

Hume Catchment-Based Alcohol and Other Drug

Strategic Plan 2015 –2018

June 2016

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List of Acronyms

ABI	Acquired Brain Injury
ABS	Australian Bureau of Statistics
AOD	Alcohol and Other Drugs
CALD	Culturally and Linguistically Diverse
DHHS	Department of Health and Human Services
GH	Gateway Health
GP	General Practitioner
GV	Goulburn Valley
IRSED	Index of Relative Socioeconomic Disadvantage
LGA	Local Government Area
MH	Mental Health
MHCSS	Mental Health Community Support Services
NDIS	National Disability Insurance Scheme
NSW	New South Wales
PHN	Primary Health Network
PIR	Partners In Recovery
VIC	Victoria

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Executive Summary

Catchment-based Planning forms part of the 2014 recommissioning of Victorian state-funded mental health community support services (MHCSS) and alcohol and other drug (AOD) services. The primary purpose of the Hume AOD Catchment-based Planning function is to assist AOD providers operating in Hume to develop an agreed catchment-based strategic plan which will identify critical service gaps and pressures and cohesive strategies to improve responsiveness to people with a serious mental illness and psychiatric disability, particularly those facing significant disadvantage. Gateway Health is the fund holder for the Hume AOD catchment planning funds. This position is managed on a day-to-day basis by Gateway Health, who employs the catchment planning officer.

Catchment-based Planning in Hume follows the Victorian DHHS guideline for Health Planning. Environmental surveys include consumer, carer, service provider and community engagement to inform stakeholder perspectives on AOD critical service gaps in Hume. Data analysis also includes review of DHHS and other health functions information on mental health consumers in Hume (DHHS, 2014).

Critical service gaps and pressures for AOD consumers in Hume, although reflective of catchment-specific need, are indicative of broader state-wide issues. Emerging from evidence as priority areas are; improved physical health for AOD consumers; social connectedness; service access; and understanding the reformed AOD system.

Catchment-based Planning in Hume provides a new strategic direction for identifying and addressing AOD critical service gaps and pressures. Hume catchment-based planning will maintain relevance and currency throughout the life of The Plan to ensure service gaps and pressures are met with the most suitable and effective measures within the capacity of existing stakeholders. To ensure relevance and currency, it is recommended that the Hume Catchment-based Plan (DHHS, 2014);

- Implement strategic plan in agreed stages to maximise effectiveness of agreed actions
- Maintain AOD consumer and carer consultation throughout the life of The Plan
- Review trajectory of The Plan at agreed intervals to ensure alignment with stakeholder identified prioritisation of critical service gaps and pressures

Limitations of the Plan

At the time of development, Catchment-based Planning in Hume is cognisant of limitations to the planning process. Further consumer engagement is required to maintain currency and relevance throughout the life of The Plan. Future significant social, political, economic and environment changes in are not fully accounted for in The Plan. Data analysis is limited by the availability of accurate, relevant and current data on AOD consumers in Hume. At the time plan development, such limitations extend to:

- Limited availability of DHHS AOD-specific service data for 2014-15
- No availability of DHHS data for AOD-specific service data for 2015-16
- New Hume catchment boundary does not align with current Hume data collection boundary

Section 1: Context

AOD Catchment planning is directed at addressing critical service gaps in the sixteen catchments across Victoria for consumers of State funded Alcohol and Other Drug services. The identification of catchment-based critical service gaps informs the development of a catchment-wide strategic plan to address these gaps within the scope of the planning function and capacity of existing stakeholders. The planning process has involved several methods of investigation which are detailed in relevant sections of this plan.

Section 1.1: Background

As a result of extensive consultation and review with clients, families, carers and service providers, the Victorian Government has introduced changes to the delivery of AOD services across the state (DHHS, 2014).

The Hume Catchment AOD Planning function assists AOD providers to identify critical service gaps and pressures and cohesive strategies to improve responsiveness to people with AOD issues, particularly those facing significant disadvantage.

The plan will also provide the basis for improved cross service coordination at the catchment level and by doing this achieve a more planned, joined-up approach to the needs of people with AOD issues. In addition, it will support providers of AOD in a catchment to efficiently participate in relevant service coordination and planning platforms.

The Department of Health and Human Services (DHHS) has allocated a total of \$48,000 per catchment to selected AOD providers for the delivery of this function

Section 1.2: Purpose, scope and objectives of the plan

Catchment planning will inform AOD stakeholder collaboration and service delivery in Hume. The plan will be an ongoing, living document which is responsive to relevant changing needs across the catchment in the context of AOD service and delivery and issue more broadly. The primary purpose of this plan, in accordance with the DHHS specifications (2014) is to:

- Assist AOD providers to identify critical service gaps and pressures and develop strategies to improve responsiveness to people with a serious mental illness and psychiatric disability, particularly those facing significant disadvantage.
- Provide the basis for improved cross service coordination at the catchment level and by doing this achieve a more planned, joined-up approach to the needs of people with a psychiatric disability in areas such as homelessness, housing, primary health, recreation, social participation, education and employment.
- Facilitate better understanding of current mental health consumer needs and the community mental health support landscape in Hume
- Engage relevant stakeholders in coordination and planning to develop and commit to a catchment-wide strategic plan which addresses identified needs
- Meet the stated requirements of Catchment Planning as set out in the AOD catchment Planning Function Service Specifications

The scope of the Hume catchment-Based Planning Function includes organisations funded to deliver the following AOD programs and functions in Hume, who are actively involved in the development, implementation and review of the catchment-wide strategic plan:

- Intake and Assessment providers
- Counselling providers
- Non-residential withdrawal providers
- Care and Recovery Coordination providers
- Residential AOD withdrawal providers
- Residential rehabilitation providers
- Aboriginal services
- Youth and adult AOD providers
- Other state-funded AOD program providers

The objective of the catchment-based AOD Planning function is to:

- Gather and analyse relevant health and population data to identify and understand the distinct and diverse needs of adults (16-64 years) with a psychiatric disability living in the service catchment, particularly those facing significant disadvantage.
- Identify service gaps, needs and pressures and monitor and analyse trends in expressed demand for AOD in the catchment.
- Develop cohesive strategies to improve responsiveness to community need and population diversity in response to identified service gaps and demand pressures, taking into account available resources in the AOD program and the community more broadly.
- Formulate and regularly review a catchment-based strategic plan for implementation by AOD providers and key stakeholders.
- Engage with relevant agencies and planning structures and support AOD providers to participate in discussions and planning to:

- Identify and develop shared strategies to address systemic barriers to access by people with a psychiatric disability, particularly primary health and community services.
- Achieve a more coordinated response to the full health and wellbeing needs of people living with a psychiatric disability, taking into account the social determinants of health.
- Ensure the needs of people with a psychiatric disability living in the catchment are taken into account in other local planning activity and service delivery.
- Ensure the views of consumers and carers inform the development and review of the catchment-based strategic plan and are represented in other relevant planning forums.

Section 1.3: Key Features

The AOD Planning function has the following key features:

- A three year catchment-based strategic plan developed in collaboration with, and on behalf of, funded AOD providers in the catchment, specialist clinical mental health services, consumers and carers and other key stakeholders.
- The strategic plan will be based on analysis of relevant health and population data and mental health (expressed) demand data, and other secondary data sources, supplemented by targeted consultation and qualitative analysis as required.
- Active involvement and collaboration with relevant local planning structures and processes to influence and jointly plan for the needs of people with a psychiatric disability and their carers and family at the catchment level.

Section 2: Hume Catchment Planning Governance Structure

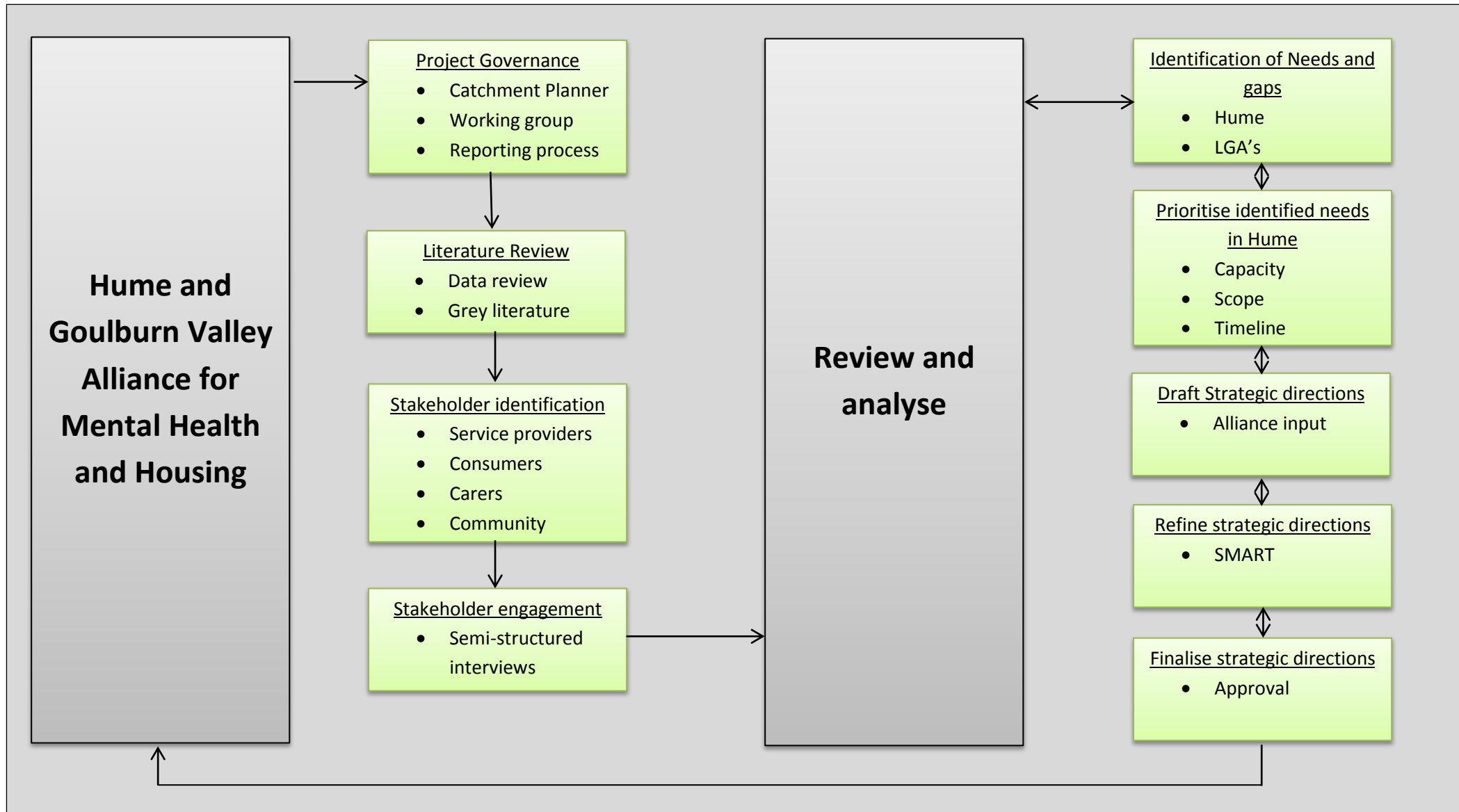
The Hume and Goulburn Valley Alliance for Mental Health and Housing provide governance for the overall development and implementation of the Hume MHCSS catchment plan.

Mind Australia is the fund holder for the Hume MHCSS catchment planning funds. To maximize the benefits of the funding, Mind has partnered with Gateway Health to develop a single AOD and mental health planning position for the Hume catchment. This position is managed on a day-to-day basis by Gateway Health, who is the employer of the catchment planning officer.

The Hume and Goulburn Valley Alliance (The Alliance) for Mental Health and Housing is currently reviewing its structure for short, mid and long term strategic planning purposes. The Hume Catchment-based Planning Function will continue to be overseen by The Alliance throughout the life of the plan, with formal Alliance membership, structure and working groups to be finalized in the near future.

Figure 1: Hume AOD Catchment-based Planning Process

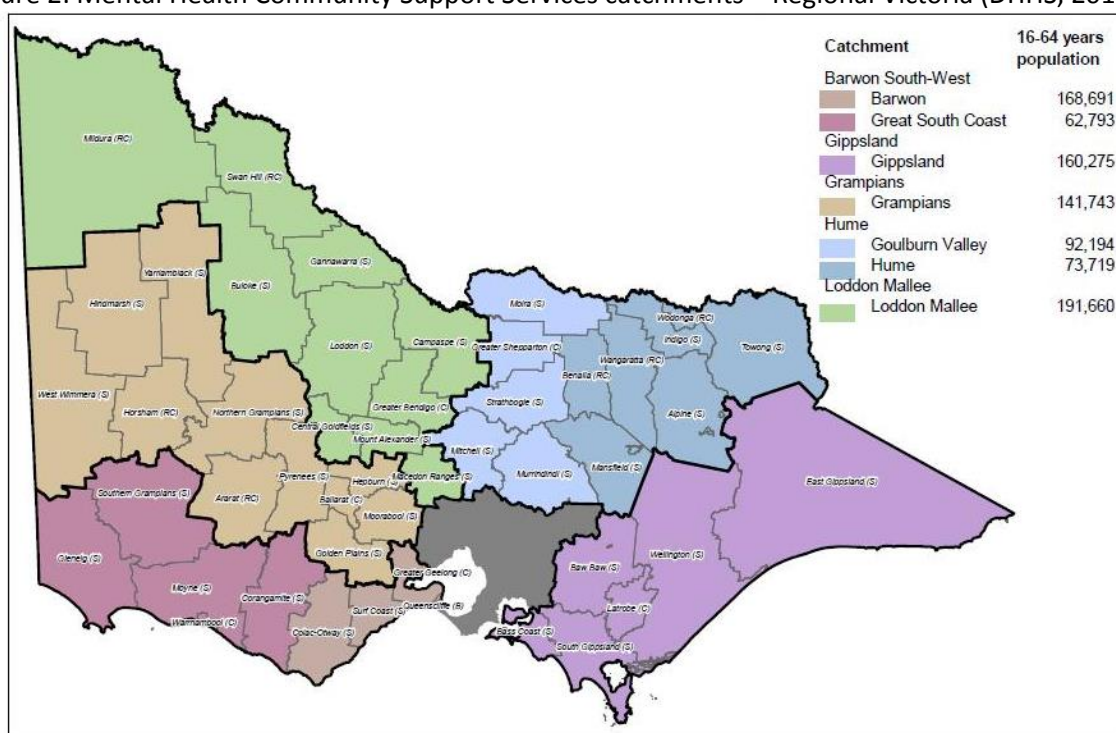
The process undertaken to develop the Hume Region AOD Catchment Plan reflects both the level of planning previously undertaken in the catchment and the process undertaken to develop this plan. An outline of the major steps in the process is shown in the diagram below.



Section 3: Socio-demographic data for Hume

The wider Hume Region of Victoria is made up of four sub-regions; Upper Hume, Lower Hume, Central Hume and Goulburn Valley. The Catchment Planning function refers to the sub-regions of Central Hume and Upper Hume, which are referred to as 'Hume' for this purpose. There are seven Local Government areas situated within the Hume Catchment Planning Function; Alpine shire, Rural city of Benalla, Indigo shire, Mansfield shire, Towong shire, rural city of Wangaratta and rural city of Wodonga. Unless otherwise stated, all data in the Catchment Planning Function is representative of the abovementioned LGA's, collectively referred to as Hume.

Figure 2: Mental Health Community Support Services catchments – Regional Victoria (DHHS, 2014)



Detailed descriptions of Local Government Areas in Hume can be found in Appendix F of this report.

Table 1; Hume Catchment Localities

Alpine– Benalla- Indigo – Mansfield – Towong – Wangaratta - Wodonga

Abbeyard	Barwidgee	Bogong	Bright	Buckland
Buffalo Creek	Buffalo River	Cobungra	Coral Bank	Dandongadale
Dargo	Dederang	Dinner Plain	Eurobin	Falls Creek
Freeburgh	Gapsted	Germantown	Glen Creek	Gundowring
Harrietville	Havilah	Hotham Heights	Kancoona	Kergunyah South
Merriang	Mongans Bridge	Mount Beauty	Mount Buffalo	Mount Hotham
Mudgeegonga	Myrtleford	Nug Nug	Ovens	Porepunkah
Rosewhite	Running Creek	Selwyn	Smoko	Tawonga
Tawonga South	Upper Gundowring	Wandiligong	Wongungarra	Wonnangatta
Archerton	Baddaginnie	Barjarg	Benalla	Boho South
Bonnie Doon	Boweya	Boxwood	Bridge Creek	Broken Creek
Bungeet	Bungeet West	Chesney Vale	Creek Junction	Devenish
Glenrowan	Glenrowan West	Goomalibee	Goorambat	Greta West
Lake Mokoan	Lima	Lima East	Lima South	Lurg
Lurg Upper	Major Plains	Molyullah	Moorngag	Mount Bruno
Myrrhee	Samaria	Stewarton	Strathbogie	Swanpool
Taminick	Tarnook	Tatong	Thoona	Tolmie
Upper Ryans Creek	Wangandary	Warrenbayne	Winton	Winton North
Allans Flat	Barnawartha	Beechworth	Brimin	Browns Plains
Bruarong	Carlyle	Charleroi	Chiltern	Chiltern Valley
Cornishtown	Gooramadda	Great Northern	Gundowring	Huon
Indigo	Indigo Valley	Kergunyah	Kiewa	Lilliput
Mudgegonga	Norong	Norong Central	Osbornes Flat	Prentice North
Red Bluff	Rutherglen	Sandy Creek	Staghorn Flat	Stanley
Tangambalanga	Wahgunyah	Woolshed	Wooragee	Yackandandah
Ancona	Barjarg	Barwite	Bonnie Doon	Boorolite
Bridge Creek	Creek Junction	Delatite	Eildon	Gaffneys Creek
Goughs Bay	Howes Creek	Howitt Plains	Howqua	Howqua Hills
Howqua Inlet	Howqua Plains	Jamieson	Kanumbra	Kevington
Lake Eildon	Licola North	Lima South	Macs Cove	Maindample
Mansfield	Matlock	Merrijig	Merton	Mirimbah
Mount Buller	Mountain Bay	Nillahcootie	Piries	Reynard
Sawmill Settlement	Strathbogie	Tolmie	Woodfield	Woods Point
Bellbridge	Berringama	Bethanga	Biggara	Bullioh
Bungil	Burrowyne	Colac Colac	Corryong	Cudgewa
Dartmouth	Eskdale	Georges Creek	Granya	Guys Forest
Huon	Jarvis Creek	Koetong	Lucyvale	Mitta Mitta
Mount Alfred	Nariel Valley	Old Tallangatta	Pine Mountain	Shelley
Talgarno	Tallandoon	Tallangatta	Tallangatta East	Tallangatta South
Tallangatta Valley	Thologolong	Thowgla Valley	Tintaldra	Tom Groggin
Towong	Towong Lower	Walwa	Archerton	Bobinawarrarrah
Boorhaman	Boorhaman East	Boorhaman North	Boralma	Boweya
Bowmans Forest	Bowser	Byawatha	Carboor	Cheshunt
Cheshunt South	Docker	Dockers Plains	Edi	Edi Upper
Eldorado	Everton	Everton Upper	Glenrowan	Greta
Greta South	Greta West	Hansonville	Killawarra	King Valley
Laceyby	Londrigan	Lurg Upper	Markwood	Meadow Creek
Milawa	Moyhu	Murmungee	Myrrhee	Oxley
Oxley Flats	Peechelba	Peechelba East	Rose River	Springhurst
Tarrowingee	Tatong	Tolmie	Wabonga	Waldara
Wangandary	Wangaratta	Wangaratta East	Wangaratta North	Wangaratta South
Whitfield	Whitlands	Whorouly	Whorouly East	Whorouly South
Yarrunga	Bandiana	Baranduda	Barnawartha North	Bonegilla
Castle Creek	Ebden	Gateway Island	Hume Weir	Huon Creek
Killara	Leneva	Staghorn Flat	Wodonga	Wodonga West

Health, social and demographic indicators (Victorian Regional Health Planning Profile, 2012)

Planning for this catchment presents a challenge due to the dichotomy between the rapid growth of the rural cities, its young population profile and its hinterland, which contrasts with an ageing, dispersed and often declining population in the more remote areas of the catchment. However this hinterland provides both a quality of living and accessibility that make these areas vital for catchment growth. Parts of Hume have a significant Indigenous population living predominantly along the Murray River corridor.

Population

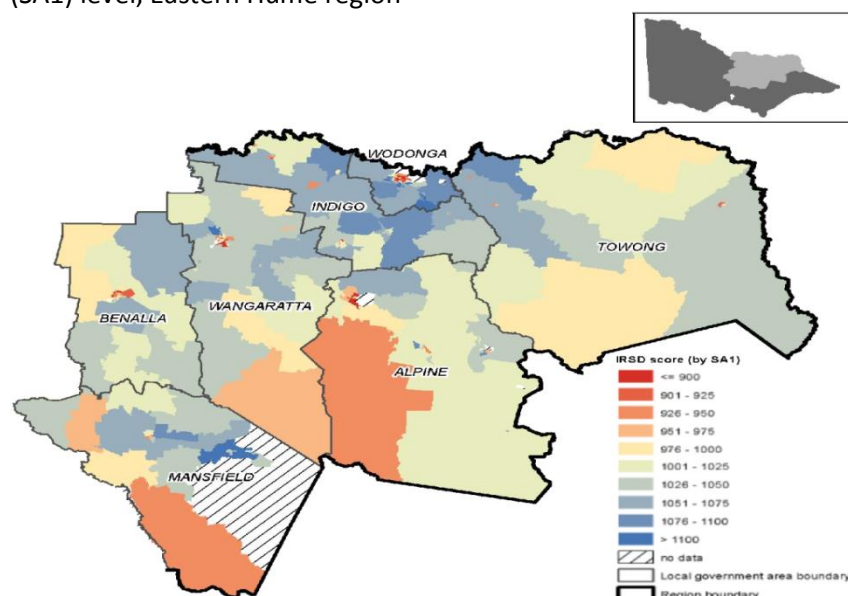
Hume has experienced below average population growth since 2002 but growth is projected to increase to just below the Victorian average through to 2022. The population skews older, with the 15-44 age group underrepresented and the 45+ age group overrepresented.

Table 2: Current and projected resident population in Hume, 2011 and 2021

LGA	2011	2021	% Change
Alpine (S)	12,103	13,214	9.2%
Benalla (RC)	13,754	15,251	10.9%
Indigo (S)	15,376	17,187	11.8%
Mansfield (S)	8,031	9,015	12.3%
Towong (S)	5,958	6,437	8.0%
Wangaratta (RC)	27,110	30,295	11.7%
Wodonga (RC)	36,043	43,037	19.4%
Hume (total region-12 LGA's)	267,071	324,812	21.6%
Victoria	5,534,526	6,500,653	17.5%

IRSED

Figure 3: Map of Index of Relative Socio-economic Disadvantage (IRSD) 2011, at statistical area 1 (SA1) level, Eastern Hume region



Indigenous communities

Hume has a rich Indigenous history, with the rural city of Wodonga being a traditional meeting place for the Aboriginal nations of Wiradjuri, Yorta Yorta, Waveroo and Ngurraillam, which all converge at the current location of Wodonga (DHHS, 2014).

Table 3: Number of Aboriginal and Torres Strait islander people in Hume, 2011, Hume LGAs

LGA	Aboriginal persons	% of population
Alpine (S)	83	0.73%
Benalla (RC)	166	1.27%
Indigo (S)	143	0.98%
Mansfield (S)	57	0.74%
Towong (S)	86	1.48%
Wangaratta (RC)	258	0.99%
Wodonga (RC)	706	2.05%
Hume (total region-12 LGA's)	4,566	1.82%
Victoria	37,699	0.74%

Multiculturalism

History - After World War II, over 300,000 migrants arrived in Bonegilla migrant centre (near Wodonga). About half the refugees arriving in Australia immediately after WWII came through Bonegilla in 1998/99. Bandiana Army Barracks (near Wodonga) hosted several hundred displaced Kosovar Albanians who were offered Temporary Safe Haven Visas. Migrants came from over 50 countries including Germany, the Netherlands, Britain, Austria, Italy, Greece, Hungary and Germany, Sweden, Norway, Finland, Spain, Yugoslavia and Czechoslovakia.

Today Hume is a key region for the Federal Government resettlement process through Humanitarian Settlement Service and Settlement Grants Fund providers operating in several locations in Hume. Hume has a large skilled migrant and international student population. In recent years, humanitarian entrants have arrived in significant numbers from countries including; Bhutan and the Democratic Republic of Congo (Victorian Government, 2015).

Table 4: Indicators of cultural diversity (immigration and ethnicity) 2011-12, Hume LGAs

LGA	New settler arrivals per 1000	Humanitarian arrivals-% of total arrivals	Community acceptance of diverse cultures
Alpine (S)	107.41	30.8%	45.1%
Benalla (RC)	94.52	0.0%	36.8%
Indigo (S)	97.55	0.0%	51.0%
Mansfield (S)	49.81	0.0%	47.1%
Towong (S)	67.14	0.0%	40.8%
Wangaratta (RC)	81.15	0.0%	46.7%
Wodonga (RC)	241.38	27.6%	45.4%
Hume (total region-12 LGA's)	241.51	25.1%	N/A
Victoria	656.28	12.3%	50.6%

Housing

The demand for social housing, rental assistance and accommodation service is a significant issue in Hume. Other co-occurring social issues present commonly among individuals and families who experience housing difficulty. Issues such as mental illness, substance use, family violence and legal problems are commonly seen as contributing factors (Hume profile, DHHS, 2012).

Table 5: Economic and housing characteristics, Hume LGAs

LGA	Median household income	% with food insecurity	% with mortgage stress	% with rental stress	Median house price	Median rent for 3 BR house	Social housing as % of total dwellings
Alpine (S)	\$829	7.4%	14.9%	25.6%	\$268,000	\$230	1.6%
Benalla (RC)	\$827	8.4%	12.2%	32.0%	\$198,500	\$250	5.4%
Indigo (S)	\$1,066	8.4%	10.7%	25.4%	\$259,500	\$265	2.1%
Mansfield (S)	\$891	7.6%	16.0%	20.3%	\$255,000	\$275	1.5%
Towong (S)	\$850	3.1%	13.2%	20.3%	\$160,002	\$195	1.1%
Wangaratta (RC)	\$913	6.4%	12.3%	28.3%	\$241,000	\$245	4.9%
Wodonga (RC)	\$1,075	6.4%	9.3%	25.9%	\$265,000	\$280	9.2%
Hume (total region-12 LGA's)	N/A	6.9%	12.7%	26.2%	N/A	\$280	4.7%
Victoria	\$1,216	5.6%	11.4%	25.1%	\$380,000	\$320	3.8%

Hume has the highest rate of mortgage stress in the state at 12.7%.

Unemployment

Unemployment in Victoria's labour force regions ranges from 4.6% – 9.3%, with Hume sitting at 5.6% (Australian Department of Employment, March 2016). An alarming figure however is Youth Unemployment in Hume, which was ranked among the ten worst locations in Australia in March 2015.

Youth Unemployment (age 15-24)	17.5 %	Ranked 9 th in Australia
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Geographic location

All LGAs in Hume have lower than average percentages of population near public transport. In Alpine and Mansfield, only 3.1% of the population live near public transport. This is far lower than other catchment areas, yet the number of persons requiring access services such as mental health and substance use support is higher than in other areas (Hume profile, DHHS, 2012).

Table 6: Transport and accessibility

LGA	Persons with >2 hr. commute	Passenger vehicles per 1000 pop.	% households with no motor vehicle	% pop. Near public transport
Alpine (S)	8.3%	356.4	5.3%	3.1%
Benalla (RC)	NA	373.2	7.8%	41.5%
Indigo (S)	NA	358.2	4.1%	7.2%
Mansfield (S)	5.7%	353.2	3.9%	3.1%
Towong (S)	7.3%	381.4	4.7%	5.7%
Wangaratta (RC)	NA	352.1	6.7%	46.8%
Wodonga (RC)	NA	331.2	6.9%	53.4%
Hume (total region-12 LGA's)	4.7%	341.1	6.1%	34.5%
Victoria	11.6%	289.5	8.7%	74.3%

Mental Health and AOD

AOD and mental health clients per 1000 population are generally higher in Hume than the state average. Contributors to this include geographic isolation, lack of specialist services, service access issues and factors associated with dual diagnosis (Regional Health Profile, 2012).

Table 7: Utilisation of selected health services per 1,000 population, 2011-12 Hume LGAs

LGA	HACC clients aged 0-69 per 1000 target pop.	HACC clients aged 70+ per 1000 target population	Drug and alcohol clients per 1000 pop.	Registered mental health clients per 1000 population
Alpine (S)	198.0	409.6	3.4	16.8
Benalla (RC)	177.6	407.3	7.7	21.3
Indigo (S)	166.5	392.6	4.1	15.9
Mansfield (S)	159.0	430.0	3.6	8.0
Towong (S)	246.9	527.0	2.9	11.2
Wangaratta (RC)	141.8	438.8	7.3	18.4
Wodonga (RC)	199.1	279.4	9.1	18.2
Hume (total region-12 LGA's)	198.7	387.3	6.7	16.4
Victoria	196.9	339.6	5.1	10.3

Cross-sector issues in Hume – Family Violence, Dual diagnosis and suicide

Family violence

Hume faces significant challenges in respect to identifying, managing and preventing family violence. In 2005, over 350,000 women experienced physical violence and over 125,000 women experienced sexual violence (Australian Bureau of Statistics). The demand in Hume for family violence support services greatly outweighs the current service capacity of providers. Under-reporting of incidents, geographic and transport issues, and community perceptions of family violence present as additional factors in this context.

As an arguable extension of family violence issues in Hume, among other social factors, the percentage of children with emotional or behavioural problems in some areas in Hume is the highest in the state, as is the percentage of children who are vulnerable on two or more domains. The rate of children in out of home care is also highest in the state in some areas of Hume, and child protection orders and substantiated child abuse rates are both among the highest.

Dual diagnosis and suicide

Cross-sector issues in Hume are reflective of broader societal issues in Victoria. In addition to mental health support, there currently exists high demand in Hume for services which provide AOD treatment. The identified need for AOD services in Hume informs a need for continued dual diagnosis approaches for co-occurring issues. There also exists a need for collaborative and wide-reaching support for suicide prevention, which is known to be associated with both mental health, AOD and dual diagnosis issues (MHFA Australia, 2015).

Figure 4: Suicide/self-inflicted avoidable mortality rates in Hume, 0-74 year, per 1000 population (Regional Health Status Profile, DHHS, 2012)

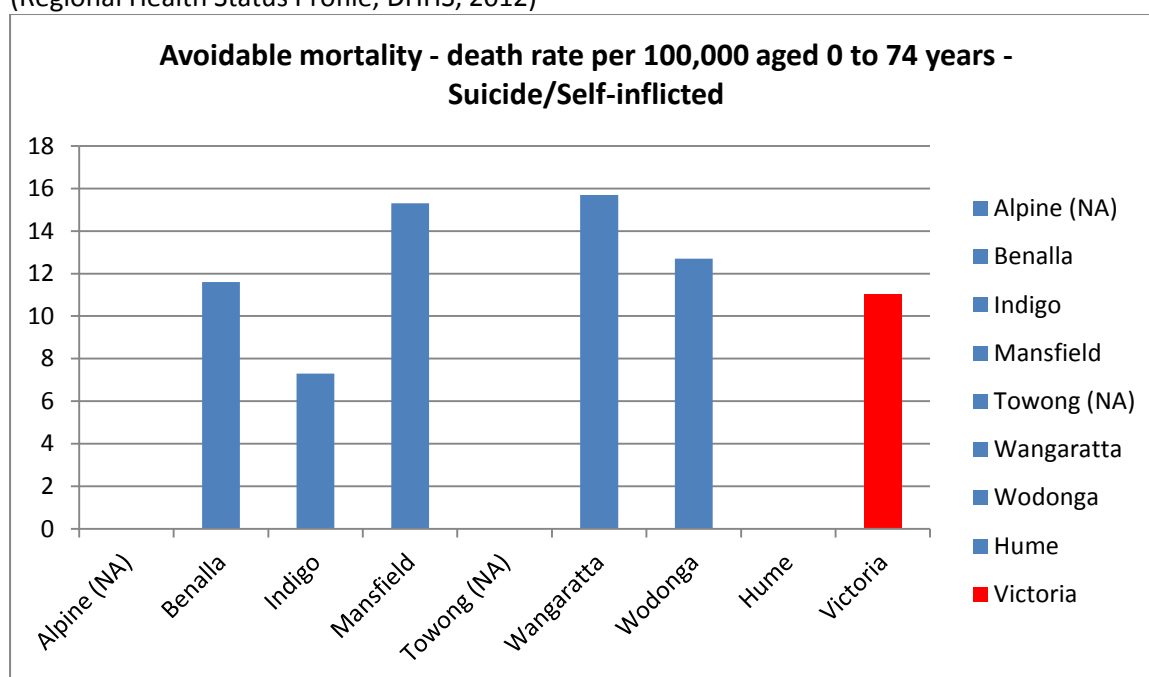
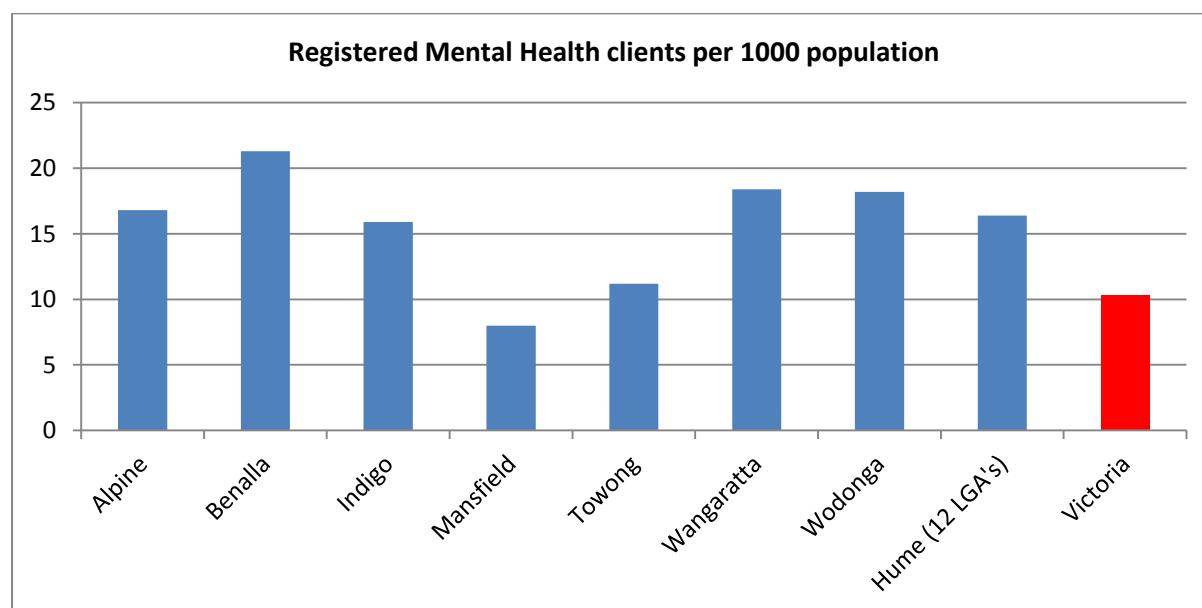


Figure 5: Registered Mental Health Clients per 1000 population in Hume (Regional Health Status Profile, DHHS, 2012)



Health system performance and utilisation

Hume fares poorly in regard to number of health professionals such as specialist medical practitioners. Combined with large geographical distances for access to treatment, and the lack of public transport availability, consumers and service providers are posed with various challenges to effective support provision.

Figure 6: Service access – service locations

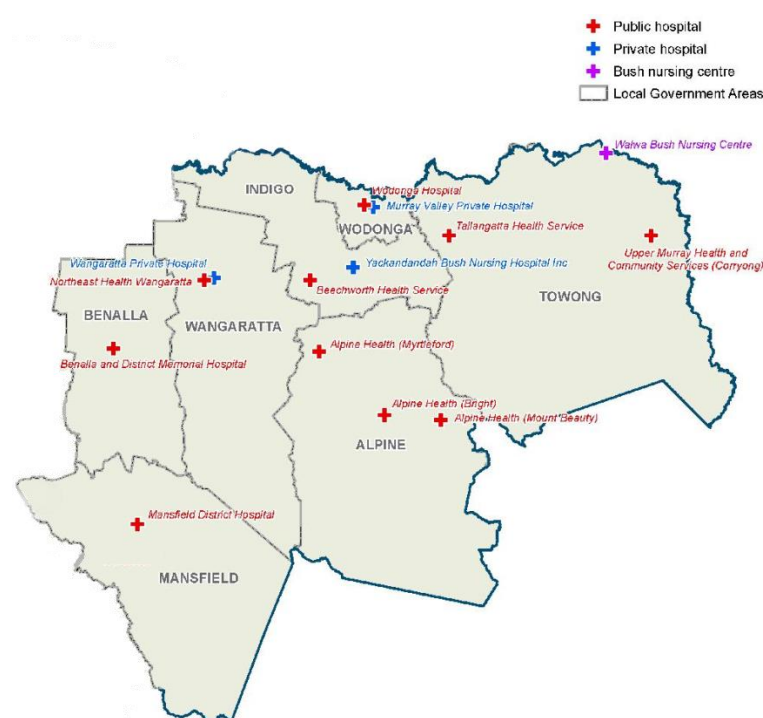


Table 8: Health professional workforce, Hume region, comparison with other regions - Practitioners per 1,000 population (DHHS, 2012)

Region	Specialist medical practitioners	Nurses/midwives	Pharmacies	Physiotherapists
Eastern metropolitan	0.74	16.42	0.90	1.30
Barwon South Western	0.56	20.38	0.73	0.86
Gippsland	0.23	16.57	0.79	0.58
Grampians	0.45	21.92	0.69	0.61
Loddon Mallee	0.32	19.79	0.76	0.74
North and West metropolitan	0.89	12.82	0.99	0.79
Southern metropolitan	0.72	13.95	0.82	1.07
Hume (total region-12 LGA's)	0.33	18.41	0.62	0.66
Victoria	0.69	15.47	0.86	0.93

Section 4: Alcohol, Tobacco and Other Drugs – Setting the scene

Section 4.1: Alcohol

National

(Druginfo, 2016)

Alcohol is the most widely used drug in Australia.

- 86.2% of Australians aged 14 years and over have drunk alcohol one or more times in their lives.
- 37.3% of Australians aged 14 years and over consume alcohol on a weekly basis.
- The age group with the greatest number of Australians who drink daily is 70+ years.
- Around 1 in 5 (18.2%) Australians over 14 drink at levels that put them at risk of alcohol-related harm over their lifetime.
- Around 1 in 6 (15.6%) people aged 12 years or older had consumed 11 or more standard drinks on a single drinking occasion in the past 12 months.
- 1 in 4 women drink alcohol while, even though the Australian alcohol guidelines recommend not drinking during this time.
- \$7b is generated by alcohol-related tax. But alcohol costs society \$15.3b annually³.
- Alcohol caused more than twice as many deaths (3,494) than road accidents (1,600) in 2005.
- 1 in 10 workers say they have experienced the negative effects of a co-worker's use of alcohol.

Victoria

(Druginfo, 2016)

- On average, there were 34 alcohol-related ambulance attendances in metropolitan Melbourne per day in 2013/14 (11% increase from 2011/12), and 11 per day in regional Victoria (8% increase).
- The average age of these patients was 40 years¹⁰.
- Alcohol was the reason for the majority of drug-related ambulance attendances, with 12,482 attendances in 2013/14 compared to 3,021 for benzodiazepines, 1,869 for heroin, 1,714 for non-opioid analgesics (such as paracetamol) and 1,237 for crystal methamphetamine (ice).

Hume

(Alcohol-related harms & use across Victorian Local Government Areas, Vic Government, 1999/00 – 2006/07)

Alcohol-related assaults; Upward trend for the region, Alpine, Benalla, Mansfield, Wangaratta, Wodonga.

Alcohol related serious road injury; Upward trend for: Indigo, Towong.

Alcohol related courses of treatment; Upward trend for: the region, Alpine, Benalla, Indigo, Wangaratta, Wodonga.

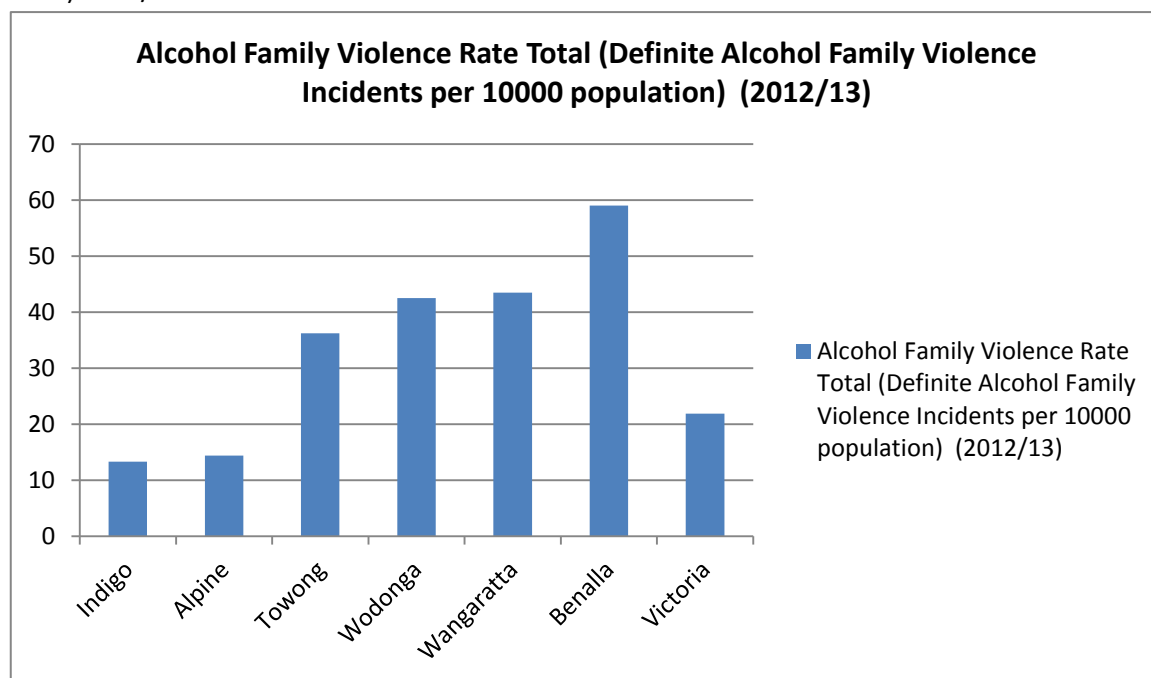
Alcohol-related hospital admission rates; Upward trend for the region, Alpine, Indigo, Wangaratta, Wodonga.

Alcohol consumption

The patterns of alcohol consumption were similar between the Region and Victoria for both males and females. Females in the Region were more likely to abstain from alcohol consumption (23.7%) than their male counterparts (8.5%). A higher proportion of males (82.7%) compared to females (71.8%) consumed alcohol at low risk levels (DHHS, 2010).

The following data, from ADIS, indicates alcohol family violence rates per 10,000 population for each LGA (where available) against the Victorian measure (aodstats, 2015).

Figure 7; Alcohol Family Violence Rate Total (definite Alcohol Family Violence Incidents per 1000 population) 2012/13



Section 4.2: Tobacco

Source; (*Druginfo*, 2016)

National

- 39.8% of Australians aged 14 years and over have used tobacco.
- More males than females are daily smokers across all age groups.
- People who smoke aged 12 years and over smoked on average 95.9 cigarettes per week.
- Around 1 in 8 (12.8%) Australians aged 14 years and over smoke daily.
- In 2012, 12.5% of all mothers reported that they had smoked while pregnant.
- This is down from 13.2% in 2011 and 13.5% in 2010/30.
- Teenage mothers accounted for 10.2% of all mothers who reported smoking during pregnancy.
- But of all teenage mothers, 34.9% reported smoking.

Victoria

- The Loddon Mallee and Grampians regions had the highest rate of hospitalisations (108 and 107 per 10,000 population. respectively), whereas the overall state rate was 89 per 10,000 population.
- This is further illustrated by the standardised morbidity ratio (SMR). The SMRs for the Loddon Mallee (1.22) and Grampians (1.21) regions are greater than one, equating to 22% and 21% more tobacco-related hospitalisations in these regions respectively compared to all Victoria combined (a statistically significant result given that the accompanying confidence interval excludes one).
- All non-metropolitan regions had tobacco-related hospitalisation rates higher than all Victoria, whereas most metropolitan regions (Southern Metropolitan aside, equal to the Victorian rate) had rates lower than the Victorian rate.
- Residents in rural Victoria have higher rates of tobacco-related hospitalisations than residents residing in metropolitan Melbourne.

Table 9; Tobacco-related hospitalisation rates by health region, Victoria, 2004–05

Health regions	Total cases	Rate per 10,000	Standardised morbidity ratio	95% CI
Barwon South Western	3,506	99.9	1.12	(1.09-1.16)
Grampians	2,289	107.3	1.21	(1.16-1.26)
Hume	2,690	103.6	1.17	(1.12-1.21)
Loddon Mallee	3,262	108.0	1.22	(1.17-1.26)
Gippsland	2,547	103.5	1.17	(1.12-1.21)
Western Metropolitan	5,300	79.1	0.89	(0.87-0.91)
Northern Metropolitan	6,473	82.4	0.93	(0.90-0.95)
Eastern Metropolitan	6,816	70.1	0.79	(0.77-0.81)
Southern Metropolitan	10,371	88.5	1.00	(0.98-1.01)
Victoria	44,185	88.9		

(Source: Victorian Admitted Episodes Database, Department of Human Services, analysis by Turning Point Alcohol and Drug Centre Inc.)

Hume

Smoking status. Source (DHHS, 2010)

Current smokers are defined as those who smoke daily or occasionally. In 2010, 25.0% of males and 18.6% of females in the Region were current smokers, similar to all Victorian males and females (17.8% and 15.8% respectively). The following data highlights tobacco use by category across the Hume region, and also by category across Hume Local Government Areas.

Hume Region is ranked second out of 8 regions for people who smoke (21%), compared to Victoria (19.1%).

Table 10; Smoking status, 2008, Hume LGAs

LGA	% current smoker	% ex-smoker	% non-smoker
Alpine (S)	19.7%	24.8%	55.3%
Benalla (RC)	17.4%	24.5%	58.0%
Indigo (S)	19.8%	25.3%	54.9%
Mansfield (S)	24.0%	29.7%	46.0%
Towong (S)	17.4%	23.8%	58.4%
Wangaratta (RC)	11.6%	24.0%	63.5%
Wodonga (RC)	20.2%	24.6%	54.9%
Hume (total region-12 LGA's)	21.0%	25.4%	53.3%
Victoria	19.1%	23.8%	56.8%

Source (DHHS)

Blue = significantly below Victorian average; red = significantly above Victorian average.

Note that sum of percentages for current, ex- and non-smokers may not add to 100 per cent due to a proportion of 'don't know' or 'refused' responses.

Section 4.3: Other Drugs

National

Source (*Australian Institute of Health and Welfare, 2013 survey*)

- Declines were seen in use of some illegal drugs including ecstasy (from 3.0% to 2.5%), heroin (from 0.2% to 0.1%) and GHB (from 0.1% to less than 0.1%) in 2013 but the misuse of pharmaceuticals increased (from 4.2% in 2010 to 4.7% in 2013).
- While there was no significant increase in meth/amphetamine use in 2013, there was a change in the main form of meth/amphetamine used. Use of powder decreased significantly from 51% to 29% while the use of ice (or crystal methamphetamine) more than doubled, from 22% in 2010 to 50% in 2013.

Victoria

Estimates based on the 2004 *National Drug Strategy Household Survey* show about 82% of Victorians aged over 14 reported recent alcohol consumption. Alcohol remains the most commonly reported drug used by Victorians. Twenty-one per cent (down from 25% in 2001) of Victorians over 14 years reported recent use of tobacco, and 10% (down from 12% in 2001) reported recent cannabis use. Reports of recent use of other drugs by Victorians over 14 years were considerably lower (analgesics, ecstasy and amphetamines at 3% each; cocaine and tranquillisers 1%; and the remainder of other drugs under 1%).

Table 11; Overview of drug use, Victoria, 1993–2004

Drug/behaviour	Per cent recently used by year				
	1993	1995	1998	2001	2004
Alcohol	71	77	80	82	82
Tobacco	27	26	27	25	21
Marijuana	12	11	18	12	10
Analgesics	n/a	n/a	6	3	3
Ecstasy/designer drugs	0.6	0.6	3	3	3
Amphetamines	2	2	3	2	3
Cocaine/crack	0.2	0.6	1	1	1
Tranquillisers	1	0.9	4	1	1
Hallucinogens	1	1	4	0.9	0.7
Inhalants	0.4	0.2	0.8	0.3	0.4
Ketamine	n/a	n/a	n/a	n/a	0.3
Heroin	0.2	0.3	1	0.3	0.3
GHB	n/a	n/a	n/a	n/a	0.2
Barbiturates	0.4	0.4	0.3	0.2	0.2
Methadone	n/a	n/a	0.2	0.1	0.1
Steroids	0.2	0.3	0.2	0.3	0.1

(Vic Government, 2004)

Hume

The following charts highlights the issues associated with illicit and pharmaceutical drug use in Hume. The data, from ADIS, indicates treatment episodes per 10,000 population for each LGA (where available) against the Victorian measure (aodstats, 2015).

Figure 8; Episodes of care for illicit drugs in Hume 2012/13

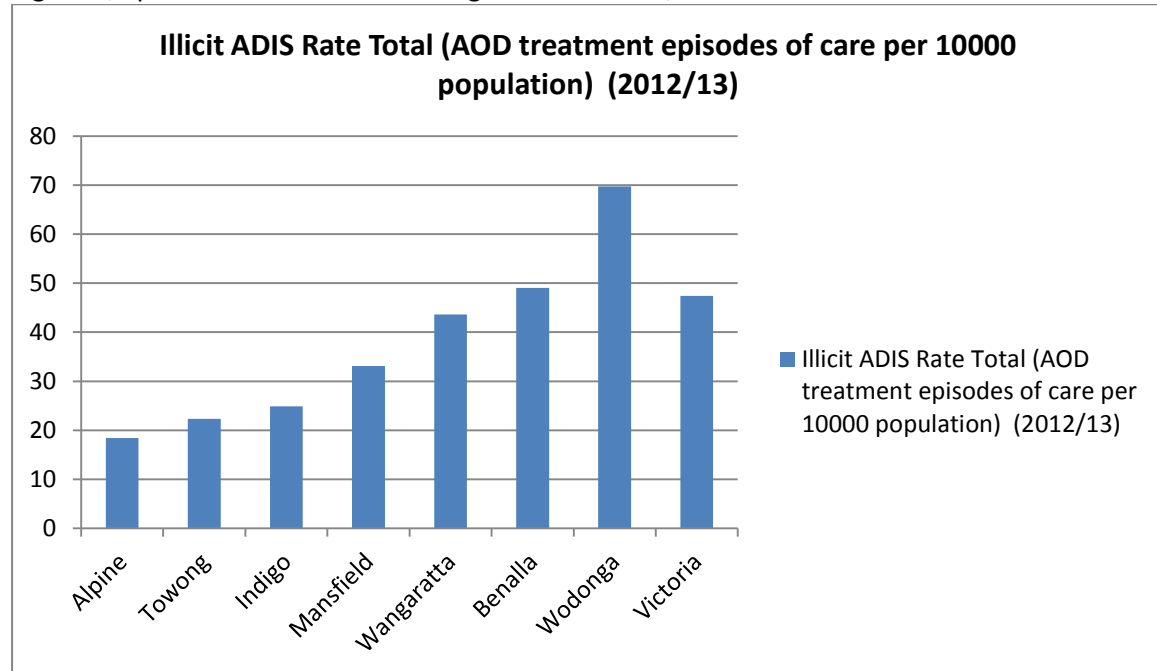
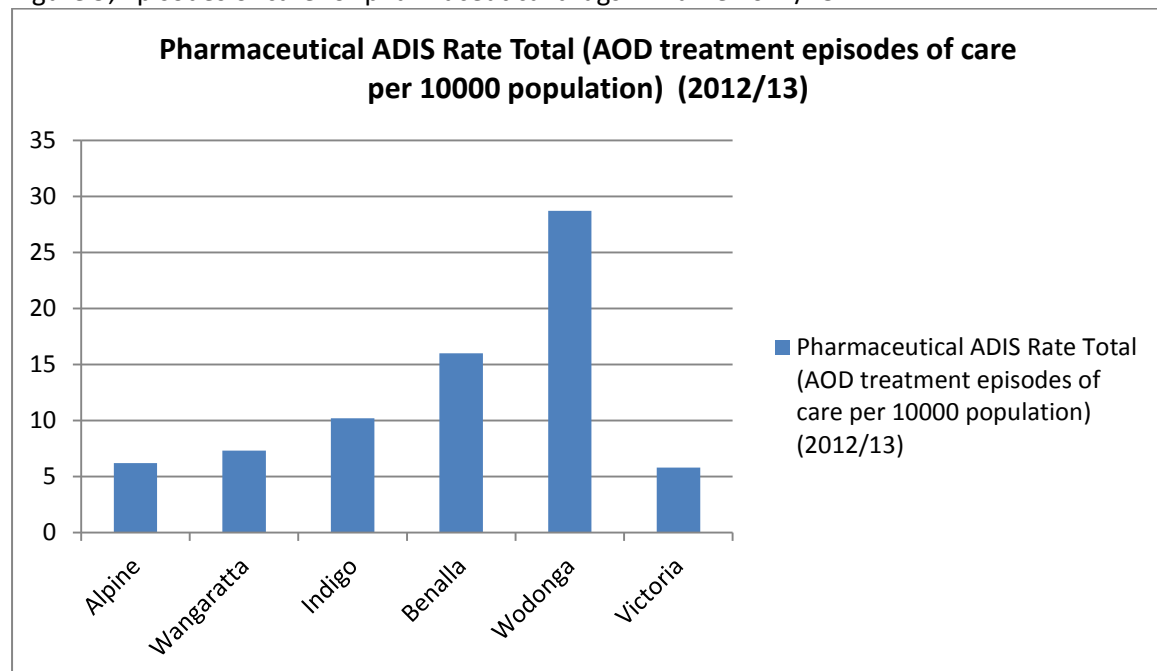


Figure 9; Episodes of care for pharmaceutical drugs in Hume 2012/13



Section 5: Needs Analysis for AOD service gaps in Hume

In addition to a review of quantitative data and grey literature (which is summarised in Appendix G of this report), semi-structured interviews were conducted with stakeholders across Hume in order to draw out existing and emerging issues. Key points from stakeholder engagement are provided below, with further information on critical service gaps being discussed in Appendix A of this report.

Findings from AOD service provider engagement

AOD service providers were consulted during the initial stage of the stakeholder engagement process in Hume. Key themes and issues emerging from the semi-structured interviews with service providers are discussed in more detail below.

Themes discussed by service providers reflect the ongoing need for holistic, recovery oriented support provision, with education for workers (and clients) seen as a priority in this context. It has emerged via consultation that conscientious implementation of recovery-oriented service delivery must be a focus. Issues around 'all of life' social inclusion and improved physical health were raised, with capacity building and education as suggestions for meeting these needs.

Post-reform service access and eligibility are areas of some concern, as are dual diagnosis, trauma informed care and workforce capacity and capability. Diverse groups and vulnerable groups present opportunities for service improvement with cultural education, cultural assumptions, and interpreter usage and service suitability being areas of interest.

Table 12: AOD Service Provider Feedback on Critical Service Gaps in Hume

Feedback on AOD services in Hume
<p>Need for improvement in service access and pathways for consumers of AOD and dual diagnosis support. Post-reform changes have impacted on service navigation and access pathways for consumers and service providers. More understanding of the reformed system is needed. Flexibility in worker roles is an opportunity also; workers have limited capacity to deliver holistic support aimed at early intervention. This can result in missed opportunities for addressing substance use issues at an earlier stage on the continuum of use.</p> <p>Issues and opportunities identified include:</p> <p>The need for an addiction medicine specialist for a wider cross-section of AOD consumers in Hume</p> <p>Education and promotion of existing AOD services – service-based, community-based and individual education and promotion.</p> <p>System and service flexibility to accommodate future system changes in, for example, intake and triage processes.</p> <p>Data and reporting – need for improved systems for input, access and retrieval of valid and relevant data which shows trends and information across catchment LGA's and whole of Hume.</p> <p>Residential detoxification and rehabilitation services – a refitted or purpose build facility combining sober-up, detox. and rehab. services would be the best outcome. Need to accommodate moderate acuity in AOD withdrawal and also psychosocial support.</p> <p>Dual diagnosis – needs to be recognised and practiced at a medical/clinical level. Knowledge of co-occurring disorders is not always translated into practice. Dual diagnosis reframed as co-occurring issues across more than two domains; AOD, mental illness, physical health, chronic disease etc.</p> <p>Tiers of substance use for eligibility purposes – there are missed opportunities for early intervention due to eligibility criteria for AOD consumers.</p> <p>Discrimination on AOD stigma, clinical fraternity views on AOD issues, moralistic views.</p> <p>AOD consumer feedback – There is limited consumer feedback processes for AOD consumers in Hume. Although frameworks exist for AOD consumer feedback, they have not been widely implemented in Hume.</p> <p>Issues and opportunities identified included the lack of detoxification and rehabilitation services in Hume; current AOD service delivery capacity does not meet the detox and rehab needs in Hume. Dual diagnosis continues to be identified as an area requiring more collaboration. Physical health needs for consumers with AOD issues was an identified priority also. The need for more reliable and widespread transport services and day programs to facilitate social connectedness and information sharing was also raised as an opportunity in Hume. Accommodation issues for AOD consumers were raised also.</p> <p>Pharmacotherapy nurses identified the need to provide holistic recovery-oriented support for consumers. It was identified</p>

that 'all of life' support must be offered to AOD consumers who are receiving treatment. Social, housing, financial, legal and spiritual support must be offered to AOD consumers to maximise the benefit of pharmacotherapy treatment and other AOD support offered under the Catchment Planning Function.

A review of AOD service access and triage systems was identified as an opportunity in Hume. It was discussed that service responsiveness to immediate need can be improved. There are opportunities to collaborate with existing service provision for more holistic recovery-oriented services such as family drug support for early intervention, education and capacity building.

There exists a need for day programs for people with AOD needs. Modelled on proven, established projects, a day program for Hume would assist in alleviating consumer, worker and systems stress of service wait times including the time lag between withdrawal and other treatment service. Day programs would contribute to self-efficacy, resilience and positive social connections. Collaboration across services and sectors, cross-border pathways, workforce development and service access processes are also areas to explore in Hume.

Transportation in Hume is a current need in the AOD service sector; outreach services are consistently identified as a service delivery gap. Residential rehabilitation and detoxification services are needed. Dual diagnosis needs are again highlighted, with the need to align mental health and AOD service delivery more collaboratively in Hume.

Assessment processes for substance use issues and more capacity to offer holistic support for AOD and sexual interaction issues were raised. The link between liver issues and AOD use in Hume is a concern, with a large percentage of overlap across sexual health, HCV and AOD consumers.

Dual diagnosis support and post-treatment support options are areas of need in Hume. Further capacity is needed for structured support AOD consumers with co-occurring mental illness in order to meet consumer needs in a more holistic way.

Community education and early intervention initiatives for AOD are opportunities in Hume, as are programs which facilitate social connectedness and general wellbeing.

The willingness of consumers and workers to learn, teach and set aside judgement was discussed. Holistic Indigenous AOD and mental health support in Hume is cited as an opportunity for improvement. Indigenous perspectives on AOD, mental health and dual diagnosis do not always align to non-Indigenous perspectives, with service provision, both psychosocial and clinical, often not being accessed and delivered appropriately. Capacity building and education is required for; understanding Indigenous and non-Indigenous approaches to AOD, mental illness and dual diagnosis, importance of Elders and community in AOD support for consumers and outreach requirements.

Findings from AOD consumer engagement 2015

Method

To ensure continuous improvement in AOD service provision, consumer engagement in Hume has been undertaken across various locations in the catchment. It is envisaged that further ongoing consultation with consumer and carer groups will continue throughout the life of the plan, thereby ensuring relevance and currency with consumer and carer needs and insights on the mental health system.

The Catchment Planning Function was explained to consumers at the beginning of group engagement sessions. It was explained that the consumer feedback was an integral component of the evidence for the plan, which aimed to identify and address mental health service strengths and delivery gaps in the Hume catchment. Privacy and confidentiality was discussed and it was made clear that the information gathered was for the use of continuous service improvement including development of the Catchment Planning Function. No personal details were recorded from consumers.

Participants had the opportunity to engage in dialogue about the current Alcohol and Other Drug support service system from a variety of perspectives. Conversations were consumer-led with feedback documented at the time of discussion. Conversations were held a variety of locations and settings across Hume.

Table 13: Consumer identified AOD Service Strengths in Hume

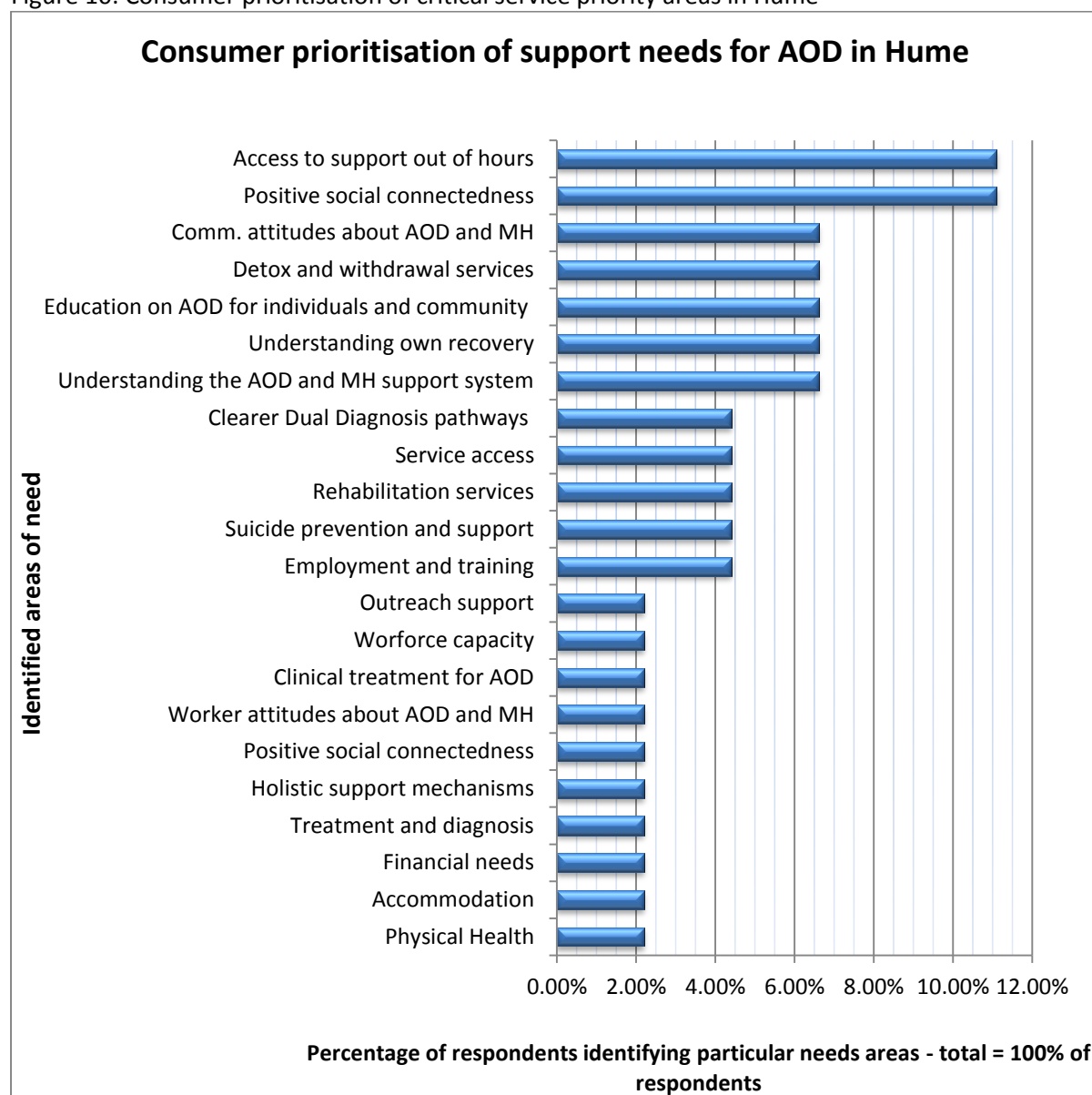
Areas of AOD service strength in Hume	Discussion
Acknowledgement of need for improved dual diagnosis service collaboration	Good foundations for dual diagnosis in Hume with ongoing dialogue about integrating service provision
Focus on issues	Media provides focus on AOD issues
Awareness of professionals	There is good awareness of most AOD professionals
De-stigmatisation	A level of community awareness of potential impacts of AOD
Support networks	Good supportive networks provided by people with lived experience, such as Alcoholics Anonymous and Narcotics Anonymous
Community focus	Awareness of such things as: pharmacotherapy 'take-outs', ice awareness, Headspace
Awareness of limited AOD services available	Many people needing AOD services are aware of where to go and who to see.
Good services, nothing needs to change	
Services are providing much needed support and distraction from the habitual nature of drug use.	
Having watched the service system, evolve, some consumers say that things are very good and that there is nothing they would change.	

Table 14: AOD Consumer Feedback on Critical Service gaps in Hume

Consumer identified AOD service gaps in Hume	Discussion on identified service gaps
Service delivery is sufficient; however more support and intervention via groups would be beneficial. Too long for someone to wait when they are asking for help.	Out of hours support is flagged as a major service gap Consumers don't know how long the waiting period is going to be, and if they should come back again for help. When people are at a point where they're coming in asking for help, they need it there and then.
Too much red tape.	For example, the number of 'takeaways has decreased for some people from 4 to 1. People have to wait extended periods to see the GP about such issues as anxiety in the meantime. Reports of consumers feeling like they're record of 'success' is not being considered with regard to future treatment.
Collocation and integration of services There needs to be more advertising for the services that are available.	Services should be all in one building
Stigma and discrimination	AOD service providers do not cast judgement, however the wider community still does not understand the complexities of AOD issues and how they affect people and they're families.
Early intervention and education	Education in primary and secondary schools is essential. People with lived experience could provide structured education, or assist with curriculum design.
Holistic recovery oriented support for dual diagnosis needs	Limited support is available across 'all of life; needs and across the spectrum of use.
Service system is confusing	Access is difficult and the system is not culturally responsive or holistic.
Detox and rehab	Need more beds in the local region. Also, in-patient and outpatient support options; residential and non-residential options.
Community education and awareness	Increase awareness and reduce stigma by educating community
Youth education	Increased AOD education options for youth
Support for families and friends	Increased support and education for families and friends
AOD accessibility	Substances are easily accessible in the community.
Outreach services	Transport issues and service limitations prevent vulnerable people from accessing services.
Drug driving	Lack of drug driving programs locally –people losing licence
All substances are 'clumped together' in support programs	Specific substances require specific interventions – use a model of individual treatment pathways.

Stakeholder engagement with service providers and consumers revealed critical service gaps. The themes identified were then discussed further with service consumers, who reviewed and prioritised the critical service gaps in Hume. Consumer prioritisation of need in Hume is represented in the chart below.

Figure 10: Consumer prioritisation of critical service priority areas in Hume



Section 5.1: Mapping of Alcohol and Other Drug Services in the Hume catchment:

As part of the needs analysis, community mental health services in Hume were mapped for the purpose of identification of existing initiatives which are meeting identified needs. The following table provides information on existing community mental health programs and services in the Hume Catchment.

Table 15; AOD service providers in Hume

Service	Description	Access in Hume
Gateway Health (Mental Health and AOD)	A broad range of services are provided by Gateway Health ranging from bulk billing medical practices, Allied Health, Alcohol and Drug services including non-residential withdrawal, counselling services, care and recovery. Other services including; men's behaviour change, Victims Assistance, Gamblers Help, Health Promotion, Chronic Disease Management, Indigenous programs, Aged Care services including Assessment, Disability Services, mental health programs including headspace, youth services, young parenting programs, Refugee Health and Sexual Health.	All LGA's
Headspace Albury Wodonga	Headspace is the National Youth Mental Health Foundation which facilitates early intervention services to 12-25 year olds. The service is designed to make it easy as possible for a young person and their family to get the help they need for problems affecting their wellbeing. This covers four core areas: mental health, physical health, work and study support and alcohol and other drug services.	All LGA's
ACSO – Intake and Referral for Hume	ACSO offer innovative services responding to unemployment, mental illness, disability, homelessness, substance use and offending behaviour throughout metropolitan and regional Victoria. These services are delivered through our 'wrap around' service delivery model that integrates ACSO's forensic residential, clinical care, disability and mental health case coordination, employment services and community enterprise divisions to achieve better outcomes for clients and the community.	All LGA's
Odyssey House	"Circuit Breaker" - Short Term Residential Rehabilitation. The program provides a six-week, live-in rehabilitation program in north-east Victoria for people affected by alcohol and other drug addiction, and associated mental health issues. The program accommodates 15 adults and aims to help people end the chaos associated with a substance dependant lifestyle. All participants are encouraged and supported to confront the underlying issues that led to their addiction. This occurs within a safe and welcoming environment where our values of trust, concern, respect, honesty, and love are promoted.	All LGA's
Albury Wodonga Aboriginal Health Service (AWAHS)	AWAHS is a non-profit organisation that was developed and set up to cater for the primary health care needs of Aboriginal and Torres Strait Islander people and their families. AWAHS offers mental health and substance use support under their social and emotional wellbeing programs, for people living in North East Victoria and Southern Riverina of NSW.	
Beechworth Health	Providers of in-patient, non-residential hospital admission for mild to moderate alcohol withdrawal. Do not provide services for complex withdrawal and addiction needs.	All LGA's

Emerging issues in Hume

Following the needs analysis in Hume, a gap analysis was conducted to highlight where existing service delivery initiatives are not providing sufficient support in the identified areas of need, and/or where areas of need are not being addressed at all.

The Primary issues are drawn from analyses of consumer and service provider feedback in Hume, health data, and literature review including federal, state and local health planning priorities. The priority areas were then cross-referenced with existing services and initiatives in Hume. The following analysis highlights the critical service delivery gaps in Hume which are not currently being addressed sufficiently by existing service delivery programs.

Table 16; Emerging issues in AOD service delivery in Hume

Identified Primary issues in Hume for AOD	Rationale	Critical areas to address
AOD service access and understanding	Stakeholder identification of issues associated with service accessibility, waiting lists and information provision and accuracy. There is widely reported confusion about the post-reform AOD system.	<ul style="list-style-type: none"> • Improved understanding of eligibility criteria post-reform • Improved consistency and quality of information about service access pathways • Increased scope of service delivery options • Improved collaboration across services
Social connectedness	Stakeholder identification of significant need for greater self-capacity of AOD consumers to access and integrate with positive social connections.	<ul style="list-style-type: none"> • Increased options for positive social connectedness • Increased education on social and interpersonal skills
System flexibility and responsiveness	Consumer and service provider identification of reduced holism capacity in service delivery post-reform. Early and immediate intervention capacity does not meet demand.	<ul style="list-style-type: none"> • Increased provision of service for immediate need • More holistic service delivery options with current system, post-reform
Detox and rehab services	Stakeholder identification, key policy review and data analysis reveal a complete lack of Victorian state-funded residential withdrawal and rehabilitation beds.	<ul style="list-style-type: none"> • Need residential detox/withdrawal beds • Need residential rehab beds • Ideally; detox and rehab in the same location
Collaborative suicide prevention strategy	Environmental survey reveals good work in this area, however, it is fragmented and does not include all relevant stakeholders in planning, delivery and evaluation. A more integrated and collaborative approach is needed.	<ul style="list-style-type: none"> • More sustainable suicide prevention programs • More engagement with community about suicide prevention initiatives • More follow up support following discharge from acute mental health units and/or residential rehabilitation services
Dual Diagnosis	Stakeholder identification and key policy priority identify the need for increased dual diagnosis support and a more join-up approach in service deliver for mental health and AOD.	<ul style="list-style-type: none"> • Increased options for holistic support for co-occurring disorders • Better collaboration between existing MH and AOD service provision – better case coordination • More information for consumers on dual diagnosis

Transport	Geographical factors and lack of outreach service provision are highlighted by stakeholders as issues related to transport systems and accessibility.	treatment options <ul style="list-style-type: none"> • More public transport • More affordable transport options • Increased education on transport access options • Service collaboration to address transport issues
Improved Physical Health for AOD consumers	Stakeholders identify a need for regular health screening to address concurrent and/or underlying health issues for AOD consumers and their carers.	<ul style="list-style-type: none"> • Improved chronic disease management • Uptake of regular appropriate exercise • Regular physical health checks

Emerging issues in Hume by LGA

The wider analysis of issues in Hume was narrowed down to identify issues in each LGA. The information gathered at the LGA level was sourced from grey literature on comprehensive needs assessments and health planning profiles.

Alpine shire

Alpine has the second highest proportion of smokers in the Hume Catchment and the third highest proportion of people with high cholesterol. The highest proportion of people reporting psychological distress is in Alpine Shire.

Service provider feedback – *AOD providers report a lack of referral pathways, service responsiveness and an increase in complex disorders as issues.*

Consumer feedback - *Weekend access to health professionals in Mt Beauty were reported (HML comprehensive needs assessment, 2014-15).*

- Area of LGA: 4,787 km²
- Total population in 2012: 12,181
- Distance to Melbourne; 286 km
- The number of registered mental health clients per 1000 population is almost twice the state measure
- The number of registered AOD clients per 1000 population is below the state measure
- Only 3.1% of the population live near public transport, compared with the Victorian average of 74.2%, and the car ownership rate is slightly higher than the Victorian average (*Hume profile, DHHS, 2012*).

City of Benalla

Benalla city socioeconomic profile is in the lowest fifth of the Nation. Services which could be considered to be insufficient in Benalla included occupational therapy, dietetics, counselling and care coordination.

Service provider feedback - *AOD providers report a lack of access to local services, gaps in workforce skills, no public funded psychology, funding, a lack of referral pathways and an increase in high complex disorders as issues. In addition there is some concern about the coordination between local services.*

Consumer feedback - *Access to General Practice was the major issue identified (HML comprehensive needs assessment, 2014-15).*

- Area of LGA: 2,352 km²
- Total population in 2012: 13,731
- Distance to Melbourne; 199 km
- The number of registered mental health clients per 1000 population is more than twice the state measure.
- The number of registered AOD clients per 1000 population is above the state measure
- Rates of family incidents and drug and alcohol offences are higher than average.
- The percentage of children with emotional or behavioural problems is the highest in the state, as is the percentage of children who are vulnerable on two or more domains. The rate of children in out of home care is highest in the state, and child protection orders and substantiated child abuse rates are both among the highest. (*Hume profile, DHHS, 2012*)

Indigo Shire (limited data available)

Indigo has the third highest proportion of people with hypertensive disease across the HML but the lowest proportions of alcohol consumption, physical inactivity and high cholesterol. Indigo has the third highest proportion of people with circulatory disease and the lowest proportions with arthritis and type 2 diabetes. Health professional services with a potential gap in Indigo include occupational therapy, dietetics, physiotherapy, counselling, psychology, podiatry, speech therapy, care coordination and drug and alcohol counselling.

(HML comprehensive needs assessment, 2014-15).

- Area of LGA: km2
- Total population in 2011: 15,376
- Distance to Melbourne; km

City of Mansfield

The lowest proportion of preventable deaths is reported in Mansfield. The third highest unemployment benefit is reported in Mansfield, although it is lower than Australia and Victoria. The highest proportion of smoking across the HML is in Mansfield.

Service provider feedback - *AOD providers report a lack of referral pathways and a limited range of treatment options as issues.*

Consumer feedback - *No public allied health access, fees and travel were reported*

(HML comprehensive needs assessment, 2014-15).

- Area of LGA: 3,843 km2
- Total population in 2012: 8,067
- Distance to Melbourne; 188 km
- The number of registered mental health clients per 1000 population is above twice the state measure.
- The number of registered AOD clients per 1000 population is below the state measure
- Individual and household incomes are below average(*Hume profile, DHHS, 2012*)

Towong Shire

Towong has the third highest proportion of chronic obstructive pulmonary disease and musculoskeletal disease across the HML.

Service provider feedback - *AOD providers report a lack of integrated planning, limited referral pathways and services for school as needs for their area.*

(HML comprehensive needs assessment, 2014-15).

- Area of LGA: 6,674 km2
- Total population in 2012: 5,941
- Distance to Melbourne; 423 km
- The number of registered mental health clients per 1000 population is above the state measure.
- The number of registered AOD clients per 1000 population is below the state measure
- The Aboriginal and Torres Strait Islander population is twice the Victorian average.
- Cultural diversity is very low, with only 0.2% reporting low English proficiency, one of the lowest percentages in the state. (*Hume profile, DHHS, 2012*).

City of Wangaratta

Wangaratta is in the third lowest percentile of the Country for socio-economic status. Wangaratta has the second highest proportion for you unemployment across the Hume Catchment, lower than Australia and Victoria.

Service provider feedback - AOD providers report issues with addressing coexisting chronic disease, a lack of referral pathways and a need for integrated planning.

Consumer feedback - Ageing and winter illnesses and mental health were the major health concerns. (HML comprehensive needs assessment, 2014-15).

- Area of LGA: 3,644 km²
- Total population in 2012: 27,236
- Distance to Melbourne; 238 km
- The rate of registered mental health clients per 1,000 target population is almost twice the state measure.
- The number of registered AOD clients per 1000 population is above the state measure
- Cultural diversity is low, rates of family incidents and drug usage and possession offences are above average (*Hume profile, DHHS, 2012*).

City of Wodonga

Wodonga has the highest proportion of 0 – 24 year olds and the lowest proportion of elderly. Wodonga is in the lowest third of the Country for socio-economic status. Type 2 diabetes is second highest in Wodonga across the Hume Catchment and Asthma, obesity, arthritis, psychological distress and osteoarthritis are third highest in proportion.

Service provider feedback - AOD providers report gaps in workforce skills, a lack of funding and service responsiveness as issues.

Consumer feedback - Ageing, mental health, drug and alcohol use and obesity were reported as health issues. Examples of system issues reported is “Finding assistance and services in all Health Groups and support systems, not linked or easy to find there are so many services, nothing linked, information not made easily accessible. When at crisis point, information not easily accessible.” (HML comprehensive needs assessment, 2014-15).

- Area of LGA: 433 km²
- Total population in 2012: 36,626
- Distance to Melbourne; 307 km
- The number of registered mental health clients per 1000 population is well above the state measure.
- The number of registered AOD clients per 1000 population is well above the state measure
- Family incidents are higher than average, as are drug offences.
- More than 9% of dwellings in Wodonga are public housing, the second highest percentage in the state.

Section 6: Priority Areas for AOD catchment-Based Planning in Hume

The gap analysis yielded a number of priority areas. Following this process, the Hume/GV Alliance for Mental Health and Housing conducted further strategic planning to consolidate priority areas which are considered by key stakeholders to be the most achievable, within the scope and objectives of the catchment planning function, and deliverable within the capacity of key stakeholders and consumers.

The priority areas for AOD in Hume are:

1. Withdrawal and rehabilitation services in Hume

State-funded residential withdrawal and rehabilitation beds are currently available in Hume. To complement existing services and initiatives, the Hume catchment-Based Planning function will take an evidence building approach to this priority area over the life the plan, with the view to provide additional evidence for state-funded resources in Hume.

2. Service access and understanding

AOD service access in Hume is considered by stakeholders to be impersonal, disjointed and not reflective of holistic or recovery-oriented service delivery frameworks. To address this issue in Hume, the plan seeks to engage in a raft of measure targeted at waitlist management, consumer awareness and information provision and service collaboration.

3. Dual diagnosis

Dual diagnosis support is raised by stakeholders at all levels of experience and expertise as an issues requiring action in Hume. Further service collaboration and supported intake and referral processes are pursued.

4. Social connectedness

Positive social connectedness as measure of wellbeing is identified at all levels of policy, and at through all stakeholder engagement. Relapse prevention supported by positive social networks and early identification of social support structures and needs are highlighted

Section7: Implementation Plan - Strategic priorities and actions

Please note: Ongoing stakeholder consultation, literature review and data analysis will occur throughout the life of the plan. The strategic priorities and actions identified herein will be subject to ongoing review, as discussed within the plan, to ensure currency and relevance with identified critical service gaps in Hume.

Strategic Priority 1: To address the reported need for Victorian State-funded AOD residential withdrawal and rehabilitation facilities in Hume

Objective	Action	Responsibility	Outcome(s)	Timeline
Build information and evidence base to support identified need for state-funded residential withdrawal and rehabilitation beds in Hume	1. Data collection on levels of need for residential withdrawal and rehabilitation services	Hume and Goulburn Valley Alliance for Mental Health and Housing	Evidence to inform proposed actions for increased provision of AOD residential withdrawal and rehabilitation facilities in Hume.	To begin July 2016 and continue over the life of the plan
	2. Conduct regional stakeholder forum to review relevance and currency of planning functions in Hume.	Gateway Health	Hume AOD catchment Plan remains current and relevant for identified needs for stakeholders.	To begin in September 2016 and be held up to 3 times per year over the life of the plan.

Strategic Priority 2: To improve outcomes in service access and understanding for AOD consumers in Hume

Objective	Action	Responsibility	Outcome(s)	Timeline
Increase awareness for consumers and carers on service access and systems	1. Review provision of information to AOD consumers on suitable support services	Collaborative approach between; Gateway Health, ACSO and Hume and Goulburn Valley Alliance for Mental Health and Housing.	Increased options for AOD consumers to be better informed about service access and provision pathways	To be completed by December 2016
	2. Review waiting list support options to address interim support needs from referral to treatment	Collaborative approach between; Gateway Health, ACSO and Hume and Goulburn Valley Alliance for Mental Health and Housing.	Increased options for consumers on waiting lists who have immediate support needs are provided with interim service	To be completed by December 2016
Gather data on service utilisation	3. Gather and review relevant data on service utilisation to support planning in Hume	Gateway Health and ACSO	Improved understanding of the nature and distribution of met and unmet expressed and unexpressed demand for AOD support services across the catchment.	To begin July 2016 – ongoing over the life of the plan

Strategic Priority 3: To improve outcomes for AOD consumers experiencing AOD and Mental Health Dual Diagnosis and suicide support needs in Hume

Objective	Action	Responsibility	Outcome(s)	Timeline
Improve service intake, supported referral and treatment collaboration for Dual Diagnosis consumers	1. Review workforce capacity to work effectively with consumers with Dual Diagnosis and suicide support needs	Collaborative approach between; Gateway Health, ACSO and Hume and Goulburn Valley Alliance for Mental Health and Housing.	Identification of workforce development needs in dual diagnosis and suicide prevention in Hume.	To be completed by December 2016
	2. Gather and review relevant data on service utilisation to support planning in Hume	Gateway Health and ACSO	Improved understanding of the nature and distribution of met and unmet expressed and unexpressed demand for AOD support services across the catchment.	To be initiated July 2016 – ongoing over the life of the plan
	3. Promote and strengthen cross-sector collaboration on service delivery in dual diagnosis and suicide prevention	Hume and Goulburn Valley Alliance for Mental Health and Housing	Increased options for collaborative treatment for dual diagnosis consumers and people in need of suicide support.	To begin July 2016
To build regional capacity to support dual diagnosis and suicide prevention practice in Hume	4. Participate in regional mental health forum to promote service collaboration and health outcomes for service users with dual diagnosis and suicide support needs.	Mind Australia, Gateway Health, Murray PHN	Consolidation and leveraging of resources to promote consumer health outcomes	Once annually throughout life of plan.

Strategic Priority 4: To improve outcomes in positive social connectedness for consumers of AOD service in Hume

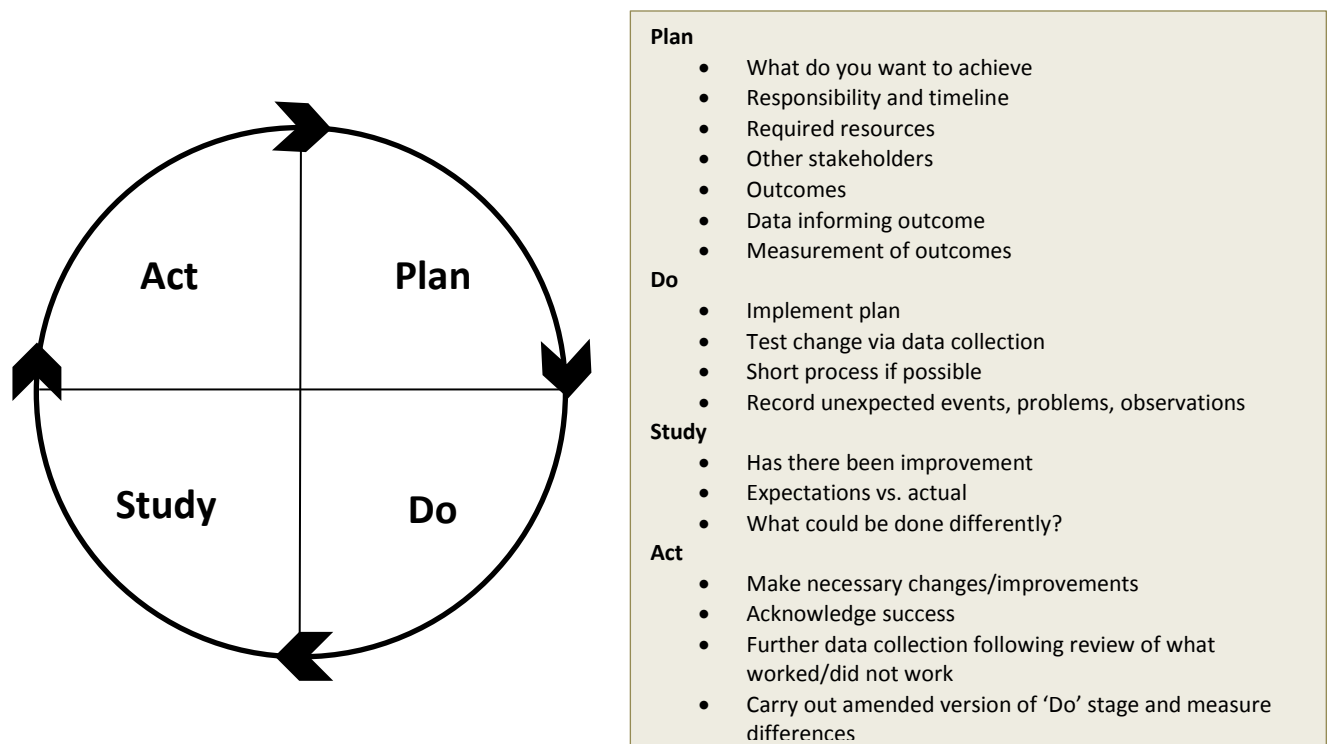
Objective	Action	Responsibility	Outcome(s)	Timeline
To facilitate increased capacity for AOD consumers to identify and respond to needs in social connectedness	1. Review tools, processes and procedures for early identification of social need and/or vulnerability in AOD consumers	Gateway Health in collaboration with ACSO and Hume and Goulburn Valley Alliance for Mental Health and Housing	Consumers social needs are better understood at an earlier stage in service delivery	To be completed by July 2016
	2. Integrate tools for positive social connectedness into new and existing relapse prevention plans for AOD consumers.	Gateway Health in collaboration with ACSO and Hume and Goulburn Valley Alliance for Mental Health and Housing	Identified consumer social needs are addressed using initiatives which are integrated into individual treatment plans	To begin December 2016 and progress over the life of the plan.
To build regional capacity to positive social connectedness for AOD consumers in Hume	3. Conduct regional stakeholder forum to review planning functions in Hume.	Gateway Health	Hume AOD catchment Plan remains current and relevant for identified needs for stakeholders.	To begin in September 2016 and be held up to 3 times per year over the life of the plan.

8: Evaluation

Evaluation of the Hume AOD catchment-Based Planning Function is undertaken using a structured framework which allows for use of specific tools that best meet the needs for evaluation of particular strategies.

The Plan, Do, Study, Act (PDSA) cycle (figure 22) uses simple measurements to monitor the effects of change over time. By starting with small changes, the process can be built into larger improvements rapidly, through successive cycles of change. It is designed to begin with realistic goals in mind, using reflection and building on learning. Suggestions for improvement can be tested quickly using the PDSA model by using existing ideas and research or through practical ideas that have been proven to work elsewhere (RACGP, 2015).

Figure 11: Hume AOD Catchment-Based Planning Function Evaluation Framework



Evaluation of the Hume catchment-Based Planning Function will be undertaken by the Hume Catchment-Based Planning working group, overseen by the Hume and Goulburn Valley Alliance for Mental Health and Housing.

Evaluation of particular strategies within the plan will occur at intervals which best suit specific initiatives. Evaluation tools will be decided upon during the evaluation period and will be selected for best suitability for evaluating particular strategies.

9: Next Steps

Formation of the Hume Catchment Planning Working Group will occur in December 2015. Hume Catchment Plan strategies will be implemented, and ongoing stakeholder consultations will be undertaken to maintain currency and relevance of the Hume plan. This work will be undertaken through the Hume Catchment Planning working group in the first instance, with final approval for actions from The Hume and Goulburn Valley Alliance for Mental Health and Housing as the governing group.

The Catchment Planning working group will carry the momentum of the plan and will seek to be the driving force behind the implementation of the Hume catchment strategies. The Alliance will maintain governance responsibility for the plan and will delegate to the working groups for addressing actionable items. Approval from the Alliance will be sought on any significant changes from the agreed plan.

Following this, the Hume Region AOD plan will form the basis of the project planning and development work that will be undertaken for AOD in Hume. It is anticipated that the project planning work will begin in January 2016. Mind Australia and The Hume and Goulburn Valley Alliance for Mental Health and Housing will take on key roles in establishing the project plan, which will be underpinned by a recovery-oriented philosophy.

Appendix A: Additional information from stakeholder engagement

Table 17: Themes from AOD Service Provider Feedback in Hume

Identified key themes	Elaboration on key themes from service providers
Social connectedness <ul style="list-style-type: none"> • Social engagement and rewarding connections • Meaningful relationships • Isolation • Contributing to society 	Service providers discussed the need, and challenges, in providing 'all of life' social inclusion. Education for participants was discussed in the context of what is available and how to access such supports.
Dual Diagnosis <ul style="list-style-type: none"> • Drug and alcohol services must run concurrently with Mental Health services • Complex support needs • Referral options and pathways 	This continues to be raised as an issue. Support provision for Mental Health and Drug and alcohol issues concurrently was agreed to be required, although challenges exist in this context. Access, eligibility, intake and holistic service provision were identified as challenges in supporting consumers with dual diagnosis. A review of service provider capacity, workforce capability, and current access systems was suggested.
Detoxification and rehabilitation services	Residential rehabilitation services remain a critical service delivery gap in the Hume region. Demand is greatly outweighing supply in this context, with large waiting lists the result. Non-residential rehabilitation guidance is offered by existing AOD services in Hume, however, this is not within the capacity of current post-reform role descriptions for AOD workers and thus places strain on existing service delivery.
Suicide prevention <ul style="list-style-type: none"> • No unified approach to suicide prevention across region • Fragmented approach at present – but good work being done 	Opportunities are identified to better use existing resources for catchment-wide suicide prevention initiatives.
Service access and eligibility <ul style="list-style-type: none"> • Centralised intake process • Post-reform system • Education for clients and workers on system access • Communication • Worker roles and flexibility 	Education for workers and consumers on the reformed AOD and mental health system was discussed. The role of workers, and consumer access were highlighted as areas needing to be pursued. Worker capacity to deliver broad holistic, recovery oriented support is flagged as a service delivery restriction. Consumer access to services post-reform is reported to be inconsistent.
Workforce skills <ul style="list-style-type: none"> • Worker up-skilling • Professional development 	Additional skills for workforce employees are discussed as important. Accredited training and review of minimum combination of formal qualifications and experience were seen as ways to address skills shortages in the mental health and dual diagnosis workforce.
Marginalised groups <ul style="list-style-type: none"> • Indigenous Australians • Refugee community – Interpreters, cultural competence and understanding • Youth • Elderly 	An attitudinal shift was discussed in regard to cultural difference. It is mentioned that cultural training will be largely ineffective if workers (and services) do not review underlying assumptions about cultural differences. Cultural understanding may be specific to geographic location and demographic composition. Training on culture should reflect this contextual difference, whilst also acknowledging broader concepts and information. For example; training on Aboriginal culture in Hume should acknowledge the complexities within the Aboriginal community, as highlighted by the converging of four Aboriginal nations in Wodonga. The refugee community in Hume comprises of various cultures with different traditions and world views. An understanding of White-Anglo culture and the historic and current human services sector is also discussed.
Physical health <ul style="list-style-type: none"> • Capacity building for consumers on physical wellbeing • Physical health areas amongst AOD clients; Chronic disease, Exercise, Diet, Sexual Health, Lifestyle 	Education on; diet, lifestyle, substance use, medication factors. Review of physical health at regular intervals – BP, BGL, cholesterol, BMI, questionnaire on smoking, substance use, sexual health, exercise regime.

Aboriginal and Torres Strait Islander feedback

Aboriginal and Torres Strait Islander service providers offered the following insights into AOD service delivery for Aboriginal and Torres Strait Islander communities in Hume.

Service Access, equity and system navigation

Mental health considerations within the Aboriginal and Torres Strait Islander communities in Hume reflect community attitudes and broader systems issues. Access to mental health, drug and alcohol and dual diagnosis support was raised as a concern in Hume. System bureaucracy, processes and a lack of empathy toward Aboriginal and Torres Strait Islander perceptions of the service system was highlighted. Reformed service access procedures, i.e. intake, are at times amplified for Aboriginal and Torres Strait Islander consumers because the pathway to service delivery has become less personable, less considerate of outreach and community engagement requirements and thus lacks wider cultural consideration.

Aboriginality

The topic of Aboriginality and thus Aboriginal and Torres Strait Islander specific service eligibility was raised. Although there are no major issues with people falsely presenting to services as Aboriginal or Torres Strait Islander, there is a percentage of individuals who do so. This was discussed as a complex albeit not significant issue. Proof of Aboriginality is not necessarily required for service eligibility. Situations where individuals have falsely presented as Aboriginal or Torres Strait Islander are often noticed, with individuals in most cases being identified as being of a non-Aboriginal, non-Australian born culture.

Diversity

Much diversity exists within the Aboriginal and Torres Strait Islander communities in Hume. With part of Hume being a traditional meeting place for Aboriginal nations, the area has become a diverse location of Aboriginal history, culture, language and traditions. This diversity adds complexities to support and service delivery for Aboriginal and Torres Strait Islander people in Hume. Cultural politics and at times a lack of clarity of nation boundaries can result in tensions among the community. Aboriginal and Torres Strait Islander cultural identity in Hume is thus a complex and often misunderstood factor for non-Indigenous people.

Worker acceptance in the community

In addition to community diversity, there exists the important consideration of acceptance among the Aboriginal and Torres Strait Islander people. It is discussed that service providers, liaison officers and support workers must take an active and acknowledged role in their community; that is, the Aboriginal and Torres Strait Islander community if they are to be accepted within these communities and thus effectively engage with the people. Acceptance in this context extends to clinical services such as hospitals; with Aboriginal Liaison officers considered important yet not always acknowledged or accepted in these roles within the Aboriginal and Torres Strait Islander community.

Recognition of Aboriginal and Torres Strait Islander workers as skilled

It is discussed that Aboriginal and Torres Strait Islander workers are not consistently acknowledged as being suitably skilled and/or qualified in their respective fields. Several considerations are discussed in this context. These considerations include; community knowledge and familiarity, cultural knowledge, community acceptance, experience, training and qualifications.

Fear, Trust and Rapport

Issues of fear and trust remain factors for Aboriginal and Torres Strait Islander consumers accessing mental health and drug and alcohol services in Hume. For reasons already mentioned, the connection between community and service provider is often not smooth, and often does not exist at all. It is discussed that a trusted, acknowledged, respected Aboriginal worker must make the link between community and service provider if there is to be engagement and sustained service delivery.

Collectivism and Individualism

White-Anglo Australia is traditionally an individualistic society. Aboriginal and Torres Strait Islander communities are traditionally collectivist societies. There are major differences between individualist and collectivist community approaches to issues such as mental health and substance use.

Collectivist cultures often seek support and guidance from community and Elders within their culture rather than seeking support from service providers. Factors such as these influence the way in which services communicate and connect with Aboriginal and Torres Strait Islander communities. A centralised intake system for mental health and drug and alcohol services, for example, does not align to collectivist cultural values and norms. Thus, effort must be made to connect with Aboriginal and Torres Strait Islander communities beyond the current service system restrictions if suitable support is to be offered and provided.

Aboriginal and Torres Strait Islander consumers offered the following insights into AOD service delivery for Aboriginal and Torres Strait Islander communities in Hume.

Table 18: AOD issues and discussions with Aboriginal and Torres Strait Islander consumers

Points raised	Discussion
Need for Indigenous AOD workers who know about Men's and Women's business	This is vital for sensitive and culturally appropriate support in a diverse Indigenous community
Tolerance for AOD	Need for greater understanding the nature of addiction
Racial issues	Ongoing; covert and overt
Community acceptance of Indigenous workers	Need for improved communication and community engagement by Indigenous workers
The white middle-class system is currently being used	The system is not culturally appropriate as a whole; specific changes can improve current access issues.

Appendix B: Partnership and collaboration in Hume

Hume is well placed to develop and implement strategic actions for short, mid and long term service provision in AOD and mental health more broadly. Hume currently has established networks for collaboration on AOD support across the catchment and into neighbouring catchments also. The Hume and Goulburn Valley Alliance for Mental Health and Housing consist of high level representation and decision-making capability across two catchment areas. The executive functions of the Alliance include oversight of working groups for identified priority areas in mental health, housing and substance use.

Wider community networks and focus groups in Hume contribute to the knowledge base on best practice recovery-oriented support in AOD. Consumer and carer representation in AOD is in need of bolstering in Hume however. Consumer representation on relevant planning and strategic committees is currently low.

Key Stakeholders

Key stakeholders in the development, implementation and review of the Hume AOD Catchment-Based Planning Functions include:

Table 19: Key Stakeholders in Hume

Stakeholder
<ul style="list-style-type: none"> Consumers of AOD services Carers, family, friends and significant others of consumers of AOD services Wider communities of Hume Hume and Goulburn Valley Alliance for Mental Health and Housing Service providers: <ul style="list-style-type: none"> Gateway Health Albury Wodonga Health Northeast Border Mental Health Service (NEBMHS) ACSO Mental Illness Fellowship Local Government Area councils Albury Wodonga Aboriginal Health Service Odyssey House Molyullah Headspace Albury Wodonga

Primary Care Partnerships

The Hume Catchment-based Planning Function will create and strengthen linkages across three Primary care Partnership regions. The following PCP's, associated member organisations and existing and future health planning will both inform and be informed by the Hume Catchment-based planning function.

PCP	Member Organisations	Priority Areas
Upper Hume	Albury Wodonga Aboriginal Health Service Albury Wodonga Health Beechworth Health Service Disability Advocacy and Information Service Gateway Health Hume Medicare Local Indigo North Health	Upper Murray Health and Community Services Vision Australia Westmont Aged Care Services Ltd Women's Health GNE
		<ul style="list-style-type: none"> Aboriginal Health Aged care Chronic care Health literacy Hume Shared care e-care planning project Integrated Health Promotion Primary care e-

Central Hume	Indigo Shire Council		communication initiative
	Kirinari Community Services		• Service integration and access
	Tallangatta Health Service		
	Alpine Health	NESAY Inc.	• Diabetes
	Alpine Shire	Rural City of Wangaratta	• Heart Disease
	Benalla Health	The Centre, Wangaratta	• Healthy eating
	Benalla Rural City Council	Uniting Care, Goulburn North East	• Aboriginal and Torres Strait Islander Health
	Gateway Health Wangaratta (formerly Ovens & King Community Health Service)	Women's Health Goulburn North East	• Focus areas as identified
	Mansfield District Hospital	Yooralla	
	Mansfield Shire Council		
Goulburn Valley	Mind Australia		
	North East Health Wangaratta		
	Berry Street	Primary Care Connect	• Aboriginal Health
	Cobram District Health	Rumbalara Health Service	• Aged care
	Connect Goulburn Valley	Rural Housing Network	• Chronic care
	Ethnic Council of Shepparton & District	Salvation Army Pathways	• Integrated Health Promotion
	Euroa Health	Shepparton Access	
	Family Care	Shepparton Villages	
	Goulburn Valley Health	Strathbogie Shire Council	
	Goulburn Valley Hospice Care	The Bridge Youth Service	
	Goulburn Valley Medicare Local	Uniting Care Goulburn North East	
	Goulburn Valley Sports Assembly	Violet Town Bush Nursing Centre	
	Greater Shepparton City Council	Vision Australia	
	Hume Regional Integrated Cancer Service	Wintringham Specialist	
	Kalona Uniting Care	Aged Care	
	Mental Illness Fellowship Victoria	Women's Health	
	MHA Care Ltd	Goulburn North East	
	Mind Australia	Word and Mouth	
	Moir Shire Council	Yarrawonga Health	
	Murchison Community Care		
	Nagambie Health Care		
	Numurkah District Health Service		
	Odyssey House Victoria		
	Ottrey Homes		

Appendix C: Definitions

Alcohol and Other Drug Use - The spectrum of substance use ranges from 'no use' to dependent use of one or more substances. A person can move along the spectrum or 'rest' at any point or move backwards. One stage does not necessarily lead to the next - the 'one hit and you're hooked' belief is a myth.

- **Experimental use** - A person 'tries out' a particular drug. Experimental use refers to 'once off' or very short-term drug use.
- **Recreational use** - A person uses one or more drugs in a deliberate or controlled way. Sometimes called social drug use, recreational use can occur very occasionally or every weekend or several times a week.
- **Situational use** - A person uses drugs to cope with the demands of particular situations.
- **Intensive use** - A person consumes a heavy amount of drugs over a short period of time, or use is **continuous over a number of days or weeks**.
- **Dependent use** - With dependent use the person has little or no control over their drug use. They feel compelled to use in order to feel normal or to cope. Often called addiction, dependency is the result of prolonged, regular use of increasing amounts of the drug.

Detoxification/Withdrawal - Withdrawal or detoxification (also called detox) is the process of cutting back, or cutting out, the use of alcohol or other drugs. Withdrawal symptoms can range from mild to severe, and differ depending on the duration of use, type of drug, age, the person's physical and psychological characteristics and the method of withdrawal. A person could develop physical or psychological dependence on a drug, or both (druginfo, 2016).

Physical dependence - **Physical dependence occurs when someone has taken a drug for a period of time and comes to rely on it, because if it's not taken withdrawal symptoms will appear (druginfo, 2016).**

Psychological dependence - Psychological dependence occurs when a person believes they need the drug to function. This could be in certain situations, such as at a party, or it could be all the time (druginfo, 2016).

Rehabilitation - Rehabilitation programs take a long term approach to treatment to help you achieve an AOD-free lifestyle. Residential programs can last from a few weeks to a number of years (druginfo, 2016).

Physical health – Relates to the efficient functioning of the body and its systems, and includes the physical capacity to perform tasks and physical fitness (Victorian Government, 2015). .

Dual diagnosis - Dual diagnosis describes the situation of a person experiencing two or more pathological or disease processes at the same time. Other terms for this are; co-occurring disorders or comorbidity. Dual diagnosis in the context of this plan refers to the coexisting presentations of mental illness and substance use issues (Victorian Government, 2015). .

Mental Health – A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of daily life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organisation, 2007).

Mental disorder and Mental Illness - A diagnosable illness which affects a person's thinking, emotional state and behaviour, and disrupts the person's ability to work carry out daily activities, and engage in satisfying relationships (American Psychiatric Association, 2013).

Psychiatric disability - means a consequence of having a mental illness that affects a person's ability to perform the tasks of everyday living and to develop and maintain effective personal and social relationships and economic participation (Victorian Government, 2015). .

Carer - Carers provide unpaid support to a family member or friend who needs assistance. They may care for a frail aged person, someone with a disability, chronic illness or mental illness, or someone recovering from an illness or accident.⁶ Carers help people to remain living at home. The caring experience is a dynamic one with the level of support offered by carers changing in relation to the dependency and health needs of the care recipient.

Appendix D: Recovery-Oriented Practice

The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnosis.

The recovery movement began in the 1970s primarily as a civil rights movement aimed at restoring the human rights and full community inclusion of people with mental health issues.

Recovery approaches are viewed by the consumer movement as an alternative to the medical model with its emphasis on pathology, deficits and dependency. There is no single description or definition of recovery because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination (National Mental Health Strategy, 2013).

Some characteristics of recovery commonly cited are that it is:

- a unique and personal journey
- a normal human process
- an ongoing experience and not the same as an end point or cure
- a journey rarely taken alone
- Nonlinear—frequently interspersed with both achievement and setbacks.

Recovery is a struggle for many people. The struggle might stem from severity of symptoms, side effects of medication, current or past trauma and pain, difficult socioeconomic circumstances, or the experience of using mental health services. Practitioners can also struggle as a result of the constraints of their work environment or when they sense a person's despair.

Personal recovery is defined within this framework as:

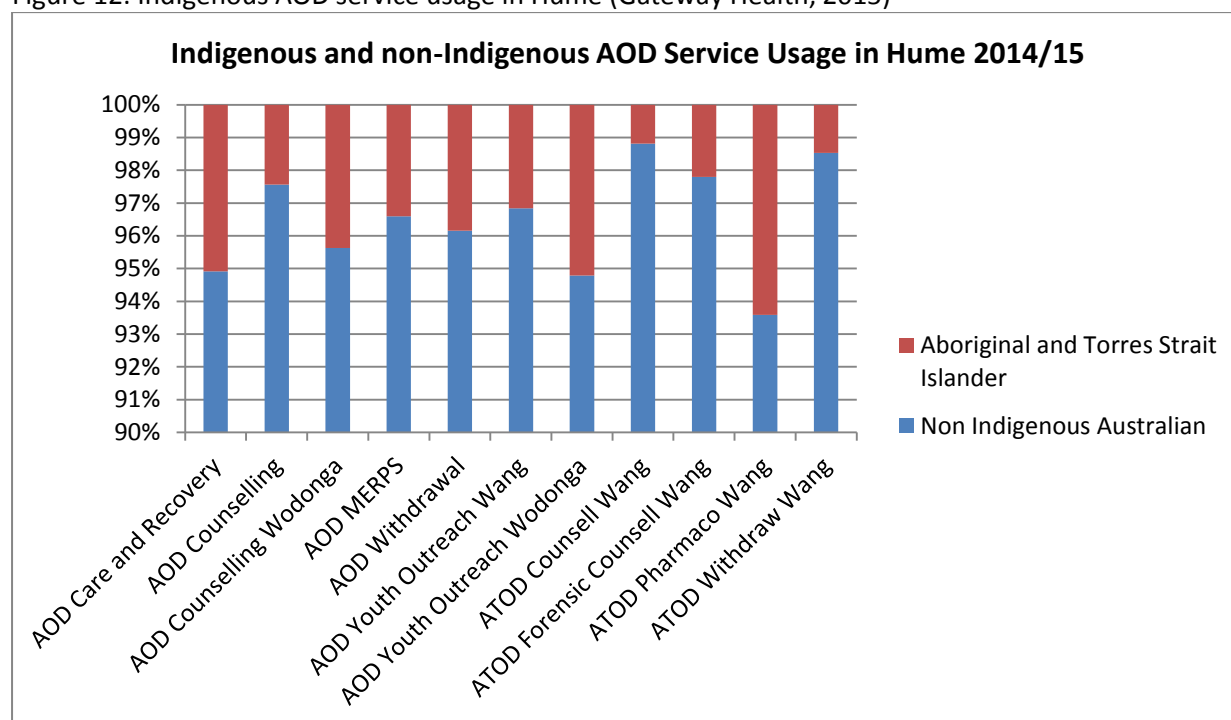
'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

Appendix E: Socio-demographic data for Hume

Regional Health Status Profile (DHHS)

Data for Hume is gathered from various sources. The data represent the demographic and statistical information available at the time of report development. Further in depth statistical information in mental health and AOD for Hume is available in Appendix A.

Figure 12: Indigenous AOD service usage in Hume (Gateway Health, 2015)



Regional Health Status Profile (DHHS, 2012)

Social engagement and crime

Hume has significantly higher rates of crime than the state measure across several domains. The figures for crime related issues reflect service provider concerns of service capacity to manage demand, and an often disjointed transition from forensic-based service provision to voluntary/recovery-oriented support.

Table 20: Rates of crime per 1,000 population, 2011-12, Hume LGAs

LGA	Family violence	Drug offences	Violent crimes	Total	% feeling safe during day	% feeling safe at night
Alpine (S)	5.1	2.8	5.4	36.1	99.2%	89.0%
Benalla (RC)	18.7	4.1	13.9	66.3	99.4%	71.6%
Indigo (S)	5.8	1.1	5.7	32.7	99.5%	93.4%
Mansfield (S)	3.2	2.8	6.7	49.9	97.8%	92.0%
Towong (S)	8.2	1.1	5.9	43.0	98.7%	95.4%
Wangaratta (RC)	14.0	6.9	13.5	73.3	99.4%	84.9%
Wodonga (RC)	14.8	3.0	11.3	83.4	98.7%	64.9%
Hume (total region-12 :GA's)	10.7	3.9	10.9	67.9	NA	NA
Victoria	9.1	3.4	9.8	70.6	97.0%	69.3%

Hume continues to engage well in community activities and reports feeling valued by society at a level above the state measure across all but one LGA. Data here reflects the reported culture among stakeholders that although demand for social and health services is high, communities are supportive of local initiatives and events which strive to address local needs.

Table 21: Social wellbeing and connectedness indicators, Hume LGAs

LGA	% households with broadband internet	% pop. Which volunteers	% who participate in citizenship engagement	% who attend community events	% who feel valued by society
Alpine (S)	65.2%	31.4%	63.4%	72.8%	61.1%
Benalla (RC)	61.7%	28.5%	64.4%	71.9%	51.6%
Indigo (S)	68.9%	33.2%	65.8%	73.0%	57.0%
Mansfield (S)	67.7%	31.8%	72.1%	74.5%	60.3%
Towong (S)	63.3%	40.5%	58.2%	76.1%	61.8%
Wangaratta (RC)	63.1%	26.9%	56.0%	71.8%	57.7%
Wodonga (RC)	69.9%	21.8%	53.0%	57.8%	55.7%
Hume (total region-12 LGA's)	65.6%	25.8%	NA	66.6%	53.9%
Victoria	72.6%	19.3%	50.5%	52.9%	52.4%

Health Behaviours

Hume scores poorly on a range of health condition indicators, with asthma, type 2 diabetes, overweight, obesity and poor dental health all reported for higher than Victorian measures. (DHHS, 2012).

Hume has a higher percentage of smokers than the Victorian measure across almost half of the catchment. Ex-smokers in Hume are higher than the Victorian measure across all LGA's, with non-smokers reported to be lower than the state measure across almost half the catchment area (DHHS, 2008).

Table 22: Smoking status, 2008, Hume LGAs

LGA	% current smoker	% ex-smoker	% non-smoker
Alpine (S)	19.7%	24.8%	55.3%
Benalla (RC)	17.4%	24.5%	58.0%
Indigo (S)	19.8%	25.3%	54.9%
Mansfield (S)	24.0%	29.7%	46.0%
Towong (S)	17.4%	23.8%	58.4%
Wangaratta (RC)	11.6%	24.0%	63.5%
Wodonga (RC)	20.2%	24.6%	54.9%
Hume (total region-12 LGA's)	21.0%	25.4%	53.3%
Victoria	19.1%	23.8%	56.8%

Blue = significantly below Victorian average; red = significantly above Victorian average.

Note that sum of percentages for current, ex- and non-smokers may not add to 100 per cent due to a proportion of 'don't know' or 'refused' responses.

Hume experiences significant issues with short term risk of alcohol consumption and a lack of people meeting guidelines for physical activity. Reflecting in stakeholder feedback, Hume experiences issues with dual diagnosis (Mental Health and Alcohol and Other Drugs) issues, and physical health issues, especially amongst disadvantaged groups, such as those experiencing mental illness.

Table 23: Alcohol and soft drink consumption, Hume LGAs

LGA	% with short term risk from alcohol consumption	% who purchased alcohol in last 7 days	% who drink soft drink every day
Alpine (S)	11.6%	43.3%	9.9%
Benalla (RC)	9.3%	31.7%	13.6%
Indigo (S)	19.7%	39.3%	11.2%
Mansfield (S)	17.1%	44.7%	7.2%
Towong (S)	11.6%	32.2%	9.9%
Wangaratta (RC)	10.5%	35.2%	11.9%
Wodonga (RC)	11.3%	40.8%	18.4%
Hume (total region-12 LGA's)	13.6%	35.4%	14.6%
Victoria	10.2%	36.3%	12.4%

Red = above Victorian average.

* Estimate has a relative standard error between 25 and 50 per cent and should be interpreted with caution.

Table 24: % not meeting guidelines for physical activity, males and females in Hume, 2008

LGA	Males	Females	Persons
Alpine (S)	31.0%	17.2%	26.1%
Benalla (RC)	27.4%	27.5%	28.2%
Indigo (S)	24.1%	21.9%	24.1%
Mansfield (S)	12.6%	24.4%	21.0%
Towong (S)	12.3%	27.7%	21.3%
Wangaratta (RC)	16.7%	25.6%	21.6%
Wodonga (RC)	27.8%	23.0%	25.4%
Victoria	27.5%	27.2%	27.4%

Blue = below Victorian average.

Hume has significant percentages of people considered obese, and also those reporting asthma and type 2 diabetes. Almost the entire Hume Catchment is considered obese on DHHS measures at 2008, with women faring slightly worse than men in this context.

Table 25: Obesity, males and females, 2008, Hume LGAs

LGA	% Males overweight or obese	% Females overweight or obese	% persons overweight or obese
Alpine (S)	62.1%	51.9%	56.0%
Benalla (RC)	63.7%	46.4%	53.9%
Indigo (S)	53.1%	47.9%	51.0%
Mansfield (S)	53.1%	37.3%	46.4%
Towong (S)	61.9%	50.3%	56.7%
Wangaratta (RC)	67.8%	48.4%	57.5%
Wodonga (RC)	62.8%	47.2%	55.2%
Hume (total region-12 LGA's)	63.8%	47.3%	55.4%
Victoria	57.2%	40.3%	48.6%

Red = above Victorian average.

Table 26: Asthma and diabetes incidence and admissions, Hume LGAs

LGA	% persons reporting asthma	% persons reporting type 2 diabetes	Asthma admission ratio	Diabetes admission ratio
Alpine (S)	7.3%	3.7%	0.27	0.58
Benalla (RC)	17.2%	5.5%	1.23	0.77
Indigo (S)	16.1%	3.3%	0.21	0.45
Mansfield (S)	8.0%	4.0%	0.84	0.78
Towong (S)	7.7%	4.6%	0.32	0.83
Wangaratta (RC)	12.5%	5.2%	0.86	0.81
Wodonga (RC)	10.7%	6.5%	0.57	1.17
Hume (total region-12 LGA's)	10.8%	4.5%	0.74	0.97
Victoria	10.7%	4.8%	1.00	1.00

Again higher than the Victorian state measure across almost the entire Hume Catchment is avoidable mortality. Cancer rates are higher than the state measure across every LGA, with circulatory system distress, respiratory system distress, road traffic injuries and suicide all measuring higher than Victorian measures for the majority of the Hume Catchment.

Table 27: Avoidable mortality by cause, 0 to 74 years, 2003-2007, Hume LGAs - Average annual death rate per 100,000 aged 0 to 74 years

LGA	Cancers	Circulatory systems distress	Respiratory systems distress	Road traffic injuries	Suicide/self-inflicted	All causes
Alpine (S)	107.9	45.5	12.5	18.5	NA	161.7
Benalla (RC)	106.4	61.4	19.3	10.1	11.6	164.1
Indigo (S)	117.4	62.8	12.4	21.4	7.3	180.8
Mansfield (S)	104.3	30.2	25.4	15.9	15.3	146.0
Towong (S)	108.8	57.1	NA	NA	NA	156.2
Wangaratta (RC)	114.3	44.2	13.4	11.8	15.7	163.4
Wodonga (RC)	111.0	60.4	15.2	9.8	12.7	183.5
Hume (total region-12 LGA's)	NA	NA	NA	NA	NA	NA
Victoria	103.0	49.2	12.5	6.2	11.0	158.2

Appendix F: Local Government Area profiles

Alpine Shire

The Alpine Shire is about 300 km north east of Melbourne and 70 km south of Albury/Wodonga. About 92% of the shire is public land including parts of the Alpine National Park and all of the Mount Buffalo National Park. Most of the freehold lands are alluvial flood plains along the Ovens, Kiewa and Buffalo Rivers together with the adjoining gentle slopes and hills. The Shire's economy is based on tourism, forestry and agriculture.

Population	Females	Males	Total	% Total LGA	% Total VIC
00-14	1,016	1,003	2,019	16.6%	18.3%
15-24	502	672	1,174	9.7%	13.6%
25-44	1,227	1,236	2,463	20.3%	29.2%
45-64	1,872	1,966	3,838	31.6%	24.5%
65-84	1,193	1,120	2,314	19.1%	12.4%
85+	201	123	324	2.7%	2.0%
Total	6,012	6,119	12,131	100.0%	100.0%

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	0.9%	41	0.8%
% born overseas	15.7%	33	27.7%
% born in non-English speaking country	9.1%	31	20.9%
Top 5 overseas countries of birth	(UK – 4.7%) (Italy – 3.3%) (New Zealand – 1.1%) (Germany – 1.1%) (Netherlands – 0.7%)		
% speaking LOTE at home	9.1%	32	24.2%
Top 5 languages spoken other than English	(Italian – 4.8%) (German – 0.9%) (Croatian – 0.3%) (Dutch – 0.3%) (Greek – 0.3%)		
% with low English proficiency	1.2%	32	4.0%
New settler arrivals per 100,000 pop.	313.2	43	1,415.1
Humanitarian arrivals as per % of new settlers	10.5%	15	7.2%
Community acceptance of diverse cultures	45.1%	43	50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	978	35	NA
Drug usage and possession offences per 1,000 population	3.0	44	3.8
Social networking used to organise time with family/friends	27.7%	51	35.1%
% believing there are good facilities in the LGA	77.7%	48	85.2%
Unemployment rate	3.8%	64	5.8%
Median household income	\$829	67	\$1,216
Mortgage stress	14.9%	12	11.4%
Unemployment rate	3.8%	64	5.8%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students	1,653	NA	869,698
% of 19 yr. olds completing yr. 12	83%	41	84.2%
% who do not complete yr. 12	60.3%	30	43.7%
% completing higher ed. qualification	29.7%	43	45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma	7.2%	76	10.9%
% reporting type 2 diabetes	5.0%	35	5.0%

% reporting high BP	22.7%	60	24.5%
% reporting heart disease	6.8%	43	6.9%
% reporting overweight	30.8%	58	32.5%
Poor dental health	4.7%	54	5.6%
% current smokers 18+	16.5%	35	15.7%
% at risk of short term harm from alcohol consumption	7.8%	60	9.1%
% who share a meal with family at least 5 days p/w	71.7%	32	66.3%
% who do not meet physical activity guidelines	24.3%	69	32.1%
% who sit for at least 7 hrs. p/d	20.3%	70	32.6%
Male life expectancy	78.8	49	80.3
Female life expectancy	84.8	18	84.4
% reporting a high/very high degree of psychological distress	11.5%	29	11.1%
% sleeping less than 7 hrs. per day	26.4%	64	31.5%
% with adequate work/life balance	44.6%	65	53.1%

Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services	3	NA	305
GP's per 1,000 pop.	1.6	7	1.2
Dental service sites per 1,000 pop.	0.1	67	0.2
Allied health service sites per 1,000 pop.	1.1	8	0.5
Pharmacies per 1,000 pop.	0.2	26	0.2
Number of schools	12	NA	2,238
% with private health insurance	39.6%	43	48.0%
GP attendances per 1,000 pop. - Male	4,065.8	49	4,633.4
GP attendances per 1,000 pop. - Female	5,560.0	50	6,257.0
GP attendances per 1000 pop. - Total	4,804.0	49	5,452.1
Drug and alcohol clients per 1,000 pop.	3.8	66	5.8
Registered Mental Health clients per 1,000 pop.	20.4	8	11.1

LGA of Benalla

Benalla Rural City Council is located approximately 180kms north east of Melbourne. The Council was formed in 2002 following the de-amalgamation of Delatite Shire Council into Benalla Rural City and Mansfield Shire Council. The Rural City has a diverse economic base with the main industries by employment being wholesale and retail trade (20%); manufacturing (19%); agriculture, forestry and fishing (12%); health, cultural and community services (10%); and education (8%).

Population	Females	Males	Total	% Total LGA	% Total VIC
00-14	1,125	1,225	2,350	17.1 %	18.3%
15-24	732	845	1,577	11.5%	13.6%
25-44	1,348	1,257	2,604	19.0%	29.2%
45-64	2,121	2,058	4,179	30.4%	24.5%
65-84	1,333	1,236	2,569	18.7%	12.4%
85+	285	167	451	3.3%	2.0%
Total	6,944	6,787	13,731	100.0%	100.0%

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	1.5%	19	0.8%
% born overseas	8.4%	61	27.7%
% born in non-English speaking country	4.3%	56	20.9%
Top 5 overseas countries of birth	(UK – 2.9%) (New Zealand – 0.8%) (Germany – 0.8%) (Netherlands – 0.5%) (India – 0.4%)		
% speaking LOTE at home	3.0%	61	24.2%
Top 5 languages spoken other than English	(Italian – 0.3%) (German – 0.4%) (Mandarin – 0.2%) (Hindi – 0.2%) (Dutch – 0.1%)		
% with low English proficiency	0.4%	56	4.0%
New settler arrivals per 100,000 pop.	276.8	52	1,415.1

Humanitarian arrivals as per % of new settlers	2.6%	31	7.2%
Community acceptance of diverse cultures	36.8%	69	50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	957	16	NA
Drug usage and possession offences per 1,000 population	5.0	15	3.8
Social networking used to organise time with family/friends	28.8%	50	35.1%
% believing there are good facilities in the LGA	85.9%	23	85.2%
Unemployment rate	5.6%	29	5.8%
Median household income	\$827	69	\$1,216
Mortgage stress	12.2%	31	11.4%
Unemployment rate	5.6%	29	5.8%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students	1,945	NA	869,698
% of 19 yr. olds completing yr. 12	86.7%	29	84.2%
% who did not complete yr. 12	63.7%	22	43.7%
% completing higher ed. qualification	26.7%	58	45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma	11.6%	35	10.9%
% reporting type 2 diabetes	5.1%	30	5.0%
% reporting high BP	26.0%	34	24.5%
% reporting heart disease	6.3%	57	6.9%
% reporting overweight	29.9%	65	32.5%
Poor dental health	5.0%	53	5.6%
% current smokers 18+	17.8%	22	15.7%
% at risk of short term harm from alcohol consumption	14.0%	15	9.1%
% who share a meal with family at least 5 days p/w	73.9%	18	66.3%
% who do not meet physical activity guidelines	28.3%	55	32.1%
% who sit for at least 7 hrs. p/d	21.6%	61	32.6%
Male life expectancy	78.5	52	80.3
Female life expectancy	83.2	60	84.4
% reporting a high/very high degree of psychological distress	4.8%	78	11.1%
% sleeping less than 7 hrs. per day	31.7%	32	31.5%
% with adequate work/life balance	42.3%	72	53.1%

Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services	1	NA	305
GP's per 1,000 pop.	1.0	50	1.2
Dental service sites per 1,000 pop.	0.2	26	0.2
Allied health service sites per 1,000 pop.	1.0	10	0.5
Pharmacies per 1,000 pop.	0.2	33	0.2
Number of schools	9	NA	2,238
% with private health insurance	39.3%	44	48.0%
GP attendances per 1,000 pop. - Male	3,779.0	64	4,633.4
GP attendances per 1,000 pop. - Female	5,324.6	63	6,257.0
GP attendances per 1000 pop. - Total	4,561.1	65	5,452.1
Drug and alcohol clients per 1,000 pop.	8.5	19	5.8
Registered Mental Health clients per 1,000 pop.	24.3	4	11.1

Indigo Shire

Indigo Shire is 270 km north-east of Melbourne, bordering the Murray River, Australian Alps and the municipalities of Wodonga, Wangaratta, Towong, Alpine and Moira. It is rural in nature with supporting services in small towns. The shire's economy is based on value-adding to local primary produce of the region, especially milk, cereals and grapes, and providing services to people, including tourism. Tourism is also important the Rutherglen wine producing area and the historic townships of Beechworth, Chiltern and Yackandandah attract thousands of visitors. The main industries include flour mill and cereal food manufacturing, agriculture, other food manufacturing, beverage and malt manufacturing. Residents also commute to Wodonga and Wangaratta for employment (Hume profile, DHHS, 2012).

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	0.9%		0.8%
% born overseas	NA		27.7%
% born in non-English speaking country	NA		20.9%
Top 5 overseas countries of birth	NA		
% speaking LOTE at home	NA		24.2%
Top 5 languages spoken other than English	NA		
% with low English proficiency	NA		4.0%
New settler arrivals per 100,000 pop.	NA		1,415.1
Humanitarian arrivals as per % of new settlers	NA		7.2%
Community acceptance of diverse cultures	NA		50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	1016.2	56	NA
Drug usage and possession offences per 1,000 population			3.8
Social networking used to organise time with family/friends			35.1%
% believing there are good facilities in the LGA			85.2%
Unemployment rate			5.8%
Median household income			\$1,216
Mortgage stress			11.4%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students			869,698
% of 19 yr. olds completing yr. 12			84.2%
% who did not complete yr. 12			43.7%
% completing higher ed. qualification			45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma			10.9%
% reporting type 2 diabetes			5.0%
% reporting high BP			24.5%
% reporting heart disease			6.9%
% reporting overweight			32.5%
Poor dental health			5.6%
% current smokers 18+			15.7%
% at risk of short term harm from alcohol consumption			9.1%
% who share a meal with family at least 5 days p/w			66.3%
% who do not meet physical activity guidelines			32.1%
% who sit for at least 7 hrs. p/d			32.6%
Male life expectancy			80.3
Female life expectancy			84.4
% reporting a high/very high degree of psychological distress			11.1%
% sleeping less than 7 hrs. per day			31.5%

% with adequate work/life balance			53.1%
Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services			305
GP's per 1,000 pop.			1.2
Dental service sites per 1,000 pop.			0.2
Allied health service sites per 1,000 pop.			0.5
Pharmacies per 1,000 pop.			0.2
Number of schools			2,238
% with private health insurance			48.0%
GP attendances per 1,000 pop. - Male			4,633.4
GP attendances per 1,000 pop. - Female			6,257.0
GP attendances per 1000 pop. - Total			5,452.1
Drug and alcohol clients per 1,000 pop.			5.8
Registered Mental Health clients per 1,000 pop.			11.1

Mansfield shire

Mansfield Shire is located about 180 kms north east of Melbourne. The main town is Mansfield. The surrounding smaller settlements only have small numbers of permanent residents but swell considerably during holidays. Natural attractions include Mount Buller, Mount Stirling, parts of Lake Eildon and Alpine National Parks and the Great Dividing Range. The Alpine Resort areas of Mount Buller and Mount Stirling are wholly surrounded but excluded from the municipal district. A significant part of the municipality is Crown land. The main industries are tourism, farming (seed, sheep and cattle), light industry, light manufacturing, related timber industries and retail farming.

Population	Females	Males	Total	% Total LGA	% Total VIC
00-14	729	760	1,490	18.5 %	18.3%
15-24	410	533	942	11.7%	13.6%
25-44	847	783	1,631	20.2%	29.2%
45-64	1,224	1,244	2,469	30.6%	24.5%
65-84	639	731	1,370	17%	12.4%
85+	114	51	166	2.1%	2.0%
Total	3,964	4,103	8,067	100.0%	100.0%

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	0.8%	46	0.8%
% born overseas	12.3%	42	27.7%
% born in non-English speaking country	5.5%	44	20.9%
Top 5 overseas countries of birth	(UK – 4.8%) (New Zealand – 1.2%) (Germany – 1.3%) (Netherlands – 0.4%) (U.S. – 0.3%)		
% speaking LOTE at home	4.3%	47	24.2%
Top 5 languages spoken other than English	(German – 1.3%) (Mandarin – 0.3%) (Japanese – 0.2%) (Spanish – 0.2%) (French – 0.2%)		
% with low English proficiency	0.3%	62	4.0%
New settler arrivals per 100,000 pop.	260.3	56	1,415.1
Humanitarian arrivals as per % of new settlers	0.0%	49	7.2%
Community acceptance of diverse cultures	47.1%	34	50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	1012	54	NA
Drug usage and possession offences per 1,000 population	2.0	61	3.8
Social networking used to organise time with family/friends	23.3%	72	35.1%
% believing there are good facilities in the LGA	75.6%	55	85.2%
Unemployment rate	3.6%	70	5.8%
Median household income	\$891	57	\$1,216
Mortgage stress	16.0%	4	11.4%
Unemployment rate	3.6%	70	5.8%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students	1,091	NA	869,698
% of 19 yr. olds completing yr. 12	79.0%	58	84.2%
% who did not complete yr. 12	56.5%	41	43.7%
% completing higher ed. qualification	28.9%	46	45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma	12.4%	28	10.9%
% reporting type 2 diabetes	4.5%	45	5.0%
% reporting high BP	23.7%	52	24.5%
% reporting heart disease	8.0%	19	6.9%

% reporting overweight	30.2%	63	32.5%
Poor dental health	5.4%	45	5.6%
% current smokers 18+	16.2%	37	15.7%
% at risk of short term harm from alcohol consumption	10.6%	34	9.1%
% who share a meal with family at least 5 days p/w	77.7%	6	66.3%
% who do not meet physical activity guidelines	23.5%	72	32.1%
% who sit for at least 7 hrs. p/d	19.5%	72	32.6%
Male life expectancy	78.2	57	80.3
Female life expectancy	84.0	35	84.4
% reporting a high/very high degree of psychological distress	6.4%	74	11.1%
% sleeping less than 7 hrs. per day	22.5%	76	31.5%
% with adequate work/life balance	49.4%	43	53.1%

Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services	1	NA	305
GP's per 1,000 pop.	1.6	9	1.2
Dental service sites per 1,000 pop.	0.1	54	0.2
Allied health service sites per 1,000 pop.	1.5	4	0.5
Pharmacies per 1,000 pop.	0.2	25	0.2
Number of schools	7	NA	2,238
% with private health insurance	41.6%	34	48.0%
GP attendances per 1,000 pop. - Male	3,601.4	68	4,633.4
GP attendances per 1,000 pop. - Female	4,931.1	69	6,257.0
GP attendances per 1000 pop. - Total	4,265.7	69	5,452.1
Drug and alcohol clients per 1,000 pop.	4.1	61	5.8
Registered Mental Health clients per 1,000 pop.	13.6	30	11.1

Towong Shire

Towong Shire is a pristine rural and relatively unpopulated area. The economy of the shire is based around primary production, particularly agriculture and forestry. There are many small towns in the municipality, such as Corryong and Tallangatta that service these industries.

Population	Females	Males	Total	% Total LGA	% Total VIC
00-14	502	556	1,058	17.8 %	18.3%
15-24	297	280	577	9.7%	13.6%
25-44	574	517	1,091	18.4%	29.2%
45-64	890	1,016	1,905	32.1%	24.5%
65-84	584	582	1,130	19%	12.4%
85+	113	67	181	3.0%	2.0%
Total	2,924	3,017	5,941	100.0%	100.0%

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	1.7%	14	0.8%
% born overseas	7.9%	66	27.7%
% born in non-English speaking country	3.3%	67	20.9%
Top 5 overseas countries of birth	(UK – 3.4%) (New Zealand – 0.7%) (Germany – 0.7%) (Netherlands – 0.5%) (South Africa – 0.2%)		
% speaking LOTE at home	1.9%	76	24.2%
Top 5 languages spoken other than English	(German – 0.5%) (Italian – 0.2%) (Spanish – 0.1%) (Cantonese – 0.1%) (Dutch – 0.1%)		
% with low English proficiency	0.2%	75	4.0%
New settler arrivals per 100,000 pop.	151.5	74	1,415.1
Humanitarian arrivals as per % of new settlers	0.0%	49	7.2%
Community acceptance of diverse cultures	40.8%	58	50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	996	42	NA
Drug usage and possession offences per 1,000 population	1.0	73	3.8
Social networking used to organise time with family/friends	24.5%	67	35.1%
% believing there are good facilities & services in the LGA	64.2%	71	85.2%
Unemployment rate	3.9%	62	5.8%
Median household income	\$850	62	\$1,216
Mortgage stress	13.2%	21	11.4%
Unemployment rate	3.9%	62	5.8%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students	1,101	NA	869,698
% of 19 yr. olds completing yr. 12	77.7%	61	84.2%
% who did not complete yr. 12	66.1%	13	43.7%
% completed higher ed. qualification	24.1%	73	45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma	10.3%	49	10.9%
% reporting type 2 diabetes	5.1%	31	5.0%
% reporting high BP	31.0%	6	24.5%
% reporting heart disease	5.5%	70	6.9%
% reporting overweight	37.4%	9	32.5%
Poor dental health	5.1%	50	5.6%
% current smokers 18+	14.3%	56	15.7%
% at risk of short term harm from alcohol consumption	9.4%	46	9.1%
% who share a meal with family at least 5 days p/w	70.7%	38	66.3%
% who do not meet physical activity guidelines	21.5%	77	32.1%

% who sit for at least 7 hrs. p/d	16.2%	77	32.6%
Male life expectancy	78.6	47	80.3
Female life expectancy	83.4	55	84.4
% reporting a high/very high degree of psychological distress	11.3%	31	11.1%
% sleeping less than 7 hrs. per day	29.6%	45	31.5%
% with adequate work/life balance	52.0%	30	53.1%

Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services	2	NA	305
GP's per 1,000 pop.	0.9	66	1.2
Dental service sites per 1,000 pop.	0.0	73	0.2
Allied health service sites per 1,000 pop.	0.7	33	0.5
Pharmacies per 1,000 pop.	0.5	6	0.2
Number of schools	11	NA	2,238
% with private health insurance	41.2%	38	48.0%
GP attendances per 1,000 pop. - Male	3,187.3	79	4,633.4
GP attendances per 1,000 pop. - Female	4,547.9	77	6,257.0
GP attendances per 1000 pop. - Total	3,857.6	78	5,452.1
Drug and alcohol clients per 1,000 pop.	3.0	71	5.8
Registered Mental Health clients per 1,000 pop.	12.0	46	11.1

LGA of Wangaratta

Wangaratta is a manufacturing and commercial centre in north-east Victoria. The rural city's traditional strengths of clothing and textile production have been supplemented in recent years by the manufacturing of wine and wood products.

Wangaratta is the municipality's largest urban centre, with approximately 18,000 residents.

The region prides itself on its wineries, gourmet food, spectacular scenery, historic legends, cultural heritage and access to numerous State and National Parks. The outdoors is also a focus for popular leisure activities in the region.

Population	Females	Males	Total	% Total LGA	% Total VIC
00-14	2,461	2,601	5,062	18.6 %	18.3%
15-24	1,578	1,509	3,087	11.3%	13.6%
25-44	3,070	3,091	6,161	22.6%	29.2%
45-64	3,867	3,728	7,595	27.9%	24.5%
65-84	2,425	2,137	4,562	16.7%	12.4%
85+	506	263	769	2.8%	2.0%
Total	13,907	13,329	27,236	100.0%	100.0%

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	1.1%	29	0.8%
% born overseas	8.4%	62	27.7%
% born in non-English speaking country	4.8%	49	20.9%
Top 5 overseas countries of birth	(UK – 2.4%) (Italy – 1.5%) (New Zealand – 0.7%) (Germany – 0.6%) (Netherlands – 0.5%)		
% speaking LOTE at home	4.8%	42	24.2%
Top 5 languages spoken other than English	(Italian – 2.5%) (German – 0.3%) (Greek – 0.2%) (Dutch – 0.1%) (Tagalog – 0.1%)		
% with low English proficiency	0.7%	38	4.0%
New settler arrivals per 100,000 pop.	246.0	58	1,415.1
Humanitarian arrivals as per % of new settlers	0.0%	49	7.2%
Community acceptance of diverse cultures	46.7%	37	50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	981	30	NA
Drug usage and possession offences per 1,000 population	6.5	7	3.8
Social networking used to organise time with family/friends	25.5%	64	35.1%
% believing there are good facilities & services in the LGA	85.6%	26	85.2%
Unemployment rate	4.6%	49	5.8%
Median household income	\$913	52	\$1,216
Mortgage stress	12.3%	29	11.4%
Unemployment rate	4.6%	49	5.8%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students	4,942	NA	869,698
% of 19 yr. olds completing yr. 12	87.1%	27	84.2%
% who did not complete yr. 12	60.9%	28	43.7%
% completed higher ed. qualification	29.6%	44	45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma	12.7%	24	10.9%
% reporting type 2 diabetes	4.2%	50	5.0%
% reporting high BP	26.7%	25	24.5%

% reporting heart disease	6.4%	56	6.9%
% reporting overweight	36.5%	15	32.5%
Poor dental health	4.3%	62	5.6%
% current smokers 18+	13.0%	44	15.7%
% at risk of short term harm from alcohol consumption	16.3%	8	9.1%
% who share a meal with family at least 5 days p/w	72.6%	28	66.3%
% who do not meet physical activity guidelines	27.9%	58	32.1%
% who sit for at least 7 hrs. p/d	24.7%	45	32.6%
Male life expectancy	79.2	34	80.3
Female life expectancy	83.0	63	84.4
% reporting a high/very high degree of psychological distress	9.3%	70	11.1%
% sleeping less than 7 hrs. per day	25.5%	70	31.5%
% with adequate work/life balance	46.6%	57	53.1%

Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services	2	NA	305
GP's per 1,000 pop.	1.2	29	1.2
Dental service sites per 1,000 pop.	0.2	25	0.2
Allied health service sites per 1,000 pop.	0.9	13	0.5
Pharmacies per 1,000 pop.	0.2	50	0.2
Number of schools	24	NA	2,238
% with private health insurance	40.8%	40	48.0%
GP attendances per 1,000 pop. - Male	3,204.9	78	4,633.4
GP attendances per 1,000 pop. - Female	4,531.6	78	6,257.0
GP attendances per 1000 pop. - Total	3,8576.6	77	5,452.1
Drug and alcohol clients per 1,000 pop.	7.8	22	5.8
Registered Mental Health clients per 1,000 pop.	19.7	9	11.1

LGA of Wodonga

Wodonga is the twin city to Albury in New South Wales. The cities together form a major growth centre which services a wide rural hinterland in both Victoria and New South Wales. Wodonga's major residential growth complements Albury's retail and commercial focus. The main industry is food manufacturing, and together with retail trade, these two areas are the region's largest employers. The area also boasts an enviable climate of hot, dry summers, perfect autumns and springs and cool winters.

Population	Females	Males	Total	% Total LGA	% Total VIC
00-14	3,858	3,944	7,802	21.3%	18.3%
15-24	2,585	3,124	5,709	15.6%	13.6%
25-44	4,970	4,882	9,852	26.9%	29.2%
45-64	4,381	4,304	8,684	23.7%	24.5%
65-84	2,168	1,830	3,998	10.9%	12.4%
85+	363	217	580	1.6%	2.0%
Total	18,325	18,301	36,626	100.0%	100.0%

Diversity	LGA Measure	Rank among LGA's	VIC Measure
Aboriginal and Torres Strait Islander population	2.4%	7	0.8%
% born overseas	10.0%	53	27.7%
% born in non-English speaking country	6.0%	41	20.9%
Top 5 overseas countries of birth	(UK – 2.6%) (New Zealand – 0.9%) (Germany – 0.9%) (Netherlands – 0.4%) (Philippines – 0.4%)		
% speaking LOTE at home	4.9 %	41	24.2%
Top 5 languages spoken other than English	(Italian – 0.4%) (German – 0.5%) (Croatian – 0.4%) (Other Indo Aryan Languages – 0.4%) (Serbian – 0.2%)		
% with low English proficiency	0.6%	41	4.0%
New settler arrivals per 100,000 pop.	464.2	33	1,415.1
Humanitarian arrivals as per % of new settlers	18.8%	9	7.2%
Community acceptance of diverse cultures	45.4%	40	50.6%

Social engagement, crime and socio-economic factors	LGA Measure	Rank among LGA's	VIC measure
IRSED	975	26	NA
Drug usage and possession offences per 1,000 population	5.1	13	3.8
Social networking used to organise time with family/friends	36.5%	17	35.1%
% believing there are good facilities & services in the LGA	91.3%	12	85.2%
Unemployment rate	5.8%	26	5.8%
Median household income	\$1,075	35	\$1,216
Mortgage stress	9.3%	67	11.4%
Unemployment rate	5.8%	26	5.8%
Unemployment rate	5.8%	26	5.8%

Education	LGA measure	Rank among LGA's	VIC measure
FTE Students	7,158	NA	869,698
% of 19 yr. olds completing yr. 12	88.2%	22	84.2%
% who did not complete yr. 12	58.3%	35	43.7%
% completed higher ed. qualification	25.8%	58	45.7%

Health and wellbeing	LGA measure	Rank among LGA's	VIC measure
% reporting asthma	9.2%	69	10.9%
% reporting type 2 diabetes	6.4%	8	5.0%
% reporting high BP	27.5%	15	24.5%
% reporting heart disease	9.2%	5	6.9%
% reporting overweight	38.8%	5	32.5%

Poor dental health	6.3%	30	5.6%
% current smokers 18+	15.6%	43	15.7%
% at risk of short term harm from alcohol consumption	9.7%	40	9.1%
% who share a meal with family at least 5 days p/w	71.5%	34	66.3%
% who do not meet physical activity guidelines	31.7%	31	32.1%
% who sit for at least 7 hrs. p/d	29.6%	29	32.6%
Male life expectancy	80.3	16	80.3
Female life expectancy	84.4	24	84.4
% reporting a high/very high degree of psychological distress	9.5%	45	11.1%
% sleeping less than 7 hrs. per day	30.8%	34	31.5%
% with adequate work/life balance	55.5%	19	53.1%

Services and access	LGA measure	Rank among LGA's	VIC measure
Number of hospitals/health services	2	NA	305
GP's per 1,000 pop.	1.5	12	1.2
Dental service sites per 1,000 pop.	0.2	27	0.2
Allied health service sites per 1,000 pop.	0.7	39	0.5
Pharmacies per 1,000 pop.	0.1	68	0.2
Number of schools	17	NA	2,238
% with private health insurance	36.1%	57	48.0%
GP attendances per 1,000 pop. - Male	3,563.4	70	4,633.4
GP attendances per 1,000 pop. - Female	5,320.3	64	6,257.0
GP attendances per 1000 pop. - Total	4,442.6	66	5,452.1
Drug and alcohol clients per 1,000 pop.	9.9	14	5.8
Registered Mental Health clients per 1,000 pop.	18.9	10	11.1

Appendix G: Literature review

The Hume AOD Catchment-based planning function included a comprehensive review of relevant literature from International, national, state and local health and planning resources. The following section provides key points identified from the literature.

Key policy and Reports

The following key policy and strategic documents highlight the emphasis placed on AOD service delivery and intervention initiatives at a global, national, state and local level. The priorities outlined in the key documents form part of the evidence base for the strategic plan in Hume.

Table 28: International AOD Priorities

United Nations Office on Drugs and Crime and World Health Organisation (2008)
Preconditions for evidence-based and responsive alcohol and drug treatment systems:
1. Availability and accessibility of drug dependence treatment
2. Screening, assessment, diagnosis and treatment planning
3. Evidence-informed drug dependence treatment
4. Drug dependence treatment, human rights and patient dignity
5. Targeting special subgroups and conditions
6. Addiction treatment and the criminal justice system
7. Community involvement, participation and patient orientation
8. Clinical governance of drug dependence treatment services
9. Treatment systems: Policy development, strategic planning and coordination of services

Table 29: Australian Government AOD Strategy

National Drug Strategy 2010-2015 (2011)
Three key pillars: supply reduction, demand reduction and harm reduction. These pillars are underpinned by commitments to:
<ul style="list-style-type: none">• Partnerships across sectors• Consumer participation in governance• Building the evidence base, evidence-informed practice and innovation• Monitoring performance against the strategy and its objectives• Developing a skilled workforce that can deliver on the strategy
Draft National Drug Strategy 2016 - 2025
Three key pillars: supply reduction, demand reduction and harm reduction. These pillars are underpinned by the following priorities:
<ul style="list-style-type: none">• Increase participatory processes that facilitate community engagement and involvement in identifying and responding to the key national alcohol, tobacco and other drug issues.• Improve national coordination for identifying and addressing drug use and its harms, sharing jurisdictional information on innovative approaches, and developing effective responses.• Develop and share data and research that support evidence informed approaches.• Develop new and innovative responses to prevent uptake, delay the first use and reduce harmful levels of alcohol, tobacco and other drug use.• Develop responses that restrict or regulate the availability of alcohol, tobacco and other drugs.• Reduce the adverse health, social and economic consequences associated with alcohol, tobacco and other drug use by enhancing harm reduction approaches.

Table 30: Taking Action to Tackle Suicide

Australian Government - Taking Action To Tackle Suicide (TATS) 2014
1. More frontline services and support for those at greatest risk of suicide
2. More services to prevent suicide and boost crisis intervention services
3. Target men who are greatest of suicide
4. Programs to promote good mental health and resilience in young people

Table 31: National Suicide Prevention Strategy

Australian National Suicide Prevention Strategy	
Objectives	
<ul style="list-style-type: none"> • Build individual resilience and the capacity for self-help • Improve community strength, resilience and capability in suicide prevention • Providing targeted suicide prevention activities • Implement standards and quality in suicide prevention • Take a coordinated approach to suicide prevention • Improve the evidence base and understanding of prevention 	

Table 32: Koori Alcohol Action Plan

Australian Government - The Koori Alcohol Action Plan (KAAP) 2010-2020	
KAAP Actions:	Aim
Theme 1 – Strengthening communities	To reduce the harms associated with alcohol use by building on and developing partnerships that strengthen Aboriginal communities.
Theme 2 – Responsible access to alcohol	To address access-to-alcohol issues, focusing on young people, with the aim of preventing and reducing alcohol-related harms.
Theme 3 - Improved information and understanding	To improve the provision of information and understanding regarding alcohol and associated harms to encourage safer consumption and patterns of use.
Theme 4 - Improving responses and services	To improve responses and services with a focus on proactive and partnership approaches.

Table 33: Victorian AOD Strategies

Reducing the Alcohol and Drug Toll – Victoria's plan 2013 - 2017
Victorias 15 point plan; Alcohol <ol style="list-style-type: none"> 1. Reducing alcohol-related violence, antisocial behaviour and drink-driving 2. Effective liquor regulation 3. Changing drinking culture 4. Better health promotion in education 5. Better, earlier healthcare for alcohol problems Pharmaceutical Drugs <ol style="list-style-type: none"> 6. Better controls and evidence on misused pharmaceutical drugs 7. Improved clinical, prescribing and dispensing practices Illegal Drugs <ol style="list-style-type: none"> 8. Strong laws to protect the community from drugs and drug trafficking 9. Better referral of drug users to education and treatment 10. Improved harm-reduction services and targeted prevention Care, Treatment and Recovery <ol style="list-style-type: none"> 11. New directions in treatment services 12. Better person-centred care through social services, especially for vulnerable families 13. Community-based action on social factors driving substance misuse 14. Promoting recovery and reducing stigma in the community Leadership <ol style="list-style-type: none"> 15. Leadership to reduce the toll
Proposed Victorian Alcohol and Drug Treatment Principles - 2012 Principles guiding the design of alcohol and drug systems, programs and interventions, and <ol style="list-style-type: none"> 1. The nature of addiction 2. Treatment accessibility 3. Continuity of care 4. Harm minimisation approach 5. Individualised and holistic care 6. Evidence-based practice 7. Integrated care 8. Recovery focussed 9. Client, carer and family participation 10. Workforce

Victorias Ice Action Plan

- Helping Families
- Supporting Frontline Workers
- More support where it's needed
- Prevention is better than cure
- Reducing supply on our streets
- Safer, stroger communities

Table 34: Hume and Goulburn Valley Alliance for Mental Health and Housing Priorities

Hume Mental Health Priorities
Hume and Goulburn Valley Alliance for Mental Health and Housing priorities - set 2013, 3 year strategic plan
<ul style="list-style-type: none">• Improving health outcomes for our consumers• Planning Services and Resources for our region based on identified population needs• Managing and maintaining partnerships in the Alliance• Advocating on key workforce issues and needs

Table 35: Hume Local Government Area Health Planning Priorities

Alpine	<ul style="list-style-type: none"> • Support the health wellbeing of communities • Improve the resilience of communities • Ensure appropriate services and programs for early years, youth and families • Support positive living and ageing. 			
Benalla	<ul style="list-style-type: none"> • Implement the Benalla Rural City Youth Strategy to ensure a whole of Council and community approach to youth related issues. • Develop plans and strategies that target specific health and wellbeing needs within our community. • Support a range of existing programs and initiatives throughout the Benalla Rural City aimed at promoting good nutritional practices and encouraging people to adopt healthier diets. • Pursue the State Government's Integrated Health Promotion priorities: Healthy Eating and Mental Health and Wellbeing in partnership with Benalla Health and the Central Hume Primary Care Partnership. • Pursue opportunities to enhance access to services and facilities. • Connect and engage with Aboriginal and Torres Strait Islander people in our community • Collaborate and develop partnerships with the education sector to facilitate community health and wellbeing and economic development outcomes. 			
Indigo	<ul style="list-style-type: none"> • Increase transport options • Enhance the feeling of community connectedness • Value cultural diversity including ethnicity and lifestyles • Build social networks 	<ul style="list-style-type: none"> • Promote regular exercise • Encourage healthy eating • Improve oral health • Promote good mental health 	<ul style="list-style-type: none"> • Address smoking as a major contributor to poor health • Plan for our ageing population • Improve access to health services 	<ul style="list-style-type: none"> • Support services for children and families • Recruit and retain health professionals • Create employment opportunities for youth
Mansfield	<ul style="list-style-type: none"> • Strong and effective partnerships and networks • Ensure that health planning and service delivery is reflective of current • health and community data • Continue to collaboratively plan and deliver integrated, high quality 	<ul style="list-style-type: none"> • community facilities that meet a range of health, cultural, education and • community needs • Increase the available support, services and opportunities to participate in • community life for people who are disadvantaged 	<ul style="list-style-type: none"> • Identify and focus initiatives to areas of high disadvantage • Promote healthy living and lifestyle choices • Promote and support a safe and inclusive community 	<ul style="list-style-type: none"> • Plan for the needs of an ageing community • To enhance mental health and wellbeing, provide opportunities for people to • be involved, connected and engaged
Towong	<ul style="list-style-type: none"> • To improve community health and wellbeing • To strengthen community resilience and connectedness • To promote, improve and protect the wellbeing of older people • To address the needs of young people and young families 			
Wangaratta	<ul style="list-style-type: none"> • Recognising and valuing diversity within our community; • Acknowledging that all residents have the right to participate in community life with its attendant rights and responsibilities; • Ensuring that no groups are treated less favourably; • Recognising that every person has the right to live life without discrimination; and • Undertaking actions that are responsive to the aspirations of its community and contribute to the wellbeing of residents 			

Wodonga	<ul style="list-style-type: none"> • Effective, strategic partnerships • Accessible and equitable services and resources • Strong and resilient individuals, families and communities • A safe and protected community • Healthy lifestyles • Economic resilience
	<ul style="list-style-type: none"> • People; Providing a great lifestyle - Our people will enjoy an excellent quality of life • City: Planning for growth and development - Wodonga is a prosperous regional city, alive with possibilities and thriving on growth and investment • Future: Managing our business to support our community - We are innovative, responsive and responsible in the way we conduct business.

Figure 13: Existing Hume Catchment Health and wellbeing Plans

Below are the existing health planning functions in Hume (Hume Health Planning Toolkit, 2015). The Hume AOD Catchment Planning Function seeks to align with and compliment, rather than duplicate, the existing regional initiatives.

Hume Region Health and Aged care Plan	Chronic Care Strategy	Closing the Health Gap Plan	Integrated Aged care Plan	Integrated Health Promotion Strategy	Integrated Oral Health Plan	Sub-acute Service Development and Implementation Plan
<p>Increase the systems financial sustainability and productivity</p> <p>Improve prevention, early intervention and primary care response</p> <p>Develop sub-regional plans and approaches</p> <p>Respond to ageing population</p> <p>Respond to disadvantaged groups</p> <p>Implement continuous improvement and innovation</p>	<p>Adopt the National Chronic Disease Strategy and the service improvement frameworks in all local services, to support consistent evidence-based practice</p> <p>Develop agreed service delivery frameworks, roles and pathways for care across the continuum.</p> <p>Embed self-management approaches in all aspects of care</p> <p>Provide clear and consistent information people with chronic conditions and their carers</p> <p>Maximise information technology approaches</p> <p>Align workforce development and capacity across all strategic priorities</p> <p>Explore opportunities for new and innovative service models and/or funding and reporting mechanisms to support improved care</p>	<p>Improve the client journey from hospitals to primary care services</p> <p>Increase cultural competency of the health system</p> <p>Identify needs and develop service models for Aboriginal communities living in Central Hume and Lower Hume</p> <p>Improve the services and programs for young Aboriginal women</p> <p>Reduce the rate of tobacco smoking in Aboriginal communities</p>	<p>Promote effective collaboration between aged care providers through further development of Hume region's partnership approaches, planning structures and processes</p> <p>Improve mechanisms to provide and share information among providers and ensure service information is accessible for consumers</p> <p>Tate innovative approaches to building and maintaining capacity and capability in the aged care workforce to meet current demand and projected demand</p> <p>Promote innovative and flexible service models to enable service providers to better respond to the needs of older people and their carers</p> <p>Promote health and wellbeing for older people</p>	<p>Limit the number of health promotion priorities addressed at the agency and sub-regional (currently Primary Care Partnership) level to allow consolidation of effort and sharing of resources and knowledge</p> <p>Support and integrated approach to planning and evaluation at regional and sub-regional levels</p> <p>Concentrate IHP activity to focus mainly on the identified state-wide health promotion priorities</p> <p>Support and increased focus on evidence-based or evidence informing practice</p> <p>Support an increased focus on vulnerable groups and individuals within the community</p>	<p>The integrated Oral Health Plan focuses on the following priority action areas:</p> <p>Development and leadership</p> <p>Access</p> <p>Priority Groups</p> <p>Workforce</p> <p>Oral health students</p> <p>Service coordination</p> <p>Oral health promotion</p> <p>Infrastructure</p>	<p>Analyses and maps the current sub-acute services profile, including service levels, models of care and systems pathways</p> <p>Provides forecast or expected demand for sub-acute services</p> <p>Identifies the key issues for consideration in enhancing sub-acute services</p> <p>Identified preferred options for future development</p>

References

- Addiction info. (2015). Stages of change model. Retrieved from <http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html>
- Alpine shire council. (2015). Health and wellbeing planning priorities. Retrieved from <http://www.alpineshire.vic.gov.au/page/HomePage.aspx>
- Australian Department of Health (2014). National suicide prevention strategy. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-nsps#obj>
- Australian Department of Health (2015). Recovery across the mental health service spectrum. Retrieved from <http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-7>
- Australian Department of Health (2015). NDIS in Victoria. Retrieved from <http://www.ndis.gov.au/about-us/our-sites/vic>
- Australian Department of Health (2009). 4th national mental health plan. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09>
- Australian Government, (2014) National review of mental health programs and services. *National Mental Health Commission*. Retrieved from <http://www.mentalhealthcommission.gov.au/our-reports.aspx>
- Australian Government, (2013). National mental health recovery framework; guide for practitioners and providers. Retrieved from [https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/\\$File/recovgde.pdf](https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf)
- Australian Government (2013). Practitioner guide to recovery principles that support recovery-oriented mental health practice: journey of hope and new beginnings. *Australian Department of Health*. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-p-recovpra>
- Australian Government (2014). Taking action to tackle suicide; Department of Health. Retrieved from <http://www.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~background~taking-action>
- Benalla city council, (2015). Health and wellbeing planning priorities. Retrieved from <http://www.benalla.vic.gov.au/>

Central Hume Primary care Partnership, (2015). Planning priorities. Retrieved from

<http://www.centralhumepcp.org/>

Commonwealth of Australia. (2011) National Drug Strategy 2010 - 2015

<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/nds20102015>

Commonwealth of Australia. (2015). National Drug Strategy 2016 - 2025

<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/draftnds>

Drug info (2015). Drugs; the facts. Retrieved from <http://www.druginfo.adf.org.au/drug-facts/drugs-the-facts>

<http://www.druginfo.adf.org.au/topics/quick-statistics#sthash.rcjZ5B3y.dpuf>

Goulburn Valley Primary Care Partnership, (2015) Planning priorities. Retrieved from

<http://gvpcp.org.au/>

Hume and Goulburn Valley Alliance for Mental Health and Housing, (2015). Strategic priorities 2013 - 3 year strategic plan

Indigo shire council, (2015). Health and wellbeing planning priorities. Retrieved from

<http://www.indigoshire.vic.gov.au/Home>

Mansfield shire council, (2015). Health and wellbeing planning priorities. Retrieved from

<http://www.mansfield.vic.gov.au/home.aspx>

Mental Health Council of Australia (2013). Providing psychosocial disability support through the NDIS; a proposal for the national disability insurance agency prepared by the mental health council of Australia. Retrieved from <https://mhaustralia.org/publication/providing-psychosocial-disability-support-through-ndis>

Murray Primary Health Network, (2013). Population health report Priorities, 2013

[National suicide prevention strategy](#)

Royal Australian College of General Practitioners (2015). Plan Do Study Act. Retrieved from

<http://www.racgp.org.au/your-practice/guidelines/greenbook/prevention-in-general-practice/planning-for-prevention/plan,-do,-study,-act-cycle/>

Towong shire council, (2015). Health and wellbeing planning priorities. Retrieved from

<http://www.towong.vic.gov.au/>

Turning Point, Australia, (2008). Alcohol and other drug brief interventions in primary health care. Retrieved from <http://www.turningpoint.org.au/site/DefaultSite/filesystem/documents/AOD%20Brief%20Interventions%20in%20Primary%20Care,%20Final%20Report,%202008.pdf>

Upper Hume Primary Care Partnership, (2015). Planning priorities. Retrieved from <http://www.upperhumepcp.com.au/>

Victorian Department of Health (2019) Because mental health matters; Victorian mental health reform strategy, 2009 – 2019. Retrieved from https://www2.health.vic.gov.au/getfile/?sc_itemid=%7BBBDAB24E-CD8C-4880-A3A8-3732327A9849%7D&title=Because%20Mental%20Health%20Matters%20-%20Victorian%20Mental%20Health%20Reform%20Strategy%202009%20-%202019

Victorian Department of Health (2013). Victoria's priorities for mental health reform 2013 – 2015. Retrieved from file:///C:/Users/dax.matthews/Downloads/1211034_VPMH%20reform_WEB_FA%20-%20PDF.pdf

Victorian Department of Health (2012). Regional Health Status Profiles. Retrieved from https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b71754C0E-3112-4FA1-83F3-A4546E71412A%7d&title=2012%20Regional%20Health%20Status%20Profile%20Hume%20Region

Victorian Department of Health (2011). Victorian health priorities framework 2012 - 2022; rural and regional health plan. Retrieved from file:///C:/Users/dax.matthews/Downloads/VHPF_2012-22_Rural%20-%20PDF.pdf

Victorian Department of Health (2011). Recovery-oriented practice Literature review. Retrieved from file:///C:/Users/dax.matthews/Downloads/1106004_Recovery%20oriented%20practice%20literature%20review_Web%20-%20PDF.pdf

Victorian Department of Health (2014). Service specifications for AOD catchment-based planning function

Victorian Department of Health (2014). Service specification for MHCSS catchment-based planning function

Victorian Department of Health (2015). Hume Region Health Planning Toolkit. Retrieved from <http://www.health.vic.gov.au/regions/hume/toolkit.htm>

Victorian Government, (2013). Local government area profiles. Retrieved from <http://www.health.vic.gov.au/modelling/planning/lga.htm>

Victorian Department of Health, (2015). Hume region health and aged care plan 2013 – 2018.

Retrieved from

[http://docs.health.vic.gov.au/docs/doc/ADA7A647003B91A5CA257B5100105FAD/\\$FILE/Hume%20Region%20Health%20and%20Aged%20Care%20Plan%202013-18.pdf](http://docs.health.vic.gov.au/docs/doc/ADA7A647003B91A5CA257B5100105FAD/$FILE/Hume%20Region%20Health%20and%20Aged%20Care%20Plan%202013-18.pdf)

Victorian Department of Health, (2015). Victoria's priorities for mental health reform 2013-15.

Retrieved from <http://www.health.vic.gov.au/mentalhealth/priorities/>

Victorian Department of Health (2015). Mental health services directory. Retrieved from

<https://www2.health.vic.gov.au/mental-health/mental-health-services>

Victorian Municipal Health and Wellbeing Plan (2013). Retrieved from

<http://www.oehcsa.org.au/sites/default/files/A%20guide%20to%20MPHWB%20planning.pdf>

Victorian state government adolescent community profiles (2015). Retrieved from

<http://www.education.vic.gov.au/about/research/Pages/reportdataadolescent.aspx>

Victorian Department of Health (2010). Koori Alcohol Action Plan 2010 - 2020 September 2010

https://www2.health.vic.gov.au/getfile/?sc_itemid=%7B5C555439-43A7-4669-BEB1-947EF68D867D%7D&title=Koori%20Alcohol%20Action%20Plan%202010%20-%202020%20September%202010

Victorian Department of Health (2015). Ice action plan. Retrieved from

<https://4a5b508b5f92124e39ff-cdd8d0b92a93a9c1ab1bc91ad6c9bfdb.ssl.cf4.rackcdn.com/2015/03/Ice-Action-Plan-Final-Summary-Document-Web-Version.pdf>

Victorian Department of Health (2012). Reducing the Alcohol and Drug Toll; Victoria's plan 2013 –

2017. Retrieved from https://www2.health.vic.gov.au/getfile/?sc_itemid=%7B3A95D095-9869-4915-9E3FCF52CB71458A%7D&title=Reducing%20the%20alcohol%20and%20drug%20toll%3A%20Victoria%92s%20plan%202013%962017%20-%20Strategy

Wangaratta city (2015). Health and wellbeing planning priorities. Retrieved from

<http://www.wangaratta.vic.gov.au/>

Wodonga city (2015). Health and wellbeing planning priorities. Retrieved from

<http://www.wodonga.vic.gov.au/>

World Health Organisation, (2015). Determinants of health. Retrieved from

<http://www.who.int/hia/evidence/doh/en/>