ALCOHOL AND OTHER DRUGS CATCHMENT BASED PLAN 2018-2021

OVENS MURRAY (HUME) AREA

Prepared by Louise Richardson | Planning consultant

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Acknowledgements

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Australian Community Support Organisation (ACSO)
Albury Wodonga Aboriginal Health Services (AWAHS)
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Gateway Health AOD Staff and Clinicians
Goulburn Valley Health
Justice Health
Murray Primary Health Network
Members of the Ovens Murray Committee
North East Water
The Centre
Upper Hume Primary Care Partnership
Victorian Dual Diagnosis Initiative
Victoria Police
3 White Horses

Client input

Special thanks to a group of clients, past and present, who contributed their time and experiences to help our understanding of various client journeys and the needs, gaps and barriers that are encountered during treatment.

This report was prepared, and process led, by
Louise Richardson | Planning consultant
www.louiserichardson.com.au
louise@louiserichardson.com

Executive summary

This report details the Ovens Murray Area's Alcohol and Other Drugs (AOD) Catchment Based Plan 2018-2021.

Following the 2014 Alcohol and Other Drugs (AOD) Service Reforms, the Catchment Based Planning function was established by the Victorian Department of Health and Human Services (DHHS), and is now conducted by service providers and planners in local areas. Gateway Health is responsible for the Catchment Based Planning function for the Ovens Murray (also known as Hume) Area of Victoria.

What is catchment based planning?

Catchment Based Planning (CBP) is a systematic way to respond to the service needs of our local communities. The primary purpose of the CBP function is to produce local plans that identify critical service gaps and pressures, and to provide an evidence base for strategies that improve responsiveness to people with AOD issues, considering population diversity and broader community need.

Our approach

Information gathering

In the Hume catchment area, we have:

- carried out extensive data analysis on catchments, clients and services;
- conducted multi-stage stakeholder consultation for problem definition, brainstorming, sense-making and priority setting.

Report structure

This report is the result of six months of AOD Catchment based planning activity in the Ovens Murray Area, and the findings from our information gathering processes. This report provides detail around the process undertaken to compile this plan, including information around the AOD services, programs and identified issues in the Ovens Murray Area, and presents an overview of available data in the Hume catchment.

Data analysis

As well as a high-level overview of available catchment data, we have carried out analyses of available client data against the following areas:

(1) AOD Client snapshot
(2) Primary Drug of Concern
(3) Geographic analysis of service demand and access
(4) Culturally and linguistically diverse (CALD) AOD Clients
(5) Aboriginal and Torres Strait Islander AOD clients.

Priorities

Our consultation process resulted in eight key priority areas (more detail and definition are provided on page 43):

- Proactive and effective governance
- Workforce and capacity building
- Addressing stigma at all levels
- Aboriginal inclusion
- Early intervention
- Funding and service sector influence
- Community connection (including Recovery champions)
- Service integration and improvement.

Activity plans

We have developed seven Activity Plans (pages 45-51 of this document). These activity plans are designed to address the identified needs, gaps and barriers for AOD clients, the Hume community and the broader service system within which we operate. Each has a set of specific actions, itemised against year 1, year 2, and year 3 of this planning cycle.

The activity areas are:

- Activity 1: Data integrity working group
- Activity 2: Youth AOD service redesign
- Activity 3: Proactive and effective governance
- Activity 4: Aboriginal inclusion across the AOD service system
- Activity 5: Establish a consumer advisory committee
- Activity 6: AOD workforce and capacity building
- Activity 7: Future services, future sector.

This plan within the broader context

This plan has necessarily focused on improving service delivery, access and equity within the current funding and service model parameters, and will ensure a continuous improvement approach involving key stakeholders and users of the system in future planning and delivery. The interest from stakeholders in Ovens Murray in "doing things differently" to impact demand and improve outcomes also has been highlighted through the consultation process.

The issues and opportunities raised include:

- Substance misuse and its impacts do not occur in a vacuum. AOD actions and outcomes must link closely with actions and outcomes around family violence, mental illness, justice, safety of children, community safety and resilience.
- Strong and effective cross government and cross sector partnerships will begin to ensure that the interconnected issues faced by people using alcohol and other drugs are addressed - recognising this work is often not funded, but that we cannot impact demand unless we work differently.
- There is a need to work closely with and support community driven priorities and activities that have a prevention focus and a positive impact on mental health and wellbeing.

- The need to recognise the impacts of trauma, stigma and judgment on substance use and on recovery, housing, employment opportunities, re-engaging with education, mental health and wellbeing, parenting etc.
- The need to empower individuals and communities to clearly see that there is hope, and recovery is achievable
- Modelling and advocating for a whole-of-person, whole-of-community and whole-of-government approach to improving the mental health and wellbeing of people living in Ovens Murray.

The ongoing work to provide high quality AOD treatment services and at the same time to reduce demand will not stop based on the life of this plan. Sustaining partnerships and commitment to prevention, reducing risk and building strong communities and individuals in Ovens Murray is what will make the difference in our communities over time.

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Our approach

Gateway Health is committed to ensuring that AOD Catchment based planning is informed by best available evidence. With the input of Louise Richardson, an expert AOD catchment based planning consultant, a number of information sources were drawn on.

Environmental scan

- Existing plans and processes

Data analysis & review

- Catchment data
- Client data
- AOD Service information

AOD Service consultation

- AOD workers
- Gateway AOD leadership team
- Goulburn Valley Health

Broader stakeholder consultation activity

Workshop

- Problem definition workshop with Ovens Murray Committee.

1:1

- Meeting and advice from the Primary Care Partnership and two DHHS representatives.

Online survey

- Online survey to scope for issues, strengths, needs, gaps and barriers experienced by people who work within and alongside the local AOD service system.

AOD Consumer focus groups

- 2 targeted consumer focus groups were run in Wodonga and Wangaratta.

½ day prioritisation forum

- Half day prioritisation forum attended by a broad range of organisations and individuals across the Ovens Murray Area's social services sectors.

The catchment based planning process has emphasised that in order to develop strong evidence based and locally relevant interventions we need to ensure that we fully understand the issues we are seeking to address.

There is a three-year planning cycle which is conceptualised as follows:

2018 plan (this document):

- Reviews available evidence for indications of need, gaps and barriers within the local service system
- Consults broadly with intersectoral stakeholders, other community service agencies, governing bodies, AOD workers, clients and other sources to ensure our process is informed by local knowledge and experience 'on the ground' in the Ovens Murray Area
- Directs our focus for the first year of activity to collaborative prioritisation processes.
- Activity plans against the emergent priorities with a focus on what can be done now, and what needs further direction, information and understanding before it can be developed.

Year 1 activity (2019):

- Information gathering & further evidence building
- Focus on improving data quality, collection, reporting and monitoring
- Seek to deeply understand the issues that have been raised through our consultations and ensure we are addressing the 'real problem' not just their symptoms
- Build and support partnerships and key stakeholder relationships.
- Target action informed by consumers and partners across the catchment to ensure maximum impact against the priority areas for years 2 & 3
- Monitor and evaluation.

Year 2 activity (2020):

- An evaluation of activity
- A new workplan with identified areas for action for year 2
- Feed into the 2020 AOD Catchment based planning update

Year 3 activity (2021):

- Further evaluation to ensure that learning and continuous improvement are integrated into our approach and shared across the relevant sectors.
- A new workplan with identified areas for action for year 3.
- Feed into the 2021 AOD Catchment based plan update.

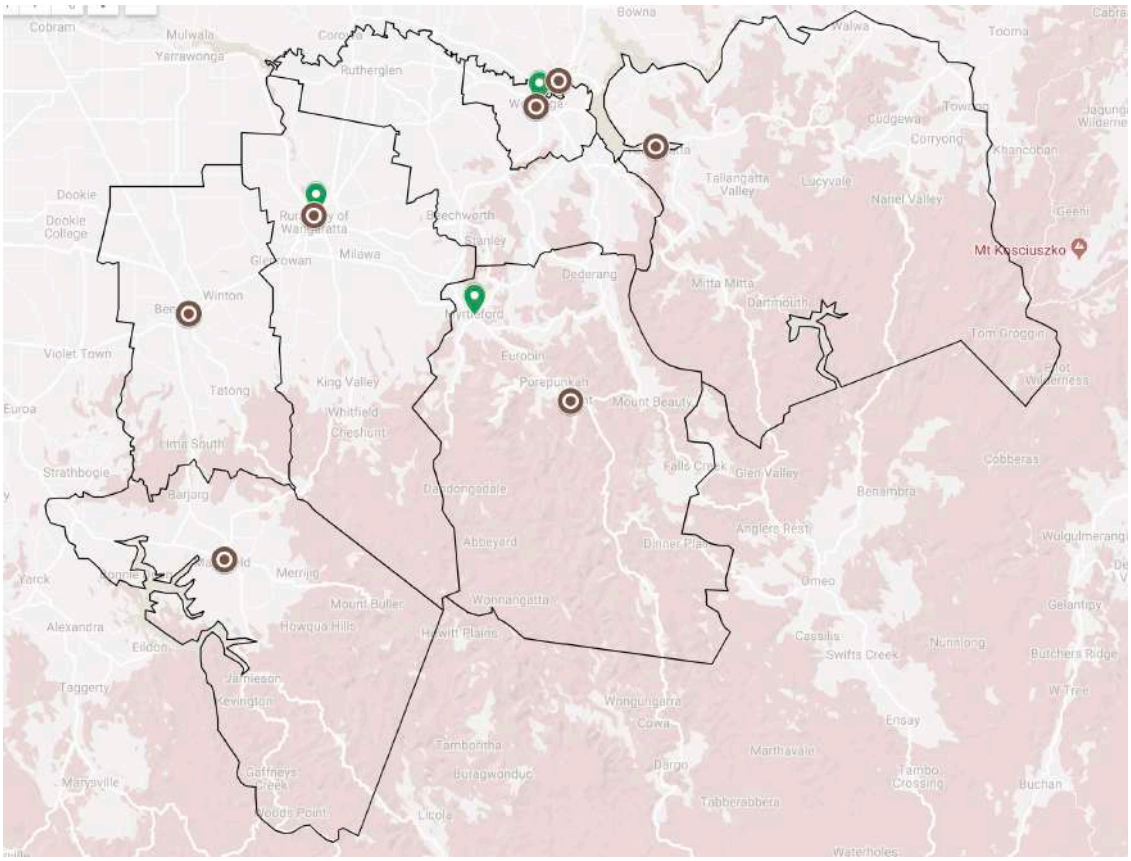
AOD Services in the Ovens Murray Area

This section looks at the AOD services that are provided in the Ovens Murray Area. It includes a catalogue of treatment types delivered at Gateway Health's fixed service sites as well as a review of EFT, current vacancies and details about the stability of staffing against each of the provided AOD programs.

Ovens Murray Area AOD service map

The map below shows Gateway Health's AOD service distribution throughout the Ovens Murray Area; including the borders of 7 LGAs.

- The green markers indicate the fixed service sites in Wangaratta, Wodonga and Myrtleford.
- The brown circles are sites we regularly outreach to, according to client demand.



Gateway Health Wodonga	Gateway Health Wangaratta	Gateway Health Myrtleford
• AOD Assessment • Non-residential withdrawal • AOD Counselling • Care and Recovery Coordination	• AOD Assessment • Non-residential withdrawal • AOD Counselling • Care and Recovery Coordination	• AOD assessment provided by outreach as required • Non-residential withdrawal • AOD Counselling • Family Drug support

Gateway Health Wodonga	Gateway Health Wangaratta	Gateway Health Myrtleford
• High Risk of Overdose Program • Multidisciplinary Enhanced Rural Pharmacotherapy Service (MERPS) • Non-residential rehab (Gateway Recovery and Support Program (GRASP)) • Needle and syringe program • Family Drug Support • Self-Management and Recovery Training (SMART) Program • Pharmacotherapy team base (outreaches to GPs in Benalla and Wangaratta) • Youth AOD services: - Outreach - Counselling - Care Coordination - Capacity building	• High Risk of Overdose Program • Non-residential rehab (GRASP program) • Needle and syringe program • Family Drug Support • SMART Recovery Program • Youth AOD services: - Outreach - Counselling - Care Coordination - Capacity building	• Needle and Syringe Exchange • Youth AOD service: - Outreach - Capacity building

Outreach as required to:

- Benalla Community Health
- Albury Wodonga Health (Albury Base hospital)
- Albury Wodonga Health Wodonga Hospital
- Alpine Health (Bright)
- North East Health Wangaratta
- Tallangatta Health Service
- Mansfield District Hospital

AOD Service mapping – detail

The following pages provide further detail against AOD treatment services, provided by Gateway Health, including: Service sites, funding streams, service types, geographic area covered, staff EFT, vacancies and stability.

In addition to the services that Gateway Health is funded to provide, there are other providers of AOD services in the Ovens Murray area, and these include:

Organisation	What is provided
ACSO	Conduct intake into Oven's Murray AOD services, support to access treatment services, bridging support while waiting for services & link family & carer into supports.
AWAHS	The Social & Emotional Well Being Team offers AOD Counselling and support in Albury, Wodonga & Wangaratta.
Beechworth Hospital, Mansfield Hospital, Benalla Hospital, Myrtleford Hospital, Mt Beauty, Wangaratta	Mild to moderate level support for withdrawal from alcohol and/or cannabis. Individual arrangement with each facility.
Odyssey House Victoria	The Circuit Breaker AOD Residential Rehabilitation 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 dependent lifestyle.
Albury Wodonga Health	NSW Funded AOD service, provide services north of the border: • AOD clinical nurse liaison consultant based in Albury & Wodonga ED. • Clinical Nurse Consultant • Victorian Dual Diagnosis Initiative- Upper Hume/Border Area
Private Providers & Community Groups, i.e. Alcoholics Anonymous	Providing a range of AOD services including counselling, support groups and AOD driver program.
GP prescribers	Managing and prescribing pharmacotherapy treatment to patients with opioid dependence.

The information in the table below is correct as at Friday 18 January 2019.

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
AOD assessment						
Victorian funded	**Fixed service sites:** • Gateway Health Wangaratta 45-47 MacKay Street • Gateway Health Wodonga 155 High Street	Ovens Murray Area	**AOD assessment:** Comprehensive AOD assessments of clients resulting in referral to treatment services and/or other appropriate service. Other support includes brief interventions, bridging support, family/carer support and education.	3 staff members, total 2.0 EFT 2 x 0.8 1 x 0.4	No Vacancy	0.4 was vacant for 6 of the last 12 months
	Outreach as required to: Dependent on client need and including but not limited to: • Gateway Health Myrtleford 32 Smith St • Benalla Community Health • Albury Wodonga Health • Wangaratta Hospital • Tallangatta Hospital	Ovens Murray Area				
	Phone assessment where necessary to facilitate access or according to client choice	Ovens Murray Area				
Non-residential withdrawal						
Victorian funded	**Fixed service sites:** • Gateway Health Wangaratta 45-47 MacKay Street • Gateway Health Wodonga 155 High st • Gateway Health Myrtleford 32 Smith St		**Non-residential withdrawal (NRW):** offers assessment & case management to support clients through Outpatient, Home or Hospital based withdrawal,	3 staff members, all registered nurses, total 1.8 EFT 1 x 0.4 1 x 0.6 1 x 0.8	No vacancy	Staffing has been stable for the last 12months

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
	Outreach as required to: Dependent on client need including: • Beechworth, Benalla, Mansfield, Mt Beauty, Bright, Rutherglen, Tallangatta, Yackandandah	Ovens Murray Area	including a consultancy service for health professionals.			
Counselling						
Victorian funded	**Fixed service sites:** • Gateway Health Wangaratta 45-47 Mackay Street • Gateway Health Wodonga 155 High Street • Gateway Health Myrtleford 32 Smith St	Ovens Murray Area	**AOD counselling:** counselling program focuses on people wanting to make a change or wanting a break/cutting down on the use of alcohol and/or other drugs. Support includes - a private and safe environment to talk about issues; identify safer choices; throughout the process of change and recovery; with referral for withdrawal and/or rehabilitation; to access other specialist services if required.	7 staff members, total of 5.4 EFT 1 x 1.0 1 x 0.9 2 x 0.8 1 x 0.7 2 x 0.6	0.1 EFT Vacant	Some movement, but generally stable
	Regular Outreach to: • Benalla Community Health Centre • Mansfield Hospital	Ovens Murray Area				
	Other (irregular) outreaches as required for individual clients e.g. Beechworth, Bright,	Ovens Murray Area				
	Phone counselling: not regular but if necessary	Ovens Murray Area				

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
Care and recovery coordination						
Victorian funded	**Based at fixed service sites:** • 1 staff member based at: Gateway Health Wangaratta 35-37 Mackay Street • 1 staff member based at: Gateway Health Wodonga 155 High Street **Outreach provided across the Ovens Murray Area**	Ovens Murray Area	Provides support for people with drug and alcohol dependence who are also experiencing other issues impacting on their life, such as housing, legal, health and social issues.	2 staff members, total 1.7 EFT 1 x 0.8 1 x 0.9	0.3 EFT vacant	Staffing has been stable for the last 12months
High risk of overdose						
State funded, commenced March 2018	**Based at fixed service site:** • Gateway Health Wangaratta 35-37 Mackay Street • Gateway Health Wodonga 155 High St	Ovens Murray Area	Secondary consultations, supporting other AOD staff, responding to clients with high risk of overdose Naloxone training and access to subsidized naloxone	0.4 registered nurse	No vacancy	Staffing has been stable since commencement of program March,2018
Non-residential rehabilitation program (rewire -> GRASP)						
Commonwealth funded, through the Murray Primary Health Network (MPHN)	**Fixed service sites:** • Gateway Health Wangaratta 45-47 Mackay Street • Gateway Health Wodonga 155 High Street	PHN Area	**Group program GRASP**: clients attend 8-week program 2 days per week –regular	2 staff, EFT varies depending on group	No vacancy	Staffing has been stable for the last 12months

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
			additional support sessions for clients during program.	program timetable 1 x 0.6-0.8 1 x 0.6-0.8		
Family drug support						
State Ice Action funded, until June 2019	**Fixed service sites:** • Gateway Health Wangaratta 45-47 Mackay Street • Gateway Health Wodonga 155 High Street • Gateway Health Myrtleford 32 Smith St	Ovens Murray Area	**Family Drug Support:** provides counselling and support for carers and family members who are involved in the lives of a person who is misusing substances.	1 staff member total 0.4 EFT, 1 day a week based at Wodonga/Wangaratta	Huge demand for more resources but not enough funding	Staffing has been stable for 12 months
Needle and syringe program						
State funded	**Fixed service sites:** • Gateway Health Wangaratta 45-47 Mackay Street • Gateway Health Wodonga 155 High Street • Gateway Health Myrtleford 32 Smith St Open Monday - Friday 8.30-5.30pm	Ovens Murray Area	**Needle and syringe program (NSP):** This free service provides injecting drug users with sterile injecting equipment, discourages the sharing of injecting equipment, minimises the	- Wangaratta site: NSP co-ordinated by AOD Assessment Worker- not funded. Reception staff dispense N&S packages		Staffing has been stable for the last 12months. No funding received to support this service. Free equipment only. -Diminishes opportunity to address high risk of overdose with

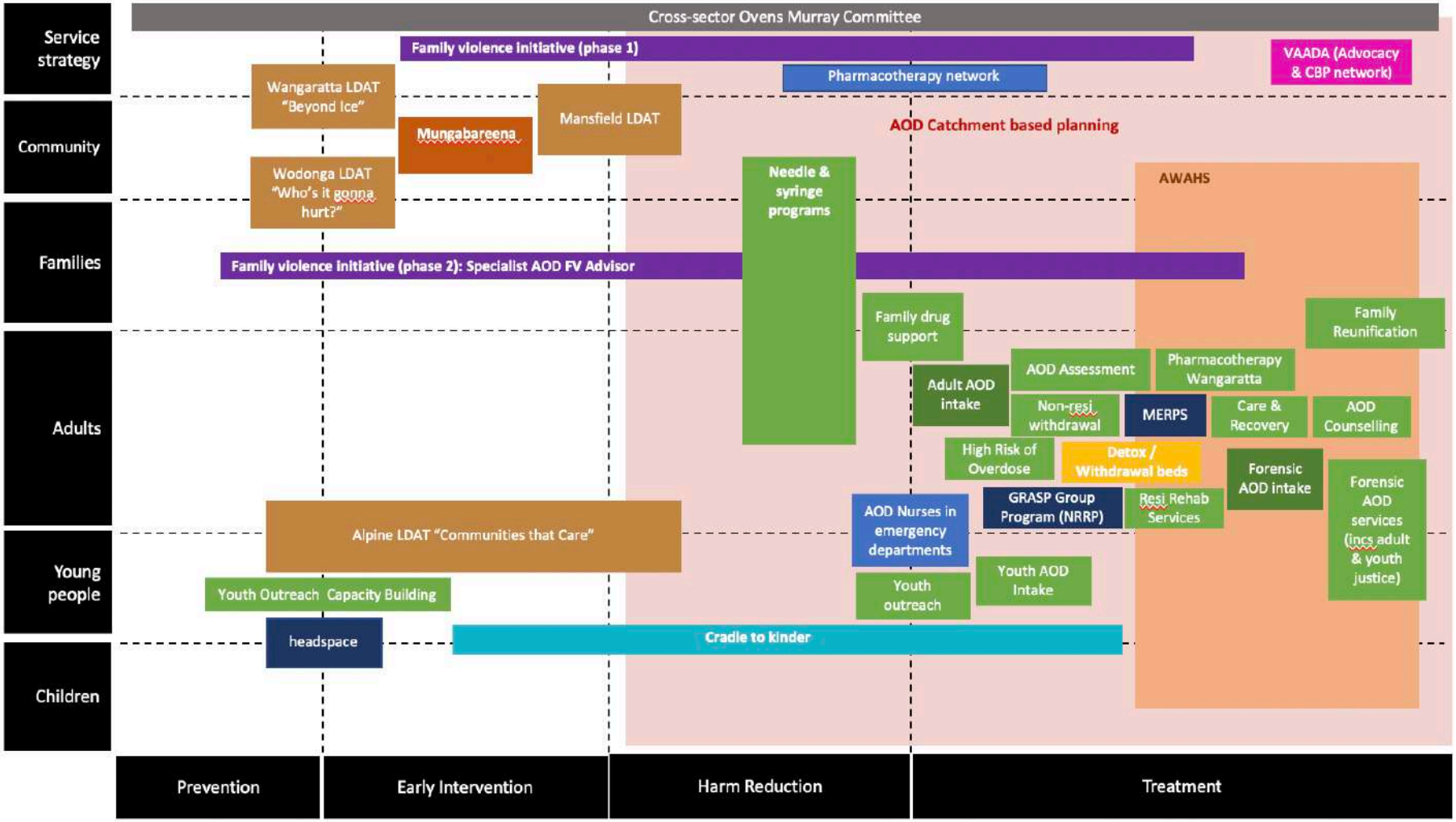
Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
			transmission of blood borne diseases, provides referral services to injecting drug users and provides the safe collection and disposal of injecting equipment in the community. The service also provides free condoms and safe sex advice. The NSP operates out of the Wodonga and Wangaratta sites.	- Wodonga site:0.5 EFT concierge manages dispensing at Wodonga –not funded -Myrtleford Site: Receptionist dispenses and manages NSP program		clients/ opportunities to engage clients into services required
Youth AOD						
State funded	Headspace High street, Wodonga	Ovens Murray Area	AOD Intake			
	Gateway Health Wodonga, 155 High street Headspace 2days /week	Wodonga area	**Youth AOD Outreach, Counselling / Care Coordination, Capacity building:** Supports people aged 12—25 years with service being	**0.9**	0.9	Vacant for about a month. Position filled January,2019
	Gateway Health Wangaratta 45-47 Mackay Street	Wangaratta area		**0.8**	0	Extended leave for 2 weeks. Recruitment of new staff member December, 2019

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
	Gateway Health Wangaratta 45-47 Mackay Street	Ovens Murray Area	provided at the young person's place of choosing i.e. home, school, other. Provides assessment; information and education on alcohol and drugs; access and referral to residential withdrawal and rehabilitation services; harm reduction strategies; treatment, advocacy and support; therapeutic case management; referrals and other support services; provide support to generalist agencies that work with young people and provide appropriate services for carers and families.	0.8	0	
Pharmacotherapy						

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
State funded	Based at Gateway Health Wangaratta 45-47 Mackay Street Works out of GP practices in Benalla and Wangaratta to support their pharmacotherapy clinics	Ovens Murray Area	Pharmacotherapy service, client education, support, referral, overdose prevention	0.6	0	Stable
Commonwealth funded MHPN Multidisciplinary Enhanced Rural Pharmacotherapy Service (MERPS)	Gateway Health Wodonga 155 High Street Albury Wodonga Aboriginal Health Service 644 Daniel Street, Glenroy, NSW 2640	PHN Area	The program provides treatment for people managing opioid dependence. Weekly MERPS clinic. GP contracted + 2 nurses. Clients access clinic to get scripts and ongoing appointments. Ongoing support and referral provided to clients via nurses.	2 x 0.6 registered nurses 1 x GP for 5 hrs/week	0	1 of the 0.6 went on 1-year LWOP. 4-5 months gap. Challenging to recruit experienced pharmacotherapy nurses and prescribing GPs- highly specialised skill set. *see AOD Programs issues snapshot on following pages.
SMART recovery groups						
UNFUNDED (more info provided in the issues section below).	5 groups delivered weekly at 2 Gateway Health sites: • 2 groups per week in Wangaratta, 45-47 Mackay Street	Ovens Murray Area	Group work of the SMART recovery program. CBT, evidence based. -ongoing open group enabling	2 hours per week per worker- 10 hours per week total (2.63EFT)		

Funding source: State, Commonwealth	Service site: fixed address, regular outreach sites, phone-based	Geographic area covered	Services types delivered	Number of staff (EFT)	Vacancies (EFT)	Staffing/vacancy % fully staffed over last 12 months
	• 3 groups per week(including one gender specific group) in Wodonga 155 High Street		clients to engage as needed.			

AOD Programs in Ovens Murray (Hume)



AOD Programs in Ovens Murray (Hume)

The diagram on the previous page is a visual representation of AOD programs in the Ovens Murray Area. It shows existing interventions across the continuum of service delivery from prevention through to treatment, and looks at where these sit in relation to servicing across the life course (children, young people, adults and families) and goes on to include community groups and strategy.

This demonstrates the areas where the AOD clients and community needs are really well serviced, and highlights where there are potential gaps and areas for further development.

We can see from this image that there is a comprehensive range of services to address the needs of adults, particularly at the treatment end of the spectrum. We can compare this with a big gap in programs that cater to children and young people, and especially at the prevention and early intervention side of the continuum.

Vast amounts of research indicate the benefits to population health and economic savings to the health system when dollars are spent earlier on in the continuum, and earlier in people's lives. One of the difficulties of the current AOD service model is that there is a lack of funded service options for people before they get to crisis and dependency. The system is designed to respond to clients only once they get to a certain level of complexity.

In the Ovens Murray Area we will be approaching things differently. Our local Department of Health and Human Services (DHHS) advisors and a number of other key local organisations whose clients are impacted by substance misuse, have indicated an appetite for innovation and for ensuring that the area health dollar is spent where it will make the biggest difference.

In contrast to the limits placed around Catchment Based Planning in other areas, DHHS have indicated that in the Ovens Murray Area, AOD Catchment Based Planning *can* include scoping for prevention and intervention earlier on in the continuum of service delivery. This is reflected throughout this plan, in the more inclusive and holistic framing we have been afforded.

There is also a key focus on Youth AOD services, which were not a part of the AOD sector reform in 2014 and have seen some notable challenges in their delivery in this catchment. Effective Youth AOD services are critically important, thus we have included a particular activity stream in this plan to address the needs for improvement in this catchment.

Consultation with AOD Leadership Team

AOD Programs – issues snapshot
(Sources: AOD Team Leader & AOD Program Manager, Gateway Health)

- **Non-residential withdrawal:** Non-residential withdrawal is a complex service requiring highly experienced and qualified staff. The service is required to cover the OM catchment; however, funding levels are not adequate to ensure equity of access and support.
- **Care and recovery coordination:** This service is for people with highly complex needs with clients in this program often presenting with multiple issues across the entire social determinants of health. This program is incredibly important as a treatment option with care and recovery coordination being crucial to clients' ability to navigate treatment to AOD services and assist with their wider health and wellbeing needs. The complexity of work impacts on staff workload, wellbeing and requires a broad skill set including the ability to develop and maintain partnerships with other key services such as Justice, Mental Health and Housing.
- **Family drug support:** This service is funded until June 2019 for 2 days per week under the Victorian Ice Action Plan. Program supports clients with high level of complexity across a wide range of areas. It has been very successful in helping families manage by providing intensive assistance. It is however unable to meet current demand and with no guaranteed and/or increased funding, future service will be impacted.
- **Youth AOD:** Youth AOD service was out of scope of the 2014 AOD system reform. As a result, the expectation and statewide direction of this service is out of step with the rest of the AOD sector, further fragmenting and complicating service delivery. Ovens Murray Youth AOD intake is provided by headspace Albury Wodonga. Availability and retention of workforce with skills and qualifications in Youth AOD service delivery is a significant issue in Areaal and rural areas.
- **Outreach:** Some client groups are unable to access center-based services due to geography and lack of transport options; physical and cognitive impacts of long-term substance use, multiple vulnerabilities and co-morbidities. Outreach services are a vital part of the service delivery model particularly in rural areas but add a level of complexity, can carry increased risk to staff and often require significant amounts of travel. Good outreach needs to be well funded and supported to be able to provide prevention and early intervention services as well as timely and effective crisis intervention and support.
- **Links between intake and assessment:** As part of the 2014 reform, access to AOD services in OM is through a statewide service provider. There are ongoing access concerns for timely assessment when people ready to act on their substance issues must use a phone-based intake as a separate step. Access is also impacted by a lack of up to date local knowledge and awareness of broader services available.
- **Bridging support between intake and assessment:** 'Bridging support' refers to the support provided to clients after they've carried out intake and before they get access to an assessment and following assessment before they begin treatment. There is an average of 2-4 week wait, which can be problematic. If we don't appropriately look after clients during this time there is a risk we may lose them. ACSO is funded to deliver the bridging support for clients while waiting to be assessed and Gateway Health provides bridging support after assessment whilst waiting for treatment, but we lack the metrics to quantify to what extent this is happening. Gateway Health, as a result of the challenges in this part of the service system has moved to provide SMART recovery groups to clients during this time (see the below paragraph).
- **SMART Recovery Groups:** There isn't currently objective, quantifiable outcomes monitoring for the impact of these groups, but anecdotally, they are one of the most positive aspects of service delivery for both clients and workers. 90min group sessions according to the SMART framework, these are evidence based, function on cognitive behavioural therapy approaches, peer led, and provide connection and belonging for clients, along with an increase in staff confidence for the interventions they're delivering.

Whilst SMART recovery groups are not specifically funded, they provide bridging support as a component of assessment. However, data to reflect this bridging support is not available. This is an important initiative that Gateway has set up to help 'hold' and support clients who require bridging assistance between assessment and access to treatment. A cost analysis and framework for evaluation and outcomes is required to further evidence the impact that this initiative is having (this work has been included in *Activity 7: Future services, future sector* of this plan).

"SMART was the best thing about my treatment. It really helped me, I think everyone should do it" – AOD Client and Focus Group Participant, Wodonga, 2018

- **Collaborative working:** We don't currently collect information that reflects the level of collaborative practice and cross-sector working between the AOD sector and other areas of the health and social services system (Family violence, mental health, housing, primary care, etc). This is unfunded work but requires significant time and resources to do properly. The funding structure of AOD service provision doesn't fully acknowledge the level of resource that this requires.
- **Workforce:** Structuring and growing AOD services to meet community needs in a rural and Areaal area, and recruitment and retention of qualified workforce to deliver is difficult and can impact on quality of services delivered. Workforce effectiveness and flexibility is impacted by increasing levels of complexity in funding and required reporting. **AOD Nursing:** current Non-residential withdrawal AOD Nurses provide in-services at local hospitals to support staff to manage withdrawals/AOD presentations.
- **Pharmacotherapy:** Pharmacotherapy is a vital part of treatment and recovery for a number of clients who have particular issues and needs. Recruiting and retaining qualified medical practitioners and pharmacies to ensure the program can run at required capacity to meet client needs remains an ongoing issue, particularly in rural and Areaal areas. Pharmacotherapy clients often experience stigma from within the health system, which can lead to diminishing engagement and poorer health outcomes (DoH, 2013).
- **Access to withdrawal and detox:** Although the Goulburn Valley have 4 beds, there is extremely limited access to these for Ovens Murray Area's consumers, for a number of reasons. Further exploration of the reasons for such barrier to entry is currently underway. We hope that in future there will be beds based in OM.
- **AOD data for outcomes and service monitoring:** Organisational and state-wide data concerns around our capacity for consistent collection, analysis and monitoring is significantly impeded. Further attention has been given to this in *Activity 1: Data Integrity working group* later in this plan.

Issues snapshot: Consultation with AOD workers
Consultation workshop held at the all AOD Staff Meeting
Wednesday 19 September 2018

Due to their position within the service system, AOD workers have a valuable perspective on opportunities for service improvement. Catchment based planning is committed to making sure that the voices of local AOD workers are heard, and that the challenges they raise and suggestions they are incorporated into our Area's planning activity, especially when they triangulate with issues raised by other key stakeholders.

The following issues were raised in catchment based planning consultation with all Gateway's AOD staff. These issues were used to inform this plan's key priority areas and have been organised against these areas within the list below. These issues have also been incorporated into the activity plans at the end of this document.

Key areas for improvement

- **Service integration and improvement:**
  - Local access to detox and rehab: Wait times and other access issues are really hard to manage for workers and for clients, especially for rehab in this area.
  - Increased capacity for rural outreach
  - Better collaboration with mental health services so we can respond to client needs better
- **Stigma:**
  - The need to change the stigma associated with AOD use and AOD clients, especially from other agencies, was emphasised.
- **Workforce and capacity building:**
  - Orientation for new or junior staff – there is no standardised orientation process, and supervision is time consuming and demanding. AOD workers desire a standardised approach to this aspect of workforce development.
  - Contract terms are short and insecure.
- **Data integrity:**
  - Data entry and admin is time consuming and input into the client data management system can be frustrating to navigate.
  - We need more detailed data (and to receive regular feedback of that data) so we know how we're doing, how we're improving, what we need to focus on.
  - How do we measure who is missing out on our services?
  - How does our performance and the outcomes we achieve compare to other AOD services?
- **Client advisory committee:**
  - We need to be able to understand what's working really well for clients, and what's not?

Issues snapshot: Consultation with clients
2 x Focus groups (Wangaratta and Wodonga)
Monday 19 November 2018

- ***Hardest parts:*** **Focus group attendees were asked 'what were the hardest parts of receiving the AOD service you needed?'**, these were three key answers:
  - **Communication between agencies**: Clients are often navigating the entry and inclusion requirements of multiple community service and health agencies. They spoke of feeling frustrated when agencies don't communicate with each other in ways that makes it easier for the clients.
  - **Wait times for detox and rehab**: Clients spoke of their experiences with long wait times. They wanted to know why this is happening and what's being done to fix it.
  - **Services seem to be more complicated than they need to be:** For some clients their experience was that the process for getting the treatment they needed was slow. At times when they've had to wait for appointments, they said things can change while they're waiting and often get worse. One client said *"sometimes issues can't wait for when the service is ready; they have to be there when [we are] ready".*

- **Clients' ideas for service improvement:**
  - **Education of staff at emergency departments and outpatients' clinics**: Work should be done to reduce the stigma experienced by clients in these settings and to increase staff's ability to help when AOD clients present.
  - **Women's behaviour change programs**: Clients talked about the usefulness of men's behaviour change programs, and questioned why this isn't also available for women. They described "men's behaviour isn't the only problem" and described that women are sometimes violent and could do with help in these ways too.
  - **More support for people on wait lists:** Some of the clients we spoke to had attended the SMART recovery programs, offered by Gateway Health to support people during the time between their assessment and receiving treatment. Attendees were very positive about these programs, and said there needs to be more offered to help people waiting to receive the treatment they need.
  - **Reducing the complication in communicating between agencies:** AOD clients are resourceful and have often had to learn how to navigate complex service arrangements between multiple agencies in a way that works for them. Attendees of our focus groups had various ways they had devised to help themselves in these situations.
    - One client carries his medication and prescriptions with him at all times because he's so often asked what he's taking, and how much, and it can be hard to remember all the details.
    - Another client, as a result of his frustration with the feeling that different agencies were not communicating with each other, created his own "file summary" document. A printed few pages with all his details, the names of his clinicians and the services he's engaged with, his client numbers, along with medications and anything else that's relevant. He carries this document to every appointment. There was considerable discussion between focus group attendees about how helpful this would be if clients were given a simple file summary per person.
    - Similarly, a client said **"***Give us a list of what you need at the beginning"* instead of going backwards and forwards with more requests for information that end up delaying the service they need.

Catchment data

The data below has been obtained from a range of sources, including the Australian Bureau of Statistics (ABS) 2016 Census, AOD Stats (Turning Point), DHHS Area Profiles. Unfortunately, much of the 2016 census data has not yet been released / transcribed into the level of granularly that we require for planning purposes. As such, there is some variance in our data sources depending on best available data for those measures.

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The Ovens Murray Catchment covers the seven local government areas (LGAs) of Alpine, Benalla, Indigo, Mansfield, Towong, Wangaratta and Wodonga, with a total population of 124,380 people (ABS, 2016 Census).

The table below shows each local government area in the Ovens Murray Area, alongside the resident population and the percentage of the catchment's population within that area. This provides an overview of the geographic distribution of our resident population. We can see more detail around geographic service demand later in this report.

Local government area	Population	Percentage of total catchment population
Wodonga	39,351	31.64%
Wangaratta	28,310	22.76%
Indigo	15,952	12.83%
Benalla	13,861	11.14%
Alpine	12,337	9.92%
Mansfield	8,584	6.90%
Towong	5,985	4.81%
Total	124,380	

2016 ABS Census data

Socio economic factors

The Ovens Murray Area has some excellent community indicators demonstrating significant strengths in the local population. Specifically, the data shows that the Area has the highest in the state for: percentage of people who feel safe on the streets alone, people able to get help from their neighbours, percentage of people who attend local community events and percentage of people who rated their community as good or very good for community and support groups (DHHS, Ovens Murray Area area profile, 2015).

Conversely, the area also has the highest percentage of households with mortgage stress in the state at 12.7% (DHHS, Ovens Murray Area area profile, 2015). The area also has lower median weekly incomes (personal and household incomes) than the state average (ABS, 2016). There is a significant proportion of households with no internet access (in Benalla and Towong this is as high as 22.5%, compared to 13.6% for Victoria) (ABS, 2016). Towong also has a very high proportion of single parent families that are headed by a male (31.1%, compared to 17.8% in Victoria) (ABS, 2016).

Age distribution

Census data for the Ovens Murray Area population shows an older age distribution than the state average. In general, the catchment has a lower proportion of young people (persons aged 0-24yrs) than the state average (29.3% of the total population compared to 31.3% in Victoria), and higher proportion of older people (over 65years) compared to the state average (Australian Bureau of Statistics, Census 2016).

Local government area	Number of young people (0-24years)	Percentage of young people (0-24years)	Percentage of older people (over 65years)
Wodonga	13,486	34.3%	14.9%
Wangaratta	8,050	28.4%	22.5%
Indigo	4,382	27.5%	20.6%
Benalla	3,600	26.0%	26.0%
Alpine	3,038	24.7%	24.4%
Mansfield	2,336	27.2%	23.9%
Towong	1,504	25.3%	25.8%
Victoria state		31.3%	15.6%

2016 ABS Census data

Young people

Although the Ovens Murray Area has a lower than average proportion of young people (0-24 years) in its resident population, there are a number of indicators that demonstrate some vulnerabilities for this group. There is significant research round the mental health risks for young people in country areas; with factors such as isolation, a lack of privacy, having 'nothing to do', pessimism about future prospects and a high use of alcohol and other drugs (DHS, 1997; Chin & Vella-Brodrick, 2018).

The Ovens Murray Area has:

- Lower than average rates of year 12 completion (80% compared to 88.2% in state),
- Lower than average rates of year 9 students with national minimum literacy standards (90.5% compared to 92.0% in the state), and national minimum numeracy standards (94.8% compared to 95.6%),
- Lower rates of people who completed higher education qualification (27.7% compared to 45.7%) (DHHS, 2015).

The data below looks at available indicators of vulnerability in the social determinants of wellbeing of Oven's Murray children (who will be the Area's 'young people' in the very near future), with a particular focus on education-related measures. Research suggests a number of complex links between education participation, attainment and inequality and substance use later in life (Galea, Ahern, Tracy, Rudenstine & Vlahov, 2006). Due to limitations in available data, we often need to draw from proxy measures as indications of future or projected need for services. When we do this for the Ovens Murray area, we can see:

- Lower than average kindergarten participation (94.3% compared to 98.1% in state)
- Higher than average children with emotional or behavioural problems at school entry (5.3% compared to 4.6%)

- Higher rates of children with speech or language problems at school entry (18.3% compared to 14.2%)
- High rates of children developmentally vulnerable in one or more domains (21.8% compared to 19.5%), and children developmentally vulnerable in two or more domains (11.2% compared to 9.5%). This data around developmental vulnerability is derived from the Australian Early Development Index and is a measure of how young children are developing in Australian communities, across the five domains deemed important for child development and good predictors of adult health, education and social outcomes (DHHS, Ovens Murray Area area profile, 2015).

Aboriginal and Torres Strait Islander peoples

The Ovens Murray Area of North East Victoria includes Aboriginal and Torres Strait Islander people forming a diverse community from many clan groups and Aboriginal nations living in this area.

There are approximately 3500 plus (ABS 2016) Aboriginal and or Torres Strait Islander people in the Albury, Wodonga, Wangaratta, Benalla, Myrtleford, Mansfield, Bright, Mt Beauty, Tallangatta, Rutherglen, Barnawartha, Chiltern, Beechworth, Corryong and Walwa communities.

It is critically important that as community health services we continue to ask the identifying question of our clients, allowing them to indicate if they identify as Aboriginal and or Torres Strait Islander to support accurate data and facilitate access to appropriate services and supports.

Diversity

Cultural and linguistic diversity (CALD) is defined as “people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as “main English-speaking countries”, it excludes Canada, New Zealand, the United Kingdom, USA and Ireland (ABS, 2018). The cultural and linguistic diversity of the population is an important consideration when we look at equality of access for all communities within our catchment areas. This is analysed in more detail on page 37.

There is a relatively low level of cultural diversity in the Ovens Murray catchment; the Area has lower than average rates of:

- People born overseas (11.1% compared to 27.7% in state)
- People born in non-English speaking country (6.6% compared to 20.9%)
- People who speak a language other than English at home (6.6% compared to 24.2%)
- New settler arrivals per 100,000 population (156.4 compared to 982.5)
- Humanitarian new settler arrivals 20.0% compared to 9.3% in state, (DHHS, 2015).

Indicators of AOD related need and harms in the community

One of the difficulties in understanding what our communities need is that we can measure data for people accessing services but we do not know the extent of need for those who do

not ask for help. We do not know what we do not know, and indicators of need can be far reaching and complex.

The Ovens Murray Area rates:

- Second highest in the state for people at an increased risk of alcohol related harm on a single occasion of drinking 50% (compared to state average of 42.5%)
- Second highest smoking rate in the state (people over 18 who are current smokers 16.1%, compared to 13.1% state average)
- Third highest in the state for family violence incidents per 1,000 population 17.1 compared to 12.4
- Lower than average for clients that received AOD Treatment services per 1,000 population 4.2 compared to 5.0 per 1,000 population (DHHS, 2015).

We can look a little further into the detail of these measures with other available data sources. AOD Stats (a Turning Point data analysis tool), shows, from 2016/17 data:

- Wangaratta has the 3rd highest rate in the state for *Alcohol related serious road injuries during high alcohol hours* for 15-24year olds (a rate of 16.3 per 10,000 young people).*
- The rates of *definite or possible alcohol related family violence incidents* (rate per 10,000 population 2016/17) are particularly high in Benalla (43.7), Towong (38.5), Wangaratta (35.7) and Wodonga (33.9).

Whilst this plan recognises the impacts of substance use and misuse across communities, families, workplaces, service providers, and on individual and community safety it does not address these in detail.

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* **High alcohol hours** – Alcohol intoxication is a major contributing factor to road accidents in Victoria. However, there is no data source currently available in Victoria that measures alcohol involvement in road injuries. To provide improved understanding of alcohol involvement in road injuries, surrogate measures have been developed. 'High alcohol hours' is defined as Fridays or Saturdays between 8pm and 6am. Research has shown that, in high alcohol hours, 38% of drivers admitted to hospital or killed as a result of a crash had a blood alcohol concentration in excess of 0.05 per cent. This compares with 4% in low alcohol hours. Serious road crashes occurring during these high alcohol hours are referred to as alcohol-related serious road injury in AODstats (Turning Point, 2018).

AOD Client data in Ovens Murray Area

The following pages present specific analyses of AOD client data under the following headings:

1. AOD Client snapshot
2. Primary drugs of concern
3. Geographic analysis
4. Culturally and Linguistically diverse clients
5. Aboriginal and Torres Strait Islander clients

AOD Client data has not previously been collected, analysed, monitored or reported in a systematic way in this catchment. There are a number of challenges with Trakcare (the client data management system) that make it difficult to extract data consistently, or even to view multiple measures at a time. Much of the data is not collected 'per client' but 'per questionnaire' which impacts the reliability of the data and the conclusions we can draw from it.

Whenever we start to collect client and service data in a systematic way, we immediately encounter missing data, fields that have been misinterpreted, and other limitations. Service planning requires clever application of 'best available data', and acknowledging when it is not perfect. Gateway Health has approached this exercise with an ethos of transparency and an appetite for improvement in this area.

This presents a powerful opportunity for AOD services and the broader community health sector in this Area to start to shape and track indicators that are important to service planning, needs analysis and outcomes monitoring.

In the future we aim to have the data to analyse a broader range of relevant data sets to give a fuller picture of needs, gaps and barriers in AOD service provision in the Ovens Murray Area. We aim to set data standards and specifications that enhance our ability to monitor trends, track changes over time, and draw multiple indicators together to create a clearer picture of the needs, gaps and barriers in this Area.

This is a baseline analysis, and shows significant room for improvement. Activity 1 (later in this document) is to *Establish a Data integrity Working Group* to address this challenge and enhance our future capacity.

OVENS MURRAY REGIONAL ANALYSIS 1: AOD CLIENT SNAPSHOT

This paper presents a brief overview of client demographics data from the Ovens Murray Area. The data relates to people presenting to adult services at Gateway Health, and does not include data from other service providers, residential or youth programs at this stage. Data for the 12-month period of July 2017-June 2018 were analysed, this represents a total of 1,102 individual clients, and 2,239 episodes of care.

Our average client:

62% male

40% issues with alcohol

97% Australian born

99.8% English speaking

Lives in:

36% Wodonga or

21% Wangaratta

23.27% private rental

59% referred by ACSO/COATS

33% Treatment type: AOD Counselling

OVENS MURRAY REGIONAL ANALYSIS 2: PRIMARY DRUG OF CONCERN

This paper presents an overview of primary drugs of concern data from the Ovens Murray Area. Data from a total of 1,851 questionnaires were analysed representing all clients aged 16+ years who accessed AOD services through Gateway Health between July 2017 and June 2018.

Across our total dataset, the highest proportion of clients are seeking help for their issues with Alcohol use, followed by Cannabis. Together these two substances account for 2/3rds of our client group's primary drugs of concern.

Top 4 listed primary drugs of concern:

39.74% Alcohol
23.61% Cannabis
19.45% Amphetamines
4.97% Methadone

Further detail for primary drugs of concern is provided in the table below, where we can see the prevalence of other substances our client groups are seeking help for.

Primary drug of concern	Total questionnaires with primary substance noted	% of questionnaires with substance noted as primary
Alcohol	736	39.74%
Cannabis	437	23.61%
Amphetamines	360	19.45%
Methadone	92	4.97%
Buprenorphine	61	3.30%
Heroin	57	3.08%
Opioid analgesics, n.f.d.	34	1.84%
Nicotine	16	0.87%
Benzodiazepines	13	0.70%
Codeine	8	0.43%
Ecstasy	6	0.32%
Analgesics, n.f.d.	4	0.22%
Stimulants and Hallucinogens, n.f.d.	4	0.22%
Cocaine	3	0.16%
Morphine	2	0.11%
Other drugs, n.e.c.	1	0.05%
Inadequately described	17	0.92%
Total	1851	

A note on the data:

Because of the way data is collected and recorded within Gateway's client management system primary drug of concern data is garnered from completed questionnaires, not individual client records. This means that the figures in this analysis do not represent proportion of clients, but the proportions of questionnaires that note a particular substance as the primary. Clients may, throughout the course of their treatment, complete a number of questionnaires, which AOD workers use to comprehensively assess client treatment needs and progress.

OVENS MURRAY REGIONAL ANALYSIS 3: GEOGRAPHIC ANALYSIS

This paper presents an overview of geography in terms of AOD service demand and client access across the Ovens Murray Area. We have based this analysis on 12 months of AOD service data from July 2017 to June 2018.

A key consideration in AOD Catchment Based Planning is whether our catchment's AOD services are located in the right places for clients to be able to access them.

Higher level local government area (LGA) analysis

Local government area	Percentage of the catchment's resident population who reside in this area	Percentage of total AOD clients from each local government area
Wodonga	31.64%	38.35%
Wangaratta	22.76%	22.77%
Indigo	12.83%	5.39%
Benalla	11.14%	10.4%
Alpine	9.92%	5.03%
Mansfield	6.90%	2.51%
Towong	4.81%	2.15%

Source: 2016 ABS Census data and Gateway Health AOD Client data

Client data were analysed to look at areas where people accessing our catchment's AOD services are coming from, relative to population distribution. The table above shows each LGA against the percentage of the catchment's population and percentage of total AOD clients. There are a number of determining factors as to why clients access services in some areas more than others. We know that when services are located in the areas that people live (or can easily access) they are more readily utilised. The Ovens Murray Area has just 3 fixed service sites; Wodonga, Wangaratta and Myrtleford (in Alpine Shire LGA), serving a population of 124,000 people.

We can see in the table above that there is a slightly higher proportion of clients from Wodonga than the proportion of people residing in that area (38.35% of clients, and 31.64% of population). From this we may understand that Wodonga is reasonably well serviced, the site is easily accessible and the community is aware of how they can access it. It's a similar story for Wangaratta (22.77% of clients and 22.76% of the population) and Benalla (10.4% clients, compared to 11.14% of the population).

Looking at the data for the other LGAs we may start to question whether we have the right service sites and/or community awareness of them in that area:

- In indigo we are seeing less than half the clients we would expect from a population that size (5.39% compared to 12.83%)
- In Alpine the story is similar, 5.03% of clients compared to 9.92% of our resident population (even though Alpine itself has a fixed service site).

- In Mansfield 2.51% compared to 6.90%, and in Towong 2.15% compared to 4.81%.

Please note that the data for Mansfield may be impacted by a 3-year philanthropically funded AOD service, which means that our Mansfield data may not fully reflect the numbers of clients accessing AOD service in that area.

In the table below, we take a more granular look at this data, drilling down to client postcode level. The analysis demonstrated that 2/3rd (65.95%) of clients come from just 3 postcodes, and that 8.07% of clients for this time period reside 'across the border' in New South Wales.

These postcodes are outlined below.

Suburb	Postcode	LGA	# clients	% of clients
West Wodonga, Wodonga, Wodonga Plaza	3690	Wodonga	200	35.84%
Yarrunga, Wangaratta	3677	Wangaratta	118	21.15%
Benalla	3672	Benalla	50	8.96%
South Albury, Ournie, North Albury, Moorwatha, Thurgoona, Talmalmo, Table Top, Splitters Creek, Wymah, Mirlinga, West Albury, Albury, Bungowannah, East Albury, Ettamogah, Glenroy, Lavington	2640	NSW *(not in catchment)*	22	3.94%
Hamilton Valley, Springdale Heights, Lavington	2641	NSW *(not in catchment)*	16	2.87%
Wooragee, Stanley, Murmungee, Beechworth	3747	Indigo	15	2.69%
Mansfield, Mirimbah, Barwite	3722	Mansfield	13	2.33%
Havilah, Gapsted, Merriang South, Merriang, Barwidgee, Abbeyard, Dandongadale, Buffalo River, Selwyn, Wonnangatta, Nug Nug, Rosewhite, Mudgegonga, Myrtleford	3737	Alpine	13	2.33%
Bandiana, Barandud, Barnawartha North, Bellbridge, Allans Flat, Coral Bank, Castle Creek, Ebden, Dederang, Bethanga, Berringama, Bungil, Bonefilla, Kergunyah, Kancoona, Kiewa, Kergunyah South, Glen Creek, Gateway Island, Huon Creek	3691	Wodonga	12	2.15%
Bathumi, Boosey, Esmond, Telford, Yarrawonga, Yarrawonga South, Bundalong, Bundalong South, Burramine, Burramine South	3730	Moira *(not in catchment)*	10	1.79%
Gooramadda, Great Southern, Prentice North, Rutherglen, Carlyle, Browns Plains, Briin, Boorhaman North	3685	Indigo	9	1.61%

Meadow Creek, Milawa, Londrigan, Markwood, King Valley, Laceby, Everyon Upper, Killawarra, Tarrawingee, Wabonga, Peechela East, Rose River, Oxley Flats, Peechelba, North Wangaratta, Oxley, Whitlands, Wangaratta South, Wangaratta Forward, Wangadary, Waldara, Boorhaman, Bobinawarrah, Bowser, Boorhaman East, Carboor, Byawatha, Cheshunt, Chshunt South, Dockers Plains, Docker, Edi, East Wangaratta, Evertyon, Edi Upper	**3678**	Wangaratta	6	1.08%
Smoko, Mounth Hotham, Harrietville, Hotham Hieghts, Freeburgh, Germantown, Bright	**3741**	Alpine	6	1.08%
Yackandandah, Bruarong	**3749**	Indigo	6	1.08%
Falls Creek, Mount Beauty, Nelse, Bogong	**3699**	Alpine	5	0.90%
Dartmouth, Eskdale, Granya, Mitta Mitta, Tallangatta Valley, Tallangatta South, Tallandoon, Shelley, Old Tallangatta	**3701**	Towong	5	0.90%
Towong Upper, Towong, Tom Groggin, Thowgla Valley, Nariel Valley, Corryong, Colac Colac, Bringenbrong, Biggara	**3707**	Towong	5	0.90%

NB: Data showing fewer than 5 clients per postcode has been removed to protect the confidentiality of our clients.
Source: Gateway Health AOD Client data

Data has not been collected in this catchment in this way before. We will use this data to monitor changes in geographic service access overtime.

Clients with injecting history

The Needle and Syringe Program (NSP) is a free service that provides injecting drug users with sterile injecting equipment, discourages the sharing of injecting equipment, minimises the transmission of blood borne diseases, provides referral services to injecting drug users and provides the safe collection and disposal of injecting equipment in the community. The service also provides free condoms and safe sex advice.

The top 20 residential postcodes of clients with injecting history have been imported into the map, below, with a blue pin point in the centre of their location. The red stars show the locations of NSPs within the Hume catchment.

This map shows the accessibility of NSPs in relation to clients with injecting history. Clients with injecting history are not necessarily currently accessing NSPs, but the geographic distribution is relevant when we consider if we have the right service structure.

OVENS MURRAY REGIONAL ANALYSIS 4: CULTURALLY AND LINGUISTICALLY DIVERSE CLIENTS

Cultural and linguistic diversity is defined as "people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as "main English-speaking countries", it excludes Canada, New Zealand, the United Kingdom, USA and Ireland (ABS, 2018). The cultural and linguistic diversity of the population is an important consideration when we look at equality of access for all communities within our catchment areas.

Population diversity in the Hume catchment:

Although diversity in this catchment is low compared to state measures (which include metropolitan Areas), the area rates highly on some measures of diversity compared to other Areaal catchments. This is particularly true for rates of humanitarian arrivals as a percentage of new settler arrivals 11.5%, compared to 9.3% in Victoria; primarily due to the high rates in Wodonga and Alpine, which can be seen in the table below. Humanitarian arrivals are those from a refugee or asylum seeker background; these are people who have a unique and often traumatic experience of migration, persecution and displacement (Department of Health, 2006). Health service provision in a multicultural context requires an understanding of the differences that arise through cultural and linguistic diversity and a strong commitment to action that addresses issues of health equity (Department of Health, 2006).

	Alpine	Benalla	Indigo	Mansfield	Towong	Wangaratta	Wodonga	Victoria
% of population born overseas	15.7%	8.4%	8.7%	12.3%	7.9%	8.41%	10.0%	27.7%
% of population born in a non-English speaking country	9.1%	4.3%	3.7%	5.5%	3.3%	4.8%	6.0%	20.9%
% population speaking a language other than English at home	9.1%	3.0%	2.3%	4.3%	1.9%	4.8%	4.9%	24.2%
Low English proficiency	1.2%	0.4%	0.3%	0.3%	0.2%	0.7%	0.6%	4.2%
New Settler Arrivals per 100,000	313.2	103.0	64.9	48.7	17.3	246.0	464.2	682.5
Humanitarian arrivals as % of NSA	10.5%	0.0%	0.0%	0.0%	0.0%	0.0%	18.8%	9.3%

Source: DHHS Local Area Profiles, 2015

Client diversity

12 months of client data were analysed, from the period 1 July 2017 to 30 June 2018, relating to 1,102 client records.

This section of the paper compares available measures of diversity in our client group to our catchment's resident population. This is one way to interrogate whether our services are meeting the needs of our diverse population in the same ways that we are of our white, Australian born community.

People born overseas:

17.5%

of our catchment population were

born overseas

but just

3.3%

of our clients were

Language:

4.5%

of our catchment population

speak a language other than English at home

1.2%

of our catchment population have low English proficiency

…. But only

0.22%

Of our clients noted a language other than English as their preferred.

Comparing country of birth and language data of AOD clients with the Hume catchment population suggests that we may not be meeting the needs of our CALD community in equitable ways. This may speak to cultural appropriateness of service, cultural stigma and shame, health literacy, or the need for service orientation and community engagement initiatives.

CALD groups are universally underrepresented in AOD services, but this isn't because they have a lower prevalence of AOD use disorders (Marel, et al. 2016); rather, their under-representation is often due to a number of barriers to treatment which have been researched extensively, including:

- Cultural shame, stigma and fear of judgement around treatment
- Cultural appropriateness of services
- Cultural differences between clients and therapists

- Lower levels of health literacy and a lack of education or exposure to public health campaigns, including a lack of familiarity with the availability of AOD treatment services and how to access them
- Language barriers making it difficult to participate in AOD treatment programs or to clarify differing expectations of treatment (Marel, et al. 2016).

A note on the data:

Because of the way data is collected and recorded within Gateway's client management system we are not currently able to extract gender for CALD clients. The *Activity 1: Data integrity working group* will work to address these issues within Gateway's client data system to achieve more consistency in data extraction and reporting.

OVENS MURRAY REGIONAL ANALYSIS 5:
ABORIGINAL AND TORRES STRAIT ISLANDER CLIENTS

This paper providers a brief overview of data relating to clients who are Aboriginal. It utilises data from the Ovens Murray Area AOD service catchment. Of the 1,181 clients aged 16+ who accessed AOD services in the Ovens Murray Area between July 2017 and June 2018, 8.81% identified as Aboriginal, Torres Strait Islander or both, this number represents 104 individuals. The data in this factsheet are drawn from those clients.

Twin Cities – Albury – traditionally known by Aboriginal people as Bungambrawatha and Wodonga – traditionally known as Woodanga. Communities saw the twin cities as one and saw the Murray (Millewa) not as a divider of states but a shared resource. Albury was a resettlement area which was initiated by government in the mid 1970's to entice Aboriginal people to live in a place which had better housing, education, health and employment opportunities. Wodonga was a place Aboriginal people decided to move to.

There was word "no Aboriginals lived in Wodonga"; in the 1980's a small and dedicated group of local Aboriginal people came together to have a voice and a place for community. The group formed a committee Local Aboriginal Education Consultative Group (LAECG) in the late 1980's and provided a homework centre for Aboriginal children. There was a vision to unite and service the community, by providing a place that we could come together, and build a future for our children and community. From this concept **Mungabareena Aboriginal Corporation** (MAC) was formally incorporated on the 29 September 1994. Today MAC provides services in the City of Wodonga, Albury and North East Victoria. The focus of Mungabareena Aboriginal Corporation is to 'drive future direction and growth for all Aboriginal people in the Area to enhance and improve their quality of life, health and wellbeing.'

Albury Wodonga Aboriginal Health Service (AWAHS) was developed through a joint partnership between Mungabareena Aboriginal Corporation, Wandoo Aboriginal Corporation and Woomera Aboriginal Corporation. This enabled the three organisations to undertake a project to establish the gaps in Aboriginal health. The final document produced was the Koori Cross Border Health Plan 2001, which called for an Aboriginal Health Service to address the appalling health statistics for Aboriginal people. Planning and lobbying for the establishment of AWAHS spanned more than thirty years. AWAHS was incorporated in September 2003 and the Health Service commenced full operational service in June 2005 from a rental premises in central Albury. In 2007 a joint venture between the Office of Aboriginal and Torres Strait Islander Health (OATSIH) and NSW Health saw AWAHS receive funding to build a purpose-built health facility. AWAHS officially opened its new building in August 2009. AWAHS has rapidly grown and has opened the doors of a second campus in Wodonga, with AWAHS Social Emotional team providing support and access for AWAHS client living across the river in Victoria. In 2017 AWAHS outreach to Wangaratta and had set up service at the NESSAY building delivering D&A mental health and suicidewith a doctor and nurse once a week. The service also outreaches to Bright and Mansfield

Aboriginal Victoria supports the development of the **Local Indigenous Networks (LAN).** Aboriginal communities have begun to strengthen and have a voice and a place to set priorities, develop community plans, improve social cohesion, empower Aboriginal

Victorians to participate in civic and community life. In our areas LAN's have been set up in the townships of Wangaratta – Dirrawarra Indigenous Network, Wodonga Aboriginal Network, and Mansfield – Gadhaba Local Aboriginal Network. LANs are voluntary community networks provide a safe and welcoming space for the Aboriginal community to connect, share, learn and lead. LANs provide a critical and effective channel to engage and celebrate the diversity within the Aboriginal community. Dirrawarra Indigenous Network have been working toward the development of a Gathering Place.

Aboriginal and Torres Strait Islander **Gathering places** have been described as a community hub that promote the importance of culture in supporting positive health and wellbeing for Aboriginal and Torres Strait Islander people. Definitions of gathering in an Aboriginal and Torres Strait Islander context include activities such as sharing food, performing ceremony, exchanging knowledge and creating supportive networks to ensure continuity of culture and traditional practices that create culturally safe places. Gathering places are safe, welcoming and inclusive spaces that provide social connections and create opportunities for personal and community empowerment.

The first organisation of its kind in Australia, **Victorian Aboriginal Child Care Agency** VACCA has worked to protect the rights of vulnerable Aboriginal families and children since 1976. VACCA was born of an urgent concern in the Victorian Aboriginal community about the large number of Aboriginal children being removed from their families and adopted or fostered into non-Aboriginal families. At forums during 2017 including the Aboriginal Children Forum (ACF) there has been a call to action to further progress the transition of Aboriginal children to their local ACCO. 2018 VACCA are establishing an office in Wangaratta to support Aboriginal children in out of Home Care and support the capacity of organisations, workers and community.

Gender

There is a higher proportion of Aboriginal women in treatment compared to the general client group. 41.35% of all Aboriginal and Torres Strait Islander clients are female, compared to 38.65% of our general client group.

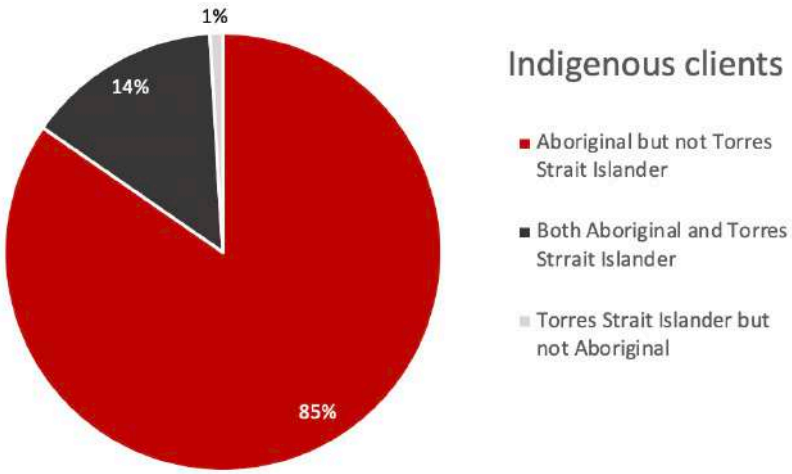
41.3% of 104 indigenous clients
in this 12-month period were female
(men made up 58.7%).

Consultation in other AOD catchment areas has suggested that the higher proportion of Aboriginal women in treatment may occur as a result of child protection issues, family violence and other factors related to intergenerational trauma. More work needs to be done to determine if these factors are also relevant to the Ovens Murray Area.

It is a notable strength that young Aboriginal women are seeking treatment at higher than average rates and one of our tasks is to ensure we utilise this momentum as much as possible.

Culture

Of our Indigenous client group, the largest proportion identify as Aboriginal but not Torres Strait Islander, 14% are recorded as both Aboriginal and Torres Strait Islander, and just under 1% are Torres Strait Islander but not Aboriginal.



AOD use

When we look at the four most commonly cited primary drugs of concern recorded for Aboriginal clients we see the same 4 substances as the general client group but in different proportions:

Top 4 listed primary drugs of concern

32.71% Cannabis (compared to 23.61% in the general client group)
31.90% Alcohol (compared to 39.74% in the general client group)
12.90% Amphetamines (compared to 19.45%)
8.58% Methadone (compared to 4.97%)

- Cannabis surpasses alcohol as the number one recorded primary drug of concern for Aboriginal clients.
- There is a lower proportion of Alcohol and Amphetamines noted as primary drug of concern in the Aboriginal dataset.
- A higher proportion of clients seeking help for methadone than in the general client group.

Local AOD system priorities

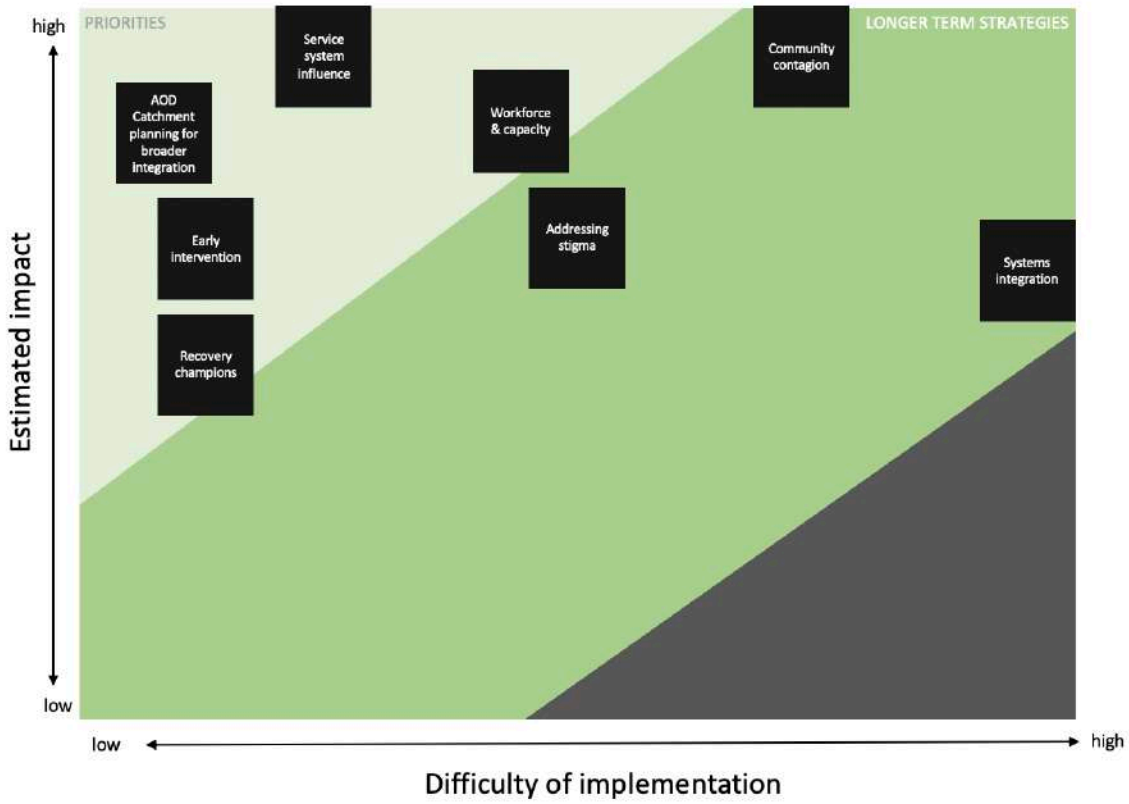
The vision for the Ovens Murray AOD Catchment based plan is **'To work with communities to support every person in Ovens Murray to lead a safe and healthy life'.**

Following data analysis, consultation and collaborative priority setting consensus was reached on the following areas of focus to address this:

Proactive and effective governance	Establishing a governance structure that uses the AOD Catchment planning process as a mechanism for much broader integration across health and community sectors in the Ovens Murray Area.
Workforce and capacity building	Implementing strategies to comprehensively address workforce needs in attraction, retention, capacity and effectiveness for Hume. With particular attention given to the unique challenges of Areaal areas.
Addressing stigma at all levels	Implementing strategies to create communities that understand addiction and supports recovery and lives free from substance abuse.
Aboriginal inclusion	Powerful and proactive Aboriginal inclusion throughout all aspects of AOD service design, planning and provision.
Early intervention	Implementing strategies to effectively address the needs of children, young people and parents affected by substance use, including those in early stages (less severe, non-dependant) AOD disorders.
Funding & service system influence	Advocate for the Ovens Murray Area to transcend the limiting nature of funding specifications, creating service systems integration based on an overarching ethos of service selflessness and 'what is best for the clients and community'.
Community connection	This plan and its activities will actively support positive community connection. Our underlying ethos will be to acknowledge and empower our community in their capacity to collectively support recovery. There is a specific emphasis on prevention (through partnerships), early intervention (through advocacy for funding), reducing stigma, and incorporating hope into the recovery journey. Effectively utilises Recovery Champions
Service integration & improvement	Implement strategies that address local service system needs and improve our responsiveness. Build an effective AOD service system that is based in best practice, effectively addresses local needs, gaps and barriers and works in partnership in pragmatic ways.

When we prioritise needs at this level, what emerges is a collection of areas to focus on; and there are multiple ways we could go about addressing them.

Before the collaborative prioritisation and strategy session adjourned, participants helped to map the resultant priorities into the matrix below mapping them against estimated impact and difficulty of implementation:



This helped to frame the priorities for year 1, year 2 and year 3 activity plans detailed in the following pages. Effort has been made in this plan has been to ensure that high level strategy flows down to real world activity. In order to do that each of these priorities have been organised into activity plans that aim to address the needs of the local AOD service system in a comprehensive and systematic way.

The following pages outline key overarching activities, and for each:

- a vision or aim for what they are working to achieve
- the structures that will be employed to oversee, inform or direct them
- a high level workplan or set of actions that they will deliver against
- and the corresponding priorities they are seeking to address.

Activity 1: Establish a data integrity working group

Vision:
To create excellence through processes and systems that enable Gateway Health and partners to collect, analyse and monitor AOD client and service data consistently and efficiently. This group will work to equip AOD workers, services, the AOD sector and all related sectors locally with high quality data and information to ensure best possible service monitoring and excellent client outcomes. Year 1 activity focuses on Gateway data integrity, and year 2 moves to include broader catchment services.

Workgroup membership:
Members will be sought from relevant strategic, technical and data analysis areas to ensure that we have representation across the service system from an understanding of service needs, to data systems structure, technology, analysis and evaluation expertise.

Workplan:

Year 1	Membership and terms of reference established. This work group will meet every 6 weeks in the first year to address: - Victorian Alcohol and Drug Collection (VADC) compliance - Stipulated changes to Trakcare (client data management system) and internal reporting processes - Consistency in extraction parameters - Agreement on what's to be monitored and collected over the next three years. - Establish reporting cycles and dissemination channels - Monitor and report on improvements in data quality - Maintaining a log of the improvements made in system capacity as a result of the actions of this group.
Year 2	- Create an excellent data integrity update for the AOD Catchment based plan annual update - Create a workplan for the second year's focus - Report back to AOD workers, services, the AOD sector and related sectors the changes that have been made and the outcomes of those changes - Provide an easy-to-access AOD data snapshot for use in service planning, quality monitoring and stakeholder engagement - Continue to maintain a log of the improvements made in system capacity as a result of the actions of this group.
Year 3	- Evaluate data integrity group approach. - Create an excellent data integrity update for the AOD Catchment based plan annual update - Create a workplan for the third year's focus - Report back to AOD workers, services, the AOD sector and related sectors the changes that have been made and the outcomes of those changes

Addresses the priorities of:

Proactive and effective governance

Workforce and capacity building

Systems integration and service improvement

Funding & service system influence

Aboriginal inclusion

Activity 2: Youth AOD Service Redesign

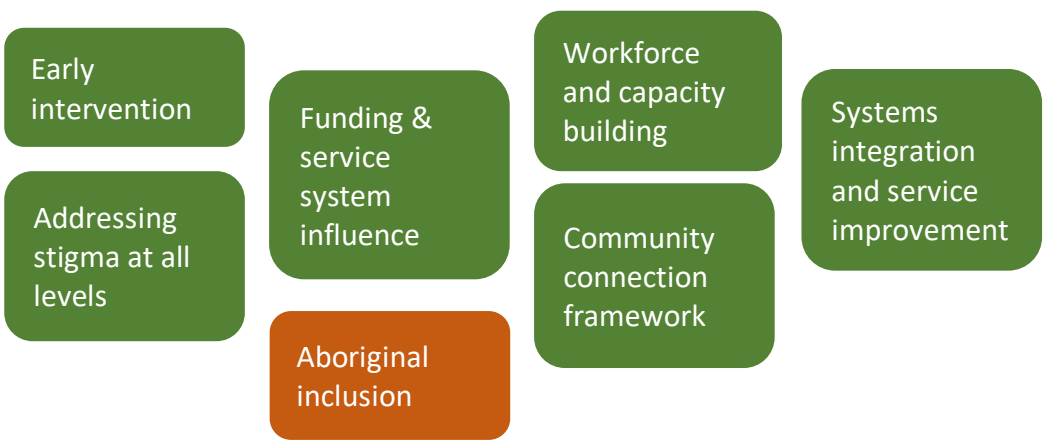
Vision: To establish an excellent Youth AOD Service in the Ovens Murray Area. That effectively identifies, engages with and treats those affected by and at risk of substance use. A proactive, health promotion and community engagement approach, this service is energising and mobilised.

This work will include: Close collaboration with the organisations and programs that are already underway in this area, including the four Local Drug Action Teams (LDATs), headspace, the Wangaratta Council Youth Survey, the Wodonga Council Youth Strategy (in development) and other key stakeholders, committees and networks in this space.

Workplan:

Year 1	- Reset the Youth AOD team (already underway) - Develop a communication strategy to manage external perceptions of Gateway's reputation as a Youth AOD service provider - Run a facilitated 'visioning workshop' for future service design, including consultation with local young people. - Create a workplan, enlist relevant stakeholders - Feed into the Data integrity working group what data is required to effectively monitor. - Set up a monitoring and evaluation framework to measure the success of this new service structure
Year 2	- Report on the changes and the outcomes of those changes in the 2020 AOD Catchment based plan annual update - Survey youth clients, youth AOD staff and relevant related Youth services for how well the Youth AOD services are now running and to get a sense of the work that still needs to be done.
Year 3	- Evaluate the new service structure and report on the lessons and learnings of these changes, including the process of implementing these changes. - Report on the changes and the outcomes of those changes in the 2021 AOD Catchment based plan annual update - Create a workplan for the third year's focus.

Addresses the priorities of:



Activity 3: Proactive and effective governance

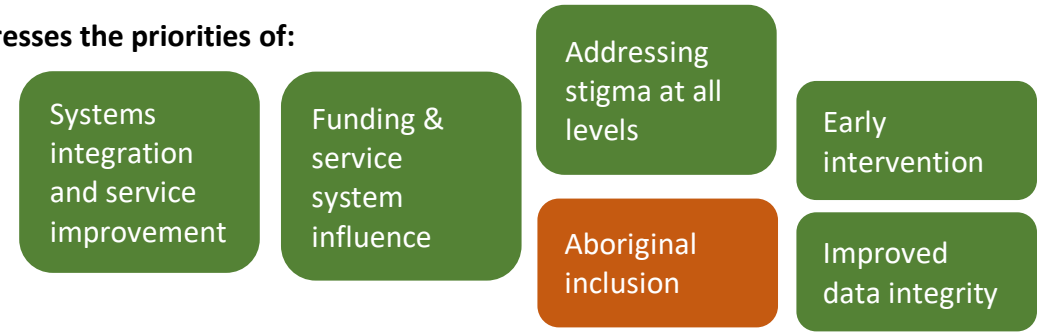
Vision: That the AOD Catchment Based Planning process is a mechanism for broad cross sector service and systems integration in the Ovens Murray Area. That the activities of the catchment plan have effective oversight and AOD system changes are seen as a springboard for other integrated improvements that support every person in Ovens Murray to have a safe and healthy life.

How: The Ovens Murray Committee (an established cross-sector executive level advisory group) meets bi-monthly and dedicates an hour of every meeting to overseeing the activities of the AOD catchment based plan to ensure sustainable progress for all health and community services locally. That AOD catchment based planning functions as a springboard project for addressing identified needs, gaps and barriers across the broader service systems in the Ovens Murray Area.

Workplan:

Year 1	- The Ovens Murray committee meets to review the AOD Catchment based plan, and agree on relevant work points. - A workplan for oversight, monitoring and evaluation is established and relevant linkages with other sectors and services are agreed. - That an agreed framework is employed (such as Using Collaboration as a Capacity Building Tool) to set up the required mechanisms for effective cross-sector collaboration. - The Ovens Murray Committee meets bi-monthly, and an hour of every meeting is dedicated to overseeing the activities of the plan. - An overarching log of the successes and improvements that have been made as a result of this mechanism is maintained. - Create a media and communications strategy.
Year 2	- A brief evaluation of the effectiveness of the Ovens Murray Committee Collaboration is carried out and reported on (lessons, successes and failings) in the 2020 AOD Catchment based plan annual update, including the changes that have been implemented as a result of this approach. - Membership is reviewed to ensure appropriate stakeholder representation.
Year 3	- A brief evaluation of the effectiveness of the Ovens Murray Committee Collaboration is carried out and reported on (lessons, successes and failings) in the 2021 AOD Catchment based plan annual update, including the changes that have been implemented as a result of this approach. - Create a workplan for the 3rd year's focus.

Addresses the priorities of:



Activity 4: Aboriginal inclusion across the AOD service system

Vision: To provide culturally safe and inclusive services that support Aboriginal clients in the most effective and relevant ways to prevent harm from AOD misuse, access AOD services they need and have excellent recovery outcomes.
How: Work within existing local Aboriginal communities' self-determination and governance structures; partner with AWAHS, Mungabaraeena, Indigenous clients and other local stakeholders for advice and guidance on the best and most desired ways for AOD services to achieve the above vision.

Workplan:

Year 1	- Erect the Aboriginal flag, Torres Strait Islander flag and Australian flag at all service sites immediately.
	- To meet with representatives from AWAHS, Mungabareena and other local Aboriginal stakeholders and seek their advice on:
	  - Creating a meeting structure that works best for effective design and oversight of this key activity area; including work to ensure that Gateway Health as an AOD treatment provider uses all available resources to establish our sites and services as culturally safe centres of excellence.
	  - Planning for the roll out of Indigenous intergenerational trauma education for all AOD providers (services and workers) in the Ovens Murray Area
	  - AOD CBP's access to AWAHS data for effective monitoring of service quality and client outcomes, to improve our understanding of the needs, gaps and barriers that our Indigenous clients face and how we can work with community to address them.
	  - Creating a workforce capacity building approach to identifying Aboriginality in a safe way for Indigenous clients. Initiate relationships to help facilitate Aboriginal people / Aboriginal health workers to obtain AOD qualifications.
	- Create and maintain a log of the improvements to service and access for Aboriginal clients and community as a result of this activity area
	- Establish a data baseline so we can track any improvements these initiatives may make to the numbers of Aboriginal and Torres Strait Islander clients accessing services, and identifying as Indigenous.

Year 2	- A brief evaluation of the effectiveness of this activity area is carried out and reported on (lessons, successes and failings) in the 2020 AOD Catchment based plan annual update. - The views of AOD clients and workers are collected to get feedback on any changes in clinician confidence, cultural appropriateness of service and other relevant measures. - Work with ACCOs and Indigenous clients to create a workplan for the 2nd year of activity.
Year 3	- A brief evaluation is carried out and included in the 2021 AOD Catchment based plan annual update. - Work with ACCOs and Indigenous clients to create a workplan for the 3rd year's focus.

Addressing the priorities of:

Activity 5: Establish a Consumer Advisory Committee

Vision: To create a strong and sustainable mechanism for meaningful consumer input into AOD service delivery, system planning, monitoring and improvement in the Ovens Murray Area. So that the AOD service system is informed by the consumer experience and clients are empowered to contribute to creative solutions.

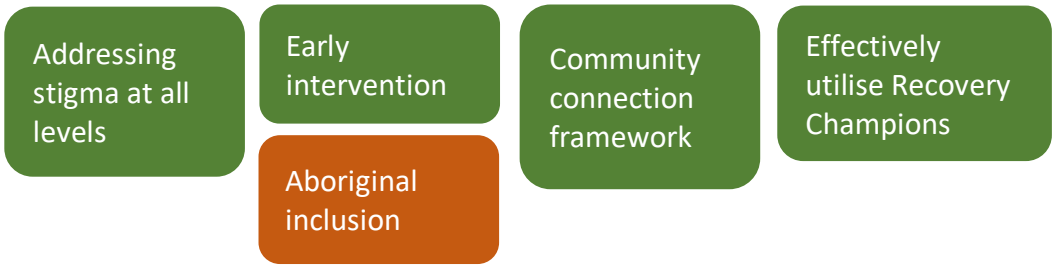
As part of the 2018 catchment based planning process, focus groups were held with a small number of AOD service clients in Wodonga and Wangaratta.

Participants were positive and engaged and provided a wealth of information about the consumer experience of AOD services in the Ovens Murray Area, as well as their perspectives of what could be done to improve it.

Workplan:

Year 1	- Recruit clients and community representatives for Committee membership, including efforts to include rural/remote members. - Utilise APSU resources to establish a workplan and engagement strategy - The first year workplan will include recovery champions, storytelling and reducing stigma. - Utilise the resource Straight from the Source (APSU podcast) - Meet three times per year - Have consumers articulate, what would success in this process look like to them? - Create a log of issues raised, and what has been done to address them.
Year 2	- Provide the consumer voice for the 2020 AOD Catchment Based Plan annual update. - Create a workplan for the 2nd year's focus.
Year 3	- A brief evaluation is carried out and included in the 2021 AOD Catchment based plan annual update. - Create a workplan for the 3rd year's focus.

Addressing the priorities of:



Activity 6: AOD workforce and capacity building

Vision: That the AOD workforce in the Ovens Murray Area is equipped to operate at a level of excellence in responding to the needs of AOD clients and the broader community. That continuous professional development is prioritised and high-level skills are attracted to and retained within the Area.

That other community sectors (such as general practice, emergency services, mental health, family services, etc) are up-skilled and empowered to respond confidently to their clients who also experience substance use and our sectors support each other in providing for integrated and sustainable client outcomes.

That the community and consumer voice is actively incorporated.

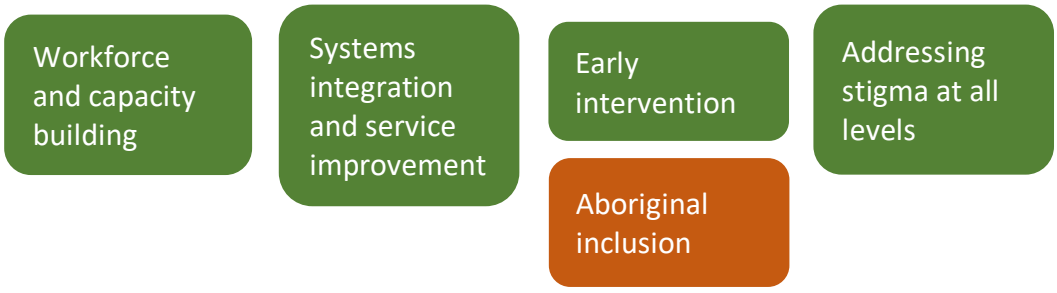
Particular attention is given to the challenges of operating high-level community health services in regional areas.

Workplan:

Year 1	- Survey the AOD workforce for desired skills, and collect baseline data around their confidence in dealing with particular issues.
	- Review all workforce and capacity building issues that were raised during the 2018 catchment based planning consultation processes.
	- Create a 3-year workforce training plan, with particular attention to:
	  - Utilising existing resources in the health sector
	  - Ensuring training is delivered in accordance with the Aboriginal inclusion activity plan
	  - Dual diagnosis capabilities
	  - Up-skilling other community sectors in better responding to AOD needs in their clients
	  - A communication strategy for general practice, to empower them to better respond to AOD needs in their patients.
	- Create a log of activity that has occurred as a result of this workstream; monitor numbers of workers attending various training.

Year 2	- A brief evaluation of worker satisfaction and retention in the last 12 months - Provide an update into the actions that have been carried out for the 2020 AOD Catchment Based Plan annual update. - Create a workplan for the 2nd year's focus.
Year 3	- A brief evaluation of worker satisfaction and retention in the last 12 months is carried out and included in the 2021 AOD Catchment based plan annual update. - Create a workplan for the 3rd year's focus.

Addressing the priorities of:



Activity 7: Future services, future sector

Vision: That the Ovens Murray Area develops the structures, services and programs to support our communities to lead a safe and healthy life. That we are innovative and responsive to funding opportunities, proactive with policy and legislative changes, and embed improvements sustainably and creatively into all service structures. That our approach is underpinned by an ethos of systems excellence and collaboration.
We comprehensively respond to consumer, stakeholder and community needs.

Workplan:

Year 1	- **Family drug service** - A request for more funding for the Family Drug Service is compiled and submitted to the DHHS. - **Pharmacotherapy** – Conduct a review of the pharmacotherapy model and best practice approaches to addressing the inherent challenges in embedding this in the health system. Connect with other catchments who are excelling in this area (such as the North West Pharmacotherapy Network, run by cohealth). - **SMART recovery groups** – Build a cost analysis framework and quantifiable outcomes monitoring approach to evidence the impact this program is having. - **The Ovens Murray Area's new residential rehab facility** – having influence on the design and structure of the newly funded facility; an implementation plan is developed. - **Family Violence Capacity Building Initiative** – work collaboratively with CAV and Albury Wodonga Health to recruit to the AOD and Mental Health Family Violence Advisor position. A 3-year workplan for this initiative is developed, linking to phase 1 of the initiative. - **Information sharing initiatives:** There are three key information sharing initiatives currently being implemented that have an impact on AOD service, these are (1) Child information sharing (2) Family Violence Information Sharing Scheme and (3) MARAM (formerly known as the CRAF). For each of these, we will carry out the following actions: ○ Policy guidelines are reviewed to understand their application in service delivery and strategy. ○ Organisational policies and procedures are developed to support the initiative. ○ Implementation of these changes are communicated to staff and staff are supported to develop their skills in accordance with these requirements. ○ Collaborate with broader stakeholders to embed these changes into the wider service system.
Year 2	- Review year 1 actions and required activity. Further workplans are developed. - Residential rehab facility: Review of timeframes and implementation plan to create a year 2 workplan for facility roll-out. - Ongoing participation in the mediums for information updates, policy changes and new initiatives.
Year 3	- Residential rehab – service delivery commences in the new facility. - Ongoing participation in the mediums for information updates, policy changes and new initiatives.

Addressing the priorities of:

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