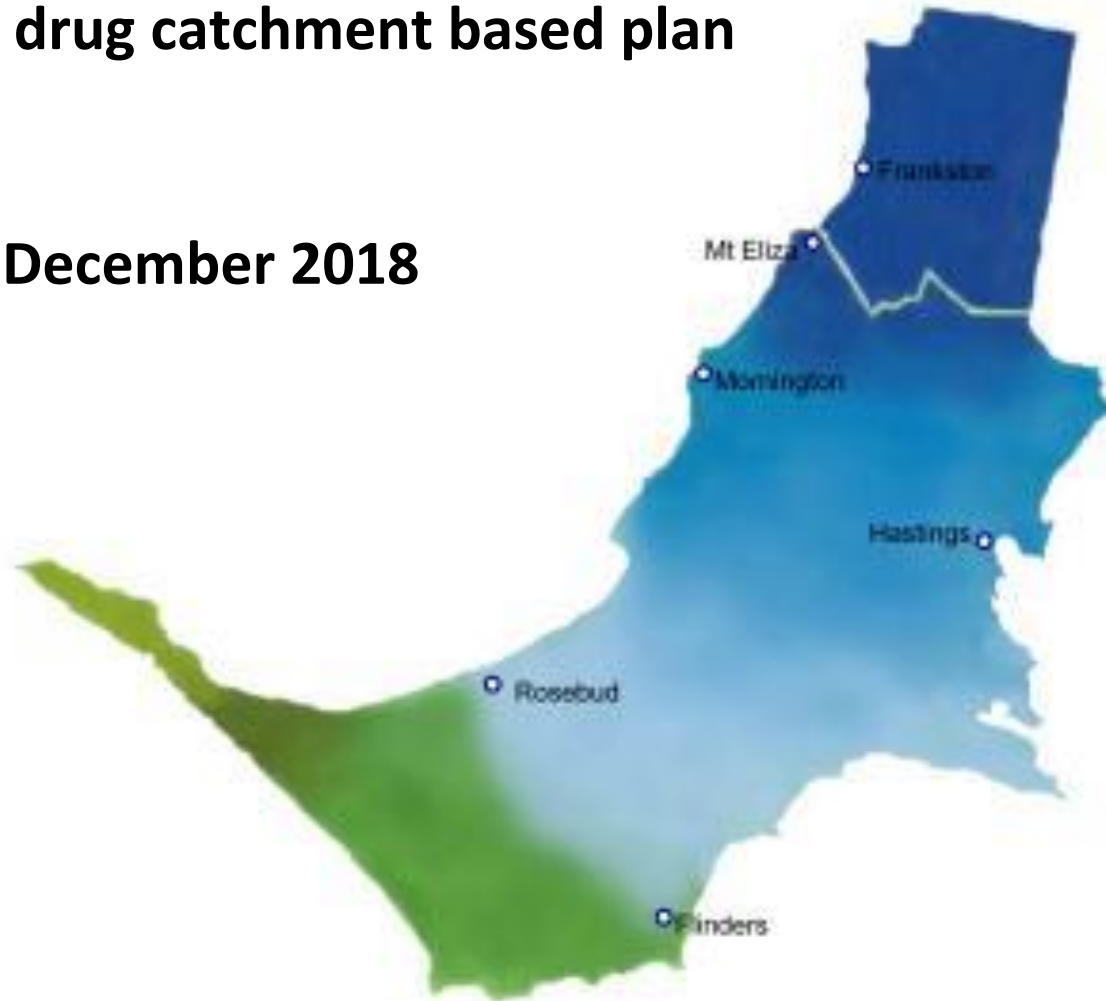


Frankston Mornington Peninsula Alcohol and other drug catchment based plan

December 2015 – December 2018



EXECUTIVE SUMMARY

The Frankston and Mornington Peninsula (FMP) Alcohol and Other Drug Catchment Based Plan 2015-2018 will inform the priorities and work of the Alcohol and Other Drug Alliance and associated working groups with an overall aim to address alcohol and other drug use in the catchment along the continuum of response including promotion/prevention, early intervention and treatment. Targeted activities will aim to influence the community's understanding of problematic alcohol and other drug use as a health issue, build capacity for non-AOD specific services, general practice and primary health to respond to AOD issues and improve the accessibility and integration of specialist AOD treatment services with the broader health and community service system.

The FMP catchment has a number of health and social issues such as mental health, family violence, vulnerable youth and families and homeless which have complex relationships with AOD use. Evidence of needs related to AOD use in the catchment has been identified through hospital and ambulance data, service provider knowledge and AOD treatment data however there continues to be significant gaps relating to the accessibility of data that assists identifying emerging trends and planning service response around these needs.

Over the past 12 months there has been significant work in the catchment to embed the reformed treatment system and develop mechanisms to monitor data and service utilisation. Strong partnerships have also been developed within the AOD treatment system and the broader health and human services and Government bodies to undertake work that addresses broader social needs related to and influencing AOD across the catchment. A number of key projects have been delivered which has proven to enhance accessibility to the treatment system and also enhance responsiveness to AOD issues in non-AOD specific services. The catchment has established mechanisms with networks that are strong and can be mobilised to deliver projects and responses that require multisectoral input such as the Responding to Alcohol and other Drugs in Frankston and Mornington Peninsula (RAD-FMP) project.

This plan acknowledges that non-AOD related health and community services play an integral part in responding to AOD use in the community and activities such as screening and brief intervention for AOD and capacity building can enhance responses. With a strong multi-sectoral AOD Alliance already in operation it is acknowledged that opportunities to undertake collaborative innovative projects to address the broader community needs relating to AOD are possible.

It is recognised that having an accessible and integrated AOD treatment system that is responsive to identified needs is essential in supporting consumers, families and the broader community. Ensuring collaborative partnerships are maintained and partnerships developed, that the workforce remains skilled and feels valued, building collaborative practice with general practice and the broader service system and monitoring data to ensure services are responding to expressed need as well as meeting targets and achieving positive outcomes for clients is recognised as key to an effective treatment system.

Unique to FMP is the Peninsula Model, an established model of collaborative planning and action. The AOD Alliance has been active since September 2014 and has been instrumental in embedding the reformed adult AOD treatment system in the catchment and responding to emerging issues related to the reforms. Whilst this work will continue to ensure an accessible and responsive AOD treatment system, this three year plan looks at the continuum of care and how non-AOD specific health and community services can be equipped to respond to AOD in their communities.

This plan has been endorsed by the AOD Alliance and received input from working groups associated with the Alliance.

Recommendations

1. Build capacity across primary care and non-AOD specific community services to respond to consumers who are no longer eligible to receive treatment and require early intervention, in addition to the more complex clients who require AOD intervention however do not wish to engage in AOD treatment
2. Explore alternative models of AOD intervention in order to provide great choice for consumers. This includes looking for additional funding for programs such as a non-residential rehabilitation program and the development of group programs and programs delivered in partnership.
3. Identify opportunities to work in partnership to increase responsiveness to youth AOD consumers across the catchment via capacity building of non-AOD youth services and identifying funding opportunities to increase specialist youth AOD in the catchment.
4. Continue to monitor service utilisation data to identify emerging trends, ensure equitable distribution of referrals, identify needs for outposts or outreach and monitor forensic referrals.
5. Understand the consumer experience and family experience of accessing the AOD treatment system and utilise partnerships to develop a response where a need is identified.
6. Ensure both AOD specialists and those working with consumers who use AOD in broader health and human services have access to high quality, localised training to ensure they are delivering evidence based interventions to address new and emergency drug trends
7. Build capacity in the AOD treatment setting to identify and respond to those who perpetrate and those who are victims of family violence
8. Build capacity in the AOD treatment setting to identify and respond to consumers with problematic gambling
9. Utilise strong partnerships in the catchment to address broader social determinants of health that contribute and influence the use of AOD across the catchment
10. Work in collaboration with the RAD-FMP project to enhance responsiveness to AOD in the catchment
11. Revisit the catchment based plan and re-align priorities based on the Government's response to recommendations contained in the Aspex Independent Review of the AOD and MHCSS Reforms report

1. INTRODUCTION

1.1 The Frankston Mornington Peninsula catchment

The Frankston-Mornington Peninsula catchment is a mixed urban and semi-rural area of about 850 square kilometres. The Mornington Peninsula Shire comprises small urban areas, tourist towns, rural agricultural areas and national parks across 20 postcodes, while the City of Frankston is more urban with higher population density, and comprises five postcodes. The catchment covers two Local Government Areas (LGAs): the Frankston City Council (FCC) and the Mornington Peninsula Shire (MPS) across a total land area of 85,200 hectares.

In 2013 the population estimate across the catchment was around 286 000 with the largest numbers in the **0 to 15 and 65 years and over age groups**. The level of cultural diversity is much smaller than neighbouring catchments, and the indigenous population comprises 0.7% of the population which is slightly larger than the Melbourne average (0.5%). The catchment is characterised as semi-rural with pockets that have very limited public transport services while other areas do not have access to any public transport. Reliance on private forms of transport (cars, taxis) is not always practical or affordable. Access to services and other amenity across the catchment is a key issue with impacts on health care and social isolation¹.

1.2 Health and social issues

Frankston SEIFA index of disadvantage is 997 and Mornington Peninsula, 1022. While there are areas of obvious wealth there are 'hot spots' of entrenched disadvantage in Frankston North and Frankston Central, Seaford and Carrum/Carrum Downs (FCC), Hastings, Rosebud, Rye, and Baxter (MPS)².

1.2.1 Mental health

According to the Frankston Mornington Peninsula Needs Analysis 2014³ the prevalence of serious mental illness is one of the most important issues in the catchment. Whilst there is no exact data for the number of people experiencing mental health issues in the catchment it has been assessed based on National data, it could be expected that

- between 5640-8460 people have a severe, disabling mental health condition
- about 1/3rd of those, about 2800 people, will be living with a psychotic condition
- between 11200-16900 will have a moderate mental health condition
- another 25400-33800 will have a mild mental health condition⁴.

Mental health and its relationship to AOD use is complex and evidence identifies a need to respond to co-occurring mental health and substance use in an integrated manner. Whilst data related to the prevalence of dual diagnosis is unknown at a local level, an audit of the Peninsula Health/ Peninsula Support Services Mental Health

¹Frankston Mornington Peninsula Primary Care Partnerships Population Health Atlas 2012

²Frankston Mornington Peninsula Population Health Needs Analysis 2014

³Ibid

⁴ Ibid, p. 65

Homelessness Program in March 2015 identified that 100% of their clients used alcohol or other drugs. It is noted that there is a significant lack of data available on a local level relating to mental health and it is important to understand the prevalence and presenting needs regarding mental health given the strong association between mental health and alcohol and other drug use. It was also indicated that only a very small percentage of their client group were accessing an AOD treatment service at the time the data was collected. A larger dual diagnosis file audit has been completed across mental health and AOD agencies in the catchment, with 74 clinicians providing data on their current caseloads. Analysis of this data is currently being completed and findings and recommendations will be provided to both the AOD and Mental Health Alliance and recommendations actioned through the dual diagnosis working group.

1.2.2 Homelessness

The catchment has significant levels of homelessness with Centrelink reporting that Frankston is one of the top six areas nationally, for homelessness. About 20% of all ED presentations to Peninsula Health are by people experiencing homelessness⁵. AOD treatment data from 2013-2014 suggest that a very small percentage of clients accessing AOD treatment report being homeless. This data identifies that people experiencing homeless in the Frankston Mornington Peninsula may not be accessing services to respond to their AOD specifically however may present with problematic AOD use and be accessing non-AOD services such as the crisis centre, mental health and the emergency departments. With representation on the AOD Alliance from the Regional Manager and Manager from SalvoCare East (the primary homelessness and housing service in the catchment) strategies are currently being explored to look at a project that will enhance both primary care and specialist responses (including AOD) to those at risk of or who are homeless.

1.2.3. Family violence

Rates of family violence are double the Victorian average in the City of Frankston, which is ranked top of all metropolitan Local Government Areas (LGAs) in the SMR for incidences of family violence. In the City of Frankston, reported family violence incidents increased by 53.6% from 1154 in 2009/10 to 1773 in 2013/14. A significant increase in the Mornington Peninsula was also reported during this time which showed a 82% increase in five years from 635 reported cases in 2009/10 to 1157.9 reported cases in 2013/14⁶. Frankston rates 8th of all LGAs across Victoria regarding family violence incident reports⁷. Within the City of Frankston it was reported that children were present at 29.3% of family violence callouts⁸. It is noted that Victoria Police, Pro-Active Policing Unit, are making significant connections with local community services regarding innovative partnerships to address family violence and interconnecting issues across the catchment.

1.2.4. Vulnerable children and youth

Child protection issues in Frankston are one of the highest in Victoria – in North Frankston, the rate is double the SMR, and in Hastings, the rates are triple those for the SMR overall. The rate of substantiated adolescent child protection rates is higher in Frankston than the Victorian average. Anecdotal reports from service providers responding to these families identify a high percentage of their clients present with problematic AOD use. At present there is no data to identify what proportion of these clients do and whether there are other co-occurring issues within these families.

⁵Frankston Mornington Peninsula Population Health Atlas 2012

⁶Victoria Police Family Violence Incident Report Data 2014

⁷Department of Health (2014) LGA Profile Data <http://docs2.health.vic.gov.au/docs/doc/2013-LGA-profiles-data>

⁸Catchment Wide Strategy to Prevent Violence against Women and their Children 2014-2017- Peninsula Model and Women's Health In the South East

2011 Adolescent Health and Wellbeing indicators suggest the Frankston youth population has significantly higher than average levels of nearly all risk factors including substance use, anti-social behaviour and, mental health issues. Frankston has higher rates of youth (15-24 years) disengagement from education and employment compared to the rest of Victoria (14.8% and 10.7% respectively)⁹ in addition to low educational attainment in addition to higher levels of psychological distress in adolescents from both LGAs¹⁰. The rate of births to teenage women in Frankston was 16.4 per 1000 women aged 15 to 19 years. This was greater than the rate in Victoria (10.6 per 1000 teenage women) and double the rate of the Mornington Peninsula Shire¹¹.

The Frankston Mornington Peninsula Strategic Framework for Youth People 2015-2019 identifies the need for information and awareness raising regarding young people and alcohol and other drugs.

Anecdotal reports from staff working with high risk young people such as Youth Justice, Victoria Police and Child Protection identify a high proportion of the young people they have contact with have issues related to alcohol and other drug use, in addition to other health and social issues, and either find it difficult to engage in AOD treatment due to their chaotic lifestyle or are resistant to engaging on a voluntary basis. Given these reports are anecdotal a data collection activity is planned for 2016 that will identify the needs of these young people and the results informing innovative partnership responses.

1.2.5. Criminal behaviour

Frankston saw an increase of 60.1% in the number of cultivating, manufacture and trafficking offences from 2012/13 to 2013/14. This is over 7 times the Victorian state average increase. In addition possession and use has increased by 17.8% which is approximately twice the Victorian State average¹². However, over the past 12 months there has been a considerable decrease (15.95%) in drug trafficking offences for the catchment. Liaison with Victoria Police highlights that data is representative of local priority policing and dependent on particular policing activities in the local area. Victoria Police are represented on the AOD Alliance and are currently working in collaboration with multiple agencies to develop local diversionary responses to at risk young people in the catchment and to ensure drug diversionary systems are working well at a local level.

1.2.6. Gambling

Around 70% of problem gamblers have a dependency to alcohol and 30% have a drug misuse problem¹³. The Victorian Commission of Gaming Liquor Regulation indicates the Mornington Peninsula Shire has ranked losses of \$78.9 million over the 2012–13 financial year, making the Shire the 11th highest local government area for expenditure in the state. In 2011-2012 \$71,286,100 was recorded in electronic gaming machine expenditure in the municipality, suggesting an average spend of \$119,607 per machine; over \$19,000 higher than the Victorian average spend per machine¹⁴. Given the high level of social disadvantage across some areas of the

⁹ Frankston Mornington Peninsula Strategic Framework for Young People 2015-2019

¹⁰ Frankston Mornington Peninsula Primary Care Partnership Population Health Atlas 2013

¹¹ Ibid

¹² Victorian Police Crime Statistics 2014

¹³ Thomas, S. and Jackson, A. (2008). *Report to beyondblue: Risk and Protective Factors, Depression and Comorbidities in Problem Gambling*, Monash University and University of Melbourne; Department of Human Services (2009). *Because mental health matters: Victorian Mental Health Reform Strategy 2009-19*, Mental Health and Drugs Division, Department of Human Services, Melbourne.

¹⁴ Frankston City Council Response to the Social and Economic Costs of Problem Gambling in Victoria 2012

catchment and the relationship between gambling and problematic AOD use there needs to be greater links developed between AOD and gambling services across the catchment and a focus on capacity building in each area to enhance collaborative and integrated responses to individuals.

1.2.7. Unemployment

Of the 11,063 total labour force of young people in the Frankston municipality 12% are unemployed. High areas of unemployment in Frankston is the suburb of Frankston North at 26.3% with Frankston central, Frankston Heights, Carrum Downs, Karingal and Langwarrin South being higher than the Victoria unemployment rate of 12%. Across the Mornington Peninsula of the 9.1% of 10,728 labour force are unemployed with high areas being West Park at 24.3%, Baxter-Pearcedale, Tyabb and Hastings¹⁵ Research into the area of unemployment and problematic AOD use highlights a number of relational factors including 1) Risky alcohol consumption (associated with hazardous, binge, and heavy drinking) is more prevalent among the unemployed 2) Unemployment is a significant risk factor for substance use and the subsequent development of substance use disorders 3) Unemployment increases the risk of relapse after alcohol and drug addiction treatment¹⁶.

1.2.8. Indigenous population

The 2011 census data reported that 1,985 Aboriginal and Torres Strait Islanders live in the Frankston-Mornington Peninsula catchment. Although this only represents 0.5% of the population, Aboriginal Victorians in general are significantly socioeconomically disadvantaged compared with non-Aboriginal.¹⁷ An Aboriginal Alliance operates across the Frankston Mornington Peninsula in order to provide oversight into the implementation of the Koolin Balit strategy in the catchment. 4.5% of clients accessing AOD treatment services in the catchment identify as Aboriginal or Torres Strait Islander. As a result of the State Government alcohol and drug sector reforms, there is no longer a Koori specific AOD worker in the catchment. Subsequently efforts have gone into training and development of staff working in the catchment to respond in a culturally sensitive manner and encourage them to work collaboratively with Koori specific services. Relationships with Indigenous specific service will continue to be fostered to allow for continual learning and identify areas for partnership work and capacity building. The AOD catchment planner will continue to communicate with the Aboriginal Health Alliance which operates under the Peninsula Model to ensure that any needs related to AOD in the local Indigenous community are identified and a response co-ordinated through the AOD Alliance.

1.2.9. Aged persons

Whilst there is little research on a local level regarding risky drinking and older adults, the catchment has a large cohort of older adults and a unique AOD program to respond to older adults who use alcohol and other drugs. It is recognised that older adults are at an increased risk of alcohol-related harm due to having additional health related problems that are exacerbated by alcohol use and often using prescription medication which has an adverse reaction with alcohol consumption. Whilst Australian guidelines suggest that each older adult should access professional advice from primary care regarding what is a safe drinking limit for them, there is a lack of awareness around older adults and risky drinking across primary care and aged persons' services. Local education regarding available resources and supports is required to support health professionals respond appropriately to their patients/clients.

¹⁵ Australian Bureau of Statistics 2011

¹⁶ Henkel, D. (2011). Unemployment and substance use: a review of the literature (1990-2010). *Current Drug Abuse Reviews*, 4(1).

¹⁷ Aboriginal Health, Peninsula Model website <http://www.peninsulamodel.org.au/aboriginal-health-alliance>

1.3 Alcohol and other drug use

1.3.1. Smoking rates

Smoking rates are higher than the Victorian average in many parts of the LGA, and deaths from lung cancer are higher than the Victorian average; smoking cessation among low-income communities is therefore, a priority. Smoking: the overall incidence of smoking in the catchment is 20.5% for males and 19.7% for females. Smoking rates are higher than the Victoria average (21.9%) in four of the five SLAs in the catchment. Males in Mornington Peninsula South have the highest rate of 25.5%¹⁸. Peninsula Health's Health Promotion Team have Smoking Cessation as a priority area and activity in this area is also occurring through the Prevention and Better Health Alliance of the Peninsula Model.

1.3.2. Alcohol and other drugs

In terms of drug use, the Turningpoint and Ambulance Victoria research project 2012/13 identified that Frankston had the highest number of ambulance call-outs in the State for incidents involving:

- Antidepressants
- Opioid analgesics
- Antipsychotics

Frankston was the second highest for:

- Cannabis
- Benzodiazepine
- Other analgesics

Over this same period, Frankston rated in the top six of all LGAs for every substance category apart from heroin¹⁹.

Ambulance callouts related to anticonvulsants in Mornington Peninsula were the highest in Victoria and Mornington Peninsula also rated in the top six catchments for ambulance calls out regarding other prescription medications including antidepressants, antipsychotics and other analgesics²⁰

Whilst individual alcohol and drug type data is not yet available for 2013/2014, summary data identifies that Frankston rates third of all LGAs in Victoria in relation to call out rates for alcohol, six for illicit substances and first for pharmaceuticals overall²¹.

¹⁸Frankston Mornington Peninsula Population Needs Analysis 2014

¹⁹Turning Point Ambulatory Research Project 2012-2013

²⁰Ibid

²¹Turning Point AOD Stats

According to the Victorian Drug Trends (2013) research, local injecting drug users in Frankston have replaced heroin with methamphetamine and are injecting it more frequently than previously. Anecdotal reports from the local needle syringe program (NSP) manager identify that they have maintained a relatively consistent client profile with the 35-40 year old age group being most prevalent and drug of choice being dependent on local availability and whilst they have seen an increase in their client's using methamphetamine, heroin has recently become more available so the drug of choice will swing again. The program manager further noted that even with the availability of methamphetamine in the local area they have not seen a change in their client profile and young injecting drug users are still a very small minority utilising their service.

Although there is some data regarding types of substances being used in the catchment it is important to note that this data is often collected from service providers and health services where there is an expressed need. Although there is limited local data, anecdotal evidence from NSPs identify an increasing trend in the use of performing enhancing and imaging drugs (PEID). Current research is being undertaken by Dr Matt Dunn and Dr Fiona McKay, Deakin University, highlights a significant increase in detections of PEID by customs over the past three years (up 106% and a further 57% the following year). Data from NSPs also demonstrate a 7% increase in self reports from consumers who identified that the last drug injected was a PEID. Dunn and McKay identify that consumers who use PEID differ considerably from other service users and there is a lack of knowledge across professionals to PEID use²². There is a need for further exploration and research into the prevalence around the impact of PEID use across FMP.

Anecdotal reports from the local NSP program manager identifies a gradual increase in the dispensing of injecting paraphernalia linked to PEID and also that linked to melatonin injections. Whilst he identifies that this is a very small percentage of their core business this type of drug use is often hidden so data regarding use is very difficult to obtain. This is an area to consider in prevention and health promoting messaging relating to AOD across the catchment.

1.3.3. Pharmacotherapy

The Department of Health and Human Services have invested resourcing to understand the multiple and complex issues relating to perception of alcohol and other drugs in the Frankston central business district. This project is auspiced by the AOD Alliance and the AOD catchment based planner works collaboratively with the project co-ordinator to undertake the scope of work outlined in the project proposal which includes a focus on pharmacotherapy, research pertaining to emerging trends in AOD use. The Area 4 Pharmacotherapy Network is also engaged in the AOD Alliance and collaboration occurs to ensure work being conducting in the catchment supports their plan.

1.3.4. Emergency department presentations

Alcohol Emergency Department presentations for Frankston have increased from 134 in 2003/04 by 155% to 342 in 2012/13. Frankston and Mornington Peninsula also have extremely high numbers of presentations to emergency for illicit drugs and pharmaceuticals²³. It is noted that over the past two years Peninsula Health have been undertaking a project "Better Responses to AOD in ED" that focuses on implementing screening for AOD to all patients in emergency. It is envisaged that this project, in addition to a new electronic patient information management system, will assist with data collection pertaining to patients presenting with AOD issues in the emergency department.

1.3.5. Hospital admissions

Frankston Hospital has the highest rate of hospital admissions related to alcohol use in Victoria and the third highest rates of hospital admissions for illicit substances and

²²Dunn, M & McKay, F. (2014).CHASE Research March 2014. Retrieved from http://www.deakin.edu.au/data/assets/pdf_file/0006/263679/CHASEMarch2014.pdf

²³TurningpointAODstatswww.aodstats.org.au

pharmaceuticals²⁴. Peninsula Health Alcohol and Other Drug Services employs a Clinical Liaison Consultant through Federal funding that provides advice and consultation to the hospital regarding AOD and also provides training and capacity building where possible. This consultant works closely with the Clinical Liaison Addiction Medicine Specialists who provide consultation to medical staff in the hospital.

1.4 The FMP health and community service system

The AOD treatment system in the catchment is well connected to the broader health and community service sector. In 2013, there were around 75 general practices in the catchment, with 323 general practitioners (incl 23 registrars) and 138 practice nurses in 51 practices, about 256 allied health providers, and 69 pharmacies²⁵. Other primary health services include a Headspace Centre in Frankston which includes the Youth Early Psychosis Program; a 'Medicentre': after-hours general practice service co-located at Frankston Hospital site of Peninsula Health; 30 Maternal and Child Health Services across the ML catchment which are managed through local government. Adult non-clinical community-based mental health services are provided by three mental health community support services .

Innovative and collaborative programs are embraced by service providers in the catchment with partnerships formed to deliver a mental health homelessness program, rooming house projects and youth specific initiatives. A majority of services operating in the catchment are based locally and outpost across the catchment in high needs areas.

²⁴ Ibid

²⁵ Frankston Mornington Peninsula Medicare Local Annual Plan and Budget 2013-2014

1.4.1 Needs analysis results & service provider responses

In March 2015 a needs analysis was undertaken for service providers in the catchment regarding alcohol and other drugs in their client cohorts. Over 220 individuals responded from a variety of sectors including education, justice, child and family services, allied health and family violence. Over 60% of respondents reported that more than 60% of their client group presented with AOD issues however their confidence level in responding to AOD issues was a majority moderate. Approximately 84% of respondents were aware of AOD services in the catchment and the top three needs that were listed in relation to AOD drugs include knowledge of referral pathways, AOD/MH champions within organisations and opportunities for secondary consultations.

A further service provider survey was distributed in June 2015 to obtain feedback in relation to their client’s experience in accessing AOD treatment post reform and their input into current local issues in relation to AOD. Over 50 surveys were returned from across a range of sectors. Feedback from these surveys identify that of 95% of respondents were aware of how to access AOD treatment for their clients. The following figures articulate responses from service providers regarding AOD treatment and identified needs in the community.

Figure 1: Perceived challenges for clients accessing AOD services in FMP

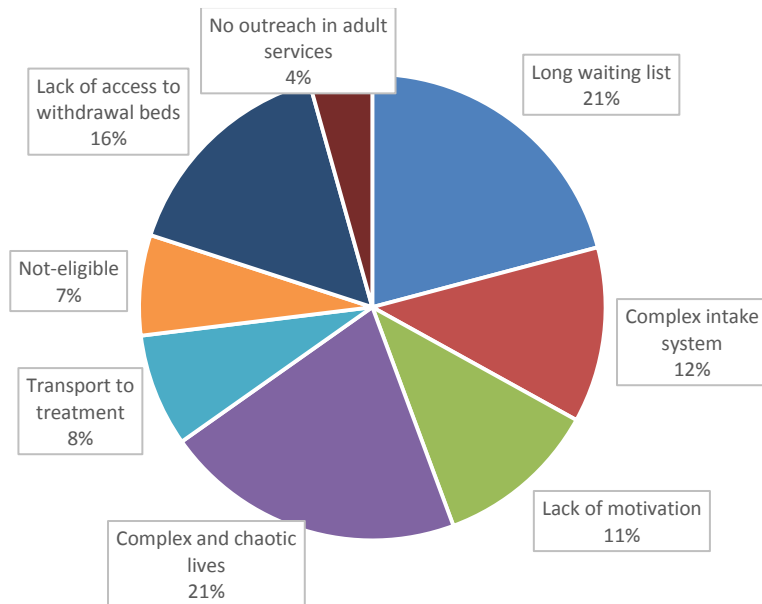
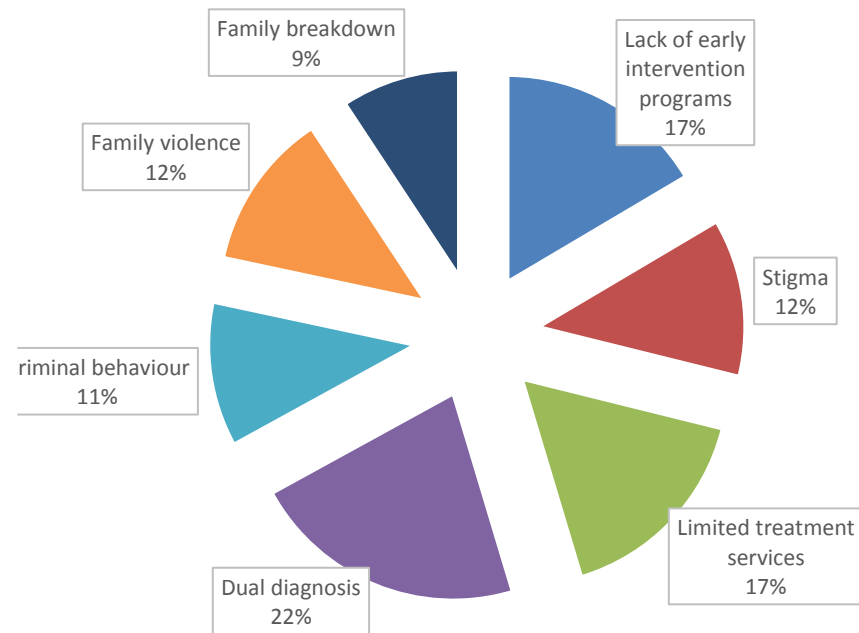


Figure 2: Perceived current issues in relation to AOD in the community



1.5 AOD Treatment System

Peninsula Health AOD Services

FaMDAS

Central intake and assessment
FaMDAS Counselling (Frankston & Mornington)
FaMDAS Non-residential withdrawal
FaMDAS Care and Recovery

****Older Wiser Lifestyle Program (For older adults 60+)**

****Peninsula Health Youth (12-25yrs)**

- Youth AOD Supported Accommodation
- Youth Outreach and Counselling

SHARPS Needle Syringe Program

Drink and Drug Drive Programs

Stepping Up Consortium

Counselling (Frankston, Rosebud, Hastings)

Care and recovery

Non-residential withdrawal (Delivered via Windana)

****YSAS (12-21 yrs)**

Youth outreach across FMP including Young parents program

****Anglicare Linking Youth and Families Together (LYFT)**

Family therapy for families where a young person has issues with AOD

Other AOD

Bunjilwarra Healing Centre – Koori Residential Rehabilitation

Beleura Private – private residential alcohol withdrawal program

Clinical Liaison Addiction Medicine Specialist (in patient clinical consultation)- Peninsula Health

**** Referrals do not go through recommissioned AOD central intake**

1.5.1 AOD treatment staff profile

Professionals working in the AOD service system in FMP have multidisciplinary backgrounds with varying lengths of experience in the AOD sector.

Peninsula Health AOD

Peninsula Health AOD program employ 23 staff (22.2 EFT) across their program area who hold an average of 12 years experience in AOD treatment. Peninsula Health's Frankston and Mornington Drug and Alcohol Service (FaMDAS) operate the central intake and assessment for the catchment. The assessment team is a multidisciplinary team comprised of senior clinicians who hold either psychology, nursing or social work degrees. The majority of the remaining AOD staff have undergraduate degrees in social work or the human services sector or are currently undertaking undergraduate studies with minimum Diploma qualifications. Peninsula Health AOD primarily service

the Frankston Mornington area however central intake and assessment operate across the catchment with assessment clinicians outposted to Hastings and Rosebud as required.

Stepping-Up Consortium

The clinicians in Stepping-Up Consortium also bring a vast amount of experience to the catchment with an average of 8 year of experience in AOD treatment across the 8 staff employed in the catchment, most of who also hold undergraduate degrees. Stepping-Up Consortium staff are located in Frankston and outposted across the Southern Peninsula. The non-residential withdrawal nurse is employed by Windana and two AOD clinicians by Anglicare, Stepping-Up Consortia members.

Youth AOD

YSAS, LYFT and Peninsula Health Youth make up the AOD treatment system servicing young people in the FMP catchment. YSAS employs three AOD specific clinicians that provide outreach services to young people across the catchment whilst PH Youth also have three AOD outreach workers however it is noted that only 3.6EFT of these clinicians are State Government funded.

The Linking Youth and Families Together (LYFT) program (provided by Anglicare) delivers family interventions for young people with problematic AOD use and works collaboratively with YSAS and PH Youth to provide holistic, family centred practice. LYFT is comprised of two staff both of whom have family therapy qualifications. LYFT is Federally funded for a further 6 months. YSAS also delivers the Young Parents Program which employs two clinicians who work with pregnant and young parents who also have AOD issues. This service is also Federally funded.

Bunjilwarra Koori Healing Centre

Located in the catchment is a residential rehabilitation for Koori young people aged 16-25. This facility is a partnership between YSAS and Ngwala. A large number of casual staff work in care and recovery roles at Bunjilwarra and they operate their own assessment and intake service taking in young people from all over Victoria and other States where required.

Peer workforce/ family support

Peninsula Health AOD supports two peer facilitated support groups in the Frankston area, SMART and a newly created SHARC group. SMART peer facilitators receive supervision and support from a team leader in Peninsula Health AOD whilst peer facilitators of the SHARC group obtain this from SHARC. These groups are well supported by Peninsula Health AOD. Peninsula Health also support the AOD Consumer Advisory Group who are utilised in any planning relevant to consumer access and engagement.

Stepping-Up Consortium has recently supported SHARC to commence a peer support group on the Southern Peninsula.

It has been identified by AOD professionals in FMP that peer support is an integral component of the AOD service system and further development and support of peer workers across this catchment is a priority. In June 2015, mental health services opened a peer workforce hub for mental health peer workers. It is hoped in the near future that this will encompass support and training for peers operating in the AOD space.

Two family support groups also operate in the Frankston area, Family Drug Help and Family Drug Support. These groups are well supported by AOD treatment agencies however capacity to extend these groups to the Southern Peninsula needs to be explored. A scoping exercise by the Southern Metropolitan Mental Health Council in 2014 identified gaps in mental health and AOD services around formal assessments and support plans for carers. Whilst the current funded AOD treatment system does not fund treatment and intervention specifically for family and carers there is an opportunity to work collaboratively with funded AOD and MH agencies to provide a response to families and carers across the catchment.

1.5.2. Summary of FMP AOD Treatment Services

Staff working across AOD treatment in the catchment are highly skilled and qualified. These services work collaboratively across youth and adult, with management and senior clinicians of the services participating in monthly meetings as a working group of the AOD Alliance to discuss collaborative practice, referral pathways and any identified needs in service areas. As a result outcomes of this working group include resolving concerns regarding the distribution of forensic referrals in the catchment, the development of a FMP AOD Consumer Information Booklet and a catchment wide model of supported accommodation. Services also work collaboratively to undertake capacity building in the catchment where there has been an identified need e.g. delivering AOD education workshops to teachers in schools. This working group will continue to meet on a monthly basis under the AOD Alliance.

It has been recognised that there is a significant need for youth specific AOD responses across the catchment given the health and social needs identified through data however there are only a small number of youth AOD workers in the catchment to cover a vast geographical area. Whilst adult AOD treatment settings can see young people aged 16 and over it is noted that the model of adult AOD treatment is not conducive to the needs of majority of young people, with limited outreach and ability for early intervention which is central to work in the youth AOD field.

2. Clients accessing FMP central intake and assessment

2.1 FaMDAS Central Intake and Assessment

From 1 September 2014 to 30 June 2015 there were 1070 referrals to the FaMDAS Central Intake Service (CIS). 53% of these clients went on to obtain a full assessment and 6% were referred post-screen to other AOD treatment services in the catchment such as youth or older adults. 16% of those who contacted the FaMDAS CIS were deemed ineligible and 27% were non-contactable or declined further intervention post the initial referral²⁶.

From July 2015-October 2015 there has been 500 referrals to the CIS. 48% of these clients went on to obtain a full assessment and 3% were referred post-screen to other AOD treatment services in the catchment. 18.6% of referrals were deemed ineligible and 34% were non-contactable or declined further intervention post initial referral²⁷. It is noted that both the ineligible rate and non-contactable rate has increased slightly however it is noted that the percentage is taken over a shorter period. These figures will be monitored through the Accessible and Integrated Treatment working group on a monthly basis with the purpose of monitoring trends and developing responses to address identified needs.

2.1.1 Ineligible referrals

Since July 2015, 18.6% of all referrals to the FaMDAS central intake service were deemed ineligible and were referred to non-AOD services for support. 33% of these clients were uncontactable when central clinicians attempted to make contact to complete the screen. Of the remaining clients, 13.5% were out of catchment and referred to the suitable intake service, 81% scored too low on the eligibility screen and the remaining 5.5% of clients declining to participate in the screening process.

The FaMDAS central intake clinicians utilise a range of catchment based resources to refer those clients who are deemed ineligible to support. Options provided to clients deemed ineligible for treatment include telephone counselling, local peer facilitated support groups, relevant services to address other presenting needs and referral to a general practitioner to obtain a mental health care plan for private counselling. A number of resources have been developed to assist the central intake clinicians which includes a catchment specific resource manual that collates information and referral pathways for non-AOD specific services and a database that is maintained locally that details private psychologists in the local area who are low cost and respond to AOD issues.

2.1.2 Non-contactable/ declined

A high proportion (34%) of initial referrals to the CIS were non-contactable or declined any further intervention. Reports from the FaMDAS team leader identify that this is often due to the initial referral being made due to pressure from an external source such as family members and that senior clinicians in the assessment team conduct assertive follow up with these referrals in an attempt to engage them in the service and also offer outreach assessments where required. This number will continue to be monitored through the Accessible and Integrated Treatment working group on a monthly basis, with the group currently exploring how to obtain further evidence for the client not engaging in treatment and responses to reduce the proportion of these clients.

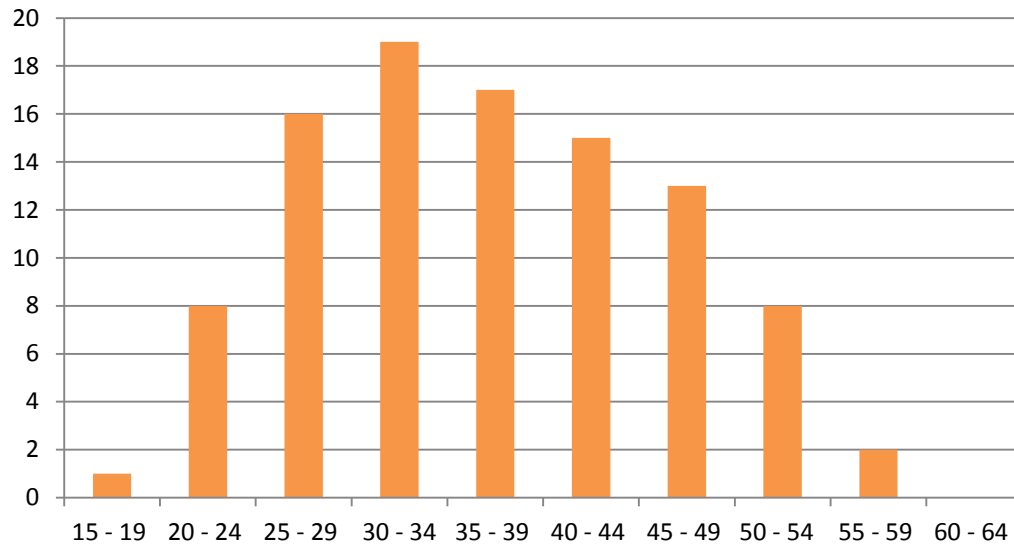
²⁶Peninsula Model- Accessible and Integrated Data Collection Strategy September 2014- June 2015

²⁷ Peninsula Model- Accessible and Integrated Data Collection Strategy July 2015- October 2015

2.2. Central Intake client demographics

2.2.1. Age distribution

Chart 2- FaMDAS Central Assessment Team – Age Distribution (Percentage)



Source: Peninsula Health Alcohol and Other Drug Services

2.2.2 Culture and gender

4.5% of clients accessing FaMDAS central intake identify as Aboriginal or Torres Strait Islander.

85% of clients were born in Australia, 2% from New Zealand, 2% England and other 11% comprising of various countries. These figures are consistent with catchment demographics.

37% of clients are female and 63% male.

Age, gender and country of birth information regarding client's accessing adult AOD treatment is consistent with referrals to the AOD treatment system pre reform²⁸.

²⁸Department of Health and Human Service Alcohol and Drug Treatment Data 2013-2014

2.2.3 Client's residential location

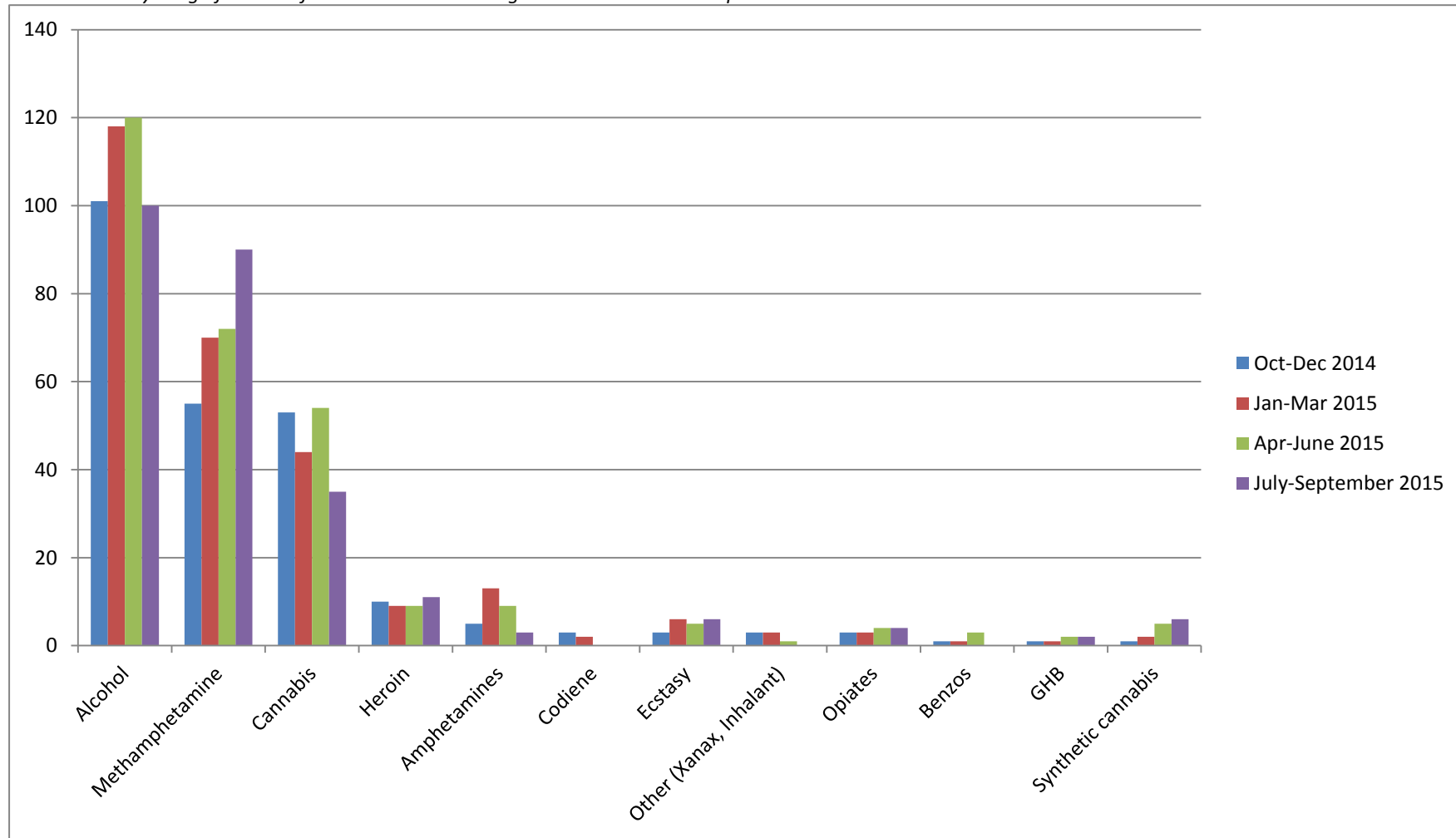
Figure: Top six residential suburbs of clients assessed through FaMDAS

Suburb	Percentage of clients
Frankston	33%
Seaford	8%
Frankston North	7%
Hastings	6%
Mornington	6%
Rosebud	6%

These figures are consistent with data pre-reform which indicates that clients continue to be serviced across the catchment.

2.2.4 Primary drug of choice- FaMDAS Assessment

Chart 2: Primary drug of choice of clients assessed through FaMDAS Oct 2014-September 2015



Source: Peninsula Health Alcohol and Other Drug Services

Alcohol continues to be the primary drug of choice for clients accessing AOD treatment in the FMP catchment however methamphetamine has become the second highest primary drug of choice for clients accessing AOD treatment in the catchment and has increased significantly in the reformed treatment system, with cannabis reducing significantly. This is a change to the primary drug of choice in AOD treatment which has predominately been alcohol first and cannabis second. It can be hypothesised that due to the scoring system for entry to the AOD treatment system, a majority of clients who previously access treatment to address their cannabis and alcohol use and no longer deemed eligible due to a low score on the AUDIT or DUDIT resulting in an increased complexity and change in drug of choice for the clients accessing treatment. This change in client cohort highlights a need to upskill clinicians working in AOD treatment to ensure they are equipped with evidence based interventions suitable to respond to client's using methamphetamine and other newly emerging substances such as synthetics and prescription medication.

2.3 Treatment utilisation

It has been noted that referrals to non-residential withdrawal across the catchment have been low since September 2014. There has been a concerted effort to promote this service type and build collaborative links between the non-residential withdrawal nurses, general practice and other service types. The three non-residential withdrawal nurses across both adult AOD services have been extremely proactive and continue to be supported by initiatives to increase referrals numbers by the treatment providers. In the last quarter an increase in referrals to non-residential withdrawal services across the catchment has been noted with the nurses attributing this to their promotional activity and collaboration with primary care. Referrals will continue to be monitored and strategies to address low referral numbers will continue to be undertaken in the Accessible and Integrated Treatment Working Group of the AOD Alliance.

2.4 Consumer survey results

During July 2015, Peninsula Health and Stepping-Up Consortium undertook quality improvement activities to understand the consumer experience in accessing treatment post reform. The return rate of consumer surveys was low due to limited lead in time and period in which they were completed however of the 19 surveys that were returned client's reported that the found accessing treatment in the catchment easy with barriers to accessing the service relating to length of waiting time and being unsure who to call. A majority reported no barriers to accessing treatment. A high proportion of clients who responded also spoke positively of their experience with the service with specific feedback commenting on the supportive, non-judgemental and helpful nature of the clinicians working in the service. Whilst 75% of clients did not identify areas requiring improvement, the other 25% identified the need for shorter wait times to access treatment. 42% of clients accessing AOD treatment also reported currently requiring or receiving treatment for mental health concerns.

It is acknowledged that such a small sample provides little statistical significance and reliable data however there is intention to continue obtaining consumer feedback in order to address any identified needs and gaps and emerging trends in AOD treatment service delivery. The catchment will work closely with the Association of Participating Service Users who have rolled out a Statewide consumer survey and can analyse responses on a catchment level. It is also noted that the surveys can be tailored for catchment need and initial discussion has occurred to develop a strategies to obtain feedback from consumers deemed ineligible to access treatment. This will assist in identifying pathways for those consumers. .

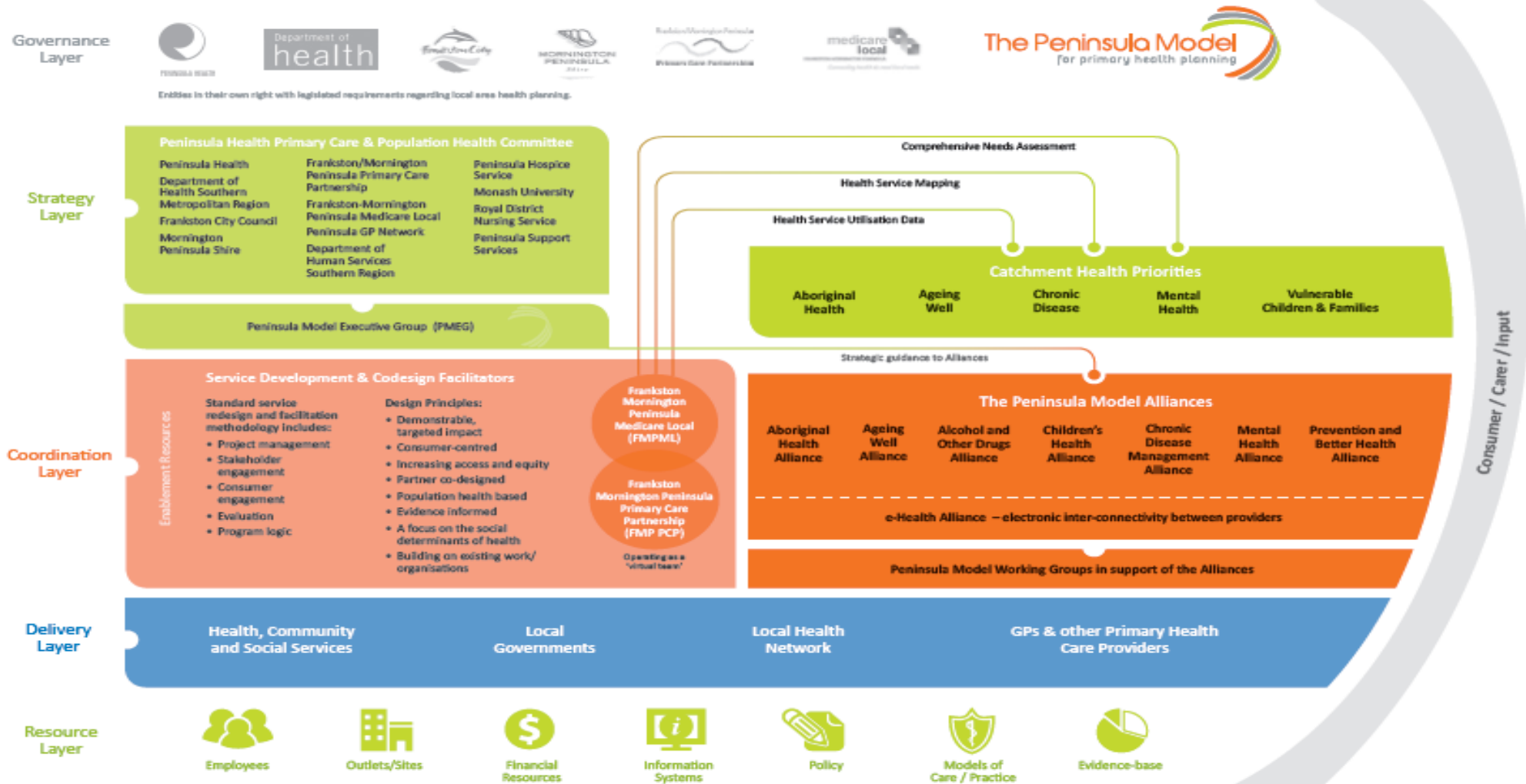
2.5 Future monitoring

A data strategy has been developed with FaMDAS intake that sees intake and assessment data monitoring via a working group of the AOD Alliance. This includes referrals numbers, distribution to services, forensic clients and treatment type. Due to challenges in obtaining data to inform this plan regarding client issues such as co-occurring

presentations and complexity factors it has been identified that such data will be collated on a quarterly basis through the AOD catchment based planner and presented to the working group and broader Alliance where issues and needs will be identified and responded to. Tracking this data will also further assist to understand where resourcing needs to be focused and prioritise interventions.

In addition to specific treatment data there is an intention to do a catchment wide data strategy that identifies areas in primary and allied health and non-AOD services where clients may present with AOD needs and not be accessing services.

3 GOVERNANCE



The *Peninsula Model for Primary Health Planning* is unique to the FMP catchment and aims to provide a functional primary health care planning framework and subsequently governance system aimed to;

- improve integration of disparate plans
- reduce duplication of efforts
- strengthen collaboration

The Primary Care and Population Health Committee comprising CEO/Director level representatives provides the oversight for the collaborative work undertaken within The *Peninsula Model for Primary Health Planning*. Alongside is a Peninsula Model Executive Group (PMEG) who is responsible for overall strategy formation across the Peninsula Model, and facilitates the formation of Alliances and Working Groups. It also provides oversight for actions undertaken across the Alliances, supporting areas of interface.

The Alcohol and Other Drug Alliance was established in August 2014 in response to the state Government reforms of the adult AOD treatment system. The AOD catchment based planning position provides secretariat support to the Alliance and associated working groups and provides co-ordination of the work being undertaken across the AOD Alliance and any interface with other Alliance work.

Membership of the AOD Alliance provides multisectoral governance to planning activities related to AOD in the catchment. Terms of reference for the AOD Alliance are located in appendix a. Priorities identified by the AOD Alliance through a catchment wide analysis provided the impetus for the creation of the working groups that operate under the AOD Alliance. These working groups provide the delivery layer of the Peninsula Model. The AOD Alliance has senior representation from 16 agencies and the working groups have representation across a total of 23 organisations with multiple program areas represented in larger organisations such as Peninsula Health and local Government. A consumer from the Peninsula Health AOD Consumer Advisory Group also participates on the Alliance. A list of current Alliance and Working Group members is located in appendix b.

The AOD Alliance and associated working groups have been in operation since September 2014 and have made significant progress in embedding the reformed adult AOD treatment system into the catchment and broader health and community service system. Priorities have focused on data collection to monitor AOD treatment system utilisation, consumer access, information dissemination including training on newly reformed system for professionals from primary care and community services and building capacity in these sectors to respond to low impact AOD use.

Achievements thus far have included;

- Development of FMP AOD Consumer Information Booklet
- Map of Medicine Alcohol and Other Drug pathway
- Delivery of four community forums incorporating screening and brief intervention training
- Direct engagement with over 20 general practice clinics
- Successful funding to deliver AOD education to professionals working in schools
- Development of a catchment wide model of support accommodation
- Data monitoring strategy in place since December to track client need and service utilisation

The AOD Alliance and associated working groups will provide the mechanism to undertake activities supporting the priorities of the AOD catchment based plan over the next three years in addition to providing Governance around the model.

3.1 Engagement with key stakeholders in development of the plan

This AOD catchment based plan has been developed with input from all key stakeholders involved in the AOD Alliance and associated working groups and has been endorsed by the AOD Alliance. Furthermore consumer and service provider feedback has been sought regarding the reformed AOD treatment system and community needs, which has been informed priorities and the action plan.

The plan has also been developed in consideration of the following plans relevant to the FMP catchment;

- Mornington Peninsula Shire and Frankston City Council Health and Wellbeing Plans
- Peninsula Health Health Promotion Plan
- Women's Health in the South East Integrated Health Promotion Plan 2015
- Mental Health Community Support Services 3 year Catchment Based Plan 2015-2018
- FMP Catchment Wide Strategy To Prevent Violence Against Women and their Children 2014-2017
- Communities for Children Frankston Community Strategic Plan 2015-2019
- Victorian Ice Action Plan
- Aspex Independent

3.2 Review of catchment based plan

Data pertaining to AOD treatment will be reviewed quarterly through the AOD Alliance and associated Accessible and Integrated Working Groups. Work plans will be developed across the three working groups of the AOD Alliance to undertake the work identified in the action plan. The work plans are endorsed by the AOD Alliance and progress on achievements is reviewed on a bimonthly basis with a formal review and revision of the workplans occurring yearly unless otherwise required.

4. CATCHMENT NEEDS

Relevant to social determinants in FMP

- Significant pockets of disadvantage with specific locations identified as being most disadvantaged including Frankston North, Hastings and Rosebud West
- High prevalence of complex needs in the catchment - homelessness, family violence, mental health and vulnerable children
- High level of family violence incidents- anecdotal reports identify alcohol or drug use present in around 60% of incidents however there is a need for greater understanding of the interconnection between AOD and family violence in the catchment
- Higher than average rates of child protection notifications- significantly high proportion in two identified areas of need- Frankston North and Hastings
- High levels of early school leavers and disengaged youth and at risk alcohol consumption in young people
- Above average rates of smoking
- Higher than average individuals 'at risk' of risky alcohol consumption
- High levels of ambulance responses for prescription medications with the catchment experiencing the highest number of call outs in the State across three prescription medication categories

Relevant to broader health and community service sector

- AOD treatment services do not have the funding to focus on health promotion activities and minimal attention is given directly to AOD in health promotion plans in the catchment
- Minimal screening currently being done for problematic AOD use in general practice, primary care and allied health
- High rates of misuse of prescription medication resulting in ambulance call outs
- High expenditure on gambling
- Lack of recognition of AOD as a health issue by primary care
- Unknown data on needs relating to the local Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) community
- Lack of confidence reported by non-AOD related services to respond to AOD issues
- Reforms across Child, Family, Family Violence and Mental Health services has resulted in a lack of knowledge of referral pathways for at risk cohorts in the catchment
- Ageing population and minimal awareness in the aged care sector and primary health regarding the importance of screening for risky alcohol consumption
- Lack of data available in broader health and community service sector to assist in understanding presentations of clients/patients involving AOD issues

Relevant to AOD treatment in the FMP

- Reformed treatment system is not designed to respond at an early intervention stage- policy direction identifies primary care as being responsible however there is a need for resourcing and education around screening and brief intervention
- Adult AOD treatment system has limited capacity to deliver alternate models of treatment to meet the needs of consumers experiencing complex issues
- The catchment does not have any other funded adult treatment service type to respond to broader community needs e.g. non-residential rehabilitation
- Collaborative practice across treatment services covering the treatment spectrum and ensure that these services are responding to identified needs
- High demand for AOD treatment and limited treatment availability resulting in waiting lists either at assessment or counselling
- Low resourcing of youth specific AOD workers to respond to a large geographical area
- Low number of pharmacotherapy prescribers and dispenses

4.1 Activity to date in the FMP catchment

There has been significant work actioned in the catchment through the AOD Alliance and associated working groups over the last 12 months that has assisted in a developing a co-ordinated and responsive local AOD treatment system.

- Development of monthly data collection strategy across adult AOD services to monitor service utilisation
- Catchment specific AOD resource guide outlining treatment types, how and where to access treatment and support for families
- Catchment wide model for AOD supported accommodation, with practice guidelines and templates to ensure consistency across services
- Statewide residential AOD services guide
- Catchment specific resource guide for central intake
- Direct engagement with primary care to educate on reformed treatment system
- Needs analysis pertaining to professional development needs across multiple sectors regarding AOD and mental health
- Dual diagnosis file audit that returned 74 completed templates to identify dual diagnosis needs presenting in mental health and AOD services
- Delivery of multiple training and education sessions for allied health and non-AOD specific services to assist in navigating service sector and build capacity to respond to AOD needs
- Specialist training for AOD treatment specialists to enhance networking and build skill set around single session family work and dual diagnosis clients.

4.2 Links with the Responding to Alcohol and Other Drugs in the Frankston Mornington Peninsula (RAD-FMP) project

The AOD Alliance was identified as an appropriate Governance structure to oversee a project funded by DHHS to address issues related to pharmacotherapy in Frankston and the surrounding area. In April 2015 a steering group was convened with high level representation from multiple sectors to oversee the project. A technical advisor from University of Melbourne with experience in AOD was acquired and in June 2015 a project co-ordinator was employed through the Primary Care Partnerships. The project co-ordinator and the FMP AOD catchment planner work in close collaboration with the catchment planner also an associate researcher with the project. Whilst the project has a specific focus on the Frankston transit precinct there is also a component that looks to address broader social determinants that are contributing to AOD use across

the catchment. The project and catchment planning role share resources, intelligence and undertake joint initiatives to progress common priorities. The project thus far has garnered a great deal of support across local and State Government, Victoria Police, Monash University and local health services. It is envisaged that recommendations made in the project will influence key activities in the catchment planning.

4.3 Links with the Mental Health Community Support Services catchment based planning function

In the last six months there has been significant progress in developing links between AOD and MHCSS on a direct practice level, management level and in catchment planning. There have been a number of common goals and aims identified across both sectors that will see activities undertaken in collaboration particularly in relation to capacity building activities and data collection, as well as activity to address broader social determinants in the catchment. The FMP AOD catchment planner works closely with Neami National who has the MHCSS function for the catchment to identify any common threads and pool resources to ensure a united approach. Future work will be influenced by the priorities outlined in both the final MHCSS and AOD catchment based plan. It is noted that the regional manager of Neami National sits on the AOD Alliance, the AOD catchment planner sits on the Mental Health Alliance and there is a dual diagnosis working group operating under the AOD Alliance that has senior representation from all AOD and mental health services in the catchment.

5. PRIORITIES AND OBJECTIVES

Priority	Objective	Needs Addressed by Priority	Link to other plans
<p>1. <i>Build capacity and competency across general practice, primary care and allied health (including dental) to recognise and respond to AOD related needs at the individual and community level</i></p>	<ul style="list-style-type: none"> Utilise established partnerships to ensure local health promotion and health and wellbeing plans identify AOD as an important factor in health planning Understand how general practice, primary care and allied health currently identify and respond to consumers with problematic AOD use Identify/ develop AOD screening/risk assessment tool for services and practices to incorporate into their intake processes Build capacity in non-AOD related services via training and secondary consultation to enhance worker's ability to identify clients engaging in harmful AOD use, undertake stage-appropriate interventions and place supported referrals to specialist treatment when necessary 	<ul style="list-style-type: none"> Minimal AOD focus in health promotion plans and local Government health and wellbeing plans Reformed AOD treatment system requires low impact AOD use to be responded to in non-AOD related services, particularly primary care and general practice No standardised method for screening for AOD related harms being utilised in general practice, primary care and allied health 	<p>Peninsula Health's Health Promotion Plan Mornington Peninsula Shire and Frankston City Council Health and Wellbeing Plan Communities That Care Plan</p>
<p>2. <i>Improve the understanding of the impact of AOD in at risk cohorts including mental health, family violence,</i></p>	<ul style="list-style-type: none"> Obtain data on the prevalence of AOD use in clients accessing non-AOD related services with a priority on at risk cohorts to understand AOD needs and 	<ul style="list-style-type: none"> High rates of child protection notifications Lack of data at local level regarding AOD issues in at risk client cohorts of non-AOD 	<p>Child and Family Services Catchment Plan Communities for Children Frankston Community Strategic Plan 2015-2019 WHISE Integrated Health Promoted Plan</p>

<p><i>vulnerable youth, homeless, indigenous, vulnerable families, LGTIBQ, aged persons and forensic cohorts. Identify opportunities to improve the consumer journey and undertake innovative partnerships that respond to needs regarding AODs within these cohorts</i></p>	<p>referral pathways for these client groups</p> <ul style="list-style-type: none"> • Identify interventions that address the compounding influence of AOD on other complex needs • Develop a multidisciplinary community clinical review panel for workers in the community to obtain guidance for clients presenting with complex needs • Build capacity and competency around AOD interventions and referral pathways in non-AOD specific community services • Develop collaborative partnerships to undertake promotion/ early intervention activities for young people and aged • Leverage existing partnerships and evidence gathered, to pilot innovative responses that address AOD use in at risk cohorts using a place based approach 	<p>services</p> <ul style="list-style-type: none"> • High level of complex needs in catchment • Limited available funding to respond in creative manners • Specific hot spots of entrenched disadvantage and transportation issues requiring place based approaches • High level of vulnerable young people • Ageing population • Limited capacity for AOD services to undertake community development activities 	<p>FMP Catchment Wide Strategy To Prevent Violence Against Women and their Children 2014-2017</p>
<p>3. <i>Build capacity in the AOD treatment sector to identify and respond to clients experiencing or perpetrating family violence and develop collaborative partnerships to support catchment and</i></p>	<ul style="list-style-type: none"> • Actively support AOD service providers to integrate with initiatives resulting from the Royal Commission into Family Violence • Understand how AOD services are identifying those at risk of family violence 	<ul style="list-style-type: none"> • High rates of family violence incident reports 	<p>WHISE Integrated Health Promotion Plan FMP Catchment Wide Strategy To Prevent Violence Against Women and their Children 2014-2017</p>

<p><i>regional strategies around family violence</i></p>	<ul style="list-style-type: none"> • Undertake capacity building across AOD services in relation to family violence including risk assessment and response 		
<p>4. <i>Ensure the AOD treatment system is accessible, responsive and integrated with the broader health and community services system in the catchment and dual diagnosis capable.</i></p>	<ul style="list-style-type: none"> • Identify emerging AOD trends across the catchment through quantitative and qualitative methods • Ensure services are placed where there is demand and identify funding opportunities to increase youth AOD workforce and provide more variety of AOD treatment • Monitor consumer experience of AOD treatment • Monitor service usage data and respond effectively to identify needs in a timely manner • Build capacity in the AOD peer workforce and carers • Support the Pharmacotherapy Network to enhance access to pharmacotherapy treatment • Develop models of collaborative practice with general practice and enhance their capacity to respond to AOD use in patients • Provide education and resourcing to primary care and aged persons services regarding older adults and risky drinking 	<ul style="list-style-type: none"> • Newly reformed treatment service to be embedded in the catchment • Low referral numbers to non-residential withdrawal services and no local withdrawal or rehabilitation service • Lack of awareness of referral pathways • Limitations of reformed treatment system to see families/carers and to provide long term support • High rate of ambulatory call outs for prescription medication • High number of complex needs in the catchment • Lack of pharmacotherapy prescribing and dispensing in catchment • Presence of mental health issues in the catchment 	<p>Mental Health Community Support Services Catchment Based Plan Area 4 Pharmacotherapy Network Plan AOD Alliance Project Plan</p>

6. ACTION PLAN

The Alliance has identified the following actions under each priority area which are supported through partnership with key stakeholders.

Priority 1						
<i>Build capacity and competency in non-AOD services to respond to AOD related needs at the individual and community level</i>						
Objective	Action	Responsibility	Outcome Measures	Timeline		
Local health promotion and health and wellbeing plans identify AOD as an important factor in health planning	<ul style="list-style-type: none"> Utilise existing partnerships to engage in the planning process 	AOD Alliance	Reference to AOD in Peninsula Health's Health Promotion Plan, Frankston City Council Health and Wellbeing Plan and Mornington Peninsula Shire Health and Wellbeing Plan	Year 1	Year 2	Year 3
Understand how general practice, primary care and allied health currently identify and respond to consumers with problematic AOD use	<ul style="list-style-type: none"> Conduct audit of current screening tools in place Undertake needs analysis across general practice, primary care, and allied health in relation to patients presenting with AOD issues 	AOD Alliance and associated working groups Primary Health Network Primary Care Partnerships Peninsula Health GP Liaison	Greater understanding of how patients with AOD issues are identified and responded to			
Identify/ develop AOD screening/risk assessment tool for services and practices to incorporate into their intake processes	<ul style="list-style-type: none"> Develop standardised screening questions Incorporate screening questions into relevant service/ practice 	AOD Alliance Primary Health Network Primary Care Partnerships	Increase in number of organisations/ services screening for AOD across catchment			
Build capacity in non-AOD related services via training and secondary consultation to	<ul style="list-style-type: none"> Develop and deliver training based on results of needs 	AOD Alliance AOD treatment agencies	Limited ineligible referrals to AOD treatment Improvement in confidence of service			

enhance worker's ability to identify clients engaging in harmful AOD use, undertake stage-appropriate interventions and place supported referrals to specialist treatment when necessary	<i>analysis incorporating referral pathways</i>		<i>providers/practitioners managing AOD use in clients</i>			
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Priority 2
Improve the understanding of the impact of AOD in at risk cohorts including mental health, family violence, vulnerable youth, homeless, indigenous, vulnerable families, LGTIBQ and forensic cohorts. Identify opportunities to improve the consumer journey and undertake innovative partnerships that respond to needs regarding AODs within these cohorts

Objective	Action	Responsibility	Outcome Measures	Timeline		
Obtain data on the prevalence of AOD use in clients accessing non-AOD with a priority on at-risk cohorts to understand AOD related needs and referral pathways	<ul style="list-style-type: none"> • <i>Develop data collection tool and accompanying strategy</i> • <i>Implement data collection strategy</i> • <i>Map referral pathways</i> • <i>Analyse data and compile report with recommendations</i> 	<i>AOD Alliance AOD Alliance Dual Diagnosis Working Group Key stakeholder agencies</i>	<i>Priority areas identified</i>	<i>Year 1</i>	<i>Year 2</i>	<i>Year 3</i>
Identify interventions that address the compounding influence of AOD on other complex needs such as mental health, homelessness, family violence and disengaged young people	<ul style="list-style-type: none"> • <i>Review of proven interventions</i> • <i>Identify suitable interventions to respond to catchment specific needs</i> 	<i>AOD catchment based planner</i>	<i>Innovative interventions identified with the possibility of implementing these in catchment</i>			
Develop collaborative partnerships to undertake promotion/ early intervention activities with	<ul style="list-style-type: none"> • <i>Identify opportunities for partnerships</i> • <i>Deliver capacity building sessions to individuals in learning environments re delivering AOD education</i> 	<i>AOD catchment based planner AOD catchment based planner Catchment youth organisations School Focused Youth Services</i>	<i>Increased awareness of risks associated with AOD use in young people and aged persons</i>			

young people and aged persons						
Leverage existing partnerships to pilot innovative responses that address AOD use in at risk cohorts	<ul style="list-style-type: none"> Explore funding opportunities 	AOD Alliance AOD catchment based planner	Innovative programs developed to respond to catchment needs related to AOD and at risk cohorts			
<p>Priority 3</p> <p><i>Build capacity in the AOD treatment sector to respond to clients experiencing or perpetrating family violence and develop collaborative partnerships to support strategies addressing family violence in the catchment</i></p>						
Objective	Action	Responsibility	Outcome Measures	Timeline		
Actively support AOD service providers to integrate with initiatives resulting from the Royal Commission into Family Violence	<ul style="list-style-type: none"> Communicate recommendations to AOD Alliance and develop strategies to integrate these initiatives in the current service system 	AOD Catchment based planner AOD Alliance				
Understand how AOD services are identifying victims of family violence and protocols to respond	<ul style="list-style-type: none"> Undertake audit of AOD intake/ screening/ assessment documentation Articulate referrals pathways specific to family violence in AOD Provide education on referral pathways 	AOD Alliance Accessible Integrated Working Group Family violence agencies Primary Care Partnerships	AOD treatment services are identifying individual's at risk and providing support and referral			
Implement training regarding FV into AOD agencies	<ul style="list-style-type: none"> Ensure all AOD clinicians across the catchment are training in identifying and responding to family violence 	AOD treatment agencies	Increased confidence in practitioners responding to clients at risk, experiencing and perpetrating family violence. Consumers more supported to disclose and are referred to appropriate services			

Priority 4

Ensure the AOD treatment system is accessible, responsive and integrated with the broader health and community services system in the catchment

Objective	Action	Responsibility	Outcome Measures	Timeline		
Identify emerging AOD trends across the catchment	<ul style="list-style-type: none"> Utilise AOD Alliance project co-ordinator to undertake primary data collection to identify emerging trends 	AOD Alliance Project Co-ordinator AOD Alliance Accessible and Integrated Working Group AOD Alliance Project AOD treatment services	Increased awareness of local needs resulting in the development of targeted strategies	Year 1	Year 2	Year 3
Monitor service usage data and respond effectively to identify needs in a timely manner	<ul style="list-style-type: none"> Broaden current data collection strategy to include additional data collection sources including hospital, mh services Monthly review of AOD treatment service data particularly referral numbers to service types and locations Quarterly review of client treatment data including forensic client profile, primary drug of choice, referral sources, co-occurring disorders, client outcomes Develop appropriate responses based on 	AOD Alliance Accessible and Integrated Working Group AOD treatment agencies	AOD services are delivered via evidence demand modelling and re-orienting service delivery to respond to identify needs DTAU targets being achieved			

	<i>identified needs e.g low non-residential withdrawal numbers</i>					
Monitor consumer experience of AOD treatment	<ul style="list-style-type: none"> • <i>Work collaboratively with the Association of Participating Service Users (APSU) to embed the consumer experience survey in catchment</i> • <i>Undertake 12 monthly quality improvement activities across AOD adult and youth treatment agencies via consumer surveys</i> • <i>Implement changes based on consumer feedback</i> 	<p><i>APSU Accessible and integrated working group AOD treatment agencies PH AOD Consumer Advisory Group</i></p>	<p><i>Consumers reporting treatment experience Positive outcomes reported by consumers DTAU targets being achieved Service responding to consumer identified needs</i></p>			
Build capacity in the AOD peer workforce and carers	<ul style="list-style-type: none"> • <i>Develop a partnership with the Mental Health Peer Hub to provide support and collaboration with peer workers across the FMP AOD sector</i> • <i>Expand peer support groups across catchment</i> • <i>Better understand the needs of families and carers supporting people with AOD issues</i> • <i>Implement an evidence based model to respond to identified needs and gaps in collaboration with mental health services</i> 	<p><i>AOD Alliance Accessible and Integrated Working Group AOD Treatment Service PH AOD Consumer Advisory Group MH Alliance Peer Workforce Working Group</i></p>	<p><i>AOD peer workforce integrated with mental health peer workforce Number of peer support groups operating in catchment Family and carers report an improvement in their access to support</i></p>			

<p>Support the Pharmacotherapy Network to enhance access to pharmacotherapy treatment</p>	<ul style="list-style-type: none"> • <i>Ensure AOD Alliance priorities align with work outlined in the AOD Alliance Project Plan and Area 4 Pharmacotherapy Network Plan in addressing pharmacotherapy accessibility across the catchment</i> 	<p><i>AOD Alliance Project Co-ordinator Area 4 Pharmacotherapy Network AOD Alliance Accessible and Integrated Working Group</i></p>	<p><i>Number of prescribers increased Dispensers located where required</i></p>			
<p>Develop a model of collaborative practice with general practice and enhance their capacity to respond to AOD use in patients</p>	<ul style="list-style-type: none"> • <i>Develop communication guidelines</i> • <i>Utilise media and communication to educate around risks associated with prescription medication overdose/ addiction</i> • <i>Provide education and resourcing to primary care and aged persons services regarding older adults and risky drinking</i> 	<p><i>AOD Accessible and Integrated Working Group AOD treatment agencies Older Wiser Lifestyle Program Peninsula health Primary Health Network Primary care</i></p>	<p><i>GP referrals to AOD treatment with eligible with screening completed Increased non-residential withdrawal referral numbers Decreased ambulance responses to prescription medications Recognition that responding to AOD use in the community requires more than specialist AOD services Increased referrals to Peninsula Health- Older Wiser Lifestyle Program</i></p>			
<p>Endorsed by Alcohol and Other Drug Alliance</p>						
<p>Signature: Name: Shelley Cross (Chair) Date: 01/12/2015</p>						

7. Appendices

Appendix a

Peninsula Model for Primary Health Planning

Alcohol and Other Drug Alliance

Terms of Reference

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1. PURPOSE

The *Alcohol and Other Drugs Alliance* of the Peninsula Model for Primary Health Planning (PMPHP) is responsible for leading service planning and redevelopment, and driving reform in relation to the new policy directions for *Alcohol and Other Drug* services in the catchment. It has a key role in establishing and maintaining strategic stakeholder relationships and providing advice and recommendations to the Peninsula Model Executive Group.

The agreed priorities of the *Alcohol and Other Drugs Alliance* for 2014 are:

- Dual diagnosis
- Common treatment frameworks
- Pathways to and prioritisation for service delivery
- Health promotion and early intervention

Additional to these priorities, the Alcohol and Other Drugs Alliance will be responsible for;

- Overseeing work commissioned in relation to the Frankston Transit Precinct project and build on existing mechanisms at the LGA level to conduct issue-based research and promote evidence based interventions

- Addressing specific departmental barriers to achieving outcomes in relation to this work and promoting intersectoral collaboration
- Feeding the results of any work commissioned into Community Working Group of the Frankston Transit Precinct Taskforce

2. BACKGROUND

The Peninsula Model for Primary Health Planning (the Peninsula Model) is a catchment-based partnership between a range of health and community service organisations, key stakeholders, consumers, carers and communities. Working collaboratively, the partnership identifies the health needs of Frankston and Mornington Peninsula communities and develops effective service responses to meet those needs.

Based on a population health approach, the model wraps the collective effort of providers around agreed health priorities to address service gaps for the catchment. This collective effort maximises impact and makes efficient use of resources through integrated planning, reduced duplication of effort, and shared ownership of processes and outcomes.

The Peninsula Model priorities have been determined by population health data and through a comprehensive engagement process. The Model encompasses goals of improving service coordination, health promotion, early intervention and client experience in each priority area.

Alliances, comprising health and community service managers, private practitioners and consumers, have been formed to develop, implement and monitor improvement plans for each priority. All Alliances have a number of working groups that focus on specific Alliance action issues or areas.

The Alcohol and Other Drugs Alliance has been identified as a mechanism to contribute to the scope of work being undertaken by the Frankston Transit Precinct Taskforce that is exploring the re-development of the Frankston Train Station and accompanying areas. This will include the auspicing of research and evidence based interventions.

3. SHARED GOALS

The work of the Peninsula Model aims to deliver tangible outcomes against the shared goals that partners have jointly committed to.

	Shared Goals	Outcomes
Consumer	<i>Address the service gaps for local consumers</i>	Accessible, equitable services that meet local consumer health needs
Service Delivery	<i>Provide consumer-centred, coordinated and integrated services</i>	Improved consumer health journeys
Health Promotion	<i>Impact the long term health of the local community through targeted and impactful health promotion initiatives</i>	Improved long term health of the community
Service System	<i>Improve capacity to deliver evidence based care</i>	Resources and capabilities better aligned to meet local needs at a consistent high standard

4. OBJECTIVES

The key objectives of the *Alcohol and Other Drugs Alliance* are:

1. Improve drug and alcohol risk screening and access to early intervention services, within the primary care system and more broadly across the service system
2. Improve access to coordinated drug and alcohol services, including integration with pharmacotherapy services that deliver improved outcomes for clients
3. Establish new models of care that meet policy directions and address service gaps
4. Advocate for the needs of people with drug and alcohol issues, ensuring services meet demand and are provided in appropriate locations

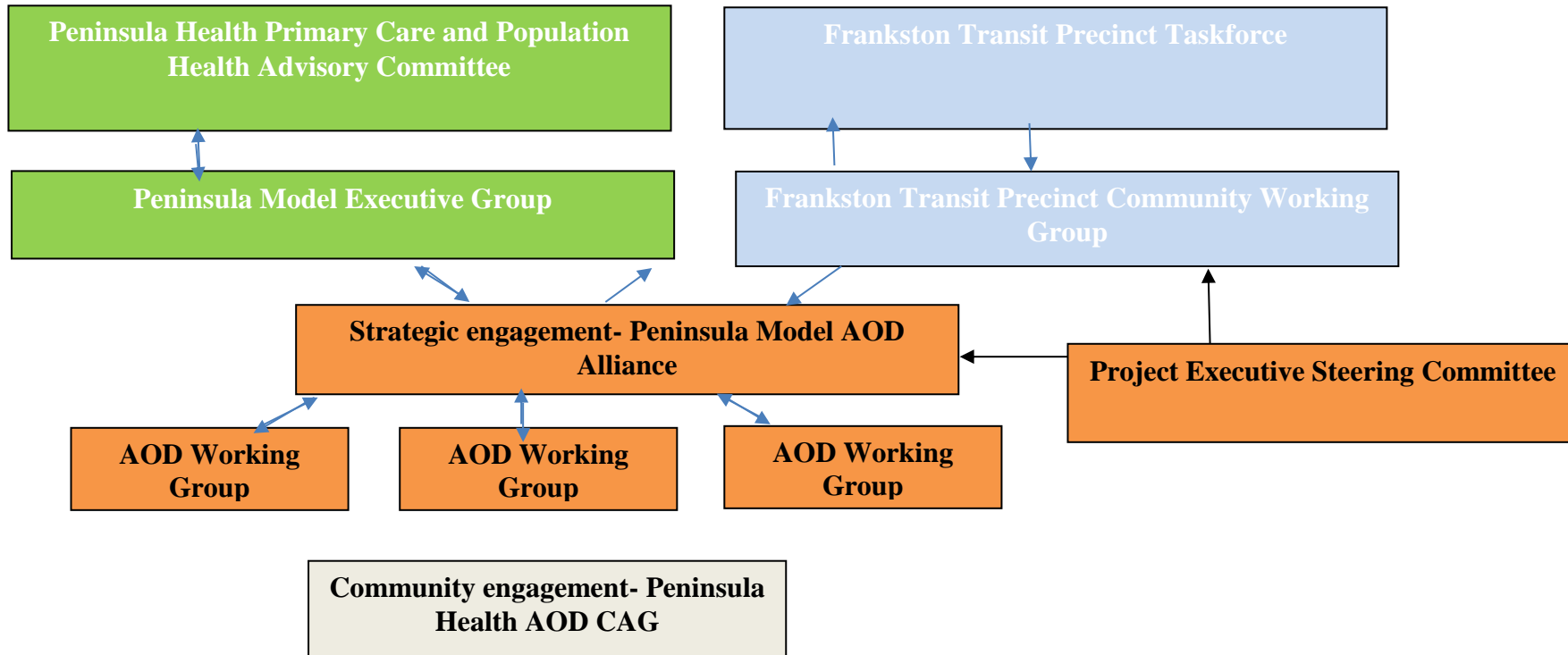
5. RESPONSIBILITIES

The key responsibilities of the *Alcohol and Other Drugs Alliance* are:

- To lead partnership development and relationship building amongst health and community services, in order to improve outcomes for people with alcohol and drug issues and addressing any issues that have been identified as posing barriers to achieving successful outcomes
- To undertake planning on behalf of the alcohol and other drug (AOD) service system including setting priorities and determining objectives and outcomes that will improve people's access to and experience of coordinated services.
- To lead the development and implementation of catchment wide models of care that align with new policy directions.
- To establish a program of work that meets the above objectives and make recommendations in relation to project work, resource allocation etc.
- To develop, implement and monitor the AOD program of work progressed through working groups and report progress to the PMEG.
- To advocate for services and funding that address the needs of communities in the catchment.
- To ensure all work is undertaken within the agreed service redesign and facilitation methodology and is underpinned by the agreed Peninsula Model design principles.
- To provide strategic advice and recommendations to the PMEG in relation to services for people with alcohol and drug issues.
- To auspice the work required to the Frankston Transit Precinct re-development taskforce and provide high level support and authorisation of this work on behalf of their respective organisations.
- Provide input and feedback into the work of the Alliance
- Provide access to and share data and provide departmental or local intelligence to assist in identifying issues, whilst maintaining data confidentiality requirements of each data source
- Share updates of the work being undertaken through their networks

6. REPORTING RELATIONSHIP

This Alliance is responsible for strategic planning and for leading and driving integration initiatives. To undertake this role it connects with the Peninsula Health AOD Community Advisory Group and the Operational Management Group (responsible for ensuring integrated AOD service delivery across the catchment).



The Alliance is responsible for establishing working groups to undertake projects and initiatives of the Alliance. Working groups have a broader membership than the Alliance and include health and community services, government agencies, service providers and consumers/carers that are key to embedding changes and improvements to the management of AOD within the community and across the sector.

The Alcohol and Other Drug Alliance will have a dual reporting role with the second structure being that of the Frankston Transit Precinct Taskforce: Community Working Group whilst it is in operation.

5. MEMBERSHIP

5.1 Membership

Each of the listed organisations will nominate a senior management representative to the *Alcohol and Other Drugs Alliance*. Organisational membership includes:

- Peninsula Health (PH)
- Frankston Mornington Primary Care Partnership (FMPPCP)
- Frankston City Council
- Mornington Peninsula Shire
- Stepping Up Consortium
- Anglicare
- YSAS
- Department of Health and Human Services
- Victoria Police
- Beleura Private Hospital
- ACSO Australian Community Support Organisation
- Neami National
- Salvation Army
- Area 4 Pharmacotherapy Network representative
- Consumer representative
- Taskforce Community agency
- Windana
- Chamber of Commerce

5.2 Chairperson

The Chairperson will be appointed by the *Alcohol and Other Drugs Alliance* on an annual basis.

5.3 Secretariat Support

FMPML and PH will provide secretariat and project support to the *Alcohol and Other Drugs Alliance*. Secretariat support will carry out the following tasks:

- Support the Chairperson to develop agendas and organise meetings
- Minute taking and distribution of minutes and associated documents

- Provide a link between the Alliance and Working Groups
- Undertake projects on behalf of the Alliance and Working Groups

6. FUNCTION OF MEETINGS

6.1 Decision Making

Decisions will normally be made through consensus. If however, there are times when consensus cannot be reached despite open and thorough exploration of the issues and options, the Chairperson will ask for a vote.

6.2 Quorum

A quorum for the *Alcohol and Other Drugs Alliance* is 50% +1 of the membership.

6.3 Meeting Frequency

In the first three-months, the *Alcohol and Other Drugs Alliance* will meet monthly to (i) review the evidence base and set priorities, (ii) develop its Alliance Plan and (iii) establish its Working Groups. Following this time, it may only need to meet bimonthly.