North & West Metro Catchment based planning Regional Stakeholder consultation

July 2015

Alcohol & Other Drugs and Mental Health Community Support Services Consultation findings report
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Introduction

Catchment based planning is a systematic way to understand and respond to the service needs of our local communities.

**THE PRIMARY PURPOSE OF THE PLANNING FUNCTION IS TO PRODUCE CATCHMENT BASED PLANS THAT IDENTIFY CRITICAL SERVICE GAPS AND PRESSURES, AND DEVELOP STRATEGIES TO IMPROVE RESPONSIVENESS TO PEOPLE WITH AOD AND MENTAL HEALTH ISSUES, POPULATION DIVERSITY AND BROADER COMMUNITY NEED. THE MAIN FOCUS IS ON AOD TREATMENT AND MENTAL HEALTH COMMUNITY SUPPORT SERVICES, BUT PLANNING WILL ALSO CONSIDER PREVENTION AND EARLY INTERVENTION ACTIVITIES IN THE REGION, WHILE WORKING TO PROMOTE INTEGRATED APPROACHES TO SERVICE DELIVERY.**

Up to now, planning was conducted by the Department of Health, but following the 2014 service reforms of Mental Health Community Support Services (MHCSS) and Alcohol and Other Drugs (AOD) services, catchment based planning has become a locally based function. This report relates to the planning function of the North & West Metropolitan Region of Melbourne. With a population of 1.78 million (44% of Melbourne's population) it includes the four catchments of:

- Inner North Melbourne (Melbourne, Moreland, Moonee Valley & Yarra)
- North Melbourne (Darebin, Banyule, Whittlesea & Nillumbik)
- North West Melbourne (Maribyrnong, Brimbank, Melton & Hume)
- South West Melbourne (Hobsons Bay & Wyndham)

For these catchments, MHCSS planning is being conducted by cohealth, and AOD planning by the North & West Metro AOD Service Partnership with Odyssey House Victoria and Uniting Care ReGen as the lead agencies. Because of the geographic cross-over of responsibility and the interrelated nature of clients in the two sectors, the planners saw close collaboration on the initial planning activities to be an efficient use of time and resources.

This document presents the consolidated findings of the combined AOD and MHCSS catchment based planning consultations that spanned December 2014 - June 2015. This process provided an evidence base to the subsequent Catchment Based Plans produced by the respective sectors, ensuring our interpretation of findings, data, service orientation and recommendations were both endorsed by -and based on the views of- those who work within and alongside local AOD and MHCSS services.

Adhering to the nature of ‘catchment based planning’ information in this report is presented by catchment with a tabular presentation of area priorities, further emphasis emerging from relevant discussions, and what our stakeholders think should be done about it. We then look at some ‘whole of region’ needs, and what the overall consultation process might mean for planning.

**It is important to note that the focus for catchment based planning is on service provision at the secondary to tertiary end of the service spectrum. While we are commissioned to identify and document issues across the board it is not in our remit to address them. Prevention and early intervention work is outside the scope of our services, but planning activity will highlight important matters and ensure they are passed on to the relevant agencies for action.**
An overview of our consultation process

<table>
<thead>
<tr>
<th>What</th>
<th>Outputs</th>
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</table>
| **Service Provider Forum** | • Initial discussion about priorities, needs, gaps and barriers  
• Local service providers endorsed proposed structure and process for catchment based planning, including: consultation, carer & consumer involvement, data and information management, evaluation and monitoring  

December 2014 |
| **Individual meet & greet consultations** | • Introduction to the new catchment based planning function  
• Initial scoping of existing partnerships, programs and data sets  
• 3 key questions:  
  1. what networks exist that we should know about?  
  2. what do you see as key planning issues for your service or area of work?  
  3. what mechanisms or processes do you currently have in place for supporting consumer engagement  

Jan - May 2015 |
| **Sector survey** | • Endorsed our understanding of local populations and communities, including needs and vulnerabilities  
• Confirmed service priorities in local government areas  
• Added any missed priorities  
• Ranked priorities  

March 2015 |
| **Analysis & consolidation** | • Produced resources: LGA summaries (needs, gaps, barriers, planning priorities at LGA level) & catchment summaries (overview of priorities, needs & relevant LGAs)  
• Pre-reading documents for the forum  

April 2015 |
| **Regional Stakeholder Forum** | • Networking and engagement  
• Priorities tested  
• Initial scoping of existing activity in the region  
• Collaborative action mapping  
• Sector endorsed work plan & activities for Catchment Based Planning  

May 2015 |
Our consultations highlighted work for the catchment based planning function to be done in the following areas:

### Networking & communication

#### Better networking, communication & information sharing:
- Facilitate understanding of roles and responsibilities across the sector
- Partnership activities: Create regular opportunities for services to meet, share knowledge, resources & data. Market programs to each other.
- Improve service coordination and service links to create connection points to and from other services. We need a common language and referral pathways.
- Re-establishing existing alliances post reforms.
- Improve client understanding of how to access services.

#### Improve data and information about client needs and services now and for the future:
- Support data collection / analysis to inform decision making and create an evidence base.
- Provide information and evidence to:
  - Advocate for change / challenge services to think differently.
  - Help with decision and resource allocation in a planned manner.
  - Identify drug trends, new AOD problems & cohorts.
- Create a short, medium & long term vision. Collect the evidence to monitor effectively.
- Gap analysis and mapping of unfunded work.

### Data & information

#### “Plan for the future - think about what we will need to know”

### Evaluation & review

#### “Ensure that we learn from this process”

#### Evaluation and review of the service model:
- Evaluate the new service systems and understand what the impacts have been for clients, the organisations and the service system, include:
  - Who is missing out?
  - Is there timely access to AOD services?
  - What service use patterns have changed?
- Monitor the impact of the change to understand who is being affected.
- Explore the impact of the NDIS.
- Address carer / family issues (noting that AOD reforms have made working with families difficult, as they are expected to refer on).

### Service creativity

#### “Challenge the service system to break down the silos”

#### Identify opportunities for creativity in the service models:
- Find new / innovative / different service models. Rethink outreach, explore virtual service options or pop-up service locations.
- New partners.
- Innovative mediums for delivery - be creative and flexible.
- Share what is working across catchments - test and tweak.
- Creative utilisation of existing resources.
- More flexible hours for working families.
- Use schools as a service delivery point (peer-based programs, outreach).
Improving and future-proofing workforce & system capacity:

- Build capacity of the broader service system to respond to our clients - schools, courts, hospitals, GPs, Pharmacists, child & early years services.
- Support a workforce that has capacity to respond to complex needs and families.
- Capacity building for dual diagnosis capability.
- Orientate new staff in different services throughout the system: AOD clinicians need mental health / housing / family services orientation.

Facilitating understanding across the intervention continuum:

- Plan across the continuum (prevention - early intervention - treatment).
- Understand and address the social determinants of health (think about gambling, culture of alcohol, housing, education and health literacy).
- Family violence issues need to be addressed through a focus on families - men, women and the whole community.
- Map service provision across the continuum.
- Improve prevention and early intervention activity, address the gap here. Be clear about the role of local government.

Coordinate planning across all 16 catchments:

- We need coordination across the various planning activities.
- Map partners, networks and services in the area.
- Create opportunities for shared planning.
- Respond to the needs of young people and families through better planning and links with relevant services: Maternal child health, family support, homelessness, community health, primary care, gambling support, schools.
- Plan for the future - think about what is going to be needed, future land use, future service planning.

Effective consumer engagement:

- Improve and increase opportunities for consumer involvement in service design, development and evaluation.
- Different models of engagement are needed for youth.
- There is an opportunity for consumers to have a stronger role in the service system - both in educative / preventative roles and in offering peer support.
- Involve consumers in developing information for consumers about how to navigate the service system.
- Create guidelines for professional and voluntary roles.
The regional stakeholder forum

Held on Tuesday 5th May 2015 at the Darebin Arts & Entertainment Centre, the first North and West Metro AOD and MHCSS Catchment Based Planning Regional Stakeholder forum was attended by eight consumer representatives, and a further 100 representatives from a wide range of organisations across the North and West Metro area.

Attendees were provided with the four catchment summaries (included as appendices to this report) one week prior to the forum. These documents provided a summary of the key issues and demographic characteristics of each catchment area, the key priorities that had emerged from our consultation up to that point, and a snapshot of the distinct qualities of each local government area contained within.

This was a deliberative exercise that allowed for collaborative cross-sector action planning. The results are summarised on the following pages.

Forum consultation activities

Session 1: Testing the Priorities

This session sought to confirm - or deepen - our understanding of the catchment and its priorities. Participants were asked to provide evidence for any additions or changes, but in many cases this did not occur.

- All priority areas were endorsed.
- Some additional priorities emerged:
  - two regional themes - ‘System Change’ and ‘System Innovation & Development’.
  - for the Inner North - ‘Appropriate Service Mix’.
- Within each of the priority areas some aspects were emphasised and others not mentioned at all.
- In some cases, particularly in relation to priority client groups, some were added.

We recognise that it is inherent in the nature of workers and organisations to lobby for those for whom they work. As we move into the next stage of planning, it will be important to further identify where the greatest need lies with consideration of available data, service priorities and existing effort and commitment to change.

The discussion around the two new regional themes was progressed as part of session 3.

Attendees included representatives from:

- ACSO
- APSU
- Banyule Community Health
- Breakthru People Solutions
- Brimbank City Council
- Carers Victoria
- Childrens Protection Society
- City of Melbourne Council
- Darebin Community Health
- DELWP
- Department of Education & Training
- DePaul House
- Department Health & Human Services
- Djerriwarrh Health Service
- EACH
- Headspace Cragieburn, Glenroy, Sunshine, Werribee
- Health West Partnership
- Homeground
- Hume City Council
- Inner North West Melbourne Medicare Local
- INWPCP
- Jesuit Social Services
- Kildonan
- Mackillop Family Services
- Maribyrnong City Council
- Melton City Council
- Mercy Mental Health
- Merri Community Health Services
- Mid-West Area Mental Health Service
- Mind Australia
- NEAMI National
- NEAMI Broadmeadows
- NEAMI Cragieburn
- NEXUS Dual Diagnosis Service
- Nillumbik Shire Council
- North East PCP
- North Richmond Community Health
- North Western Mental Health
- Northern Melbourne Medicare Local
- Orygen Youth Health
- Pharmacotherapy Network
- Plenty Valley Community Health
- RDNS
- SHARC
- St Marys House of Welcome
- St Vincents Hospital
- STAR Vincent Care
- Stepping Up Consortium
- Sunbury Community Health
- Uniting Care ReGen
- Victorian AIDS Council
- Victoria Police
- Victorian Aboriginal Health Service
- Victorian Mental Illness Awareness Council
- Western Health Drug Health Service
- WOMBAT
- Wyndham City Council
- YSAS
Session 2: What’s already happening?
This session asked people sitting in catchment areas relevant to their work to fill out templates to describe existing activities/programs/projects that are currently in place to address some of the needs and priorities we had previously agreed upon.

The aim was to get an initial sense of where the sectors’ resources and energies currently are and are not directed, and to lead to an understanding of the areas of greatest need and least activity.

The completed templates were pinned on the wall under catchment and ‘priority need’ headings. This presented a visual representation of our discussions.

Figure 1: ‘What’s already happening’ template

Session 3: What are we going to do about it?
This session was conducted as a world café session. Attendees answered questions about what can be done to address the areas of need that were outlined in previous discussions. Large templates on the tables had three key areas of focus:

1. Actions for AOD/MHCSS treatment services.
2. Actions for the other people in the room / the broader service system.
3. How can the planning function contribute?

A note on the write up in this report:
As would be expected the discussion was sometimes free ranging. Records of discussion suggested that it did not always follow the program sequence, often addressed more than one priority area and sometimes more than one catchment or no particular catchment at all. In order to make sense of all the information, the write up has attempted to order the information into the framework of the consultation.
Outcomes of the Regional Stakeholder forum for the Inner North Melbourne catchment

Our consultation activity endorsed the priority areas and the understanding of the catchment we had presented. The recommissioning affected the Inner North catchment through significant changes to service providers as well as changes in the service models which had been built on the integration of homelessness, mental health and AOD services. There is a perceived loss of service accessibility – particularly for youth, people who are homeless and some AOD treatment models, for example some resources have been moved away from the City of Yarra (an historical hotspot of AOD service need), but the need in this location has not decreased. Services are focussed on rebuilding or establishing service pathways for clients and see that (re)creating a seamless service response for clients is challenging. Responding to people who are experiencing homelessness is a significant concern, and participants also drew attention to the needs of families (and the need to access family services data to better understand this).

The recent 2015 State budget announcement announced that mental health funding had been reinstated to St Mary’s House of Welcome and the Jesuits who run the youth focussed artful dodgers program. As these programs are re-established they may address some of the concerns regarding links between MHCSS and homelessness services, in addition to improving access to mental health community support for people experiencing homelessness.

<table>
<thead>
<tr>
<th>Priorities identified before the forum</th>
<th>Session 1: Testing the priorities</th>
<th>Session 3: What are we going to do about it?</th>
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</thead>
<tbody>
<tr>
<td><strong>Client need</strong></td>
<td>This priority area was confirmed, and more detail was provided.</td>
<td>Understand and address social determinants of health – gambling, culture of alcohol, housing, education and health literacy.</td>
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</tbody>
</table>
| Responding to a diverse client population and improving understanding of the client profile and service use for: | Special mention was made regarding **access difficulties** for:  
  - Ageing drug users.  
  - Aboriginal & Torres Strait Islanders.  
  - Culturally & linguistically diverse groups.  
  - People who are homeless or people with housing issues.  
  - Young people (including the student group in particular).  
  - LGBTIQ.  
  - People with a dual diagnosis. | Plan across the prevention/early intervention/treatment continuum. |
| - Youth.  
- People from CALD backgrounds.  
- People who are LGBTIQ. | There is concern about the requirement for young people to have a diagnosis before accessing services, suggesting this is counter intuitive to the work done to avoid “stigmatising”. | Build the capacity of the broader service system to respond to our clients – schools, courts, hospitals. |
<p>| Workforce development – dual diagnosis, assessment skills, consumer roles (link with workforce priority as per the Regional Management Forum) and training at under graduate level. | More flexible service responses (this is particularly in response to people who are homeless or at risk of homelessness and for whom the pathways into the service system have significantly changed; also for young people who may not respond to “office” based services). | Improve client understanding of how to access services. |</p>
<table>
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<tr>
<td><strong>Understanding the impacts of the service changes</strong></td>
<td></td>
<td>Evaluate the new service models to understand what the impacts have been for clients, the organisations and the service system. Include:</td>
</tr>
<tr>
<td>a) Concern around the loss of certain service approaches that were relevant to the local population:</td>
<td>This priority was confirmed.</td>
<td>• Who is missing out?</td>
</tr>
<tr>
<td>• Harm Reduction Focus.</td>
<td>Emphasis was given to the changes which have reduced group programs, and a perception of reduced social and community support options and “easy” to engage with service types (eg: shop fronts).</td>
<td>• Is there timely access to AOD services?</td>
</tr>
<tr>
<td>• Safe spaces / casual drop in centres.</td>
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<td>• What service use patterns have changed, for example, what was the most used AOD service type in the catchment and what is it now?</td>
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<tr>
<td>• Opportunistic intervention &amp; motivational enhancement practice.</td>
<td></td>
<td>Improve &amp; increase opportunities for consumer involvement in service design, development and evaluation.</td>
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<td>b) Potential redirection of resources away from the Inner North.</td>
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<tr>
<td><strong>[New priority]</strong></td>
<td><strong>Appropriate Service Mix</strong></td>
<td>Create a functional working relationship between mental health, AOD and homeless services.</td>
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<tr>
<td>Comments were made on the service mix in this catchment stressing the importance of ensuring that the right services are present and available. These included:</td>
<td></td>
<td>Improved service/sector collaboration, problem solving, links and coordination - need local responses and collaborative models.</td>
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<tr>
<td>• Concern about a lack of local AOD responses – including residential rehabilitation and detox; and long term treatment options.</td>
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<td>Integrate intake services (including homelessness intake) – clients should not need to tell their story three times.</td>
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<td>• Early intervention and prevention responses.</td>
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<td>More flexibility in intake (ie: different mechanisms for young people) and provide support to assist people navigate the process.</td>
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<td>• AOD housing options.</td>
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<td>Consider if outreach work should be thought of as an additional AOD treatment type. Particularly in response to “special” populations of youth/homeless/mental health.</td>
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<tr>
<td>• Services being able to respond to homelessness and housing needs.</td>
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<td>Suggested sources of information:</td>
</tr>
<tr>
<td>• Family Services.</td>
<td></td>
<td>• Turning Point AOD data (with regard to ambulance calls)</td>
</tr>
<tr>
<td>Improve the link between MHCSS and AOD when responding to people in crisis accommodation, improving outreach services, crisis and affordable housing options for these groups.</td>
<td></td>
<td>• Sacred Heart Mission Project – Journey to Social Inclusion,</td>
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<td></td>
<td></td>
<td>• Family Services Data.</td>
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</table>
What’s already happening in the Inner North (session 2)?

There was a very low number activities identified for the Inner North during this session.

Services/responses identified appeared to be predominately responding to inner city homelessness – including outreach and accessible service delivery for people with a mental illness and/or AOD issues.

The lack of Partners in Recovery (PIR) was noted for mental health clients, while the presence of Day to Day living and Personal Helpers and Mentors (PHaMs) programs in the City of Moreland are noted as perhaps meeting some of the demand in that area and therefore providing a potential explanation for lower MHCSS service access rates.
Outcomes of the Regional Stakeholder forum for the North Melbourne catchment

Our consultation activity endorsed the priorities and understanding of the catchment. Whittlesea remained a key issue for service providers, with the lack of existing infrastructure – both capital and community – raised as the key barrier to service access, delivery and coordination. While capital investment to encourage and support new services into the area was seen as optimal solution, participants also identified a number of opportunities and ideas for improving accessibility. Services need to think creatively about responses to a population characterised by young people and families, including better links with non-traditional partner agencies such as schools, maternal and child health services and family services.

There are significant concerns about fragmentation in the service system as a result of recommissioning, that clients were not adequately prepared for the change and that intake/assessment was not accessible during this time.

<table>
<thead>
<tr>
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</table>
| Growth corridor                      | The lack of physical service locations in Whittlesea is seen as a significant issue. | Respond to the lack of service infrastructure in Whittlesea, including for general health and community support services. Ideas included: Increased capital investment:  
- A service hub – like that being built in Melton - a fully integrated (not just co-located) model bringing together a number of different services.  
New/ innovative/different service models:  
- Rethinking outreach - eg: more flexible models of service delivery – is it possible to have a virtual site or pop up location to overcome logistics and enable workforce to do outreach in the growth corridor; increase hours of support to enable better responsiveness while more permanent solutions are devised.  
- Assertive outreach, IT and better use of existing infrastructure.  
- Utilising existing resources, such as up-skilling GPs and Pharmacists.  
Improve service coordination and service links and create referral pathways and connection points to and from other services.  
Plan for the future - think about what is going to be needed in future years; map service locations and gaps, think about land use and service planning. |
<table>
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<tbody>
<tr>
<td><strong>Client need:</strong> Specific client groups require local planning attention.</td>
<td>Families, people who are homeless or at risk of homelessness and Aboriginal and Torres Strait Islanders be added to the service access issues list.</td>
<td>Respond to young people’s and family’s needs through better planning and links with relevant services – Maternal Child Health, family support, homelessness, community health, primary care, gambling support/schools.</td>
</tr>
</tbody>
</table>
| **Service access issues for:**  
  - Young people.  
  - People with disabilities (including respite care)  
  - Older people.  
  - Culturally and linguistically diverse groups.  
  - People who are isolated. | Older people (including people ageing with a mental illness), younger people and people who are isolated were emphasised as priorities. | Support a workforce that has capacity to respond to complex needs and families. |
| **Complexity in the client group:**  
  - Bush-fires affected communities.  
  - People with dual diagnosis.  
  - Family violence.  
  - Gambling. | Family violence and dual diagnosis were emphasised in relation to complexity, as were clients in the Cities of Banyule and Darebin. | Provide social support for people with a mental illness to reduce social isolation. |
| **Service sector / System change**  
  - Access issues: identifying the right people & the right entry points.  
  - Awareness & promotion of the new services & system change:  
    - For clients.  
    - For other services.  
  - Seamless client pathways.  
  - Collaboration.  
  - Funding: we need more, not just different. | The concerns about the service sector and the changes were confirmed by participants. | Family violence issues need to be addressed through a focus on families – men, women and the whole community. |
|  |  | Increase funding to address complexity of clients in the Cities of Banyule and Darebin. |
|  |  | Participants identified a number of suggestions to improve the intake/assessment function including:  
  - Better information about the services.  
  - Finding clients for services rather than the other way around.  
  - Actively supporting clients through the process.  
  - Streamlining referrals.  
|  |  | Improve links and service integration with schools – including using schools as a service delivery point (eg: peer based programs or outreach/ prevention programs).  
|  |  | Share information/client management systems (it is assumed that this is in response to the separation of the systems and a desire for a more streamlined process for clients between the systems).  
|  |  | Evaluate the new service systems. Identify and/or create early intervention and prevention activities, including community education and health promotion.  
|  |  | Explore the impact of the NDIS. |
**What’s already happening in the North (session 2)?**

With the exception of headspace in Greensborough and an acknowledgement that it hoped to outreach to Whittlesea, there was no identification of services or other activity for the growth corridor. It is in stark contrast to that of the other growth corridors.

However, there appears to be a number of programs which may not be available elsewhere in the Region, including PACER and the Partners in Recovery Program for people with a mental illness. A services connect pilot is located at Child Protection Services (CPS) in Thomastown.

There are a couple of initiatives targeting dual diagnosis including capacity building, and the service connect pilot puts a focus on young people and families.
Outcomes of the Regional Stakeholder Forum for the North West Melbourne catchment

The stakeholder consultations endorsed the priorities as previously identified. A key theme throughout the consultation for this catchment was the importance of service coordination: the need to integrate a siloed service system acknowledging the subsequent difficulties for clients and services in navigating their way through different service types. There is energy around the new service hub planned for Melton and a feeling that this will significantly improve service access issues in this area. As with the North growth corridor attendees consider non-traditional service partners such as education and early childhood services as part of the response to the needs of youth and families. The North West catchment is distinctive in its contrasting communities - well established 'hotspot'-type areas such as Footscray contrast with new and emerging populations and service needs in the growth corridors.

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<tr>
<td><strong>Growth corridor</strong></td>
<td>The corridor between Broadmeadows and Craigieburn (Hume) was also identified as an emerging hot spot. Concerns include the growth in the over 65s and vulnerable young families. The importance of delivering services locally was emphasised as was the need to respond to young people in Melton.</td>
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<td>Responding to strong population growth and a need for responsive resources in light of emerging trends. Melton and Sunbury identified as hot spots.</td>
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<td>- Poor infrastructure: transport.</td>
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<td>- Limited service availability: location, choice, specialists.</td>
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<td>- Lack of prescribing GPs.</td>
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<td><strong>Service / sector coordination</strong></td>
<td>The need for coordinated and integrated care and clear service entry points and pathways were key themes around this priority – as well as the need to communicate these to clients (improve health &amp; health service literacy). The need for consistent pathways out of prison to community services; and better links with council services such as HACC and youth was noted. Fragmentation and siloing of services is a continuing concern.</td>
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<tr>
<td>Opportunities for cross sector collaboration for problem solving &amp; innovation.</td>
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<td>Enhanced service coordination.</td>
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<td>Consider an integrated service at Sunshine. As services/teams move out of the Harvester clinic into the new community services hub planned for Melton, the space could be used to co-locate/integrate other services.</td>
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<td>Share knowledge about the new system/ service pathways – creating quick referral pathways (share paperwork – flexibility required). Information days and networking forums – services to sell themselves &amp; inform others. Enhance primary care through training and capacity building.</td>
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<td>Address fragmentation and service siloes through better service coordination and service pathways for clients. Participants wanted:</td>
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<td>- Services to wrap around people.</td>
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<td>- Integrated treatment options.</td>
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<td>- Care coordination that reduces fragmentation and duplication.</td>
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<td>- Dual diagnosis capability.</td>
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<td>- More coordination at the intake point.</td>
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<td>- Clarity about pathways to care across sectors.</td>
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<td>Utilise the new community health centre in Melton (auspiced by Djerriwarrh Community Health Service) as an opportunity to test models for collaboration and demonstrate the benefits of this. This impact should be evaluated.</td>
<td></td>
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</tr>
<tr>
<td>Priorities identified before the forum</td>
<td>Session 1: Confirming and Understanding the Priorities</td>
<td>Session 3: What are we going to do about it?</td>
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</tr>
<tr>
<td><strong>Client need</strong></td>
<td>Families featured strongly in the comments. They included the need to respond to clients as parents:</td>
<td>Improve links with schools and early childhood services.</td>
</tr>
<tr>
<td>Specific client groups require local planning attention.</td>
<td>- Experiencing stress and presenting as a “dysfunctional” family to the school.</td>
<td>Capacity building required for dual diagnosis capability, better engagement of GPs.</td>
</tr>
<tr>
<td><strong>Service access issues were identified for:</strong></td>
<td>- Coping with post natal depression.</td>
<td>Different models of engagement needed for youth (including young men).</td>
</tr>
<tr>
<td>- Culturally and linguistically diverse groups.</td>
<td>- The needs of their children – including their physical health and children as service users.</td>
<td>Improve prevention and early intervention activity:</td>
</tr>
<tr>
<td>- Aboriginal and Torres Strait Islander peoples.</td>
<td>The AOD service model is limited in its work with families. This was identified as an issue in being able to respond to the client in the family context. Although able to work with families, services are not necessarily able to provide the treatment type that families want.</td>
<td>- Engage with local government.</td>
</tr>
<tr>
<td><strong>Complexity in the client group</strong></td>
<td>Comments were also made about:</td>
<td>- Need to have strategies across the continuum.</td>
</tr>
<tr>
<td>- Culturally and linguistically diverse groups.</td>
<td>- A lack of mental health provision at Sunshine hospital and the impact this was having on refugee and asylum seekers.</td>
<td>- Identify opportunities – local council, presentations at schools (use of lived experience).</td>
</tr>
<tr>
<td>- Young people.</td>
<td>- Older people ageing in place and their use of prescription drugs; and</td>
<td></td>
</tr>
<tr>
<td>- People with gambling challenges.</td>
<td>- The lack of ORT and primary NSP in Brimbank.</td>
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<tr>
<td>- Family violence related need.</td>
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<tr>
<td>- Clients with medical co-morbidities.</td>
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</tbody>
</table>

**What is already happening in the North West catchment (session 2)?**

- Appears to be good awareness of the access issue in Melton and there is both planning and investment in place to address these.
- The new community services hub coordinated through Djerriwarrh health services is recognised as significant and should go some way to address infrastructure and service access issues in that area.
- The Broadmeadows area and the Hume Local Government Area are also targets for more planning activity.
- There is a strong emphasis on programs for young people, including capacity building as well as direct service initiatives.
- The other key area of activity is increasing awareness of mental health issues for people who are from CALD backgrounds.
- Services connect pilots are located in Hume Moreland & Melton Brimbank.
Outcomes of the Regional Stakeholder forum for the South West Melbourne catchment

The consultation confirmed all the priority areas for the South West catchment and there seemed to be a good awareness of the issues, existing service effort and opportunities in the area. There is recognition of the need for service delivery to respond to young people and families, to establish/ re-establish appropriate service pathways and improve service coordination as well as prevention and early intervention activities.

<table>
<thead>
<tr>
<th>Priorities identified before the forum</th>
<th>Session 1: Confirming and Understanding the Priorities</th>
<th>Session 3: What are we going to do about it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wyndham the growth corridor</strong></td>
<td>The Wyndham growth corridor was confirmed as a priority area. There were concerns about:</td>
<td>Respond to the disruption of the service and the lack of knowledge/ understanding of service system and improve relationships/ partnerships and knowledge.</td>
</tr>
<tr>
<td>Wyndham was repeatedly raised as an area of specific priority.</td>
<td>• Access to mental health beds.</td>
<td>Participants suggested:</td>
</tr>
<tr>
<td>• Allocation of resources.</td>
<td>• Detox beds/ AOD specific accommodation.</td>
<td>• Re-establishing existing alliances post reforms.</td>
</tr>
<tr>
<td>• Poor infrastructure: transport, service provision.</td>
<td>• Access to Paediatricians.</td>
<td>• Marketing programs to one another.</td>
</tr>
<tr>
<td>• Specific area demographics, representing priority need.</td>
<td>• Assistance for young carers.</td>
<td>• Creating a common language and referral pathways.</td>
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<tr>
<td></td>
<td>• Limited housing options or supported accommodation.</td>
<td>• MoU between agencies re communication.</td>
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<td></td>
<td>A lack of GPs was also identified and the impact this has on the coordination of service pathways and primary health care.</td>
<td>Acknowledge issues in addressing clients from a non-English speaking background (increased funding for interpreters).</td>
</tr>
<tr>
<td></td>
<td>Medicare local and PCP data, as well as the Wyndham community profiles were identified as useful data sources. The latter apparently highlighting road safety issues as being significant.</td>
<td>Address carer issues for MH and AOD (noting that the AOD reforms have made working with families difficult as they are expected to refer on).</td>
</tr>
<tr>
<td><strong>Service system</strong></td>
<td>The absence of Partners in Recovery (PIR) and limited family services was noted.</td>
<td>Get to know each other.</td>
</tr>
<tr>
<td>Specific needs raised around:</td>
<td>The need to focus on the wider determinants of health, such as family violence, was noted.</td>
<td>Address gap in prevention and early identification. Respond to social determinants of health (be clear about role of local government)</td>
</tr>
<tr>
<td>• GPs: more training &amp; awareness in recognising AOD issues / needs in their patients, pharmacotherapy permits.</td>
<td>A strong focus on consumer wellbeing through providing opportunities for healing such as community gardening, connecting with nature, community arts programs, engaging with culture and faith.</td>
<td>There is opportunity for consumers to have a stronger role in the service system – both in educative/preventative roles and in offering peer support.</td>
</tr>
<tr>
<td>• Opportunities for cross sector collaboration for problem solving &amp; innovation.</td>
<td>Consumer view is that there is a lack of “safe places”.</td>
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</tr>
<tr>
<td>Priorities identified before the forum</td>
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<td>Session 3: What are we going to do about it?</td>
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</tr>
<tr>
<td><strong>Client need</strong></td>
<td>The comments made in the consultation strongly reflected the already identified client need priorities of young people, CALD (especially refugees) and families.</td>
<td>Different service delivery models are required to respond to the different and changing demographics in this area (young people and families). These include:</td>
</tr>
<tr>
<td>Specific client groups require local planning attention.</td>
<td>For young people, the importance of access to employment and links with schools and the lack of services generally were noted.</td>
<td>• More flexible hours for working families.</td>
</tr>
<tr>
<td><strong>Service access issues were identified for:</strong></td>
<td>Possible data sources included women’s health west and police attendance data re understanding family violence and child protection.</td>
<td>• Being responsive to different needs – eg: post natal depression.</td>
</tr>
<tr>
<td>• Young people.</td>
<td></td>
<td>• Greater alignment with child and family and early years services.</td>
</tr>
<tr>
<td>• Culturally and linguistically diverse groups (especially refugees).</td>
<td></td>
<td>• Greater resource allocation at early intervention level.</td>
</tr>
<tr>
<td>• Families.</td>
<td></td>
<td>The need for infrastructure is noted, with suggestions for services to coordinate to create new infrastructure and shared spaces and/or hub and satellite models.</td>
</tr>
<tr>
<td><strong>Complexity in the client group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cultural &amp; linguistically diverse groups (especially refugees).</td>
<td></td>
<td></td>
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<tr>
<td>• People with gambling issues.</td>
<td></td>
<td></td>
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<tr>
<td>• People with medical co-morbidities.</td>
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</table>

**What’s already happening in the South West Catchment (session 2)?**

There was a strong identification of existing services and programs across this catchment addressing the identified client needs, including many responding to families and youth in the Wyndham area. There was some indication of good service collaboration with services out-posting themselves to another service’s building and a couple of other such opportunities identified.

There is some indication of existing service coordination/collaboration/ planning activities in place including around youth, mental health, homelessness, pharmacotherapy providers and refugees/asylum seekers.
Outcomes of the Regional Stakeholder Forum for the Whole of Region

In session 1, two additional priority areas emerged, that fell outside the confines of a specific catchment area. (1) System Change and (2) System Innovation and Development were added to the discussion rounds and discussed at a ‘whole of region’ level.

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>What are we going to do about it?</th>
</tr>
</thead>
</table>
| **System Change**                 | • Develop a plan to support the change process.  
• Involve consumers.  
• Provide information to consumers and to other services about how to navigate the service system.  
• Provide assistance/support to clients to easily access intake and services (provide a soft entry – it is an assumption that consumers are able to engage in the process).  
• Monitor the impact of the change to understand who is being affected.  
• Ensure that we learn from the process.  

Evaluate and review the processes. Data to evaluate success and identify issues is required.  

Rethink options/opportunities for service integration and challenge the service system to break down the silos. For example:  
• Services connect model.  
• Colocation of different services (integrate at location level).  
• Innovation – eg: mobile service bus.  
• Technology.  

Maintain - or rebuild - focus on homelessness and ensure better linkages with forensic system. |
| **System Innovation and development** | • Improve service coordination and integration – with a particular focus on navigating the intake systems and reducing the number of times a client needs to tell their story.  
• Improve consumer involvement and engagement – including in service design and the catchment based planning process (create guidelines for both professional and voluntary roles).  
• Address service navigation issues – for both consumers and services (address communication and information needs).  
• Use technology as an enabler to support better communication and information, but recognise that it should not be relied on.  
• Target front door services, such as headspace or drop in centres (including commonwealth funded programs) to engage consumers. |

Service system is still in a change process, following recommissioning.  

Services and clients are trying to maintain stability while these changes occur.  

System is not promoting a “no wrong door approach”.

This topic created significant discussion, and asked many questions and generated ideas about what some of the answers might be.  
• Effective coordination and prioritisation.  
• Services must be easy to access.  
• Better service navigation for clients and services.  
• Central/coordinated data collection.  
• Maintenance and promotion of successful programs.
A summary - What it means for the catchment based planning function?

Session 3 included a discussion on the role of the catchment based planning function. We asked participants to think about what they thought would be useful for their work. The discussion occurred at both a catchment and regional level. Strong themes emerged as can be seen by the table below.

<table>
<thead>
<tr>
<th>Key themes</th>
<th>Inner North</th>
<th>North</th>
<th>North West</th>
<th>South West</th>
<th>Region</th>
</tr>
</thead>
</table>
| **NETWORKING & COMMUNICATION** | Better networking, communication & information sharing                       | Improve service coordination and service links and create referral pathways and connection points to and from other services. | Share knowledge about the new system/ service pathways – creating quick referral pathways (share paperwork – flexibility required). | Respond to:  
  - The disruption of the services  
  - The lack of knowledge/ understanding of service system  
  - Improve relationships/ partnerships and knowledge. | Facilitate understanding of roles and responsibilities across the sector. |
|                            | Create regular opportunities for services to meet to share knowledge, resources and data (provider conferences). | Improve service coordination Support partnership activities – forums, review boundaries and alliances. | Gap analysis and mapping of unfunded work.  
  Information/ data which raises awareness of issues and needs. | Identify barriers to services having a presence in Wyndham (lack of accommodation, price and staff).  
  Provide data and information to support health service planning (land and capital needs in the growth areas); but also identify emerging trends future/current specialist services; understand gaps at local level (e.g. suburbs in Hobsons Bay).  
  Identify new MH/AOD problems and cohorts | Provide information and evidence to:  
  - Advocate for change/ challenge services to think differently.  
  - Help with decision and resource allocation in a planned manner – e.g. where are people not getting access and where should services be located.  
  - Identify drug trends. |
| **DATA & INFORMATION**     | Support data collection/analysis to inform decision making and create an evidence base.  
  Create a short, medium and long term vision – population based and local. | Contribute data and information to support future (capital) investment in Whittlesea.  
  Plan for the future - think about what is going to be needed in future years; map service locations and gaps, think about land use and service planning. | Gap analysis and mapping of unfunded work.  
  Information/ data which raises awareness of issues and needs. | Identify barriers to services having a presence in Wyndham (lack of accommodation, price and staff).  
  Provide data and information to support health service planning (land and capital needs in the growth areas); but also identify emerging trends future/current specialist services; understand gaps at local level (e.g. suburbs in Hobsons Bay).  
  Identify new MH/AOD problems and cohorts | Provide information and evidence to:  
  - Advocate for change/ challenge services to think differently.  
  - Help with decision and resource allocation in a planned manner – e.g. where are people not getting access and where should services be located.  
  - Identify drug trends. |
<p>| <strong>EVALUATION &amp; REVIEW</strong>    | Review intake and assessment process in AOD.                                | Evaluate the new service systems.                                    | Is there an evaluation planned of cost and benefit of recommissioning?     | Monitor the impact of the change to understand who is being affected.    | Monitor the impact of the change to understand who is being affected.  |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Evaluation and review of service model</td>
<td>Evaluate the new service models to understand what the impacts have been for clients, the organisations and the service system.</td>
<td>Evaluate new innovative/different service models.</td>
<td>New service partners.</td>
<td>Need different service delivery models to respond to the different and changing demographics in this area (young people and families).</td>
<td>Evaluate and review the processes - we need data to identify successes &amp; issues. Ensure that we learn from this reform process.</td>
</tr>
<tr>
<td>SERVICE CREATIVITY</td>
<td>Identify best practice.</td>
<td>New/ innovative/different service models.</td>
<td>New service partners.</td>
<td>Need different service delivery models to respond to the different and changing demographics in this area (young people and families).</td>
<td>Innovative mediums in service delivery – creative and flexible. Share what is working across catchments (test and tweak). Rethink options/ opportunities for service integration and challenge the service system to break down the silos.</td>
</tr>
<tr>
<td>Identify opportunities for creativity in the service models</td>
<td>More flexible service responses.</td>
<td>Rethink outreach, explore virtual or pop-up service locations.</td>
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<td></td>
<td>New partners.</td>
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<td></td>
<td>Creative utilisation of existing resources - GPs and pharmacists.</td>
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<tr>
<td>WORKFORCE DEVELOPMENT</td>
<td>Build the capacity of the broader service system to respond to our clients – schools, courts, hospitals.</td>
<td>Support a workforce that has capacity to respond to complex needs and families.</td>
<td>Capacity building required for dual diagnosis capability, better engagement of GPs. Enhance primary care through training and capacity building.</td>
<td></td>
<td>Orientate new staff in different services throughout the system to enable cross-sectorial understanding.</td>
</tr>
<tr>
<td>Improving and future-proofing workforce &amp; system capacity</td>
<td>Workforce development – dual diagnosis, assessment skills, consumer roles (link with workforce priority as per the RMF) and training at under graduate level.</td>
<td>Up skill GPs and Pharmacists.</td>
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</tr>
<tr>
<td>UNDERSTANDING THE CONTINUUM</td>
<td>Plan across the prevention/early intervention/treatment/specialist continuum.</td>
<td>Identify and/or create early intervention and prevention activities, including community</td>
<td>Improve prevention and early intervention activity.</td>
<td>Address gap in prevention and early identification. Respond to social determinants of health (be clear about the role of local government in this).</td>
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</tr>
<tr>
<td>Key themes</td>
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<tr>
<td><strong>COORDINATE PLANNING</strong></td>
<td>Understand and address wider determinants of health – gambling, culture of alcohol, housing; education and health literacy.</td>
<td>education and health promotion.</td>
<td>Coordination across the various planning activities, including mapping partners/services in the area – create opportunities for shared planning.</td>
<td>Coordinate networks (analyse new models – don’t want to go to 100s of meetings) – understand who needs to meet and why.</td>
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<tr>
<td><strong>CONSUMERS</strong></td>
<td>Coordinate across and with the various planning functions.</td>
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<tr>
<td><em>Effective consumer engagement</em></td>
<td>More opportunities for consumer involvement in service design, development and evaluation.</td>
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<tr>
<td><strong>SOURCES</strong></td>
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<tr>
<td><em>Other data/information/evidence/ideas</em></td>
<td>Turning point data, with regard to ambulance calls outs to AOD</td>
<td>Planning should liaise with Ravenhall prison about pathways out of prison and into community services.</td>
<td>Women’s health west and police attendance data re understanding family violence and child protection data.</td>
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<tr>
<td>Sacred Heart Mission Project – Journey to Social Inclusion might be useful.</td>
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</tbody>
</table>
Where to from here?

MHCSS and AOD Catchment planning thank all organisations and individuals involved in this consultation process. Your efforts have assisted us to understand the relevant local issues as they relate to our services and our services’ relationships with other sectors, to map out the next steps and to scope future activity.

From here, the content provided to us will be summarised and an analysis will be included in the Catchment Based Plans that are submitted to the Victorian Department of Health and Human Services.

We will use what we have learned to progress key priority areas that fall within our responsibilities, and to advocate for those that don’t.

In particular we feel the sector has requested two fundamental actions from the department:

1) Improved communications to services and to consumers about the changes. The change that has occurred across multiple sectors has left many unclear about who is providing what services, how to refer and appropriate referral service pathways.

2) Evaluation and reflection on the reform process that has taken place. An expression of the learning that will be taken on board to ensure future service changes do not repeat this level of disruption. That this is acknowledged and communicated.

It is important to us that we maintain momentum and engagement with the individuals and organisations that matter.

If you have any questions about the Catchment Based Planning processes, please contact:

Louise Richardson
AOD Health Service Planner
Odyssey House Victoria & Uniting Care ReGen
lrichardson@odyssey.org.au

Or

Visit: cohealth.org.au/#communities
Appendix A: Inner North Melbourne catchment summary

**Inner North catchment: an overview**

The Inner North catchment includes the cities of Melbourne, Yarra, Moonee Valley and Moreland and has a population of almost half a million. With the majority of the catchment within 8km of the CBD it has good access to transport, health services and amenities. While population growth will continue to 2021, only in the City of Melbourne is it expected to be significant and remain much higher than the State average into the future.

Cultural diversity is high across the catchment compared to Victorian averages, with 37% of people born overseas. The City of Melbourne has a very high number of new settler arrivals (although only 1% of these are for humanitarian reasons). The proportion of Aboriginal and Torres Strait Islander people is lower than the State average.

Despite median incomes being close to or higher than the Victorian average and low rates of mortgage and rental stress, there are a number of indicators suggesting socio-economic disadvantage.

- With the exception of Yarra, the proportion of people reporting poor health is higher across the catchment than the state average.
- Gaming losses are high in both Melbourne and Moonee Valley, but low or average in Yarra and Moreland.
- Yarra ranks 12th in the State for unemployment.
- Very high proportion of social housing (except in Moreland), and Melbourne has the highest rate of new dwelling approvals.
- Total number of offences per 1000 population is higher across the whole catchment than the Victorian average, and very high in both Yarra and Melbourne.
- High rates of alcohol and marijuana use by 15 – 17 year olds.

Melbourne and Yarra share a number of common characteristics, including very high offending rates, a much higher proportion of young adults (15 - 44 years); consistently high scores in almost all indicators relating to alcohol and illicit drugs and a high proportion of people seeking professional help for mental health problems. The city attraction of people into the city and the concentration of accommodation around the Universities possibly explain some of these characteristics.

Moreland also stands out for people reporting high levels of psychological distress and adolescents who report being recently bullied. While it has a high rate of registered mental health clients per 1000 population, it has a lower rate of MHCSS clients. Moreland is also the only LGA area within the Inner North catchment where less than 85% of the population believe there are good facilities and services.

**Priorities for the Inner North catchment**

1. **Client need**

   Responding to a diverse client population and improving our understanding of the client profile and service needs for:
   - Ageing drug users
   - Aboriginal and Torres Strait Islander people
   - Culturally and linguistically diverse groups
   - People who are homeless or people with housing issues
   - Young people (with a particular focus on the student group)
   - GLBTIQ
   - People with a dual diagnosis

2. **Understanding the impacts of the service changes:**

   a) Concern around the loss of certain service approaches that were relevant to the local population:
      - Harm reduction focus
      - Safe spaces / casual drop in centres
      - Opportunistic intervention & motivational enhancement practice

   b) Potential redirection of resources away from the Inner North
MOONEE VALLEY (pop 113,258)

Moonee Valley is located in Melbourne’s north-west. Population growth has been considerably below average and future projections are around average. Age distribution in this area is relatively average.

Moonee Valley is diverse; a quarter of people were born in a non-English speaking country and more than 30% speak a language other than English at home. The unemployment rate is below average, household income is above average and mortgage and rental stress are low. That said, the percentage of social housing is the third highest in the state.

Moonee Valley has the third highest rate of gaming machine losses per head of adult population among our 14 LGAs in the North and West catchments ($766.2pp/year compared with the state average of $549.5). There are some AOD risks to note in the 15-17 year olds in this area, with higher than average rates of 15-17 year olds who drank alcohol and smoked tobacco in the past 30 days, who have ever used marijuana and other illegal drugs. The overall smoking rate is higher than average – especially among males. Total offences and drug use & possession offences are slightly higher than average.

MELBOURNE (pop 105,376)

The City of Melbourne is made up of the CBD and some inner suburbs, including the social housing estates around Kensington and the University precincts. Per annum population growth has been very strong over the last 10 years and this is forecast to continue. Rates of new settler arrivals are around three times the Victorian average but only 1% of these are humanitarian arrivals. The area has a very youthful population with around 72% of people aged between 15-44 years. 54% of people were born overseas and 43% speak a language other than English at home. The most commonly spoken languages other than English are Mandarin, Cantonese and Indonesian.

While it has the highest number of new dwelling approvals per 1000 population in the state it is also ranked 6th for social housing.

The rate of total offences is the highest in the state and drug offences are the second highest. Some of this may reflect activity in the city rather than resident behaviour per se. Looking at the relevant AOD measures across the whole of the North & West catchments Melbourne has its highest rate of alcohol-related ambulance call outs, serious road injuries during high alcohol hours, alcohol-related assaults, pharmaceutical ambulance rates, illicit drug-related ambulance rates and total ED presentations for illicit drugs. Melbourne has an extremely high rate of child protection orders at 19.4 per 1000.

MORELAND (pop 156,180)

Moreland is located in inner north Melbourne, around 5km from the CBD. Per annum growth has been lower than average since 2002 but is projected to be above average through to 2022. Residents aged 25-44 are overrepresented compared to the state average, as are those aged 85+, while other age groups are underrepresented.

Moreland is culturally diverse, with 36% of people born overseas and 42% speaking a language other than English at home. The percentage of persons reporting fair or poor health is relatively high. While the level of psychological distress is high, the lifetime prevalence rates for anxiety and depression are close to average and the proportion of people seeking assistance for a mental health problem is one of the lowest in our catchments. However, Moreland has the highest rate of registered mental health clients across the whole North & West catchments.

Rates of smoking and drinking alcohol at levels likely to cause short term harm are relatively low. The ADIS rate for treatment episodes of care relating to pharmaceuticals is high for the 15-24 year olds, males and females. There are some risky behaviours in the 15-17 year olds relating to AOD use, with Moreland reporting the third highest rate of 15-17 year olds who have ever used marijuana across all 14 of our LGAs.

YARRA (pop 80,593)

The City of Yarra is located in inner-east Melbourne. Per annum population growth has been around average but is projected to increase to 2022. Almost half the population are adults aged 25-44 years. Cultural diversity in Yarra is similar to the Victorian average. The percentage of social housing is the highest in the state.

Yarra is an area of significant concern in the AOD statistics. It has the third highest rate of drug crime and the fourth highest rate of overall crime across the whole of Victoria. The area consistently scores in the top 3 highest rates across our North & West catchments for almost all indicators relating to alcohol and illicit drugs, and for many of those relating to pharmaceuticals.

Yarra has its highest rate of registered Drug and Alcohol clients (11.1 per 1000) as well as the second highest rate of registered mental health clients across our North & West catchment areas.

Typical measures of geographical access are good, 100% of the population live near to public transport, and there is a high distribution of GP and allied health and other community services.

Yarra residents are the highest seekers of assistance for professional help for a mental health problem and males have a high life time prevalence of depression and anxiety (24.1%) compared to the Victorian average of 14.6%.
Appendix B: North Melbourne catchment summary

North catchment: an overview

The Northern Melbourne catchment includes the cities of Whittlesea, Nillumbik, Darebin and Banyule and has a combined population of half a million people. The catchment can be characterised by two distinct corridors – with Whittlesea and Darebin out to the North; comparatively disadvantaged on a number of socio-economic indicators and Banyule and Nillumbik out to the North East; comparatively advantaged. Banyule and Darebin are closer to the city while Whittlesea and Nillumbik are located on the urban/rural fringe which has an impact on service access. A challenge for this catchment is planning for and responding to the very different age, resident and service access profiles across each of the LGAs. For example, only Banyule has an ‘average’ age distribution; Whittlesea has a higher proportion of children (under 14 years), Nillumbik has an over representation of the 0-24 and 45-65 year old groups and an under representation of the 25-44 year olds, and Darebin has a much greater proportion of 25–44 year olds. Both Whittlesea and Darebin are culturally diverse with more than 40% of residents in each LGA speaking a language other than English at home, comparatively this group represents just 7% of the population in Nillumbik and 17% in Banyule. Whittlesea is also the only LGA in the catchment with strong projected population growth.

As described above, Whittlesea and Darebin are comparatively disadvantaged on many social economic indicators. They have higher than average rates of unemployment, gaming machine losses, poor self-reported health status and residents who do not feel safe walking alone after dark. Whittlesea has a higher than average rates of family incidents; and Darebin a high rate of child protection orders. They contrast starkly with Banyule and Nillumbik where almost all indicators are within the average or suggest advantage – it is important to note, however that there is a significant pocket of disadvantage within Banyule in the Heidelberg West area which is disguised by LGA-wide averages.

Some notable exceptions to this general pattern are the:

- High rate of alcohol-related family violence in Banyule.
- High hospitalisation rates for mental health in Nillumbik.
- High rates of alcohol, marijuana and tobacco use among 13 – 17 year olds across the whole catchment. Whittlesea also has a very high rate of glue sniffing or chromat.
- Illicit drug use (and use of AoD services for illicit drug use) is also high in Banyule.
- Banyule records a very high rate of lifetime prevalence of anxiety and depression for females.

Service access is generally better in Darebin and Banyule, with the rates of allied health, pharmacies, dental services and general practitioners all higher for these areas than the outer areas. The rate of GP attendance is very high in Darebin and Whittlesea (with the latter ranked second in the State). MHCSS services and AoD services have higher utilisation rates in the inner areas. Darebin has the North catchment’s highest rate of AoD service use for alcohol, pharmaceuticals and illicit drugs and Banyule second for pharmaceuticals and illicit drugs. The proportion of registered mental health clients, however, does not follow this pattern.

Nillumbik records one of the lowest rates of access to mental health services in the State, and Whittlesea and Banyule are also below average. The proportion of people seeking help for a mental health problem is lower than average in Whittlesea, and but higher than average in Banyule.

Priorities for the North catchment

1. Growth corridor
   Strong population growth and a need for responsive resources to address emerging trends.
   - Service distribution: demand outstrips supply
   - Poor infrastructure: transport & other community services
   - Reallocation of services: there is concern that this will take services away from areas that still need them.

2. Client need: Specific client groups require local planning attention.
   Service access issues identified for:
   - Young people
   - People with disabilities (including respite care)
   - Older people
   - Culturally & linguistically diverse groups
   - People who are isolated
   Complexity in the client group:
   - Bushfire affected communities
   - People with dual diagnosis
   - Family violence
   - Gambling.

3. Service sector / system change
   - Access issues: identifying the right people & the right entry points
   - Awareness & promotion of the new services & system change: (a) for clients, and (b) for other services
   - Seamless client pathways
   - Collaboration
   - Funding: we need more, not just different.
WHITTLESEA (pop 169,471)

Whittlesea is about 20km north of Melbourne’s CBD. It has had rapid population growth since 2002, and this is set to continue. It has a younger than average age profile (20% are under 14 years old), and a high level of cultural diversity (44.3% speak a language other than English at home).

Unemployment is above average, and there are very high levels of mortgage and rental stress. Whittlesea residents are the least likely to visit green space each week, are ranked second for sleeping less than seven hours a night and commute times are high (long commute time is associated with a range of negative health effects). Poor self-reported health is the fourth highest in the State and the rate of GP attendance is the second highest. The proportion of Whittlesea residents accessing professional support for mental health issues (10.4%) is lower than the state average (12.4%).

Of our 14 LGAs in the North & West AOD Partnership, Whittlesea has the highest percentage of 15-17 year olds who drank alcohol in the past 30 days (69.8% compared to a state average of 24.7%), the highest percentage of 15-17 year olds who smoked tobacco in the last 30 days (28.8% compared to a state average of 12.3%). Family violence incidence is also among the top 3 highest rates for our whole catchment (12.3 per 1000 population).

The rate of pharmacies, allied health services and GPs per 1000 people is ranked within the bottom ten of the State. As a measure of service distribution, this may mean people find it difficult to access the health services they need.

DAREBIN (pop 144,086)

Darebin is a small LGA to the north east of Melbourne’s CBD with a low projected growth rate. Residents aged 25-44 are overrepresented, and the area is culturally diverse with 41% of residents speaking a language other than English at home. It has our third highest rate of low English proficiency at 8.3%.

Darebin has the North & West’s highest proportion of people identifying as Aboriginal and Torres Strait Islander at 1.0% (compared to the state average of 0.8%).

Unemployment rate is higher than average, as are the percentages of low income individuals and households. The proportion of social housing dwellings is among the highest in the state. Smoking rates are above average, especially for males (28% compared to 16.5% in the state), and ambulance attendances for alcohol related call outs are high with the total attendances per 10,000 and the attendances for females per 10,000 both ranking among the top three highest across all four of our catchments. Darebin is the seventh most likely LGA to have residents reporting fair or poor health.

Access to public transport is very good and it has one of the lowest rates of car ownership in the State. However, perceptions of feeling safe while walking alone are low.

NILUMBIK (pop 62,651)

Nilumbik is 25km north east of Melbourne, with lower than average population growth and a skewed age-distribution (residents aged 0-24 years and 45-65 years are over represented, while there’s a dip below average in the 25-44 year olds).

Cultural diversity is very low, household incomes are well above average, mortgage stress, rental stress and social housing are lower than average. The health data indicates this area fares much better than most, with the lowest diabetes incidence in the state, cancer, smoking and obesity are low, participation in screening is high, breastfeeding rates are high and there are far fewer than average people living with a disability. Public transport is limited across the LGA with only half the population close to transport routes.

The rates of AOD clients and registered mental health clients are much lower than average. There are a few stand-out blips in the local data for pharmaceutical drug use; with ambulance callouts and ED presentations relating to pharmaceuticals among the top 3 highest rates across entire North & West catchments. Alcohol use in young people is double the state average. A higher proportion (19.4%) of males in Nilumbik also experience a lifetime prevalence of anxiety and depression compared to the State average of 14.6%.

BANYULE (pop 123,544)

Banyule is a city fringe municipality to the north east of Melbourne’s CBD.

Age distribution is generally aligned to state average and population growth is below average. The area is predominantly English speaking (lower than average proportion of people speak a language other than English at home), and is relatively advantaged across most major economic indicators. It has amongst the lowest rates of mortgage stress, food insecurity and being overweight in the State. However, there is a pocket of notable socio-economic disadvantage in the Heidelberg West area.

Banyule has one of the highest percentages of the population who commute for more than 2 hours per day – a measure that is closely linked with mental health risks. The levels of reported psychological distress is the third highest across our 14 local government areas and males in Banyule have a significantly higher lifetime prevalence of anxiety and depression (26.1% compared to 14.6% in the state).

There is a high smoking rate, especially among males. The data shows women are accessing services at a higher than average rate for illicit drug use and alcohol use, and the ADIS rate for illicit drug use is among the top 3 for young people (15-24 years). There is a high rate of alcohol-related family violence.
Appendix C: North West Melbourne catchment summary

North West catchment: an overview

The North West Melbourne catchment includes the cities of Maribyrnong, Brimbank, Melton and Hume and is home to over 560,000 people. A significant challenge for the catchment will continue to be its significant growth, most pronounced in the growth corridors of Hume and Melton, as well as Maribyrnong (to a lesser extent). Only in the City of Brimbank will growth be minimal. Melton in particular also has a very high proportion of children (under 18 years). The catchment is characterised by its significant cultural diversity and high proportion of new settler arrivals. In Brimbank, almost 50% of the population are born overseas.

There is a high overall level of disadvantage as evidenced by:

- Low household incomes [except for Melton which is similar to the average]
- High unemployment rates
- High gaming machine losses
- High levels of mortgage and rental stress [except for Maribyrnong]
- High rates of family incidents [except Maribyrnong]
- High rates of total offences.

There are also a number of indicators suggesting poor health, particularly related to young people. In some areas, the rates of drug use in young people are among the highest in the State. In Hume 28.6% of 15-17 year olds have used other illegal drugs compared to a state average of 3% and 14% of children are developmentally vulnerable on two or more domains (compared to a state average of 9.5%).

Catchment wide issues include:

- High rates of reported fair or poor health
- High rates of reported high/very high levels of psychological distress [in all except Maribyrnong]
- Higher proportion of children with emotional or behavioural problems at school and adolescents who report being recently bullied (Melton and Hume only)
- High rates of young people drinking alcohol
- High rates of young people using marijuana [in all except Hume].

There is some evidence of service access challenges across the catchment, which become more pronounced with increasing distance from the city. Service use rates for Mental Health Community Support Services (MHCSS) and Alcohol and Drug (AOD) services are lower than average in both Hume and Melton. The rate of registered mental health clients is similar across the catchment, but slightly higher in Hume. The usage rates of General Practitioners are amongst the highest in State even though there are a lower than an average number of general practitioners per 1000 population (particularly in Hume and Melton).

Priorities for the North West catchment

1. Growth corridor
   Responding to strong population growth and a need for responsive resources to address emerging trends. Hotspots: Melton & Sunbury.
   - Poor infrastructure: transport
   - Limited service availability: location, choice, specialists
   - Lack of prescribing GPs

2. Service / sector collaboration
   - Opportunities for cross sector collaboration for problem solving & innovation
   - Enhanced service coordination

3. Client need: Specific client groups require local planning attention.
   Service access issues identified for:
   - Culturally & linguistically diverse groups
   - Aboriginal and Torres Strait Islander peoples

   Complexity in the client group:
   - Culturally & linguistically diverse groups
   - Young people
   - Gambling and family-violence related need
   - Clients with medical co-morbidities

Catchment Based Planning - North & West metro Melbourne - AOD & MHCSS (Forum papers: May 2015)
MELTON (pop 117,982)

Melton is an urban fringe municipality west of Melbourne’s CBD. It has a very high population growth rate projected to continue to 2031. It has the highest unemployment rate in the whole of the North & West, and the third highest in Victoria.

Melton has a relatively young population (24% aged 0-14 years), and the North & West’s highest proportion of 15-17-year-olds who drink alcohol in the past 30 days (58.7% compared to 24.7% in the state). Young people’s main substances of choice appear to be alcohol, tobacco and marijuana.

The population at risk of short term harm from alcohol is relatively low but overall smoking rates are second highest in the State. There is a high incidence of family violence including where alcohol was involved (especially for the 18-24 year olds).

Melton has the highest rate of psychological distress in the State but the proportion of people seeking professional help for a mental health problem is lower than average (10.2% compared to 12.4% in the state). This suggests an access issue further evidenced by the low rates of GPs and pharmacists per 1000 of the population.

Melton has the lowest female life expectancy across all catchments at 82.3 years (state average 84.4) and the highest percentage of residents reporting type 2 diabetes (8.3%, state average 4.8%).

BRIMBANK (pop 193,668)

Located about 20km from Melbourne’s CBD, Brimbank is a city of socioeconomic extremes.

It is our most culturally diverse LGA across the 14 in the North & West catchments with the second highest proportion of people born in a non-English speaking country in Victoria. 15% of people speak Vietnamese at home, and 13% have low English proficiency.

Of the 14 LGAs in our 4 catchments, Brimbank has the highest level of disadvantage, highest rate of gaming machine losses, lowest percentage of people who feel safe walking alone on the street at dark, poorest self-reported health status, lowest percentage of people who think there are good services and facilities in the LGA (77.7%, equal with Maribyrnong, compared to state average of 85.2%). There is a high rate of developmental vulnerability in children, and mortgage and rental stress are among the highest in the state. It also has comparatively lower number of general practitioners per 1000 population but a high level of attendance.

There is a high incidence of alcohol-related serious road injuries and young peoples’ AOD risk taking behaviours, and above average rates of both drug offences and total offences.

HUME (pop 177,994)

Hume is an urban fringe municipality with very strong projected population growth, and a relatively young population – 38% are under the age of 25. It has a high level of cultural diversity (43% of residents speak a language other than English at home). While the rate of new settler arrivals is only slightly above average the proportion who are humanitarian is 36% - the 3rd highest of all Victorian LGAs.

Unemployment is higher than average, rental stress is the highest in the state and mortgage stress is the second highest. The area has the highest percentage of one parent families and low income families with children in Victoria. Over 14% of children are developmentally vulnerable on two or more domains (compared with the state average of 9.2%). The rate of psychological distress is the third highest of all LGAs but use of professional support for a mental health issue is slightly lower than average (11.2% state average 12.4%). Poor health for women is second highest in Victoria and people sleeping less than seven hours a day is the highest in the state.

Hume has an extremely high percentage of 15-17 year olds who have used ‘other illegal drugs’ a rate almost 10 times the state average (28.6% compared with 3%). It also has a high female smoking rate and high rate of pharmaceutical ED presentations in females.

The rate of GPs, allied health services and pharmacies among the general population is well below the state average. However, residents in Hume have the highest rate of general practitioner attendance in Victoria.

MARIBYRNONG (pop 76,289)

Located directly to the west of Melbourne’s CBD, Maribyrnong is densely populated with high projected population growth and a proportion of 25-44 year olds that is well above average. Over 10% of residents were born in Vietnam, and almost half speak a language other than English at home.

Gaming machine losses are the 3rd highest of all Victorian LGAs, drug offences are the 5th highest and total crime is well above average. Unemployment rates are also high.

Looking across the relevant AOD indicators across our four North & West catchments, Maribyrnong emerges as a ‘hot spot’, featuring in the top 3 for 29/60 measures we have available – especially around pharmaceuticals and illicit drugs. The lifetime prevalence of anxiety and depression for men is high (18.2 compared to 14.6 in the state), however, the proportion of people seeking professional help for a mental health issue is slightly lower than the average (11.2 compared to 12.4 for the state). The area has the lowest percentage of people who believe there are good facilities and services in the LGA across our 4 catchments.
Appendix D: South West Melbourne catchment summary

**South West catchment: an overview**

The South West Melbourne catchment includes the cities of Hobsons Bay and Wyndham and has a current population of almost 270,000. A significant challenge for the catchment is managing and responding to the differences in the two local council areas. Hobsons Bay is relatively advantaged, close to the State average in many key socio-economic indicators, well serviced by public transport and health service provision and its growth rate remains below average. In contrast, indicators suggest higher levels of disadvantage in Wyndham, including higher than average rates of unemployment, mortgage/rental stress, food insecurity, family incidents, alcohol related family violence and lower rates of service provision (including fewer pharmacies) and transport challenges. It is also the second fastest growing municipality in Victoria and the proportion of young people is greater than the State average.

Despite the differences, the two LGAs are similar in relation to:

- **Cultural diversity**: both have high rates of people born in a non-English speaking country and speaking languages other than English at home. People from India represent the largest group from a non-English speaking country. The rate of new settler arrivals in Wyndham is much higher than the state average.
- **Gambling measures**: both LGAs are ranked within the top 20 LGAs for gaming machine losses per head of adult population.
- **Alcohol and other Drug (AOD) risk taking in young people**: a range of indicators show particular vulnerability amongst young people aged 15 – 17 years – including high rates of smoking and alcohol, marijuana and illicit drug use.
- **High rates of use of AOD services for alcohol and high number of presentations to emergency departments for pharmaceutical use**, particularly for the 15 – 24 year old age group in Hobson’s Bay.

Both catchments have lower rates of registered mental health clients. However, Wyndham has a lower rate of MHCSS clients per 1000 population than the regional average and Hobsons Bay is higher. The rate of people seeking professional help for a mental health problem in Hobsons Bay is also higher than the State average although other indicators of psychological issues are similar.

![Priorities for the South West catchment](https://example.com/priorities.png)

**Catchment Based Planning - North & West metro Melbourne - AOD & MHCSS (forum papers: May 2015)**
Wyndham (pop 179,195)

Located on the south western fringe of Melbourne, growth is one of Wyndham’s key challenges – it is currently the 2nd fastest growing municipality in Victoria, and had the 4th largest population growth rate in Australia for the year 2012-13.

Wyndham has a relatively young population with 23% aged 0-14 and less than 7% aged 65+. There is a high level of cultural diversity, 27% were born in a non-English speaking country and 32% speak a language other than English at home. Unemployment is above average, but median household income is higher than average. The percentage of current smokers, rate of family incidents and developmentally vulnerable children are all higher than the state average.

Wyndham faces service distribution challenges, with the lowest current rates of GPs per 1000, Allied Health per 1000 and Pharmacies per 1000 in the whole of the North & West catchments. More than 26% of people commute over 2hours per day (associated with a range of negative health effects including: stress, lower life satisfaction, negative impacts on relationships, financial costs and less time spent on health promoting behaviours).

AOD risk taking behaviour by young people is higher than the state average, particularly in relation to 15 to 17 year olds who have ever taken illicit drugs. There is also a high rate of alcohol related family violence in 18 to 24 year olds.

Hobsons Bay (pop 88,408) Hobsons Bay

Hobsons Bay has a relatively high level of cultural diversity with 25% of people born in a non-English speaking country and 31% speaking a language other than English at home. There is a slightly lower than average rate of new settler arrivals. The most commonly spoken languages are Arabic, Italian and Greek which together equate for just over 10% of the population. Unlike neighbouring Wyndham, Hobsons Bay’s growth rate is projected to remain below average for the next 2 decades and its population distribution across age groups is broadly similar to that of the state.

AOD risk taking behaviour by young people is significantly higher than the state average. Men’s health is an area of particular concern for Hobsons Bay, with male obesity (26.6%) and male smoking rates (30%) both well above average (17.4% and 18.5% respectively). Persons who do not meet fruit and vegetable intake and physical activity guidelines are among the highest in the state.

Hobson’s Bay is relatively well serviced and is close to the state average in many key socio economic indicators. It ranks fifth in the state for its residents having adequate work/life balance (61.9%).