Alcohol and Other Drugs 2019 Needs Assessment

phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Preliminary notes

This report is solely for the purpose and use of the Central and Eastern Sydney Primary Health Network (CESPHN). The report has been prepared through a consultancy process. In most cases the consultant has relied on published data or unpublished data supplied by interviewees in the consultation process. Where policy positions are determined from qualitative feedback within the consultation process this is indicated within the report.

The report follows as closely as possible the needs assessment undertaken in 2016. This is to allow for clear comparisons and to identify the source of any strategic realignment. Where available data or interview outcomes allow for new lines of inquiry this is clearly identified in the report.

Suggested Citation

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- The NSW Ministry of Health, and Local Health Districts and Networks within the CESPHN catchment
- Consumers and carers involved in our governance and advisory structures
- Aboriginal health and social agencies with expertise on the local needs of Aboriginal people within the CESPHN region including Redfern AMS and Tribal Warrior.

Project team

Finally, CESPHN would like to thank the project team:

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- Chris Keyes – Drug Health Manager, CESPHN
- David McGrath – David McGrath Consulting

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Abbreviations and definitions

ABF	Activity-based funding
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
AOD Core	The label applied to certain funds by the Commonwealth Department of Health reflecting the aggregation of pre-existing AOD funding sources that are now administered by PHNs
ATS	Amphetamine Type Stimulants
CALD	Culturally and Linguistically Diverse
CES	Central Eastern Sydney
CESPHN	Central Eastern Sydney Primary Health Network
DASP	Drug and Alcohol Service Planning tool
DoH	Commonwealth Government Department of Health
DRG	Diagnosis-Related Group
ED	Emergency Department
GP	General Practitioner
IGCD	Intergovernmental Committee on Drugs
IRSAD	Index of Relative Socio-Economic Advantage and Disadvantage
LGA	Local Government Area
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning
LHD	Local Health District
LHN	Local Health Network
MDAF	Ministerial Drug and Alcohol Forum
MDS	Minimum Data Set
MERIT	Magistrates Early Referral into Treatment
MHCC	Mental Health Coordinating Council
NADA	Network of Alcohol and Other Drug Agencies
NGO	Non-government Organisation
NGOTGP	Non-Government Organisation Treatment Grants Program now referred to as AOD Core by the Commonwealth Department of Health
NSW Health	The umbrella term for all NSW Government funded health services and associated administrative entities

NWAU	National Weighted Activity Unit – the standardised measure of health service activity under Activity Based Funding arrangements
OSP	Opiate Substitution Program
OTP	Opiate Treatment Program
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners
SEIFA	Socio-Economic Indexes for Areas
SESLHD	South East Sydney Local Hospital District
SLHD	Sydney Local Health District
WHO	World Health Organisation
Yarndi	A term used in Aboriginal populations to refer to cannabis.

Executive summary

This needs assessment builds on prior work of CESPHN to identify the population need for alcohol and other drug (AOD) service responses. The 2016 needs assessment details the characteristics of the CESPHN region. Briefly, the CESPHN catchment area spans 626 square kilometers within the Sydney basin bounded by the suburb of Strathfield, the Sutherland Shire, Bondi, and Sydney Harbour and also includes Lord Howe Island and Norfolk Island. Its population is approximately 1.6 million and contains many diverse sub-populations.

This needs assessment utilises a relatively traditional health service planning approach to identify service enhancement objectives. The elements of this planning approach are:

- A mapping of existing service infrastructure
- An assessment of service need based on:
  - Estimated care needs for diagnostic prevalence and illness severity categorisations in standard populations
  - Adjusted for concentrations of cohorts with specific needs in a given region
  - An assessment against existing service availability and utilisation.
- Consultation with key stakeholders
- Identification of system roles and responsibilities of the agency undertaking the planning exercise
- Identification of a strategic framework for action
- Identification of actions against that framework.

Key demographic and service attributes include:

- High number of homeless people which correlates with expected higher prevalence rates of alcohol disorders (37%) and other drugs (24%)
- High number of released prisoners who settle in this region upon release from prison. This cohort has an expected 11 times higher rate than the average population for AOD disorders
- High number of Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning (LGBTIQ) people, with a higher than expected methamphetamine usage rates, and rates of injecting drug use that are up to four times the general population
- Exceptionally low number of pharmacies participating in the provision of Opiate Substitution Treatment (OST) - less than 10% as compared to the state average of 30%
- Low number of GPs providing specialist drug treatment interventions, out of the more than 2,000 practicing GPs actively engaged in supporting and referring patients with AOD needs
- Higher than average prevalence of AOD disorders requiring hospitalisation
- Higher ambulance call outs to opioid overdoses than other NSW regions
- Higher risky drinking rates than the average NSW PHN
- Identified growth in prescription medication misuse particularly related to benzodiazepines.

This document indicates a likely continuing deficit between population treatment service need adjusted for complexity and current AOD service provision in the CESPHN region. Further structural changes within the broader health system are likely to impact in the forthcoming period with NSW Health prioritising consultation liaison service activity and the arrival of long acting depot medications for OST treatment. These structural changes will result in changes to service delivery approaches in primary care and NGO service providers.

The planning process utilised a combination of available data and a wide-ranging consultation with key experts and stakeholders to identify target activity. This activity falls within the three identified priority areas:

- Increase access to drug and alcohol treatment services
- Increase access to drug and alcohol treatment in the primary care setting
- Enhance capacity to address high need populations and clinical complexity.

There is evidence of strong gains in the AOD program since 2016 within the CESPHN region and clear feedback from stakeholders that CESPHN has positively impacted on service provision. The document provides a solid framework for future CESPHN commissioning activity to build on those gains.

Introduction

Purpose

This needs assessment builds on prior work done by CESPHN to identify the population need for AOD service responses within their catchment area, beginning in 2016.

The initial work was stimulated by the Commonwealth Government response to the National Ice Taskforce Report[1] and its associated $241.5 million in new funding rolled out through Primary Health Networks (PHNs). This new funding required an assessment of local population and service need to facilitate the commissioning of new service responses consistent with the roles and responsibilities of PHNs.

The 2016 needs assessment was the first stage in a three-step process. The second step was the development of a regional operational drug and alcohol plan that committed to actions to improve the alcohol and other drug treatment service system within the PHN region. The final step was a commissioning process and associated framework to disperse funds.

This current comprehensive review has been initiated to identify the currency of the outcomes of the 2016 process in preparation for new commissioning responsibilities for CESPHN in 2020. These responsibilities require local PHN decision making on the ongoing commissioning arrangements for funds held by existing contracted providers under the previously termed Non-Government Organisations Treatment Grants Program (NGOTGP), now referred to by the Commonwealth as AOD Core. That local decision making will be built on the outcomes of this needs assessment.

CESPHN region

The 2016 needs assessment details the characteristics of the CESPHN region. Briefly, the CESPHN catchment area spans 626 square kilometres within the Sydney basin bounded by the suburb of Strathfield, the Sutherland Shire, Bondi, and Sydney Harbour and also includes Lord Howe Island and Norfolk Island. The boundaries align with those of South Eastern Sydney Local Health District and Sydney Local Health District. It is the second largest of the 31 primary health networks across Australia by population, with more than 1.6 million individuals residing in the region. The catchment population is characterised by cultural diversity, with 40% of the community born outside Australia, 38% speaking a language other than English at home and high population growth. There are over 13,000 Aboriginal and Torres Strait Islander people within the PHN.[2]

The CESPHN catchment has areas of both high and low socio-economic advantage based on ABS data. The vast majority of the Eastern Suburbs of Sydney sit in the most advantaged quintile as Is most of the Inner West, Sutherland Shire and the suburbs that overlook the Georges River. However, there are pockets of the PHN region that sit in the lowest quintile, that is the most disadvantaged, including parts of Botany, Mascot and Maroubra in the East, and small areas of Sutherland and Jannali and Menai in the South.[3]

As identified in the 2016 needs assessment the region covered by the PHN includes principal referral hospitals, Royal Prince Alfred, Prince of Wales, St Vincent's and Concord Repatriation General Hospital together with other major metropolitan hospitals, St George, Canterbury and Sutherland. Included amongst the specialist facilities are the Sydney Children's Hospital, the Sydney Dental

1 Commonwealth of Australia, Department of the Prime Minister and Cabinet, Final Report of the National Ice Taskforce.

2 https://www.cesphn.org.au/documents/planning-strategy-and-evaluation/2853-snapshot-eis-health-annual-report-2018-19-final-digital/file

3 These are at the Statistical Area 1 level which equate to small clusters of streets in a postcode. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2033.0.55.001~2016~Main%20Features~IRSAD%20Interactive%20Map~16 accessed on November 4, 2019.

Hospital, the Sydney Eye Hospital, the Royal Hospital for Women and the Forensic Mental Health Hospital run by the Justice and Forensic Mental Health Network.

There are over 2,000 GPs providing more than nine million consultations per year, over 12,000 AHPRA registered allied health professionals, 164 residential aged care facilities and 2,000 community pharmacists.[4] There are five major community health centres in the Sydney Local Health District, eleven across the South Eastern Sydney LHD and St Vincent's provides outpatient clinic services and a range of specialist outreach services.[5]

Consultation and data gathering

This needs analysis was undertaken subject to consultation with senior staff in the two Local Health Districts within the CESPHN region along with the St Vincent's Health Network. Consultation was also undertaken with the NSW Ministry for Health, and the peak bodies for Non-Government Organisations (NGOs) providing drug and alcohol services (NADA) and mental health services (MHCC), and the Drug and Alcohol Multicultural Education Service (DAMEC). All current CESPHN commissioned service providers were contacted and provided advice, and in some cases data, to support the assessment process. A number of specialist Aboriginal service providers participated in the consultation including Tribal Warrior, Redfern AMS and St Vincent's specialist Aboriginal drug and alcohol worker.

Finally, the consultation structures already existing within the PHN were utilised including discussions with the CESPHN Clinical Council, the CESPHN Community Council, the AOD Advisory group members and the Mental Health Suicide Prevention Advisory Group.

Data was sourced where possible from the individuals interviewed. Relevant publicly available data sets were also accessed, including those sets managed by the PHN.

Planning approach

This needs assessment utilises a relatively traditional health service planning approach to identify service enhancement objectives. While individual planning exercises can vary the order in which the elements are applied, the elements are generally consistent. The elements of this planning approach are:

1. A mapping of existing service infrastructure
2. An assessment of service need based on:
    - Estimated care needs for diagnostic prevalence and illness severity categorisations in standard populations
    - Adjusted for concentrations of cohorts with specific needs in a given region
    - An assessment against existing service availability and utilisation.
3. Consultation with key stakeholders
4. Identification of system roles and responsibilities of the agency undertaking the planning exercise
5. Identification of a strategic framework for action
6. Identification of actions against that framework.

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[4] https://www.cesphn.org.au/documents/planning-strategy-and-evaluation/2853-snapshot-eis-health-annual-report-2018-19-final-digital/file

[5] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

The document is structured to reflect the approach based upon the historical structure of previous needs assessments by CESPHN which were in turn based on parameters to the planning process prescribed by Commonwealth Government funding agencies.

The mapping of service infrastructure within the health field is traditionally difficult due to the complex array of funding agencies and funding sources, overlaid with often inconsistent nomenclature for service types and variations over time in individual services focus and intent. This report makes best endeavours to provide a map of AOD related service provision within CESPHN but the authors would note that a jointly commissioned audit between state and federal funding bodies would be the most efficient method to establish a baseline of services across PHN regions. The benefit of an audit of this type was noted in the 2016 needs assessment.

Alcohol and other drug service mapping

The 2016 needs assessment included a service mapping exercise to ascertain the range, quantum and distribution of AOD services within the CESPHN region. This section provides an update on that service mapping process. The current distribution of services will provide the baseline for future commissioning decisions.

Updated 2016 overview

Two Local Health District run specialist alcohol and other drug programs operate in the region covered by CESPHN, Sydney and South Eastern Sydney, along with government services provided by the St Vincent's Local Health Network. There are also Non-Government service providers who have both widely applicable models of care and specifically targeted models of care. In addition, there are alcohol and other drug interventions provided by general practice and community pharmacy, and some residents of the PHN are able to access private treatment programs although in the main these are located outside the PHN boundaries.

There has also been a growth in availability of online self-help and low intensity intervention platforms targeting substance use behaviour change. Examples include Hello Sunday Morning and Breaking the Ice, with these available to PHN residents with access to internet-based services. These platforms supplement existing peer led self-help approaches such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) which are also accessible at various locations within the PHN boundaries.

Finally, there are Community Drug Action Teams (CDAT's) and Local Drug Action Teams (LDAT), organised by interested members of the community, who undertake population style interventions in the AOD area. There is little difference in intent between CDATs and LDATs, however LDATs are supported by Commonwealth funding and policy frameworks while CDATs are similarly supported by the NSW Government.

The 2016 overview utilised baseline data to identify that there was uneven distribution by LGA of services across the PHN region. There have however been a number of new government initiatives announced since the 2016 assessment.

The NSW Government announced a drug package in the 2016/17 state budget that provided $75 million of enhancements over four years for specific initiatives. The package has increased the annual NSW government spend on AOD services to $231.6 million in the 2019/20 year, up from $197 million in 2016/17. The enhancements targeted the following service needs over a four-year period beginning in 2016/17:

- $16 million for youth detoxification across NSW
- $8 million for research into innovation in early intervention approaches
- $15 million for additional substance use in pregnancy services
- $8 million for residential rehabilitation services for women and children
- $1.5 million to support families and carers
- $12 million for community treatment and aftercare, and to increase access to the Merit program
- $14.5 million for assertive community support for severe dependence and high complexity.

While details of the announcements are easy to locate, there is a dearth of information on how and where the announced funds have been allocated. CESPHN covers approximately 22% of the NSW population and it would be expected that on a population basis additional investment in the CESPHN region would be in the vicinity of $6.5 million per year since 2016, however this cannot be confirmed nor can it be allocated to service types or target cohorts. It is noted that both youth and families are targeted cohorts and it is possible that the Sydney Children's Hospital Network, which has a campus at Randwick, received funds for these services.

In the Commonwealth Government Budget for 2019/20, $189.1 million was announced over four years to fund support for families affected by drug misuse particularly in rural areas, the implementation of take-home naloxone for managing opioid overdose and improved access to pain management in rural areas.[6] The majority of this package will have little impact on service need in the CESPHN region given its focus on rural areas, however the take home naloxone program will benefit CESPHN residents. This program is a being led by SESLHD who play a key role in implementation across NSW by delivering training and credentialing to government service providers. The 2018/19 Budget statement indicate 'no material change' to the AOD program resulting from the budget measures.[7] There were few substantively funded initiatives in the 2017/18 Federal Budget outside of implementation of the NIAS funding package.

Sydney Local Health District (SLHD)

SLHD had recently completed a five-year strategic plan in 2016. This remains their current strategic plan and the services listed there the most definitive summary of service capacity. As stated in 2016:

'The SLHD program provides the full suite of alcohol and other drug interventions with the exception of residential or day rehabilitation programs. It does provide community counselling and the associated components of rehabilitation that can be provided in that setting. The services are provided at Canterbury, Concord and Royal Prince Alfred Hospitals (RPAH), and from community health centres at Redfern, Canterbury, Croydon and Marrickville.'[8]In recent years SLHD has also commenced two assertive outreach teams.

SLHD Drug Health Services currently provides:

- RPAH and Concord Hospitals offer inpatient beds for management of complex withdrawal and medical problems related to substance use.
- Approximately 450 outpatient Opiate Substitution Treatment places
- Ambulatory withdrawal clinic at RPA Hospital
- Specialist clinics including toxicology, comorbidity, pain management, liver disease
- Outreach hepatitis C assessment and treatment services
- Hospital Consultation and Liaison
- Outpatient services including: counselling, withdrawal, pain management, hepatitis clinics, tobacco cessation, Rapid Access Stimulant (Ice) Clinic
- Perinatal and Family Drug Health services
- MERIT court diversion program
- Harm Reduction Program including Primary Care Clinic at Redfern
- Needle Syringe Program

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[6] Commonwealth Government of Australia. Fact Sheet: Budget 209-20: Whole of Government Drug Strategy. Accessed @ https://www.health.gov.au/resources/publications/budget-2019-20-whole-of-government-drug-strategy on November 13, 2019.

[7] Commonwealth Government of Australia. Budget 2018-19. Portfolio Budget Statements. Budget Paper No 19. Health Portfolio. Accessed @ https://www.health.gov.au/sites/default/files/health-portfolio-budget-statements-2018-19.pdf on November 13, 2019.

[8] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

- Nurse Practitioner (youth)
- Research Unit
- Integrated models of service delivery.

The 2019/20 service agreement between SLHD and the NSW Ministry of Health does not detail a specific budget line item for the AOD program, nor does it detail the distribution of services within the region. It does provide AOD specific activity based funding (ABF) volumes for the first time and performance measurement related to the provision of hospital consultation liaison services and as such it should be anticipated that the provision of these would be a focus of management endeavour.

Since 2016 Sydney LHD received additional support for severe substance dependence and for drug use in pregnancy services as a part of the 2016/17 NSW drugs package, along with additional funding from CESPHN, via SESLHD, for GP consultation liaison as part of the GP Liaison in Alcohol and other Drugs (GLAD) project. It is unlikely to have received any of the funds set aside by the NSW Government for additional residential rehabilitation or for aftercare as these are usually services provided by NGOs.

South Eastern Sydney Local Health District (SESLHD)

SESLHD released a clinical services plan in 2017, the release of which was foreshadowed in the 2016 needs assessment. The plan outlines the following services provided by SESLHD in response to drug and alcohol problems:

''Core' clinical services comprise intake and assessment, counselling, case management and support, withdrawal management, opioid treatment, medication-assisted treatment, hospital D&A consultation liaison services, D&A hospital admissions and court diversion programs. Additional clinical services include addiction medicine outpatient clinics, the enhanced community care options team, cannabis clinics, psychiatric co-morbidity clinics, GP-shared-care, pharmaceutical opioid clinics, chemical use in pregnancy services, and outreach services with particular populations (e.g. youth mental health, Aboriginal services).'[9]

SESLHD clinical services are provided with consumer involvement by an established consumer workforce, adherence to clinical guidelines and quality standards, and with contributions to clinical research, teaching, and learning and development. Services are provided in inpatient, outpatient and community outreach settings.[10]

The SESLHD service comprises non-admitted/community based services delivered from Surry Hills, Kogarah and Caringbah and Hospital Drug and Alcohol Consultation Liaison, Substance Use in Parenting & Pregnancy Service (SUPPS), inpatient admissions at Sydney and Sydney Eye Hospital (SSEH) and St George Hospital, and consultation liaison services across SSEH, Prince of Wales Hospital, Royal Women's Hospital, St George and Sutherland Hospitals.

Consistent with the Clinical Services Plan, there has been a greater focus upon establishing services to meet areas of demographic growth and socioeconomic need, including Sutherland Shire, Botany, Maroubra and Malabar. CESPHN is identified as a key partner to achieve this objective. The plan also identifies that this will require considerable investment in capital infrastructure.[11] The monitoring

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[9] NSW Government. South Eastern Sydney Local Health District. Drug & Alcohol Clinical Services Plan 2017. South Eastern Sydney Local Health District. Taren Point. NSW. Accessed @ https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Planning_Population_and_Equity/Health_Plans/DandAPlan.pdf on November 15, 2019.

[10] NSW Government. South Eastern Sydney Local Health District. Drug & Alcohol Clinical Services Plan 2017. South Eastern Sydney Local Health District. Taren Point. NSW.

[11] NSW Government. South Eastern Sydney Local Health District. Drug & Alcohol Clinical Services Plan 2017. South Eastern Sydney Local Health District. Taren Point. NSW

framework for the plan does not identify any regular public disclosure of progress, nor does it indicate any available budget for capital spending.[12] The consultation process with SESLHD did not identify specific initiatives for expansion associated with the implementation of the plan.

From the 2016 Drug Package, SESLHD received enhancements enabling a SUPPS position at Caringbah and a jointly funded D&A position within SESLHD Child Youth and Family Services; the Assertive Community Drug & Alcohol Team including 2 FTE social workers and 1 FTE neuropsychologist to respond to complex and hard to engage patients was established permanently and investment in 2 FTE of additional social workers at St George and Sutherland made to strengthen the psychosocial interventions within the multidisciplinary team.

SESLHD has also had contract management accountabilities for the GLAD project and two other CESPHN capacity building projects. CESPHN funding has facilitated the expansion of shared care CNC FTE from 1.63 FTE to 2.47FTE; and the joint development and delivery of HealthPathways and training with SLHD and St Vincent's Health Network. Also, workforce capacity to deliver a 12-week DBT group counselling intervention has increased from 2 to 4 staff and groups have been facilitated at 2 additional sites – Caringbah and St George. SESLHD also partnered with the Recovery College to co-design and deliver drug and alcohol modules.

Since 2016 SESLHD has expanded treatment options for opioid dependence with the introduction of depot buprenorphine and been commissioned by NSW Health to deliver training across the state as part of the jurisdictional roll out.

St Vincent's Health Network

St Vincent's Hospital Sydney serves both a local population and many patients from across the state. The Alcohol and Drug Service does not have a defined catchment area, however, largely serves an inner-city population within the geographical boundaries of SESLHD. The service is also closely located to the boundaries of SLHD – 10% of inpatients and 25% of outpatients live in the Darlinghurst area.

St Vincent's provides:[13]

- Counselling
- Inpatient and outpatient withdrawal management from alcohol and other drugs
- Opioid-agonist treatment (with methadone or buprenorphine)
- Treatment for people who use stimulants
- Information on drugs and alcohol
- Group programs
- Needles and syringes, for people who inject drugs
- Support for partners, family or friends
- Specialist advice for health professionals
- Specialist treatment for young people (16-24 years) and their families
- Hospital Consultation Liaison
- Telehealth

[12] NSW Government. South Eastern Sydney Local Health District. Drug & Alcohol Clinical Services Plan 2017. South Eastern Sydney Local Health District. Taren Point. NSW.

[13] https://www.svhs.org.au/our-services/list-of-services/alcohol-and-drug-service

- Gambling counselling.

In addition, St Vincent's operates a number of statewide telephone advisory services including:

- Alcohol and Drug Information Service (ADIS)
- Drug and Alcohol Specialist Advisory Service (DASAS), which was enhanced in 2019/2020.

St Vincent's similarly would have benefited from some of the NSW Government investments since 2016.

Primary care

There remains a dearth of pharmacies dosing OTP in the CESPHN area. Reference to the NOPSAD report 2018 indicates that at the time of publication of that report, there were zero dosing points in 33 out of 92 of the SA2[14] (Statistical Areas) across CESPHN.[15] There were a further 18 SA2s with only one dosing point. No update is available from NSW Health on total active pharmacies across CESPHN with the number being 38 in 2016.

As noted in 2016 there are over 2,000 GPs within the region, although the number of these that are formally involved in specialist AOD treatment is likely to be low. There were only 118 active accredited Opioid Treatment Program prescribers in the CESPHN region in 2016/17.[16] Notwithstanding this, the majority would have to address alcohol and other drug problems in some form in their day to day practice, as GPs should be expected to screen and brief assess for concerns. Therefore, while it is likely that only a handful are involved in the provision of OST or structured ambulatory detoxification, all GPs should be considered a potential part of the resource base to respond to problems, particularly for those requiring a brief intervention.

Non-government providers

The AIHW reports that the number of NGOs in the CESPHN region has risen from 27 to 41 between 2015/16 and 2017/18.[17] It is not clear if this is unique agencies or reflects the number of agency numerical identifiers including where an agency provides more than one service type, for example WHOS.

The NIAS funding package provided additional funding to CESPHN to support commissioning of services to meet objectives identified in the 2016 needs assessment. Table 1 details these services provided with new funds since 2016.

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[14] An SA2 area is roughly equivalent to a postcode.

[15] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/nopsad-2018/contents/opioid-pharmacotherapy-dosing-points

[16] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[17] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-phn/contents/phn-data-visualisations/aod-treatment-agencies

Table 1: CESPHN commissioned services since the 2016 needs assessment

Organisation	Funded program/activity
ACON Health LTD	• Substance Support Program • Pivotpoint website • LGBTIQ Inclusive guidelines for AOD treatment providers • LGBTIQ Inclusivity training for AOD workers
Community Restorative Centre	• AOD Transition Program for individuals exiting custody
We Help Ourselves (WHOS)	• Withdrawal Management Program within residential service • Aboriginal Engagement workers
Odyssey House Community Services	• AOD community treatment program
NSW Users and AIDS Assoc (NUAA)	• Consumer Academy (peer work training) • Volunteer Program (NSP) and Women's wellbeing groups
SESLHD	• GP Liaison in Alcohol and other Drugs 'GLAD' Project – a GP shared care program across SESLHD, SLHD and St Vincent's Health Network
SESLHD	• AOD Dialectical Behaviour Therapy program
SESLHD Recovery and Wellbeing College	• Courses developed and delivered for students who experience AOD use
Drug and Alcohol Multicultural Education Centre (DAMEC)	• Workforce development related to CALD community engagement
Family Drug Support	• Family Inclusive Practice training for AOD treatment services • Establishment of additional Family Support Meetings in the region
NADA	• Development of AOD Treatment Guidelines for working with Aboriginal and Torres Strait Islander People in a non-Aboriginal setting

The table below lists all the known NGO AOD service providers operating with CESPHN boundaries and includes those new services funded by CESPHN. CESPHN funding has contributed to the growth in overall NGO service provision with the number of NGO 'treatment agencies' operating in CESPHN increasing by over 50% since 2015/16.[18]

There are also private Opioid Treatment Clinics within the region including Regent House in Newtown and United Gardens in Summer Hill.

[18] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-phn/contents/phn-data-visualisations/aod-treatment-agencies

Table 2: Non-government AOD providers in CESPHN region (as provided by NADA and HealthPathways)

Organisation	Service
2 Connect	St George Youth Services
Alcoholics Anonymous (AA), Narcotics Anonymous (NA)	Self-help, peer led support groups.
ACON	ACON Substance Support Service
Aboriginal Medical Service	Drug and Alcohol Treatment Program
Exodus Youth Worx	Youth Support Services
Haymarket Foundation	Haymarket Foundation Bourke Street Project
	Haymarket Foundation Centre HIV/AOD Program
	Haymarket Foundation Waitlist Support Program
Odyssey House McGrath Foundation	Odyssey House Community Services
Salvation Army	Alf Dawkins Detox
	William Booth House
	Pathways Maroubra
Salvation Army OASIS Youth Sydney	SA Oasis Youth Drug and Alcohol Program/Choices
St Vincent de Paul Society	Continuing Coordinated Care Program
SMART Recovery Australia	SMART Recovery Groups
Ted Noffs Foundation	Program for Adolescent Life Management (PALM)
The Station Ltd	The Station
Waverley Drug and Alcohol Centre	Waverley Drug and Alcohol Centre
Waverly Action for Youth Services WAYS	Waverly Action for Youth Services WAYS
Womens Alcohol and Drug Advisory Centre	Jarrah House Detoxification
Wayback Committee	Jarrah House Rehabilitation
Alcohol and Drug Foundation NSW	Kathleen York House Aftercare
	Kathleen York House Residential
Alcohol and Drug Foundation NSW Catholic Care Holyoake Co.As.It.	Kathleen York House Transition
	Holyoake Family AOD Program
	Co.As.It.
Construction Industry Drug and Alcohol Foundation	Foundation House
Community Restorative Centre	Alcohol & Other Drugs Transition Project
Drug and Alcohol Multicultural Education Centre (DAMEC)	Drug and Alcohol Counselling for CALD communities (Culturally and Linguistically Diverse background)
Glebe House	Glebe House
Grace Manor	Grace Manor
Guthrie House	Guthrie House
Kathleen York House	Kathleen York House
Leichhardt Women's Community Health Centre	Leichhardt Women's Community Health Centre
Mission Australia	MA Centre - Drug and Alcohol Program
Sydney Women's Counselling Centre	Sydney Women's Counselling Centre
Weave Youth and Community Services Inc	WEAVE
WHOS	WHOS Sydney Gunyah
	WHOS Sydney MTAR Men
	WHOS Sydney New Beginnings
	WHOS Sydney OSTAR2
	WHOS Sydney Peppercorn
	WHOS Sydney RTOD
	WHOS Sydney Women's MTAR

Service utilisation measures

Global measures

The AIHW's Alcohol and Other Drug Treatment Services in Australia report covering the period 2017/18 indicates that there were 7,005 closed treatment episodes during that year in the CESPHN region provided to 4,359 clients. Clients in the CESPHN region were more likely to be older and female than the national average, and less likely to identify as being of Aboriginal and/or Torres Strait Islander origin. The AIHW report does not differentiate its data between service sectors and so the proportion of government and non-government service within the CESPHN region cannot be ascertained.

Of the clients receiving treatment, 32.6% attended for counselling, 20.8% for withdrawal management, 11% for rehabilitation and 15.7% for support and case management. Counselling services as a proportion of overall service provision has grown strongly since 2015/16. Almost 97% of all clients in the CESPHN region received services in a non-residential setting, which is nearly 10% higher than the national average (87%).

Closed treatment episodes provided in the CESPHN region had higher proportions of heroin and alcohol than the national average, and much lower proportions of cannabis users.

General hospital measures

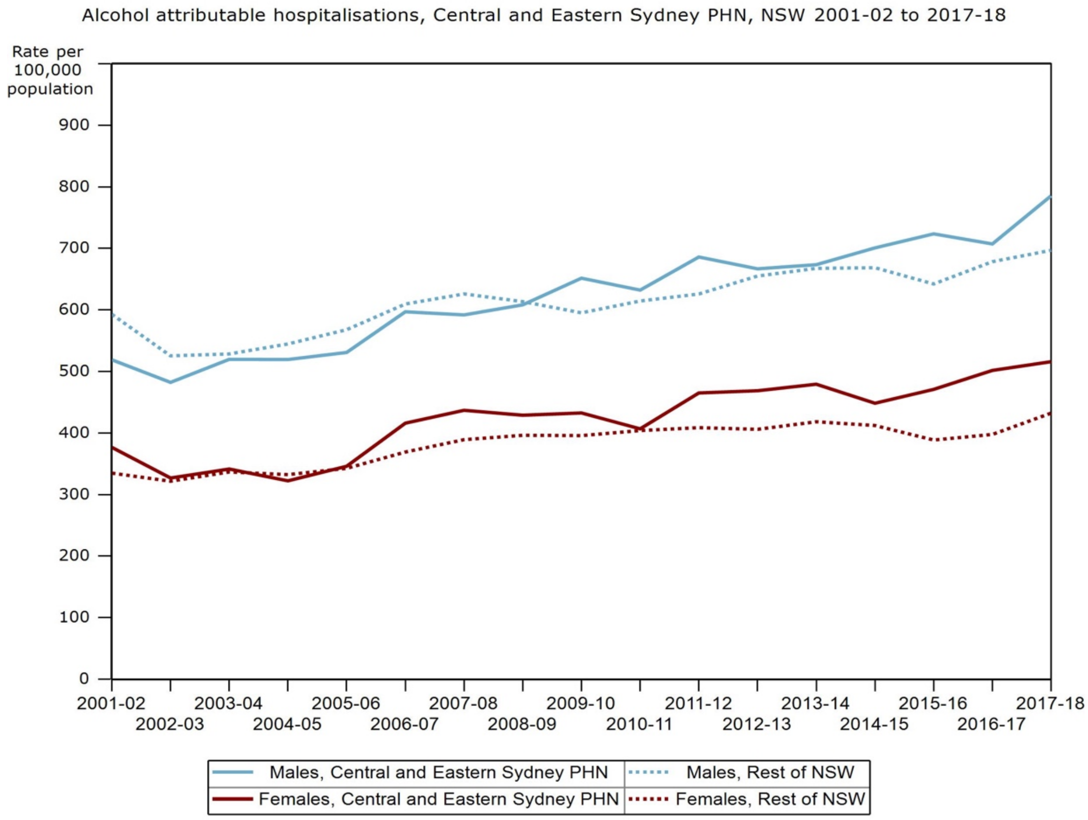
The NSW Healthstats website provides comparative data by LHD and PHN on indicators related to drug and alcohol use. There were 6,433 alcohol attributable hospitalisations for males across CESPHN in the 2017/18 financial year, and 4,446 for females. CESPHN had the highest absolute number for both genders and the second highest per capita rate for both genders behind NSPHN. The trend in alcohol hospitalisations within CESPHN, for both genders, has been steadily rising on per 100,000 population basis since the turn of the century.[19]

Alcohol related emergency department presentations are not published by PHN or LHD but on a state-wide basis. There has been a slight decline for 18-24 year olds and increasing gradually for 25-64 year olds. For those over 65 years the trend is stable.[20]

[19] http://www.healthstats.nsw.gov.au/Indicator/beh_alcafhos/beh_alcafhos_phn_trend?&topic=Alcohol&topic1=topic_alcohol&code=beh_alc

[20] http://www.healthstats.nsw.gov.au/Indicatorgroup/IndicatorviewList?IndicatorGroupCode=beh_alcedage&code=beh_alc&topic=topic_alcohol&name=AlcoholTopic

Figure 1: Alcohol attributable hospitalisations in the CESPHN region[21]



With regard to alcohol consumption around 29.3% of the CESPHN population consumed more than 4 standard drinks on a single occasion within the past four weeks on the sample date in 2018. This was the third highest percentage of the ten NSW PHN regions.[22] Alcohol consumption posing long term risks has been relatively stable for the last decade within the CESPHN region.

Methamphetamine hospitalisations are no longer published by LHD on Healthstats. The Ministry of Health advises that this is due to concern over the low frequency of cases providing misleading trends due to volatility of measurement. However, on a state-wide basis the rate has dropped from 137 per 100,000 persons in 2016/16 to 121.2 per 100,000 in 2017/18. Methamphetamine related emergency department presentations have similarly dropped on a state-wide basis from 3.0 per 1,000 unplanned presentations in 2015/16 to 2.4 per 1000 unplanned presentations in 2017/18.[23]

There are no available updates to the DRG data provided to CESPHN by the Commonwealth Department of Health in 2016.

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[21] Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au. Accessed November 13, 2019.

[22] http://www.healthstats.nsw.gov.au/Indicator/beh_alcsor_age/beh_alcsor_phn_snap?&topic=Alcohol&topic1=topic_alcohol&code=beh_alc

[23] http://www.healthstats.nsw.gov.au/Indicator/beh_illimethed/beh_illimethed?&topic=Drug%20misuse&topic1=topic_illi&code=beh_illi

Specialist AOD services

There have been substantial changes to the way service agreement activity volumes are purchased by NSW Health for drug and alcohol in the 2019/2020 LHD service agreements. The 2016 CESPHN needs assessment reported on closed treatment episodes and client numbers as a way of quantifying service utilisation in specialist LHD D&A services. This is no longer the approach used in the 2019/20 service agreements. For the first time Schedule D to the agreements, which details the purchased activity volumes in National Weighted Activity Units (NWAUs), include designated targets for specialist AOD services, whereas previously these were absorbed in global activity targets.

There are two targets, one for admitted AOD services and one for non-admitted. However, there is likely to remain block funded AOD services within the LHDs and these are not readily visible in the agreements. The activity targets for the LHDs within the CESPHN region are detailed in the table below.

Table 3: National Weighted Activity Units by LHD/LHN in 2019/20 service agreements

LHD	Non-admitted NWAU	Admitted NWAU
Sydney LHD	2,582	1,393
South Eastern Sydney LHD	3,393	349
St Vincent's Health Network	5,248	1,216

These NWAUs demonstrate the relative investment in admitted and non-admitted care across LHD/LHNs, as NWAU are standardised comparable measures of purchased activity. This will allow the PHN to identify the relative prioritisation of new AOD service investment within LHD/LHNs. It will also allow comparison across AOD service types. For example, it is noteworthy the low level of admitted care purchased in SESLHD.

The other change is a performance requirement to maintain the number of consultation liaison consultations from prior years. The measures from prior years of withdrawal episodes, outpatient episodes and OTP clients have been dropped. This will require a recalibration of activity measurement with 2019/20 providing a baseline for LHD investment in future years. Quantifying continued block funding in this context will be important as this is not measured in NWAU calculations.

Primary care services

No data was available on MBS or OTP service provision for this analysis. The NOPSAD study provides state-wide data on dosing and prescribing but does not allow comparisons across PHNs. This is important as there is wide variability across PHNs in OTP provision and state-wide data does not assist in making investment or planning decisions. The points made in the 2016 needs assessment regarding GP shared care arrangements with AOD patients are still valid and were referenced again as part of the qualitative consultation.

CESPHN funded services

NADA has provided from their NADABase, activity measurement tool data on services that CESPHN provides funding to where services are provided within the CESPHN boundaries. These are summarised below. Not all service activity within the table is funded by CESPHN.

Table 4: No. of clients and episodes of care by all agencies funded by CESPHN, 2018/19

Distinct clients	Episodes
1,528	1,810

Ambulance callouts to opioid overdoses

SESLHD provided data on administration of Naloxone for opioid overdose by NSW Ambulance services. The data demonstrates that the two highest LHDs for opioid overdose responses, both in absolute terms and per head of population, for most of the last three measurement periods are SLHD and SESLHD (noting Illawarra had the second highest per head rate for one quarter).

Table 5: Administration of Naloxone by Ambulance NSW, by LHD

LHD	LHD population (2010 estimate)	Administrations (estimated)			Crude rate (per 100,000 pop.)		
		Jan - Mar 2017	Jan - Mar 2018	Jan - Mar 2019	Jan - Mar 2017	Jan - Mar 2018	Jan - Mar 2019
South Eastern Sydney	**841,501.7**	**117.3**	**113.7**	**130.1**	**13.9**	**13.5**	**15.5**
Illawarra Shoalhaven	381,698.3	38.1	33.1	54.0	10.0	8.7	14.2
Sydney	**574,552.3**	**95.0**	**83.4**	**71.9**	**16.5**	**14.5**	**12.5**
South Western Sydney	865,185.3	88.9	92.5	98.2	10.3	10.7	11.3
Western NSW	270,805.9	25.0	24.8	30.0	9.2	9.2	11.1
Mid North Coast	205,788.3	17.0	25.8	21.7	8.3	12.5	10.6
Western Sydney	831,839.4	66.8	65.6	80.2	8.0	7.9	9.7
Murrumbidgee/Albury	284,572.6	26.0	23.0	23.0	9.1	8.1	8.1
Central Coast	320,361.0	32.2	32.0	23.8	10.1	10.0	7.4
Nepean Blue Mountains	346,048.7	38.4	37.0	23.7	11.1	10.7	6.9
Hunter New England	866,408.7	68.1	73.6	59.4	7.9	8.5	6.9
Northern NSW	286,301.0	33.1	26.9	17.0	11.6	9.4	6.0
Southern NSW	195,091.1	14.0	17.0	10.5	7.2	8.7	5.4
Northern Sydney	842,812.3	35.1	36.7	27.5	4.2	4.4	3.3
Total	**–**	**695**	**685**	**671**	**9.8**	**9.6**	**9.4**

This suggests that within the CESPHN region, opioid use leading to overdose is a more substantial problem than elsewhere in NSW. This may reflect the historical supply centres within CESPHN rather than the needs of the resident population, however it indicates a disproportionate need to address high risk opioid use within CESPHN boundaries.

Both the Commonwealth and NSW Governments have allocated funding to projects to provide greater access to naloxone for injecting drug users. CESPHN should give consideration to appropriate partnership arrangements to build on these funding opportunities and respond to the disproportionate need in this area.

Population measures of need

Prevalence data

Identification of the population prevalence of relevant disorders is the first step in identifying service delivery need for a given specialty. The 2016 needs assessment details the role of measuring population prevalence in service planning.

The source of the data modelling used in this needs assessment is the Drug and Alcohol Services Planning (DASP) model developed through the Ministerial Council on Drug Strategy (MCDS) and now managed by its antecedent in the COAG structure, the Ministerial Drug and Alcohol Forum (MDAF). The national DASP model is currently being used by Local Health Districts and state health Departments to undertake planning for AOD service need. This makes it an appropriate tool for the PHN to align its planning to as it ensures congruence with LHD planning activity.

'NSW Health has used the outputs of the Drug and Alcohol Services Planning model, along with other service utilisation analyses, to inform activity purchasing discussions with LHDs from the 2019-20 fiscal year onwards. This analysis has contributed to a greater focus on the equity of access to all drug and alcohol-related treatment services across NSW local health districts and networks, and a better understanding of the relative mix of services needed by setting, for example in the admitted, non-admitted ambulatory and residential setting. It has resulted in greater emphasis on enhancing the provision of non-admitted drug and alcohol treatment services.'[24]

'Other factors such as population demographics, changing patterns of drug use, new treatment evidence, funding from different levels of government, local service needs and health system innovation are [also] considered.'[25]

The technical materials presented in the 2016 needs assessment, particularly the technical explanation of the DASP model and its calculations for service configuration need, will not be reproduced here. Reference should be made to the 2016 assessment if a detailed explanation of the DASP model and data is required.[26]

The DASP predicts that for every 100,000 people in a broadly representative population the number with a diagnosable alcohol or other drug disorder is as shown below:[27]

- 8,838 will have an alcohol use disorder
- 646 will have a methamphetamine disorder
- 465 will have a benzodiazepine misuse disorder
- 2,300 will have a cannabis misuse disorder
- 793 will have a non-medical opiate (including heroin) misuse disorder.

The tables below translate these rates to the current and future populations of the CESPHN region and provides an age breakdown of likely presentations to assess the need for particular configurations or modalities of service delivery.

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[24] Special Commission of Inquiry into the drug 'Ice', submission number 143. NSW Government submission in response to the issues papers. Paragraph 9.13. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

[25] Ibid. Paragraph 9.12.

[26] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[27] See 2016 Needs assessment for breakdown of this epidemiology.

Table 6: CESPHN estimated population prevalence of drug disorders at 2018 and 2031

Drug Disorder Type	Standard population rate	Population prevalence - 2018	Population prevalence - 2031
Alcohol	8,838	144,680	167,922
Methamphetamine	646	10,575	12,274
Benzodiazepine	465	7,612	8,835
Cannabis	2,300	37,651	43,700
Non-medical opiate	793	12,981	15,067
Total	**13,042**	**213,499**	**247,798**

Table 7: Age breakdown of CESPHN estimated prevalence of drug disorders at 2018 and 2031

Age Cohort (years)	Standard population rate	Population prevalence - 2018	Population prevalence - 2031
12-17	1,716	28,091	32,604
18-64	9,662	158,168	183,578
65+	1,664	27,240	31,616
Total	**13,042**	**213,499**	**247,798**

As noted in 2016, the above numbers are representative of all population groups as they would appear on an average basis within the general population. If a particular geography has an over-representation (above average) of a particular high, or low, prevalence group then that requires reweighting of the estimates.

A brief note on wastewater analysis

One of the funded initiatives resulting from the National Ice Action Strategy (NIAS) was the analysis of wastewater treatment sites for the presence of metabolites associated with the excretion of illicit drugs. The Australian Criminal Intelligence Commission was funded to test wastewater at sites across Australia and make estimates of the prevalence of drug use. This is a technique used in Europe and North America to monitor drug trends.[28]

Seven reports have been prepared to date with the most recent released in April 2019. The seventh report covered wastewater sites aligned to 54% of the Australian population. There were 8 sites in NSW, 3 in the city and 5 in the regions, however these have not been made public.

The National Wastewater Drug Monitoring Program found that, compared to August 2018, of the substances tested in December 2018 in NSW:[29]

- average alcohol consumption decreased in capital city sites and increased in regional sites
- average methylamphetamine consumption increased in both capital city and regional sites
- average cocaine consumption decreased in capital city sites and increased in regional sites
- average MDMA consumption increased in capital city sites and decreased in regional sites
- average MDA consumption increased in both capital city and regional sites
- average oxycodone consumption decreased in capital city sites and increased in regional sites
- average fentanyl consumption decreased in capital city sites and increased in regional sites

[28] https://www.acic.gov.au/publications/intelligence-products/national-wastewater-drug-monitoring-program-report

[29] https://www.acic.gov.au/media-centre/media-releases-and-statements/wastewater-results-show-high-levels-cocaine-heroin-and-mda-consumption-new-south-wales

- average heroin consumption increased in both capital city and regional sites
- average cannabis consumption decreased in both capital city and regional sites.

Wastewater analysis is potentially a useful adjunct to other population prevalence measures however it does not provide any delineation of treatment need as it does not discriminate who was using the substances and what their diagnostic situation may be. It is reported here for completeness and to allow for monitoring of global use trends, as it may provide a more robust alternative to the National Drug Strategy Household Survey (NDSHS) over the medium term.

Population modelling

The 2016 needs assessment began with a baseline measure of population need based on the DASP model, a population prevalence based tool. Ascertaining the expected population prevalence of disorders allows for the development of a model to stream this expected prevalence into the menu of available service responses. DASP uses the best available evidence and relies on the balance of clinical opinion when there is no published alternative.[30] The national DASP modelling process utilised a review of the available literature and the input of approximately 200 experts in the field to identify an appropriate estimate of treatment service need.[31]

Some assumptions of the DASP related to residential rehabilitation have been subject to review since 2016. A specific piece of work was undertaken by the DPMP at UNSW, the original devisers of the DASP, to model residential rehab bed rates.[32] This is the only element of the DASP modelling that has been assessed for change.

There is as yet no agreed process endorsed by MDAF for formal updates to the DASP model. This suggests that any modifications in published form should be treated circumspectly and for planning purposes PHNs would be wise to stick to outputs that match those being used by other planning bodies. It should also be noted however that the DPMP was the organisation with responsibility for original derivation of the model outputs and as such their work should be ascribed some weight in decision making.

The targets below are based on the same estimates of treatment rates and population need as the 2016 assessment. In turn it should be noted that the 2016 assessment was based on the figures released from the DASP via the Western Australian Mental Health Commission as the full DASP was unavailable.

It is expected that the DASP will continue to be reviewed and modified as new research becomes available or as more effective treatment models are developed. These changes must be monitored and adjustments to modelling made accordingly.

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[30] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[31] Ibid.

[32] Richard Mellor and Alison Ritter (2019). Modelling bed numbers for NSW using the Drug and Alcohol Service Planning Model (DASPM). Drug Policy Modelling Program, SPRC, UNSW.

Table 8: Estimated AOD resourcing needs in the CESPHN region[33]

Service Type	Quantum needed 2018 (population 1.637 million)	Quantum needed 2031 (population 1.90 million)
Community Support Services		
Harm Reduction and Personal Support (hours per annum)	126,600	147,900
Post residential rehabilitation support (hours per annum)	32,740	38,000
Community based bed services		
Low medical withdrawal (beds)	31	36
Residential Rehabilitation (beds)	457	531
Community based treatment services		
Non-residential treatment (hours per annum)	1,220,100	1,416,270
Hospital based services		
Complex medical withdrawal (beds)	69	80
Consultation liaison for both MH and D&A (hours per annum)	183,350	212,600
Diversion Services		
Community Diversion Programs (hours per annum)	102,600	119,130

A challenge for PHNs is to garner the available resources and support across multiple sectors and levels of government to audit existing service provision against these targets. This remains a need nationally, in order to allow for effective treatment service planning.

Similarly, some standardisation of the 'units' of service purchased (e.g. beds or episodes of care or hours of service or FTE employed) in commissioning decisions and associated performance measures would assist greatly in improving commissioning decisions in all PHNs.

The figures in the table above provide a global baseline for service delivery in the CESPHN region. Some of the described treatment services are not within the PHN area of funding responsibility however their availability or otherwise has a flow on effect to those service streams within the PHN remit.

Screening and brief Intervention

The DASP modelling also attempts to estimate population level requirements for screening of at risk patients in the primary care setting. It does this through estimates of risk by drug type and age group. The resultant calculations provide an estimated number of screening interventions that are necessary for a standard population.[34] These rates have not changed since the 2016 needs assessment with the estimates updated for current population projections. Data is not available on current screening rates and volumes but it should be noted that the estimates below would require every GP in the CESPHN region to undertake at least 200 interventions per year.

[33] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW. The 2016 assessment utilised the DASP figures published in the 2015-25 Western Australian Mental Health and Drug & Alcohol Plan developed by the Western Australian Mental Health Commission.

[34] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

Table 9: No. of screening interventions per year required in the primary care setting by drug type for a standard 100,000 population and the CESPHN population

Drug Type	Standard pop rate of screening interventions	CESPHN population 2018 (1.637 million)	CESPHN population 2031 (1.90 million)
Alcohol	14,617	239,280	277,720
Amphetamine	896	14,660	17,020
Cannabis	9,270	151,750	176,130

Populations with special considerations

As stated above disproportionate representation of particular populations can lead to minor modifications to distributions in the model. At the level of a state these representative differences lead to only trivial changes to the model's outputs, however at smaller levels of geography where clusters of sub-groups can occur, the difference can be more material. In practical terms, particular clusters are best addressed with specialist services that then deduct from the overall general resource base that is required.[35]

This section updates the available research on the populations below to assess if there are have been any changes requiring adjustments to service planning. By necessity it deals only with research that has become available since the 2016 needs assessment. It does not seek to document the outcomes of the consultation process and the qualitative information available there. The data in this section should be considered alongside the qualitative feedback to create the most comprehensive assessment. For a given population if there is no new material then the assumptions of the 2016 needs assessment will be retained.

Aboriginal and/or Torres Strait Islander peoples

Illicit drugs have been estimated to cause 3.4% of the burden of disease and 2.8% of deaths among the Aboriginal and/or Torres Strait Islander population compared to 2.0% and 1.3% among the non-Indigenous population. Aboriginal and Torres Strait Islander males are hospitalised for conditions, to which alcohol makes a significant contribution, at rates between 1.2 and 6.2 times those of non-Indigenous males, and Aboriginal and Torres Strait Islander females at rates between 1.3 and 33.0 times greater. Similarly, deaths from various alcohol-related causes are 5 to 19 times greater than among non-Indigenous Australians.[36]

Suicide is strongly associated with harmful use of AOD. Rates of suicide are substantially higher in Aboriginal and Torres Strait Islander peoples, accounting for 4.2% of all Aboriginal and Torres Strait Islander deaths compared to the 1.6% national suicide rate. In Queensland, from 1998 to 2006, two-thirds of Aboriginal and Torres Strait Islander people who died by suicide had consumed alcohol, and more than one-third had used drugs such as cannabis, amphetamines, inhalants or opiates at the time of their deaths.[37]

In 2017-18 the AODTS-NMDS indicated that 16% of all clients in AOD services nationally were Indigenous, and Indigenous Australians were 7 times more likely to receive AOD services than non-Indigenous Australians.[38]

[35] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[36] Commonwealth Government 2014. The National Aboriginal and Torres Strait Islander People's Drug Strategy. Updated November 2017.

[37] Commonwealth Government 2014. The National Aboriginal and Torres Strait Islander People's Drug Strategy. Updated November 2017.

[38] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18-key-findings/contents/clients

The 2016 needs assessment noted the Aboriginal and Torres Strait Islander communities have varied drug and alcohol use patterns compared to the non-indigenous communities, with Indigenous people 1.5 times more likely to be abstainers from alcohol, but for those who do drink they are 1.1 times more likely to drink in a high-risk pattern. Indigenous people were twice as likely to engage in short term binge drinking than non-Indigenous people. Approximately 22% of indigenous persons indicated they had used an illicit drug in the last twelve months, compared to 15% in the general population.[39]

Recent interest in methamphetamine prevalence has identified that Aboriginal people are 2.2 times more likely to use methamphetamines than non-Indigenous people,[40] are around five times more likely than non-Indigenous people to be hospitalised for conditions related to methamphetamine use,[41] and account for 10% of all patients with methamphetamine-related hospitalisations.[42]

The DPMP identified that additional care elements are needed for Aboriginal people in their modelling work for Aboriginal service need. *'The care elements identified for appropriate and evidence-based clinical care for Aboriginal clients included attention to kinship and family relationships; greater time and flexibility in providing immersion in cultural activities; the need for transport; greater time in counselling to address complex issues, needs and comorbidities; additional ongoing care and assertive follow-up; enhanced tobacco intervention; and return to country/community. Only a proportion of Aboriginal clients will require some of these.'*[43]

The number of CESPHN residents that identified as Aboriginal and/or Torres Strait Islander was 13,489 (0.8%) in 2016.[44] The distribution of Aboriginal and/or Torres Strait Islander residents varies by sub-region with the highest proportion residing in the Inner Sydney City (3,604 persons), followed by Eastern Suburbs South (2,806 persons) and Sutherland-Menai-Heathcote (1,454 persons).[45] There is no additional data available to suggest that the impact of Aboriginal service need on population need has changed since 2016, however the impact of methamphetamine use on this population should continue to be monitored.

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[39] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[40] Australian Institute of Health and Welfare, Commonwealth, National Drug Strategy Household Survey 2016: detailed findings (Report, 2017).

[41] Centre for Population Health, New South Wales Government, Methamphetamine Use and Related Harms in NSW - Surveillance Report to December 2017 (Report, 4 April 2018)

[42] HealthStats NSW, New South Wales Government, 'Methamphetamine-related Hospitalisations', HealthStats NSW (Web page, 23 March 2018)

[43] Gomes M, Ritter A, Gray D, Gilchrist D, Harrison K, Freeburn B and Wilson S (2014). Adapting the Drug and Alcohol Service Planning Model for Aboriginal and Torres Strait Islander people receiving alcohol, tobacco and other drug services: Components of care and a resource estimation tool. Drug Policy Modelling Program, NDARC, UNSW.

[44] https://www.cesphn.org.au/documents/planning-strategy-and-evaluation/2853-snapshot-eis-health-annual-report-2018-19-final-digital/file

[45] Estimated resident Aboriginal and Torres Strait Islander and Non-Indigenous populations, SA2 - 30 June 2016 found at https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.0.55.001June%202016?OpenDocument.

LGTBIQ+ Community

The 2016 NDSHS found that, compared with heterosexual people in the previous 12 months, homosexual/bisexual people were:[46]

- 5.8 times as likely to use ecstasy (11.0% compared to 1.9%)
- 5.8 times as likely to use meth/amphetamines (6.9% compared to 1.2%)
- 3.7 times as likely to use cocaine (8.9% compared to 2.4%)
- 3.2 times as likely to use cannabis (31.4% compared to 9.7%)
- 2.8 times as likely to misuse pharmaceuticals (12.0% compared to 4.3%).

After adjusting for differences in age, people who were homosexual or bisexual were still far more likely than others to use illicit drugs and misuse pharmaceuticals.[47]

Data from the Sydney Gay Community Periodic Survey (SGCPS) 2018, a large cross-sectional survey of gay and homosexually active men recruited at gay community sites in Sydney, indicates rates of crystal methamphetamine use among gay and bisexual men (GBM) decreased from 14.6% in 2010 to 10% in 2018. In HIV-positive gay men, crystal methamphetamine use decreased from 35.9% in 2010 to 27.4% in 2018.[48] *'Drug use remained common within the sample however, with 65.4% reporting any drug use in the six months prior to the survey. The most frequently used drugs were amyl/poppers (45.2%), cannabis (31.9%), ecstasy (25.6%), cocaine (27.6%), Viagra or other erectile dysfunction medication (23.5%), and GHB (13.0%). Since 2014, there have been significant declines in the use of amphetamine/speed and crystal methamphetamine, alongside a significant increase in the use of amyl, Viagra, cocaine, ketamine, and GHB.'*[49]

The 2018 Sydney Women and Sexual Health (SWASH), a comprehensive survey of health issues relevant to lesbian, bisexual, queer (LBQ) recruited at a community sites in Sydney, reported about 45% of LBQ women reported recent use of illicit drugs (within the last 6 months), compared to 13% of Australian women and 12% reported recent crystal methamphetamine use.[50]

The *First Australian National Trans Mental Health Study* found that trans and gender diverse people were twice as likely to have used an illicit drug as the general population in the last 12 months, including twice as likely to have used ecstasy and more than three times as likely to have used some form of amphetamine.[51]

The Following Lives Undergoing Change (Flux) Study (2018) reports that over the past four years, on average around a third of men use drugs such as ecstasy, speed, cocaine, crystal, GHB, ketamine, LSD. Most of those men, however, only use these drugs very infrequently, that is, once or twice in six

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[46] Special Commission of Inquiry into the drug 'Ice', submission number 77. AIDS Council of NSW (ACON) submission in response to the issues papers. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

[47] Ibid.

[48] Ibid.

[49] Broady, T., Mao, L., Lee, E., Bavinton, B., Keen, P., Bambridge, C., Mackie, B., Duck, T., Cooper, C., Prestage, G., & Holt, M. (2018). Gay Community Periodic Survey: Sydney 2018. Sydney: Centre for Social Research in Health, UNSW Sydney.

[50] Special Commission of Inquiry into the drug 'Ice', submission number 77. AIDS Council of NSW (ACON) submission in response to the issues papers. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

[51] Ibid.

months, and that these rates have remained stable over the four years of the study. The SWASH study also reports no increase of ATS use among LBQ women over the past 6 years.[52]

In 2016 it was noted that studies investigating relative levels of alcohol dependence in the LGTBI community and the general population have found that amongst women there is a higher prevalence rate for those that identify as LGTBI than the general population but this effect is not as clear for men. With regard to drug dependence the findings are clearer, with the majority of studies finding significantly higher dependence rates in the LGTBI community than the general population, and this effect was found for both genders. The effect for men was approximately 1.33 times then the general population but for women the rate was approximately 3 times higher.[53]

The impact on CESPHN of population prevalence amongst the LGTBIQ+ community remains the same as 2016. There is no evidence of substantial changes in concentration within CESPHN for this community. ACON estimates that the non-heterosexual population makes up between 3.2% and 11% of the Australian community[54] and favoured residential areas and community centres for this population remain within CESPHN boundaries. It is noted that CESPHN has funded ACON for additional services to this group however there is currently a wait for access and demand continues to grow.[55]

Persons recently in contact with the criminal justice system

Between 2012 and 2018 the prison population in NSW grew 40% from 9,602 inmates to 13,630. As at June 2019, the adult prison population was 13,403; 23% of whom identify as Indigenous Australians. In the 12 months ending June 2019, 19,394 people entered into custody and 19,664 people were discharged. That means, on average, 54 people a day enter the prison system in NSW and 55 leave it.

In 2015 two- thirds of the prison population were using crystal methamphetamine before entering custody and 41% of all inmates were using methamphetamines daily prior to their incarceration. In 2015, which is when the last comprehensive Justice Health survey was conducted, there were 16,106 people who entered into custody which means that in that year around 6,700 inmates must have detoxed from methamphetamine in custody, and this figure does not include people who are detoxing from other drugs.[56] Applying the rate used in 2015, that means that last year [2019] around 8,000 people entered into custody with an active methamphetamine use. That's approximately 22 people per day.[57] The majority of these leave prison again within the same year.

Dr Mandy Sotiri of the Community Restorative Centre gave evidence to the Special Commission of Inquiry into the drug 'Ice' *that '10% of people in prison have come from primary homelessness and around 26% have come from unstable accommodation. At least 4,000 people each year are released from custody into homelessness. Seventy per cent of inmates have problematic alcohol or other drug use, around 60% have mental illness and 15% have a cognitive impairment. Most people in prison are themselves victims of crime. 70 per cent of women in prison are survivors of trauma as children or*

52 Ibid.

53 Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

54 Special Commission of Inquiry into the drug 'Ice', submission number 77. AIDS Council of NSW (ACON) submission in response to the issues papers. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

55 Email communication from Sarah Lambert to David McGrath on October 17, 2019.

56 Senior Counsel Assisting Sally Dowling SC, transcript of Proceedings of the Special Commission of Inquiry into the Drug Ice. Custodial Services and community corrections hearing. Monday, 2 September 2019. Accessed @ https://www.iceinquiry.nsw.gov.au//assets/scii/transcripts/custodial-services-and-community-corrections/20190902-Custodial-Hearing-Transcript.pdf on November 17, 2019.

57 Ibid.

adults and 24% of women in prison were in out of home care when they were children.'[58] This is a very complex population and one that is growing at a rate much faster than the general population.

The 2016 needs assessment noted that *'the relevance of this to CESPHN becomes clear when an analysis of the place of residence for prisoners on release is considered as detailed in the NSW inmate survey. The survey mapped released prisoners against the configuration of Area Health Services at that time. CESPHN covered the northern half of SESIAHS and the North Eastern half of SSWAHS. The NSW inmate survey identified that 37.2% of all released prisoners were released to SESIAHS and SSWAHS. If an assumption is cast, perhaps erroneously, that CESPHN covers half of this prior AHS population then approximately 19% of all prisoners in NSW could possibly be released to the remit of CESPHN.'* There is no evidence to suggest that the distribution of prisoners upon release has changed and simultaneously the size of the population is growing. This is a cohort that requires planning investment on the part of CESPHN.

It is noted that CESPHN has funded the CRC to work with this group however with the volume growth and the likelihood that 7 people per day[59] with substance misuse histories are being released from prison to reside in the CESPHN area this additional funding would have had little impact on the service gap against population need. The funding aims to engage 100 people over a 12-month period, and while the agency has exceeded these performance targets there is still a substantial gap.[60]

Culturally and linguistically diverse communities (CALD)

As noted in the 2016 needs assessment, *'it is very difficult to identify rates of alcohol and other drug use in CALD communities. Australian national surveys tend to be administered in English and there are limitations in the way data is collected, which undermines understanding the differences in substance use, prevalence and harms within CALD populations and comparatively between groups.'*[61]

Analysis of data from the NDSHS suggests that overall AOD rates amongst CALD respondents are lower than non CALD communities.[62] Data from 2018/19 from the Drug and Alcohol Multicultural Education Centre (DAMEC) suggests that 'Ice' is the highest ranking illicit primary substance of concern for their CALD clients seeking treatment.[63]

DAMEC notes that 'pre-migration experiences of forced displacement, torture and trauma can increase AOD consumption while other risk factors include the loss of economic, family or social identity, disruption to traditional parenting relationships which can impact on the ability to discipline young people, and adaptation to Australian settings where certain substances may be more widely available and use is tied to social practices.'[64]

DAMEC estimates that about 6% of all AOD specialist service presentations relate to CALD clients. As noted in 2016 the proportion seeking treatment is much lower than the general resident population proportion, for example, despite 43% of the SLHD population speaking a language other than English at home, these people make up only 7% of AOD inpatient separations and 4% of outpatient

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[58] Ibid.

[59] This is based on 50 people released per day, with 20% residing in CESPHN (10 persons) and 70% of those released having a substance misuse history (7 persons).

[60] CESPHN performance report to the Commonwealth 2017/18.

[61] Special Commission of Inquiry into the drug 'Ice', submission number 139. Drug and Alcohol Multicultural Education Centre (DAMEC) submission in response to the issues papers. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

[62] Ibid.

[63] Ibid.

[64] Ibid.

separations between 2011 and 2014.[65] Under-representation of CALD communities in AOD treatment is continuing with little improvement in recent years and there remains no existing cultural assessment framework within the drug and alcohol sector that considers the specific needs of CALD communities.[66] Addressing the underlying factors for this under representation is merited.

It is noted that DAMEC have been funded by CESPHN to improve service engagement practices with CALD communities. This is not specifically a demand management strategy but does contribute to overall capacity building. CESPHN may wish to establish a data collection over time to monitor the impacts of this.

Homelessness

The 2016 needs assessment noted *'the population of individuals who are homeless have higher prevalence rates of drug and alcohol dependence disorders than the general population. A meta-analysis of studies from western countries assessed the pooled prevalence estimate of alcohol dependence at 37.9% of the homeless population. Similarly, the pooled prevalence estimate of drug dependence was 24.4% of the homeless population. Both of these rates are many magnitudes higher than for the general population.'*[67]

There is a dearth of data on this population. The AIHW collects data annually from Specialist Homelessness Services (SHSs) with data from the 2017/18 survey indicating that 7.5% of those seeking assistance from SHSs did so for problematic drug or substance misuse.[68] Data presented in the Inner City Sydney Registry Week Report, published in 2016, was obtained from surveying 516 people experiencing homelessness, who were either rough sleeping or in crisis accommodation, boarding houses or Temporary Accommodation. The report notes that 36% of the sample reported using intravenous drugs, 37% reported using alcohol daily for 30 days straight and 72% reported substance abuse.[69] No other new data was found.

There are were 13,180 homeless people within CESPHN boundaries in 2016, which makes up 35% of the entire NSW homeless population.[70] While the total numbers are relatively small as part of the general population, their needs are orders of magnitude higher, and they remain disproportionately represented in CESPHN.

Young People

In 2017/18, there were 743 instances of methamphetamine related public hospital admissions amongst young people aged 16 – 24, an 18.6% decline from the peak of 913 persons in 2015/16.[71] In

[65] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[66] Jaworksi, A., Green, B., Rowe, R., & Mayol, A. (2019) *Boosting understanding, Enhancing communication, and Supporting change (BES Project) Alcohol and other drug treatment needs among Western Sydney's CALD communities,* Sydney: DAMEC & Went West Primary Health Network.

[67] Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW.

[68] Special Commission of Inquiry into the drug 'Ice', submission number 33. Homelessness NSW submission in response to the issues papers. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

[69] Ibid.

[70] Australian Bureau of Statistics. 2049.0 - Census of Population and Housing: Estimating homelessness Canberra: ABS; 2018 [Available from:https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2049.0Main+Features12016?OpenDocument.

[71]http://www.healthstats.nsw.gov.au/Indicator/beh_illimethhos/beh_illimethhos_age_snap?&topic=Drug%20misuse&topic1=topic_illi&code=beh_illi

2017/18 there were also 860 methamphetamine related emergency department presentations of persons 16-24 years across NSW, a 25.6% decline on the peak in 2015/16.[72]

While drug use is declining, across Australia in 2017/18, 39.2% of the 134,000 clients seen nationally were aged under 30. In CESPHN this proportion was much lower with those under 30 years only accounting for 27.8% of the 4,359 clients recorded in the AIHW data set.[73]

In NSW in the 2016/17 financial year rates of emergency department visits for drug overdose were highest among young people aged 15- 24 years.[74]

According to the NDSHS 2016 the proportion of those 14–19 years consuming 5 or more drinks at least monthly significantly declined between 2013 and 2016 (from 25% to 18%) and has more than halved since 2001 (39%). There were no significant declines between 2013 and 2016 in illicit drug use in the same age group. For those in their twenties the only illicit drug to decline was amphetamines.[75]

The Australian Secondary School Students Survey of Alcohol and Drug Use (ASSAD) 2018 reported on data collected in 2017. This survey indicated that fewer students are drinking alcohol since 2011 down from 74% to 66%, with 15% drinking in the last week. Use of illicit drugs remains low in this group with 2% having used opiates, 2% cocaine and 3% ecstasy.[76]

There has been a steady downward trend in use of alcohol and illicit drugs amongst secondary school students reflecting a potential change in attitudes and behaviours. Modelling for this group generally promotes outpatient engagement and community-based approaches. The ongoing need for residential care options should be monitored.

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[72] http://www.healthstats.nsw.gov.au/Indicator/beh_illimethed/beh_illimethed_age_snap?&topic=Drug%20misuse&topic1=topic_illi&code=beh_illi

[73] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-phn/contents/phn-data-visualisations/client-demographics

[74] Special Commission of Inquiry into the drug 'Ice', submission number 122. Youth Action NSW submission in response to the issues papers. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

[75] Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.

[76] Guerin, N. & White, V. (2018). ASSAD 2017 Statistics & Trends: Australian Secondary Students' Use of Tobacco, Alcohol, Over-the-counter Drugs, and Illicit Substances. Cancer Council Victoria.

Outcomes from the consultation

The development of this needs assessment was built on an extensive consultation process. The consultation was designed to triangulate advice from diverse sources of expertise on current experiences in the AOD field. Three methods were used to aggregate advice from approximately 100 individuals with experience in the AOD field within the CESPHN region.

Individuals who participated in existing consultation structures within the CESPHN governance structure were consulted in a group within the usual meeting agenda for that structure.

Telephone interviews were conducted with individuals who represented particular viewpoints and a set of structured questions were proposed that formed the initiation point for evidence gathering. Interviews then proceeded dependent upon the initial responses to the structured questions. In many cases this led to follow up data being provided by the interviewee.

The third approach was to provide structured questions to agencies in email format and use the response to generate follow up questions. This approach was generally utilised where an initial telephone interviewee wished to seek advice from multiple colleagues in a large organisation, or where logistics precluded a telephone interview.

In addition, a final stakeholder forum was scheduled for anyone interested who had not previously been contacted through the earlier methods.

The participants in the interview process were:

- CESPHN Advisory Structures – CESPHN Community Council, CESPHN Clinical Council, CESPHN Mental Health Suicide Prevention (MHSP) Advisory Group.
- Current CESPHN Commissioned Service Providers – A representative was contacted from all 15 currently contracted AOD service providers and an interview conducted with at least one member of each agency.
- CESPHN AOD Advisory Group – Individual members of this advisory group were contacted for one on one telephone interviews. Some members were contacted as part of other identified groups but of those not otherwise covered 76% (16) of them were interviewed.
- Representatives from Aboriginal service providers – A small group forum was held with specialist Aboriginal service providers from Tribal Warrior and St Vincent's Hospital. Additionally, interviews were held with Redfern AMS and with Aboriginal elders from the Eastern part of the PHN catchment.
- Representatives of NSW Health – Interviews were held with representatives of the Ministry of Health, Sydney Local Health District, South Eastern Sydney Local Health District and St Vincent's Health Network.
- Peak bodies representing areas of the AOD field – This included the Network of Alcohol and Drug Agencies (NADA), the Mental Health Co-ordinating Council (MHCC) and the Drug and Alcohol Multicultural Education Centre (DAMEC).

The outcomes from the consultation addressed here reflect qualitative responses from participants. Where data was provided to support an assertion that data appears in other sections of this document. Four key areas of inquiry arose from the consultation and these are addressed sequentially.

Changes to the drug use market or drug using population

Participants were questioned on observed changes to patterns of drug use or to the nature of the cohort using drugs within the context of their particular professional perspective. Participants were asked to target their advice to changes over the last three years since the 2016 needs assessment.

There was relatively uniform agreement that methamphetamines and alcohol were the two most commonly occurring sources of substance related problems within the CESPHN catchment. These substances remain the two most prevalent causes of drug related harm in the opinion of those questioned. Those working in the mental health field felt that the number of individuals using methamphetamine was decreasing but harm and case complexity was increasing. The current public discourse related to increasing methamphetamine related harms, and particularly crystal methamphetamine ('Ice') related harms, was reiterated by many consultation participants. The unpredictable and potentially volatile behaviour of service users was referenced, along with the increasing propensity to disinhibited behaviour such as unprotected sex, or spontaneous violence. Increasing mental health co-morbidities within this population were also referenced along with the difficulties in addressing psychosis in methamphetamine users. There were reports of greater ATS use amongst those aged over 50 years.

The majority of commissioned service providers however made clear that alcohol was still the drug of primary concern, and the source of greatest harm to their clients. A number made reference to ensuring this message was understood despite the regular public reporting of harms from illicit drugs. Similarly, the Clinical Council noted the increase in presenting alcohol problems in general practice, noting the higher incidence of presentations of those aged over 50 years.

Amongst the medical staff consulted, and particularly in discussion with the CESPHN Clinical Council, there was concern about pharmaceutical drug misuse. Benzodiazepines in particular were reported as being more visible currently than for some period of time. Xanax was a specific drug mentioned with some regularity as a misused drug. It is worth noting that Aboriginal service providers highlighted their concerns about benzodiazepine misuse within their local populations in a similar way, again with specific reference to Xanax. Self-medication to assist with withdrawal from other illicit drugs was referenced as a theme. The Clinical Council also reported misuse of Gabapentinoids and discussed the relationship between prescribing of these substances and benzodiazepines. Despite mainstream media coverage of concerns over the arrival of Fentanyl and its derivatives in Australia, there was little evidence of use of these drugs from participant reports in the CESPHN region. The exception was SESLHD who indicated that there were 39 reportable incidents with Fentanyl in the 2018/19 financial year.[77]

Cannabis, or 'Yarndi', misuse remains relatively constant in terms of prevalence compared to 2016, and Aboriginal interviewees reported it as the most common initial substance misused amongst the young people they have contact with. A single reference was made in the consultation to cannabis issues on Norfolk Island which sits within CESPHN's remit.

Heroin use remains lower than in the early part of this century and oxycontin use has dropped substantially since the reformulation of the product by the manufacturer. There has been no observed increase in presentations to general practice for codeine prescriptions since its rescheduling, based on the consensus of the clinical council, although there were reports that patients may be accessing larger medical centres for this purpose.

The most relevant changes in drugs of choice since 2016 reported in the consultation was the increase in benzodiazepine use and the concomitant decrease in oxycontin use. There is no evidence

[77] Presentation on the Safe Opioid Use Program 'SOUP' provided by Prof Nick Lintzeris to David McGrath. Presentation dated 12 September 2019.

these two observations are linked. GHB was also referenced as making a resurgence in particular cohorts as outlined below.

There was general agreement amongst clinical service providers interacting with the hospital system that emergency department presentations for drug and alcohol problems were increasing rapidly and this is validated by available data.

ACON reported consistent problems with methamphetamine use and GHB use among the LGBTIQ+ community, particularly within the context of use in sexualised settings. The Clinical Council indicated similar experiences of increased GHB use along with increased LSD use in transgender populations. GHB use was also referenced by the MHSP advisory group.

Aboriginal participants commented on increase use amongst adolescents, particularly of 'Yarndi' and benzodiazepines. Services targeting use of prescription drugs by Aboriginal youth were considered a priority.

The Norfolk Island community reported continuing problems with marijuana cultivation and use amid concerns for a limited appreciation of the risks within the local community. There were also reports of increasing crystal methamphetamine ('Ice') presentations.

Reported service gaps

Participants were questioned on service gaps they identified on the basis of their recent professional experience. Participants were asked to link this to potential models that they may be aware of that could address those gaps, or for service partnerships that could be created to design service responses.

Responses to stimulants

Lack of specific treatment interventions for methamphetamine use was raised by clinicians, service providers, mental health professionals and consumers. Most current services were constructed to deal with alcohol and heroin which have very different psychological and physical withdrawal profiles than stimulants. The lack of any substitution therapy for stimulant drugs was also noted.

Distribution of services and access

Geographic distortions in service accessibility and the matching of services to localised need were also commonly referenced. These distortions were consistent with the issues identified in LHD clinical service plans and reflect outcomes from the 2016 needs assessment, with the southern part of the eastern peninsula and the Sutherland Shire raised as areas with poor access. Alongside this was a general reference to lack of outreach services targeting difficult to reach cohorts. Where uniform geographical access is difficult to achieve outreach services can provide a viable alternative.

The general lack of availability of residential rehab beds across the state was a strong theme of evidence from the consultation. The length of waiting periods to access a bed and the poor service continuity with withdrawal services was raised frequently. The obvious inefficiencies of this were noted. Transitions between services could be improved between most service modalities however the withdrawal/rehab link was the primary focus of most commentary. The link with increasing homelessness in NSW and the concomitant increase in presentations for rehab admission was noted.

The link between drug and alcohol use and violence was a common theme in the consultation. This was in relation to both domestic violence and other forms of violence. The impact of polydrug use on decision-making in this regard was referenced. Early intervention and population wide culture change programs were both discussed as important service gaps to respond to the significant harms associated with violence in the CESPHN community.

Aboriginal service providers made similar comments to other participants with regard to problems with access in specific locales. La Perouse and the southern part of the eastern peninsula were often referenced as poorly serviced. Difficulty accessing rehab, and particularly accessing culturally appropriate rehab was referenced by all aboriginal participants. Commentary was made regarding the restrictiveness of exclusion criteria for many rehabs and frustration with the lack of transparency regarding exclusions and the impact this had on the willingness of individuals to persevere in pursuing treatment. Aboriginal providers indicated the importance of culturally specific services, healing centres and connection to community in the provision of services. These were all preferred to standard rehab programs. There was a general preference for medically supervised inpatient withdrawal services instead of withdrawal managed in the home, particularly greater access to detox services staffed by aboriginal people.

Co-morbidities

Aboriginal service providers also highlighted the relationship between suicide and drug misuse and the need for specific service responses to this. This link was similarly emphasised by the MHSP, with a reference to those aged 18-24 years in the general population in the context of the 'come down' from binge stimulant use. Dealing with mental health co-morbidities in the context of AOD use was a central theme in almost every consultation. While suicide risk was frequently highlighted the relationship between AOD use and mood and anxiety disorders were also frequently noted. For stimulant and cannabis use the limited skills in addressing psychotic symptoms within the AOD workforce was referenced. Some participants suggested funding psychiatric in-reach services to AOD services to improve mental health outcomes.

Physical co-morbidities were also noted. Addressing Hepatitis C, a current Commonwealth Government priority, in AOD populations and within the correctional system was considered a high priority. The impact of extensive stimulant use on general physical welfare, including dental hygiene, was also raised. Lack of access to pain management services and the potential impact on opioid misuse was raised by clinicians participating in the consultation.

Improvements in care co-ordination and team-based service provision were also raised as models of care that should be pursued. Access to psychology, nutrition, medical and social work were all necessary to provide holistic care. A role for pharmacists as potential treatment co-ordinators was raised.

High-needs groups

The lack of specific services for women and lack of utilisation of services from those from a CALD background were noted by consultation participants.

The Community Council made reference to the dearth of available services for those recently released from the prison system, and the impact this has on relapse. Aboriginal providers noted that young men who are involved with the correctional system in particular were very short of supports to respond to AOD use upon release. The CRC reinforced the paucity of services for those recently released, and also reinforced the lack of culturally appropriate transition services for Aboriginal people. Increasing imprisonment rates generally and associated increased release rates were also noted. Case management of this cohort was described as short term, inadequate and ineffective. The interface between unavailability of accommodation and subsequent AOD relapse was noted. Potential partnerships with boarding house providers was seen as a possible service response to this gap.

The majority of participants in the consultation process expressed support for increased access to support services that addressed the multitude of problems generally associated with a significant substance misuse problem. The concept of holistic support, with wraparound service provision for employment and education needs along with day to day living support were all acknowledged as positive aims.

Numerous participants noted the low proportion of CALD clients within AOD services, compared to the population of CALD people living within the CESPHN catchment. Poor access to interpreter services was raised as a barrier to participation for these clients and some participants questioned whether specialist transcultural counselling services could be used to bridge this gap.

New service opportunities

There were a number of participants in the process who commented on the potential impact of long acting depot opioid substitution medications on the treatment system. These medications could allow for monthly dosing of opioid substitution therapy via injection, freeing up treatment resources and dramatically changing the needs of the treatment infrastructure. It could also potentially dramatically change the social needs of program participants who build on daily dosing relationships as part of their social assets. CESPHN will need to consider the impact of these medications on existing primary care practice related to OST.

Program development opportunities

Participants were questioned on the potential program development initiatives that CESPHN could invest in to improve the operation of the drug and alcohol program as a whole. Program development investments are designed to improve overall system operation and could be related to themes such as workforce development and education, information technology and data collection or research and model design.

There was substantial commentary on the benefits of better information dissemination and education for general practice on responding to drug disorders. The greater availability of specialist advice for GPs was also referenced, and access to training regarding trauma informed care. The capacity to practice trauma informed care could be enhanced across the region, and for all providers, through appropriate program development initiatives from CESPHN.

There was interest amongst participants in assistance with better pathway navigation through the service system. Members of the Community Council indicated that extensive amounts of staff time were being utilised in trying to match clients to service eligibility criteria and investments in making these more transparent and disseminating relevant advice, would be valued. It was felt by some that service connection initiatives and the building of inter-service relationships may assist in addressing this.

It was considered beneficial for the PHN to invest in activities to engage the community regarding AOD issues. Workshops and forums where the PHN could lead discussion, and potentially address stigma, were considered a valuable opportunity.

Support was also expressed for workforce development initiatives that improve the capacity of the existing AOD workforce to address the complexity of substance misuse. This could include awareness and screening for blood borne viruses, dealing with the issues associated with post prison release, having basic skills in mental health assessment and interventions and addressing the specific cultural needs of communities within the CESPHN region including Aboriginal people and those who identify as LGBTQI+. Improvements by mainstream services in providing services with cultural competence and inclusiveness were desired by many participants.

Comments on commissioning and contract management

Participants were questioned on the approach taken by CESPHN to their general business practices as system planner and service commissioner. This included feedback on compliance and contract management, planning and consultation and commissioning and service procurement.

Responses to queries regarding feedback on CESPHN commissioning, planning, compliance and contact management approaches were positive. The feedback provided in this section should be viewed within a framework of general gratitude for the PHNs approach to these tasks and very positive comparative feedback against experiences with entities of a similar type to CESPHN. CESPHN was described as ‘a remarkably consultative and transparent PHN to deal with’.

NADA commented on the importance of feedback being provided to the Commonwealth Government on the need for standardisation of approaches to compliance and performance management and on the basic principles of commissioning and planning. Most NGOs are involved in state-wide service provision and as such have interfaces with many PHNs. The variability in practice across PHNs was adding to compliance costs for NGOs and reducing the efficiency of expended funds. NADA argued for standardised KPIs and standardised application of PROMS and PREMS. Within this context however CESPHN was described as ‘the gold standard’ for contract development and negotiation, describing the approach as ‘active’ leading to ‘no surprises’. NADA also indicated that recommissioning of NGOTGP funds requires sufficient notice and planning to ensure that service provision is not affected.

The issue of short-term funding and the associated uncertainty of tenure was raised by a number of commissioned service providers, while also acknowledged as an issue that is largely out of CESPHN’s power to resolve. A number of providers referenced the difficulty retaining staff and the loss of efficiency in ramping down services as a contract end period approaches. A number of providers also commented on the lack of funding growth aligned to CPI and wage growth and the requirement to reduce service capacity over the forward years as a result.

There was general positivity about the approach of CESPHN to consultation, planning and commissioning with Aboriginal community providers. The need for inclusion of aboriginal people in all stages of planning and commissioning processes was reinforced.

Access to staff development opportunities were valued and most participants considered these well promoted and accessible.

Gaps and priorities

Standard service configurations and uses[78]

The Commonwealth Government has commissioned the Drug Policy Modelling Program at UNSW to develop a National Treatment Framework.[79] This document is currently in draft form and is being modified subject to the outcomes of consultation with stakeholders. When completed it will provide, amongst other things, a standardised nomenclature for drug treatment service types.[80] Until this document is formally endorsed by the Ministerial Drug and Alcohol Forum, any impact on the streams described in the 2016 needs assessment is unknown. As such this needs assessment will retain the 2016 structure.

In NSW, the AOD treatment program is generally broken up into six streams that encompass the totality of the funding provided by government. These streams are:

- Prevention, and/or population health, including brief interventions
- Withdrawal Management
- Residential rehabilitation
- Hospital Consultation/liaison
- Outpatient Counselling, Rehabilitation and Psychological Interventions
- Opioid Substitution Treatment.

Most services fit into one of these six categories with the injecting centre in Sydney LGA sitting in the population health category. Traditionally the non-government sector has predominantly been involved in the provision of long-term residential rehabilitation services, with the public sector managing the remaining streams, although this delineation is not as clear as it once was.

There are general client pathways into treatment that accept individuals who meet specified entry criteria for that type of treatment, and also a range of specialist client pathways, which stream people into one of the above service types based on priority client characteristics. Examples of these are substance specific treatment pathways such as cannabis or stimulant treatment services, court diversion pathways for those with drug related offences such as MERIT, and special population pathways for groups such as pregnant injecting drug users, or indigenous populations. However, all of these specialist pathways utilise the suite of treatment options listed above. There are also a range of coerced or compulsory treatment pathways such as the Adult Drug Court, Youth Drug Court, Compulsory Correctional Drug Treatment Centre (CDTCC) and the Involuntary Drug and Alcohol Treatment (IDAT) program. Again, these programs utilise the same treatment approaches.

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[78] Largely reproduced from Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW. p40. This was reproduced as the principles remain current and their placement here is necessary for the purposes of this document being able to stand alone.

[79] https://www.arts.unsw.edu.au/social-policy-research-centre/our-projects/national-treatment-framework

[80] Special Commission of Inquiry into the drug 'Ice', submission number 143. NSW Government submission in response to the issues papers. Paragraph 9.14. Accessed @ https://www.iceinquiry.nsw.gov.au/submissions/submissions-in-response-to-issues-papers/ on November 17, 2019.

Relative roles and responsibilities of funding bodies[81]

One of the articulated goals of the National Treatment Framework project is to 'provide specific guidance relating to Commonwealth and jurisdictional roles in specialist drug and alcohol treatment planning, commissioning and monitoring.'[82] This has been an issue in delineating the boundaries of service planning for PHNs and LHDs for some time. It is likely that the outcomes of this project, if endorsed by governments within the COAG structure, will clarify responsibilities and improve planning precision. Until that endorsement occurs the material below from the 2016 assessment remains current.

A challenge in undertaking planning at one level of the service system is synthesising the activities of all parties involved in planning and commissioning, while prioritising actions that reflect the delineated roles and responsibility of the planning agency.

PHNs have accountability for local planning that reflects the primary health care needs of their populations. This includes a substantial component of the traditional community care provided by State health services, and those community services provided by NGOs. It is not anticipated that PHNs will become involved in the planning and funding of hospital services, associated specialty consultation and liaison services or specialist outpatient services provided on hospital campuses. There is however anticipated in some national strategic documents a role for PHNs in co-ordinating planning across levels of government within their local catchment areas, thus participating in discussions regarding interfaces between PHNs and LHDs. The National Drug Strategy 2017-2026 intends closer planning co-ordination between LHDs and PHNs to drive the implementation of actions within the strategy.[83]

At this point in time the PHNs are acting on behalf of the Commonwealth Government in undertaking their planning and commissioning activities, however they have the capacity to undertake commissioning on a wider scale. The Commonwealth Government has generally targeted funding to general practice and related primary care endeavour, and NGOs when funding AOD treatment service capacity. This is to prevent duplication with state funding which has been targeted at hospital withdrawal services, consultation/liaison and public opiate substitution clinics. Both levels of Government have funded community setting counselling services, and non-government rehabilitation services. PHNs should not feel bound by these funding histories but should consider them when making decisions on actions in response to need.

Gap analysis

The 2016 needs assessment identified six priorities for action which formed the initial basis of activity planning. The six categories of activity were:

- Governance and oversight
- Service capacity
- Populations with special considerations
- Clinical complexity and clinical pathways
- Population health interventions

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81 Largely reproduced from Central and Eastern Sydney Primary Health Network. (2016). *Alcohol and other Drugs Prevention Needs Assessment, April 2016*. Central and Eastern Sydney Primary Health Network, Kogarah, NSW. p40. This was reproduced as the principles remain current and their placement here is necessary for the purposes of this document being able to stand alone.

82 https://www.arts.unsw.edu.au/social-policy-research-centre/our-projects/national-treatment-framework

83 https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026_1.pdf accessed on November 15, 2019.

- Program infrastructure.

The PHN has invested considerable time and resources in building a network of providers and other stakeholders, and a strong interface between service sectors for planning and information sharing. This has improved relationship building between service providers and facilitated a culture of shared problem solving. There remains little evidence though of joint service planning with local health districts, and shared investment decisions. There is also limited evidence of shared clinical governance between services facilitated through PHN arrangements. Serious incidents reviews, joint teams responding to emerging AOD issues and sharing of workforce to grow professional experience and understanding are all absent from the current arrangements.

Work with health pathways has improved the understanding of referral options and client matching, however there still remains no clear shared understanding of service roles and capabilities. As such while it can be said that establishing a collaborative network has been successful, there is still a requirement to establish mechanisms to improve general understanding of service methods and configurations, and that improve clinical governance. Achieving joint clinical participation will improve dramatically the service experience of consumers and their carers.

Investments by state and federal governments accompanied by CESPHN commissioning has had some impact on service capacity. However, the funds have been highly targeted and would likely have done little more than address growth in demand with standard population growth over the three-year period. The growth has largely been in community care hours with other service modalities not receiving any noteworthy enhancements. Further investment in capacity for targeted high-risk populations, residential rehabilitation beds and pharmacy involvement in OTP are all clearly necessary. Specific services for the homeless, those recently released from prison and those who identify as LGBTI are still in need of enhancement. The figures on persons released from prison into the CESPHN region are particularly noteworthy. In addition, metropolitan Sydney continues to have insufficient Aboriginal specific treatment services built on culturally relevant models, and none at all for Aboriginal women and their children. These populations require tailored treatment responses. The CESPHN has made some impact through targeting services to these high-risk populations, however these investments have not mitigated the need for further investment and policy work with these groups.

The increasing complexity and co-morbidity of AOD patients was consistent feedback in this assessment process. Mental health, intellectual disability and blood borne virus risk are common but service models are poorly designed for these. Holistic service models to deal with trauma, social needs and health needs are required. Service providers must build service networks and consortia to achieve these outcomes effectively.

The service provider sector remains concerned about the overall structure of the AOD service system. Improving treatment outcomes through research, addressing the ageing workforce and dealing with funding arrangements and compliance are all areas of concern. Improving the program infrastructure remains a priority.

The PHN has made solid gains across all of its six priority areas with funding, policy and facilitation approaches that have progressed planning objectives. This is reflected in the updated priority actions in the 2017 AOD needs assessment which narrowed and targeted priority actions.

The 2017 update to the 2016 needs assessment aligned the AOD priorities to those of the global CESPHN needs assessment. The global needs assessment addresses all the health priorities in CESPHN including AOD. This alignment shifted the three priority actions in the 2017 updated AOD needs assessment to the following:

- Increase access to drug and alcohol treatment services
- Increase access to drug and alcohol treatment in the primary care setting
- Enhance capacity to address high need populations and clinical complexity.

In order to retain the alignment to the global needs assessment these three priority actions will be retained in this document and the activities to be progressed aligned to them in the table below.

Table 10: Outcomes of the health needs analysis

Key issue	Description of evidence
Population modelling of prevalence rates of disorders – modifications since 2016.	There has been no adjustment to source prevalence data since 2016 therefore the assumptions inherent in the 2016 needs assessment are still valid. The growth in the CESPHN population over this time has not been significant enough to substantially modify the CESPHN population prevalence estimates. As such: For every 100,000 people in a broadly representative population the DASP predicts: • 8,838 will have an alcohol use disorder. • 646 will have a methamphetamine disorder • 465 will have a benzodiazepine misuse disorder • 2,300 will have a cannabis misuse disorder • 793 will have a non-medical opiate (including heroin) misuse disorder. For CESPHN this translates to: • 144,680 people with alcohol use disorder • 10,575 people with a methamphetamine use disorder • 7,612 people with a benzodiazepine use disorder • 37,651 people with a cannabis use disorder • 12,981 people with a non-medical opiate use disorder Higher prevalence rates will be observed in populations that have greater than average concentrations of: • People who are homeless • People who identify as LGTBI • People who have recently been released from prison
Need for screening and brief interventions – no modification since 2016	It is estimated that for the CESPHN population there are 239,280 people who need screening and brief intervention for alcohol use in a given year, 14,660 who need screening and brief intervention for amphetamines and 151,750 who need screening and brief interventions for cannabis use.
Unclear signals on methamphetamine use	Reported prevalence rates are down but harms are more visible. Increased police seizures are having no effect on price suggesting a solid supply. Qualitative reports via the consultation indicates increases in methamphetamine presentations to services and increased difficulty in managing methamphetamine clients including their psychiatric needs and impulsive behaviours.
High rates of alcohol related hospitalisations	CESPHN has very high rates of alcohol related hospitalisations relative to other PHNs. CESPHN has the highest absolute number of alcohol related hospitalisations and the second highest per capita rate in NSW after NSPHN.
Patterns of pharmaceutical misuse are changing	The most significant reported change from the stakeholder consultation is the reduction in Oxycontin misuse, and the concomitant rise in Xanax misuse. Reports of misuse of Gabapentinoids are also noteworthy. There are limited reports of Fentanyl misuse although SESLHD did present data on non-trivial numbers of Fentanyl overdoses in their hospitals in 2018. Responding to pharmaceutical drug misuse remains a priority.
Relatively high proportion of homeless people within CESPHN	The rationale for prioritisation of this population as a health need in 2016 remains pertinent in 2019. CESPHN remains a concentration point for this population and the small amount of additional data available makes it clear that AOD problems are still greatly overrepresented in the group.

High proportion of prison releases into residences in the CESPHN region.	Data from the Special Commission of Inquiry into 'Ice' demonstrates that growth in the prison population is much faster than overall population growth. More than 19,000 people leave prison in NSW every year, or around 55 people per day, and according to the 2015 JH&FMHN inmate survey 70% of these people are likely to have had a drug misuse problem on entry. Approximately 19% of these people leaving prison are likely to be released to reside in the CESPHN area. This means that more than 2,000 people per year are leaving prison with a pre-existing substance problem to reside in CESPHN.
High representation of LGTBIQ identified people in CESPHN	LGTBIQ people are: • 5.8 times more likely to use ecstasy • 5.8 times more likely to use methamphetamines • 3.2 times more likely to use cannabis • 3.7 times more likely to use cocaine • More likely to drink at risky levels. Recent studies such as SWAH, Flux and the Sydney Gay Community Periodic Survey reaffirm the higher prevalence of drugs in the LGBTIQ+ community, particularly stimulant drug use in the context of 'chemsex'. GHB and LSD are being reported as more prevalent than for some time in some sub-populations, such as the Trans community.
Co-morbidities associated with drug use are becoming more concentrated in treatment populations	The complexity of cases presenting to services continue to grow. Behavioural disturbance, psychosis and mood disorders were referenced by almost all participants in the consultation process. The impact on suicides in Aboriginal populations is noted in the data. Hepatitis C remains a problem and the focus of current Commonwealth Government intent.
There is a disproportionate number of opioid overdoses in the CESPHN region	Data on ambulance callout demonstrates that CESPHN has a much higher rate than any other NSW PHN. This may reflect traditional supply centres that exist within the CESPHN region and the likelihood of use, and overdose, immediately consecutive to supply. There does not appear to be an obvious trend in the three years of data presented, however access to naltrexone within CESPHN is a priority, compared to other PHN regions.
The AOD needs of CALD communities continue to appear to be unmet	There is still very low uptake of treatment services by those individuals from CALD communities compared to their representation in the general population. Data from NADA indicates that nearly 100% of ACON clients have English as their preferred language, 97% of CRC clients, 88% of Haymarket clients, 97% of Odyssey House clients, 100% of Salvation Army clients, 100% of the Station clients and 100% of Weave clients. This suggests that almost none of the services funded by CESPHN are attracting clients from CALD communities.

Table 11: Outcomes of the service needs analysis

Key issue	Description of evidence
Geographical distortions in service delivery within the PHN	The stakeholder consultation reinforced the access difficulties referenced in the prior needs assessment. These will not be replicated in detail here but Maroubra, Randwick and the Sutherland Shire remain areas with poor AOD service access. Sparse service provision on the SE peninsula of region with a large and growing population was reinforced. Services are concentrated in the eastern end of SLHD with poor access in Canterbury and Strathfield. Urban growth areas in Green Square, The Bays Central to Eveleigh, Parramatta Road, Canterbury Bankstown rail corridor, Riverwood and Waterloo Housing Estate re-developments and a large number of private sector urban developments.
Holistic service models required	Client complexity requires service models that address more than just AOD need. Service models need to address trauma, accommodation, BBV, mental health disorders, and co-ordination of care provisions across specialty teams. Those exiting the criminal justice system need particularly comprehensive service models, particularly women exiting that system. There was concern that treatment should be available for perpetrators of domestic violence, noting the links with substance misuse.
Lack of specific treatments for methamphetamine misuse and dependence	Current service systems are based on traditional models of treatment for heroin and alcohol dependence. There is also no approved pharmacotherapy for stimulant substitution treatment. Evidence suggests that existing models need modification for stimulant users and this was reinforced by the consultation. Investment in research examining effective treatment approaches for stimulants is required.
System modifications needed with the arrival of depot OST medications	New long acting buprenorphine-based medications will dramatically reduce the impost of dosing of OST, on both patients and treatment providers. Supports will be required to manage this transition particularly in primary care settings.
AOD specialists in Emergency Departments	The public hospital system has prioritized consultation liaison services in LHD service agreements. This aligned with 4-hour Commonwealth funding targets for discharge or admission from ED suggests that significant NSW Government endeavor will be going into this service modality. This is an area that may not require additional support from the PHN over the medium term.
Continued lack of clarity about who delivers which type of interventions between funded providers.	'Multiple providers with various funding sources undertaking a variety of interventions but no single service providing the whole spectrum of services from detox to follow up and support after rehabilitation making navigating care complex for consumers and service providers.' (2016 assessment). Aboriginal service providers in particular raised the issue of lack of transparency in service exclusions and thresholds and difficulty in retaining motivation in young Aboriginal people once turned away. Cross referrals to other services often not appropriate. Issue of who services those with a violent criminal record or past sex offence was raised as these people are often declined service at mainstream rehabs. GPs have indicated that lack of reliable service referral pathways is an impediment to more active involvement with the AOD client base. Client matching to service criteria is time consuming and often inefficient. One NGO service indicated that it was nearly a full time (1FTE) job for a staff member to navigate service entry points.

Lack of available interpreters for those who prefer a language other than English.	The consultation process indicated a profound difficulty in accessing interpreter services. The data from CESPHN funded service providers indicates that nearly all of their clients preferred English, suggesting that CALD clients are simply not accessing services. Interpreters were raised as a critical support tool for engaging with CALD communities and addressing sensitive issues such as trauma, BBV and other drug related harms.
Lack of engagement by pharmacists within CESPHN	More than half of the SA2 areas in CESPHN have either one or no OTP dosing point. CESPHN had very low pharmacy participation in 2016 and NOPSAD data suggests that this is still the case.
Lack of available services for people released from prison	The demand for services from those recently released from prison outstrips supply on the basis of the data presented here. Specific service models and more reliable referral pathways are necessary to improve service outcomes for this complex group.
Lack of access to residential rehabilitation facilities	Recent modelling by NADA suggests that current bed capacity is anywhere from 1,000 to 1,500 short of population need. Investment since 2016 have focused predominantly on day programs and community based settings and there has been little investment in residential services to keep up with population growth. There continues to be a particular shortage of services for women and children, and services which cater for families. The assessment of 2016 remains current, with regard to these service gaps.
Limited culturally appropriate services for Aboriginal people	Aboriginal service providers indicated that despite higher population rates of drug disorders in Aboriginal communities, there remains insufficient culturally specific AOD services for Aboriginal people. The need for healing centres and traditional treatment approaches was referenced. The capacity to build on engagement programs such as Tribal Warrior and to build interventions around accepted Aboriginal social practice was raised.
Funding arrangements	All commissioned providers were complimentary about CESPHN business practices however most raised issues with short term funding uncertainty, and inefficiency in repetitive competition for funding. NADA indicated that lack of consistency across PHNs in performance management, contract conditions, KPIs and commission processes was adding to red tape and reducing the efficiency of funds committed.

Table 12: Opportunities, priorities and options

Priority	Possible options	Expected outcome	Possible performance measurement	Potential lead
Increase access to drug and alcohol treatment services				
Overall governance and improved policy capacity	Undertake detailed mapping exercise of capacity and resourcing of services within the CESPHN region and map the gaps against the population need outputs of the DASP Establish a role delineation framework for the PHN, LHD and ACCHOs based on the National Treatment Framework	Improved understanding of provider capacity and service gaps. Potential to build a service directory. Reduce duplication of endeavour. Identify accountability for leadership on policy issues as they arise	Regional service profile and directory completed. Gap analysis available. Role delineation framework completed.	CESPHN
Rehabilitation capacity	Prioritise available investment to facilitate increased access to rehabilitation services	Improved flow through into behaviour modification and psychosocial support rehabilitation programs. Reduced drug related harms Reduced relapse rates	Increase in the % of "needs met" for residential services under the DASP modelling	CESPHN
Withdrawal management services	Raise awareness across CESPHN referral agencies on the range of available withdrawal options and how best to match referrals to withdrawal options. Facilitate collaboration between withdrawal providers to improve matching of clients to referral options. Prioritise available investment to facilitate increased access to withdrawal services	Improved access to withdrawal management services as the entry point to the care continuum.	Episodes of care Number of facilities providing service	CESPHN & LHDs

	Request and disseminate withdrawal management arrangements for local hospitals including appropriate referral pathways and entry criteria Facilitate and incentivise GP assisted withdrawal in the home Develop agreed referral pathways from GP assisted withdrawal to residential rehab facilities			
Manage the availability of long acting depot OST medications	Promote appropriate treatment guidelines for use of these medications Facilitate intersectoral supports to manage patient transitions to new medications Partner with NGO service providers to manage the social consequences of these new medications for clients of the program	Increased availability of OST therapy	Number of patients on depot medications	CESPHN in collaboration with NSW Health
Addressing disproportionate opioid overdose in CESPHN region	Develop partnership arrangements with NGO and government agencies to build on available funding for Take Home Naloxone (THN) projects	Reduced ambulance callouts to opioid overdose	Partnership models developed	CESPHN
Improve contracting arrangements for contracted service provision	Build contract provisions into commissioning models that create greater certainty for services and their clients through reasonable contract periods and transparent and predictable processes for contract renewals Reduce unnecessary tendering processes through the establishment of preferred provider panels	Contract periods of a length that builds service certainty and clear business decision making Expedite commissioning decisions when new funds become available by having an accredited provider take on the funds where service skills match funding need	Contracting models complete Policy on provider panel available	CESPHN in collaboration with NADA

Continue to develop planning tools within the PHN and build on this needs analysis	Seek access to state data on service capacity and resourcing to better map existing service delivery	Improved planning and knowledge	Data accessed	CESPHN
Performance Measurement	Negotiate at a national level for greater consistency across PHNs in performance management, compliance and commissioning processes to reduce administrative burden on service providers	Better value from commissioned funds and greater reductions in drug related harms	Standardised KPIs, consistent selection criteria for commissioning	CESPHN
Continue to build a stepped care, holistic, consumer led care continuum through effective commissioning	Encourage innovative models and consortia that can address multiple client needs including trauma, housing, AOD and mental health concerns Build models that transition people through service settings and treatment milestones built on consumer advice, and that include appropriate aftercare arrangements.	Reduction in service transitions and treatment drop-outs Better long-term treatment outcomes and reduced drug related harms	Consumer driven consultations held Service models documented and distributed Services commissioned	CESPHN
Increase access to drug and alcohol treatment in the primary care setting				
Improve access to treatment through primary health care	Increase the engagement of GPs in responding to drug and alcohol problems Negotiate referral protocols between specialist AOD services and GPs to facilitate shared care arrangements and build on the GLAD shared care project Promote opportunities for GPs to engage in prescribing for OST Promote better prescribing practices for benzodiazepines and gabapentinoids	Increased number of patients supported in primary healthcare setting Increased integration between primary health and specialist treatment services Reduce over-prescribing of pharmaceuticals	Amount of allocated Indigenous-service funding expended on in-scope activities Protocol agreed and disseminated Increase in GP prescribers in CESPHN region Quality Improvement – evidence of support for health professionals; number of education/training modules delivered Reduced reports of benzodiazepine and gaba abuse	PHN

	Develop, disseminate and pilot an opioid screening tool for early identification of dependency in primary care settings			
Progress a clinical governance structure	Establish a joint clinical governance framework including PHN funded service providers, Aboriginal community controlled organisations and LHD clinical staff which provides for agreed referral pathways, case conferencing, complex case reviews and adverse event reviews Establish a process for establishing a monitoring and rapid response group to address hot spots and emerging trends	Better care connections, clearer understanding of referral pathways and entry criteria to services, smoother patient transition Collective effort in addressing complex demographic and supply problems	Publication of framework Establishment of an agreed protocol and thresholds for establishing a group and managing its activity	CESPHN & LHDs
Develop a region wide approach to alcohol consumption and alcohol related harms	Promote best practice in prevention for alcohol related harm, including in addressing opportunities for feedback on issues of outlet density for liquor licensing decisions, taxation and trading hours. Work with general practice to promote screening and early intervention for alcohol related problems	Reduced population prevalence of alcohol harms within the CESPHN region	Lower alcohol hospitalisations Reduced problematic consumption levels	CESPHN & LHDs
Enhance capacity to address high need populations and clinical complexity				
Residential services appropriate for families / children (particularly women)	Establish referral pathways into existing services for families and children across NSW and disseminate to all CESPHN service providers Prioritise future commissioning related to this group	Improved access to residential treatment services and services in general for families	Increased access and utilisation	CESPHN
Culturally appropriate AOD services and services specifically for Aboriginal and Torres Strait Islander people	Undertake a targeted service development initiative with local aboriginal service providers Identify service models built on Aboriginal experiences of health and social care and develop commissioning options	Improved access for Aboriginal populations	Population access to treatment rates	CESPHN

Develop more effective service models for CALD communities	Commission research on unmet need for CALD services Look to train multi language staff in specialist AOD interventions Investigate the capacity to support use of interpreters Utilise skills of existing groups with community reach to engage with communities	Improved access for CALD groups	Population access to treatment rates	CESPHN
Continue to develop more effective service models for LGBTIQ community.	Engage with ACON regarding targeting service delivery responses to different cohorts within their service remit Investigate joint venture service delivery and consortia models with ACON that may improve service configuration and responses with the LGBTIQ community utilising service providers with complimentary skill sets	Improved access for LGBTIQ community members	Population access to treatment rates	CESPHN
Develop service models for individuals recently released from prison	Commission specialist service provision for this cohort Commission holistic multi-complexity service consortia to respond to complex needs within this population Develop priority pathways for prison release patients to general practice OTP management Develop a model of care for prison release patients that includes options for commissioning innovative models of support	Increasing range of services providing a broader range of interventions with improved flexibility to meet the needs of people leaving custody	Transfer of care rates and measures of treatment continuity	CESPHN