Central and Eastern Sydney Primary Health Network

Alcohol and Other Drugs Needs Assessment

(Dec 2017)

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **15 November 2017** as required under Item E.5 of the Standard Funding Agreement with the Commonwealth.

Name of Primary Health Network

Central and Eastern Sydney PHN

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Instructions for using this template

Overview

This template is provided to assist PHNs to fulfil their reporting requirements for a Needs Assessment as required under Item E.5 of the Standard Funding Agreement (Funding Agreement) with the Department.

Further information for PHNs on the development of needs assessments is provided in the *Needs Assessment Guide*, available on the Department's website (www.health.gov.au/PHN).

The key output of needs assessment will be to inform the Activity Work Plan. In addition, the information provided by PHNs in this report may be used by the Department to inform programme and policy development.

Reporting

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 5 – Checklist

PHN reports must be in a Word document and provide the information as specified in Sections 1-5.

Limited supplementary information may be provided in separate attachments if necessary. Attachments should not be used as a substitute for completing the necessary information as required in Sections 1-5.

While the PHN may include a range of material on their website, for the purposes of public reporting the PHN <u>is required</u> to make the tables in Section 2 and Section 3 publicly available on their website.

Submission Process

The Needs Assessment report must be lodged to the Grant Officer via email on or before 15 November 2016.

Reporting Period

This Needs Assessment report will cover the period of 1 July 2016 to 30 June 2018 and will be reviewed and updated as needed by 15 November 2016.

Section 1 – Narrative

Needs Assessment process and issues (500-600 words)

The Central and Eastern Sydney PHN 2017 Needs Assessment has been conducted according to the procedures described by the Department of Health in the Needs Assessment Toolkit (December 2015). These procedures are described in brief below.

The aim of the 2017 Needs Assessment was to provide an update of the health needs and service gaps identified in the 2016 Baseline Needs Assessment with both updated quantitative and qualitative data where available. These identified areas of need will be explored in more detail with reference to updated research and in line with recent sector developments, and will then be prioritised in future CESPHN strategic planning and activity delivery.

The drug and alcohol needs assessment follows a four-step process of:

1) Health needs analysis to understand the needs of the treatment population
2) Service needs analysis to understand the current drug and alcohol treatment services available
3) Gap analysis and synthesis of need verse current service provision
4) Set priorities in the context of limited resources.

Quantitative data was used to update the health needs analysis, and all data sources have been appropriately referenced within this needs assessment. Relevant quantitative data sources were identified with reference to the Needs Assessment Toolkit.

In order to identify service needs, service gaps and to establish priorities for CESPHN workplan activity, CESPHN has engaged in extensive sector and stakeholder consultation. These consultations focused on the identification of treatment needs, service mapping and treatment service system purchasing arrangements.

Qualitative data from these consultations was consolidated and analysed to identify treatment gaps and areas of highest treatment need. Consultations were undertaken with the seven key stakeholder groups identified by the Department of Health in the Needs Assessment toolkit, as well as additional identified organisations who represent CESPHNs priority populations. The following organisations contributed to these consultations: National Drug and Alcohol Research Centre, Ministry of Health, South Eastern Sydney Local Health District, Sydney Local Health District, St Vincent's Health Network, ACON, DAMEC, Pharmacy Guild, NADA, NUAA, an independent Aboriginal Consultant, Uniting Sydney Medically Supervised Injecting Centre and independent General Practitioners.

Based on the quantitative and qualitative data considered in this needs assessment, priorities were then identified that involved the consideration and triangulation of the highest areas of need and the most significant treatment gaps. After identifying these priorities, a sample of key stakeholders were further consulted to ensure the priorities accurately reflected these areas and gaps.

Additional Data Needs and Gaps (max 400 words)

Gaps in Data available on PHN website:

• Alcohol and Other Drugs data sources remain sparse and where possible should align with the key areas for mental health focus

General Data Gaps and Limitations:

• Data form the NSW Inmate Health Survey is from 2009. The 2015 data is not publicly available, However it is anticipate that the data will reflect national trends.
• The latest available data for Pharmaceutical Opioid related deaths is from 2013 but projected estimates suggest there will be a continued upward trend in accidental overdose deaths.
• NMDS data for LHDs/LHS was not attainable. NADAbase data used.

Primary Health Care data gaps and limitations:
• The CESPHN database of health professionals is continually being updated and reflects a snapshot in time.

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below. For more information refer to Table 1 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Outcomes of the health needs analysis		
Priority Area	Key Issue *(identified gap and needs with statistics or qualitative summary)*	Description of Evidence *(reference and limitations)*
Prevalence of Alcohol and Other Drugs	The health needs analysis will: • Provide an update of data sources where relevant • Conduct a deep dive into prevalence statistics for the Central and Eastern Sydney PHN (CESPHN) region • Consider the associated harms and identify areas of primary concern • Understand CESPHN priority populations • Recognise current and emerging need within the region.	
	According to the NADAbase National Minimum Data Set (NMDS) collection, 3103 clients accessed treatment from 37 NGO services within the CESPHN catchment in 2016/2017. A significant shift in client profile occurred, with amphetamine including methamphetamine accounting for 39% of primary drug of concern presentations, increasing from 27% in 2015/16. Alcohol was identified as the second primary drug of concern at 22%.	NADAbase NMDS 2016/17
	An analysis of Public Health Information Development Unit (PHIDU) data showed that the estimated number of people aged 15 years or over who consumed more than two standard drinks per day in the CESPHN region is 195,499 (15.7 per 100 people). This places CESPHN region lower than NSW state rates of 16.7 per 100 people. Six SA3 regions have rates higher than the state rate: - Cronulla- Miranda – Caringbah (22.7 per 100) - Eastern Suburbs – North (21.4 per 100)	Social Health Atlas of Australian. Data by SA3 area. New South Wales & Australian Capital Territory. [Internet]. Public Health Information Development Unit, Torrens University Australia. 2017 [cited 10 Oct 2017]. Available from: http://phidu.torrens.edu.au.

Outcomes of the health needs analysis

	- Leichhardt (20.6 per 100) - Sydney Inner City (19.3 per 100) - Sutherland - Menai – Heathcote (18.6 per 100) - Eastern Suburbs – South (17.2 per 100)	
	In 2015-16, the CESPHN region had a methamphetamine related hospitalisations rate of 126.7 per 100,000 population and a persons hospitalised rate of 81.4 per 100,000 population (persons ages 16 and over). CESPHN region has the fifth, highest hospitalisation rates per 100,000 population, out of ten NSW PHNs, however CESPHN has the fourth lowest rate per 100,000 population of persons hospitalised. This indicates that, within the CESPHN region, unique individuals are more frequently hospitalised for methamphetamine compared to other PHN regions in NSW.	NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health; http://www.healthstats.nsw.gov.au/Indicator/beh_illimethhos/beh_illimethhos_phn_snap?&topic=Drug, accessed 8 November
	For all Drug and Alcohol related hospitalisations, CESPHN is ranked the highest PHN nationally in terms of number of bed days, with 2,041 per 100,000 compared to the national rate of 1,369 per 100,000. This indicates that people within our region require longer periods of hospitalisation for drug and alcohol related issues. Within the CESPHN region the SA3 with the highest rate, Sydney Inner City SA3 (3,487 per 100,000) has the 4th Highest rate of bed days per 100,000 nationally. Leichhardt (3,171 per 100,000) has the 6th highest rate followed by Marrickville – Sydenham – Petersham (2,948 per 100,000) with the 7th highest rate. Sydney Inner City falls within the top 1 percentile, and Leichhardt and Marrickville – Sydenham-Petersham fall into the top 2 percentile nationally.	AIHW, Mental Health Hospitalisations, 2015-16
	Prevalence predictions suggest that within the CESPHN population aged 12 years and over: • 115,000 people will have an alcohol use disorder • 8,500 people will have a methamphetamine use disorder • 6,000 people will have a benzodiazepine use disorder • 30,000 people will have a cannabis use disorder • 10,500 people will have a non-medical opiate use disorder In 2016 the National Drug Strategy household survey found pharmaceuticals were among the most frequently misused illicit drugs, with 26% reporting daily or weekly use. 1 in 20 (4.8%) of people had misused a	Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW Updated with 2016 ABS Census data

Outcomes of the health needs analysis

	pharmaceutical in the previous 12 months with 75% of this population reporting misuse of over the counter codeine products. People who misused pharmaceuticals were older than illicit drug users and most common among those in their 40s. Australia wide there has been a substantial increase in the number of people seeking treatment for pharmaceutical opioid dependence, but this is noted as a small fraction of the estimated number of people who experience pharmaceutical opioid use disorders. Around 750,000 of the 3 million Australians who are annually prescribed opioids are using them long-term. 75,000 meet the diagnostic criteria for pharmaceutical opioid dependency. Stakeholders have noted that the increase in pharmaceutical opioid use disorders has been associated with dramatic rises in associated harms; including dependence, morbidity and mortality. Around 800 opioid-related deaths occur in Australia every year, with 32% of these deaths occurring in New South Wales. 70% of all opioid related overdose deaths are attributable to pharmaceutical opioid, overtaking overdose mortality rates of both heroin and methamphetamine. The last available data is from 2013, but projected estimates suggest there will be a continued upward trend in accidental overdose deaths.	National Drug Strategy Household Survey, 2016, Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-detailed/contents/table-of-contents accessed on 29 September 2017. Drug utilisation sub-committee (DUSC). Opioid Analgesics: Overview. 2014. Rogers KD, Kemp A, McLachlan AJ, Blyth F, 2013, 'Adverse selection? A multi-dimensional profile of people dispensed opioid analgesics for persistent non-cancer pain.' PloS one; 8(12):e80095. Degenhardt L, Bruno R, Lintzeris N, Hall W, Nielsen S, Larance B, et al, 2015. 'Agreement between definitions of pharmaceutical opioid use disorders and dependence in people taking opioids for chronic non-cancer pain (POINT): a cohort study.' Lancet Psychiatry;2(4):314-22. Roxburgh A, Bruno R, Larance B, Burns L. Prescription of opioid analgesics and related harms in Australia. Med J Aust. 2011;195(5):280-4. Roxburgh A & Burns L, 2017. 'Accidental drug-induced deaths due to opioids in Australia, 2013. Sydney, National Drug and Alcohol Research Centre. https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/OpioidDeaths_2013_Website_FINAL_0.pdf accessed 20 November 2017 **Limitations:**

Outcomes of the health needs analysis		
		The last available data is from 2013 but projected estimates suggest there will be a continued upward trend in accidental overdose deaths
Priority Populations	Whilst Drug and alcohol related harm can affect the whole population, certain population groups are disproportionately represented within AOD services within the CESPHN region and should be prioritized in CESPHN strategies to ensure equity, access and appropriateness of treatment services. These priority populations have been identified using the latest available population health and health related harm data. **Aboriginal and/or Torres Strait Islander Peoples** Aboriginal and/or Torres Strait Islander peoples experience a disproportionate amount of harms from drug and alcohol use. Drug-related problems play a significant role in the health and life expectancy disparities between Aboriginal and/or Torres Strait Islander peoples and the non-indigenous population. Illicit drugs represent 3.4% of the burden of disease and 2.4% of deaths amongst Aboriginal and/or Torres Strait Islander peoples, compared to 2% and 1.3% respectively within the non-indigenous population. The interconnected issues of cultural dislocation, trauma and ongoing stress of disadvantage contributes to heightened risk of harmful drug and alcohol use, poorer health outcomes and deterioration of family and community. These factors can affect employment, education, health and have a whole of life and intergenerational impact. Whilst Aboriginal and/or Torres Strait Islander peoples comprise of 0.93% of the CESPHN region population, they account for 15.66% of the presentations at Drug and Alcohol treatment services within the region. It is recognized that the majority of Aboriginal and/or Torres Strait Islander peoples do not use illicit drugs, however, national surveys have consistently reported higher rates of 'recent' (within the last 12 months) illicit drug use compared to the non-Indigenous population. **Culturally and Linguistically Diverse Communities.**	Intergovernmental Committee on Drugs, 2015. 'National Aboriginal and Torres Strait Islander peoples' drug strategy 2014-2019,' Canberra, National Drug Strategy. http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/6EE311AA9F620C82CA257EAC0006A8F0/$File/FINAL%20National%20Aboriginal%20and%20Torres%20Strait%20Islander%20Peoples'%20Drug%20Strategy%202014-2019.pdf accessed 3 October 2017. 2016 Census, Australian Bureau of Statistics NADAbase 2016/17 MacRae A, Hoareau J (2016) Review of illicit drug use among Aboriginal and Torres Strait Islander people. Australian Indigenous HealthInfoNet. http://www.healthinfonet.ecu.edu.au/uploads/docs/Illicit-drugs-review-2015-web.pdf Accessed 3 October 2017

Outcomes of the health needs analysis

	The CESPHN region has an increasingly secular demographic and is comprised of diverse populations. 2016 ABS census data showed 27.08% of CESPHN residents were born in a non-English speaking country, and 38.13% of the CESPHN population spoke a language other than English at home. CESPHN recognises that CALD communities are not homogenous in nature and a best practice approach that seeks to understand particular communities substance use practices, help-seeking behaviours and associated harms will achieve the best treatment outcomes. CESPHN commissioned the Drug and Alcohol Multicultural Education Centre (DAMEC) to conduct a scoping exercise to better understand CALD communities residing within the CESPHN catchment. From the 2016 census, the top 5 non-english speaking countries of birth are China, India, Greece, Italy and Indonesia. DAMEC identified the following communities as having potential for increased vulnerability to particular health issues and likely to experience service access barriers: • Nepalese • Bangladeshi • Indonesian • Thai North American and Middle Eastern communities were reported as having lower awareness of blood borne virus status, higher reports of recent receptive needle sharing and lower access to diagnostic testing. Analysis of Drug and Alcohol data relating to CALD population found that being born outside of Australia was associated with lower levels of contact with drug and alcohol treatment services. DAMEC's report found those who do access Drug and Alcohol services from a CALD background often receive less than adequate care and barriers such as language and unfamiliarity with the Australian healthcare system lead to an inability to engage in a meaningful way. • Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) Communities	NADAbase 2016/17 2016 Census, Australian Bureau of Statistics DAMEC, 2017 Literature Review Australian Bureau of Statistics, 2013 http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features10July+2013 accessed on 29 September 2017.

Outcomes of the health needs analysis		
	The CESPHN region has a high concentration of LGBTIQ couples residing in the area as identified in the 2011 census data. LGBTIQ communities are identified as a priority population at both national and state level due to experiencing significant health inequalities compared to their heterosexual counterparts, specifically pertaining to higher rates of recent illicit drug use. Findings from the 2016 National Drug Strategy Household Survey have shown that recent use of illicit drugs by those who identify as part of the LGBTIQ communities is up to 5.8 times higher than those who identify as heterosexual. A 2017 survey on gay men found 63.2% of gay and bisexual men recruited from the CESPHN region had reported any drug use in the six months prior to the survey, compared to the 15.6% of men nationally who reported illicit drug use in the previous 12 months in the general population (NDSHS, 2016). The most frequently used drugs identified were cannabis (32.2% compared to 10.4% of the general population), ecstasy (24.3% compared to 2.2% of the general population) cocaine (23% compared to 2.5% of the general population and GHB (13.8%; no national comparison). HIV positive men are disproportionately more likely to report recent drug use (78.7%) and more likely to report using crystal methamphetamine (27.8% compared to 1.4% of general population) with 15.1% reporting recent injecting drug use compared to 0.3% of the general population. The 2016 Sydney Women and Sexual Health (SWASH) survey found that 45% of women identifying as lesbian, bisexual or queer had used any illicit drug in the preceding six months compared to the 13% of women who reported illicit drug use in the previous 12 months in the general population over the previous 12 months (NDSHS,2016). Tobacco (30% compared to 18% of the general population), alcohol (83% compared to 75% of the general population), cannabis (29.4% compared to 8% of the general population), ecstasy (18.8% compared to 1.9% of the general population) and pharmaceuticals/ benzodiazepines (18.5% compared to 3.6% of general population) were each found to be used at a disproportionally higher rate amongst women who identified as lesbian, bisexual or queer.	ABS Census Data, 2011 National Drug Strategy Household Survey, 2016, Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-detailed/contents/table-of-contents accessed on 29 September 2017. Hull, P., Mao, L., Lea, T., Lee, E., Kolstee, J., Duck, T., Feeney, L., Prestage, G., Zablotska, I., de Wit, J., & Holt, M, 2017. Gay Community Periodic Survey: Sydney 2017. Sydney: Centre for Social Research in Health, UNSW Sydney. http://doi.org/10.4225/53/59598c5643b4d Accessed 29 September 2017 Mooney-Somers, J, Deacon, RM, Klinner, C, Richters, J, Parkhill, N (2017) Women in contact with the gay and lesbian community in Sydney: Report of the Sydney Women and Sexual Health (SWASH) Survey 2006, 2008, 2010, 2012, 2014, 2016. Sydney: ACON & Sydney Health Ethics,

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	NADAbase data around the proportion of LGBTIQ individuals presenting at services is problematic due to gender and sexuality indicators being new fields, which are non-compulsory and not collected at an AODTS-NMDS level. Amongst presentations where sexuality data was captured, 12% of respondents identified as LGBTIQ. **<u>People in contact with the criminal justice system</u>** In the 2016 CESPHN Baseline Alcohol and Other Drugs Needs Assessment, it was identified that the CESPHN region becomes the place of residence for approximately 19% of all people exiting custodial settings in New South Wales. The 2009 NSW Inmate Health Survey conducted by Justice and Forensic Mental Health Network found: - 84 % of those exiting custodial settings had used illicit drugs (compared to 38% of general population) - Cannabis was the most common drug ever used (84%); followed by amphetamines (57%), cocaine (45%), ecstasy (44%) and heroin (41%). Data from the 2015 iteration of the NSW Inmate Health Survey is due to be released soon and we anticipate higher reported rates of ever using an illicit drug, as well as a rise in ever used amphetamines consistent with trends in national prevalence data. Reintegration into society from custodial settings is fraught with difficulty. The risk of death is twelve times higher for individuals with a history of illicit drug use in their first week post release than it is for the general population, and the risk of overdose is 129 times higher. **<u>Youth</u>**	University of Sydney accessed 29 September 2017 NADAbase NMDS 2016/17 Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kumar, S. & McNamara, M. (2010) 2009 NSW Inmate Health Survey: Key Findings Report. Justice Health. Sydney. http://www.justicehealth.nsw.gov.au/publications/2009-ihs-report.pdf accessed on 15 November 2017. Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW

Outcomes of the health needs analysis		
	Drug and Alcohol use amongst young people can have substantial associated impacts on brain development, as well as contributing towards poorer long-term health and social outcomes. Young people are less likely to access treatment support or engage with health care professionals. The 2016 NDSHS data showed an increase in the proportion of young people who had never smoked tobacco, with the most significant increase being in the 14-19 age group, increasing from 89% in 2013 to 94% in 2016. The proportion of 14-19 year old's who consume more than five or more drinks at least monthly declined from 25% in 2013 to 18% in 2016. There were no significant changes in illicit drug use rates, with the most commonly used illicit substances identified as cannabis and ecstasy.	National Drug Strategy Household Survey, 2016, Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-detailed/contents/table-of-contents accessed on 29 September 2017.
	3.3% of young people across the region are presenting with alcohol and or other drugs being their primary issue. This is higher than the national rate of 2.4%. Miranda (5.4%), Hurstville (3.7%), Camperdown (3.2%) and Bondi Junction (3.0%) all have higher rates the national rate.	Headspace National Youth Mental Health Foundation. Headspace centres Central and Eastern Sydney PHN Financial Year 2016/17 (1 July 2016 – 30 June 2017)
	People experiencing homelessness The 2016 CESPHN baseline Alcohol and other drugs needs assessment identified that while the total number of people experiencing homelessness are relatively small as part of the general population, they are disproportionately represented in the CESPHN region, particularly in inner city areas.	Alcohol and other Drug Treatment Services, 2017, Central and Eastern Sydney PHN, Kogarah NSW.
	The population of people experiencing homelessness have higher prevalence rates of substance use dependence disorders and co-occurring mental health conditions than the general population, as well as more complex histories of drug and alcohol use. Research looking at the profile of homeless adults within the greater Sydney area found that 42% met criteria for severe depression, 57% were currently experiencing Post Traumatic Stress Disorder and 37% had a lifetime psychotic disorder.	Larney S, Conroy E, Mills K.L, Teesson M, 2009. 'Factors associated with violent victimisation among homeless adults in Sydney, Australia,' Australian and New Zealand Journal of Public Health, 33, 347-351.

Outcomes of the health needs analysis		
	People experiencing homelessness have more complex needs and face higher barriers to service accessibility due to not having identification, phone, access to emails and no stable accommodation. This can present as a challenge for accessing pathways to care, as services can be unwilling to discharge an individual into homelessness. Through the review of literature and consultation with stakeholders, CESPHN have identified the following as other areas of prioritized need: **People with comorbid mental health and alcohol and other drug conditions** Comorbid mental health and alcohol and other drug use disorders have been identified as one of health's most significant challenges. Individuals experiencing comorbid conditions often present to treatment services with more complex needs and face more barriers and difficulties in accessing care. The siloed treatment approach results in fragmented care, with many individuals falling through the gaps. Comorbid mental health and substance use disorders are one of the more complex areas to treat, as once they are established they can perpetuate and exacerbate one another. Individuals who experience comorbid mental health and substance use disorders have an average life expectancy of 20 to 30 years shorter than the general population, with the last ten years of life spent living with disabling chronic illness. It is estimated that up to three quarters of those using mental health services also have drug and alcohol issues, and 90% of those in drug and alcohol treatment settings have a co-occurring mental health condition. Partners in recovery is an initiative that works to better support people who experience severe and persistent mental illness with complex support needs through care coordination and referrals to services across multiple sectors. CESPHN region Partners in Recovery services indicated that only 29% of clients did not currently use illicit drugs or alcohol.. 71% of clients met criteria for dependence or refused to answer questions pertaining to substance use.	Mental Health Commission National Report Card, 2012 Teesson M, Kay-Lambkin F, Mills K, Barrett M. 2014, 'Effective models of care for comorbid illness and illicit substance use. An Evidence Check Review Brokered by the Sax Institute for the NSW Mental Health Drug & Alcohol Office NSW Mental Health Commission, 2014. 'Living Well: Putting people at the centre of mental health reform in NSW,' Sydney, NSW Mental Health Commission. National Drug Strategy Household Survey, 2016, Australian Institute of Health and Welfare,

Outcomes of the health needs analysis

	Older People Available national data and stakeholder consultation have identified people aged 50 or older as an emerging priority population. Despite widespread under recognition and under diagnosis within this age cohort, problematic drug and alcohol use is increasing. The 2016 NDSHS showed a decline in risky drinking in all age groups except those aged 50 and over. The largest increase from 2013 to 2016 in drug misuse was in those aged 60 and over, with the key drug of concern being non-medical use of pharmaceutical opioids (rising from 11.1% to 11.7%). Substance use in older populations can present with more complex challenges. Physiological changes associated with ageing can lead to an increased risk of associated adverse physical effects, such as physical health, risk of falls and negative medication interactions. **Access to treatment for families** In 2015 the National Ice Action Strategy identified a role for greater family inclusion in both the prevention and treatment process, as well as a need for an increase in accessible information, education and support for communities, families and carers of those affected by substance misuse. A loved one experiencing problematic drug and alcohol use can cause significant emotional and psychological effects on families, families of choice and their communities. Feelings of powerlessness to assist loved ones can significantly impact their own mental health and wellbeing. The role of the family is increasingly becoming recognized as a critical factor for influencing substance use behavior as well as enhancing treatment outcomes. The role of families need to be considered as part of the holistic treatment model, treating the family unit as opposed to just the individual experiencing problematic substance use. 2016/17 NADAbase figures show that family members make up 8.3% of the referrals into treatment, with very few services being dedicated to working with families in their own right.	https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-detailed/contents/table-of-contents accessed on 29 September 2017. National Drug Strategy Household Survey, 2016, Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2016-detailed/contents/table-of-contents accessed on 29 September 2017. National Ice Strategy, 2015, Department of the Prime Minister and Cabinet, Commonwealth of Australia, https://www.coag.gov.au/sites/default/files/communique/2015%20National%20Ice%20Action%20Strategy.pdf accessed 16 November 2017 Gethin A, Trimingham T, Chang T, Farrell M & Ross J, 2015, ‘Coping with problematic drug use in the family: An evaluation of the Stepping Stones program,’ Drug and Alcohol Review, Australian Professional Society on Alcohol and other Drugs.

Outcomes of the health needs analysis		
	As part of a commissioned process, CESPHN conducted a mapping project to assess current levels of access to treatment and support for families. The report highlighted the need for 'Child and Family Sensitive Practices,' focusing on raising awareness of the impacts of substance use on families, with a need to see the family as the unit of intervention rather than the individual. This approach is essential for working effectively with Aboriginal and/or Torres Strait Islander peoples to achieve positive outcomes, create significant change and break the intergenerational cycle of disadvantage by addressing the complex and interwoven needs of children, parents, families and communities. **<u>Role of Primary Health</u>** In 2016 84% of the CESPHN population saw one of the regions 2400 general practitioners within the previous 12 months. This indicates that general practitioners are ideally placed to provide screening and assessment, conduct early and brief interventions, manage treatment and create holistic care plans for patients presenting with drug and alcohol concerns. However, there is little evidence to show what does occur around drug and alcohol treatment in a community based setting. NADAbase data for 2016/17 shows only 1.1% of all referrals into a treatment setting came from general practice settings, compared to 45% being self-referral. Whilst self-referral to treatment indicates an individual is ready to engage in their recovery journey, the median delay among those with alcohol use disorders who eventually make treatment contact is 18 years. While there is little evidence to show what does occur in a general practice setting, there is evidence detailing why the involvement of general practice in drug and alcohol treatment and formal shared care arrangements are low. The barriers identified for involvement include: - A lack of adequate training and support - Perceived patient resistance - Discomfort around discussing substance use - Time constraints - Lack of awareness around MBS items for drug and alcohol - Stigma around drug users being chaotic and non-compliant	NADAbase 2016/17 Alcohol and other Drug Treatment Services, 2017, Central and Eastern Sydney PHN, Kogarah NSW. Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW NADAbase 2016/17 Chapman C, Slade T, Hunt C, Teesson M 2015. 'Delay to first treatment contact for alcohol use disorder.' Drug and Alcohol Dependence, 147, 116-121. McEvoy B, 2008, 'Addiction and addiction medicine: exploring opportunities for the general practitioner.' Med J Australia, 189 (2): 115-117.

Outcomes of the health needs analysis		
	- Perception that involvement in drug and alcohol is not part of their role. It is not possible to divorce the practice of medicine from the society in which it is practiced. The prevalence rates of people experiencing substance use disorders within the CESPHN region as well as the high percentage who visit a general practitioner setting annually, highlights the pivotal role that primary care providers have in ensuring equitable access to healthcare and providing drug and alcohol support within a community based setting. In 2016/17 there were 118 active accredited Opioid Treatment Program prescribers in the CESPHN region. This indicates a low participation rate; with only 4.9% of all CESPHN region general practitioners who are confident, capable and willing to engage in prescribing of pharmacotherapy options for opioid dependency. The 2016 CESPHN baseline Alcohol and other drugs needs assessment identified an exceptionally low participation of community pharmacies in the Opioid Treatment Program. CESPHN had a 10% participation rate compared to a national participation average of 30%. Pharmacy involvement is essential for increasing access to treatment and reducing stigma by normalizing Opioid Substitution Therapy as medical treatment.	Pharmaceutical Services, NSW Health Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

<table>
<tr><th colspan="3">Outcomes of the service needs analysis</th></tr>
<tr><th>Priority Area</th><th>Key Issue</th><th>Description of Evidence</th></tr>
<tr><td><u>Service Accessibility</u></td><td>The health needs analysis identified several barriers faced by individuals experiencing substance use dependency when attempting to access treatment. A strategic objective which CESPHN will continue to implement is to increase treatment accessibility through a range of initiatives:

<u>1.1 Improving the capacity of Primary Health to respond to Drug and Alcohol concerns in a community based setting.</u>

Within the CESPHN region, there are 118 General Practitioners actively prescribing pharmacotherapy for opioid dependency. 103 of these General Practitioners are accredited and serving the SA3 areas:
• Sydney Inner City n=67
• Kogarah-Rockdale n= 12
• Eastern Suburbs-North n=12
• Eastern Suburbs-South n=2
• Strathfield-Burwood-Ashfield n=8
• Botany n= 6
• Canterbury n= 5
• Marrickville-Sydenham-Petersham n=2

The SA3s of Sutherland-Menai-Heathcote, Canada Bay, Cronulla-Miranda-Caringbah and Hurstville do not have any accredited prescribers serving these regions. There are 15 non-accredited prescribers located in the below SA3s:</td><td></td></tr>
</table>

Outcomes of the service needs analysis		
	• Sutherland-Menai-Heathcote n=3 • Cronulla-Miranda-Caringbah n= 1 • Canada Bay n=1 • Cronulla-Miranda-Caringbah n=1 • Eastern Suburbs-North n=1 • Kogarah-Rockdale n=1 • Strathfield-Burwood-Ashfield n=1 As identified in the health needs analysis, primary health practitioners are ideally placed to provide assessment and intervention and create appropriate referral pathways specific to the presenting individual's unique needs. Treatment within the community is a cost-effective model that is more accessible for individuals and more conducive to maintaining work and family commitments. Current barriers for general practice such as low confidence, knowledge, skills and attitudes can be addressed through education. Motivational interviewing skills have been identified as an area of need to effectively engage patients in an open, non-stigmatizing, constructive dialogue around problematic use. Community based treatment will become increasingly important with the rescheduling of codeine from an over-the-counter analgesic to prescription only medication on 1 February 2018. While it is difficult to predict the impacts of the change, it is anticipated by stakeholders that there will be a rise in people accessing general practice settings for pain management who meet the criteria for codeine dependency. As noted in the health needs section, this demographic may have other factors to consider, such as being of an older age and with higher rates of employment. Another factor which will impact the capacity of general practice to better respond to and manage drug and alcohol concerns within the community is the release of the new Opioid Treatment Guidelines. It is anticipated that the new guidelines will allow for General Practitioners to prescribe buprenorphine for up to 20 patients and methadone for 10 stable patients without having to complete the Opioid Treatment Accreditation Course (OTAC).	Intergovernmental Committee on Drugs, 2015. 'National Alcohol and Other Drug Workforce Development Strategy 2015-2018,'Canberra, National Drug Strategy. http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/C8000B21B6941A46CA257EAC001D266E/$File/National%20Alcohol%20and%20Other%20Drug%20Workforce%20Development%20Strategy%202015-2018.pdf accessed 22 September 2017.

Outcomes of the service needs analysis		
	Stakeholders have identified that the following strategies will be important to address the above changes: • formal shared care arrangements • utilization of clinical nurse consultants • promotion of MBS item numbers to encourage the development of care plans development and promotion of HealthPathways including prescription of Naloxone to prompt conversations about overdose risk **1.2 <u>Low rates of pharmacy participation in Opioid Treatment Program</u>** CESPHN's low pharmacy participation rate in OTP is a factor which impacts access to treatment. Strathfield and Woollahra LGA's were identified as having no participating pharmacies. This low participation rate could cause additional pressure on participating pharmacies should there be an increase in individuals accessing pharmacotherapy treatment for codeine dependency after 1 February 2018. Stakeholders identified that the most significant barrier to engagement of pharmacies is stigma and discrimination, with pharmacies being reluctant to have their business associated with treatment of addiction medicine clients. This can be ameliorated through education and training and is important for removing a moral perspective and treating addiction medicine clients the same as any client seeking treatment of a health condition. Encouraging engagement of pharmacies will increase accessibility to and ease of treatment for people engaged in OTP, minimizing the impact on everyday life and promoting wellbeing. Engagement of pharmacies will allow for increased communication and care planning in consultation with General Practitioners. Pharmacists are well placed to identify high prescribing doctors who may need additional education, as well as identification of people who meet the criteria for dependency and deliver alternative referral points.	Consultation with Key Stakeholders, October/November 2017

Outcomes of the service needs analysis		
	1.3 Increase access to treatment for families A report CESPHN commissioned to NADA identified limited services which cater for women with children. The report recommended that CESPHN should prioritise community based treatment models which provide after-hours and weekend treatment options or provide childcare facilities.	Consultation with Key Stakeholders, October/November 2017
2. Focus on person-centred, quality service delivery	Through consultations it is understood that there is an emerging sector-wide understanding and commitment towards establishing a person centred rather than service centred system. To attain positive outcomes, treatment should be holistic and integrated and meet individual AOD needs at their point of access. A cross sectoral care approach across all health and social service systems and community is required. Stakeholders noted that the current funding system creating a fragmented and siloed treatment approach. A population and public health preventative approach should be implemented through engagement of the AOD sector with the wider service system to meet the holistic and interrelated needs of individuals. CESPHN will continue to commission evidence-based programs and actively contribute towards sector activity to establish a quality framework and standardised patient outcome and experience measurements. This strategy is in line with commitments outlined by the National Drug Strategy and includes building workforce capacity, building sector partnerships and encouraging the enhancement of quality service provision. **2.1 Equity of access for priority populations and workforce development opportunities** Ensuring the delivery of culturally appropriate treatment for priority populations is essential to ensure ongoing engagement with the treatment process and ensure a person-centred treatment approach to meet the individuals needs and enable positive treatment outcomes.	Consultation with Key Stakeholders, October/November 2017

Outcomes of the service needs analysis		
	Stakeholders have identified that the sector has inconsistent capacity in the delivery of culturally sensitive care for Aboriginal and/or Torres Strait Islander peoples. The CESPHN region encompasses one Aboriginal Community Controlled Health Organisation (ACCHO), the Aboriginal Medical Service (AMS) which operates in Redfern and is at full capacity. It is essential to strengthen the capacity and capability of mainstream services to address and understand unique individual needs which impact on treatment outcomes; utilising best practice approaches in treatment. Use of inclusive language is an essential component for ensuring cultural appropriate service delivery and is both a powerful deterrent and enabler to accessing treatment and support. Language use which is perceived as stigmatising, judgmental or culturally inappropriate will make service engagement and retention challenging. This can be ameliorated through targeted training for priority populations, including Aboriginal and/or Torres Strait Islander peoples, LGBTI communities and people from CALD backgrounds. Stakeholders have identified the importance of treatment services implementing a trauma informed best practice approach, recognizing the relationship between trauma histories and substance use dependency. It is recognised that further training opportunities for the AOD workforce in this area is required, increasing sensitivity to and skills in understanding and responding to the impacts of trauma. This is especially important for women accessing treatment, with additional consideration applied to Family and Domestic Violence factors. CESPHN will continue to ensure commissioned services work to ensuring equity of access by requesting the development and implementation of strategies to ensure service appropriateness for CESPHN region priority populations. **2.2 <u>Role of families</u>** The health needs analysis identified the important role that families play in the treatment process, as well as the need to provide support for those affected by a loved one’s problematic substance use in	Consultation with Key Stakeholders, October/November 2017

Outcomes of the service needs analysis		
	their own right. There is a need for providers to demonstrate how they create safe and accessible service environments for families and include the needs of family members, carers and significant others. This is imperative for achieving and sustaining change, particularly in the context of family functioning and breaking intergenerational cycles of disadvantage. A holistic model should address the complex and interwoven needs of children, parents and families. Consultations with stakeholders identified that implementing Child and Family sensitive practice is essential for seeing the family, rather than the individual, as the unit of intervention. This is especially important for closing the gap in disadvantage experienced by Aboriginal and/or Torres Strait Islander peoples, who have a holistic view of health which focuses on the spiritual, physical, cultural, emotional and social wellbeing of the individual, family and community. An effective holistic approach will strengthen cultural systems of care. Stakeholders also noted that access to parenting programs from treatment services was limited, as well as recommending the incorporation of family function questions into the assessment processes to ensure holistic, best practice and effective intervention for people engaged in treatment for problematic drug and alcohol use. **2.3 <u>Role of a peer</u>** Stakeholders have identified the importance of consumer participation as an essential component in co-designing treatment services and programs. The Drug and Alcohol sector is absent of the peer based work force present in the Mental Health sector and there is an increasing move by services toward ensuring meaningful consumer participation. Meaningful engagement of lived experience needs to be incorporated into the service philosophy and reflected in the attitudes and beliefs of the organisation to deliver a holistic and person-centred treatment.	Consultation with Key Stakeholders, October/November 2017

Outcomes of the service needs analysis		
	Stakeholders reflected the success of peer delivered initiatives in service initiatives including engagement in Hepatitis C treatment, increasing the delivering harm reduction information and increasing the distribution of sterile injecting equipment. Stakeholders identified that people may be reluctant to involve themselves in participation during their treatment, particularly in short-term detox settings. An additional barrier is a reluctance to self- identify as having lived experience due to stigma and discrimination. Stakeholders identified a gap as a lack of formal training opportunities on advocacy and participation, a barrier which prevented active consumer involvement.	
3.0 Integrated Service Delivery	CESPHN's vision is to work collaboratively to support a flexible, coordinated, responsive and person-centred treatment system. In order to create effective and seamless pathways of care for individuals accessing treatment support it is essential to establish robust and effective partnerships between Local Health Districts, Local Hospital Networks, primary care, non-government organisations and ACCHOs. In order to create holistic treatment plans which promote long term sustainable outcomes, a greater connection with social support services is required to meet the other interrelated needs of people presenting with substance use dependency. The siloed treatment approach has been identified as a barrier to effective person-centred treatment by stakeholders. A fragmented approach to care creates a more complex treatment service system for people to navigate despite a large intersection of services treating the same client base. Stakeholders have identified that comorbidity is an area which requires training and development, with mental health services often having exclusion criteria for people engaged in substance use, and drug and alcohol services having exclusion criteria pertaining to people experiencing severe mental health symptoms. **3.1 A suite of service options**	

Outcomes of the service needs analysis		
	All stakeholders identified a lack of service capacity and difficulties accessing appropriate treatment support as an important issue. While it is difficult to ascertain the level of regional need due to delays in treatment seeking, it is predicted by stakeholders that approximately 1 in 6 people who require treatment can access it. Other noted issues include: • Limited access to detox facilities (requirement for residential rehabilitation) • Long waiting periods and the importance of engaging people in treatment when they seek support • Lack of withdrawal management supports within the community for low-moderate symptoms • Limited aftercare/continuing care service provision, essential in promoting sustainable long-term wellbeing and preventing relapse • Recognition that many services utilise a recovery model which is abstinence based and will not be homogenously congruent to all individual's treatment goals An effective treatment system will utilise a stepped care approach and offer a suite of person-centred and integrated treatment services. Stakeholders recognised the essential role harm reduction services play in reducing harms associated with drug and alcohol use, as well as providing opportunistic and non-stigmatising engagement with health care providers and encouraging empowerment and help-seeking behaviour. Needle and Syringe Programs are essential for ensuring the continued increase in distribution of injecting equipment, reducing receptive needle sharing and the transmission of blood-borne viruses.	Consultation with Key Stakeholders, October/November 2017

Section 4 – Opportunities, priorities and options

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- *may be considered in the development of the Activity Work Plan, and supported by PHN flexible funding;*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Primary Health	• Improving the capacity of General Practitioners respond to drug and alcohol concerns within the community • Improve confidence and competence of primary health to engage in the provision of ambulatory withdrawal service. • Provide support, resources and education for General Practitioners to effectively engage in comprehensive treatment plans, develop motivational interviewing skills and use of appropriate language. • GLAD shared care project implemented with GPs across the region • Increase number of General Practitioners engaging in prescribing for OST to meet potential increased need for people presenting with codeine dependency, utilise	Increased number of patients supported in primary healthcare setting Increased integration between primary health and specialist treatment services Increased awareness and use of HealthPathways and DASAS Establish referral links with Allied Health providers, including pain management specialists.	Amount of allocated mainstream funding expended on in-scope Activities Amount of allocated Indigenous-service funding expended on in-scope Activities Number of formalised partnerships/collaborations established with local key stakeholders Number of formalised partnerships/collaborations	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	additional capacity from anticipated OST guideline changes • Education for allied health professionals to engage with General Practice in creating alternative care pathways for people experiencing codeine dependency. • Develop, disseminate and pilot an opioid screening tool for early identification of dependency in primary care settings	Reduce over-prescribing of pharmaceutical opioids	established with local key Aboriginal and Torres Strait Islander stakeholders Quality Improvement – evidence of support for health professionals; number of education/training modules delivered Number of Providers with (or in the process of getting) suitable accreditation	
Person-centred, quality service delivery	• Collaborate with peaks and other training providers to deliver professional development opportunities (training and resources) to the AOD workforce to better respond to the needs of CESPHN priority populations. • Provide continuing professional development which spans to other sectors, including mental health, sexual health, pain management and family and domestic violence.	Provision of a skilled workforce to meet the needs of CESPHN priority populations Increased access and improved treatment outcomes for priority populations A cross-sectoral response to meeting holistic support needs	Amount of allocated mainstream funding expended on in-scope Activities Amount of allocated Indigenous-service funding expended on in-scope Activities Number of formalised partnerships/collaborations	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Work with NUAA to promote approaches for meaningful inclusion of lived experience (including peer workers) in co-design, implementation and evaluation of AOD services. • Promote child and family sensitive practice in service delivery and provide education opportunities to embed best practice within service models • Promote a trauma informed practice approach in service delivery and provide education opportunities to embed best practice within service models • Inclusion of standardised client experience measures as a commitment to ongoing quality improvement by commissioned services	Establishment of a peer AOD workforce and meaningful consumer representation roles Increased wellbeing and inclusion of families with loved ones experiencing substance use dependency	established with local key stakeholders Number of formalised partnerships/collaborations established with local key Aboriginal and Torres Strait Islander stakeholders Quality Improvement – evidence of support for health professionals; number of education/training modules delivered Number of Providers with (or in the process of getting) suitable accreditation	
Integrated Service Delivery	• Improve regional care coordination by commissioning shared care projects with LHDs and LHNs. • Provide forums for engagement of services across the AOD and primary health sectors	Increased responsiveness to changes in the sector and avoid duplication of effort	Amount of allocated mainstream funding expended on in-scope Activities	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	such as education forums and regular newsletters • Continued consultation with CESPHN region AOD advisory group to facilitate sector integration and promote sector activities • Engagement of consumers, carers and community to understand the barriers in navigating the service system • Commission services across the continuum of care to ensure a person centred stepped care approach, prioritising community based day programs and continuing care models • Promote practices which support integrated service delivery through regular reporting frameworks and deliverables for commissioned services • Address the waiting times for service access through the provision of supports to encourage continued engagement in treatment seeking.	Improved service capacity across the PHN region Seamless pathways of care created for community Accessible support in the right time at the right place Empowerment of people experiencing substance use dependency to remain engaged during waiting times.	Amount of allocated Indigenous-service funding expended on in-scope Activities Number of formalised partnerships/collaborations established with local key stakeholders Number of formalised partnerships/collaborations established with local key Aboriginal and Torres Strait Islander stakeholders Quality Improvement – evidence of support for health professionals; number of education/training modules delivered Number of Providers with (or in the process of getting) suitable accreditation	

Section 5 - Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for programme planning and policy development.	✓
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓