

**Southern Grampians & Glenelg  
Primary Care Partnership**



# **Southern Grampians and Glenelg Drug and Alcohol Action Plan**

**2010 - 2012**



## FOREWORD

The 2010-2012 Southern Grampians and Glenelg Drug and Alcohol Action Plan is the result of an extensive collaborative planning process undertaken by the Southern Grampians and Glenelg Primary Care Partnership.

In 2008 The Department of Health recognised that traditional approaches in relation to developing strategies in the Drug and Alcohol arena have on occasions been problematic and have resulted in little ownership, “buy in” or commitment to strategies identified by relevant stakeholders in this sector.

It is recognised that the delivery of programs to address issues in relation to drug and alcohol needs a community approach. It needs to be evidence based and be underpinned by a harm minimisation approach with provision of support services provided across the spectrum i.e. prevention, early intervention and specialist/tertiary services.

The Department of Health saw the PCP as the ideal platform for the development of this plan. The structures and process and skill sets within the PCP has enabled the development of a fully integrated plan which will be delivered through collaborative partnership arrangements within the community.

A key success so far in relation to the plan has been its endorsement by both local governments and support from key drug and alcohol support agencies across the sub region.

There has been an effective process established to ensure strategies identified in the plan are implemented. The SGGPCP Integrated Planning Committee provides the ideal structure to ensure that this plan, as well as other key plans of the PCP, is progressed.

I am looking forward to seeing the actions in the plan being progressed and the continual development of more effective partnerships between agencies across the Southern Grampians and Glenelg catchment to ensure that the outcomes identified in the plan are achieved.

**Kevin O'Brien**

*Chair*

*Southern Grampians/ Glenelg Primary Care Partnership*

*October 2010*

## Executive Summary

The Southern Grampians and Glenelg Primary Care Partnership (PCP) has developed this Action Plan following a request from the Minister for Mental Health and Chair Ministerial Taskforce on Alcohol & Public Safety, the Hon Lisa Neville MP. The Action Plan adopts a preventative and a harm minimisation approach.

The plan has a clear focus on alcohol as the main priority, with some attention to tobacco use. This focus was decided following an examination of the data and the input from agencies and the community through the consultation process. Whilst illicit drug use is not as significant as alcohol at this stage, it will be monitored and reviewed during the implementation of the Action Plan.

A health promotion framework has been adopted for the development of this Plan, including the use of the Ottawa Charter to guide our choice of action.

The Action Plan relies on existing agency resources for health promotion. Careful consideration has been given to ensure actions are achievable within existing resources to maximise impact and outcome.

The Action Plan focuses on four priority issues:

- Social acceptability and responsibility: to support cultural change through work with sporting clubs, parents and the media.
- Social connection and resilience: to increase social connection and resilience of vulnerable groups.
- Availability and access: to strengthen local liquor licensing and policing and support harm minimisation at events.
- Service integration and partnership: to improve the coordination of services across health and related sectors, to better meet the needs of clients.



# 1. Background & Approach

The Southern Grampians and Glenelg Primary Care Partnership (PCP) has developed this Action Plan following a request from the Minister for Mental Health and Chair Ministerial Taskforce on Alcohol & Public Safety, the Hon Lisa Neville MP.

The approach sought by the Minister and agreed by the PCP is for the Action Plan to adopt a preventative and a harm minimisation approach.

This means that while we seek to prevent the excessive intake of alcohol and tobacco use and use of illicit drugs, we acknowledge that where use occurs, we need to minimise the harmful effects to the individual and to the community.

The plan has a clear focus on alcohol as the main priority. The decision to focus on alcohol was made following an examination of the data and the input from agencies and the community through the consultation process (as detailed below). There is also some attention given to tobacco use, due to the significant health impacts of smoking in the catchment and following consultation with local service providers. Whilst illicit drug use is not as significant as alcohol at this stage, it will be monitored and reviewed during the implementation of the Plan.

A health promotion framework has been adopted for the development of this Plan, including the use of the Ottawa Charter to guide our choice of action.

The Action Plan relies on existing agency resources for health promotion. Careful consideration has been given to ensure actions are achievable within existing resources to maximise impact and outcome.



## 2. Context: Alcohol & Tobacco – the evidence

### 2.1 NATIONAL PERSPECTIVE

In 'Australia: The Healthiest Country by 2020' (National Preventative Health Taskforce, 2009), the National Preventative Health Taskforce focuses on obesity, tobacco and excessive consumption of alcohol. Over 7% of the burden of disease in Australia is attributed to smoking and more than 3% to the harmful effects of alcohol.

### 2.2 VICTORIAN PERSPECTIVE

#### 2.2.1 Alcohol & Tobacco

The impact of alcohol and other drugs misuse is significant. Alcohol is estimated to directly account for 4.9 per cent of the total burden of disease in Victoria (Department of Human Services, 2005a). People who drink regularly at high levels place themselves at increased risk of chronic ill health, injury and premature death through accidents and violence. There are also significant impacts on family members and the broader community.

According to the Victorian component of the National Drug Strategy Household Survey, alcohol remains the most widely used drug in Victoria with nearly half of Victorians over the age of 14 years being daily or weekly drinkers. Thirty-three per cent of all Victorians adults drink at risky or high-risk levels for short term harm. This is even higher for young people with 18 per cent of 18–24 year olds undertaking risky drinking at least weekly, 44 per cent at least monthly and 64 per cent at least yearly (Australian Institute of Health and Welfare 2005).

The leading cause of preventable death in Victoria is smoking. Tobacco kills one-third to one-half of all people who use it, on average, 15 years prematurely (DHS 2008). Smoking-caused deaths in every area of the state outstrip other major avoidable deaths caused by alcohol, other drugs and road deaths, even when combined. The proportion of avoidable deaths due to smoking in Victoria is 11.9 per cent compared with 3.9 per cent due to alcohol, other drugs and road deaths combined (Quit 2009). Smoking also causes the most significant proportion of avoidable chronic illness and hospitalisation from conditions cancer, cardiovascular disease and chronic obstructive pulmonary disease (DHS, 2005).

There were an estimated 759 alcohol-related deaths in Victoria in 2005, representing two per cent of all Victorian deaths (The Cancer Council Victoria 2005). On average, out of every 1,000 deaths in Victoria:

- > 122 are caused by **smoking**
- > 25 are caused by **alcohol**
- > 14 are caused by **road deaths**
- > 5 are caused by **all other drugs**

In 2004 the Australian Institute of Health and Welfare estimated that 17.4 per cent of people aged 14 years and over smoked daily. Of particular concern is the smoking rate among Aboriginal people, which in 2002 was reported to be 51 per cent – more than double that of the wider community. Death rates from tobacco-caused disease are higher among Indigenous people than in the non-Indigenous population, and Indigenous Australians are more likely to die from these diseases at a younger age (Better Health Channel 2009).

It is widely recognised that crime is strongly influenced by patterns of drinking, particularly intoxication. It is estimated that between 41 and 70 per cent of violent crimes in Australia are committed under the influence of alcohol (Drugs & Crime Prevention Committee 2006).

Data suggest that there is also a connection between alcohol consumption and family violence. In 2002–03, 28,454 family incident reports were submitted across Victoria. Of these, alcohol was identified as a definite hazard factor in 7,924 incidents (28%) and as a possible hazard factor in a further 2,798 incidents (10%) (Drugs & Crime Prevention Committee, 2006).

## 2.3 REGIONAL PERSPECTIVE

### 2.3.1 Alcohol

While risky drinking occurs across the Victorian population, a number of specific groups are particularly at risk including young people; rural and regional populations; people with a mental illness; and Indigenous and CALD communities (DHS, 2008a).

The 2001 National Drug Strategy Household Survey found that males in regional areas were about 30 per cent more likely to engage in risky or high-risk alcohol consumption than males in major cities. The 2004 Victorian Youth Alcohol and Drug Survey found that more young people living in regional Victoria drank at levels that put them at high risk of harm than did their metropolitan peers (Premier's Drug Prevention Council 2005).

In developing the Drug Action Plan for Glenelg & Southern Grampians Shires (Halstead 2001), an extensive consultation process was undertaken with schools, individuals and community agencies. Two of the four key issues identified for both municipalities were binge drinking and underage drinking (particularly spirits and mixed drinks).

A local and regional analysis of the evidence by Turning Point (2007) indicated that:

- **alcohol is the most common primary drug of concern:** in relation to alcohol and drug treatment services, alcohol dominated courses of treatment in Southern Grampians & Glenelg Shires in 2004-05 (37%) followed by cannabis (18%). SG Shire had a majority of treatment for alcohol at 51%.
- **more young people hospitalised for alcohol related issues:** higher proportion of alcohol-related hospitalisations in the Southern Grampians Glenelg PCP were less than 35 years old, compared with the region and the state (see Table 1);
- **more young people bed days for alcohol related issues:** a higher proportion of alcohol-related hospital bed days in the Southern Grampians Glenelg PCP were less than 35 years old, compared with the region and the state (see Table 2);
- **high rates of alcohol-related assaults:** the Southern Grampians Shire had one of the highest rates of alcohol-related assault offenders compared with other LGAs in the region, and was in the top 13 per cent of all Victorian LGAs;
- **younger offenders of alcohol-related assaults:** approximately two thirds of the offenders in Southern Grampians & Glenelg were aged less than 25, compared with half of the offenders in the Barwon PCP catchment;
- **high rate of alcohol-related family incidents:** alcohol was assessed as being involved in 40% of family incidents reported in the Southern Grampians & Glenelg Shires in 2004-05. This is a substantial number but similar across the region and the state. Victims are mostly women between the ages 25–39 years.

**Table 1: Alcohol-related hospitalisations by age of residents: 2004–05 (%)**

AREA	< 35 YEARS %	35 – 49 YEARS %	50 – 64 YEARS %	65 YEARS+ %
Southern Grampians Glenelg PCP	40	21	22	18
Glenelg (S)	37	26	20	16
Southern Grampians (S)	44	13	23	20
Barwon South West region	32	26	22	20
Victoria	29	26	26	19

(Source: Victorian Admitted Episodes Dataset DHS, analysis by Turning Point Alcohol and Drug Centre Inc.)

**Table 2: Alcohol-related hospital bed days by age of residents: 2004–05 (%)**

AREA	< 35 YEARS %	35 – 49 YEARS %	50 – 64 YEARS %	65 YEARS+ %
Southern Grampians Glenelg PCP	29	21	22	27
Glenelg (S)	33	29	13	26
Southern Grampians (S)	24	10	36	29
Barwon South West region	17	24	25	34
Victoria	18	24	26	32

(Source: Victorian Admitted Episodes Dataset DHS, analysis by Turning Point Alcohol and Drug Centre Inc.)

Note: The Action Plan has adopted the data from Turning Point 2007 combined with local expert knowledge of partners as the best available evidence.

### 2.3.2 Tobacco

Tobacco is also a significant issue in Southern Grampians and Glenelg Shires. The number of avoidable deaths due to smoking is significantly higher in our catchment with 13.2 per cent of deaths Southern Grampians and 12.3% for Glenelg, compared with 11.9 per cent for Victoria. This was reflected in the findings of the Drug Action Plan for Glenelg & Southern Grampians Shires (2001) which identified use of tobacco as one of the four key issues for the catchment.

In addition, Turning Point (2007) found that:

- tobacco-related deaths occurred at a higher rate in the Southern Grampians Glenelg PCP than elsewhere in the region in 2004.
- Southern Grampians Shire had one of the highest rates of tobacco-related deaths and years of life lost compared with other LGAs in the Barwon South Western region for 2004, and was in the top six per cent of all Victorian LGAs.
- rates of tobacco-related hospitalisations were among the highest in the region for Southern Grampians Shire. Southern Grampians Shire also had one of the highest rates for tobacco-related bed days. Importantly the Shire ranked in the **top quarter of all Victorian LGAs.**

## **2.4 THE APPROACH**

### **2.4.1 National Preventative Health Taskforce (NPHT)**

The NPHT's Strategy is directed at primary prevention in both health and non-health sectors. Well planned prevention programs have significantly improved our community's quality of life. Examples in recent years include improvements in tobacco control, road trauma, drink driving and skin cancer. Our Drug & Alcohol Action Plan is informed by the NPHT Strategy and adopts some of its proposed actions.

### **2.4.2 State Government Alcohol**

The Victorian Government's 'Restoring the balance' (DHS 2008a) "seeks to create an environment and culture that encourages appropriate use of alcohol while acknowledging the needs and support required for those members of our community affected by the inappropriate use of alcohol."

Restoring the balance provides a vision for long-term change in the community and identifies four priority areas for action:

1. families – including more support in mainstream health services to help people reduce their drinking early and providing the best quality care for more serious alcohol use problems
2. culture – sustaining community awareness to encourage a safe and sensible approach to alcohol
3. community – enforcing controls on the sale and marketing of alcohol and preventing and reducing the consequences of excessive alcohol use, especially alcohol-fuelled violence
4. partnerships – working with the Commonwealth and other state and territory governments to ensure a national approach.

### **Tobacco**

The Victorian Tobacco Control Strategy 2008-2013 (DHS 2008b) seeks to reduce smoking rates of all Victorian adults and particularly among pregnant women, Aboriginal and other high prevalence groups and in socio-economically disadvantaged areas. Action will include implementing legislation and undertaking other actions in collaboration with local government, the health sector and other tobacco control organisations.

The Southern Grampians & Glenelg Drug and Alcohol Action Plan reflects the above priorities identified by the Victorian Government.

## 3. Developing the Plan

### 3.1 THE PROCESS

The development of the Action Plan was coordinated by the Integrated Planning Sub-Committee of the PCP's Executive Committee. The sub-committee comprises PCP member agencies including local government, health services, drug and alcohol services and neighbourhood house.

The Sub-Committee conducted the following initiatives over an 18 month period to gather input and agreement on the Action Plan.

- i) Individual Agency consultation
- ii) Workshops/Focus Groups
  - A major workshop was held in Hamilton to establish key areas for action, facilitated by Anita Thomas, Integrated Health Promotion consultant
  - Consultation was held in Portland, Balmoral and Casterton to build on the draft areas for action
- iii) Surveys – a survey was undertaken with a group of rural women
- iv) Invitations for input by the public
  - Information and invitations to comment will be issued in local papers and local websites, including PCP and local government

Appendix 1 provides a summary of organisations consulted to date and the mechanism used to gain their input.

### 3.2 CONSULTATION RESULTS

The evidence gathered from statistical data and from the experience of the range of stakeholders consulted in the development of this Plan identifies the following:

#### 3.2.1 Alcohol

Alcohol has a significant impact on the health and wellbeing of our community, including in direct impacts on health but also as a common cause of crime, assault, family violence, vehicle accidents etc. Alcohol is of the greatest concern to the majority of those consulted.

Priority issues:

- binge drinking
- underage drinking (including sale of alcohol to minors)
- role of sporting clubs and alcohol (and underage members)
- dominance of alcohol at social and public events

#### 3.2.2 Tobacco

Smoking is the greatest cause of preventable death in our catchment. Priority issues include:

- lack of knowledge and referral to Quit educators
- absence of smoke free sporting facilities / external areas.

### 3.2.3 Drugs

Illicit and prescription drugs are an issue in our catchment, in particular:

- dependence on prescription drugs
- emerging use of illicit drugs for chronic pain relief
- increasing rate of intravenous drug use



## 4. Our Approach

### 4.1 PREVENTION AND EARLY INTERVENTION

Health promotion is often said to be everybody's business. In other words, the promotion of people's health is a universal concern, requiring multi level, multi sector action. The Ottawa Charter for Health Promotion (WHO, 1998) provides an internationally recognised framework that focuses on addressing the causes not the symptoms of ill health.

This represents a comprehensive social and political process. It not only encompasses action toward enhancing the skills and capabilities of individuals but also action towards changing social, environmental and economic conditions to alleviate their impact on public health (Kelleher & Armstrong, 2003).

The PCP recognises the following key health promotion principles (DHS, 2003):

- Best available **evidence**: this includes evidence for:
  - problem definition - evidence to define the problem to be addressed
  - solution generation - evidence to know what strategies are going to work; and
  - evaluation - evidence to demonstrate success and effectiveness.
- **Population** focused in contrast to focusing on individual health status;
- Addresses the **broader determinants of health**, including the social and economic determinants;
- Seeks to reduce **social inequities and injustice** to reduce health inequalities;
- Emphasises **active consumer and community participation**;
- **Empowers** individuals and communities;
- Considers differences in **culture and gender**;
- Facilitates **cross-sector collaboration**.

The PCP has used a health promotion approach in the development of this Framework as it provides a holistic framework for addressing the broad determinants of health. Direct service responses to diseases or illnesses associated with alcohol are not dealt with in this Plan.

## 4.2 PRIORITY ISSUES & STRATEGIES

The current information on reducing the harmful effects of alcohol, tobacco and drug use suggests the following issues are of greatest priority for the SGG PCP catchment:

### **Social acceptability and responsibility**

- it is culturally acceptable to drink at harmful levels
- our policies and public events support excessive drinking
- we are role modelling inappropriate behaviour to our children and perpetuating the cycle of harm

### **Social connection and resilience**

- to increase the protective factors against the use of alcohol, tobacco and drugs

### **Availability and access**

- to reduce the sale of alcohol and cigarettes to minors and the ease of excessive intake for all

### **Service integration and partnership**

- to ensure a coordinated response

This section uses the Ottawa Charter for Health Promotion to outline the mix of strategies to address the four priority action areas. Effective health promotion action requires the implementation of a mix of interventions and at different levels – at both the whole population and individual levels. The Ottawa Charter Action Areas are:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

An action plan follows this section which details strategies and actions to be undertaken.

#### **4.2.1 Social acceptability and responsibility**

##### **i) What the evidence tells us**

There is a wide acceptance of alcohol. It is used to celebrate, to commiserate and to relax.

##### **ii) Action required**

The cultural change required to reduce the harmful intake of alcohol clearly requires a national approach. Evidence has shown however that local action can be effective.

##### **iii) Strategies using the Ottawa Charter**

- **Create supportive environments:**
  - the Good Sports Program which works with sporting clubs to encourage responsible serving and intake of alcohol
  - more alcohol free events, particularly events for young people
  - more smoke-free external areas at local sporting clubs
- **Strengthen community action**
  - process to review adverse impacts of alcohol misuse
- **Develop personal skills**
  - local media campaigns
  - parent education program on harm minimisation

#### **4.2.2 Social connection and resilience**

##### **i) What the evidence tells us**

- **Social isolation**

In rural areas, individuals are at greater risk of social isolation as a result of barriers to getting together, such as distance, transport, time and cost (DrugInfo Clearinghouse Feb 2008). There is also more pressure to "fit in" in smaller communities.

For some, alcohol can be used to 'escape' from loneliness and boredom. For others it is a means of celebrating events or occasions where people get together. This may be reinforced by the seasonal nature of rural activities, such as harvests, or the influx of visitors in the holiday season. Research has linked country sporting clubs and excessive drinking, particularly football clubs and to a lesser extent, cricket and bowls clubs (DrugInfo Clearinghouse Feb 2008).

- **Infrastructure limitations**

Limited access to a variety of entertainment, recreation and sporting facilities can result in local pubs being the social hub of activity. Young people report the view 'that there is nothing to do' making them more susceptible to drinking for entertainment. The lack of leisure facilities is compounded by the lack of transport options for accessing facilities in larger towns (DrugInfo Clearinghouse Feb 2008).

- **Individual, family and community stress**

People who live in rural areas experience poorer health than their urban counterparts. This is reflected in lower life expectancy, higher mortality and morbidity rates. The impacts of drought, bushfires and floods increases stress and can impact on community resilience. Cases of mental illness and suicide have been increasing in rural areas. Alcohol is commonly used in times of stress and is a major risk factor for suicide (DrugInfo Clearinghouse Feb 2008).

## **ii) Action required**

There are a number of local initiatives that are already being effective in increasing the social connection and resilience of people most at risk of drug and alcohol issues. Many of these initiatives have been planned from evidence of what works and their implementation has been evaluated using research methodology.

The PCP will work in a collaborative way with other key agencies to further support and promote these initiatives, while working to expand such opportunities to other vulnerable target groups and areas.

## **iii) Strategies using the Ottawa Charter**

- **Reorient health services**

- integrated planning with health and non-health agencies
- identify and promote local social connection and resilience initiatives
- local government include health inequalities data in its planning

### **4.2.3 Availability and access**

#### **i) What the evidence tells us**

- **Place**

Research indicates that the density of alcohol outlets is indicative of the level of alcohol-related harm. The number of licensed premises per head of population in rural Victoria is significantly higher than the state average. In the Southern Grampians and Glenelg Shires, the number of licensed premises per head of population is 65 per 10,000 residents aged 15+ compared with only 41 in Victoria (Turning Point 2007).

- **Promotion**

Alcohol advertising is widespread and linked to common community activities, such as sport.

- **Price**

Alcohol is relatively low priced and is increasingly available at higher strength. The growing number of discount alcohol retailers in our catchment ensures affordable alcohol is increasingly available, including to young people.

## **ii) Action required**

Action is needed to manage liquor licensing of outlets and events in a strategic way which focuses on harm minimisation, and to limit tobacco sales in sporting venues and to minors.

## **iii) Strategies using the Ottawa Charter**

- Build healthy public policy
  - Strengthen liquor licensing policies by local government
- Create supportive environments
  - reduce number of BYO alcohol events and support harm minimisation initiatives at events
  - reduce number of tobacco sales in sporting facilities and to minors
- Reorient health services
  - advocate for increase in local VicPolice liquor licensing resources

### **4.2.4 Service integration**

#### **i) What the evidence tells us**

A service system that is well informed and coordinated in its assessment and referral practice ensures better health outcomes for its clients.

## **ii) Action required**

Action is needed to improve the coordination of agencies across the health and non-health sectors and that agencies take an informed and more holistic approach in identifying clients' needs.

## **iii) Strategies using the Ottawa Charter**

- **Reorient health services**
  - enhanced service integration, including between health, education, police, community services, drug/alcohol services, family violence services, smoking cessation services
  - identify drug and alcohol service gaps
  - principles and statement of D&A Action Plan are included in relevant plans/ policies including the PCP's Strategic Plan
  - agencies implement and monitor the Plan collaboratively

## 5. Action Plan

**Goal – to minimise the harm to individuals and the community from the excessive consumption of alcohol and intake of tobacco and other drugs.**

### Summary of Key Action Areas:

1. **Social acceptability and responsibility**
2. **Social connection and resilience**
3. **Availability and access**
4. **Service integration**
5. **Implementation and monitoring**

### Action 1 – Social acceptability and responsibility

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
<p>Good Sports Program (GSP)</p> <p>1.1 By September 2010 SG &amp; G Shires will actively encourage sporting clubs that lease shire infrastructure have a Licence Agreement or receive sport infrastructure grants, to participate in the Good Sports Program.</p> <p>1.2 By August 2010 the Shires will establish an advocacy and promotion strategy, in conjunction with the Good Sports Program.</p> <p>1.3 Five new sporting clubs with leases or funding grants with Shires are participants in Good Sports Program per annum.</p>	<ul style="list-style-type: none"> <li>- SG and G Shires to introduce process for encouraging participation in GSP by sporting clubs that use shire facilities/ receive grants.</li> <li>- SG and G Shires and GSP to develop a promotion and advocacy strategy for GSP with sporting clubs.</li> <li>- advise community (media) of changes and rationale</li> <li>- monitor sporting clubs' participation</li> <li>- promote/ support existing club participation.</li> </ul>	<ul style="list-style-type: none"> <li>- Shire Councils will have a process in place and all sporting clubs are notified by September 2010.</li> <li>- Advocacy and promotion strategy established by August 2010. Five new sporting clubs with leases or funding grants with Shire are participants in GSP pa.</li> </ul>	<p>Southern Grampians Shire</p> <p>Glenelg Shire</p> <p>Good Sports Program/ Shires/ South West Sports Assembly</p> <p>VicPolice to assist in development/ implementation as required</p>

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
1.4 Increase funding available to support two additional clubs per annum to participate in GSP, Responsible Serving of Alcohol Courses and/ or Club Liquor Licensing Seminars.	<ul style="list-style-type: none"> <li>- identify Shire, club or other sources of possible funding</li> <li>- meet with organisations and seek funding commitments</li> </ul>	<ul style="list-style-type: none"> <li>- Funding increased to support two clubs pa to participate in GSP, Responsible Serving of Alcohol Courses and/ or Club Liquor Licensing Seminars.</li> </ul>	PCP/ Shires
<p><i>Smoke-free external areas</i></p> <p>1.5 By November 2010, identify best practice policies for smoke-free external areas at sporting facilities.</p> <p>1.6 By April 2011 identify current policies for smoke-free external areas at local sporting facilities and promote best practice policies.</p>	<ul style="list-style-type: none"> <li>- identify best practice policies for smoke-free external areas at sporting facilities through sporting bodies, VicHealth, MAV and other key stakeholders.</li> <li>- undertake an audit of smoke-free external areas at sporting facilities.</li> </ul>	<ul style="list-style-type: none"> <li>- Best practice identified by November 2010.</li> <li>- Audit completed and best practice policies promoted to sporting clubs/ facilities by April 2011.</li> </ul>	To be determined by PCP's Integrated Planning Sub-Committee (IPS)
<p><i>Community Review Process</i></p> <p>1.7 By August 2010 SG &amp; G Shires will establish a role in each Shire for the Community Safety (or relevant) Committee to review issues with any sporting club identified as having real or perceived adverse community impacts due to alcohol misuse.</p>	<p>With reference to the ADF's DrugInfo Clearinghouse and Community Alcohol Action Network and other relevant resources:</p> <ul style="list-style-type: none"> <li>- establish a role for a Community Safety (or relevant) Committee in each Shire</li> <li>- establish a process for community input</li> <li>- advise all sporting clubs of role</li> <li>- promote ADF's Community Alcohol Support Service to communities.</li> </ul>	<ul style="list-style-type: none"> <li>- Community Safety (or relevant) Committee role &amp; process established by August 2010.</li> <li>- Community Safety/ relevant Committee has commenced reviewing issues.</li> </ul>	Southern Grampians Shire & Glenelg Shire VicPolice to assist in development/ implementation Community Safety (or relevant) Committees convened by VicPolice
<p><i>Communications/ Social Marketing</i></p> <p>1.8 By October 2010 develop &amp; implement a plan and resources to inform local community of actions being taken under the A&amp;D Plan, complementing Federal and State Awareness Campaign Initiatives.</p>	<p>With reference to ADF's DrugInfo Clearinghouse and Community Alcohol Action Network and other relevant resources</p> <ul style="list-style-type: none"> <li>- identify Fed/State govt campaigns and messages re: alcohol and identify appropriate timing of local media coverage</li> </ul>	<ul style="list-style-type: none"> <li>- A plan and resources have been prepared by October 2010</li> </ul>	PCP

<b>Objective What is the change?</b>	<b>Strategy Activity to make the change</b>	<b>KPI Indicators of change and implementation of the strategies</b>	<b>By whom</b>
<p>1.9 To initiate 3 local media stories pa across key towns re: A&amp;D actions under the Plan / awareness messages.</p> <p>1.10 Raise awareness of issues related to alcohol and drugs such as family violence.</p> <p>1.11 By September 2010 encourage Shires, sporting clubs and other agencies to include smoking cessation messages and service info in their community newsletters.</p>	<ul style="list-style-type: none"> <li>- prepare communications plan and resources, including key messages, media release template, local spokespeople etc.</li> <li>- support local agencies to implement communications plan.</li> <li>- identify and raise awareness of issues related to alcohol and drugs such as family violence within A&amp;D and health services and to their clients.</li> <li>- provide smoking cessation messages and service information to member agencies and encourage them to include it in newsletters.</li> </ul>	<ul style="list-style-type: none"> <li>- local A&amp;D media stories in local papers 3 times pa across key towns</li> <li>- Circulation of info on FV services to A&amp;D and health services by Oct 2010.</li> <li>- Circulation of info on FV services to clients by A&amp;D and health services by Oct 2010.</li> <li>- QUIT info provided to Shires, sporting clubs and other agencies by Sept 2010</li> </ul>	<p>PCP/SWSA/ Local govt to support local agencies</p> <p>Integrated FV Services</p> <p>PCP, A&amp;D services, health services</p> <p>PCP, smoking cessation services</p>
<p><i>Parent Information</i></p> <p>1.12 By Nov 2010 member agencies can identify the key contacts and resources available to deliver effective evidence based approaches to increase parents' understanding of alcohol/ drug reduction strategies.</p> <p>1.13 By August 2011 local agencies will have implemented local information campaigns for parents.</p>	<ul style="list-style-type: none"> <li>- identify effective evidence based approaches targeting parents to increase their understanding of alcohol/ drug reduction strategies.</li> <li>- consider how campaign may link with existing Peer Education and other programs.</li> <li>- implement local information campaigns</li> </ul>	<ul style="list-style-type: none"> <li>- By Nov 2010, 80% of member agencies are able to identify key contacts and resources available to deliver effective evidence based approaches.</li> <li>- Local agencies have implemented information campaigns for parents by August 2011.</li> </ul>	<p>DEECD with support from PCP</p> <p>Quamby/ DEECD/ schools/ PCP</p> <p>Local agencies</p>

## Action 2 – Social connection and resilience

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
<p>2.1 Facilitate integrated planning and action to increase social connection of vulnerable groups.</p> <p>2.2 By July 2010 identify evidenced based projects which improve social connection and resilience of vulnerable groups.</p> <p>2.3 Form partnerships with &amp; promote/ support evidenced based projects by September 2010.</p>	<ul style="list-style-type: none"> <li>- establish and support the Social Connection Working Group to develop and implement an action plan.</li> <li>- identify and promote evidenced based projects</li> <li>- support capacity building of agencies in understanding and delivery of effective social connection programs and activities</li> <li>- explore opportunities to link with the 'Communities that Care' (Deakin Uni), RMIT's Youth Landscapes project, Read the Play and other relevant projects.</li> </ul>	<ul style="list-style-type: none"> <li>- Integrated Action Plan developed by June 2010.</li> <li>- Evidenced based projects which improve social connection and resilience of vulnerable groups are identified by July 2010.</li> <li>- Partnerships are established with evidence based projects by July 2010</li> <li>- By Sept 2010, 80% of agencies involved in the A&amp;D Plan are able to identify local initiatives to increase social connection and resilience of vulnerable groups</li> </ul>	<p>PCP, Shires, Social Connection Working Group members, IHP Reference Group, Integrated Planning Sub-Committee, local agencies</p>
<p>2.4 That local government includes health inequalities data and information in their 2010 planning processes.</p>	<ul style="list-style-type: none"> <li>- provide health inequalities data and information to both shires</li> </ul>	<ul style="list-style-type: none"> <li>- Health inequalities data and information is included in both Shires' 2010 planning processes</li> </ul>	<p>PCP/ DH to provide data Shires</p>

### Action 3 – Availability and access

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
3.1 Each Shire to develop a Liquor Outlet Policy by July 2011 to guide planning decisions, including type, density and hours of operation of liquor outlets.	<ul style="list-style-type: none"> <li>- identify best practice re: policy development by local govt on liquor outlets</li> <li>- include liquor outlet policy within Municipal Public Health Planning</li> <li>- include link to MPHP in Shire's Liquor Outlet Policy.</li> <li>- promote ADF's Community Alcohol Support Service to Shires and communities.</li> </ul>	<ul style="list-style-type: none"> <li>- Shire policy on Liquor Outlets in place by July 2011 in both Shires</li> </ul>	Southern Grampians Shire & Glenelg Shire
3.2 Increased Police liquor licensing resources for SW Victoria, in line with Premier's Alcohol Action Plan.	<ul style="list-style-type: none"> <li>- Advocate liquor licensing resource issue with SG and G Shires.</li> <li>- Support Shires to formally advocate to State Govt for increased Police liquor licensing resource(s) to be based in SW Vic</li> </ul>	<ul style="list-style-type: none"> <li>- advocacy position adopted by SG and G Shires and PCP Police liquor licensing resources for SW Victoria increased</li> </ul>	Southern Grampians Shire Glenelg Shire PCP in liaison with Victoria Police
3.3 To reduce the number of BYO alcohol events. 3.4 To support harm minimisation initiatives at public events.	<ul style="list-style-type: none"> <li>- Support Vic Police action to change BYO licenses</li> <li>- Continue to support harm minimisation initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>- reduced number of BYO alcohol events</li> <li>- harm minimisation initiatives at public events are supported</li> </ul>	A&D Partnership VicPolice Health/youth & community agencies
3.5 By August 2010 identify enforcement processes used by Shires to monitor cigarette sales to minors and presented to IPS.	<ul style="list-style-type: none"> <li>- Southern Grampians Shire and Glenelg Shire officers identify processes used.</li> <li>- Findings presented to IPS for discussion and action if required.</li> </ul>	<ul style="list-style-type: none"> <li>- Processes identified and presented to IPS by Aug 2010</li> </ul>	Shires IPS members

#### Action 4 – Service integration

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
<p>4.1 Develop strategies by August 2011 to ensure that all relevant staff (at local health services, Quamby, Police, courts, mental health and family violence services) are able to identify client needs and local referral options &amp; processes for:</p> <ul style="list-style-type: none"> <li>- family violence</li> <li>- mental health</li> <li>- alcohol &amp; drug</li> <li>- smoking cessation</li> </ul>	<ul style="list-style-type: none"> <li>- IPS to facilitate discussions between relevant services</li> <li>- identify/ develop &amp; support needs identification, referral and feedback processes</li> <li>- provide training for workers in identification of needs and referral options and processes for family violence, mental health, alcohol &amp; drug and smoking cessation issues.</li> <li>- establish mental health screening in D&amp;A services and D&amp;A screening in mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>- Strategies developed by August 2011.</li> <li>- needs identification/ screening, referral and feedback processes documented for alcohol &amp; drug, family violence, mental health services and smoking cessation.</li> <li>- family violence, mental health and alcohol &amp; drug training attended by workers.</li> <li>- smoking cessation program information provided</li> <li>- participating organisations report increased knowledge and referral practice</li> </ul>	<p>IPS members Quamby Psych Services WDHS/ PDH Vic Police Courts Integrated Family Violence (IFV) Services Community Connections IFV Coordinator</p>
<p>4.2 By Aug 2011 information on family violence services (eg DV services &amp; men's referral services) be included in information to clients by A&amp;D, health services and mental health services</p>	<ul style="list-style-type: none"> <li>- identify and provide family violence service information to A&amp;D, health services and mental health services</li> </ul>	<ul style="list-style-type: none"> <li>- family violence service information provided.</li> </ul>	<p>PCP/ Community Connections IFV Coordinator</p>

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
4.3 By May 2010, undertake an audit to identify the workers who provide smoking cessation services in SG & G, the target groups they currently work with, and identify any high risk groups not currently accessing services. 4.4 Increase referrals of high risk groups not currently accessing smoking cessation services by Feb 2011.	<ul style="list-style-type: none"> <li>- Undertake an audit of:</li> <li>- the number and location of smoking cessation services/ workers and the target groups they work with;</li> <li>- any high risk groups not currently accessing smoking cessation services.</li> <li>- Develop strategies to increase access to services by high risk groups.</li> </ul>	<ul style="list-style-type: none"> <li>- audit completed by May 2010.</li> <li>- strategies to increase access to services by high risk groups.</li> <li>- referrals for high risk groups not currently accessing services increased by 10% by Feb 2011</li> </ul>	PCP Smoking cessation services
4.5 To document current drug and alcohol services, and identify service gaps and strategies to address gaps by July 2010	<ul style="list-style-type: none"> <li>- explore recovery models</li> <li>- identify unmet needs</li> <li>- consult with other stakeholders re service gaps and strategies</li> </ul>	<ul style="list-style-type: none"> <li>- A&amp;D services &amp; service gaps identified and strategies to address gaps developed.</li> </ul>	PDH (Quamby)
4.6 To have the principles and statements of the D&A Plan reflected in relevant plans/ policies by June 2010.	<ul style="list-style-type: none"> <li>- distribute D&amp;A Plan to relevant agencies, encouraging them to include key principles in their plans/ policies.</li> <li>- include relevant actions in PCP's Strategic Plan</li> </ul>	<ul style="list-style-type: none"> <li>- All relevant agency plans and policies reflect the principles and statements of D&amp;A Plan.</li> </ul>	PCP/ local agencies

#### Action 5 – Implementation & monitoring

Objective What is the change?	Strategy Activity to make the change	KPI Indicators of change and implementation of the strategies	By whom
5. Strategies and actions under the Action Plan will be implemented and monitored in an integrated and coordinated way.	<ul style="list-style-type: none"> <li>- Progress is regularly reviewed by the Integrated Planning Sub-Committee.</li> </ul>	<ul style="list-style-type: none"> <li>- IPS meets and reviews progress at least quarterly</li> </ul>	IPS with support from PCP

## 6. Glossary

### **GOOD SPORTS PROGRAM**

The Good Sports Program is a national initiative of the Australian Drug Foundation (ADF) to develop safer and healthier communities.

It is a free program that helps sporting clubs change their culture to become more focused on young people and families, and less on the consumption of alcohol at high risk levels.

Good Sports works to create sustainable change by enabling sporting clubs to change their systems and practices around the responsible serving of alcohol. The Program has been developed to:

- reduce general alcohol consumption and risky drinking
- reduce alcohol-related problems, particularly drink driving
- increase club viability and influence within the community.

The Program works through a three level accreditation program with the support of a local Good Sports Project Officer.

For more information see:

[http://www.druginfo.adf.org.au/druginfo/fact\\_sheets/sport\\_prevention\\_of\\_alcohol\\_related\\_harms/developing\\_safer\\_and\\_healthier\\_communities.html](http://www.druginfo.adf.org.au/druginfo/fact_sheets/sport_prevention_of_alcohol_related_harms/developing_safer_and_healthier_communities.html)

For other programs or services of the Australian Drug Foundation go to [www.adf.org.au](http://www.adf.org.au) or <http://druginfo.adf.org.au/>

### **Integrated Planning Subcommittee (IPS)**

The Integrated Planning Subcommittee is a subcommittee of the Southern Grampians & Glenelg Primary Care Partnership's Executive Committee.

## 7. References

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- DrugInfo Clearinghouse 2008, Prevention of harm from alcohol consumption in rural and remote communities, Prevention Research Quarterly, Australian Drug Foundation, Melbourne
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- Turning Point Alcohol & Drug Centre 2007, Barwon South Western Region: Alcohol & Other Drug Profile A local & regional analysis 2002–03 to 2004–05
- Turning Point Alcohol and Drug Centre 2007, Victorian drugs statistics handbook: Patterns of drug use and related harms in Victoria, Drugs Policy and Services Branch, State of Victoria, Melbourne
- The Cancer Council Victoria 2005, 'Tobacco tragedy: smoking toll devastates Victorian communities', Media release, 16 February 2005.

## Appendix 1 - Organisations consulted and consultation method

Organisation	Consultation Methodology
Drug and Alcohol Services - Quamby Drug Treatment Service - Western Region Alcohol and Drug Service (WRAD)	- member of Integrated Planning Sub-Committee - individual agency consultation - workshop - individual agency consultation
Psych Services - SW Health Care	member of Integrated Planning Sub-Committee - individual agency consultation - workshop
Victoria Police	- individual agency consultation - workshop
Health services - Portland District Health - Western District Health Service	- member of Integrated Planning Sub-Committee - individual agency consultation - workshop
Local Government - Southern Grampians Shire - Glenelg Shire	- member of Integrated Planning Sub-Committee - individual agency consultation - Workshop
Family and Community Services - Community Connections - Salvation Army Accommodation Service - Uniting Church	- individual agency consultation - workshop
Education - Dept of Education, Early Childhood & Development - School Nurse, DHS	- member of Integrated Planning Sub-Committee - individual agency consultation - workshop - individual agency consultation
Department of Human Services - Regional Office	- individual agency consultation
South West Sports Assembly	- individual agency consultation
AFL	- individual agency consultation - workshop
Good Sports Program	- individual agency consultation
Indigenous community - Winda Mara - Gunditjmara – regional D&A officer	- individual agency consultation - workshop
Regional Women	- survey via Regional Women's Network

