCSS and AOD services for young people with the aim of capturing innovative practice ideas and ways to better address service integration  Look at creative ways to co-design with young service users	Develop an engagement strategy and research methodology to seek feedback regarding service improvement	Working Group Others to be decided
		Determine resources and leadership to conduct consultation and support from relevant organisations	
		Undertake community engagement with young service users	
		Research methods for the co-design of services and share with organisations interested in participating	
Cross sectoral collaboration	Partner with headspace to gather qualitative data on service needs/ gaps and pathway access	Partner with headspace Knox in their planning event on 17 March 2017 to consult with EMR Local Learning and Employment Network (LLEN), school staff, GPs in schools, Youth Justice, Child Protection, and the Ice Taskforce to determine service needs and gaps	headspace Others to be decided
		Identify opportunities to collaborate with services supporting young people who may be service users of MH or AOD	
Service integration	Partner with the PHN to collaboratively action plan with catchment-based planning	Support PHN to develop a model of care for Early Psychosis in Primary Care to improve MH outcomes for young people. Working Group to participate in December Forum led by PHN	PHN Others to be decided
		Provide support and input to PHN in identifying gaps in services, models, and evidence	



## Appendix 3: Client file review findings

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### *File review findings pertaining to family violence*

The following figures are based on a review of client files (50 for MHCSS, 110 for AOD) to identify any evidence of experience of family violence. This evidence could have been identified as part of screening or assessment questions (where available), or through the review of written case notes. All figures relate to family violence specifically, not general violence.

#### **Experience of family violence for MHCSS consumers (males n=20; females n=30)**

- More females (43%) than males (25%) had evidence in their case notes about having identified experiencing or having experienced family violence
- Most reports of family violence experience related to the past only, and were not recorded as being current: 83% for males and 77% for females
- All females who reported experiencing current family violence (10% of all cases reviewed) also reported past experience
- Of all MHCSS clients (n= 19) reviewed who reported family violence (whether past, current or both), only one (5%) was recorded as having been referred to a specialist family violence service, and six (32%) to a counselling service

#### **Experience of family violence for AOD consumers (males n=50; females n=60)**

- More females (55%) than males (15%) had evidence in their case notes about being a victim of current or past family violence
- Most reports of family violence experience related to the past only, and were not recorded as being current: 56% for males and 76% for females
- Of all cases reviewed, being a current victim of family violence was recorded for one male (2%) and five females (8%)
- Few consumers reported currently perpetrating family violence, or having done so in the past (five males, seven females)
- Half of the consumers identifying as perpetrating family violence also identified as victims
- Of those who had identified experience of family violence (whether victim, perpetrating, or both; n = 42 in total), only 14 (33%) were referred to other services (specialist family violence, counselling, or others)

## *File review findings pertaining to service users with dependent children*

Initial screening identifies service users with dependent children, and throughout screening tools there are references to children and their safety. Identification of safety risk was subjective and varied, and there appeared to be no focus beyond safety, to mental wellbeing of children where a parent has a mental illness or substance issues. Key issues identified are presented here in terms of screening and risk, and referrals to family services.

### **Screening and risk**

- Vulnerable children/risk – identification, response and referral appears to relate to safety risk rather than wellbeing
- Some cases with current family violence trauma occurring between parents were recorded no risk to children
- Indicative analysis – mental health issues are the focus; in majority of cases children are recognised in data collection/mentioned in notes - but not as having mental health needs or as carers

- Parenting not raised/recorded in the treatment
- Children as a protective factor for parent was frequently identified

### **Referral to family services**

- At the request/initiation of client
- One family service referral was for child's physical disability
- Do not occur where Child Protection involved – assumed that family services will be consulted
- When referral to family services raised can be declined by client

## *Summary - Results from MHCSS and AOD client file review*

Provider	File review results
ECADS	60 clients – 17 with dependent children living with Risk to children – 7 Referrals regarding risk – 4 Child Protection; 1 IFS; 2 no referral Children's support needs identified - 9
SURe	20 with dependent children - 11 living with Children at risk – 3 Child Protection involvement – 2 IFS referral – 1 (not at risk) Children's support needs identified – 2 (one physical needs)
MHCSS	20 with dependent children – 18 living with Children at risk – 4 Child Protection involvement – 5 IFS referral – 2 Children's support needs identified - 6

## MHCSS and AOD Intake and Assessment tools

Screening for parents with dependent children and referral to family services can happen at Intake and Assessment. An analysis showed:

- MHCSS Common Intake/ Assessment tool - If the client raises the need for a service for children, at first contact Intake can give them referrals to other agencies (e.g. Family Services), however this is not recorded on the Intake screening tool and would appear as a progress note. The Intake tool refers to dependent children, and vulnerable at risk identified, and whether family services are already involved. There is no prompt to record action or referral on the tool (including mandatory referral). This may appear in the progress notes. Trakcare data records referrals in and not out.
- MHCSS Comprehensive Assessment – Identification of children's needs and referral appears in progress notes.
- AOD Intake – Dependent children are recorded on the (Non mandatory) screen tool (Step 1), but no specific reference of risk to children other than general harm
- A Comprehensive AOD Assessment tool (step 2) is mandatory, but is not always completed for AOD if a screen (step 1) is completed. There are several references to risk/action/referral, however the completion relies on the worker assessment of risk which is likely to be filled in where there is physical risk rather than psychological harm/mental health. Protective factor is identified
- AOD – other tools are being used e.g. by Turning Point, Eastern Drug & Alcohol Service, that either don't reference dependent children/action/referral, or are more comprehensive than the Step 2 tool.
- Recognising dependent children at intake and at assessment however does not mean it will translate into an action regarding the children. Referrals/action can also be recorded in the progress notes, if not identified the assessment tool
- It cannot be concluded without a more thorough audit, whether referral to family services are happening and not being recorded, or not happening. Recorded (audit) figures are low.
- Significant numbers of clients have dependent children temporarily not living with them (due to the nature of their condition), or don't have children (due to age). Significant numbers of clients with dependent children living with them have Child Protection/Family Services involved in their case management prior to seeking service for MHCSS/AOD. Preliminary audits appear to indicate that further action regarding children by AOD/MHCSS is not undertaken in these cases.

### Priority of Access

- For MHCSS a score of 1 (the lowest) is given for: any child protection history; is a single parent; is a parent caring for children under five; is an expectant mother. Unless there are significant other issues, this will not elevate them to priority 1. If they are not immediately assessed as priority 1, the client needs six points or more to be elevated to priority 1. Being a parent is not considered an at risk group for purpose of priority.
- For AOD, tiers 1 -5 are based on risk associated with substance abuse. This can be short term harm through to long term dependency. The priority for service and treatment is based on this plus additional points for complexity. Pregnancy and Care of Children receive a score of 1 each.

### Practitioner Training

- There may be an assumption that low referrals to family services from AOD/MHCSS are due to lack of worker training in family centred practice, however there is no consensus regarding the role of practitioners in doing this, and the funding model time allowance (both for training and for casework) may be a barrier. Other issues in addition to AOD/MH are also increasingly screened for (and as such needing to be responded to) such as family violence, dual diagnosis, physical health, homelessness, etc.
- In addition, there needs to be consensus from the sector on the minimum training required to achieve this – examples for consideration include: 'Let's talk about Children', family centred practice, Child Safety standards, Parenting vulnerable children. The EMHSCA sector audit on workforce capacity should be reviewed and further discussion should take place with FaPMI

### Referrals to IFS

- AOD Intake have the following services listed in data fields: Child first; Family AOD; Family Drug help; Anglicare Parenting Program; EACH Youth & Family Services; EACH Youth GP Clinic.

## Appendix 4: Membership of working groups established in 2016

Family violence working group			
#	Name	Role / Agency	Representing
1	Peter Ruzyla	CEO, EACH	Priority Lead
2	Jenny Jackson	CEO, EDVOS	Priority Co-Lead
3	David Digapony (Sept-Oct 2016) Véronique Roussy (Oct 2016 onwards)	Coordinator Service Planning, Research and Evaluation, EACH	Catchment-based planning team
4	Jelena Djurdjevic	Family Violence Regional Integration Coordinator, EDVOS	Regional Family Violence Partnership
5	Jim Allen	Chair, Eastern Men's Behaviour Change Consortium, Anglicare	Men's Family Violence Services
6	Gina Kennard	Program Manager Intake, EDVOS	Women's Family Violence Services
7	Molly O'Shaughnessy	General Manager Operations, Safe Steps	Women's Family Violence Services
8	Carrie Ashley	Team Coordinator, MHCSS Intake Assessment, EACH	Mental Health Intake/Assessment
9	Edward Marrinen	Service Manager, Neami National	Mental Health Service Providers
10	Deborah McGenniskin	Team Leader, SURE AOD, EACH	SURE Consortium
11	Tamsin Short	Executive Director of Alcohol and Other Drug Services, Access Health and Community/ Connect4Health Consortium	ECADS Consortium Connect4Health Consortium
12	Kristy McKellar	Women's FV survivor advocate	Consumer Representative



Service users with dependent children working group			
#	Name	Role / Agency	Representing
1	Rebecca Johnson	A/Program Director Mental Health, Director of Nursing & APD, Adult Acute Inpatient Services, Eastern Health	Priority Lead
2	Amanda Exley	Manager Family Services, Anglicare	Priority Co-Lead
3	Sonia D'Urbano	Anglicare	SURe Consortium
4	Tracey Blythe	Coordinator Catchment Planning, EACH	Catchment-based planning team
5	Stephanie Frazer	Consumer	Consumer representative
6	Sian Pietsch	Consumer	Consumer representative
7	Anne-Maree Rogers	Program Manager AOD, EACH	SURe AOD Consortium
8	Alan Wood	Service Manager, Neami	MHCSS service provision
9	Gavin Foster	Manager Turning Point Eastern Treatment Services, Eastern Health	Turning Point AOD Consortium
10	Rebecca Allchin	Coordinator FaPMI, Eastern Health	FaPMI program
11	Dejoel Upkett	Operations Manager, Eastern VACCA	Aboriginal Child & Family services
12	Daniela Pepe	Integrated family services Alliance Catchment Planner	Integrated family services
13	Kirsty Jungwirth	Coordinator, FaPMI, Eastern Health	FaPMI program

Young people working group			
#	Name	Role / Agency	Representing
1	Anthony Raitman	Area Executive Director Outer East North Eastern Victoria Regional Services Group Department of Education and Training	Priority Lead
2	Peter Stockton	AOD Youth Principal Practitioner, YSAS	Acting Co-Lead
3	Tracey Blythe	Coordinator Catchment Planning EACH	Catchment-based planning team
4	Kylie Scoullar	Manager CYMHS, Eastern Health	Clinical MH
5	Joel Robbins	Manager Youth, MH & AOD, EMPHN	EMPHN
6	Richard Lough	Manager Youth and Family, and headspace, EACH	Youth and Family services
7	Allicia Garrett	Service Manager Hawthorn, NEAMI	MHCSS
8	Matthew Pearse	Manager NEAMI National	MHCSS
9	Joel Chatelier	Consumer	Consumer representative
10	Allysha Taylor	Consumer	Consumer representative
11	Russell Jackman	Carer	Carer representative

## Appendix 5: Attendance lists for Action Planning Workshops

Family violence workshop, 21 October 2016		
#	Participant name	Affiliation
1	Joel Chatelier	Consumer
2	Peter Ruzyla	EACH
3	Eddie Thomson	Community member
4	Sian Pietsch	Consumer
5	Gina Kennard	EDVOS
6	Melissa Stepancic	Neami
7	Stephanie Frazer	Consumer
8	Tricia Maloney	Consumer
9	Stephen O’Kane	Wesley Mission
10	Sue Gibbons	EACH SURe AOD
11	Deb McGenniskin	EACH SURe AOD
12	Jess Bernales	Neami
13	Rachael Bloom	Neami
14	Tom Stylli	EACH SURe AOD
15	Ed Marrinan	Neami
16	Graeme Cochrane	EACH
17	Tamsin Short	Connect4Health / ECADS Consortium
18	Jim Allen	Anglicare / Men’s Behaviour Change Consortium
19	Victoria Monahan	Turning Point / ECADS Consortium
20	Jelena Djurdjevic	Regional Family Violence Partnership
21	Annette Rudd	EACH
22	Catherine D’Arcy	EACH
23	Mike Quaass	EACH Mental Health
24	Teddy Sikhali	Turning Point / ECADS Consortium
25	Leigh Garde	Department of Health and Human Services
26	Kerryn Super	Link Health and Community / ECADS Consortium
27	Jenny Jackson	EDVOS
28	Jacky Close	Outer East Health and Community Support Alliance
29	Russell Jackman	Carer

### Service users with dependent children workshop, 3 November 2016

#	Participant name	Affiliation
1	Joel Chatelier	Consumer
2	Sian Pietsch	Consumer
3	Stephanie Frazer	Consumer
4	Peter Ruzyla	EACH
5	Rebecca Johnson	Eastern Health
6	Amanda Exley	Anglicare
7	Sonia D'Urbano	Anglicare
8	Anne-Maree Rogers	EACH SUR <sub>e</sub> AOD
9	Dejoel Upkett	Eastern VACCA
10	Alan Wood	Neami
11	Gavin Foster	Turning Point/Eastern Health
12	Rebecca Allchin	Eastern Health
13	Kirsty Jungwith	Eastern Health
14	Trudy Parker	DHHS EMR
15	Leigh Garde	DHHS EMR
16	Victoria Monahan	Turning Point / ECADS Consortium
17	Jade Gibson	Child Protection
18	Jacqui Smith	Child Protection
19	Rachel Pritchard	EMPHN
20	Monica Robertson	Connections
21	Bronwyn Williams	EMHSCA / Eastern Health

## Appendix 6: Themes from Action Planning workshops

### Themes identified as part of the family violence workshop

#### What's working well?

Workshop participants identified a number of things that are currently working well, in terms of the service response currently being provided to EMR residents who are experiencing co-occurring family violence and mental health and/or AOD issues. They were themed under practice domains:

Practice domain	What's working well?	
	About the processes	About the system
Intake and screening	<ul style="list-style-type: none"> <li>• Co-location of family workers/AOD/ family violence services in schools and community settings</li> <li>• Listening to clients</li> <li>• Identification of family violence at screening</li> <li>• Listening to clients</li> <li>• Staff capacity to have conversation and explore, not just screen</li> </ul>	<ul style="list-style-type: none"> <li>• Centralised and standardised process</li> <li>• Clear access points</li> <li>• Family violence screening tool already incorporated into mental health/AOD manuals</li> <li>• Capacity building across services</li> </ul>
Assessment	<ul style="list-style-type: none"> <li>• Inter-service relations (AOD)</li> <li>• Similar language used across disciplines</li> <li>• Secondary consultations with family violence workers, legal services</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of additional assessment tools for family violence</li> <li>• Standard forms in AOD</li> <li>• Consumer-driven referrals (AOD)</li> <li>• Whole-of-person approach (AOD)</li> </ul>
Needs register	<ul style="list-style-type: none"> <li>• Reporting of family violence increases priority level (mental health)</li> <li>• Proactive follow-up (mental health)</li> </ul>	<ul style="list-style-type: none"> <li>• Opportunities to reprioritise if circumstances change (MH)</li> <li>• Recognition of bridging work (AOD)</li> <li>• Use of standardised priority criteria</li> </ul>
Allocation	<ul style="list-style-type: none"> <li>• More experienced clinicians identified to work with clients with family violence</li> <li>• Flexibility of gender of worker (MH)</li> <li>• Collaboration</li> <li>• Family violence alerted when allocating to a worker (AOD)</li> </ul>	<ul style="list-style-type: none"> <li>• Consumers with family violence are picked up quickly</li> <li>• Suitable referrals made (AOD)</li> <li>• Ability to apply consistent principles and criteria for allocation</li> </ul>
Service delivery	<ul style="list-style-type: none"> <li>• Thorough consumer history, needs and requirements identified</li> <li>• Appropriate referrals made for clients experiencing family violence</li> <li>• Collaboration during referral processes</li> <li>• Staff building trusting relationships with consumers (MH)</li> <li>• Case management</li> <li>• Some after-hours services for AOD</li> <li>• Family single session and brief intervention as a funded activity (AOD)</li> </ul>	<ul style="list-style-type: none"> <li>• Co-location, secondary consultation and capacity building already starting in the EMR between family violence and AOD sectors</li> <li>• Collaborative action on shared system issues (e.g. TFER)</li> <li>• Mandated staff skills in some areas (AOD)</li> <li>• Governance groups and activities in EMHSCA</li> <li>• Shared training opportunities</li> <li>• Dual diagnosis and family sensitive approach (AOD)</li> </ul>



		<ul style="list-style-type: none"> <li>• Care recovery and coordination for complex AOD cases</li> <li>• Increased MHCSS worker awareness and education in identifying family violence and response pathways</li> </ul>
Discharge	<ul style="list-style-type: none"> <li>• Exit interviews ask about quality of relationships established (MH)</li> </ul>	<ul style="list-style-type: none"> <li>• Consumer-centred and goal-oriented (AOD)</li> <li>• Clear understanding of support available for future if required</li> <li>• Opportunity to ask about follow-up or referral to other service needs</li> </ul>

### *What's not working well? Identified issues*

The following themes were identified as the top 10 priority issues needing consideration across the EMR, with regards to community members experiencing co-occurring AOD, mental health and family violence:

- Barriers to intake: at initial contact, intake is not user friendly, multiplicity of forms and screening tools, phone-based process
- Lack of service provision for specific client groups e.g. cultural and linguistic diversity, disability, homelessness, LGBTI, Aboriginal and Torres Strait Islanders
- Interagency communication, with regards to data sharing, systems, processes and information. Agencies currently operate in silos, and there is a lack of cooperation
- Identification of service provision for all population groups affected by family violence, currently not explicitly covering all gender, age, and types of family relationships
- Services are not consumer-centric or consumer-led
- Lack of resources are impacting on consumer/provider relationships, including qualifications and clinical
- Social stigma and personal shame associated with mental health issues, AOD concerns and experience of family violence, are barriers to community members reaching out to seek support
- Lack of recognition of family violence within AOD and mental health services, partly due to a lack of understanding and agreement on the definition of family violence and associated levels of risk
- Lack of discharge planning and after-care gaps
- Organisational and clinical training programs for family violence that is evidence-based and accredited.

## Themes identified as part of the service users with dependent children workshop

### What's working well?

The workshop reflected on the consumer journey, strengths of the service system and positive changes since the reform, and identified improvements and good practice across community mental health, AOD and family services. This was an important place to start from and address what needed to be built on. These were themed into practice domains:

Practice domain	What's working well?
Intake and screening	<ul style="list-style-type: none"> <li>• Standardised screening – not individual practitioner dependent</li> <li>• Family and carer specific questions in screening tool</li> <li>• Workers, intentions to assist consumers</li> <li>• AOD – engagement with client, increase in referrals to family services</li> <li>• There is a screening tool for MH</li> <li>• Improved intake – gathering information, consistent approach</li> <li>• Child First provides a lot of information and advice to families and services regarding risk and support options</li> <li>• Good identification of AOD and MH issues impact on parental capacity – Child First &amp; IFS</li> <li>• Non-compulsory questions</li> <li>• Screening tools to identify vulnerable children</li> <li>• Adapted to reform AOD – added to mandated work to include family work</li> <li>• Screening tools identify parenting in MH</li> </ul>
Assessment	<ul style="list-style-type: none"> <li>• Options to utilise additional modules in AOD i.e. Family violence</li> <li>• Face to face assessment where possible</li> <li>• Assessment team clinical review</li> <li>• Solid assessment criteria to child first</li> <li>• Best interest assessment and planning to address issues to improve family functioning and child safety</li> <li>• Some staff explore the needs of children further and consider appropriate referral</li> </ul>
Needs register	<ul style="list-style-type: none"> <li>• Family is identified early (AOD)</li> <li>• Client recovery focussed</li> <li>• Monitoring of consumers on the needs register</li> </ul>
Allocation	<ul style="list-style-type: none"> <li>• Weekly allocation meeting (AOD)</li> <li>• Allocation from needs register can reflect prioritisation identified by intake/assessment</li> <li>• EMR Shared Care Protocol</li> <li>• Referral to family focus services who are consortia partners early in AOD treatment</li> <li>• If family and children are identified at screen – assessment and treatment is at the service that provides family services</li> <li>• Ability to change workers if a clash of personalities</li> </ul>
Service provision	<ul style="list-style-type: none"> <li>• Having a mix of different service options</li> <li>• After hours contact points for emergency workers/services</li> <li>• Consumer - targeted services for individual/family needs (MH)</li> <li>• Supervision themes – vulnerable children</li> <li>• Committed staff with specialist skills and trained in dual diagnosis and trauma</li> </ul>

	<ul style="list-style-type: none"> <li>• Consumer – variety of services accessible, diverse approaches, needs met when client comfortable</li> <li>• Senior family group established (AOD)</li> <li>• Care team focus (MH)</li> <li>• Care team approach (FS)</li> <li>• Experienced clinicians at each site knowledge of family focus work (AOD)</li> <li>• Maintain engagement while discussing risk to promote safety Child First (IFS)</li> <li>• MH interventions available – Let's Talk</li> <li>• Increasing awareness of children and families – included in EMHSCA shared care protocol</li> <li>• Individual recovery plans – these are improving (to include family) as we move forward in AOD</li> </ul>
<b>Transition</b>	<ul style="list-style-type: none"> <li>• Referrals and closure planning (IFS)</li> <li>• Some work started on outcomes measures in AOD includes family focus</li> <li>• AOD clinicians follow up referrals</li> </ul>
<b>System</b>	<ul style="list-style-type: none"> <li>• Child First- Child Protection partnership and community based Child Protection</li> <li>• EMHSCA</li> <li>• Regional Planning Council</li> <li>• Consumer input into service system development MH &amp; AOD</li> <li>• Range of tools available – education, resources for clients</li> <li>• Governance groups (Planning Council, Outer East Child Youth Area Partnership)</li> <li>• Interaction between service providers</li> </ul>

## Workshop issues and themes

### What's not working well?

#### Inflexible processes/multiple entry points (MH/AOD/FS)

The issues related to the need to reduce administration required by practitioners; the limitation of engagement over the phone or in short sessions; the need to streamline processes across care plans; length of time of process risks disengagement; and the need to better support transition.

#### Wider system

Issues related to time pressures and targets impacts engagement and collaboration, and are not flexible to meet client need; high demand impacting staff retention and capacity to deliver; lack of integration (AOD, MHCSS, FS) in planning and delivery; need for meaningful data; lack of services for children/parents in this situation; loss of Services Connect is a gap.

#### Obstacles to identification/response/referral (parent/child needs)

Issues included navigating worker fear of raising and disengagement and consumer fear of disclosure and unknown ramifications; and the difficulty of keeping a family focus whilst addressing presenting mental health or AOD issues.

#### Learning and knowledge/capacity building

In summary, capacity building needs to be delivered to AOD and MHCSS practitioners around the needs of children; the needs of parents who are service users; engaging with parents around their needs and their children; cultural awareness; legal implications and knowledge of child protection practice; risk, safety and assessing for child wellness; trauma informed practice; and knowledge of family services.

### Need to assess more holistically

Practitioners identified the need for better tools to support family focussed work; the need to involve consumers in any redevelopment of tools/system; and the need to consider raising the priority weighting for service users who are parents.

### Family perspective – holding child and parent vision

Specifically some issues for consideration in adopting family focused work included the need to focus on men as parents not just mothers; the need to recognise and respond to carers including children caring for parents; and exit from service needs to consider children.

## *Themes identified as part of the AOD and MHCSS Young People Service Provider Focus Group*

### System improvements:

- Need more workers trained in trauma response; BPD; youth specialist AOD
- Currently headspace is MH (not integrated with AOD - just a visiting service); starting to learn family focus since advertising campaign to families. Not enough AOD in SURE to base in all headspaces
- More rehab required for both youth and adult
- 21 year olds are seen as an adult – young men this age particularly prefer youth focused service >25 year old
- As was highlighted on Four Corners, getting a bed (detox and TC) when it is actually needed/wanted by the client
- When a young person turns 21/22 they are no longer eligible for outreach AOD support
- Recently, SURE and YSAS collaborated to create a non-residential withdrawal position that works with young people up to 25 years in an outreach capacity. This has worked really well
- While there is much discussion surrounding dual diagnosis competency, I have only come across one clinician in Eastern Health who is in a dual diagnosis classified role, otherwise people still need to have multiple people in their care team. Perhaps if there was greater collaboration between stakeholders to create positions (see point 3) that were more of a 'one-stop-shop' for people?
- A simpler, more succinct AOD screen. Not just the standard one a lot of agencies use, but also YSAS's when trying to support a person accessing detox/TC

### Kids lost in transition

Identified the need to get feedback from children during parent's treatment, and about transition and referrals.

### Challenges of collaboration

Specific areas for improvement included more collaboration with Child Protection; need for greater information sharing across MHCSS, AOD and FS, and the need for dependent children to be on the agenda of EMHSCA.



### **Youth residential mental health service offerings in the EMR. Lack of acute residential youth services**

- There are three youth residential rehabilitation services in the EMR. Hawthorn Youth Residential Rehabilitation YRR (NEAMI) and the two (ITCs) in Box Hill South and Wantirna South. We are therefore well catered for in terms of one year community residential mental health supports.
- However, there is a lack of more acute youth specific offerings such as the short stay 1 month **YPARC** (for individuals departing hospital who need more support or individuals who are deteriorating or likely to deteriorate and need additional support). There are two YPARCs available in Frankston and Dandenong. None in the EMR. We have 2 adult PARC services.
- The EMR also lacks youth specific Community Care Units (CCU). These services provide longer term mental health support in a structured residential clinical environment. Our clients who require clinical monitoring for safety and medication management need to utilise adult services.
- Adult residential mental health services are not appropriate for youth in most instances.

### **Lack of headspace accessibility**

Headspace is a great resource for local communities providing an open door for emerging mental health issues. However, headspace is not accessible to all members of the EMR unlike clinical services that are offered across the entire region. There is a Hawthorn headspace and a Knox headspace but none in Box Hill or Ringwood.

### **Accessing clinical mental health services is difficult for members of the MHCSS.**

Clinical services often redirect clients referred by MHCSS providers. I have experienced this on a number of occasions where clients that were clinically/ acutely unwell fell through the gaps with clinical services refusing to provide case management. This resulted in hospital stays and increased periods of safety issues for the client, family and other supports.

Clinical services often hold clients that don't appear to need high levels of support and meanwhile decline new clients that do need a high level of support.

### **The partners in recovery (PIR) programs need to be limited to the most complex care arrangements**

PIR programs are relatively new (maybe 5-6 years old). They provide case coordination type support to clients and hold a pool of funds to ensure complex clients. support is well organised/coordinated (i.e. liaising with care team organising meeting, arranging funds etc.). However, in practice they work with clients with varying degrees of complexity. Clients without highly complex issues such as comorbid intellectual disability, forensic and AOD issues receive this service and it is a waste of resources. The PIR service needs to be truly limited to the most complex clients (with complex service interactions). Otherwise funds should be directed to workers that work one-to-one with the clients.

### **Good Practice:**

- I would highlight the ITC (Residential Rehab) improvement of service and collaboration with clinical and other MHCSS services. Our clinical partners in Early Psychosis Team and Intensive Mobile treatment provide us with secondary consultations each month and this is another example of sharing resources and experiences that benefits the sector.
- The department's change to a new centralised intake system is an improvement as it is transparent with members of the clinical services supporting the allocation of clients to the ITC and other youth residential rehabs.
- We also have a link with the YSAS/Sure worker that enables our clients to access AOD services and residential rehabilitations with greater ease than before. Good model where AOD based next to headspace – improving collaboration.



## Appendix 7: Issues and focal points for action identified by Working Groups

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### *Service Users with Dependent Children*

#### Key issues identified by the Working Group

- Risk management, safety planning
- Screening, assessment, action - family/parent/child focused practice – funding constraints
- Support programs for parents with a mental health/substance issue, support programs for children where a parent has a mental health/substance issue
- Data/records – incomplete, not shared between AOD/MHCSS and IFS
- Children's voices – not present in planning/service delivery
- Staff knowledge of privacy regulations, referral pathways, trauma informed
- Staff skills/confidence/tensions – buy-in/responsive to client, service model constraints on building rapport e.g. AOD; complexity; time and throughput; MHCSS waiting lists
- Consumer fear to discuss children; trust in system/ lack of understanding and transparency
- Working with Child Protection

#### Focal points identified for action

- Service quality/service improvement within MHCSS and AOD – family focus, parents, children
- Staff training
- Service coordination/case management/secondary consultation – across MHCSS and AOD and IFS, Child Protection
- Data improvement
- System barriers with current model

## Young people (12-18)

Key issues identified by the Working Group

### Service Improvement – Within MHCSS and AOD Organisations

#### SYSTEM COMPONENT

Family focused work (youth plus parents/carers) – increased funding	SUPPLY
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### Staff Training

Family focused work (youth plus parents/carers) – capacity building	SUPPLY
Capacity building regarding acute young people and early psychosis	SUPPLY
Workforce capacity: increase dual diagnosis competencies, trauma informed, borderline/other personality disorders, and more practitioners in adult services having a youth focus	SUPPLY

### Service Coordination/Case Management/Secondary Consultation – Across Organisations

Case management in preference to multiple referrers	SUPPLY
Secondary consultation to schools – who can provide?	SUPPLY
Catchment Plan/Primary Health Network Plan – how to align?	CATCHMENT PLANNING
NDIS & Partners In Recovery – what are the implications for the Action Plan and services (AOD/MHCSS)?	CATCHMENT PLANNING

### Data

Comprehensive mapping of AOD/MH services/locations/EFT (supply) against demand data	CATCHMENT PLANNING
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## Pathways/Mapping

AOD/MHCSS services for parents – information and promotion	SUPPLY
Entry points e.g. MHCSS Intake, AOD Intake, headspace – promotion to local government youth services and schools	SUPPLY
Early intervention programs – information and promotion	SUPPLY

## Other Sectors (State and Federal)

Upskill school staff understanding of MH and substance use to support student literacy and referral	NEED
Schools funded to provide parent support instead of AOD/MH or FS	NEED
No headspace service in Box Hill or Ringwood	SUPPLY
Integration With headspace/AOD is limited	SUPPLY
Clinical access for complex youth in MHCSS - difficult to get youth into	DEMAND
Partners In Recovery (federally funded) - access for complex youth, more support	DEMAND

## MH/AOD Service System

More Detox/Residential Beds, Youth	DEMAND
Rehabilitation service to support youth (21+) in family breakdown (Eltham – Nillumbik & Windana - Cardinia up to four months wait). No service in the EMR	NEED
No acute youth-specific, short stay in EMR	NEED
No youth-specific Community Care Units in EMR	NEED
Outreach for over 21 year olds - No longer eligible post reform but still required	NEED
Young consumers 21>25 prefer youth focused MH not adult service (more of an issue for males than females)	SUPPLY

## Good Practice

Innovative youth AOD/MHCSS models, Ice Taskforce funding and PHN funding	
Good practice GPs in schools	
Collaboration with non-residential withdrawal	
Collaboration early psychosis/Intensive Mobile with Youth Residential	
Intake and Assessment AOD	

## Appendix 8: Policies and plans driving improvements to Aboriginal and Torres Strait Islander health and wellbeing

Victorian or Commonwealth planning document	Planning Direction, Report Recommendations and/or solutions proposed	
Koolin Balit Victorian Strategic directions for Aboriginal health 2012-2022	<p>Ten-year plan that sets the big picture of what the Victorian department, together with Aboriginal communities, other parts of government and service providers, are doing and will do to achieve the government's commitment to improve Aboriginal health.<sup>30 31</sup></p> <p>Key priorities and enablers outlined for action that are of particular relevance to the mental health and AOD sector include:</p>	
Koolin Balit Aboriginal health workforce plan, 2014-17. <sup>29</sup>	<p><b>Six Priorities informed by Aboriginal communities:</b></p> <ol style="list-style-type: none"> <li><b>1. A healthy start to life</b> <ul style="list-style-type: none"> <li>• Reduce smoking in pregnancy</li> </ul> </li> <li><b>2. Healthy childhood</b> <ul style="list-style-type: none"> <li>• Reduce the proportion of Aboriginal children and young people living in households with a current daily smoker</li> </ul> </li> <li><b>3. Healthy transition to adulthood</b> <ul style="list-style-type: none"> <li>• Reduce the take-up of high-risk behaviours such as smoking, excessive alcohol consumption and use of illicit drugs</li> <li>• Improve access to mental health services earlier for young Aboriginal people</li> </ul> </li> <li><b>4. Caring for older people</b> <ul style="list-style-type: none"> <li>• Enable all older Aboriginal people to access the information, support and culturally appropriate service responses that will maximise their health and wellbeing</li> </ul> </li> <li><b>5. Addressing risk factors</b> <ul style="list-style-type: none"> <li>• Reduce the proportion of adults who are smokers</li> <li>• Reduce the rate of emergency department presentations due to alcohol consumption</li> </ul> </li> </ol>	<p><b>Key Enablers for achievement of priorities:</b></p> <ol style="list-style-type: none"> <li><b>1. Improving data and evidence</b> <ul style="list-style-type: none"> <li>• Increase the range and quality of research and information to develop evidence-based interventions to improve the health of Aboriginal people</li> </ul> </li> <li><b>2. Strong Aboriginal organisations</b> <ul style="list-style-type: none"> <li>• Provide opportunities for community leadership in program design and decision making</li> </ul> </li> <li><b>3. Cultural responsiveness</b> <ul style="list-style-type: none"> <li>• Increase the number of Aboriginal people in the mainstream health workforce</li> </ul> </li> </ol>

<sup>29</sup> Department of Health (2014). Koolin Balit Aboriginal health workforce plan 2014-17. Accessed from: <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/koolin-balit-aboriginal-health-workforce-plan>

<sup>30</sup> For more information on Koolin Balit, see: <https://www2.health.vic.gov.au/health-workforce/aboriginal-health-workforce/koolin-balit>

<sup>31</sup> Department of Health, Koolin Balit, the strategic directions for Aboriginal health 2012-2022, State of Victoria (2012). Accessed from: <https://www2.health.vic.gov.au/about/health-strategies/aboriginal-health/koolin-balit>



	<ul style="list-style-type: none"> <li>• Reduce the proportion of Aboriginal Victorians drinking at risky and high-risk levels.</li> </ul> <p><b>6. Managing care better with effective services</b></p> <ul style="list-style-type: none"> <li>• Improve Aboriginal people's access to the range of health, mental health and other support services</li> <li>• Reduce preventable hospitalisation rates for chronic conditions &amp; reduce preventable hospital readmissions</li> <li>• Improve the coordination and integration of services for people accessing and moving between health care settings.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the cultural responsiveness of mainstream health and mental health providers so that Aboriginal people receive respect and high-quality care as a matter of course</li> <li>• Increase the capacity of mainstream health providers and their workforce to meet the health needs of Aboriginal people</li> </ul>
Aboriginal Health and Wellbeing and Safety Strategic Plan	<p>The Victorian State department has worked with the Aboriginal communities to develop the new Aboriginal Health and Wellbeing and Safety Strategic Plan. The aligned Implementation plan is due for release May 2017.<sup>32</sup> The plan has identified seven key themes for implementation, these being:</p> <ul style="list-style-type: none"> <li>o <b>Self-determination-</b> "Self-determination cannot be achieved without Aboriginal self-management and Aboriginal community control" (p.18)</li> <li>o <b>Culture and community are central to Aboriginal health and wellbeing-</b> "Culture and community connection are intrinsically linked to Aboriginal health and wellbeing outcomes" (p.20)</li> <li>o <b>Building community capacity-</b> "Implement principles of co-design, self-determination and community control in policy, programs and service design to build community capacity both internally and externally"(p.22)</li> <li>o <b>Addressing racism-</b> "Programs that combat racism, increase cultural awareness and increase cultural responsiveness need to be expanded across government and throughout the health and wellbeing sector" (p.23)</li> <li>o <b>System reform to drive real change-</b>"Funding reform is required to enable Aboriginal communities' greater flexibility to deliver culturally relevant, place-based approaches to locally determined health and wellbeing outcomes" (p.26)</li> <li>o <b>Research, monitoring and evaluation-</b>"Adopt an Aboriginal-led monitoring and evaluation process that includes Aboriginal research methodologies, culturally relevant indicators...."(p.27)</li> <li>o <b>Additional health, wellbeing and safety priorities-</b>"Special attention needs to be given to integrated support as people transition from one life stage to another" (p.30)</li> </ul>	

<sup>32</sup> Department of Health and Human Services (2016). Aboriginal Health, Wellbeing and Safety Strategic Plan. Second Symposium Report, 2 June 2016. State of Victoria. Available at: [www2.health.vic.gov.au](http://www2.health.vic.gov.au)

<b>Victorian Suicide Prevention Framework 2016-25</b>	<p>The framework recognises that the suicide rate in the Aboriginal population is twice the general population rate, and suicide generally occurs at much younger ages. It also highlights the importance of local based service models with culturally appropriate and safe responses and approaches are vital for Aboriginal people. Six local government areas over six years in partnership with Primary Health Networks and other agencies will explore the particular issues related to Aboriginal people<sup>33</sup>.</p>
<b>Ice Action Plan, Victorian Government 2015</b>  <b>The Aboriginal Metropolitan Ice Partnership Initiative.</b>	<p>The Ice Action Plan addresses the particular impacts of ice on Aboriginal Victorians. The Aboriginal Metropolitan Ice Partnership Initiative aims to increase services and support in addressing growing ice related issues impacting on Aboriginal and Torres Strait Islander Peoples, families and the community. It will in particular focus on assertive outreach, alcohol and drug support and clinical interventions as well as better access to alcohol and drug services for Aboriginal people and families with ice and other alcohol and drug issues. The service model aims to provide intensive culturally responsive support, holistic wrap around care, strengthen partnerships and referral pathways between Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs) and mainstream AOD services.</p> <p>The Aboriginal Metropolitan Ice Partnership Pilot Steering Committee guides the implementation and monitoring of the pilot. The committee comprises senior representatives from each service provider and regional representatives of the Department of Health and Human Services. Positions are based in Aboriginal Community organisations (Ngwala Willumbong Cooperative Ltd, Victorian Aboriginal Child Care Agency and Victorian Aboriginal Health Service) and community health services and alcohol and drug services (Eastern Health, Monash Health, Odyssey House, Uniting Care Re-Gen). Pilots across four metropolitan areas commenced in February 2015 and will run until 30 June 2017 to help improve access to services for Aboriginal people affected by methamphetamine and other drugs.<sup>34 35</sup></p>
<b>Victorian Aboriginal Affairs Framework (VAAF) 2013–18</b>	<p>The VAAF is based on a holistic life course approach that recognises the importance of early life intervention and effective access to services, including the significance of supporting foundations e.g. family, community, opportunities, place (home and connection to country) play in influencing a person's life. In addition, VAAF identifies other essential components that are relevant to the alcohol and other drugs and mental health service sectors, these being:</p> <ul style="list-style-type: none"> <li>o Valuing and supporting the cultural strengths of Aboriginals and working with Aboriginal people to build better futures;</li> <li>o Protecting and supporting vulnerable children and families;</li> <li>o Building prosperity through economic participation;</li> <li>o Designing and delivering services that are accessible by Aboriginal people;</li> <li>o Taking a local, placed based approach to service delivery.<sup>36</sup></li> </ul>

<sup>33</sup> Department of Health and Human Services (2016). Victoria's 10-Year Mental Health Plan. Victorian Suicide Prevention Framework 2016-25. State of Victoria

<sup>34</sup> DHHS (2016) Program guidelines, Alcohol and other drugs. PART 2. Program and service specifications. Consultation Draft Oct 2016. State of Victoria

<sup>35</sup> State Government Victoria (2014) Ice Action Plan, Victorian Government

<sup>36</sup> [http://www.dpc.vic.gov.au/images/documents/Aboriginal\\_Affairs/Victorian-Aboriginal-Affairs-Framework-2013-2018.pdf](http://www.dpc.vic.gov.au/images/documents/Aboriginal_Affairs/Victorian-Aboriginal-Affairs-Framework-2013-2018.pdf)

<p><b>Aboriginal Social and Emotional Wellbeing Plan 2015: Justice Health and Corrections Victoria</b></p>	<p>The Aboriginal Social and Emotional Wellbeing Plan 2015, Justice Health and Corrections Victoria, identifies five priority areas that the department, in partnership with the Aboriginal community will focus on to improve the mental health and wellbeing of Aboriginal people while incarcerated and upon their release:</p> <ul style="list-style-type: none"> <li>o Prevention and health promotion</li> <li>o Culturally capable workforce</li> <li>o Culturally safe and responsive services</li> <li>o Continuity of care</li> <li>o Working from and building an evidence base.<sup>37</sup></li> </ul>
<p><b>The Roadmap for National Mental Health Reform 2012- 22</b></p>	<p>The Council of Australian Governments (COAG) has outlined a number of Aboriginal initiative directions governments will take over the next 10 years, these include:</p> <ul style="list-style-type: none"> <li>o Increase Aboriginal and Torres Strait Islander Peoples involvement in developing and implementing culturally appropriate and community led mental health, social and emotional wellbeing programs</li> <li>o Increase and promote employment opportunities for Aboriginal and Torres Strait Islander Peoples in mental health and social and emotional wellbeing service areas</li> <li>o Strengthen the cultural competency of frontline providers to identify and appropriately intervene early in mental health concerns for Aboriginal and Torres Strait Islander Peoples<sup>38</sup></li> </ul>
<p><b>National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019</b></p> <p><b>Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023</b></p>	<p>The National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-19 has been developed as a guide for governments, communities, service providers and individuals to identify key issues and priority areas for action relating to the harmful use of AOD, these being:</p> <ul style="list-style-type: none"> <li>o Undertake a cross sectoral approach with mainstream AOD services and Aboriginal and Torres Strait Islander controlled services.</li> <li>o Increase access to a range of culturally responsive and appropriate services and programs that meet the local needs of individuals, families and communities</li> <li>o Build and strengthen partnerships based on respect both within and between Aboriginal and Torres Strait Islander Peoples, government and mainstream service providers</li> <li>o Establish meaningful performance measures, effective data systems that support community led evaluation to inform meaningful and sustainable service delivery<sup>39</sup></li> </ul> <p>Sitting alongside the strategy is the National Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023<sup>40</sup></p>

<sup>37</sup> <http://assets.justice.vic.gov.au/justice/resources/f99d2202-f3fe-4f22-97b9-6ab15ad91793/aboriginal-social-and-emotional-wellbeing-plan.pdf>

<sup>38</sup> Council of Australian Governments (2012), The Roadmap for National Mental Health Reform 2012- 22, Canberra: COAG.

<sup>39</sup> Commonwealth Department of Health Intergovernmental committee on Drugs. National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014 – 2019. [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/nAboriginal and Torres Strait Islander pds2014-19](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/nAboriginal%20and%20Torres%20Strait%20Islander%20pds2014-19)

<sup>40</sup> Commonwealth Department of Health, Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, Australian Government, Canberra, 2015

Always was, always will be Koori children:

Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria Report, 2016

Taskforce 1000 was established in 2013 in response to the over-representation of Victorian Aboriginal children in out-of-home care. Taskforce 1000 examined the individual circumstances of 980 children, with the following key recommendations:

- o Keep Aboriginal children safe within their family, e.g. culturally competent organisations that have rigorous methods and related training for early identification of a child's Aboriginality; Department of Education and Training funding to establish and sustain a range of Aboriginal community-based early years programs in areas with growing Aboriginal populations and high out-of-home care placement rates; DHHS to develop and implement an approach to address intergenerational trauma, grief and loss that is both child specific and Koori informed.
- o Strengthen healing-informed interventions to address family violence and intergenerational trauma.
- o Ensure Aboriginal children in out-of-home care have meaningful access to their culture.
- o Build the cultural competency of organisations providing services to Aboriginal children in out-of-home care.
- o Improve child protection responses and service provision for Aboriginal children in out-of-home care.<sup>41</sup>

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<sup>41</sup> Melbourne: Commission for Children and Young People (2016). Always was, always will be Koori children: Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria. <http://www.ccp.vic.gov.au/downloads/always-was-always-will-be-koori-children-inquiry-report-oct16.pdf>

## Appendix 9: Data and findings about Aboriginal and Torres Strait Islander Peoples' engagement with AOD and mental health services in the EMR

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### Access to AOD and mental health services

- For the 2015/16 period:
  - Sixty-six percent of Aboriginal consumers were returning for AOD service provision with 21% of consumers being between 11-25 years of age; 30% being between 26-40 years; 27% being 41-55 and 24% being between 56-65 years of age.
  - Seventy-eight percent of Aboriginal consumers were new to mental health services, with 17% of consumers being between 16-25 years of age, 31% being between 26-40 years and 52% between 41-60 years of age. It is interesting to note that 38% of consumers identified being Aboriginal and/or Torres Strait Islander post intake, during service provision.
- A random review of AOD files (n=24) indicated 21% of consumers were prioritised for service, with majority receiving a service within 1-10 days and 35% of mental health Aboriginal consumers were prioritised for service, with majority receiving a service within 1-20 days.
- For both AOD and mental health services, majority of incoming referrals were self-referrals, with second highest referral source being from either an AOD or mental health service. It is interesting to note that 14% of AOD referrals were from forensic and child protection agencies with 8% of mental health referrals coming from family and child protection services.

### Co-morbidity and key issues

- Co-morbidity was identified for 96% of Aboriginal consumers accessing mental health and 93% for AOD services.
- The primary drugs of concern being alcohol (40%) and amphetamines (21%), with 67% polydrug use.
- DHHS AOD data showed a 22% rate of unemployment and 17% identifying being homeless. A random file review (n=24) indicated higher rates of unemployment (79%) and homelessness (43%). Eighty-three percent of mental health consumers were identified being unemployed and 26% being at risk of homelessness.
- A random review of AOD files (n=24) indicated:
  - Twenty-one percent of women accessing AOD services reported being a victim of family violence in the past, with 61% of consumers living with dependent children. Half of these women were referred to either a family service or family violence specialist for support.
  - Forty-two percent of males accessing AOD services identified being a perpetrator of family violence, reporting current (within the last 3 months) and past activity (greater than 3 months), with five cases having child protection involved.



- A random review of mental health files (n=23) indicated:
  - o Seventy percent of women accessing mental health services reported being a victim of family violence with 30% living with dependent children. Of those consumers living with dependent children, 43% had child protection involved and 29% were referred to a family support service. All women were referred to a family violence service, with 13% already being linked into support.
  - o Forty-three percent of male consumers were identified as being a perpetrator of family violence, with half reporting past activity and the other half reporting current and past activity. Of those males, 67% reported experiencing family violence in the past.
- Family violence was one of the most prominently identified co-occurring issues for Aboriginal clients of both AOD and MHCSS services, and for other groups of consumers, particularly young people and service users with dependent children. Other key co-occurring issues reported from providers include housing, AOD, mental health, cultural disconnection, legal issues and financial hardship.
- Respondents described their service response to Aboriginal people as consisting of the following:
  - o Part of core service response: 100% AOD and 50% mental health agreement.
  - o Part of external referral response: both AOD and mental health 50% agreement.
  - o Part of internal referral response: 67% AOD and mental health 25% agreement.

### Aboriginal Support

Both AOD and mental health service areas had consumers linked into Aboriginal support with 57% of consumers being supported by an Aboriginal mental health support worker/coordinator and 33% of consumers accessing an Aboriginal AOD worker.

### *How are mainstream AOD and Mental Health service organisations contributing to the improvement of the health and well-being of the Aboriginal and Torres Strait Islander community?*

#### Service provider experiences and perceptions

A survey was conducted in mid-2016 with a small sample of AOD and MHCSS service providers, in order to gain insights into their perceptions and experience of working with consumers who identify as being Aboriginal and/or Torres Strait Islander. Key findings include:

- The majority of respondents from organisations in both the AOD and MHCSS sectors estimated making between one and five referrals per week to Aboriginal community controlled services. This approximation aligns with the client file review findings.

- AOD and MHCSS service providers identified a range of service providers they share consumers with, these include: Mullum Mullum Indigenous Gathering Place, Healesville Indigenous Community Services Association, Victorian Aboriginal Health Service, Boorndawan Willam Aboriginal Healing Service, Victorian Aboriginal Child Care Agency, Family Violence Programs, Aged care assessment service, legal and primary health services.

## Appendix 10: Themes from the review of service provider organisations' Reconciliation Action Plans and Closing the Gap plans

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A document review of available Reconciliation Action Plans (RAPs) and Closing the Gap plans from four organisations with Mental Health/ AOD services was undertaken to understand what organisations are planning and/ or implementing in regards to making change through their work. The key aim for RAPs is to provide a framework for organisations to make meaningful change through their connection and work with the Aboriginal community- to improve relationships, respect and attitude towards Aboriginal people <sup>42 43</sup>.

All RAP and Closing the Gap plans reviewed sat at an organisational strategic and/ or operational level, with some AOD and mental health specific activity occurring. There seems to be a lot of planning and implementation occurring in this space, with different levels of readiness and maturity. There is however, limited evidence of evaluation activity occurring to inform effectiveness of process and outcomes. Key planning/ implementation themes identified include:

### Engagement and partnership

- Create relationships with local Aboriginal Community Controlled Organisations (ACCOS) e.g. source secondments or volunteering opportunities with ACCOs or building on/ strengthening existing relationships
- Review of existing partnership agreements and Memorandum of Understandings between Aboriginal, and Torres Strait Islander organisations and mainstream organisations, including pro bono initiatives

- Establish strategies for ongoing community consultation with the Aboriginal community
- Provide sponsorship for selected Aboriginal and Torres Strait Islander events and community activities
- Organisational membership and participation on Victorian EMR Aboriginal Committees
- Attendance at local Aboriginal community lunches and gatherings
- Aboriginal consumer invitation and participation in annual service planning and/ or feedback activity

### Organisational and sector development and learning

- Establish internal working groups or committees (with Aboriginal representation) to lead and guide RAP implementation.
- Increase employee awareness and understanding of the protocols around Acknowledgment of Country and Welcome to Country ceremonies
- Provision of cultural competency and awareness training and cultural diversity learning opportunities
- Develop and implement 'asking the question' protocols, procedures and guidelines
- Undertake cultural audits and assessments to inform change management and decisions
- Establish information hubs, calendar of events and other communication methods to update organisational staff on key local and significant Aboriginal community activities and partnership activity including acknowledgement of Sorry Day and National Reconciliation Week
- Involvement and participation on local council and other community reconciliation action planning committees and working groups

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<sup>42</sup> <http://www.maggolee.org.au/respect-and-recognition/reconciliation-plans/>

<sup>43</sup> <http://www.reconciliation.org.au/raphub/>

### **Workforce development opportunities**

- Develop workforce practices, which attract, retain and support professional development for Aboriginal and Torres Strait Islander employees, including offer of work experience and placement opportunities for Aboriginal students
- Increase staff awareness of organisational Aboriginal support roles available

### **Systems and structures of service delivery**

- Ensure appropriate display and acknowledgement of all Aboriginal and Torres Strait Islander artworks, flags, visible mini-flags, posters and use of visual symbols and plaques to acknowledge Traditional Owners

- Priority access and fee waiver for all Aboriginal or Torres Strait Islander People regardless of program funding guidelines
- Development of Aboriginal specific programs with community and co-location of Aboriginal support workers with Aboriginal sector
- Development and implementation of Aboriginal consumer consultation, community engagement and feedback frameworks and activity
- Development of culturally responsive strategies and mechanisms that will support Aboriginal consumers in their service journey, including secondary consultation and co-location of providers based at an Aboriginal community service.

## Appendix 11: Consultation and engagement with Aboriginal service providers and community

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Semi-structured interviews and discussions with Aboriginal providers and community members revealed the following key themes about what needs to be improved to optimise mainstream services' engagement and relationships with Aboriginals with AOD and/or mental health concerns.

### How we should work with Aboriginal people and community

- Engagement with the Aboriginal community must be genuine, meaningful, open and honest and based on trust. Providers emphasised that there needs to be adequate time for engagement with the person/family and that current service models and funding need to be more flexible to enable this
- A strengths-based, healing informed approach to service delivery is required so the Aboriginal person's strengths and self-reliance and capability is built
- AOD and mental health service providers need to understand each person's needs, including their cultural needs. Ideally, culturally sensitive strategies and tools are developed and used such as including a cultural component to the Aboriginal person's care planning process. A strong connection to culture builds individual and family resilience. Preserving the cultural integrity of Aboriginal people, families and communities should be a priority.
- It must be remembered that:
  - Not all Aboriginals feel comfortable accessing an Aboriginal service organisation. Possible reasons could include privacy and confidentiality or to minimise the 'shame' of disclosure
  - The more vulnerable a person is, the greater the likelihood that this person will respond negatively when asked if they identify as Aboriginal

- Significant historical issues, such as the loss of cultural identity, unresolved grief and trauma, and the breakdown of community and family structures need to be addressed
- Breakdowns in culture, intergenerational trauma, ongoing racial inequality can lead to Aboriginal people feeling disempowered
- As identified by the figures from the client file review, other social determinants such as housing, education and employment need to be addressed before or in parallel to the person's mental health and/or AOD issue/problem

### Organisational structures and approaches

- An increase in dedicated Aboriginal resource will enable better connection with community. It will also enable workers time to take a breath and not 'suffer from exhaustion'. There is a current expectation that Aboriginal staff will take on a number of roles, for example liaison as well as worker role.
- There needs to be an informed local approach taken to improve coordination and allocation of resource.
- Local Aboriginal community organisations, mainstream AOD, and mental health organisations need to plan with each other, not just consult. Aboriginal community members have an equal stake in improving health outcomes.
  - *"Imposing a program on us does not work, we need to decide what works for us... what the priorities are"* (Community member, October 2016).
- There needs to be cultural governance of local services and programs and provision of services that strengthen and empower families and communities. An increase of available resource is needed to maximise the delivery of innovative, comprehensive, holistic and integrated services and programs.

