

Drug Health Services Strategic Plan



2016–2021



Health
Sydney
Local Health District



Sydney Local Health District
has a vision — “to achieve
excellence in healthcare for all”.

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1 Foreword

Drug Health Services in Sydney Local Health District (SLHD) aim to reduce the harm associated with drug and alcohol use for individuals, families and communities and to prevent drug misuse. Drug health issues pose considerable challenges to the community, requiring a comprehensive and cross-sectoral set of strategies. We are pleased to introduce the SLHD Strategic Plan for Drug Health Services for 2016-2021 which provides a blueprint to respond to patterns of drug use, new approaches to treatment and community concerns.

The pattern of substance use in the community changes over time. While tobacco smoking rates have reduced, smoking remains a major public health issue. Alcohol is the major drug-related reason for hospital admission. Public and professional concern has been expressed about alcohol use and associated violence, psycho-stimulants particularly crystalline methamphetamine ("ice") and prescription opioids.

Misuse of drugs, whether it is alcohol, tobacco, illicit drugs or prescription drugs, incurs a considerable cost to individuals, families, local communities and the broader society. Drug misuse can affect the health of the individual and their family through illness, disease, injury (including road accidents) and death. Other impacts include workplace absenteeism and reduced productivity, violence, crime and community and family breakdown. The economic cost in Australia was estimated at \$55.2 billion in 2004/5 (not including prescription

drugs). Tobacco accounted for 56.2% of this cost, with alcohol and illicit drug use contributing a further 27.3% and 14.6% respectively. The combined use of alcohol and illicit drugs contributed a further 1.9%. It is noteworthy that approximately 50% of the economic burden of substance use is borne by those who have not used the substance in question; that is children, families, victims of crime, employees, friends and the general community.

The Drug Health Services Strategic Plan identifies actions for addressing drug misuse in the District through:

- Continuous service improvement and high quality clinical care
- Service integration through collaboration with affiliated District services
- Partnerships with primary healthcare, community, government and non-government organisations and professional associations
- Targeted strategies for high priority population groups
- Effective corporate and support services management
- Enhanced research and education activity.

The Sydney Local Health District Board and Executive are strongly committed to working together with other agencies and the community to implement this plan.

We wish to thank and congratulate all those involved in the development of this important plan.



Dr Teresa Anderson
Chief Executive
Sydney Local Health District



Hon. Ron Phillips
Chair
Sydney Local Health District Board

2 Background

Australia's history and cultural background is replete with examples of the significant role played by legal and illegal drugs. Many Aboriginal peoples had traditional forms of low strength alcohol but these did not appear to be associated with harms. Higher strength alcohol was intermittently brought to the north of Australia via Macassan traders, from what is now Indonesia. But with British colonisation, stronger alcohol became more regularly available. Indeed, in the early colony, alcohol was used as currency; rum was used to exchange goods and pay for labour. The construction of the first hospital in the colony, Sydney Hospital, was undertaken using convict labour with contractors being permitted to recoup their costs by importing 60,000 gallons of rum.

Over the past two decades, there have been significant changes in the patterns of drug use in the community. Due to assertive government action, tobacco smoking has become less common in the general population; however, it remains a major public health issue, and more intensive cessation interventions are needed with remaining smokers. Target groups include young people, people with mental health conditions, Aboriginal Australians, Culturally and Linguistically Diverse populations (CALD) and Lesbian, Gay, Bisexual, Transgender and Intersex populations (LGBTI). So called 'electronic cigarettes' which deliver nicotine vapour are widely available and used in the community, however, the evidence regarding their efficacy and safety is not yet available.

Over half of all requests to the Drug Health Services inpatient consultations in SLHD hospitals are for alcohol-related problems and alcohol is a drug eliciting considerable concern in the community. Pharmacotherapies for alcohol use disorders could be more highly utilised and Drug Health Services will continue to expand clinical and community partnerships to address alcohol-related harm.

Use of synthetic cannabinoids (with high potency) and amphetamine-type stimulants continue to increase in the community, with an unknown toxicity profile due to unregulated manufacture. Mental health problems and social aggression associated with 'ice' and steroid use are major social issues. With no substitution therapy available for these substances, engagement and treatment is challenging.

There has been a continued rise in the use of prescription opioid drugs and with it, a rise in harms including overdose and dependence. Unfortunately, there is little evidence of reduced burden of pain, the key reason for the heavy use of these medications. Presentations for poisoning include individuals with deliberate attempts at self-harm, therefore, mental health issues need to be addressed in parallel with toxicology and substance use disorders.

Australia has one of the lowest rates of HIV in the world. Studies show that from 2000-2009 Needle and Syringe Programs (NSP) directly prevented 32,000 HIV infections and over 96,000 Hepatitis C infections. For every one dollar invested in NSP more than four dollars were returned in health-care cost savings. The NSW NSP is an evidence-based public health program that aims to prevent the transmission of HIV and Hepatitis C among people who inject drugs and the broader community.

Government and non-government treatment services for people with drug and alcohol problems are provided within a broad philosophy of harm minimisation. Services include withdrawal management, inpatient stabilisation, rehabilitation, opioid substitution clinics and other pharmacotherapies, court diversion programs, needle syringe and other harm reduction programs, medical consultation and counselling. Many services are provided on an ambulatory basis, supplemented by withdrawal management and rehabilitation provided as residential and inpatient care. Harm reduction programs aim to ameliorate problems associated with illicit drug use.



Our values —
c_ollaboration
o_penness
r_espect
e_mpowerment

3 The process of planning

Significant consultation has occurred with Drug Health Services staff, service partners, families and local communities throughout the development of the Drug Health Services Strategic Plan. This Drug Health Services Strategic Plan is consistent with the District's strategic plan, vision, mission and values.

4 Our vision

*Sydney Local Health District has a vision
“to achieve excellence in healthcare for all”.*

In the Drug Health Services context, “excellence” is: reduced alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities.

Our mission

To deliver evidence-based and patient centred care in collaboration with other health and non-health partners to improve the health outcomes of individuals, their families and of the broader community.

Our values

Our values are a statement of the standards and behaviours we model in our work and the way we interact with our patients, our community and amongst ourselves. These values are consistent with the CORE values of the NSW Health system:

Collaboration – Improving and sustaining performance depends on everyone in the system working together as a team.

Openness – Transparent performance improvement processes are essential to make sure the facts are known and acknowledged, even if at times this may be uncomfortable.

Respect – The role of everyone engaged in improving performance is valued.

Empowerment – There must be trust on all sides and at all levels with responsible delegation of authority and accountability.

Principles of Drug Health Service provision

1. Harm minimisation

We focus on limiting the adverse effects of drug use on individuals, families and communities.

2. Equity

We provide culturally appropriate and accessible care, irrespective of a person's demographic, socioeconomic or geographical background.

3. Patient and family centred care

We provide care that respects the social, emotional, spiritual and physical context of our patients' lives and acknowledges their past experiences and strengths.

4. Partnership

We work with our patients, families, communities and service partners to achieve our goals.

5. Evidence-based practice

We develop and deliver models of care in line with the best evidence and use continuous evaluation to monitor their effectiveness.

6. Early intervention and prevention

We engage with individuals and communities to prevent drug and alcohol related harms, including through information, brief intervention and referral.

5 Policy framework

The framework for this strategic plan is aligned with key Commonwealth and NSW Government policies. Its purpose is to support the ongoing improvement of drug health as a priority with the development of drug health services and facilities. The framework is consistent with the:

- Sydney Local Health District Strategic Plan 2012-2017
- National Drug Strategy 2010-2015
- National Guidelines for Medication-Assisted Treatment of Opioid Dependence 2014
- Australian Commission on Safety and Quality in Healthcare's National Safety and Quality Health Service Standards
- Australian Council on Healthcare Standards - EQUIP National
- The third National Sexually Transmissible Infections Strategy 2014-2017
- NSW 2021: A plan to make NSW number one
- NSW State Health Plan Towards 2021
- NSW Pain Management Plan 2012-2016
- NSW Tobacco Strategy 2012-2017
- NSW HIV Strategy 2016-2020
- NSW Hepatitis B Strategy 2014-2020
- NSW Hepatitis C Strategy 2014-2020
- NSW Aboriginal Health Plan 2013-2023
- NSW Clinical Guidelines for the Management of Substance Use During Pregnancy Birth and the Postnatal Period 2014
- NSW Framework for Substance Use and Young People 2014
- NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines 2014
- Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines 2008
- Drug and Alcohol Treatment Act 2007 Involuntary Code for Legal Status Codeset 2013
- Consumer Participation in NSW Drug and Alcohol Services Guide 2010
- Sydney Local Health District strategic and service plans
- Current former-Sydney South West Area Health Services plans: Aboriginal Health; Disability; Youth Health; Carers



Drug Health Services Strategic Plan at a glance

OUR VISION

Reduced drug related health, social and economic harms among individuals, families and communities.

OUR PRIORITY POPULATIONS

- Aboriginal populations
- Homeless population
- Women and their families
- People engaged with the criminal justice system
- Young people
- CALD population
- LGBTI populations
- People with co-morbidities
- People who inject drugs
- People with BBV
- Elderly people

PRINCIPLE DRUGS OF CONCERN

- Alcohol
- Cannabis
- Amphetamines
- Solvents
- Performance and image enhancing drugs
- Tobacco
- Hallucinogens
- Opioids
- Synthetic drugs
- Prescription medications

OUR PRIORITY AREAS AND OUTCOMES



OUR GUIDING PRINCIPLES

HARM MINIMISATION

PATIENT/ FAMILY-CENTRED CARE

PARTNERSHIPS

EVIDENCE-BASED PRACTICE

EARLY INTERVENTION AND PREVENTION

EQUITY

6 Drug Health Services Integrated Care Model

Drug Health Services provide services based on an Integrated Care Model. This model derives from a socio-ecological and holistic understanding of the complex individual, familial and social issues effecting drug use. Effective service and strategic interventions recognise the complex and intersecting factors that contribute to the uptake and maintenance of drug misuse i.e. the social determinants of health (see Figure 1).

Interventions therefore need to be conducted at a range of levels including at the individual, family, community, policy and systemic levels.

An Integrated Care approach facilitates streamlined and coordinated care across providers and settings. This approach recognises the power that derives from collaborative cross-agency care and actions.

Components of an Integrated Care Model

- Holistic assessment considering physical and mental health, suicide ideation, relationships and social support, domestic violence, blood borne virus, sexual health, education, employment, housing, legal issues, child protection, pregnancy and financial situation. Treatment planning identifies actions and interventions across all these domains. Assessment occurs at a range of primary and secondary services and considers the social determinants of health.
- Patient and family-centred case management.
- Continuum of care between community and hospital settings facilitated through Information and Communication Technologies and communication/integration systems and conjoint services.
- Clear integration with affiliated clinical partners including the Emergency Department, Mental Health, Maternity Health and Gastroenterology.
- Shared guidelines and protocols between affiliated clinical partners, Drug Health Services and community partners.
- Evidence-based range of treatment options for patients and families.
- Trauma informed care and practice.
- Strong partnerships with primary care and human services.
- Harm minimisation health promotion projects.
- Community engagement and development strategies designed to address the social determinants of health.



Drug Health Services Integrated Care Model

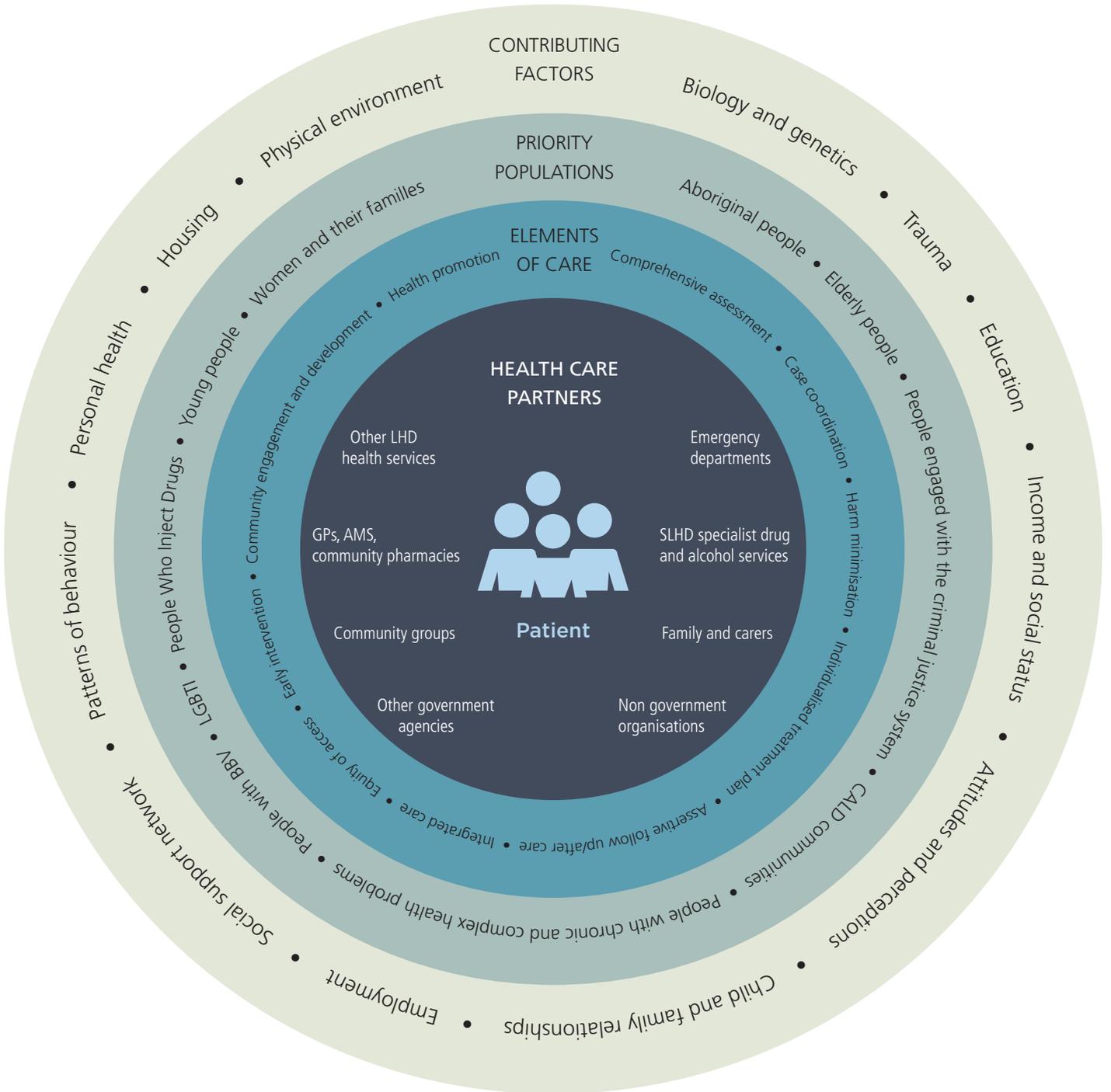


Figure 1

Examples of Integrated Care Models involving SLHD Drug Health Services

Partnership with the Aboriginal Medical Service

Redfern (AMS) has been operating for over 15 years, facilitated by a strong commitment to integrated and collaborative care. AMS medical officers prescribe opioid pharmacotherapies for patients who come to RPA Opioid Treatment Clinic for daily dosing. Support and case management and collaboratively case review is provided to all patients. Following consultation with patients, an Aboriginal women's group commenced in 2004 to provide additional support to Aboriginal women with drug dependence, their children and families. In November 2014, Drug Health Services and the AMS co-hosted an Aboriginal Drug Forum in Redfern. 76 Aboriginal and non-Aboriginal staff from a wide range of government and non-government agencies, which provide services to Aboriginal people attended. The forum provided opportunities for participants to exchange information about the roles of their organisations and to identify gaps in integrated service provision.

Living Well Living Longer integrates primary care, mental health, drug health and other specialist services to improve access to physical health care and health outcomes in people living with severe mental illness. A Tobacco Treatment Specialist from Drug Health Services runs two community centre-based clinics each week at Marrickville and Canterbury delivering counselling for mental health consumers and brief intervention training for community mental health staff. The clinician sees 8-10 patients per week for up to 12 weeks on a one-to-one basis and also offers group sessions. The clinics provide opportunities for Mental Health staff to develop their skills and knowledge in intensive tobacco treatment interventions.

RedLink Integrated Service Centre is an initiative of the NSW Government to deliver integrated human services. Led by NSW Family and Community Services, RedLink provides community, health, housing, legal and other support services to residents of the public housing buildings on site at Walker Street, Redfern. In addition, a network of community rooms and spaces within and outside the Redfern public housing estate are available for community activities and service delivery by service partners. Drug Health Services is an active partner in this project along with Community Health, Oral Health, Mental Health and Population Health.

The Needle and Syringe Primary Healthcare Clinic in

Redfern offers a "one-stop-shop" to address a broad range of health and social issues for people who inject drugs. The Clinic provides nursing care, screening, assessment, vaccinations and referral to other specialised services. This is a model that illustrates a high level of integration with internal partners including Mental Health, Youth Health, Sexual Health services and the Liver Clinic at RPA. The Liver Clinic offers fibro-scanning and medical consultation on site one afternoon a fortnight. The Primary Care Clinic partners with external health providers including local GPs, Positive Central HIV Services, Aboriginal Medical Service and Uplift Psychological Services.

Concord Hospital Drug Health Inpatient Service

Clinical Redesign project developed a model of care that is more accessible, flexible, individualised and integrated with community care providers. Rapid access referral pathways have been developed with hospital and community providers including Aboriginal Medical Services, GPs, the Medically Supervised Injecting Centre, non-government rehabilitation providers and Mental Health Services. These organisations are engaged prior to patient admission to develop care plans that facilitate patient access to services and allow seamless transition from one service to the other. Assertive discharge planning commences at initial contact. Increased support for complex patients is provided within the transition program (ward 65) and beds are then made available for other patients requiring inpatient withdrawal management (ward 64). Key outcomes include increased bed occupancy, increased access to more patients with complex physical and mental health comorbidity, increased transfers to long term rehabilitation and decreased discharge against medical advice.

7

Sydney Local Health District demographics

Sydney Local Health District is located in the centre and inner west of Sydney. It comprises the Local Government Areas (LGAs) of the City of Sydney (part), Leichhardt, Marrickville, Canterbury, Canada Bay, Ashfield, Burwood and Strathfield. The District is responsible for providing care to more than 600,000 local residents. It covers 126 square kilometres and has a population density of 4,620 residents per square kilometre (ABS 2011).

By 2021, the local SLHD population is projected to reach 681,337 people and by 2031, 772,448 people. The 33% growth rate in SLHD from 2011 to 2031, outstrips that of NSW which is projected to grow by 27%. Significant planned urban developments include: the new Green Square Development in Zetland and Beaconsfield in the City of Sydney; urban consolidation along the Parramatta Road corridor; new developments in Rhodes, Breakfast Point, Canterbury, the former Carlton United Brewery site, Redfern Waterloo, the Central to Eveleigh Corridor and The Bays urban transformation at Rozelle. Indeed, four out of six of the metropolitan Sydney UrbanGrowth projects are in the SLHD.

Sydney Local Health District is characterised by socioeconomic diversity with pockets of extreme advantage and extreme disadvantage. The Index of Relative Socioeconomic Disadvantage (IRSD) contains indicators of disadvantage such as low income, high unemployment and low levels of education. The average across Australia is 1,000, with a number below 1,000 indicating lower socioeconomic status.

The two Statistical Local Areas in SLHD with an overall score under 1,000 in 2011 were Canterbury and Burwood. Consistent with its overall ranking as the most disadvantaged LGA within SLHD, Canterbury LGA has the most suburbs experiencing disadvantage in the District (with 12 of the 20 most disadvantaged suburbs in SLHD located here). Other pockets of particular disadvantage include Waterloo/Redfern/Haymarket/Ultimo (Sydney LGA), Marrickville and Sydenham (Marrickville LGA), Homebush West/Belfield (Strathfield LGA) and Burwood (Burwood LGA).

There are 13,568 public housing dwellings in Sydney Local Health District with 6,140 single people and families currently on the waiting list for accommodation. This waiting list particularly affects the ability of vulnerable consumers to access secure accommodation and can impact on timely discharge from hospital.

District Hospitals and other facilities

- 1 Balmain Hospital
- 2 Canterbury Hospital
- 3 Concord Centre for Mental Health
- 4 Concord Repatriation General Hospital
- 5 Dame Eadith Walker
- 6 Royal Prince Alfred Hospital
- 7 Sydney Dental Hospital
- 8 Thomas Walker (Rivendell)
- 9 Tresillian Family Care Centres

Major Community Health Centres

- 10 Camperdown
- 11 Canterbury
- 12 Croydon
- 13 Marrickville
- 14 Redfern



8 Priority population groups

Aboriginal and Torres Strait Islander populations

SLHD is home to approximately 4,875 residents (0.9% of SLHD total population – 2011 census) identifying as Aboriginal or Torres Strait Islander people, with large communities in Marrickville and the City of Sydney LGAs. Between 2011 and 2014 Aboriginal and Torres Strait Islander patients represented 10% (1112 separations) of total drug and alcohol separations (Figure 2), indicating the significance of drug health issues in Aboriginal communities. For many Aboriginal people drug and alcohol use are contributory risk factors for higher levels of morbidity and early mortality.

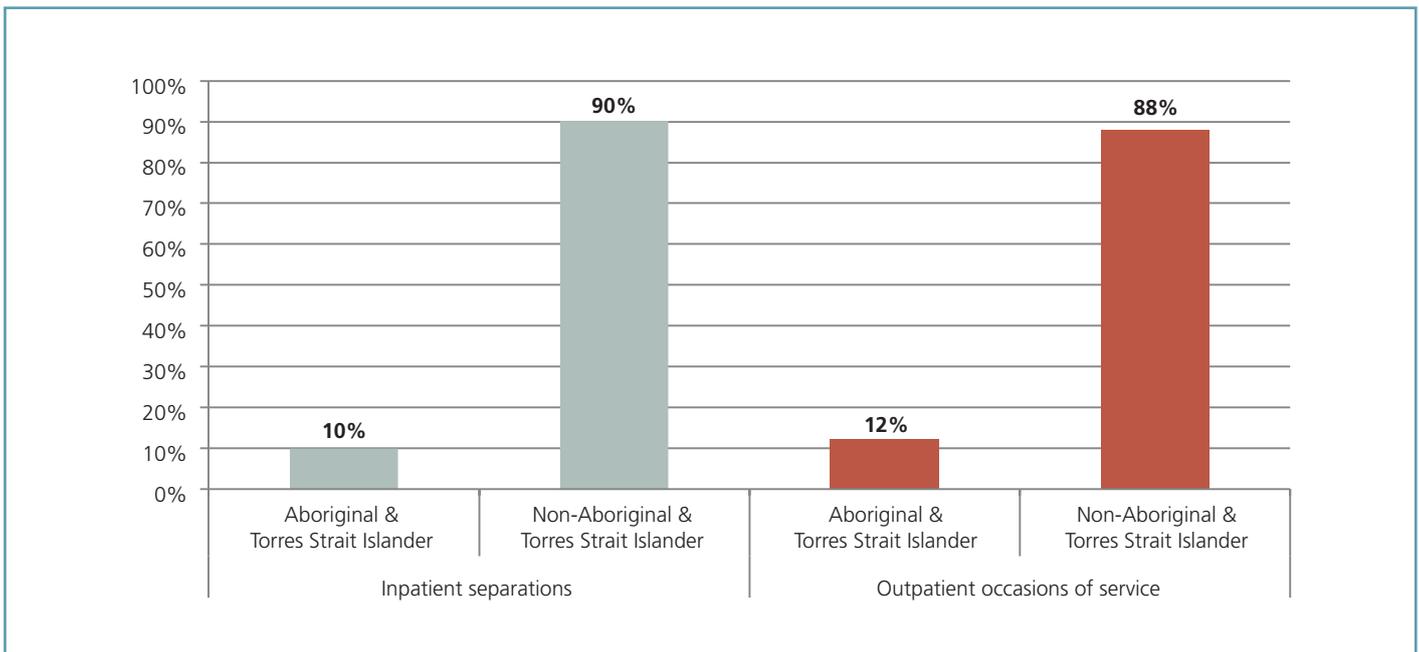
When compared to the general population, Aboriginal women are twice as likely to be victims of sexual assault and four times more likely to be victims of assault, domestic violence or otherwise.

Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander people are:

- More likely to abstain from drinking alcohol (28% Indigenous vs. 22% non-Indigenous)
- More likely to drink at risky levels
- 2.5 times more likely to smoke tobacco daily (32% Indigenous vs. 12.4% non-Indigenous)
- 1.6 times more likely to use illicit drugs
- 1.9 times more likely to use cannabis
- 1.6 times more likely to use meth/amphetamines
- 1.5 times more likely to misuse pharmaceuticals

Source: National Drug Strategy Household Survey 2013.

Figure 2: SLHD drug and alcohol separations by Aboriginality 2011-2014



Source: Flow-Info V 14.0

Homeless population

Homelessness is a significant issue within SLHD, with a large number of people sleeping rough. Official estimates of the prevalence of homelessness from the 2011 Census indicate that the area with the highest number of homeless persons is the City of Sydney LGA, with approximately 3,307 persons recorded in the region shared between Sydney and South Eastern Sydney Local Health Districts. A further 1,430 homeless people were recorded in Strathfield-Burwood-Ashfield, 910 in Marrickville-Sydenham-Petersham, 663 in Canterbury, 319 in Leichhardt and 171 in Canada Bay. Women who are homeless experience higher levels of physical and sexual violence including domestic violence.

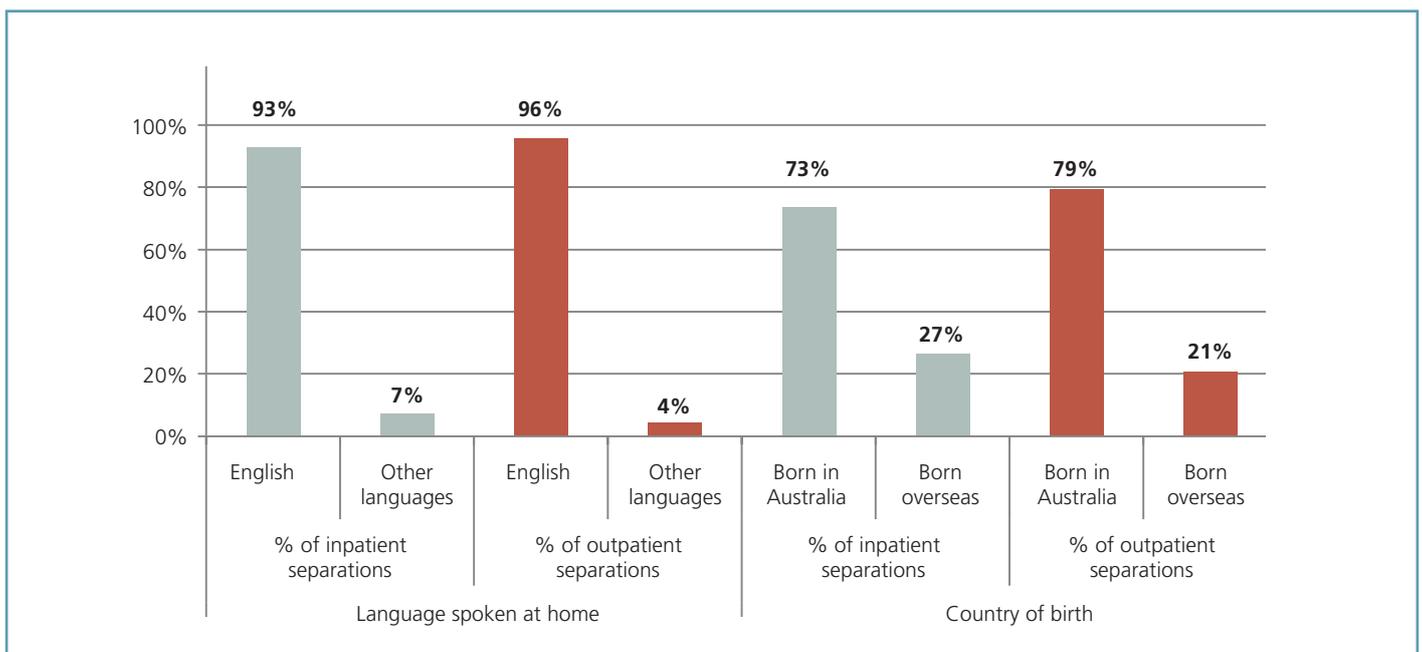
In 2010, among the rough sleepers in City of Sydney:

- 82% reported substance abuse
- 54% had a mental illness
- 48% had a dual diagnosis
- 55% had a tri-morbidity
- 63% had a serious medical issue

Culturally and Linguistically Diverse (CALD) populations

SLHD is culturally diverse with 43% of the population speaking a language other than English at home and 7.5% of Australia's refugee population initially settling in SLHD. Language barriers may create difficulties in accessing services. Figure 3 shows the usage of Drug Health Services for people born overseas and those speaking languages other than English at home. SLHD strives to ensure equal access and services for all people, regardless of their cultural background.

Figure 3: SLHD drug and alcohol separations by country of birth and language spoken at home 2011-2014



Source: Flow-Info V 14.0

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) populations

Lesbian, gay, bisexual, transgender and intersex members of the community may experience more difficulty accessing services and may encounter a higher degree of stigma and discrimination than other members of the community. The LGBTI population may be at a higher risk of developing mental health and substance use problems than the general population. Therefore advocacy, information and support are required to access drug health services including specialist services and NGOs. The national downward trend in drug use has not been seen among this group—there has been no significant declines in daily smoking, risky alcohol consumption or ecstasy use, and no significant rise in the misuse of pharmaceuticals over the past two decades.

LGBTI people are:

- 5.8 times more likely to use ecstasy
- 4.5 times more likely to use methamphetamines
- 2.9 times more likely to use cannabis
- 2.8 times more likely to use cocaine
- More likely to drink at risky levels
- More likely to smoke tobacco

Source: National Drug Strategy Household Survey 2013.

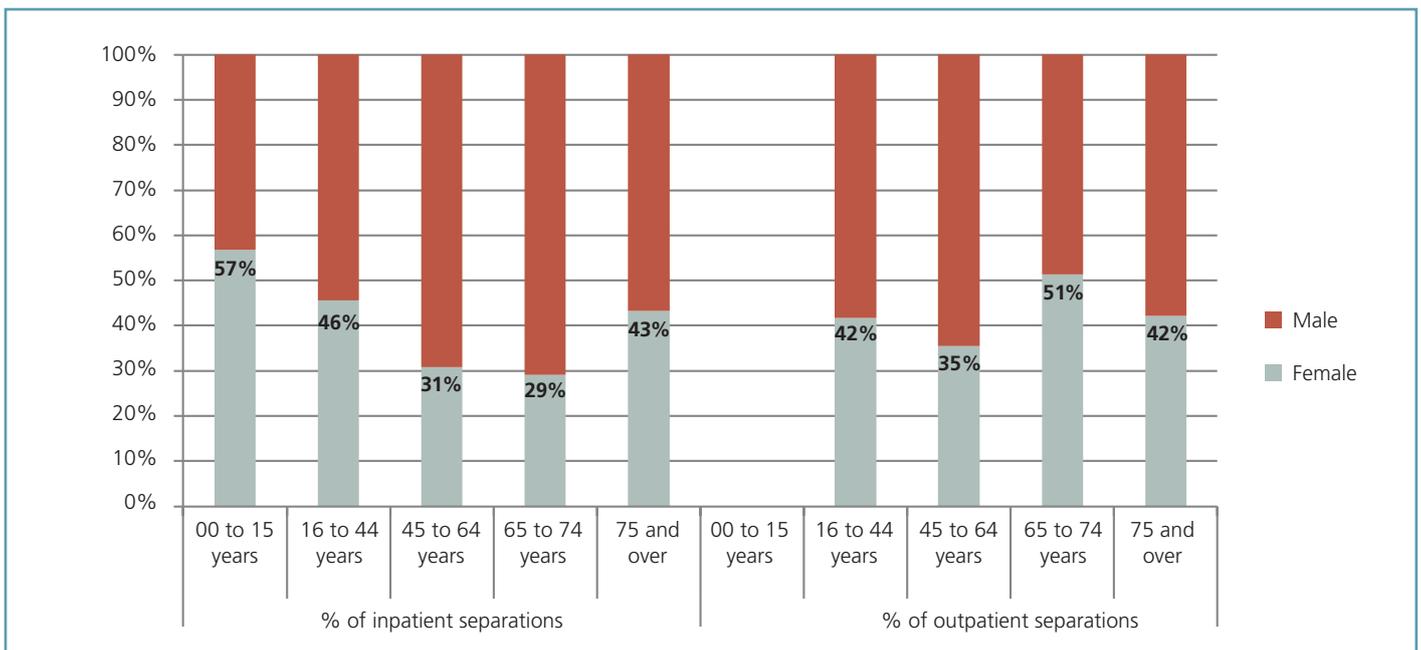
Women and their families

Maternal drug and alcohol use during pregnancy is associated with reduced foetal growth, low birth weight, miscarriage, premature birth and still birth. Between 50-80% of parents in contact with child protection services have substance abuse problems. This cohort often has concurrent mental health problems, little social support, unresolved trauma, poverty and a history of domestic violence. Drug Health Services undertake mandatory Domestic Violence Routine Screening (DVRS) and in 2014, 11% of clients reported experiencing domestic violence. There is a complex interplay of drug use as a contributor to domestic violence.

Domestic and family violence (DFV) is the leading contributor to death, disability and illness in women aged 18-44 years. The adverse effects of exposure to drugs on foetal development, Foetal Alcohol Spectrum Disorder (FASD) include developmental, behavioural and physical impacts on child health.

Figure 4 shows the breakdown of drug and alcohol separations by gender and age for the 2011-2014 financial years. Females represent 40% of total separations in SLHD DHS, with women in the child bearing age group (16-44yrs) comprising 42-46% of total separations over the same period.

Figure 4: SLHD drug and alcohol separations breakdown by age and gender 2011-2014



Source: Flow-Info V 14.0

Young people

Young people’s substance use can relate to a range of issues including parental drug use, socio-economic environment, social support, peer group behaviour, mental health and contact with the criminal justice system. There is a documented correlation between a risk of later harm and earlier onset of use. A high level of cannabis use in adolescence is associated with poorer educational outcomes, lower income, greater welfare dependence and unemployment, poorer relationships and poorer life satisfaction. Substance use can also have short term consequences including injury due to impaired decision making and harmful effects on brain development during critical phases of maturation.

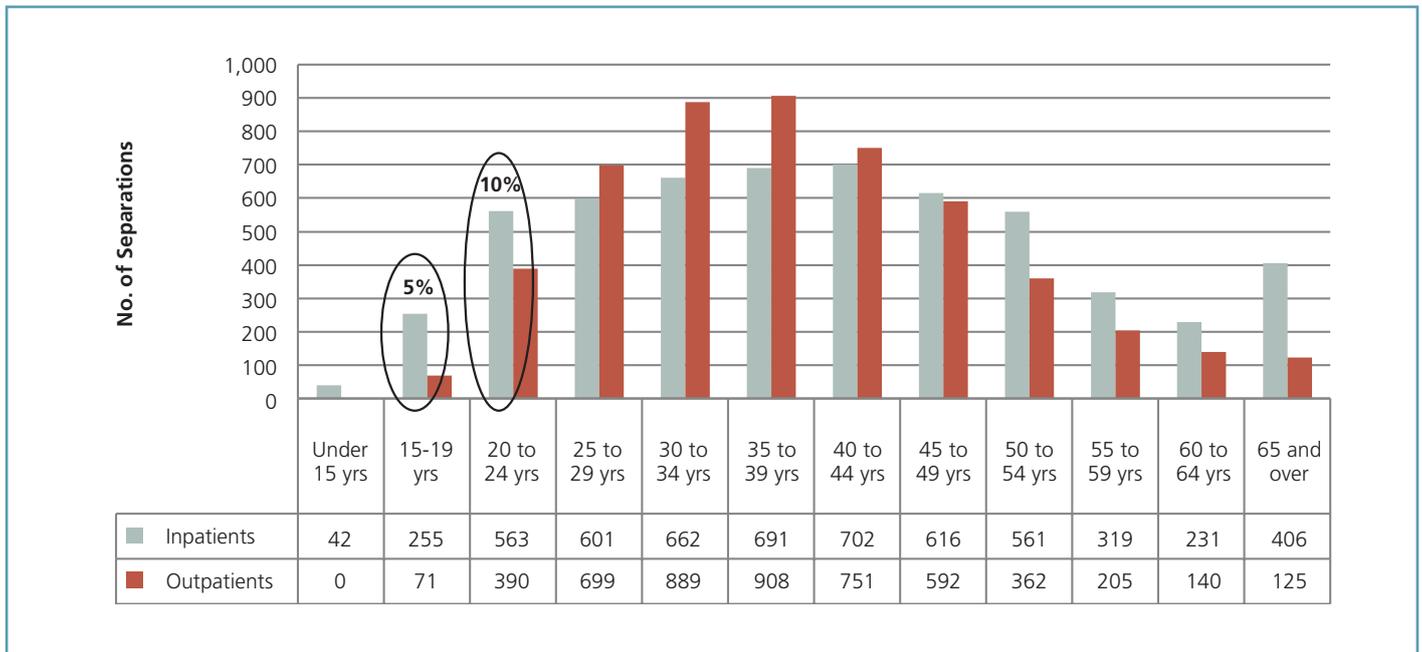
Figure 5 shows that young people under 19 years represented 5% of all separations between 2011 and 2014, (including for alcohol-related admissions). This proportion doubles by the age of 20 years and over, reflecting the need for early intervention to help reduce the engagement of young people with drug use.

Among young people:

- 3.4% of the 12-17 year age group smoke daily
- 15.4% of males and 11.3% of females engage in binge drinking among the 12-17 age group
- Alcohol consumption and binge drinking rises significantly in the 18-24 age group
- Cannabis is the most common illicit drug (15%) in the 14-19 age group
- 4% of the 14-19 age group reported using pharmaceuticals.

Source: National Drug Strategy Household Survey 2013.

Figure 5: SLHD drug and alcohol separations by age group 2011-2014



Source: Flow-Info v 14.0

People with co-morbidities

Co-morbidity refers to having more than one mental or physical disorder at the same time. Problems facing people with co-occurring mental disorders include poorer treatment response and inability to maintain functional stability, higher rates of relapse, more hospital visits, increased involvement in violence, family difficulties, limited social relationships, increased unemployment, victimisation, incarceration, homelessness and a greater likelihood of contracting Hepatitis C.^v

The Australian Institute of Health and Welfare in 2005 identified that the abuse of psychoactive substances such as alcohol and heroin were involved in most cases in Australia where a mental or behavioural disorder was recorded as the underlying cause of death. They also note that the emergence of pseudoephedrine-based amphetamines, the drug 'ice' and the increased potency of cannabis are thought to have a role in the current prevalence of psychosis as comorbidity.

People Who Inject Drugs (PWID)

People who inject drugs inevitably experience numerous health and social harms. High risk associated behaviours include alcohol abuse, illicit use of pharmaceuticals, unprotected sex and drink driving. Depression and anxiety is commonly reported among this population, as well as non-fatal overdose - often due to ecstasy. PWID also have an increased risk of HIV and Hepatitis C infections.

Elderly people

In general, the use of alcohol and drugs declines with age. However, those who persist or increase substance use are likely to experience a greater level of harm. Given that the number of older people has been increasing, the problem of substance use in the elderly is a growing issue that presents a challenge to families, aged care services and the community.

In SLHD, 7% of Drug Health Services inpatient separations related to patients aged 65 and over (Figure 5). Because of the physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance misuse, even at relatively modest levels of intake.

Compared to non-illicit drug users:

- Illicit drug users are twice as likely to have been diagnosed with mental illness
- 17.5% illicit drug users report high or very high psychological distress
- People who smoked tobacco daily are twice as likely to have high psychological distress

Source: National Drug Strategy Household Survey 2013.

In 2013, a National Drug and Alcohol Research Centre (NDARC) survey of PWID showed that:

- 45% experienced mental health problems
- 70% had previous prison history
- 96% reported recent alcohol use
- 94% reported smoking tobacco daily
- 26% experienced a non-fatal overdose
- Median age for first injection was 19 years
- 34% had driven under the influence of alcohol
- 57% had driven shortly after taking an illicit drug
- 2/3 reported obtaining syringes from a Needle and Syringe Program

Source: NDARC 2013 Survey

People with Blood Borne Viruses (BBV)

The Hepatitis B notification rate in SLHD per 100 000 population is approximately 50% higher than the NSW rate^{vi}. Burwood, Ashfield, Strathfield and Canterbury Local Government Areas (LGAs) continue to have high Hepatitis B notification rates. These rates have remained relatively stable between 2010 and 2013.

In SLHD, the Hepatitis C notification rate is approximately 10% higher than the NSW rate. It decreased between 2009 and 2012 but increased slightly in 2013. Sydney, Leichhardt and Marrickville Local Government Areas continue to have high Hepatitis C notification rates.

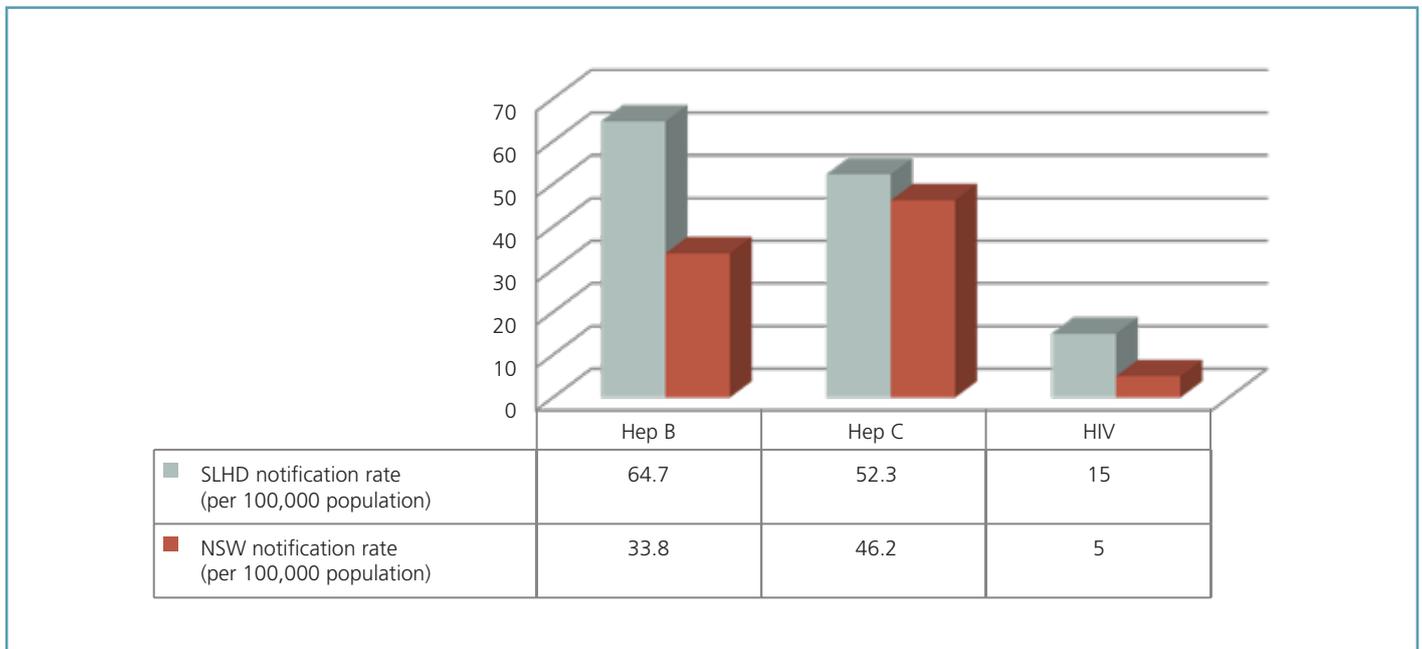
In NSW, both Sydney and South Eastern Sydney LHDs had the highest rates of newly diagnosed HIV infections.^{vii} In SLHD, the rate decreased 22% compared to 2012 and 94% of cases were male. Sydney and Marrickville LGAs had the highest rates. The average prevalence in Redfern between 2009 and 2013 was three times the national and state average^{viii}

People engaged with the criminal justice system

At 30 June 2014, the Australian Bureau of Statistics^{xi} (ABS) reported that the state with the largest prison population was NSW – with 10,566 prisoners, representing 31% of Australian inmates. In the NSW cohort, 15.6% of crime was related to illicit drug use and 24% (2,492 prisoners) identified as Aboriginal.

In 2012, the Australian Institute of Health and Welfare's *The health of Australia's prisoners*^x reported that 70% of 794 prison entrants reported using illicit drugs and almost half (46%) reported consuming alcohol at high-risk levels. Illicit drug use was slightly higher among non-Indigenous (71%) than Indigenous prisoners (67%). High risk drinking was more common among Indigenous (58%) than non-Indigenous (35%) entrants. Among the entrants, 84% were current smokers and almost all of these (93%) smoked daily. In addition, 26% were referred to mental health services following reception assessment.

Figure 6: SLHD notification rates for Hepatitis B, C and HIV



Source: Flow-Info v 14.0

9 Patterns of drug use and impact of related harm

The National Drug Strategy Household Survey is conducted every three years by the Australian Institute of Health and Welfare and provides the best overview of drug and alcohol use across the nation. Key findings from the 2013 report are summarised below.

Alcohol current use and trends

- Daily drinking for both males and females declined from 7.2% in 2010 to 6.5% in 2013 and was at the lowest level since 1991.
- Fewer adolescents were drinking alcohol with those abstaining increasing from 64% in 2010 to 72% in 2013.
- In 2013 almost 5 million people in Australia aged 14 or older (26%) reported being a victim of an alcohol-related incident.
- The average age at which people start drinking increased from 14.4 years in 1998 to 15.7 years in 2013.
- Binge drinking in younger people also declined over the three years but there was little change in people aged over 40.
- Males were twice as likely as females to engage in risky drinking, though prevalence among young women aged 18-24 years was 14.6%.

Alcohol is the principle drug of concern in 56% of all patients seen by the inpatient hospital consultation liaison team in SLHD.

Tobacco current use and trends

Tobacco smoking is a leading cause of preventable illness and death in Australia. It accounted for 8% of the total burden of disease in 2003 and was the major cause of cancer, accounting for 20-30% of cancer in Australia.^{xi}

Australia has been a world leader in reducing smoking prevalence through a comprehensive strategy addressing legislative frameworks, tobacco sales, health education campaigns and quit support. National smoking rates are now among the lowest in the developed world. In SLHD, the current smoking status reported in the Ministry of Health NSW Population Health Survey was 14.1% in 2013, (slightly higher than the state average); a reduction from 24.2% since 2002.^{xii}

Illicit drugs current use and trends

Use of illicit drugs is a direct cause of death and disability and is a risk factor for a number of diseases affecting the drug user and the community. The 2013 National Drug Strategy Household Survey identified:

- The proportion of people using illicit drugs has remained relatively stable with 42% of people aged 14 years and over reported ever illicitly using drugs.
- Cannabis is the most popular illicit drug with recent use remaining stable at around 10%.
- Use of ecstasy and heroin dropped but there was an increase in the misuse of pharmaceuticals.

The NSW Ministry of Health has established a system of periodic data collection to profile drug use behaviour of clients attending Needle Syringe Programs. From all Local Health Districts in NSW, 3,029 individuals participated in the 2014 survey^{xiii}, and methamphetamine was the most commonly reported drug last injected (27%), followed by heroin (25%), and performance and image enhancing drugs (18%).

The National Drug and Alcohol Research Centre (NDARC) also monitors markets, trends in use and harms for ecstasy and methamphetamine-related drugs in all states and territories in Australia. These drugs are reported as easy to obtain and most commonly used in social settings. The summary of the 2013 survey provides a profile and snapshot of use^{xiv}. Participants had a mean age of 25 years, 67% were male, 88% were heterosexual, 60% were single, 26% were in full time employment, 15% were full time students and 44% had post-secondary school qualifications. Median age of first use was 18 years.

- Ecstasy was the drug of choice for 32% and had been used in some form by 99% of participants. Speed powder was used by 37% and cocaine by 36% of the sample.
- Almost one quarter (23%) of participants reported recent ice/crystal use with median age of first use being 20 years and 6% reported recent use of GHB. Significant increases from the previous year were reported for ketamine (19%) and LSD (43%).
- Recent use of cannabis was reported by 85% of participants with age of first use being 15 years.
- In SLHD, the most commonly reported drug last injected was heroin (38%) followed by performance and image enhancing drugs (29%) and methamphetamine (15%).

Prescription medication current use and trends

Australia has witnessed a striking increase in prescription opioid use over the past 20 years with an increase in the number of preparations marketed for use, an increased range of accepted indications for opioid use and an ageing population.

Between 1992 and 2012, opioid dispensing episodes increased 15-fold (500,000 to 7.5 million) and the corresponding cost to the Australian government increased 32-fold (\$8.5 million to \$271 million). Opioid-related harms have also increased.

Opioid-related hospitalisations increased from 605 to 1464 cases (1998–2009), outnumbering hospitalisations due to heroin poisonings since 2001. Deaths due to accidental poisoning (pharmaceutical opioids and illicit substances combined) increased from 151 to 266 (2002–2011), resulting in a rise in the death rate of 0.78 to 1.19 deaths/100 000 population over 10 years. Death rates increased 1.8 fold in males and 1.4 fold in females. The most recent trend has been the escalating use of fentanyl patches which has been linked to both misuse and to a spate of overdoses within Australia and overseas.

Use of other psychoactive medications has overall increased with growing numbers of preparations that are subject to misuse. Quetiapine is prominent as a leading cause of drug-related overdose requiring hospitalisation. Benzodiazepine use remains at a high level but has declined by 25% over the past decade.^{xv}

Australia has experienced a substantial increase in pharmaceutical opioid supply in recent years. Data from the Pharmaceutical Benefits Scheme shows an increase in prescriptions of some pharmaceutical opioids (including oxycodone, buprenorphine and fentanyl) over the last decade. Prescription of benzodiazepines has remained stable or declined over the same period. Analysis of data suggests that prescriptions for oxycodone are increasing in Australia, predominantly for low-dose formulations and for older patients. Increased availability is linked to increased misuse, medical emergencies and poisoning deaths.

Given the high rates of prescription drug misuse, there is also a growing rate of misuse of multiple prescription drugs giving rise to interactions. Most overdoses requiring admission to intensive care units involve use of multiple drugs rather than a single agent.



10

About Sydney Local Health District Drug Health Services



Services for people with drug and alcohol problems include:

- Inpatient and outpatient withdrawal management (detoxification) programs
- Inpatient stabilisation
- Opioid substitution clinics and other pharmacotherapies
- Court diversion programs
- Needle syringe and other harm reduction programs
- Medical consultation and counselling
- Harm reduction and health promotion programs

Services are provided at Canterbury, Concord and Royal Prince Alfred hospitals and at Canterbury, Marrickville and Redfern health centres. Medical consultations are occasionally provided to Balmain Hospital through telephone consultation. Drug Health Services operates with 127 full time staff and a budget of approximately \$13.5 million AUD.

The Service regards community concerns and public amenity issues relating to drug use in the community and treatment provision as a strategic priority. Senior staff participate in a wide range of whole-of-government committees to address these issues including three Community Drug Action Teams (Redfern/Waterloo, Canterbury and Marrickville).

SLHD Drug Health engages with ten drug and alcohol non-government organisations, which receive funding from the NSW Ministry of Health, to oversee planning and performance agreement funds of approximately \$3.3 million.

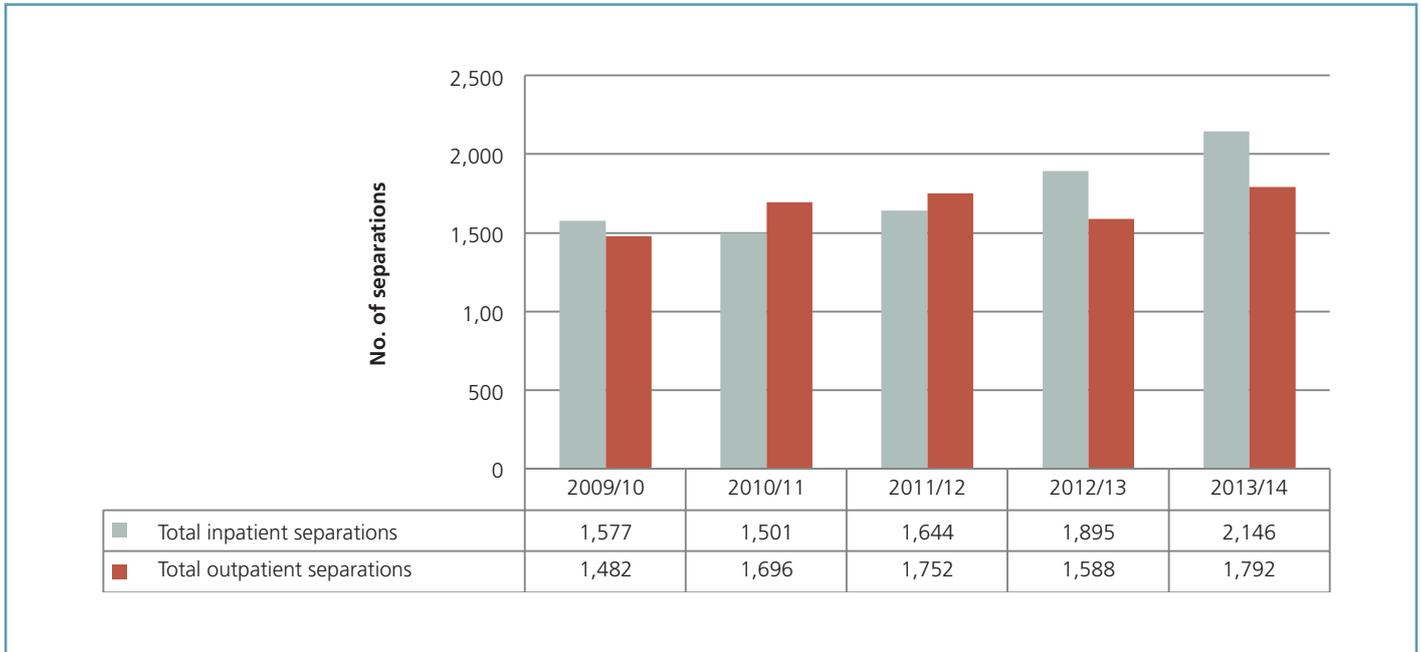
Between the financial years 2009 and 2014, Drug Health Services witnessed a significant increase in drug and alcohol activity (Figure 7). In 2014, SLHD had 569 more inpatient separations than in 2009 and 313 more outpatient separations. Of all drug and alcohol activity, 72% were for SLHD residents and 28% were for residents from other LHDs (Figure 8). The growth rate was mainly related to increased inpatient separations.

Inpatient services

Inpatient withdrawal management and stabilisation unit

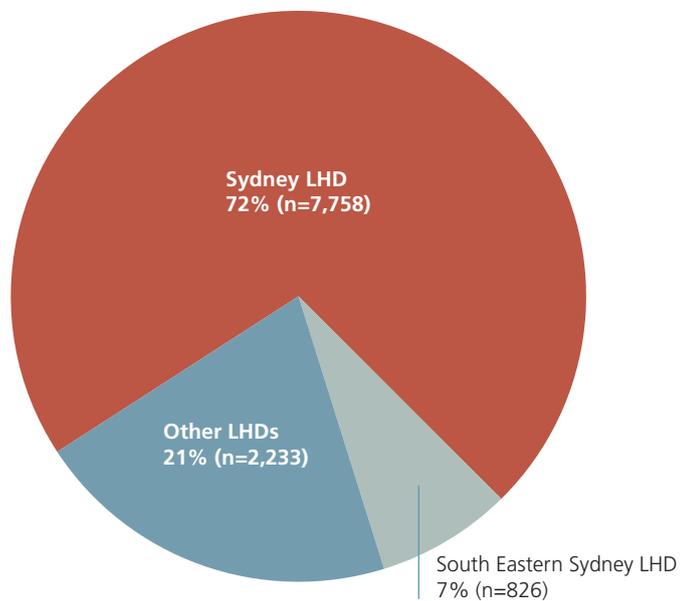
Individualised treatment is provided in a staged approach dependent on the patient's acuity and associated co-morbidities. Withdrawal treatment, stabilisation of complex co-morbid medical and psychiatric conditions, assessment post withdrawal, skills development, education, motivational interviewing and longer term care planning are incorporated in treatment planning. Located at Concord Hospital, patients can undergo withdrawal treatment (up to 7 days) and further stabilisation if needed (up to 21 days). Patients can be transferred to the Stabilisation Unit following withdrawal at another service. Royal Prince Alfred Hospital currently has six beds in the medical ward and access to beds in the Professor Marie Bashir Short Stay Unit for suitable patients to be co-admitted under psychiatry.

Figure 7: SLHD drug and alcohol activity 2009-2014



Source: Flow-Info v 14.0

Figure 8: SLHD drug and alcohol activity by LHD of residence 2011-2014



Source: Flow-Info v 14.0

Hospital Consultation and Liaison (HCL) services

Addiction specialists (medical and nursing) provide assessment, clinical intervention, referral and contribute to discharge planning for emergency department patients and inpatients who have identified drug and alcohol issues. Drug and alcohol advice and training is also provided to the treating teams and to general hospital staff. This service is available at RPA, including the Professor Marie Bashir Short Stay Unit, Concord Hospital and a limited service is provided at Canterbury Hospital. Telephone consultancy is available at Balmain Hospital.

Toxicology service (overdose)

The toxicology/overdose service at RPA supports hospital staff to manage patients in the Emergency Department, on the wards and in the Professor Marie Bashir Short Stay Unit who have overdosed.

Outpatient services

Opioid Treatment Program clinics (OTP)

Opioid Treatment Program clinics provide methadone, buprenorphine or suboxone maintenance treatment for people who are dependent on opioids. In the 2014/2015 financial year, 813 patients received treatment at the opioid treatment clinics. The aim of public health clinics is primarily to stabilise new clients onto pharmacotherapy treatments. When patients have been stabilised they are encouraged to move to community dosing either at private clinics, general practitioner surgeries or pharmacies.

Case management ensures patients have access to a range of interventions for their drug dependence and are assisted in addressing associated social problems such as employment or housing. Case managers also assist with the coordination of care when more than one service is involved.

Public opioid treatment program clinics operate at Canterbury and RPA. Community pharmacies and private clinics provide these services in the community.

Pain management clinics

Drug Health Services provide specialist services to pain management clinics through the provision of weekly clinics and referral. The aim of this service is to jointly manage

patients with both chronic pain and substance abuse problems. In most cases, this refers to chronic non-malignant pain with people experiencing difficulty controlling use of strong opioid analgesics due to opioid dependence. Drug Health Services often assumes the management of patients for whom drug dependence is significantly more prominent than their pain disorder. This service is available at RPA and Concord Hospital.

Outpatient clinics

Outpatient clinics offer medicated withdrawal treatment for patients who have no serious concurrent medical or mental health issues. They also provide medical management of any drug health issue, not provided through the pharmacotherapy or withdrawal management services. In 2014/2015, there were 1,102 completed outpatient consultations, case-management and counselling episodes undertaken by the SLHD outpatient clinics. Referrals are received from General Practitioners or other health professionals and clinics are located at RPA, Canterbury and Concord hospitals. Concord Drug Health Services also offers specialised clinics for 16-24 year olds and cannabis-specific services for patients with first episode psychosis.

Hepatitis services

Drop-in hepatitis clinics, held in partnership with the RPA Liver Clinic, have been established in the OTP clinics at RPA and Canterbury Hospitals and the Redfern Primary Care Clinic in Redfern to increase diagnosis, treatment and management of Hepatitis B and C.

Counselling services

Counselling services assist patients to manage some of the complex issues that relate to substance use. Counselling can be undertaken before, after, or concurrently with other drug health treatments. Counselling services include intake, assessment, individual and group counselling through a range of therapeutic approaches, brief intervention and relapse prevention. Counselling is also available for people whose family members are drug dependent. Counselling models include a trauma informed approach acknowledging that experiences of trauma, including domestic and family violence, can be a root cause for substance use. Services are available at RPA, Canterbury and Concord hospitals.

Tobacco cessation

Tobacco cessation clinics are available at RPA and Croydon health centres. The clinics are free and offer individual and group counselling by trained smoking cessation clinicians for all SLHD staff and patients. Cessation training is also offered to SLHD clinicians. In 2014/15, there were two four-hour clinics per week. 115 patients completed specialist tobacco cessation counselling, an 11.6% increase from the previous year.

Perinatal and family drug health services

This multidisciplinary service provides care to women with drug dependence who use substances during their pregnancy. It also promotes care to babies of drug dependent mothers and significant others. The team includes practitioners from Drug Health Services, Social Work, Neonatal Services and Obstetrics. Post-natal home visiting and support is available for the first two years following birth. In 2014/15, for families engaged with the Perinatal Drug Health team, 22 babies were born to Aboriginal mothers with 15 above the birth weight of 2700 grams, 30 babies were born to non-Aboriginal mothers with 24 weighing above 2700 grams and 73% of all drug-dependent pregnant women had attended more than five antenatal visits.

Magistrates Early Referral into Treatment (MERIT) Program

The MERIT program is a partnership program with the NSW Justice Department. MERIT is a voluntary diversion program for adult defendants with illicit drug use issues who are eligible for release on bail and motivated to undertake drug treatment.

The MERIT program is a three month intervention, reflecting the average Local Court bail period. Magistrates are provided with a comprehensive report regarding the defendant's participation in treatment so that sentences can better reflect rehabilitation prospects. In the 2014/15 financial year, 291 patients commenced treatment under the MERIT court diversion program. MERIT operates from RPA Drug Health Services and attends Burwood and Newtown courts, every Tuesday and Thursday.

Harm minimisation services

The Harm Minimisation Program aims to prevent transmission of HIV, Hepatitis B and C and other blood-borne viruses among people who inject drugs. It is often the first point of contact, providing a gateway to the wider health system for this high risk client group.

There are a number of service options available for all patients:

- Primary Needle and Syringe Program (NSP) services offer a full range of sterile injecting and safe sex equipment, information, referral and disposal facilities.
- Primary health care treatment including care of drug related injuries (wounds and secondary infections), basic health and medical assessments, screening, vaccination and monitoring of chronic hepatitis and HIV infection.
- Secondary NSP outlets provide a limited range of needles and syringes, disposal and referrals services through agencies where the provision of needles and syringes is not one of the prime purposes of the service (e.g. community health centres and non-government organisations).
- Automatic dispensing machines offer access to free sterile injecting equipment 24 hours a day.

In the 2013/2014 financial year, 1,311,485 units of sterile injecting equipment were dispensed across SLHD to prevent transmission of blood-borne viruses (hepatitis and HIV/AIDS).

In addition, there are 36 privately owned pharmacies in SLHD which participate in the Pharmacy Fitpack Scheme enabling people to purchase sterile injecting equipment for minimal cost and provide safe disposal for used equipment.

Primary services are provided at Marrickville, Canterbury and Redfern. The program also includes community consultation, training and education, and active retrieval of sharps.



Teaching and research

Drug Health Services staff specialists provide leadership and teaching in the discipline of Addiction Medicine at the University of Sydney and University of New South Wales. This includes an Aboriginal health promotion course, conducted for Aboriginal health professionals.

The Drug Health Research Unit is located at RPA. Research projects range from early interventions for drugs and alcohol, molecular mechanisms of tissue injury and clinical trials in the treatment of substance use disorders. Most research projects are funded by a number of peer reviewed grants and some involve national and international collaborations. In 2014, the Drug Health Research unit contributed to 50 publications; 35 national and international conference papers and presentations, seven books and book chapters, three reports and current grants amounted to \$12 million. There are sufficient opportunities to undertake post graduate studies in the above areas, from basic science, clinical or public health perspectives.

NSW Drug and Alcohol Health Services Library

The NSW Drug and Alcohol Health Services Library (DAHSL) is a state-wide service co-located with the Susman Library at RPA Hospital. The library supports the clinical, research and educational needs of drug and alcohol health professionals across NSW. It provides access to a broad range of quality evidence-based literature and resources and promotes sound research practices among drug and alcohol health professionals. In 2014/15, DAHSL staff received 823 requests for information and assistance with research.

In 2014, our Drug Health Services research contributed to:

- 50 publications
- 35 conference papers
- 7 books and book chapters
- 3 reports

Current grants amounted to \$12 million

11 Our partnerships

Drug Health Services work with a broad range of partners. These include internal clinical services and primary care providers in the management of individual physical and mental health issues; and government and non-government agencies and the community in the management of the broader social issues.

Internal health partners include Mental Health Services, Gastroenterology, Emergency Departments, Maternity Services, Population Health, Community Health Services (including Sexual Health, Child and Family Health and Youth Health) and Justice Health. External health partners include General Practitioners, community pharmacies, private opioid clinics, drug and alcohol non-government agencies and the Aboriginal Medical Service, Redfern.

Community partnerships include police, community corrections, housing, social services, family and community services, welfare agencies, non-government organisations, local councils, housing advisory boards and Community Drug Action Teams.

Academic partnerships provide links to the Universities of Sydney, New South Wales, and Western Sydney. Research links exist between the Centenary Institute, National Drug and Alcohol Research Centre, Central Clinical Schools and the Schools of Pharmacology and Pharmacy at the University of Sydney.

Aboriginal Medical Service Redfern

Drug Health Services has a long-standing clinical partnership with the Aboriginal Medical Service Redfern providing a range of drug and alcohol treatments and support to patients of the service. There is ongoing exchange of knowledge and skills between staff of the AMS and Drug Health Services.

Headspace

Headspace helps young people aged 12-25, providing support for problems such as depression, anxiety, bullying and body image. There are two centres in the SLHD catchment area.

Shared care

Coordinated care of patients is provided between Drug Health Services, General Practitioners (GPs) who are accredited opioid prescribers and pharmacies which dispense medication in community settings. Drug Health Services provides specialist support to all GPs in the management of complex drug and alcohol issues. In the 2014/15 financial year, 89 opioid patients per month were in shared care arrangements with private providers in SLHD.

Human services partnerships

Drug Health Services is very active in areas with known high levels of drug use and associated public amenity issues. Staff work with partners including Police, Family and Community Services, Land and Housing Corporation, local councils, non-government agencies, community members and local businesses to manage public health issues, improve service integration, support a whole-of-government response to drug use and improve community safety.

Community Drug Action Teams

Since their inception in 1999, Drug Health Services has worked with Community Drug Action Teams (CDATs) to minimise and prevent harmful use of alcohol and other drugs in communities. CDATs bring together community members, local government, NSW government departments and non-government agencies to provide a co-ordinated response to local drug issues. CDATs provide opportunities for education, engagement, brief intervention, training and referral through community networks and events.

NSW Health funded non-government organisations

Ten non-government organisations (Barnados, Co.As.It., Guthrie House, Holyoake, Kathleen York House, Leichhardt Women's Health Centre, Sydney Women's Counselling Centre, The Building Trades Group, The Fact Tree and We Help Ourselves) receive funding from the NSW Ministry of Health through SLHD to deliver drug and alcohol services to the community. Drug Health Services works collaboratively with these agencies, monitoring funding and performance agreements and developing clinical pathways to enhance treatment options for individuals, families and communities.

12 Strategic priorities

This strategic plan identifies six areas of priority to be addressed by Drug Health Services in the next five years.

Priority area 1: Continuous service improvement and high quality clinical care

Commitment to the highest standard of care is a primary focus for Drug Health Services. The service will continue to improve its clinical performance through developing a quality indicators framework that identifies and measures key performance areas within the service. Drug Health Services will continue to review its clinical processes to ensure they are contemporary, evidence-based, effective, efficient and relevant to community needs.

Ongoing service improvement and the development of a quality indicators framework will lead to more measurable, innovative and integrated models of care, as well as better treatment outcomes for our patients.

Priority area 2: Service integration through collaboration with affiliated SLHD services

In order to maximise its efficiency and effectiveness, Drug Health Services will continue to integrate and work in collaboration with its SLHD affiliated services. Drug Health Services aims to create more opportunities to build and improve communication channels across sites and clinical streams. Better aligned and integrated services will maximise the capacity of existing systems to meet the growing demand, enhance cost effectiveness and reduce systemic barriers to seamless patient care.

Priority area 3: Partnerships with primary healthcare, community, government and non-government organisations and professional associations

Ensuring effective partnerships is key to the successful implementation of this plan. In order to address the complex nature of drug and alcohol dependence, Drug Health Services will continue to identify and engage with key stakeholders and care providers. Building on existing partnerships with NGOs, primary health networks and Aboriginal Medical Services, Drug Health Services aim to establish further partnerships with consumer and community agencies. Effective and committed

partnerships will facilitate improved service responsiveness to individual and community needs, improved access to care and will strengthen clinical pathways between primary healthcare, NGOs and Drug Health Services.

Priority area 4: Targeted strategies for high priority population groups

This strategy recognises the importance of targeted services to meet the specific needs of high priority population groups.

Effective, targeted and coordinated service strategies will lead to reduced incidence and severity of drug use harm, empowered individuals, reduced stigma and discrimination, less drug related hospital admissions and improved identification of domestic and family violence.

Priority area 5: Corporate and support services management

Sound corporate and support service management is critical to sustainable service delivery. Drug Health Services aim to enhance its corporate performance through sound information and communication technology, accurate data capturing and management, and robust staff and financial management processes. Drug Health Services will continue to refine these systems and utilise data and auditing mechanisms to guide improvement. Sound corporate management will lead to improved workplace culture, improved service management and greater efficiency.

Priority area 6: Research and education

Drug Health Services is committed to supporting research that is focused on enhancing the capacity of the drug and alcohol sector to address gaps in service, improve service delivery and improve patient/client outcomes. Through the strategies outlined in this plan, Drug Health Services will continue to augment the research program already in place. It is recognised that achieving the goals set out in this plan relies upon providing the necessary training and education to all staff.

Strong research activities and staff professional development will result in enhanced evidence-based service delivery, increased national and international recognition, a more engaged skilled workforce and improved patient outcomes.





13 Outcomes

Through successful implementation of the strategies included in this plan, there are a number of outcomes Drug Health Services aims to attain for each of the following domains:

For our patients, families and carers

- Seamless care
- Higher patient satisfaction
- Better treatment outcomes
- Fewer people with substance use being subjected to stigma and discrimination
- Reduced harm from drug misuse

For our community

- Improved access to care
- Strengthened clinical pathways between community agencies and Drug Health Services
- Improved responsiveness to individual and community needs
- Empowerment of individuals and the community
- Reduced incidence and severity of drug use harm

For our staff

- Supported, engaged and skilled staff
- Positive workplace culture

For our services

- Improved service management
- Innovative and integrated service delivery models
- Greater service efficiency and effectiveness
- Measurable service quality indicators
- Improved outcomes

For our education

- Increased opportunities for professional development

For our research

- Evidence-based service delivery
- Increased national and international recognition
- Research-positive culture

For our organisation

- Greater cost effectiveness
- Reduced drug-related hospital admission

14 Plan implementation and governance

The action plan has been devised with specific strategies to achieve the objectives of this strategic plan. Five timeframes were developed to provide a sequential order of completion throughout the plan term, based on the service priorities.

The implementation of this plan will be monitored by the Drug Health Services Strategic Directions Committee which meets quarterly. The committee will subsequently develop a yearly report at the end of each financial year, in line with performance reporting of Drug Health Services, to be presented to the Drug Health Services Corporate Executive Committee, Drug Health Services Clinical Quality Council and SLHD Clinical Quality Council.

Timeframe	Completed by
Timeframe 1	2016/17
Timeframe 2	2017/18
Timeframe 3	2018/19
Timeframe 4	2019/20
Timeframe 5	Ongoing

15 Drug Health Services Action Plan 2016–2021

Priority 1: Continuous service improvement and high quality clinical care

Outcomes

- Measurable service quality indicators
- Innovative and integrated service delivery models
- Evidence-based service delivery
- Better treatment outcomes

Strategy

Strategy	Timeframe	Responsibility	Performance Indicators
<p>1.1 Develop a quality framework that identifies key performance and quality indicators</p>	1	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • DHS Quality Framework endorsed by DHS Clinical Quality Council • Development of outcome-based performance indicators
<p>1.2 Regularly review Drug Health clinical service models to ensure they are contemporary, evidence based, effective, efficient and address the needs of the community</p>	5	<ul style="list-style-type: none"> • Clinical Director • General Manager 	<ul style="list-style-type: none"> • Clinical Service models are reviewed and progress is monitored by DHS Clinical Quality Council
<p>1.3 Review patient and family centred drug health clinical service provision including:</p> <ul style="list-style-type: none"> • Review DHS intake to ensure the model is effective and facilitates patient access • Provide advice and support to families and / or significant others affected by drug use • Review discharge planning processes to extend the continuum of care and optimise treatment outcomes • Review treatment planning processes to ensure they are patient centred and involve family and/or carers as appropriate 	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Patient and Family Centred Care initiatives are in place
<p>1.4 Increase opportunities for ambulatory withdrawal management, particularly alcohol and prescription medication</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of DHS sites where ambulatory detoxification is offered

<p>1.5 Further develop Toxicology services in SLHD</p>	<p>2</p>	<ul style="list-style-type: none"> • Clinical Director 	<ul style="list-style-type: none"> • Reduce the 12 months representation rate to below 10%
<p>1.6 Increase tobacco treatment interventions across all SLHD clinical streams and within all Drug Health Services programs</p>	<p>2</p>	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of DHS sites where tobacco treatment intervention is offered • Number of clinical/project partnerships in place
<p>1.7 Conduct patient and carer experience interviews and provide opportunities for consumer feedback and relevant suggestions to be incorporated into practice</p>	<p>5</p>	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • In line with SLHD targets
<p>1.8 Complete the implementation of clinical redesign of Concord Drug Health Services to provide for patients with more complex co-morbidities</p>	<p>1</p>	<ul style="list-style-type: none"> • General Manager • Clinical Director • Head of Department, Concord DHS 	<ul style="list-style-type: none"> • Model of Care for Concord DHS is fully implemented
<p>1.9 Ensure unnecessary clinical variation is identified, minimised or removed</p>	<p>5</p>	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Clinical variation is identified through data analysis and reported to DHS Clinical Quality Council
<p>1.10 Expand the Needle and Syringe Program in line with Ministry of Health strategic goals</p>	<p>5</p>	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of ADMs • Number of secondary NSPs • Number of sterile injecting equipment distributed • Receptive sharing rates reduced by 25% • Number of pharmacies participating in the Fitpack Scheme

Priority 2: Service integration through collaboration with affiliated SLHD services

Outcomes

- Improved patient satisfaction
- Seamless care
- Enhanced cost effectiveness

Strategy	Timeframe	Responsibility	Performance Indicators
<p>2.1 Strengthen linkages with key SLHD service providers including:</p> <ul style="list-style-type: none"> • Emergency Department • Mental Health including youth services • Gastroenterology and Liver services • Oral Health • Population Health • Pain management services • Maternity services • Community Health including Sexual Health, Child and Family Health, Youth Health and Women's Health 	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of combined projects / initiatives / service delivery arrangements in place
<p>2.2 Ensure the Memorandum of Understanding and Service Level Agreement with Mental Health Services continues to be implemented to improve management of co-morbidity</p>	4	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Memorandum of Understanding is reviewed annually
<p>2.3 Work with SLHD hospitals to expand access to the drug and alcohol hospital consultation and liaison services</p>	3	<ul style="list-style-type: none"> • Clinical Director • General Manager 	<ul style="list-style-type: none"> • Number of sites where consultation and liaison services are offered
<p>2.4 Ensure regular interface meetings with facility corporate and clinical directors</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of sites where interface meetings are regularly held

Priority 3: Partnerships with primary healthcare, community organisations, government and non-government organisations and professional associations

Outcomes

- Improved access to care
- Strengthened clinical pathways between community agencies and Drug Health Services
- Improved responsiveness to individual and community needs

Strategy	Timeframe	Responsibility	Performance Indicators
<p>3.1 Participate in whole of government committees to develop and implement strategies to address public amenity and other issues associated with drug and alcohol use within a harm minimisation framework (in line with the National Drug Strategy)</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of committees where DHS actively participates
<p>3.2 Partner with Central and Eastern Sydney PHN to:</p> <ul style="list-style-type: none"> • Participate in the HealthPathways Sydney Project to develop referral pathways into Drug Health Services • Provide training for GPs and develop opportunities for shared care models for drug and alcohol treatment 	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of “live” HealthPathways • Number of GP training sessions
<p>3.3 Develop and review an annual Drug Health Services community engagement strategy</p>	2	<ul style="list-style-type: none"> • General Manager • Clinical Director • Program and Community Development Manager 	<ul style="list-style-type: none"> • Community Engagement Strategy is documented, approved by DHS Clinical Quality Council and regular progress reports are available • Number of partnership projects
<p>3.4 Work with NGOs in line with funding and performance agreements</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director • Program and Community Development Manager 	<ul style="list-style-type: none"> • Number of NGO performance agreements reviewed and evaluated
<p>3.5 Partner with community agencies to prevent harms from substance use, including through providing drug and alcohol education, early intervention and brief intervention at selected community events including Redfern/Waterloo, Canterbury and Marrickville</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director • Program and Community Development Manager 	<ul style="list-style-type: none"> • Number of community events attended by DHS staff • Number of CDAT meetings attended by DHS staff
<p>3.6 Support activities of partner agencies, colleges, and professional associations</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of activities where DHS is engaged
<p>3.7 Encourage all Drug Health Services patients to engage with a GP</p>	3	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of patients with GP identified in Cerner

Priority 4: Targeted strategies for high priority population groups

Outcomes

- Reduced incidence and severity of drug use harm
- Fewer people with substance use being subjected to stigma and discrimination
- Empowerment of individuals and community
- Reduced drug related hospital admissions
- Improved identification of domestic and family violence

Strategy	Timeframe	Responsibility	Performance Indicators
<p>4.1 Provide evidence-based information to community partners to improve community awareness and reduce stigma towards people who use drugs</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of community committees and events participated in
<p>4.2 Strengthen assessment, treatment and care coordination for priority populations, people with complex co-morbidities and women experiencing violence</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of patients managed through partnership clinic or programs including: <ul style="list-style-type: none"> • Mental Health • BBV • Increase % of women over 16 years screened for DFV
<p>4.3 Develop strategies to address Drug and Alcohol issues in the Aboriginal population:</p> <ul style="list-style-type: none"> • Partner with the Aboriginal Medical Service Redfern (AMS) to support provision of specialist drug and alcohol treatment and continue shared care drug health model • Increase opportunities for community outreach services to provide early intervention to Aboriginal people • Develop and implement strategies identified by the Aboriginal community and service providers in the Aboriginal Drug and Alcohol Forum • Employ Aboriginal staff to increase cultural safety community liaison and engagement with the Aboriginal community and agencies • Participate in key Aboriginal community events such as NAIDOC and Sorry Day 	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Completed Forum actions • Proportion of positions within DHS that are designated Aboriginal (aim for 2.6% or above) • Number of events where DHS participates • Number of staff who have completed cultural awareness training
<p>4.4 Improve the capacity of DHS to provide services to people of CALD backgrounds with drug health issues through:</p> <ul style="list-style-type: none"> • including appropriate use of interpreter services and cultural competency training • working collaboratively with Multicultural Health to engage with CALD communities 	2	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • % of patients with preferred language other than English

<p>4.5 Develop outreach models of care in partnership with community agencies accessing at risk groups including young people, LGBTI people and people living in areas with known drug and alcohol/public amenity issues</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number and type of outreach models of care
<p>4.6 Identify opportunities to partner with community agencies to provide social support for substance-using women who are pregnant and/or parenting</p>	2	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of strategies implemented • Number and type of support groups
<p>4.7 Identify opportunities to provide services for the homeless population in SLHD</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of initiatives where DHS has participated
<p>4.8 Improve access to drug health services and clinical care of young people with drug health issues through partnership with youth services</p>	2	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of partnerships developed • Number of patients aged <25 years
<p>4.9 Work with Central and Eastern Sydney PHN to develop Continuous Professional Development and health pathways to address the rising number of hospital admission related to prescription opiates</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of pathways developed • Number of education sessions
<p>4.10 Partner with NSW Justice to ensure patients involved with the criminal justice system are provided with drug and alcohol counselling and treatment</p>	5	<ul style="list-style-type: none"> • Clinical Director 	<ul style="list-style-type: none"> • Number of projects developed • Number of clients in MERIT
<p>4.11 Review DVRS data collection and reporting methods to ensure accurate reporting for Ministry of Health DVRS Snapshot Report</p>	1	<ul style="list-style-type: none"> • Clinical Director 	<ul style="list-style-type: none"> • DVRS screening rate
<p>4.12 Partner with Central and Eastern Sydney PHN and other health providers to improve access to Drug Health Services by elderly people</p>	4	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of patients aged 50-64 years; and >64 years

Priority 5: Effective corporate and support services management

Outcomes

- Improved workplace culture
- Improved service management
- Greater service efficiency and effectiveness

Strategy

Strategy	Timeframe	Responsibility	Performance Indicators
<p>5.1 Review DHS corporate processes to ensure best practice including:</p> <ul style="list-style-type: none"> • Implement SJHD Performance Development Framework • Ensure all services have annual business plans to implement the Strategic Plan • Review and monitor Drug Health Services Risk Register 	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of staff who have performance development review plans in place • Annual business plans developed • Risks in ERMS are up to date
<p>5.2 Develop and implement information services systems which facilitate performance monitoring and evaluation and that:</p> <ul style="list-style-type: none"> • are integrated and improve connectivity with the Local Health District systems • have capacity to enable full integration of eMR • facilitate strategy development and implementation for Activity Based Funding • encompasses a replacement plan for IT equipment 	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • eMR integration • CHOC implementation • IT Replacement Plan exists
<p>5.3 Implement Medicare billing strategies to increase revenue</p>	2	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Medicare billing is implemented at all sites
<p>5.4 Identify opportunities for additional funding, revenue generation and efficiency</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Roadmaps are active and effective
<p>5.5 Improve information and resources for patients, families and community through development of the Drug Health Services website</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Internet site is current and accessible

Priority 6: Research and education

Outcomes

- Research positive culture
- Increased national and international recognition
- Research translated into practice
- Increased opportunities for professional development
- Supported, engaged and skilled staff

Strategy	Timeframe	Responsibility	Performance Indicators
6.1 Research			
<p>6.1.1 Promote a research positive culture within Drug Health Services by:</p> <ul style="list-style-type: none"> • Including research in appropriate job descriptions and relevant performance appraisals • Profiling and championing research activities • Encouraging clinicians and researchers to collaborate • Increasing nurse-led research • Improving translation of research into quality projects 	3	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Research is included in relevant job descriptions • Number of services that actively participate in research projects • Number of research projects
<p>6.1.2 Establish a 'Drug Health Research Centre' to facilitate staff research, increase successful grant applications, raise the profile of research across Drug Health Services</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Drug Health Research Centre is established
6.2 Staff education and professional development			
<p>6.2.1 Embed the Drug Health Services CORE (Collaboration, Openness, Respect, Empowerment) values throughout Drug Health Services to encourage a respectful, harmonious and professional environment</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Outcomes from staff and consumer surveys
<p>6.2.2 Participate in relevant strategies promoting healthy staff</p>	3	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Staff satisfaction surveys
<p>6.2.3 Continue to support staff professional development</p>	5	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Clinical Supervision is in place • Staff are supported in accessing professional development opportunities
<p>6.2.4 Strengthen relationships with universities and colleges to provide training models in current evidence-based treatment for future health professionals</p>	2	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of sites where student placements are offered
<p>6.2.5 Provide opportunities for graduate trainee placements and rotations</p>	3	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of sites / services offering graduate trainee placements and rotations
<p>6.2.6 Expand Drug Health Services clinical placement capacity</p>	3	<ul style="list-style-type: none"> • General Manager • Clinical Director 	<ul style="list-style-type: none"> • Number of sites / services offering clinical placements

16 Glossary

Abstinence refraining from drug and/or alcohol use at all times.

Amphetamines central nervous system stimulants.

Benzodiazepines sedative/ hypnotic drugs such as diazepam and alprazolam.

Binge drinking refers to a pattern of heavy episodic alcohol consumption.

Brief intervention a treatment strategy in which a short structured therapy is offered, on one occasion or over several appointments. Aims to assist a person to reduce or cease drug and/or alcohol use.

Buprenorphine a long acting partial agonist – used to treat opioid dependence.

Cannabis a generic term given to the psychoactive substances found in cannabis sativa. The main active constituent is delta 9-tetrahydrocannabinol.

Diversion Program drug and alcohol treatment or education program for people referred by the criminal justice system, which typically includes the aim of reducing incarceration.

Drug-substitution treatment opioid substitution therapy supplies illicit drug users with a replacement drug, a prescribed medicine such as methadone or buprenorphine, which is usually administered in a supervised clinical setting.

Early Intervention the process of providing specialist intervention and support services for a person who needs them, either early in the life course, and/or early in the development of an issue or problem.

Ecstasy tablets are supposedly made up of the primary ingredient methylenedioxymethamphetamine (MDMA), but as the ingredients required to make synthetic drugs are sometimes difficult to obtain, the formulation of pills marketed as ecstasy can vary greatly.

Hallucinogen a substance that alters perception, typically by inducing illusions or hallucinations.

Harm minimisation the principle of harm minimisation underpins the National Drug Strategy and refers to interventions aimed at reducing drug related harm. It aims to reduce the adverse health, social and economic consequences of the use of licit and illicit drugs even if a person is not able to immediately cease use.

Harmful use a pattern of substance use that may cause harm to health, relationships, employment and other social factors.

Heroin an opioid, and so has depressant effects.

Illicit drugs drugs whose production, sale or possession is prohibited.

Opiate one of a group of substances derived from the opium poppy with the ability to induce analgesia and euphoria.

Opioid the generic term applied to alkaloids from the opium poppy, their synthetic analogues and compounds synthesised in the body.

Performance and Image Enhancing Drugs (PIEDS) substances that are used to enhance muscle growth and/or reduce body fat. The most commonly used substances are veterinary and human anabolic androgenic steroids.

Methadone a long-acting, synthetic opioid drug used in substitution therapy for those dependent on opioids.

Meth-amphetamine a central nervous system stimulant related to amphetamines. It is commonly known by the street names “ice” or “meth”.

Prevention primary prevention – measures to stop a harm event or health condition from occurring at all (e.g. reducing supply of alcohol to young people or education about drugs); secondary prevention – detection or intervention with those of early signs of a health condition (e.g. screening and early intervention for unhealthy drinking; screening for blood borne viruses); tertiary prevention – ameliorating or treating a health condition that has already occurred (e.g. treating alcohol dependence; or opioid dependence; or treating Hepatitis C).

Stimulants drugs which increase activity in the central nervous system.

17 Abbreviations

ADM	Automatic Dispensing Machine	Hep C	Hepatitis C Virus
AIDS	Acquired Immune Deficiency Syndrome	HIV	Human Immunodeficiency Virus
AMS	Aboriginal Medical Service	LGA	Local Government Area
BBV	Blood Borne Viruses	LGBTI	Lesbian Gay Bisexual Transgender Intersex
CALD	Culturally and Linguistically Diverse	MERIT	Magistrates Early Referral into Treatment
DAHSL	Drug and Alcohol Health Service Library	NDARC	National Drug and Alcohol Research Centre
DHS	Drug Health Services	NGO	Non-Government Organisation
DFV	Domestic and Family Violence	NSP	Needle Syringe Program
DVRS	Domestic Violence Routine Screening	PHN	Primary Health Network
eMR	Electronic Medical Record	PWID	People Who Inject Drugs
Hep B	Hepatitis B Virus	SLHD	Sydney Local Health District

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