South Eastern Melbourne Alcohol and Other Drug (AOD) Catchment-based plan 2019-21

January 2019

Prepared by enliven on behalf of SECADA in collaboration with SURe

SECADA and SURe acknowledge the support of the Victorian Government.
South Eastern Melbourne Alcohol and Other Drug (AOD) Catchment-based plan
Executive summary

The south eastern Melbourne catchment is comprised of the Cities of Greater Dandenong and Casey, and the Shire of Cardinia. It is geographically sparse with a landscape that is nearly as diverse as its population. The catchment has an assortment of characteristics – from vast differences in demography and socio-cultural profiles, to disparities in access to universal services, employment and education.

State funded Alcohol and Other Drug (AOD) services in south eastern Melbourne are provided by two consortia - South Eastern Consortia of Alcohol and Drug Agencies (SECADA), with Windana as the lead agent; and Substance Use and Recovery (SURE), led by EACH.

The South Eastern Melbourne Alcohol and Other Drug (AOD) Catchment-based plan (the plan) has been prepared by enliven on behalf of SECADA and SURE. Formulation of the plan involved a dynamic and rigorous data collection and stakeholder engagement process. This included: assessment of client data; secondary data analyses; qualitative consultation through focus groups and forums, and administration of an online survey.

Outputs from the above processes were iteratively synthesised together using inductive and deductive techniques to identify six key priority areas requiring action to address AOD-related harm:

- Cross sector collaboration
- Data accuracy, integrity and application
- Service geography
- The role of local government
- Clients and community
- Health promotion, prevention and community development

Participants in the above planning processes were also instrumental in manufacturing the actions featured in the plan following. Actions have been crafted to effect both micro- and macro-level change, ranging from those targeting AOD services themselves; to collaborative work with other sectors and organisations, and community action. As such, the plan is considered a plan for the community, and is intended to have utility for any individual, group or organisation whose path it intercepts.

The plan has been endorsed by both SECADA and SURE consortia, and with this a commitment has been made to the collaborative delivery of the actions herein.
Acknowledgements

On behalf of SECADA and SURE, enliven would like to thank the following people for their participation in one or multiple of the consultation processes.

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Representatives from the following organisations participated in consultations across the various platforms:

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<thead>
<tr>
<th>Afri-Aus Care Inc</th>
<th>enliven</th>
<th>South Eastern Melbourne Primary Health Network</th>
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<td>AMES Australia</td>
<td>Link Health and Community</td>
<td>SMRC</td>
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<td>Anglicare (SURE)</td>
<td>Monash Health Refugee Health</td>
<td>Taskforce (SECADA)</td>
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<td>City of Greater Dandenong</td>
<td>Monash Health (SECADA)</td>
<td>WAYSS Ltd</td>
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<td>City of Casey</td>
<td>Odyssey House (SECADA)</td>
<td>Windana (SECADA)</td>
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<td>Department of Health and Human Services</td>
<td>Shire of Cardinia</td>
<td>YSAS Ltd (SECADA)</td>
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<td>EACH (SURE)</td>
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enliven would also like to acknowledge the 67 respondents who participated in the anonymous online engagement survey.

SECADA and SURE acknowledge the support of the Victorian Government.
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Background

In Victoria, state funded Alcohol and Other Drug (AOD) services are delivered by catchment-based consortia with funding from the Victorian Government Department of Health and Human Services (DHHS). The south eastern Melbourne catchment is comprised of the Cities of Greater Dandenong and Casey, and the Shire of Cardinia. The consortia delivering AOD services in the catchment are: South Eastern Consortium of Alcohol and other Drug Agencies (SECADA), and Substance Use and Recovery (SURe). A key responsibility of catchment-based consortia is to develop a localised plan for their region.

“Catchment-based planning is undertaken by a single provider on behalf of, and in partnership with all alcohol and other drug services operating in the catchment and a range of stakeholders, including the department.

The primary purpose of the planning function is to assist alcohol and other drug providers operating in a given catchment to develop a regular common plan which will identify critical service gaps and pressures, and strategies to improve responsiveness to people with alcohol and other drug issues (particularly people facing disadvantage), population diversity and broader community need.

The plan provides a basis for improved cross-service coordination at the catchment level to achieve a more planned, joined-up approach to the needs of individual clients.”

As the lead agency for SECADA, Windana has led the preparation of this plan in partnership with SECADA consortium partners (Monash Health, Odyssey House, Taskforce, and YSAS); and the SURe consortium (EACH, Anglicare and YSAS).

The plan is a roadmap for use by not only SECADA and SURe but also other local providers and community groups in identifying and addressing critical service gaps and pressures; as well as cultivating opportunities for prevention, harm minimisation and early intervention, in a coordinated way.

“The AOD catchment-based planning process is an important step toward understanding the various and discrete needs of our catchment - south eastern Melbourne. SECADA, in conjunction with the SURe consortium have worked closely with enliven to identify the specific needs of our communities and how best to address them.

As a result of an extensive consultation and development phase involving multiple agencies, community members and specific groups we are proud to commend this comprehensive catchment-based plan (2019-21) for the south east region of Melbourne. This plan identifies six key areas and will form the basis of our focus for the next three years.”

Executive Officer - SECADA and Team Leader - SURe
Our catchment - the ‘where’ and ‘who’

Comprising of Greater Dandenong, Casey and Cardinia, the south eastern Melbourne (SEM) catchment covers 1,821km². Owing to several socio-demographic characteristics that are outlined in more detail below, SEM’s population is relatively transient and therefore published figures are often considered under-estimations of the exact size. However according to most recent Census data, the population is rapidly approaching 600,000 people across the catchment, with the highest concentration in Casey (326,820), followed by Greater Dandenong (164,148) and lastly Cardinia (102,425).

Interestingly, when compared to its south eastern Melbourne counterparts, Cardinia Shire recorded the highest growth rate (5.5%) in 2015-16, named the 6th fastest growing municipality in the country and the 3rd in Victoria. This rate was followed closely by Casey which also recorded a staggering rate (3.8%) making it the 12th fastest growing municipality in Australia, and the 6th in Victoria.

Although service availability per capita is relatively comparable to other areas of Victoria, for many reasons outlined later, large portions of the population remain un- or under-serviced. This is compounded by the fact that SEM has some of the highest rates of AOD-related harm in the state.


Our catchment - the ‘where’ and ‘who’

Local government profiles

City of Greater Dandenong

The City of Greater Dandenong (CGD) is famous for its diversity. Following the 2016 Census, it was re-crowned the most multicultural municipality in Australia, with residents from over 150 different birth places.

Just over half (52%) of CGD’s residents were born in countries where English is not the main spoken language, resulting in one in seven having ‘limited fluency’ in spoken English.

Similarly, in 2017 more people seeking asylum were recorded to be residing in CGD than in any other municipality in the country.

CGD’s diversity is also reflected in the variety of faiths that its residents subscribe to and there are over 100 places of worship across the municipality.

City of Casey

The City of Casey is described as an ‘Interface Council’ as it is comprised of both agricultural/low-density localities and urban expansion. It bridges the gap between metropolitan Melbourne and rural Victoria, bringing with it both urban and rural characteristics.

Casey has a significantly young population when compared to the rest of Victoria, with almost one quarter (22.6%) under the age of 14, compared to the state average of 18%. Not surprisingly Casey also has much fewer residents in the 55 and over age groups – 19.2% compared to an average of 27% across Victoria.

Casey also has a large population of residents who identify as Aboriginal and/or Torres Strait Islander, with the third highest number across metropolitan Melbourne.

Shire of Cardinia

The Shire of Cardinia, another interface Council, is the largest of SEM’s municipalities in terms of land mass. Most Cardinia residents live through the ‘growth corridor’ suburbs of Beaconsfield, Officer and Pakenham – which make up merely 10% of the municipality’s total land area.

This trend is expected to continue with predictions that by 2020, 66% of Cardinia’s population will reside in this area of growth. The challenge is to balance the resulting need for additional services, facilities and other infrastructure with the needs of existing communities in other more rural areas of Cardinia.

Not surprisingly given Cardinia’s sparsity, the vast majority of residents are required to travel some distances to work/school. Large numbers of Cardinia residents travel to work by car (77% compared to 68% across Victoria), while few travel by public transport or active travel (5.7% compared to 12.6% across Victoria).


Our process - the ‘how’

In August 2018, Windana as the lead agency for the SECADA consortium engaged enliven on behalf of SECADA and SURe to conduct the planning, monitoring and review functions for the AOD catchment-based plan in south eastern Melbourne.

In consultation with the Governance Group, enliven established, designed and executed a rigorous and dynamic stakeholder engagement and data collection process. Recognising the variable socio-demographic characteristics of the catchment, enliven ensured this process was not only multi-modal but also iterative, with each stage being informed by the previous.

Data mining and analyses

Insights relating to the profile of local AOD service clients were gleaned from the Client Information Management System (CIMS) in use at SECADA (Episoft). The findings are summarised below, and more information is available in Appendix B (online).

Additional data sources were also appraised in pursuit of a more complete understanding of AOD related issues in the catchment including those experienced by people who are not currently being serviced, or whom are accessing non-consortium services.

Additional data sources included:

- ABS, Census of Population and housing
- Public Health Information Development Unit, Social Health Atlas of Australia
- Turning point AOD Stats
- Victoria Crime Statistics Agency (CSA)
- Victorian Child and Adolescent Monitoring System (VCAMS)
- PBS data - Ambulance Victoria
- VicHealth Indicators 2015 Survey
Our process - the ‘how’

Stakeholder consultation

For the purposes of this plan, a broad definition to the term ‘stakeholder’ was adopted. In essence, enliven sought to engage with anyone in the south eastern Melbourne catchment that has an interest and the capacity to input in the planning process - from organisations both inside and exterior to the AOD service system; to existing or past clients of AOD services and their families and friends; to community members more broadly.

As a result of the relatively tight timelines, recruitment was largely conducted by convenience sampling and a small social marketing campaign through enliven’s network. As such, it should be acknowledged, that although enliven was indeed able to engage with all the above groups, the participant sample could not be considered representative of the overall catchment. In particular, consultation with AOD clients was minimal, however this deficit was acknowledged and now features as a key priority area for action within the plan.

More information on each component of the multi-modal stakeholder consultations described below can be found in the Appendices.

1. Discovery forum – service provider forum (Wednesday 31 October 2018)

Attended by 14 representatives from organisations both within and exterior to the AOD service system. Several explorative activities were facilitated to discover key issues, insights and opinions. During post-forum analyses six key themes emerged, particularly regarding areas of opportunity for development in catchment-based planning. See Appendix B (online) for full report.

2. Storming and forming – CALD community focus group (Thursday 22 November 2018)

The most recent evaluation of SECADA services highlighted insufficient participation by community members from Culturally and Linguistically Diverse (CALD) backgrounds, in all aspects of service delivery, planning and decision-making. As such, concerted efforts were made to engage with these cohorts, particularly those of African descent, in the development of the plan.

As such, this focus group was attended by 6 community members from the following cultural backgrounds: Sri Lankan (n=1), Afghan (n=1), South Sudan (n=1), Ethiopia (n=2), and Zimbabwe (n=1). A variety of ‘storming’ activities were co-facilitated to first identify issues that local communities face in relation to AOD. This was followed by ‘forming’ activities that sought to identify and prioritise potential solutions. See Appendix (online) C for full report.

3. Solutions forum – service provider forum (Thursday 6 December 2018)

Attended by 20 representatives from organisations both within and exterior to the AOD service system, including many return attendees from the Discovery forum. Findings from the Discovery forum and the CALD community focus group were presented. This was followed by facilitated activities to identify and collaboratively prioritise key objectives and areas for action.

4. Online engagement survey

On Monday 26 November 2018, an electronic survey was distributed through a variety of online channels, with the intention of capturing the voice of those who were unable to participate in face-to-face consultations. The survey was designed to mirror the process of the other fora, whereby respondents were first prompted to explore issues and areas of concern relating to AOD in their community/organisation/client-base. Following this they are encouraged to identify areas of possible action and to provide ideas or solutions that they envisage would have an impact on AOD related harm.

The survey was completed by 67 respondents. 52% of all respondents were representatives from organisations that provide non-AOD services to people in south eastern Melbourne. Nineteen (29%) respondents described themselves as representatives from AOD service providers, with the rest of the respondents comprised of:
Our process - the ‘how’

- lay community members (14.5%)
- family members of friends of people who have an AOD related problem (3%)
- AOD clients themselves (1.5%)
  See Appendix D (online) for full report.

5. Broader sector consultations

Additional opportunities were sought to further expand engagement and consultation where possible with existing groups.

- Focus group with SECADA staff (n= 28) conducted on Tuesday 4 December 2018 at staff meeting.
  Insights from the Discovery forum, CALD community focus group and early findings from the online engagement survey were presented. The team provided verification or rebuttal of themes and findings in line with their perspectives as client-facing staff.

- Focus group with *enliven*-led Community Strengthening Task group. This Community of Practice (COP) is comprised of (n=10) representatives from health, humanitarian and social welfare organisations – those primarily working with refugees, people seeking asylum and other migrants. As such, the COP were able to further articulate the barriers, challenges and issues experienced by the communities they support.

The iterative and reflexive approach for both data mining and stakeholder consultation process, was transferred into the formulation, structure and intended use of this plan. As such, this plan seeks to outline a living, working roadmap that includes the following:

- An overall vision and set of locally relevant goals for AOD services in south east Melbourne
- A set of objectives and associated indicators, as well as a raft of specific and measurable actions that are to be addressed in the first year
- A range of presently relevant priority areas that are likely to be addressed in either the second or third year but have not been prescribed specific actions at this stage to enable optimal responsivity to local needs as they change over the life of the plan.

“Denying access to good quality data to any community is actually denying them a human right, because you can’t know whether you are being treated fairly in a society, unless you have a measure of fairness”

Professor Papaarangi Reid
Our needs - the ‘why’

Figure 1. Face the facts

The social determinants of drug use

In 2016-17, the SEM catchment recorded high rates of low income, welfare dependent families compared to the state average of 8.4%.

32.8% of families in CGD experience rental stress (where rent is greater than 30% of total household income).

Expenditure on electronic gaming machines in SEM is well above the state average with $609 spent per adult, compared to $532 across Victoria. CGD recorded the highest with $927 per adult.

18.2% of families in CGD
13.5% of families in Casey
13.5% of families in Cardinia
10.2% of families across Vic.

Mortgage stress (where mortgage payments are greater than 30% of total household income), is experienced at a higher rate by families in the

CGD and Casey both consistently record family violence rates that are higher than the state average. 2017-18, 1458.4 incidents per 100,000 population were recorded in CGD, followed by 1284 in Casey (Victorian average - 1176.7).

Health Literacy

A 2016 study conducted by the Ophelia project found that Cardinia and CGD residents have overall poorer health literacy than those in other southern metro Melbourne LGAs: Stonnington, Port Phillip, Bayside, Glen Eira, Kingston, Casey, Frankston and Mornington Peninsula.

Social determinants of drug use

Socio-economic disadvantage

Socio-Economic Indexes for Areas (SEIFA) are a set of geographical based indexes developed by the Australian Bureau of Statistics to rank areas according to advantage and disadvantage. A lower score correlates with a higher level of disadvantage and vice-versa. The Victorian average SEIFA Index is 1010.

Indexes for both the Cities of Greater Dandenong and Casey rank below this average at 896 and 1004 respectively. As reflected in Figure 1, the Index for CGD is the second lowest in the state.

The SEM catchment also have high rates of unemployment, with all three local government areas recording rates that are higher than the state average of 5.9% of the population.

- City of Greater Dandenong – 12.4%
- City of Casey – 8.0%
- Shire of Cardinia – 7.0%

Not surprisingly, as a result of high unemployment rates, experiences of financial stress are also significant across
Our needs - the ‘why’

In south eastern Melbourne. In Victoria, 8.4% of families are considered ‘low income, welfare dependent’. All three local government areas in the SEM catchment have rates that are higher than this.

- City of Greater Dandenong – 13.6%
- City of Casey – 10.3%
- Shire of Cardinia – 9.8%

**Education**

Lack of education is both a consequence of, and a reinforcing factor for socio-economic disadvantage. All three local government areas in the SEM catchment record high rates of ‘early school leavers’ – people who left school at or before year 10 as indicated by an Age-Standardised Rate (ASR) per 100. SEM’s rates are notably higher than Victoria ASR of 26.0.11

- Shire of Cardinia – 33.8
- City of Greater Dandenong – 32.9
- City of Casey – 30.7

**Housing and homelessness**

In 2016, the rate of homelessness (number per 10,000 population) in Victoria was 41.9, an increase of 1% since the data was previously reported in 2011. Not only are CGD and Casey rates of homelessness higher than the average at 127.7 and 42.8 respectively, but the growth rate in the SEM catchment far exceeds the average growth across Victoria. Since 2011, the rate of homelessness has increased 20% in Cardinia, 16% in Casey, and 14% in CGD.12

Similarly, experiences of both mortgage and rental stress are also notably higher across south eastern Melbourne. With all three local government areas seeing rates particularly of mortgage stress that are significantly higher than the state average of 10.2%.

- City of Greater Dandenong – 18.2%
- City of Casey – 13.5%
- Shire of Cardinia – 10.6%

**Gambling**

Spending (losses) on electronic gaming machines in south eastern Melbourne is well above the state average with a median expenditure of $609 per adult per year, compared to $532 across Victoria. CGD recorded the highest with $927 spent per adult in 2017-18.13

**Family violence**

In the 2017-18 financial year, both CGD and Casey saw rates of family violence that were notably higher than the state average of 1,176.7 per 100,000 population. The rates of 1,458.4 and 1,284.4 respectively not only ranked the second and third highest among the ten southern metropolitan but were also among the highest in the state.14

**Health literacy**

‘Individual Health literacy’ refers to one’s ability to find, interpret and use health information and services, to make choices about their health and health care.15 It impacts the way people understand information that is given to them which might include prevention and health promotion messages, or similarly may contain critical service information.

A study conducted in 2016 by the Ophelia project across the ten southern metropolitan Melbourne local government areas highlighted that across all the nine measures Cardinia had higher proportions of people reporting difficulty than the overall sample. CGD also had higher scores for five of the measures.

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Our needs — the ‘why’

Figure 2. Face the facts

AOD use and outcomes in SEM

AOD-related presentations by CGD residents per 10,000 population at Emergency Departments are almost double state averages.
Alcohol - 22.5 (Victorian average - 13.8) Illicit drugs - 3.9 (Victorian average - 2.1)

AOD-related ambulance attendance rates in CGD per 100,000 population are notably higher than state averages.
Alcohol - 417.5 (Victorian average - 301.1) Illicit drugs - 280.8 (Victorian average - 179.6)

In the City of Casey...
...the average expenditure on alcohol in licensed premises (in the past 7 days) is double the state average.

City of Casey - $91
Victorian average - $45

73/100
Level of concern
Online consultation participants rated an average score of 73, when asked to rate their ‘level of concern’ about alcohol and drugs in south eastern Melbourne.

The top three most common reasons for the score of 73 were:
1. Decreased levels of community safety (real and perceived), and increased violence.
2. Availability and accessibility of services.
3. The obvious harms to ‘individuals’ health and wellbeing, but also the ripple effects on their families and communities.

Current SECADA client profile

8.3% of residents in Cardinia consume alcohol a levels considered ‘high-risk’ (eleven drinks or more on a single occasion).

8.3%
Over two-thirds (70%) of SECADA clients are male.

40.4%
4.75
2014-15
13.3
2017-18
The average rate of hospitalisation per 10,000 population for both ‘cannabis’ and ‘other stimulants’ have more than doubled across the entire SEM catchment in 3 years.

Over two-thirds (70%) of SECADA clients are male.

70% of SECADA clients were recorded as English-speaking, which does not match the cultural diversity of the SEM catchment.

96.37% of SECADA clients were recorded as English-speaking, which does not match the cultural diversity of the SEM catchment.

Consultation & Engagement
All forms of consultation have emphasised the importance of ‘engaging with SEM’s CALD communities’ in both service delivery and prevention and health.

Aboriginal & Torres Strait Islanders
2.81% of SECADA clients
0.49% of total SEM population

Our needs - the ‘why’

AOD use and outcomes

Spooner and Hetherington (2004) emphasise the significant impact that the social determinants of health namely the social, cultural, economic and physical environments have on either reducing or heightening the risk of individuals using drugs.

The authors conclude that treatments targeting individuals can only have a partial impact if the social determinants of drug use behaviour are not acknowledged and addressed as part of the solution.

As such, the determinants featured in Figure 1 and discussed above have been selected due to their well-researched correlation with AOD-related harm, primarily as key risk factors. In effect, they assist in explaining some of the below outcome-based findings.

Client and substance profile

Data from SECADA’s CIMS was analysed to develop a client profile for those who received AOD services in the SEM catchment between July 2017 to June 2018. A number of issues relating to data completeness and quality were encountered, and the dataset did not include extracts from SURE’s CIMS. As such, the resulting client profile cannot be considered completely representative.

- To understand the geographic distribution of clients, residential postcodes were analysed. This analysis indicates that two thirds (66.7%) of clients came from just 16 postcode areas. The highest concentration of clients reside in the below postcode areas:
  - 3175 - 12.97% (Dandenong, Dandenong South, Dandenong East, Dandenong North, Bangholme, Dunearn)
  - 3977 - 10.05% (Cranbourne, Cranbourne East, Cranbourne North, Cranbourne South, Cranbourne West, Botanic Ridge, Cannon’s Creek, Sandhurst, Skye, Devon Meadows, Junction Village)
  - 3810 - 7.97% (Pakenham, Pakenham Upper, Pakenham South, Rythdale)

These three areas all have a SECADA/SURE service site in them, meaning that just over 30% of the client group have easy access to service front doors.

- Data on age and sex was assessed, showing that the average client age for the 12-month period was 37.3 years.

Table 1: SECADA Clients - age distribution

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<th>LGA</th>
<th>Number</th>
<th>Percentage of total population</th>
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<tr>
<td>City of Dandenong</td>
<td>512</td>
<td>0.34%</td>
</tr>
<tr>
<td>City of Casey</td>
<td>1,616</td>
<td>0.54%</td>
</tr>
<tr>
<td>Shire of Cardinia</td>
<td>429</td>
<td>0.58%</td>
</tr>
<tr>
<td>Total</td>
<td>2,557</td>
<td>0.49%</td>
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Males accounted for more than double the number of clients than females, with 6,787 (69.2%) males and 3,017 (30.76%) females.

Aboriginal and Torres Strait Islander clients

According to the 2016 census 2,557 people of Aboriginal and/or Torres Strait Islander decent reside in the SEM catchment, equating to 0.49% of the catchment’s total population.

However, in the 2017-18 financial year SECADA saw 277 Aboriginal and/or Torres Strait Islander clients, accounting for 2.81% of all clients. This proportion is almost six times higher than the percentage of the total catchment population for which indigenous peoples account.

The residential breakdown of Aboriginal and Torres Strait Islander clients is shown in the table below.

Our needs - the ‘why’

Age

The average age of Aboriginal and Torres Strait Islander clients was younger than the total client group at 35.19 years (total client group average - 37.3 years).

Sex

Unlike the total client group where females only accounted for 30.76% of clients, relatively even numbers of males and females from Aboriginal and Torres Strait Islander backgrounds accessed AOD services.

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<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage of client group</th>
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<tr>
<td>Females</td>
<td>132</td>
<td>47.65%</td>
</tr>
<tr>
<td>Males</td>
<td>145</td>
<td>52.34%</td>
</tr>
</tbody>
</table>

Ethnicity, sex and age

Further examination of ethnicity, sex and age reflects that males of Torres Strait Islander descent are significantly younger than the rest of the client group, with an average age of 28.52 years.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Sex</th>
<th>Number</th>
<th>Average age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal</td>
<td>Female</td>
<td>112</td>
<td>35.69 years</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>Male</td>
<td>114</td>
<td>36.98 years</td>
</tr>
<tr>
<td>Torres Strait Islander</td>
<td>Female</td>
<td>19</td>
<td>32.89 years</td>
</tr>
<tr>
<td>Torres Strait Islander</td>
<td>Male</td>
<td>31</td>
<td>28.52 years</td>
</tr>
</tbody>
</table>

CALD clients

As mentioned previously, cultural and linguistic diversity is a key demographic feature of south eastern Melbourne’s population. People from CALD backgrounds are defined as: “those 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.”

In order to understand the CALD composition of the total client group, the fields of ‘ethnicity’ and ‘language’ were assessed. There was some inconsistency in the data quality where ethnicity and language entered suggested one or both fields were incorrect.

It should also be noted that at present the mechanism for collecting this data is unclear (eg. client-reported v clinician-attributed). As such, the results below should be interpreted with some caution.

Ethnicity

Ethnicity was recorded in 78.93% of the client records. Of those where ethnicity was recorded, 80.20% were Australian, followed by 5.50% European, and 3.65% Asian.

Language

Language was recorded for just over two thirds (67.86%) of the data set. Of these, 96.37% were recorded as English, followed by 0.55% Vietnamese, and 0.48% Tamil. These results are incongruent with the high proportions of clients whom speak English as a second language, across south eastern Melbourne.

When consulted, SECADA staff advised that as a default, English is recorded as the language when clients opt not to communicate through an interpreter. This results in an inaccurately high representation of English-speaking clients being recorded and effectively skews the number of clients whom would otherwise be considered CALD.

Substances of concern

Substances of concern are recorded both at intake and assessment, however the data capture at assessment is much more complete across the client cohort and has therefore been used to determine primary drug of concern. 93.19% of clients had their primary drug of concern recorded at assessment, as depicted in the table below.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number of clients</th>
<th>Percentage of total clients (excluding tobacco)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>793</td>
<td>40.38%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>253</td>
<td>12.88%</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>235</td>
<td>11.97%</td>
</tr>
<tr>
<td>Opioids</td>
<td>113</td>
<td>5.75%</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>108</td>
<td>5.50%</td>
</tr>
<tr>
<td>Sedatives</td>
<td>49</td>
<td>2.49%</td>
</tr>
<tr>
<td>GHB</td>
<td>12</td>
<td>0.61%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>11</td>
<td>0.56%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>1</td>
<td>0.05%</td>
</tr>
<tr>
<td>Inhalants</td>
<td>1</td>
<td>0.05%</td>
</tr>
<tr>
<td>Clients with no data entered as their primary drug of concern</td>
<td>388</td>
<td>19.76%</td>
</tr>
</tbody>
</table>

Our needs - the ‘why’

Health service outcomes

- Many residents of south eastern Melbourne who have AOD-related issues did not receive service from SECADA/SURe in the 2017-18 year and therefore are not reflected in the client profile above. As such, it is important to appraise alternative data sources in order to develop a more comprehensive understanding of the impact of AOD-related harm in the catchment. Data from other health services (non-AOD), namely hospitals and Ambulance Victoria was obtained and analysed for this exact reason.

AOD-related presentations at Hospital Emergency Departments in south eastern Melbourne are consistently higher than State averages. As reflected in Figure 1, in 2013-14, the number of presentations per 10,000 population in CGD were almost double state averages.18

Similarly, 2016-17 ambulance attendance rates per 100,000 population in CGD sit well above the State average for almost all substances.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Rate (per 100,000 population)</th>
<th>Victorian rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>417.5</td>
<td>301.1</td>
</tr>
<tr>
<td>Crystal methamphetamine</td>
<td>73.9</td>
<td>40.7</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>280.8</td>
<td>179.6</td>
</tr>
<tr>
<td>Cannabis</td>
<td>59.0</td>
<td>46.4</td>
</tr>
</tbody>
</table>


Hospitalisation rates per 10,000 population for both cannabis and other stimulants have increased significantly in the past three years. In 2014-15 the average hospitalisation rate for cannabis across CGD, Casey and Cardinia was 4.75, whereas in 2017-18 they were:
- CGD: 17.3
- Casey: 8.6
- Cardinia: 13.5

Similarly, the average hospitalisation rate for other stimulants in 2014-15 across the three local government areas was 4.5. In 2017-18 they were:
- CGD: 20.2
- Casey: 12.5
- Cardinia: 11

Community and stakeholder concerns

- The online survey platform enabled respondents who may have otherwise been unable to participate the opportunity to contribute their perspectives at their convenience and with the promise of anonymity. Aggregated survey responses also provide supplementary data that help to enhance the depth and richness to other data sets.

- Participants rated an average score of 73 (out of 100) when asked to rate their level of concern regarding alcohol and drugs in south east Melbourne. The top three reasons most commonly cited for this score were:
  1. Harmful effects of AOD use on individuals’ health and wellbeing, as well as the harms to families and communities
  2. Decreased levels of community safety (both real and perceived), and increased violence
  3. Poor availability and accessibility of services
Our priorities - the ‘what’

As described previously, stakeholder engagement and data collection processes were iterative, with each series of findings being tested by both inductive and deductive techniques to maximise validation. Creative strategic development processes and collaborative prioritisation then aided in the refinement of six priority areas for action:

- Cross sector collaboration
- Data accuracy, integrity and application
- Service geography
- The role of local government
- Clients and community
- Health promotion, prevention and community development

A vision for the desired outcome/s, as well as indicators that reflect progress or completion for each of the identified priority areas were co-designed by stakeholders at the ‘Solutions forum’. Similarly, these stakeholders were also tasked with developing specific and measurable activities for inclusion in the action plan, as well as determining when in the planning cycle they should occur.

Figure 3 (right) depicts the most commonly reported suggestions for addressing AOD-related harm in south east Melbourne across the various consultation platforms.

Governance and working group structure

Windana as the lead agency for the SECADA consortium, and EACH as the lead agency for the SURE consortium are ultimately accountable for successfully delivering on the plan that has been committed to by submission to DHHS. However, as previously stipulated the roadmap that this plan provides is a guide for all local service providers and community groups. As such, the plan does not belong to Windana or EACH, it does not belong to SECADA or SURE or to enliven. It belongs to the south eastern Melbourne community, and the south eastern Melbourne community are all responsible in some way for seeing that it is implemented in the best interests of the community.

In Year 1 a working group will be convened for each of the six priority areas, comprised of locally relevant stakeholders. Working groups will be established and coordinated by enliven and will include representatives from SECADA and SURE where appropriate. They will collectively lead the design and implementation of actions for their priority area alongside identified key stakeholders. The priority areas for action for which the working groups will be formed are:
Our priorities - the ‘what’

Priority areas for action

- Cross sector collaboration
- Data accuracy, integrity and application
- Service geography
- The role of local government
- Clients and community
- Health promotion, prevention and community development

A number of opportunities have been identified where working groups will be required either to support another group to achieve their actions, or to deliver particular activities collaboratively. Where this occurs, a badge that corresponds to the companion working group has been affixed within the plan.

A key area for response that emerged from consultation is centred on improvements required to the AOD service system itself (eg. SECADA/SURe consortia agencies or other partner organisations). The nature of the identified improvements is varied, each intersecting with at least one or multiple other identified priority areas. As such, it was deemed ineffectual to develop a working group with the sole focus of addressing service system improvements, as this group would be heavily reliant on one or multiple other groups depending on the need. Instead, it was decided that accountability for addressing the identified area of improvement would be allocated to the working group responsible for the priority area that most closely relates. These actions are denoted within each action plan below under the title ‘Service system improvements.’

A note about our approach to the planning cycle

The primary focus for the first year in the life of the plan, is ‘information gathering’ and improving data collection and reporting. This recognises that many decisions and plans for future years can and should remain either undetermined or flexible until a more comprehensive understanding is gleaned, which in effect will result in more appropriate and effective action planning. Emphasis will be placed on building the governance infrastructure and resources required for future service and program planning; as well as establishing baseline measurements for later comparison. Workplans for Year 2 and Year 3 will be shaped by these efforts and a greater understanding of the intricacies of client needs, community harms, and AOD service issues in south east Melbourne.

A note about scope

Prior to reviewing the priority areas and associated action plans, it should be noted that the scope for catchment-based planning is limited as described in the catchment-based planning service specifications. These guidelines recognise that effectively addressing population level AOD-related harm, requires a coordinated effort across multiple sectors outside of AOD.
Our priorities - the ‘what’

“Service coordination is expected across housing, mental health, gambling, primary health, justice, education and employment providers.”

However, whilst intersectoral collaboration is promoted and encouraged, the available funding does not permit actions to occur within other sectors. For this reason, no specific actions have been outlined in this plan that seek to target or take place within other sectors. Concerted efforts will however be made to ensure that representatives from periphery sectors are meaningfully involved in planning and delivering activities to optimise their relevance and uptake across the entire system.

Similarly, the service specifications classify “primary prevention activities” as out-of-scope for catchment-based planning. However, there is also strong encouragement for participation in planning structures relating to “health promotion platforms and strategies”. Stakeholders throughout all stages of consultation, from clinicians to managers, and community members themselves emphasised the need for a heightened focus on health promotion and prevention. As such, this plan features a priority area specific to this area of expressed need, but one that respects the scope prescribed by DHHS and makes sense for bodies like SECADA/SURE to lead.

## Our plan - Cross sector collaboration

<table>
<thead>
<tr>
<th>INDICATORS: What it will look like</th>
<th>ACTIVITIES: How we will get there</th>
<th>PROGRESS: Update on how we are tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Referral pathways are clear and developed</td>
<td><strong>Year 1 actions:</strong></td>
<td><img src="image" alt="Graph" /></td>
</tr>
<tr>
<td>• AOD staff report high levels of confidence in navigating/assisting clients to navigate the broader service system</td>
<td>• Establish relevant working group</td>
<td></td>
</tr>
<tr>
<td>• Increased number of appropriate referrals out of the AOD service sector ensuring clients are holistically supported in their recovery journey</td>
<td>• Collect baseline data for referrals into and out of the AOD sector</td>
<td></td>
</tr>
<tr>
<td>• A &quot;No wrong door&quot; approach is implemented throughout the catchment and AOD services are able to respond to clients wherever they present</td>
<td>• Administer survey to staff to ascertain baseline levels of confidence in service system navigation</td>
<td></td>
</tr>
<tr>
<td>• Intersectoral collaboration is enhanced by the establishment of relevant cross-sector platforms and enhanced relationships</td>
<td>• Build understanding and appreciation of key pressures and demands experienced by organisations across sectors (cross-sector empathy) in managing clients with AOD-related issues at a deliberative forum</td>
<td></td>
</tr>
</tbody>
</table>

**Service System Improvements**

**Develop/strengthen/consolidate referral pathways into and out of the AOD sector**

<table>
<thead>
<tr>
<th>Year 2 actions:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Monitor referrals data</td>
<td></td>
</tr>
<tr>
<td>• Conduct brief literature review into cross sector collaboration methodology</td>
<td></td>
</tr>
<tr>
<td>• Use literature review findings and other insights to develop a communications and engagement strategy that identifies stakeholders and platforms for collaboration (eg. task groups, forums, shared consumer groups, online base camp)</td>
<td></td>
</tr>
<tr>
<td>• Deliver cross sector empathy and collaboration forums informed by literature review findings</td>
<td></td>
</tr>
<tr>
<td>• Build capacity of internal and external staff, including GPs and other health professionals, to enhance referral practices and implement a &quot;No wrong door&quot; approach</td>
<td></td>
</tr>
<tr>
<td>• Advocate for funding to deliver collaborative AOD initiatives</td>
<td></td>
</tr>
</tbody>
</table>

**Year 3 actions:**

|  |
|----------------|---|
| • Re-administer survey to staff to compare levels of confidence in service system navigation with baseline results |  |
| • Conduct evaluation of year 1 and 2 activities, and measure progress against indicators |  |
| • Review priority area and make recommendations regarding its continuation |  |
| • Showcase learnings, including both successes and failures |  |

### DESIRED OUTCOME: What we want to see

That AOD services in south eastern Melbourne are integrated with the broader service system and strive for excellent cross-sector collaboration in responding to people experiencing AOD-related issues.
## Our plan - Data accuracy, integrity and application

### DESIRED OUTCOME:
**What we want to see**
That south eastern Melbourne AOD service and program planning is informed by accurate, relevant and comprehensive data to enable excellent evidence-based decisions and guide interactions with the community.

### INDICATORS:
**What it will look like**
- Data captures are 100% compliant with reporting requirements
- Data is routinely captured from multiple sources and used to inform planning (e.g. local government, ambulance, ABS, VicPol)
- At least 20% of data used to make planning decisions is qualitative (e.g. from consultation)
- Incomplete/unentered/insufficient data decreases as a proportion of all data collected
- Improvements to data quality and integrity are communicated and the effects that this has on the service system are clear
- SECADA/SURe take a leadership role in AOD data integrity

### ACTIVITIES:
**How we will get there**
**Year 1 actions:**
- Establish relevant working group
- Conduct a gap analysis of VADC data requirements vs. the draft catchment-based planning minimum data set
- Develop a south eastern Melbourne catchment-based planning data monitoring framework
- Develop a strategy for gathering and using qualitative data that specifies what data is to be collected when, from whom (e.g. staff, clients, community) and for what, etc.

**Service System Improvements**
Scope the need for and make any required changes to EpiSoft

**Year 2 actions:**
- Develop and implement a capacity building strategy that highlights the value of accurate and complete data collection both internally and external to the AOD sector, and includes updated practice guidelines
- Launch data monitoring framework and associated material and ensure staff are equipped to optimise it
- Implement qualitative data strategy
- Communicate feedback to the sector

**Year 3 actions:**
- Re-administer survey to staff to compare levels of confidence in service system navigation with baseline results
- Conduct evaluation of year 1 and 2 activities, and measure progress against indicators
- Review priority area and make recommendations regarding its continuation
- Showcase learnings, including both successes and failures

### PROGRESS:
**Update on how we are tracking**
## Our plan - Service geography

### INDICATORS: What it will look like

- Service locations (including co-locations) reflect community need
- Increased number of services co-located to address unmet need
- Increased service attendance across the catchment, with equitable distribution at all services relative to community need
- Information on available AOD services is provided in accessible formats according to literacy and English proficiency needs

### ACTIVITIES: How we will get there

**Year 1 actions:**
- Establish relevant working group
- Conduct scoping of council Geographic Information Systems (GIS) capacity to enhance AOD catchment-based planning service geography (includes measures of unmet need, such as Ambo, ED, VicPol, people at risk of alcohol related harm)
- Conduct annual review and update of service catalogue to inform service planning
- Consult with clients and community to understand the barriers to service access and utilise findings to inform further year 2 and 3 actions

**Service System Improvements**

Implement identified opportunities for co-location/outreach/telehealth/eHealth

**Year 2 actions:**
- Monitor service utilisation data in the context of GIS mapping output to stay informed of geographic areas experiencing gaps in service delivery
- Develop and update communications material including social marketing, ensuring it is available in accessible formats
- Scope opportunities for cross sector co-location, outreach and telehealth/eHealth options to enhance service availability, including advocacy for funding if required
- Review and make any required amendments to service catalogue

**Year 3 actions:**
- Repeat GIS mapping exercise comparing to Year 1 extract to evaluate changes to service geography
- Review and make any required amendments to service catalogue
- Conduct evaluation of year 1 and 2 activities, and measure progress against indicators
- Showcase learnings, including both successes and failures

### PROGRESS: Update on how we are tracking

**DESIRED OUTCOME:**

That south eastern Melbourne AOD services are available in a range of easily accessible locations across the catchment, and that clients and community are aware of how and when they can access them.
## Our plan - The role of local government

<table>
<thead>
<tr>
<th>INDICATORS: What it will look like</th>
<th>ACTIVITIES: How we will get there</th>
<th>PROGRESS: Update on how we are tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strategies to address AOD-related social issues are included in key council planning documents/processes with aligned priorities across the region</td>
<td><strong>Year 1 actions:</strong></td>
<td><strong>Year 1 actions:</strong></td>
</tr>
<tr>
<td>• Catchment-based planning working groups have relevant representation from local councils, and vice versa</td>
<td>• Establish relevant working group</td>
<td>• Establish relevant working group</td>
</tr>
<tr>
<td>• Clear communication channels are established and functioning between the three local councils and AOD service system</td>
<td>• Review relevant council plans for AOD-related activity and where possible align/re-align priorities to optimise consistency across both local government and catchment-based planning documents</td>
<td>• Review relevant council plans for AOD-related activity and where possible align/re-align priorities to optimise consistency across both local government and catchment-based planning documents</td>
</tr>
<tr>
<td>• All AOD catchment-based planning activity that highlights a need for local government involvement (e.g., prevention, education, community development or advocacy) is appropriately fed into local council planning processes.</td>
<td>• Establish governance structure and mechanism for optimising communication and minimising duplication between catchment-based planning and council-led working groups</td>
<td>• Establish governance structure and mechanism for optimising communication and minimising duplication between catchment-based planning and council-led working groups</td>
</tr>
</tbody>
</table>

**DESIRED OUTCOME:** What we want to see

That the AOD catchment-based planning process strengthens and enables the three south eastern Melbourne local councils to better respond to the needs of local communities.

**Year 2 actions:**

• Conduct continuum service mapping identifying activities from primary prevention through to tertiary prevention
• Share learnings between councils and with catchment-based planning working groups
• Where appropriate facilitate regional advocacy efforts and prepare joint submissions on collectively-identified issues eg, packaged liquor, sale hours, taxation etc
• Assess priority areas and identify if, how and where collaboration between local government and AOD services is appropriate

**Year 3 actions:**

• Conduct evaluation of year 1 and 2 activities, and measure progress against indicators
• Review priority area and make recommendations regarding sustainability and future priorities
• Showcase learnings, including both successes and failures
## Our plan - Clients and community

### INDICATORS: What it will look like
- Client group is increasingly reflective of the diverse community (including increased presentations from underrepresented groups, such as people from culturally and linguistically diverse backgrounds, women, etc)
- Client participation in treatment increases along with a reduction in client ‘drop-out’ during waiting times
- A client and community reference group is established and utilised appropriately
- Decision-making and planning is informed by client and community input
- Diversity in the AOD workforce reflects the diversity in the community

### ACTIVITIES: How we will get there

#### Year 1 actions:
- Establish relevant working group
- Work with the ‘Data accuracy, integrity and application Working Group’ to ensure the qualitative data strategy is developed and implemented according to the needs of clients and community
- Establish a client and community reference group that is representative of our diverse communities
- Consult with the client and community reference group when required and facilitate the translation of their insights into the work of the other working groups
- Develop a community engagement strategy, that includes reference to existing local community engagement forums that can assist in ensuring diversity of input
- Establish/consolidate/strengthen mechanism for people to provide feedback and make complaints, and ensure clients and carers are aware of their rights to do so

#### Year 2 actions:
- Review actions identified by the CALD Community focus group during consultation, and validate current relevance with client and community reference group prior to implementation (see Appendix C - online)
- Monitor client demographics in comparison with baseline data captured during catchment-based planning efforts to assess representativeness of client group
- Support the delivery of community engagement and health education programs eg. AOD and service system literacy
- Deliver a multi-modal positive messaging campaign that includes real-life accounts from people with lived experience
- Advocate and explore funding for community based quick-responses and prevention and early intervention activities
- Conduct ongoing client and community consultation to facilitate input into relevant planning and decision-making activities

#### Year 3 actions:
- Assess client demographics in comparison with baseline and year 2 data to assess representativeness of client group
- Evaluate year 1 and 2 activities and make recommendations for future priorities, ensuring client and community reference group input is included

### PROGRESS: Update on how we are tracking

#### Service System Improvements
- Develop and implement a training and workforce diversity strategy
- Monitor and develop strategies to address wait times, and provide support for clients where waiting times are unavoidable

### DESIRED OUTCOME: What we want to see
That communities and clients are meaningfully engaged and empowered to influence decision making, planning and service delivery.
Our plan  - Health promotion, prevention and community development

<table>
<thead>
<tr>
<th>INDICATORS: What it will look like</th>
<th>ACTIVITIES: How we will get there</th>
<th>PROGRESS: Update on how we are tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in/attendance at AOD services, projects and programs is representative of community demography</td>
<td><strong>Year 1 actions:</strong></td>
<td></td>
</tr>
<tr>
<td>Community consultations reflect improved understandings and attitudes towards AOD consumption and service access</td>
<td>• Establish a relevant working group</td>
<td></td>
</tr>
<tr>
<td>Existing health promotion/prevention/community development initiatives are supported and participated in where appropriate</td>
<td>• Conduct literature review to determine best practice population health and harm minimisation interventions that are relevant to south eastern Melbourne’s demographic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Establish a mechanism (eg. network, online platform) with a regional focus and clear purpose for sharing knowledge and latest research; facilitating collaborative planning; and enhancing cross-referral into prevention activities across the region</td>
<td></td>
</tr>
<tr>
<td><strong>DESIRED OUTCOME:</strong> What we want to see</td>
<td><strong>Year 2 actions:</strong></td>
<td></td>
</tr>
<tr>
<td>That the systems, structures and environments in south eastern Melbourne support members of the community to reduce harm from alcohol and drugs and to manage their own health.</td>
<td>• Gather baseline data on community understanding and attitudes towards AOD use and service access, with a particular focus on people seeking asylum and refugee communities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide service data to agencies who are delivering prevention and health promotion activities, for example to local governments whom are working with licensed venues and sporting clubs etc to prevent AOD harm in their settings</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3 actions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repeat data collection to compare community understanding and attitudes to baseline data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conduct evaluation of year 1 and 2 activities, and measure progress against indicators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Review priority area and make recommendations regarding sustainability and future priorities ensuring client and community input is included</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Showcase learnings, including both successes and failures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Background - the 'why'