Australian Government
Department of Health

phn
EASTERN MELBOURNE
An Australian Government Initiative

Primary Health Networks

Drug and Alcohol Treatment Activity Work Plan 2016–17 to 2018–19

Eastern Melbourne PHN

Introduction

Overview

The activities under the Drug and Alcohol Treatment Services Annexure to the Primary Health Networks Programme Guidelines will contribute to the key objectives of PHN by:

- Increasing the service delivery capacity of the drug and alcohol treatment sector through improved regional coordination and by targeting areas of need, and
- Improving the effectiveness of drug and alcohol treatment services for individuals requiring support and treatment by increasing coordination between various sectors, and improving sector efficiency.

Together with the PHN Needs Assessment and the PHN Performance Framework, PHNs outlines activities and describe measurable performance indicators to provide the Australian Government and the Australian public with visibility as to the activities of each PHN.

This Drug and Alcohol Treatment Activity Work Plan covers the period from 1 July 2016 to 30 June 2019. To assist with PHN planning, each activity nominated in this work plan has been proposed for a period of between 12 months and 36 months.

Regardless of the proposed duration for each activity, the Department of Health requires PHNs to submit updates to the Activity Work Plan on an annual basis.

This Drug and Alcohol Treatment Activity Work Plan template has the following parts:

1. The **Strategic Vision** of each PHN, specific to drug and alcohol treatment.
2. The **Drug and Alcohol Treatment Services Annual Plan 2016-17 to 2018-2019** which will provide:
   a) A description of planned activities funded under the Schedule: Drug and Alcohol Treatment Activities, Item B.3 Drug and Alcohol Treatment Services – Operational and Flexible Funding
   b) A description of planned activities funded under the Schedule: Drug and Alcohol Treatment Activities, Item B.4 Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Islander people – Flexible Funding.

1. Strategic Vision for Drug and Alcohol Treatment Funding

Our vision: Better primary healthcare for Eastern and North-Eastern Melbourne.

Our role: We facilitate primary care system improvement and redesign.

Our purpose: Better health outcomes. Better experience. Better system efficiency.

Our strategic objectives

1. **Leaders commit to system improvement**
   - 1a. Joint forecasting and planning occurs
   - 1b. Investment decisions are targeted for highest impact
   - 1c. Leadership and change capacity is enhanced
2. **Investment decisions are targeted for highest impact**
   - 2a. Consumers and providers (including GPs) are engaged
   - 2b. Service needs are prioritised and identified gaps are filled
   - 2c. Improvement proposals are based on best evidence
3. **Care processes designed for need and best use of resources**
   - 3a. Design and re-design occurs collaboratively
   - 3b. Services are reoriented to better meet needs
   - 3c. Patients know where to go, when and why
   - 3d. Effective, efficient services are procured

Our values

- Leadership
- Understanding
- Collaboration
- Outcomes

EMPHN Operating Model and the Commissioning Framework

In its role as a facilitator of primary care system improvement and redesign, EMPHN has adopted an operating model made up of a continuous improvement approach to commissioning, and governance structures geared towards collaboration and co-design.

Commissioning Framework

Commissioning is a cycle. Needs are assessed through community consultation and solutions are designed in partnership with stakeholders. Transparent processes are used to promote the implementation of these solutions, including the identification of providers from whom services may be purchased. Solutions are then evaluated and the outcomes used to further assessment and planning.

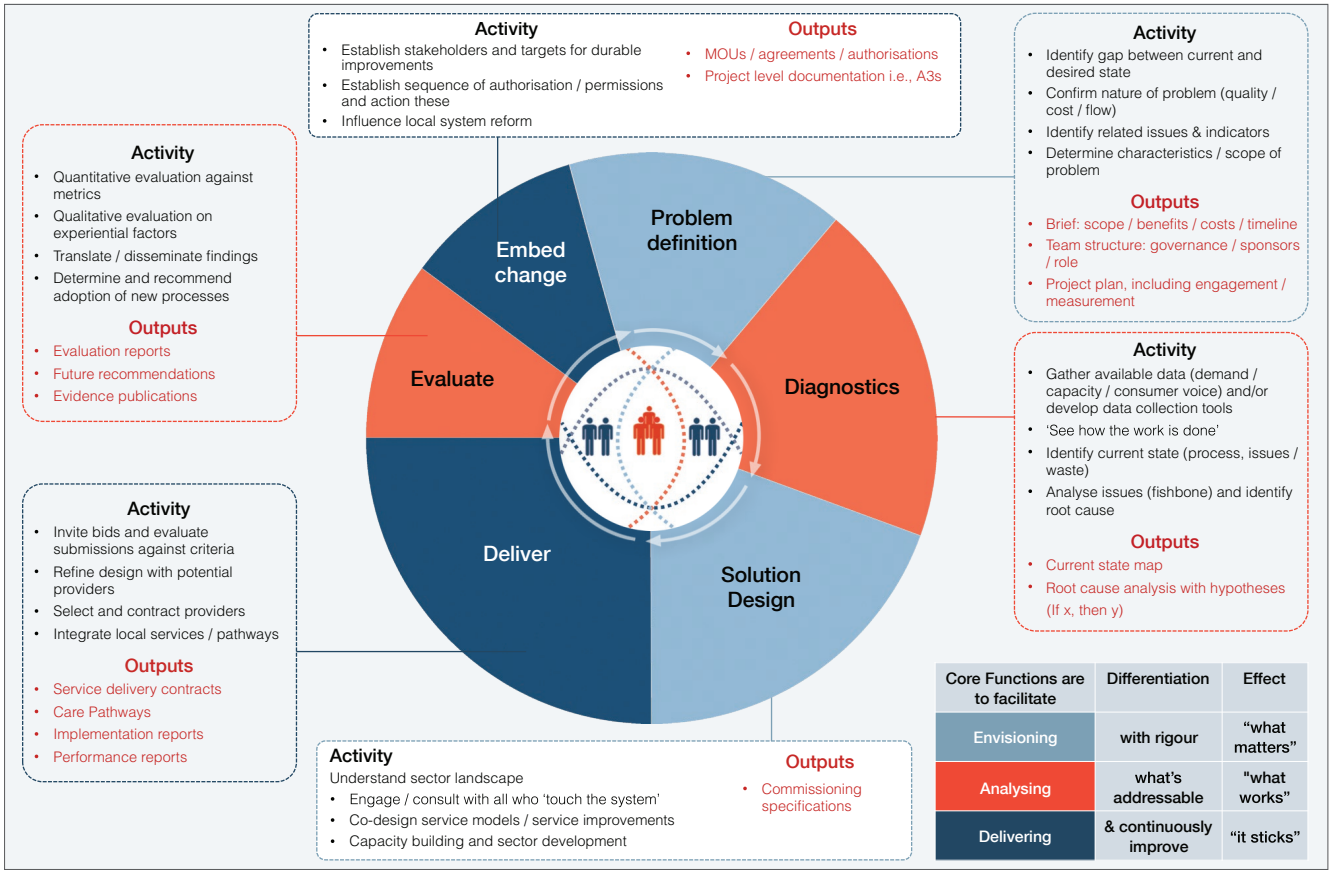

Figure 1. Commissioning cycle

Underpinning the phases of the Commissioning Cycle is a focus on ongoing relationships with consumers, providers and other stakeholders.

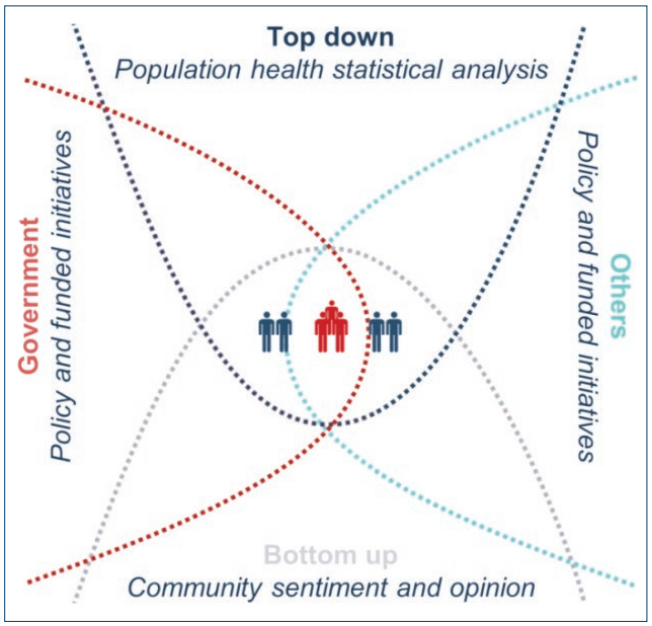

Figure 2. Prioritisation approach

Commissioning principles

1. **Understand the needs of the community** by engaging and consulting with consumer, carer and provider representatives, peak bodies, community organisations and other funders.
2. **Engage potential service providers** well in advance of commissioning new services.
3. **Focus on outcomes** rather than service models or types of interventions.
4. **Adopt a whole of system approach** to meeting health needs and delivering improved health outcomes.
5. **Understand the fullest practical range of providers** including the contribution they could make to delivering outcomes and addressing market failures and gaps.
6. **Co-design solutions;** engage with stakeholders, including consumer representatives, peak bodies, community organisations, potential providers and other funders to develop outcome focused solutions.
7. **Consider investing in the capacity of providers and consumers**, particularly in relation to hard to reach groups.
8. **Ensure procurement and contracting processes are transparent and fair**, facilitating the involvement of the broadest range of suppliers, including alternative arrangements such as consortia building where appropriate.
9. **Manage through relationships; work in partnership**, building connections at multiple levels of partner organisations and facilitate links between stakeholders.
10. **Ensure efficiency and value for money.**
11. **Monitor and evaluate** through regular performance reporting, consumer, community and provider feedback and independent evaluation

Commissioning approach

This model will underpin the planned activities and include the following steps:

1. Investigate available data in the catchment on priorities identified
2. Engagement and collaboration with stakeholder organisations to share data and identify evidence-based interventions to address the priorities.
3. Facilitate co-design processes to identify targeted interventions at the stepped-care level using partnerships with appropriate agencies.
4. Develop a commissioning plan to address the identified service gaps and challenges.
5. Implement the above commissioning plan and provide oversight including evaluation.
6. Review initial evaluation reports from commissioned agencies including a set of recommendations to EMPHN management and stakeholders to assist in future planning.

It is anticipated that over the course of 2016-2017, 1–5 of the above will be completed:

- 1st and 2nd Quarter: 1, 2 and 3
- 2nd – 3rd Quarter: 4 & 5
- 4th Quarter: 6

2017-19: Activities expected to be iterative for subsequent years in line with the commissioning cycle.

Consultative structures

The EMPHN Board will receive strategic advice on engagement and participation from to key groups:

- Clinical Council
- Community Advisory Committee
- AOD Reference Group
- Mental Health Reference Group

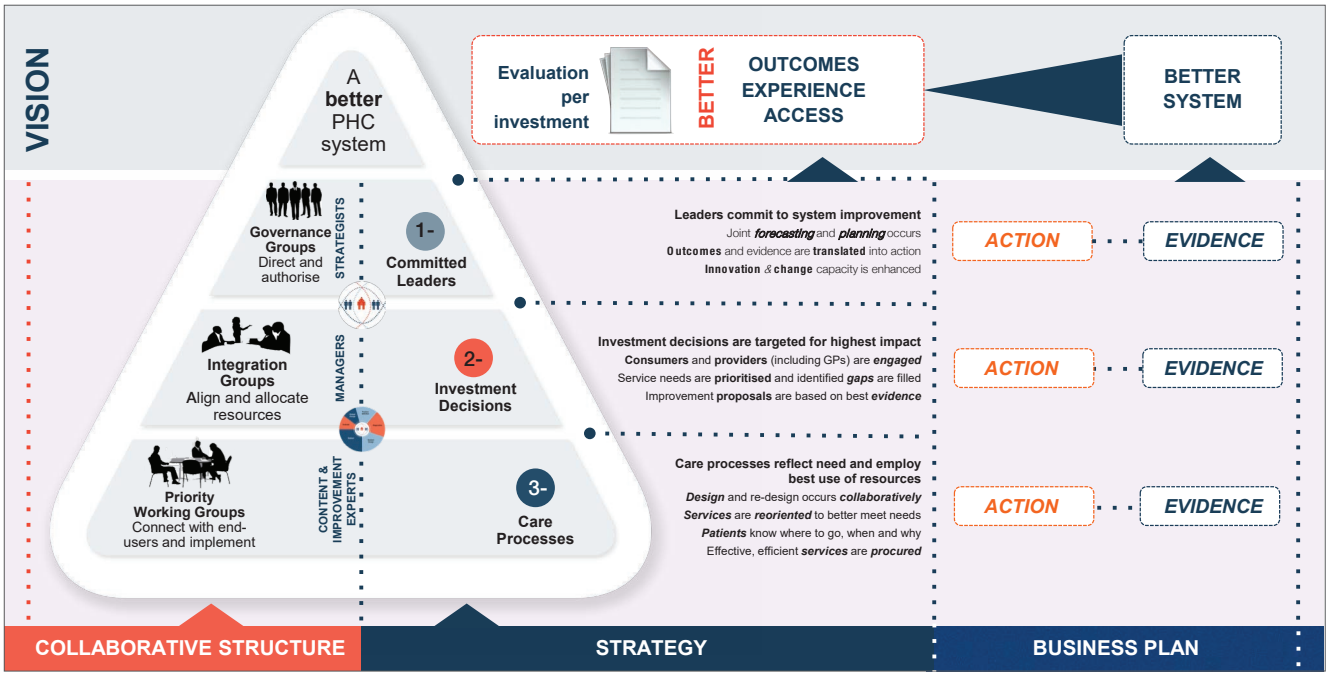

Figure 2. Collaborative Structures

The EMPHN catchment will be divided into four sub-catchments for the purposes of shared planning and governance. The sub-catchments will align with the large public health services in the catchment:

- Austin Health
- Eastern Health
- Monash Health
- Northern Health

Each sub-catchment will have three levels of collaborative structures:

1. **Governance Group**: Strategists who "direct and authorise"
2. **Health System Integration Group**: Managers who "align and allocate resources"
3. **Priority Working Groups**: Content experts who "connect with end users and implement"

Internal structures

The EMPHN organisational structure includes programs that support and develop primary care practitioners, and that support primary care improvement and integration.

In addition to the formal governance structure, EMPHN staff work across teams within specialty area streams such as Indigenous Health, Aged Care, Refugee Health and Mental Health.

EMPHN staff also work across teams to participate in improvement and innovation initiatives.

Our role in increasing service delivery capacity and improving effectiveness of AOD services

In recognition of the short time frames for the development of the AOD Regional Needs Assessment, activities, particularly those in the first quarter will look to establish collaborative working relationships with key stakeholders to further review needs for the region and co-design solutions for appropriate investment of dollars in the purchasing of services through commissioning. This will look to both:

- increase service capacity of the AOD sector
- target areas of need and underservicing
- look at best investment for effective and efficient services to ensure access for the community.

EMPHN has identified the following five AOD priority areas

Priority 1: Reduce avoidable deaths due to overdose (from alcohol and other drug)

Priority 2: Reduce avoidable hospital admissions due to alcohol and other drug

Priority 3: Reduce the harm of AOD on Aboriginal and Torres Strait Islander Communities including reducing ice use in Outer East and Outer North

Priority 4: Reduce ice-related harm in the region

Priority 5: Problematic alcohol use.

2. (a) Planned activities: Drug and Alcohol Treatment Services – Operational and Flexible Funding

The table below outlines the activities proposed to be undertaken within the period 2016-17 to 2018-19. These activities will be funded under the Schedule: Drug and Alcohol Treatment Activities, Item B.3 Drug and Alcohol Treatment Services – Operational and Flexible Funding.

Proposed Activity 1	
Activity Title	**Activity 1:** Improving responses to AOD After Hours presentations in Emergency Departments
Drug and Alcohol Treatment Priority Area	Priority 1: Reduce avoidable deaths due to overdose (from alcohol and other drug) and Priority 2: Reducing avoidable hospitalisations
Description of Drug and Alcohol Treatment Activity	This project will have AOD clinicians at two or three major hospital emergency departments in the catchment working during after-hour's period where there is high AOD traffic will commence from 1 January 2017 as six month pilot projects. This pilot will build on State-based services that operating in business hours in order to: • increase after-hours coverage of your AOD clinician to high traffic AOD periods particularly Friday and Saturday evenings, e.g. during High Alcohol Hours (HAH) designated as Fridays or Saturdays between 8pm and 6am • provide better identification, assessment and information at point of care • provide timely brief interventions, secondary consultations and referrals • provide timely post contact follow-up, support and information to family and carers.
Collaboration	Key stakeholders include: General Practices (GPs), Local Hospital networks (LHNS), commissioned AOD consortia in the catchment, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs), State Department of Health and Human services (DHHS), VAADA (Victorian Alcohol And Drug Association), Coroners Court, Local Government Areas (LGAs), police, research organisations (e.g. Turning Point, Penington Institute). In addition, collaboration was initiated with: • regional Victorian AOD managers (Eastern and Northern Divisions) to map existing State funding; and with • the State-funded AOD planners in the catchment for data sharing. An Alcohol and Other Drug Reference Group (AODRG) was convened in early September 2016 linked with the EMPHN's Clinical Council (CC), with membership that also included VAADA, and consumer and carer representatives. Direct consultation with the three Local Hospital networks has taken place to further scope the feasibility of this activity.

Indigenous Specific	No
Duration	Initial 6 month Pilot from January 2017- June 2017 with scope to extend.
Coverage	Target is whole of EMPHN catchment with the service operating out of Emergency Departments of Northern Hospital, Austin Hospital in the north east and Maroondah Hospital in the outer east.
Commissioning approach	Commissioning of the six month pilot projects and co-designed services will include an evaluation framework and clinical governance reporting requirements in accordance to the National Mental Health Standards (2010). A feedback system will be in place line with compliments and complaints procedures of EMPHN and the commissioned services.
Performance Indicator	Outputs: Comprehensive baseline data on hospitalisations due to alcohol and other drug in the catchment; list of identified evidence-based interventions. Process: Level of engagement of stakeholders in the co-design of the commissioning plan. Output: Number of clients seen; number of Episodes of Care (EOCs) completed; feedback from clients, families and significant others, and service providers. Outcome: Reduction of the number of hospitalisations due to AOD directly and/or indirectly attributed to services commissioned to implement the identified interventions; client progress using a validated outcome measure.
Local Performance Indicator target	AOD stats per LGA collected by Turning Point (2012-2013) on rates of hospitalisation due to alcohol and drug were reviewed by the AODRG and the recommendation was not to specifically target specific LGAs in addressing this priority. Additional data for consideration include: Ambulance rate: attendances per 10,000; ED rate presentations per 10,000; and Alcohol and Drug Information System (ADIS) rate treatment episodes of care per 10,000.
Data source	Hospitalisation rates due to alcohol and other drug, ED presentation rates, ambulance attendance rate. Available data will continue to be reviewed by the AODRG to assist in co-design activities.

Proposed Activity 2	
Activity Title	**Activity 2:** Improving access points to AOD services including increasing intake and assessment capacity, brief interventions for individual and families, and after hour's intake and support.
Drug and Alcohol Treatment Priority Area	Addressing the following AOD priories: Priority 1: Reduce avoidable deaths due to overdose (from alcohol and other drug) Priority 4. Reduce ice-related harm in the region Priority 5. Problematic alcohol use.
Description of Drug and Alcohol Treatment Activity	Aims: • Provide alternative after hours walk in assessments • Provision of brief intervention support at initial point of care including after hours • provision of brief intervention support to include family and cares at point of care and increase after hours access options for those working • improve a youth responsive service entry points in the adult Intake and assessment system • insure access point are inclusive and responsive to at risk and diverse populations Projects for this activity would include increasing staff resources at intake and assessment points to include brief interventions and after hour's capacity. Further options may also include strategic co-location of an AOD clinician at a GP practices such as GP Super Clinics that offer after hours services or other multi service sites. The AODRG has recommended further consultation and to work on co-de-sign of AOD treatment service activities to be commissioned in early 2017.
Collaboration	An Alcohol and Other Drug Reference Group (AODRG) was convened in early September 2016 linked with the EMPHN's Clinical Council (CC), with membership that also included VAADA, and consumer and carer representatives. Key stakeholders include: General Practices (GPs), Local Hospital networks (LHNS), commissioned AOD consortia in the catchment, Local Government Areas (LGAs) youth services, police, Headspace centres and AOD intake service providers. In addition, collaboration was initiated with: • regional Victorian AOD managers (Eastern and Northern Divisions) to map existing State funding; and with • the State-funded AOD planners in the catchment for data sharing and participation on regional service need planning for young people.
Indigenous Specific	No
Duration	Activity to be delivered from February/March 2017 for 2 years.

Coverage	Activities will involve the entire EMPHN region through the AODRG and relevant community consultations. The commissioned programs and services may involve specific LGAs and will be determined in consultation with the AODRG and collaborative with a focus on improving access the outer north and outer east LGA's.
Commissioning approach	Addressed in strategic section above
Performance Indicator	Outputs: Baseline data on avoidable overdose deaths in the catchment; list of identified evidence-based interventions Process: Level of engagement of stakeholders in the co-design of the commissioning plan. Output: Number of clients seen; number of Episodes of Care (EOCs) completed; feedback from clients, families and significant others, and service providers. Outcome: Reduction of the number of avoidable deaths due to AOD overdose attributed directly and/or indirectly to services commissioned to implement the identified interventions.
Local Performance Indicator target	A baseline for this indicator was one of the main outputs of Activity 1.1 and 1.2, and were mapped according to LGAs in the EMPHN catchment. Other indicators considered include: Rate of overdose deaths aggregated in three years = Frequency of overdose deaths/population of area = x 100; Accidental overdose death rate per 100,000 people (ABS Deaths dataset).
Data source	Coroners Court of Victoria data on frequency of overdose deaths due to AOD (involving alcohol, illegal drugs, and prescribed drugs – pharmaceuticals) according to Local Government Area (LGA) 2009-2015. Discussion and further evaluation of the available data was undertaken by the AODRG. Limitation of the data: LGA coding may either be where the fatal overdose incidents occur or where the deceased usually reside.

Proposed Activity 3	
Activity Title	**Activity 3:** Demand management initiative: Increasing access to post-withdrawal support across the catchment including peer support and outpatient group programs.
Drug and Alcohol Treatment Priority Area	Addressing AOD priorities 1, 4 and 5 Priority 1: Reduce avoidable deaths due to overdose (from alcohol and other drug) Priority 4. Reduce ice-related harm in the region Priority 5. Problematic alcohol use
Description of Drug and Alcohol Treatment Activity	Aims of this activity: • Improve follow up support post withdrawal to reduce relapse • Improve access to group base support services • Address issues of waitlist for rehabilitation services Funding model for consideration include: 1. An 8 week post withdrawal day program in the community that will: • Provide improved access to post withdrawals support • Provide continued group support during transition back into community • Be harm minimisation focused This is a group treatment model that has been successful piloted in another catchment and could easily be extended to EMNPHN catchment where there is a lack of access to such services. 2. An outpatient group program to support people on the wait list for AOD residential rehabilitation • AOD post-withdrawal peer support: to fund peer support programs to deliver on weekends increasing access to afterhours harm minimisation based support. • Seek to support those on long waitlist for residential rehabilitation treatment providing community based support and reduce relapse.
Collaboration	The AODRG has recommended further consultation and to work on co-design of AOD treatment service activities to be commissioned in early 2017.
Indigenous Specific	No
Duration	Activity to be delivered from February/March 2017 for 2 years.
Coverage	Activities will involve the entire EMPHN region through the AODRG and relevant community consultations. The commissioned programs and services may involve specific LGAs and will be determined in consultation with the AODRG and collaborative.
Commissioning approach	Addressed in strategic section above.

Performance Indicator	Outputs: Comprehensive baseline data on ice usage rates in the four LGAs; list of identified evidence-based interventions. Process: Level of engagement of stakeholders in the co-design of the commissioning plan. Output: Number of clients seen; number of Episodes of Care (EOCs) completed; feedback from clients, families and significant others, and service providers. Outcome: Reduction of ice related harms attributed to services commissioned to implement the identified interventions; client progress using a validated outcome measure.
Local Performance Indicator target	More appropriate baseline indicators for this priority will be reviewed by the AODRG.
Data source	There is limited available data on ice use in the catchment but the AODRG reviewed Turning Point 2013-14 Ambulance Attendances per 10,000 due to crystal methamphetamine and meth/amphetamine. More comprehensive data is required as to the demographic profile of ice users in the catchment along with updated data on rates. Available data on hospitalisation rates, emergency department presentation rates, and ADIS data will be reviewed.

Proposed Activity 4	
Activity Title	**Activity 4:** Increasing access and treatment to young people (Improving youth AOD Access and community pathways).
Drug and Alcohol Treatment Priority Area	Addressing Priorities 4 and 5 Priority 4. Reduce ice-related harm in the region Priority 5. Problematic alcohol use
Description of Drug and Alcohol Treatment Activity	Aims of this activity: • Improve engagement with hard to reach youth • Improve early intervention • Improve identification and referral for AOD issues • Support families for young people • Strengthen capacity AOD sector to provide youth friendly/appropriate treatment based responses • Improve continuity of care and pathways between AOD and MH services Projects under this activity may include: • Pilot of therapeutic group in the community health for youth e.g. target clients of YSAS' Eastern home-based withdrawal • Co-location of an AOD clinician at a public secondary school in outer north or outer east linking with the GPs in schools program • Increased AOD services at headspace centres to reduce waiting time for young people. The AODRG has recommended further consultation and to work on refinement and co-design of AOD treatment service activities to be commissioned in early 2017.
Collaboration	Key stakeholders include: General Practices (GPs), Local Hospital networks (LHNS), commissioned AOD consortia in the catchment, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs), State Department of Health and Human services (DHHS), VAADA (Victorian Alcohol And Drug Association), Coroners Court, Local Government Areas (LGAs), police, research organisations (e.g. Turning Point, Penington Institute). In addition, collaboration was initiated with: • regional Victorian AOD managers (Eastern and Northern Divisions) to map existing State funding; and with • the State-funded AOD planners in the catchment for data sharing. An Alcohol and Other Drug Reference Group (AODRG) was convened in early September 2016 linked with the EMPHN's Clinical Council (CC), with membership that also included VAADA, and consumer and carer representatives.
Indigenous Specific	No
Duration	Activity to be delivered from February/March 2017 for 2 years
Coverage	Whole of EMPHN catchment with particular focus on the LGAs of Whittlesea, Nillumbik in the north and Yarra Ranges, Maroondah and Knox in the outer east.
Commissioning approach	Addressed in strategic section above.

Performance Indicator	Inputs: Comprehensive baseline data problematic alcohol use in the catchment with special focus on youth in Nillumbik, Whittlesea, Wallan and the outer east; list of identified evidence-based interventions. Process: Level of engagement of stakeholders in the co-design of the commissioning plan. Output: Number of clients seen; number of Episodes of Care (EOCs) completed; feedback from clients, families and significant others, and service providers. Outcome: Reduction of problematic alcohol use attributed to services commissioned to implement the identified interventions.
Local Performance Indicator target	More appropriate baseline indicators for this priority will be reviewed by the AODRG.
Data source	Areas of problematic alcohol consumption >18 years are particularly notable in outer east (Knox, Maroondah, and Yarra Ranges) and north: North (Banyule, Nillumbik-Kinglake). The highest rates in catchment of risky drinking (4.6-5.3/100). Regions/pockets of problematic alcohol use in youth, particularly notable in outer east and north: • Nillumbik: Alcohol use by young people is double the state average • Whittlesea-Wallan: Highest percentages in catchment of underage youth having consumed alcohol in the last 30 days (69.8%) • Outer East (Knox, Maroondah, Yarra Ranges): Highest rates in catchment of alcohol-related episodes of care 15-24 years (65.1-75.4/10,000).

Proposed Activity 5	
Activity Title	**Activity 5:** Improving responses to culturally and linguistically diverse (CALD) and Aboriginal and Torres strait islander communities
Drug and Alcohol Treatment Priority Area	Addressing priorities 2 and 5 Priority 2. Reduce avoidable hospital admissions due to alcohol and other drug Priority 5. Problematic alcohol use.
Description of Drug and Alcohol Treatment Activity	This activities aims to directly response to specific needs of communities by: • improving links and access to AOD treatment services • providing culturally safe and sensitive approach by utilising workers from within identified communities • community capacity building to better respond to the impacts of AOD harm on individuals and families in these communities • pilot engagement strategy with targeted CALD communities • address problematic alcohol and AOD use in CALD populations • reduce impact of alcohol use in the targeted communities • improve family engagement and support Potential projects considered for funding may include: 1. The identified need to address problematic alcohol use in local CALD communities i.e. pilot CALD specific project to increase access and uptake of CALD AOD Services, e.g. Burmese populations in the outer east 2. Strengthening Clinical AOD support for Aboriginal AOD services: • By funding AOD Aboriginal health worker to support current CCSS providers with access to AOD counselling/coordination The AODRG has recommended further consultation and to work on refinement and co-design of these AOD treatment service activities to be commissioned in early 2017.
Collaboration	Key stakeholders include: General Practices (GPs), Local Hospital networks (LHNS), commissioned AOD consortia in the catchment, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs), Migrant Information Centres, State Department of Health and Human services (DHHS), VAADA (Victorian Alcohol And Drug Association), Coroners Court, Local Government Areas (LGAs), police, research organisations (e.g. Turning Point, Penington Institute). In addition, collaboration was initiated with: • regional Victorian AOD managers (Eastern and Northern Divisions) to map existing State funding; and with • the State-funded AOD planners in the catchment for data sharing. An Alcohol and Other Drug Reference Group (AODRG) was convened in early September 2016 linked with the EMPHN's Clinical Council (CC), with membership that also included VAADA, and consumer and carer representatives.
Indigenous Specific	Part of this activity will be Indigenous specific

Duration	Activity to be delivered from February/March 2017 for 2 years.
Coverage	Coverage will focus on LGA's with higher ATSI and CALD communities such as Maroondah, Yarra ranges, Whittlesea and Banyule and Whitehorse.
Commissioning approach	Addressed in strategic section above
Performance Indicator	Inputs: baseline data problematic alcohol use in the catchment with special focus CALD and ATSI populations in north, and the outer east; Output: Number of clients seen; number of Episodes of Care (EOCs) completed; feedback from clients, families and significant others, and service providers. Process: Level of engagement of stakeholders in the co-design of the commissioning plan. Outcome: Reduction of AOD related harms attributed to services commissioned to implement the identified interventions in targeted communities.
Local Performance Indicator target	More appropriate baseline indicators for this priority will be reviewed by the AODRG.
Data source	Reports of high alcohol abuse and reluctance to seek help in CALD communities: • Problematic alcohol misuse, often associated with home brewing, is an issue in Chin migrant communities and some refugee populations in East/inner outer East. • Cultural preference to deny problem, or in Chin Community rather than health services rely preferentially on pastoral care, especially when concomitantly associated with family violence. Alcohol abuse in the Aboriginal and Torres Strait Islander communities: • High prevalence problem use of alcohol and other drugs • Lower alcohol usage rates than in community overall, but higher individual problem usage • Highest density of Aboriginal and Torres Strait Islander communities in catchment are located in Yarra Ranges (especially Healesville) and Whittlesea. • Up to one quarter Aboriginal and Torres Strait Islander adults (males>females) are exceeding single occasion and lifetime risk levels for harm from alcohol.

Proposed Activity 6	
Activity Title	**Activity 6:** Workforce development activities
Drug and Alcohol Treatment Priority Area	Activity to address to EMPHN AOD priorities 1–5 Priority 1: Reduce avoidable deaths due to overdose (from alcohol and other drug) Priority 2. Reduce avoidable hospital admissions due to alcohol and other drug Priority 3. Reduce the harm of AOD on Aboriginal and Torres Strait Islander Communities including reducing ice use in Outer East and Outer North Priority 4. Reduce ice-related harm in the region Priority 5. Problematic alcohol use
Description of Drug and Alcohol Treatment Activity	Workforce development projects/research/evaluation/forums To strengthen current AOD and MH workforce by: • improving identification and screening of AOD issues in primary care • improving dual diagnosis capabilities of current workforce • improving access to and uptake of pharmacotherapy • improving continuity of care and treatment for clients with dual diagnosis • increasing capacity of workforce to deliver funded activities described above. Projects options being explored may include: • Training for MH nurses interested in AOD already possessing basic AOD capabilities (e.g. MI training, CBT). • GP targeted continuing professional development (CPD) on the following: o Safe opiate prescribing with a focus on improving collaboration between hospitals and GP practices in the management of patients discharged from hospitals with limited/inadequate/ inappropriate/ poorly communicated prescription during the post-acute care stages o Safe psychotropic prescribing to include quetiapine and benzodiazepine • Training for youth mental health/Headspace workers to increase dual diagnosis capabilities to support activity 4.
Collaboration	An Alcohol and Other Drug Reference Group (AODRG) was convened in early September 2016 linked with the EMPHN's Clinical Council (CC), with membership that also included VAADA, and consumer and carer representatives. Further consultation has taken place with other Key stakeholders include: General Practices (GPs), Local Hospital networks (LHNS), commissioned AOD consortia in the catchment, State Department of Health and Human services (DHHS), VAADA (Victorian Alcohol And Drug Association), Local Government Areas (LGAs), In addition, collaboration was initiated with: • regional Victorian AOD managers (Eastern and Northern Divisions) to map existing State funding; and with • the State-funded AOD planners in the catchment for data sharing.

Indigenous Specific	No
Duration	January 2017 – June 2017
Coverage	Entire EMPHN catchment
Commissioning approach	Addressed in strategic section above
Performance Indicator	Inputs: baseline data of primary health workforce in the catchment; baseline knowledge of skills and confidence (pre-test questionnaire prior to each CPD) Output: Number of people trained; improvement in knowledge, skills and confidence clients (post-test questionnaire prior to each CPD) general feedback form participants Process: Level of engagement of stakeholders in the co-design of these activities Outcome: improved collaboration between providers; improved patient outcomes as a consequence of better trained.
Local Performance Indicator target	More appropriate baseline indicators for this priority will be reviewed by the AODRG.
Data source	EMPHN's existing data on current workforce's AOD/dual diagnosis capabilities. The workforce to include GPS, MH nurses, and ATAPs providers. Information obtained from Eastern Mental Health Service Coordination Alliance (EMHSCA) re workforce capabilities and needs.

2. (b) Planned activities: Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Islander people – Flexible Funding

The table below outlines the activities proposed to be undertaken within the period 2016-17 to 2018-19. These activities will be funded under the Schedule: Drug and Alcohol Treatment Activities, Item B.4 Drug and Alcohol Treatment Services for Aboriginal and Torres Strait Islander people – Flexible Funding.

Proposed Activities	
Activity title	**Activity 7:** Integrated response to Aboriginal and Torres Strait Islander communities.
Drug and Alcohol Treatment Priority Area	Priority 3. Reduce the harm of AOD on Aboriginal Communities including reducing ice use in Outer East and Outer North Aboriginal and Torres Strait Islander Communities.
Description of Drug and Alcohol Treatment Activity	EMPHN is developing a whole of organisation commissioning framework to engage and commission Aboriginal and Torres Strait Islander (ATSI) services in the catchment. In developing EMPHN's Aboriginal and Torres Strait Islander Commissioning Strategy, it was identified that the recommissioning of Victoria's AOD services has led to complicated and reduced access to both services in general and specifically for Aboriginal people. The recommissioning of Victoria's Mental Health Community Support Services (which are soon to be subsumed into NDIS) led to a similar outcome. EMPHN believes that the ATSI-specific AOD funding is insufficient to contract clinical services that will meet the needs of the targeted Aboriginal communities that are spread across the entire EMPHN catchment. Integrating EMPHN's Aboriginal and Torres Strait Islander dedicated funding is expected to be a more effective way of building the capacity of the existing service system to meet the needs of its Aboriginal communities. The Aboriginal and Torres Strait Islander communities have asked for AOD trained peer support facilitators who are based in its healing places or co-located with services that deliver Aboriginal programs, their role will be to support people to access mainstream AOD services (and Aboriginal services where they exist) and support them in small peer support groups. Specifically, the support facilitators will provide recovery-focused service options and 'walk the journey' with the person. The AOD workers will also link with Integrated Team Care activities to drive a program that will support services to become culturally safe. This has already been piloted in Banyule LGA under the auspices of Banyule Community Health's AOD service and Aboriginal Health Unit. Peer support facilitators will complete AOD peer training with SHARC. Stakeholder consultations undertaken to date have identified a need to have increased funding for Aboriginal Health Worker capacity in the region relating to AOD and harm minimisation. Therefore, this proposal and early thinking will be incorporated in the future planning for the funding of a position as a potential solution.

Collaboration	Key stakeholders include: Aboriginal Community Controlled Health Organisations (ACCHOs), Healesville Indigenous Community Services Association (HICSA), Victorian Aboriginal Health Services (VAHS), General Practices (GPs), Local Hospital networks (LHNS), commissioned AOD consortia in the catchment,, State Department of Health and Human Services (DHHS), Department of Justice (DOJ) VAADA (Victorian Alcohol And Drug Association), Coroners Court, Local Government Areas (LGAs) research organisations (e.g. Turning Point, Penington Institute), Aboriginal and/or Torres Strait Islander people living in the Eastern Melbourne PHN catchment. Linkage with an ATSI groups in the region to provide an integrated approach addressing issues affecting physical health, mental health, family violence and education. The Alcohol and Other Drug Reference Group (AODRG), convened in early September 2016 linked with the EMPHN's Clinical Council (CC), with membership that also included VAADA, and consumer and carer representatives, will be informed and updated on the EMPHN's Aboriginal and Torres Strait Islander Commissioning Strategy in relation to the AOD funding.
Indigenous Specific	Yes
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle). Commence February 2017 – June 2019.
Coverage	Activities will involve the ATSI communities in the targeted areas of the catchment where there are higher populations of aboriginal and Torres strait Islanders such as Yarra Ranges, Banyule and Whittlesea LGAs.
Commissioning approach	All activities will follow the EMPHN Aboriginal Health and Wellbeing Commissioning Framework supporting self-determination and co-design. The commencement of the implementation of the Framework has led to procurement solutions for AOD and mental health. Commissioning of co-designed services that will include an evaluation framework and clinical governance reporting requirements in accordance to the National Mental Health Standards (2010). A feedback system will be in place line with compliments and complaints procedures of EMPHN and the commissioned services.
Performance Indicator	Inputs: Comprehensive baseline data on ice use rates in the Aboriginal and Torres Strait Islander communities of the outer east and outer north of the EMPHN catchment; list of identified evidence-based interventions. Process: Level of engagement of stakeholders in the co-design of the EMPHN Aboriginal Health and Wellbeing Commissioning Framework. Output: Proportion of Indigenous population receiving PHN-commissioned AOD services where the services were culturally appropriate. Outcome: Reduction of ice-related harm (as well as broader AOD-related harm) in Outer East and Outer North ATSI communities attributed to services commissioned to implement the identified interventions.

Local Performance Indicator target	Part of the commissioning activity in 2016-2017 involves obtaining more comprehensive data (up to date and disaggregated) on ice use in the Outer East and Outer North Aboriginal and Torres Strait Islander Communities as baseline information. Number of self-identifying Aboriginal community members accessing the service. Evaluation of the service demonstrates improved AOD outcomes for consumers of the service.
Data source	AODTS data, hospitalisation rates, emergency department presentation rates, ambulance attendance rate. Sources include but not limited to the following: National Hospital Morbidity Database (NHMD), Ambulance Victoria records, DOJ records, police records. Commissioned data collection will predominantly occur in 2016-2017. Anecdotally there is apparent Ice use in Aboriginal communities although culturally-informed responses of shame and self-isolation may both mask visibility and prevent support seeking (numerical data not available). There is a higher proportion of alcohol use identified as problematic in comparison to the non-indigenous population (i.e. fewer drinkers however more of those who drink experience difficulties with their alcohol consumption). Cultural beliefs and attitudes concerning AOD use, such as shame associated with seeking treatment, concern about getting into trouble with the law and fear of losing children contribute to barriers to engaging with services. More comprehensive data is required into rates of ice use and alcohol use in these communities and availability and accessibility of culturally safe AOD services.

FOR MORE INFORMATION

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