

DRUG & ALCOHOL CLINICAL SERVICES PLAN



2017



Health
South Eastern Sydney
Local Health District

South Eastern Sydney Local Health District
Locked Mail Bag 21
TAREN POINT NSW 2229
Phone: (02) 9540 8181
Fax: (02) 9540 8164

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Foreword

Jeffrey Wegner

Consumer Representative
SESLHD Drug & Alcohol Service

“Consumer Participation is not a project it is a change in culture”. The most significant changes that need to be made are not only structural ones but ones around stigma and discrimination. These are profound and difficult as clients of drug and alcohol services often internalise and see themselves in the negative way that is constantly reinforced by ignorance, mass media and anti-drug movements.

It is common sense to say that the importance of having consumers involved in Drug and Alcohol service delivery cannot be overstated. Consumer Involvement effects in a very crucial way the way services deliver, and relate to clients. The effect on outcomes can be pivotal for all concerned.

SESLHD Drug and Alcohol Service is making great inroads with its Consumer Workers but what progress have we made? Has that culture changed? From a consumer's point of view, I answer, yes but also no.

When asked to define “Consumer Participation” in terms of the work done by this writer, a consumer said “well, we talk to you in a different way, because we know you have the experience”. The point is crucial - having ground-up as well as professional and academic experience.



Gerry Marr

Chief Executive, SESLHD

Alcohol, prescription and other drugs are a significant cause of ill health in Australia. The SESLHD Drug and Alcohol Service has the lead responsibility across the District for addressing the significant harms that substance use causes in the residents of SESLHD and the consumers of our services. It cannot do this alone and requires the support of many other SESLHD services and partner organisations.

This Clinical Services Plan details the approach SESLHD will take over the next 5-10 years to address these important health issues. It is the culmination of much work and consultation with service providers across SESLHD, other government services, NGOs and consumers over many months. It provides the framework for what an innovative and integrated health system should look like in addressing substance use in our society, with a focus on health service responses. I would like to acknowledge the contribution of workers and consumers in developing this plan. It exemplifies their remarkable dedication to improving services for those experiencing problems related to substance use.

Professor Nick Lintzeris

Director, Drug and Alcohol Services, SESLHD

Most Australian adults have used alcohol, prescription or other drugs in the past year. About 1 in 6 Australian experience significant harms from their substance use, yet only about 1 in 6 of these have access to drug and alcohol treatment services. Substance use also impacts upon families, employers, the criminal justice system and the health system. Over 30% of hospital presentations are related to substance use.

SESLHD recognises the importance of having a systematic response across its community and hospital based services to address this important health issue together. Individuals with substance use problems experience poorer health and social outcomes, and often encounter stigma and discrimination in the community, and when accessing health services.

This Plan maps out the strategic directions for how SESLHD will provide person-centred and integrated health care for people with substance use problems, how we will enhance the capacity of hospital and community based services to better address substance use issues in their patients, and how we will continue to improve our Drug and Alcohol Services through better consumer and carer engagement, workforce development, research and evaluation and clinical information systems.



Executive Summary

The SESLHD Drug and Alcohol Clinical Services Plan (the Plan) outlines the strategic directions and priorities for clinical, service and capital development of drug and alcohol services within SESLHD over the next 5-10 years.

It provides an overview of current service delivery and presents the case for change required to ensure an appropriate range of services are provided to meet the needs of the SESLHD population. Its scope is inclusive of drug and alcohol services delivered by SESLHD Drug and Alcohol Service [DAS] as well as other health services within SESLHD.

The plan has been informed by relevant policy at Commonwealth and State levels and by the strategic directions of SESLHD. It was developed following extensive consultation internally within SESLHD and with our key drug and alcohol partners in the community.

Many sectors and providers play a key role in addressing drug and alcohol [D&A] issues within the SESLHD catchment area. Central to the achievement of the Plan's intended outcomes is collaboration and partnership between SESLHD Drug & Alcohol Services [DAS] with key internal (within SESLHD) and external partners. In addition, the Plan acknowledges the integral role of consumers and carers in informing service direction and driving change.

The overarching goal of the Plan is to improve health and social outcomes for individuals, families and the community related to drug and alcohol use.

Whilst the Plan applies across the SESLHD catchment area, it particularly focuses on the priority population groups of people with moderate to severe substance use disorders, people with complex presentations and comorbidities, and disadvantaged populations (consistent with the SESLHD Equity Strategy).

The Plan outlines three strategic directions:

1. **Provide accessible, high quality D&A treatment services aligned with community and individual needs. This is done in partnership with other (non-SESLHD) specialist D&A services**
2. **Enhance the capacity of other health (non-specialist D&A) services to manage D&A issues in their client populations efficiently and effectively**
3. **Ensure the sustainability and continued development of SESLHD D&A Services.**

A comprehensive implementation plan will be developed by DAS and key partners, as well as mechanisms for monitoring and reporting on progress.

Photo of a section of a tile mural created by clients of the Drug & Alcohol Service at the Langton Centre, Surry Hills



SESLHD D&A Services

A District wide service for people experiencing problems related to the use of alcohol, pharmaceutical or illicit drugs.

Our focus is the provision of clinical services across community and hospital settings, collaboration and support for other service providers in addressing substance use in their client populations, and research and evaluation to continue to improve services for our client population.

Plan at a Glance

OUR GOAL

Improve health and social outcomes for individuals, families and the community related to drug and alcohol use

Provide accessible, high quality D&A treatment services aligned with community and individual needs

- Improve equity of access, experience and outcomes for D&A clients across the SESLHD catchment area
- Deliver coordinated, person-centred care to clients within an integrated care framework

Enhance the capacity of other health (non-specialist D&A) services to effectively address D&A issues in their client groups

- To enhance responses to clients with D&A related presentations in acute hospitals, including multidisciplinary hospital D&A Consultation Liaison, outpatient and inpatient presentations
- To enhance responses to clients with D&A related presentations in other health and welfare sectors, including primary care

Ensure the sustainability and continued development of SESLHD D&A Services

- Consumer and carer engagement
- D&A workforce capacity and engagement
- D&A services provided from appropriate locations, in fit-for-purpose facilities
- DAS clinical, hospital and corporate governance processes
- Research, evaluation and continuous quality improvement activities

KEY PARTNERS

- D&A services in other LHD/Ns (SLHD, St Vincent's, SCHN, Justice Health)
- Non-government D&A providers
- Private providers (including primary care and specialist D&A services)
- Peak groups: MoH AoDP, NADA, CESPNN

KEY PARTNERS

- SESLHD non-D&A specialist services including acute hospitals (POWH, RHW, SSEH, SGH, TSH), Mental Health, DPPH&E, PI&CH
- Other health sectors including primary care providers & CESPNN

KEY PARTNERS

- Consumers and Community Representatives
- SESLHD Hospital General Managers, Professional Leads (Medicine, Nursing, Allied Health), iiHub
- Universities (UNSW, USYD)

Introduction

Substance use disorders [SUDs] have a significant impact on the health of the community and result in substantial social and economic cost. People with SUDs attend all parts of the health system, including hospitals, primary care, Non-Government community based services and specialist drug and alcohol [D&A] services. The responsibility for addressing the health issues for people presenting with SUDs is shared across these various parts of the health system.

SESLHD plays a key role in addressing D&A issues within the local population. It achieves this through services delivered by SESLHD specialist D&A Services [DAS] and by other health services within SESLHD including acute services (hospitals, Emergency Departments), Mental Health, Women's and Children's Services and community based services including for example Aboriginal Health, HIV and Related Programs Unit (HARP) and Kirkeaton Road Centre.

The purpose of this Clinical Services Plan is to inform the direction, of and priorities for, drug and alcohol clinical services, service and capital development within SESLHD over the next 5-10 years: 2017 to 2022 with a view to 2027.

Its scope is inclusive of services delivered by DAS as well as other health services, where the respective roles are:

- SESLHD DAS is funded as a specialist treatment service and provides a broad range of clinical treatment options for people with moderate to severe SUDs, including alcohol, pharmaceutical and illicit drugs. It also supports other SESLHD and external services to identify and address SUDs in their client population – through clinical pathways, clinical support services (e.g. outreach and hospital D&A consultation liaison services [HDA-CL]), workforce development and quality improvement (including research) activities.
- Within the LHD catchment area, a broad range of non-government [NGO] agencies provide D&A services to the population, particularly in the areas of residential rehabilitation services and services targeting specific population groups. Other Local Health Networks (including St Vincent's Health, Sydney Children's Hospitals and Justice Health Networks), NGO and private specialist D&A services, and the primary care sector are significant providers of D&A treatment services to people with SUDs. As a specialist D&A service, DAS has a key role in networking and supporting the work of community-based services, including through the development of clinical pathways for referral and provision of specialist D&A outreach services.
- Other health services (acute services, Mental Health, Women's and Children's Services and community based services) identify and manage less severe SUDs for people in their care and refer to DAS for complex care for those with more severe SUDs. These services also address other health and social needs of people with severe SUDs.

SESLHD recognises the important role of prevention in the field of Drug and Alcohol; however, primary responsibility for this remains outside the LHD, including with non-health agencies such as regulatory agencies, education services and community development organisations. DAS is committed to working with other agencies and sectors where appropriate to support D&A prevention initiatives.

SESLHD also recognises that services for tobacco cessation and prevention are also important in achieving health outcomes for the population, however general tobacco cessation and prevention activities are not in scope for this plan, and are addressed by services and health promotion activities overseen by SESLHD's Directorate of Planning, Population Health and Equity [DPPHE]. SESLHD DAS does however address tobacco cessation services for DAS clients. Similarly, services for those experiencing gambling related addiction are currently not in scope of SESLHD DAS.

3

Our Goal, Strategic Directions and Priorities

Our goal is to improve health and social outcomes for individuals, families and the community related to drug and alcohol use.

Our strategic directions aim to be flexible in responding to emerging issues in substance use in the population and trends in client presentations, and we seek to build capacity within and outside of the specialist Drug and Alcohol Service towards achieving our goal.

There are three broad strategic directions.

Strategic Direction 1:

Improve access to high quality D&A treatment services aligned with community and individual needs

People with SUDs require access to a range of D&A services provided in community, residential and hospital settings. These include comprehensive assessment, withdrawal, psychosocial services, residential rehabilitation services, medication-assisted treatment approaches and peer-support services. People with SUDs also have a range of other health and social conditions, often attended to by other health and social service providers. Optimal care for people with SUDs requires both access to high quality specialist D&A treatment and an integrated care approach of working effectively with other service providers to address other health and social conditions.

The CSP recognises the need to enhance access to high quality D&A services across the SESLHD catchment area, and the need for D&A services to work collaboratively with other health and welfare services to address the broader needs of clients, consistent with the principles of person-centred care within an integrated care framework.

Priority 1:

To improve equity of access, experience and outcomes for D&A clients across the SESLHD catchment area

SESLHD DAS will continue to prioritise and enhance services for clients with moderate to severe SUDs and complex treatment needs arising from their pattern of substance use (e.g. management of high-risk alcohol withdrawal), and/or a range of concurrent mental health, physical health, cognitive and social conditions (including homelessness, child protection and domestic violence issues). Our highly specialised and multidisciplinary workforce, and specialist community and hospital-based services ensure that we will continue to have a central role in providing services to individuals with complex treatment needs.

The plan also recognises that D&A services are provided by multiple service providers including SESLHD, St Vincent's Health Network and other Networks, NGOs, primary health and private providers. It is essential that we strengthen these partnerships and improve the experience of clients in navigating the D&A treatment system.

Proposed strategies seek to improve clinical referral pathways with better coordination and transfer of care across services, enhance efficiencies to minimise gaps in service delivery, and to build capacity within service providers. Examples include: regular networking for D&A service providers (including DAS, NGOs, private providers and primary care); and more effective partnerships with primary care partners enabling them to respond effectively to substance use issues in their clients.

DAS is committed to collaborating with key external D&A partners to advocate with funding bodies (e.g. commonwealth and state governments, universities, philanthropic sources) for the enhancement of D&A services across the SESLHD catchment area such that clients have better access to the continuum of care and support they require.



Health
South Eastern Sydney
Local Health District

South East Aboriginal Health Care



02 9540 8181



02 9540 8165



SESLHD-SEAHC@health.nsw.gov.au



Develop and implement a SESLHD Aboriginal D&A strategy

Aboriginal people are a priority population for SESLHD and for DAS, and increased efforts are required to address the D&A issues of Aboriginal communities. Currently there are gaps in service provision as well as limited understanding of specific needs and approaches required to meet the needs of communities within the catchment area.

A specific Aboriginal D&A strategy for SESLHD with a focus on building workforce capacity, young people and co-production with the community, utilising culturally appropriate approaches developed in partnership with SESLHD Aboriginal Health and other key internal and external stakeholders/service providers, will drive the necessary change to address these gaps.

Equitable access to specialist D&A services is an important consideration in addressing community needs. Our review identified a number of geographic and population-specific groups where explicit strategies to improve access to treatment services are required. In particular:

- Greater attention is required to the needs of Aboriginal communities in addressing substance use, and a specific SESLHD Aboriginal D&A Strategy will be developed in collaboration with relevant partners.
- Specific strategies are identified to improve access for people living in the areas of Botany, Maroubra and Malabar, and Sutherland.
- Particular strategies are required to address populations who may not routinely access traditional specialist D&A services – either due to age (youth, elderly) or cultural issues (Aboriginal and culturally and linguistically diverse, LGBTQI, people experiencing problems with prescription drugs). Innovative approaches and collaborations (in-reach, out-reach, co-location models) will be required to work more effectively with these population groups and services that already have access to these clients, and build upon existing collaborations (e.g. headspaces for youth, collaborations with older persons, mental health co-morbidity, pain, HCV treatment and Chemical Use in Pregnancy Services [CUPS]).
- The plan also identifies access issues for employed individuals who often struggle to access services during normal working hours (Mon-Fri, 9AM-5PM), when most specialist D&A services operate.

Ultimately, our goal is to improve the experiences and outcomes for clients accessing D&A services. A range of strategies is identified in the plan to continue to enhance consumer engagement with D&A Services, and to develop more effective responses to working with carers.

Priority 2:

Delivering person-centred care within an integrated care framework

Clients attending D&A services often have a range of other health and social problems, which may or may not be directly related to their substance use. Historically, D&A services (like many other areas of specialist health care) tended to operate in isolation from other health providers, focusing on the delivery of specialist interventions, but not always effectively attending to broader client needs or coordinating care with other service providers. There is now greater recognition in chronic disease management of the importance of person-centred care - focussing on client engagement in decision making and treatment planning, and in the principles of integrated care – with greater co-ordination between service providers to better address the broader needs of clients.

A key focus in the plan is to continue to strengthen and embed principles of person-centred care and integrated care for DAS clients. This includes developments in:

- The way we work with clients, continuing to embed treatment processes for all clients, such as:
 - Comprehensive assessments (addressing substance use, physical and mental health, cognition, and a broad range of social conditions including homelessness, legal, child protection and domestic violence issues)
 - Global Care Plans identifying the range of issues that are important for each client, client goals, and the range of services involved in the client's care to achieve these goals
 - Communication and co-ordination between service providers for each client (e.g. sharing care plans, transfer of care documentation), within the principles of client informed consent and privacy.
- The way we work with other service providers, including primary care, mental health, acute hospitals and welfare services. This includes approaches such as:
 - enhancing clinical pathways between services, and where appropriate co-location of services (e.g. in-reach, outreach)
 - specific projects (e.g. enhanced HCV treatment, contraception clinics, oral health services)
 - in some cases the development and implementation of specific strategic plans to address priority issues (e.g. Mental Health-D&A, Aboriginal D&A strategic plans).



Targeting clients with complex presentations

DAS currently operates a number of services and initiatives that aim to engage clients with complex needs who are at risk of not accessing D&A treatment.

This includes the Chemical Use in Pregnancy Service, the Enhanced Community Care Options Team [ECCO], the 'Memory Clinic', Pharmaceutical Opioid Clinic, and D&A-Mental Health co-morbidity clinics. The Plan will enhance existing services and develop additional strategies to better engage clients at risk.

Strategic Direction 2:

Enhance the capacity of other health sectors and services to effectively address D&A issues in their client groups

Substance use has an enormous impact upon broader health services, affecting acute hospitals, mental health, community and primary care services, and spanning all age groups and postcodes across the District. Not all individuals with a substance use disorder or substance use related presentation will receive direct clinical services from SESLHD DAS – either due to poor identification of substance use disorders across the health system, not having a sufficiently severe substance use disorder requiring referral or ‘transfer of care’ to SESLHD DAS, or clinical models of care that prioritise ‘shared care’ across service sectors – such as consultation liaison services in acute hospital settings. Unfortunately, stigma and discrimination against people with substance use disorders continue to be a concern across health services, and can also detract from clients accessing optimal care.

A key role for SESLHD DAS is to enhance the capacity of health services from other sectors (not specialist D&A services), to identify and address D&A-related conditions in their clientele; with the aims of enhancing appropriate care for clients, enhancing efficiencies across health services, and ultimately to enhance client outcomes.

There are two broad priorities within Strategic Direction 2:

Priority 1:

To enhance services and responses to clients with D&A-related presentations within acute hospitals

Research studies estimate that approximately 1 in 3 presentations to acute hospitals (including EDs) are drug and alcohol related, although a large proportion of these remain unidentified during routine clinical care. Recent data indicates that across SESLHD acute hospitals, 4.5% of separations and 8.4% of admitted bed days account for activity where either the principal and/or the top three secondary diagnosis for admission is drug and alcohol withdrawal or overdose.

Key strategies to enhance responses in hospital include:

- a funding and activity model that enables expansion of multidisciplinary Hospital D&A Consultation and Liaison services to address need/demand across SESLHD hospitals. Existing ‘block funding’ of HDA-CL services does not enable growth as hospital activity expands
- enhancing capacity for D&A admissions across the four acute SESLHD hospitals; at present, inpatient admissions under D&A Services are limited to SSEH (7-days a week) and SGH on weekdays
- workforce development of the hospital workforce (medical, nursing and allied health) to provide appropriate screening, treatment and/or referral of clients with D&A related conditions
- strengthening clinical pathways between DAS and hospital services, ensuring continuity of care between hospital and community settings, and embedding hospital avoidance strategies that aim to reduce preventable hospital presentations related to substance use.

Priority 2:

To enhance responses by non-specialist D&A service providers in community settings to clients with D&A related presentations, including primary care services

Substance use disorders often remain undetected in many clients across the health system, and screening for high-risk patterns of use (e.g. alcohol) and substance use disorders is widely recommended in particular clinical settings, such as primary care. Once identified, appropriate D&A treatment interventions can be safely and effectively delivered to many clients with mild or moderate severity substance use disorders by ‘generalist’ (non-D&A) providers in community settings, particularly where supported through training, clear clinical pathways and the ability to ‘escalate’ or transfer care to specialist services if problems arise. Such ‘stepped care’ approaches are increasingly recognised as an effective way of conveniently tailoring interventions for clients, with more efficient use of resources than referring ‘every client with a D&A problem’ to a D&A Service – a recipe for system congestion and poor client experience.



Enhance responses for clients with D&A related presentations in primary care settings

The capacity of primary health providers to identify and address the needs of individuals with substance use disorders will be improved by improved clinical pathways for referral and communication, stepped care and shared care models of service delivery, and workforce development activities.

Coordinated approaches are particularly required in primary care settings, and in community based services that have high prevalence of substance use disorders, including mental health, pain services, Aboriginal health, youth services, women and perinatal services (e.g. chemical dependency services).

SESLHD DAS will seek to work with these services to develop and implement a range of strategies aimed at enhancing their ability to identify and respond to substance use in their clients, including:

- Clear and effective clinical pathways that assist clinical decision making, and assist in coordination and transfer of care between D&A and 'generalist' services
- Support systems that enable 'generalist' workers to get assistance in managing D&A issues in their clients – such as 'shared care' models in primary care, consultation liaison service models, co-location of services and/or specialist referral clinics
- Workforce development and training opportunities
- Participation in quality improvement, research and evaluation activities.

Strategic Direction 3: Ensure the sustainability and continued development of D&A services

Strengthening the foundations and infrastructure required for the ongoing development and enhancement of SESLHD D&A services over the life of the plan is the focus of Strategic Direction 3.

Priorities include: strengthening models for better consumer, carer and staff engagement; continuing to develop D&A workforce development and capacity; ensuring DAS are provided from appropriate locations, in fit-for-purpose facilities with certainty of occupancy; enhancing the use of clinical information systems to further develop 'data-informed' services and coordination of care with other services; strengthening the culture of research, evaluation and continuous quality improvement; and implementing appropriate systems for high quality clinical and corporate governance.



Chemical Use in Pregnancy Service (CUPS)

CUPS helps women with drug & alcohol problems and their families before, during and after pregnancy. They are linked to perinatal services at the Royal Women's, St George and Sutherland Hospitals. Postnatal follow-up clinics are also available for babies needing treatment for neonatal abstinence syndrome.

4

Framework for D&A Service Delivery

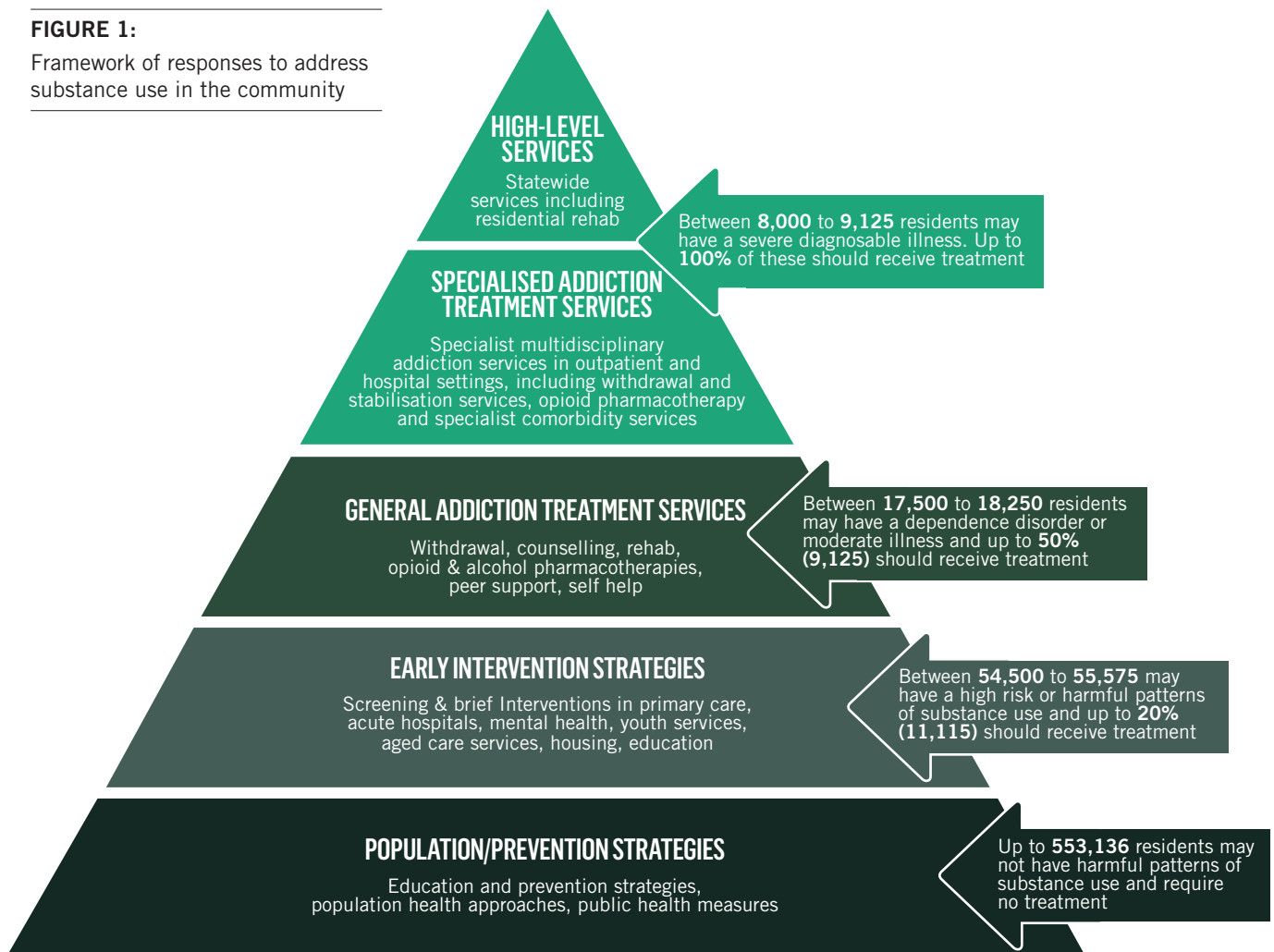
4.1 A response to address substance use in the community

The spectrum of health interventions to address substance/drug and alcohol use ranges from population health interventions through to high level specialist services.

Services at the top three tiers of the pyramid target individuals with substance use disorders. The top two tiers target those with severe and complex SUDs, and are primarily provided by specialist Drug and Alcohol Services in LHD/N, NGO and private sectors. General addiction treatment services are provided by specialist D&A services and a range of community providers in primary care and other health sectors (e.g. mental health, HIV/HCV, perinatal, youth and older persons, Aboriginal services). Although DAS does not directly conduct prevention or early intervention initiatives, it acknowledges the critical role of such interventions in the D&A field and it is committed to working with key stakeholders as appropriate, to enhance work in this area.

An estimate of the prevalence of substance use disorders in the SESLHD population between 15 to 64 years of age has been modelled and included in Figure 1 below.

FIGURE 1:
Framework of responses to address substance use in the community



Source: Australian Burden of Disease diagnosable illness classification, modelled in reference to the Western Australian Mental Health Commission and CESPHE, based on estimated rates per 100,000 population and using SESLHD 2017 population of 636,086 between 15 years and 64 years (www.healthstats.nsw.gov.au accessed July 2017).



Opioid Treatment Program (OTP)

Located at Langton Centre and St George DAS and working closely with GPs and pharmacists in the community, the opioid treatment program provides medication (eg methadone, buprenorphine), case management and counselling for people who are dependent on prescription or illicit opioids.

4.2 Model of care

The SESLHD Drug and Alcohol Services [DAS] model of care is person centred, underpinned by respect for client and carer preferences and values. It recognises the importance of coordination of care, as well as timely access to a broad range of treatment services, tailored to needs, delivered by a skilled and compassionate workforce.

The model is consistent with the service model for high performing health services developed by SESLHD Strategy and Planning Unit (2016) shown in Figure 2.

Many sectors and providers play a key role in addressing D&A issues within the SESLHD catchment area. DAS operates as one provider within an extensive network of care and support for clients with D&A issues. Clients who are seen by DAS often require coordination of care with other parts of the health system. DAS provides services within an integrated care framework and to support this, innovative localised models of service provision have been developed through which DAS staff work with other clinical teams and other care providers. Examples include the implementation of individual co-ordinated care plans for clients attending D&A Services, and Shared Care Nurses who support partnerships with primary care health providers to improve care for clients.

FIGURE 2:

Model of care for high performing health services





Counselling and psychosocial support services

Outpatient counselling and support services are offered as part of the core services at the Langton Centre, St George and Sutherland DAS sites and on an outreach basis from La Perouse, Rockdale and Engadine Community Health Centres; and Bondi Junction, Miranda and Hurstville Headspace sites. Counselling and support is provided in individual and group programs, working with clients to address their goals.

Profile of SESLHD Drug and Alcohol Services

5.1 Clinical Services: description and activity

SESLHD Drug and Alcohol Services [DAS] offers a range of treatment and support services for people with problems due to alcohol, prescription and/or illicit drug use, and provide support for their carers and families. DAS clinical services are supported by a strong foundation comprising consumer involvement, clinical guidelines, quality standards, clinical research, teaching, learning and development, funding and performance targets, and information, communication and technology.

Services are provided in inpatient, outpatient and community outreach settings.

'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.

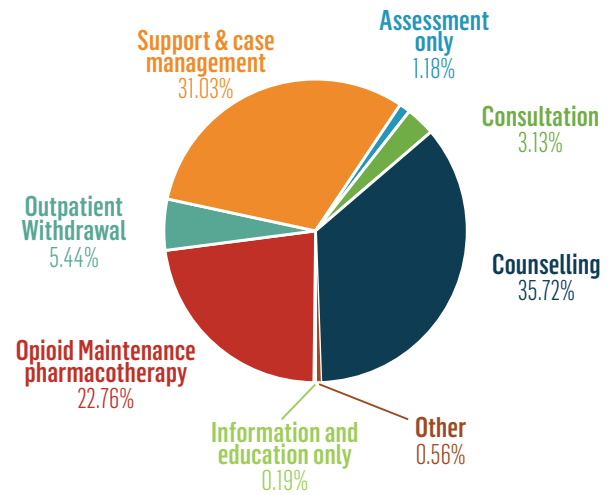
Additional clinical services include addiction medicine outpatient clinics, the enhanced community care options team, cannabis clinics, psychiatric co-morbidity clinics, GP-shared-care, pharmaceutical opioid clinics, chemical use in pregnancy services, and outreach services with particular populations (e.g. youth mental health, Aboriginal services).

In 2015/16, DAS provided approximately 2,300 D&A episodes of care for more than 1,400 clients, and over 2000 hospital D&A consultation liaison episodes of care in SESLHD hospitals. Further analysis of DAS utilisation indicates that in 2015/16:

- The top three Principal Drugs of Concern [PDoC] in community settings were alcohol at 46%; heroin, opioids and related drugs at 28%; and cannabinoids and related drugs at 12% (Fig 4)
- The average age of clients seeking services is 45 years. The average age by PDoC is:
 - alcohol - 46 years
 - cannabinoids - 36 years
 - heroin, opioids and related drugs - 42 years
 - sedatives and hypnotics - 37 years
 - stimulants - 38 years
- The top three services provided in the community were counselling 37%, support case management 30% and opioid pharmacotherapy 17% (Fig 3).

FIGURE 3:

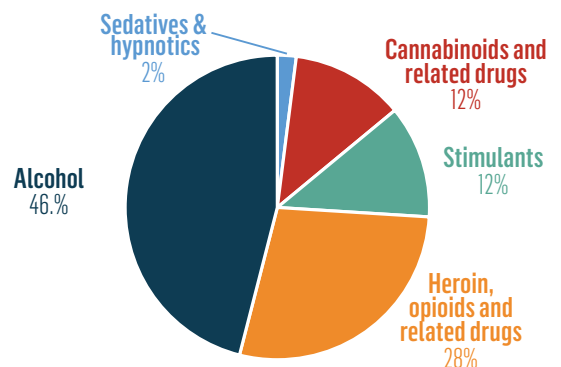
Percentage of MDS Main Services Provided by DAS for Episodes Open during 2015-16 (Community Clients only)



Source: AoD Treatment Services National Minimum dataset (AODTS NMDS), Electronic Medical Records (eMR)

FIGURE 4:

Principal Drug of Concern (episode) Breakdown, SESLHD, 2015/16



Source: AoD Treatment Services National Minimum dataset (AODTS NMDS), Electronic Medical Records (eMR)



Medication assisted treatment

There are a range of medications that can help people address their drug and alcohol use, usually in combination with counselling and support services. This most commonly includes medications such as naltrexone and disulfiram to help clients reduce their alcohol use.

5.2 Consumer involvement

SESLHD Drug and Alcohol Services are informed and strengthened by the Consumer Participation Project (CPP) and guided by the DAS framework *Consumer Participation in Drug and Alcohol Services, SESLHD 2011*. The CPP aims to improve communication with clients and partner more closely with them in their treatment journeys. Since the project began in 2013, the CPP has focused on activities that address issues relating to clinical service provision, developing systems and opportunities to listen to clients and improving the clinical environment.

Three consumer workers have been employed to engage clients individually, as well as provide advocacy and input to the organisation at a systems and strategic level.

Consumer workers assist clients by linking them with services available (both internally and externally) and providing peer support, empathy and encouragement. They facilitate weekly coffee mornings where clients can socialise. Consumer workers also ensure that feedback given via the client feedback box receives a response from the relevant manager in DAS every month.

The consumer workers work closely with staff on health promotion activities and provide feedback on various SESLHD DAS internal documents such as Global Care Plans, new policies and client friendly resources. They also participate in Management and Patient Safety and Quality meetings, and have also contributed in staff recruitment panels.

Consumer workers conduct in-service information sessions for staff to keep them updated on aspects of the project and to seek their input. These types of activities, along with developing clear communication processes to guide workers, have helped to embed the CPP into clinical service provision to the point where many staff now actively approach consumer workers for their assistance with clients.

5.3 DAS workforce learning and development

DAS clinical services are supported by a comprehensive workforce learning and teaching program, and actively promotes and fosters a learning culture.

Learning and development for all staff is provided through a range of training and development opportunities, including in-house training, professional development, access to study leave, access to clinical supervision and on-line training opportunities provided through the Health Education and Training Institute [HETI].

Learning and development specifically for medical staff is provided through undergraduate and post-graduate medical training in D&A, including accredited training for the Australasian Chapter of Addiction Medicine (RACP) [AChAM] and Faculty of Addiction Psychiatry [FoAP]. Graduates of the AChAM specialty training program are awarded the Fellowship of Australasian Chapter of Addiction Medicine [FACHAM] and graduates of the FoAP specialty training program are awarded the Certificate in Advanced Training in Addiction Psychiatry (Cert. Addiction Psych.). DAS is also an accredited training site for part of the training program for trainees in the disciplines of toxicology [ACEM], general practice [RACGP] and public health [AFPHM].

Learning and development for nursing staff is provided through placement opportunities for 2nd and 3rd year undergraduate nursing students from the University of New England, Australian Catholic University, University of Technology, University of Tasmania, University of Wollongong and the University of Western Sydney. DAS is currently documenting core skills for Hospital Drug and Alcohol-Consultation Liaison [HDA-CL] nursing, which will form the basis of a more formal training pathway for nurses wishing to further their career by working in HDA-CL nursing.

Learning and development for allied health staff is provided through mentorship and supervision of interns and new graduates, by providing access to clinical supervision and by supporting access to in-house training and a range of professional development programs. Senior Clinicians are encouraged and supported to take leading roles across a range of DAS Clinical Working Groups within the Clinical Governance Framework and also the DAS Workforce Development Group. DAS is committed to the development of a Senior Professional Lead for Allied Health, as has been established for medical and nursing staff, and to further develop links with SESLHD Allied Health and leading universities.

Future planning for DAS learning and development will include collaborative strategies to streamline and share education and training where feasible with other key D&A specialist providers, interfacing closely with D&A services in the not-for-profit sector, e.g. D&A funded NGOs and SVHN.

5.4 Clinical research and evaluation

DAS has a strong multidisciplinary research agenda that is focused on achieving better understanding of the D&A client population, the identification, development and provision of evidence informed treatment, and advocating for successful treatment outcomes for our clients.

The extensive program of research is clinically-driven, collaborative in nature and spans a diverse range of topics and platforms. These include clinical trials of novel pharmacotherapies, evaluation of models of care and the impact of drug policy on client outcomes, clinical research characterising our client population and examining predictors of treatment outcome, as well as clinical research examining treatment outcomes for D&A services.

The research team, comprising DAS and Honorary University of Sydney Department of Addiction Medicine staff, works closely with clinical staff to design, recruit to and analyse data from clinical research projects in a rigorous way that is respectful of clinical processes. Research staff act as mentors for clinical staff who wish to develop their research skills. The research and evaluation team work closely with SESLHD Research Governance and iiHub to ensure our activities meet appropriate governance standards and are linked in to research activities across the District.

Team members also work on collaborative projects with other academic organisations, including various departments within UNSW – such as The National Drug and Alcohol Research Centre, National Dementia group, and Primary Care Group. DAS has been instrumental along with the University of Sydney (Addiction Medicine) & National Drug and Alcohol Research Centre (UNSW) [NDARC] in establishing NSW DACRIN (D&A Clinical Research Improvement Network).

Since 2011 Investigators have attracted externally funded research projects (including 8 NHMRC grants as chief Investigators) exceeding \$9.3 M, and DAS staff (including honorary staff) have authored more than 70 peer review publications. DAS has been active in a number of SESLHD and NSW Health research funding grant schemes – including Inspiring Ideas Challenge (Developing an Aboriginal Drug and Alcohol Consumer Workforce 2017-19; and Responding to frequent attenders in ED with D&A related presentations: the IMPACT project, 2015-16), and a Translational Research Grant (Upscaling overdose prevention responses including take home naloxone in NSW D&A and Needle Syringe Services, 2016-18).

5.5 Information, communications and technology

DAS clinical services use the SESLHD electronic medical record system (CERNER eMR) to record client health information. This system is integrated with SESLHD hospital, outpatient and other community health services. Comprehensive up-to-date information to inform clinical decision making is available at the point of care. SESLHD has been at the forefront of the implementation of eMR in NSW Health D&A services.

NSW Health has funded SESLHD for a 4-year project (Clinical Outcomes and Quality Indicator [COQI] Project) to develop a clinical outcomes and quality indicators framework for NSW D&A Services based upon eMR. The aim is to address key issues in a performance framework such as:

- “Are services delivered well?”: examining quality of services provided
- “Do clients get better?”: examining outcomes associated with treatment.

The statewide D&A eMR project is being led by SESLHD and conducted in collaboration with Hunter New England LHD, NDARC (UNSW), University of Tasmania and NSW Health. The project also looks to align with state and commonwealth funded D&A NGO sector data frameworks.

Future planning for DAS will focus on improved monitoring of eMR and feedback of relevant clinical information to managers and clinicians to inform further refinements of the system, implications for the ongoing refinement of eMR to inform enhanced treatment outcomes and service planning, implementing a system for electronic referrals and utilisation of HealtheNet and My Health Record for clients.

5.6 Funding and performance targets

SESLHD Drug and Alcohol services have historically been project or “block funded” by the NSW Ministry of Health to deliver a broad range of services, with a limited number of project deliverables tied to budget.

In the past decade, further project funding has been provided by the Ministry to deliver new, or expand programs such as Adult Drug Court, MERIT, Cannabis Clinic, enhanced community care options, CUPS Services, and GP-shared care services.

To date the DAS budget has not been subject to direct activity-based funding. Nevertheless where inpatient D&A hospital admissions occur in SESLHD (currently at Sydney/Sydney Eye and St George Hospitals) ABF funding is generated and is directed to those hospitals.

There is no clear mechanism within current ABF or block funding models for hospital consultation liaison services by DAS. Although these services contribute to hospital ABF via the patient admission coding system they are currently resourced by the general D&A budget.

In preparation for the application of activity-based funding, DAS has been refining data collection to comply with increased standards related to activity-based funding.

Historically, Performance Indicators in the SESLHD Service Agreement with the Ministry of Health have included the:

- Number of Drug & Alcohol Withdrawal Management (Inpatient and Outpatient) episodes
- Number of Drug & Alcohol Counselling, Outpatient Consultation and Support and Case Management episodes
- Number of Opioid Treatment Program [OTP] clients.

It is expected that these will be refined in coming years with the implementation of new data reporting systems.

5.7 Quality standards and clinical guidelines

DAS clinical services and business operations are guided by the *Clinical and Corporate Governance Framework 2013* which outlines a structure for corporate (including financial, human and capital resource and risk management), and clinical governance, including patient safety and quality activities within DAS, aligned with broader SESLHD mechanisms.

At a statewide and national level there are a number of relevant guidelines and models of care addressing clinical quality and safety standards for D&A treatment services (Appendix 9). Individual DAS service streams have specific internal protocols or models of care guiding quality and safety where no statewide or national framework exists.



Shared Care Services

General practitioners are often the first point of contact for many people with a drug and alcohol problem. The Shared Care Services provide a consultation and liaison service to assist GPs and pharmacists to care for clients with substance use problems.

6

The Case for Change

The case for reforming DAS over the next 5 to 10 years is informed by:

- Stakeholder consultations conducted as part of the CSP development.
- Projected demographic changes in the SESLHD populations.
- The profile of clients of D&A Services, reflecting high levels of disadvantage and vulnerability.
- Increasing demand for D&A Services, based upon population planning models.
- Geographic and capital services infrastructure.

6.1 Demographic trends in SESLHD population

DAS Services will need to reflect community and population changes over the approaching decade:

- *SESLHD's population is growing*, from 847,965 in 2011 to 928,617 in 2017, and is projected to increase to 1,022,000 by 2027 (at an average annual growth Rate of 1.3%)
- *Geographically, the largest growth* is Sydney LGA (Inner and East) at 38% (over 30,000 new residents), followed by Botany Bay at 27% (over 11,000 new residents). The largest predicted absolute growth is the Sutherland Shire with over 36,000 residents (16.4%)
- *An aging population*. Although the group 70 years and older is expected to experience the highest overall growth (48%), in 2015/16 this group accounted for less than 1% of overall DAS activity
- More than 8,720 *Aboriginal people* lived in SESLHD in 2016, 0.9% of the total population. The highest proportions of Aboriginal residents are in the former Botany Bay LGA (1.6%) followed by Randwick LGA (1.4%). In 2015/16, 9.6% of the clients of the SESLHD Drug and Alcohol Service (and 9.1% of all episodes) identified as Aboriginal or Torres Strait Islander
- *42% of the SESLHD population were born overseas* (NSW average 25%)¹, with the largest cohort being born in China. 6.7% of residents identified as non-English speaking, the majority aged between 45 and 69 years.

6.2 High levels of disadvantage and vulnerability in clients of D&A Services

Individuals with Substance Use Disorders (SUDs) often experience significant issues related to social determinants of health. Many DAS clients have high levels of disadvantage, comorbidities or cultural backgrounds that make them particularly vulnerable to poor health and social outcomes. Examples include:

- High levels of homelessness and unstable housing. In 2015/16, 11% of DAS clients met definitions of homelessness, whilst 31% lived alone
- High levels of under-employment, including unemployment and disability. In 2015/16, only 27% of DAS clients reported any (full- or part time) employment
- High levels of domestic violence and child protection issues
- High levels of legal issues, often related to their substance use

¹ ABS, 2011, Census of Population and Housing, Age groups were not available from 2016 at time of publication of the D&A CSP



Cannabis Clinics

Operating from the Langton Centre, St George and Sutherland DAS, Cannabis Clinics provide specialist assessment and treatment for people whose primary concern is cannabis use.

- Substance users often experience stigma and discrimination when interacting with health services and in the broader community. Many substance users face additional stigma due to their identity as Aboriginal (9% of DAS clients), non-English speaking (4% of DAS clients), LGBTQI, and people who inject drugs [PWIDs] (36% of DAS clients have lifetime injecting history, 16% in past 12 months)
- Comorbidities that increase vulnerability, including mental health (30-60% of DAS clients have a comorbid mental health condition), cognitive impairment (estimated as high as 40% of DAS clients), and other forms of chronic illness, including chronic pain, HIV and/or HCV infection.

The high prevalence of disadvantaged and vulnerable populations amongst DAS clients highlights the importance of integrating service responses across the health system, and is consistent with the SESLHD *Equity Strategy*.

6.3 Increasing demand for D&A Services, based upon population planning models

It is possible to project demand for D&A Services based upon changing demographics, population planning models for D&A Services, and changing trends in health service delivery. These all point to an increasing demand for D&A Services over the next decade.

6.3.1 Projections of future service delivery

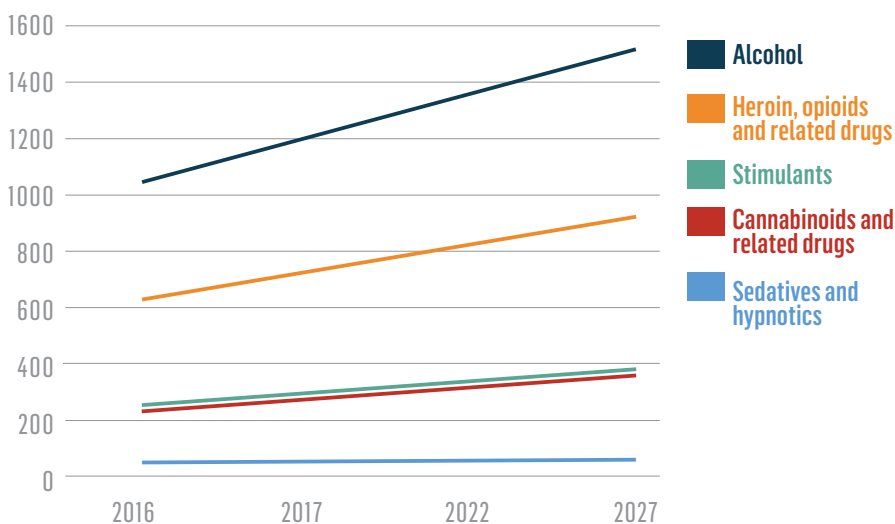
Projections of future service activity are a requirement of the NSW Government for capital projects. Initially, base case projections are developed. They take account of population growth, ageing and historic utilisation trends but assume models of care and patient flows remain unchanged.

Based on historic utilisation rates, forecasting suggests that without changes to the models of care of patient flows:

- It is predicted that if trends observed between 2012/13 and 2015/16 continue, overall activity in SESLHD will increase from 2,333 episodes in 2015/16 to 3,332 in 2026/27, an increase of 30%
- The trends between the grouped Principle Drug of Concern [PDoCs] are likely to continue on their current trajectories, however, there may be substitution effects within these groups (i.e. different types of opioids) due to the availability of illicit drugs
- It is likely that demand on DAS will continue to increase at a rate higher than the population growth rate.

FIGURE 5:

Base Case projections for episode activity by grouped PDoC, SESLHD, 2015/16 – 2026/27



Source:

Data prior to 16 February 2016 for the Langton Centre, and 23 March 2016 for St George and Sutherland was extracted from the SESLHD HIE.

Note: Due to the development of the new reporting source system, the ensuing data migration and the development of the accompanying business rules, it is believed that some peaks in the DAS utilisation data over the time series used in this plan may not be an accurate representation of service demand or utilisation. For this reason, some trends between 2013 and 2016 have been smoothed to develop DAS utilisation estimates into the future. It is believed that the 2015/16 service utilisation data is the most accurate of the time series, and as such the 2015/16 actuals have been used as a baseline to model projection estimates.



Withdrawal management, post withdrawal support and medication assisted treatment

Withdrawal services aim to help clients with the early stages of stopping or reducing their alcohol or other drug use. Offered at St George DAS and the Langton Centre, withdrawal management is commonly coupled with support, case management and counselling services. Both outpatient and inpatient withdrawal services are available, based on the client's likely severity of withdrawal, general health, social supports and preferences.

6.3.2 Population planning models for D&A services

There are considerable gaps in the availability of D&A Services in the community. It is estimated that about 1 in 10 Australian adults have a substance use disorder [SUD] in any given year, but that only 1 in 6 adults with a SUD receive an intervention from a specialist D&A treatment provider.

It is possible to estimate the range of D&A Services required in a population by a synthesis of the prevalence, severity and functional impact of SUDs, and the range of evidence based treatment interventions for the spectrum of SUDs. Such approaches have been used to inform planning for mental health services (MH-CCP), and a similar planning model has been developed for D&A Services in Australia (and subsequently used for planning purposes by the Central and Eastern Sydney Primary Health Network and the Western Australian Mental Health Commission). The model estimates the number of individuals per 100,000 population requiring D&A Services according to primary drug of concern, severity of SUD (mild, moderate, severe) and age group (child, adult, older persons), with the assumption that approximately 50% of individuals with a SUD should seek assistance within a 12 month period. Using this modelling, an estimate of the prevalence of individuals with SUDs in the SESLHD population has been calculated (Table 1) and estimated numbers requiring treatment (Fig 1).

This modelling indicates that approximately 9,125 people between 15 years and 64 years of age in the SESLHD population may have a severe SUD, requiring specialist D&A interventions. Whilst it is difficult to estimate the number of people in SESLHD receiving such interventions across LHD, Health Networks and private providers, it is estimated that fewer than one half (4,000) receive such services. There is clearly a gap between services required and available services.

TABLE 1:

Estimated population prevalence in SESLHD (15 years+) by Principal Drug of Concern and severity

Primary Drug of Concern	Mild SUD	Moderate SUD	Severe SUD	Total
Alcohol	37665	12370	6185	56220
Methamphetamine	2750	900	450	4100
Non-medical use of benzodiazepines	1980	650	325	2955
Cannabis	9800	3220	1610	14630
Non-Medical use of opioids	3380	1110	555	5045
TOTAL	55575	18250	9125	82950

Source: Australian Burden of Disease diagnosable illness classification, modelled in reference to the Western Australian Mental Health Commission and CESPHN, based on estimated rates per 100,000 population and using SESLHD 2017 population of 636,086 between 15 years and 64 years (www.healthstats.nsw.gov.au accessed July 2017).

6.3.3 Changing trends in health service delivery

The landscape of health care is changing, with increasing emphasis upon aiming for greater equity of access in health care services, integrated health care and chronic disease management, the transition of care from inpatient to community care, and the need to address social determinants of health in order to achieve improved health and social outcomes. All these point to a greater role for addressing D&A issues in our populations – including greater prevention, early intervention and treatment services, and that these are integrated across our health care systems. This requires that we reconsider how D&A Services are provided to clients with complex presentations, and how D&A Services can support the rest of the health care system to better address D&A issues in their populations. The 'D&A clinic' isolated and not integrated with the rest of the health system is no longer appropriate.



Hospital Consultation Liaison & Addiction Medicine Medical Outpatient Clinics

Drug and Alcohol consultation and liaison services operate within all the major hospitals in the district – Sydney/Sydney Eye, Prince of Wales, St George and Sutherland – providing advice about the management of D&A related issues for patients under the care of another treatment team during their hospitalisation. Hospital Consultation and Liaison services enhance the capacity of generalist health providers in their routine clinical work and coordinate multidisciplinary Addiction Medicine Outpatient Clinics to follow up patients referred from hospital emergency departments and inpatients.

D&A related presentations to SESLHD hospitals and Emergency Departments

There is increasing understanding of the need to address D&A issues in clients presenting to acute hospitals. Research studies indicate D&A related presentations account for 30-40% of all hospital (ED and inpatient) presentations, however only about one third of cases is problematic substance use identified by clinical staff. When examining SESLHD hospital activity (2014/15 data):

- Rates for alcohol attributable hospitalisation of SESLHD residents have increased by 25% between 2001 and 2015 (from 527 in 2001/02, to 660 in 2014/15), and is comparable to the NSW average (671)
- 1.2% separations and 0.7% of bed days account for activity where the primary reason for admission is drug and alcohol (withdrawal or overdose), however 4.5% of separations and 8.4% of bed days account for activity where both the principal and the top three secondary diagnosis for admission is drug and alcohol (withdrawal or overdose). POWH had the largest proportion at 6.2% of separations and 13.9% of bed days
- The average overnight length of stay is nearly double for those with a principal or top three secondary drug and alcohol diagnosis in SESLHD compared to the overall average overnight length of stay (9.3 days compared to 4.9 days).

Overall ED presentations for withdrawal or overdose have increased steadily with an annual growth rate of 6.8% (1,691 in 2010/11 to 2,196 in 2014/15). Analysis at the facility level shows that presentations are increasing the most at POWH, representing an annual growth rate of 15.3% per year, followed by St George Hospital at 14.3%.

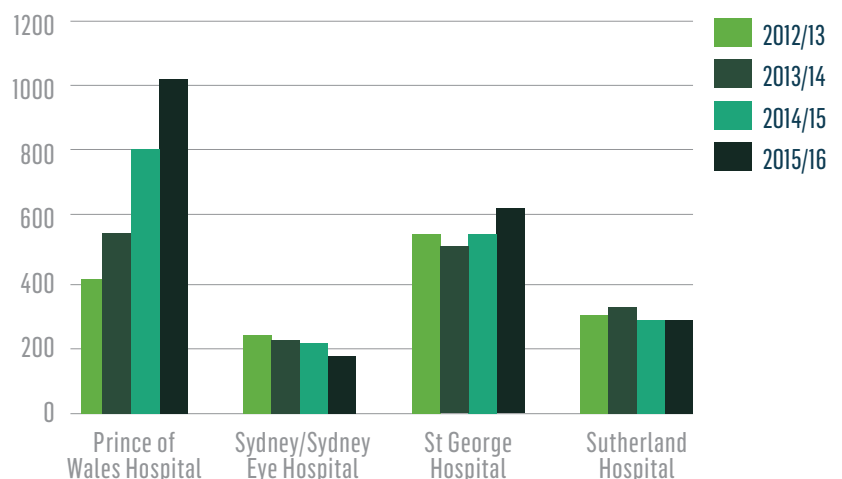
- The most common reason for presenting was acute alcohol intoxication (65% of presentations)
- 66% arrived between 5.00pm and 3.00am, with the peak time between 9.00pm and 1.00am
- The average length of stay ranged between 2.9 hours and 5.2 hours, with St George Hospital having the longest average length of stay, and Sydney/Sydney Eye having the shortest
- Most presentations were classified as Triage Category 3 or 4
- Clients with severe D&A issues account for a disproportionately high number of frequent attenders in our ED departments (estimates at 9% of frequent attenders at POWH ED, and likely to be similar across the District).

Hospital Drug & Alcohol - Consultation Liaison Services (HDA-CL)

Overall Drug and Alcohol Consultation Liaison (HDA-CL) services have increased significantly from 1,493 encounters in 2012/13 to 2,078 in 2015/16, an increase of 39% at an annual growth rate of 12% (see Fig 6). The greatest increase in activity at Prince of Wales Hospital coincided with transition from a 5-day to a 7-day a week HDA-CL Service (currently unavailable at St George Hospital and the Sutherland Hospital).

FIGURE 6:

Consultation Liaison service provided by admitting facility, Prince of Wales, Sydney/Sydney Eye, St George, and Sutherland Hospitals - 2013/13- 2015/16



Source:

SESLHD Drug & Alcohol Share-Point Consultation Liaison List

NB: Royal Hospital for Women has been excluded from this table due to small numbers.

SUTHERLAND Drug and Alcohol Service



Address geographic inequities in service access across the SESLHD catchment

The Plan will focus on greater access to services for people:

- Living in the areas of Botany, Maroubra and Malabar
- Attending Randwick Hospital campus
- Living in the Sutherland catchment area.

6.4 Geographic location of clients, services, and capital infrastructure of SESLHD D&A Services

6.4.1 Geographical location of residence and inflows

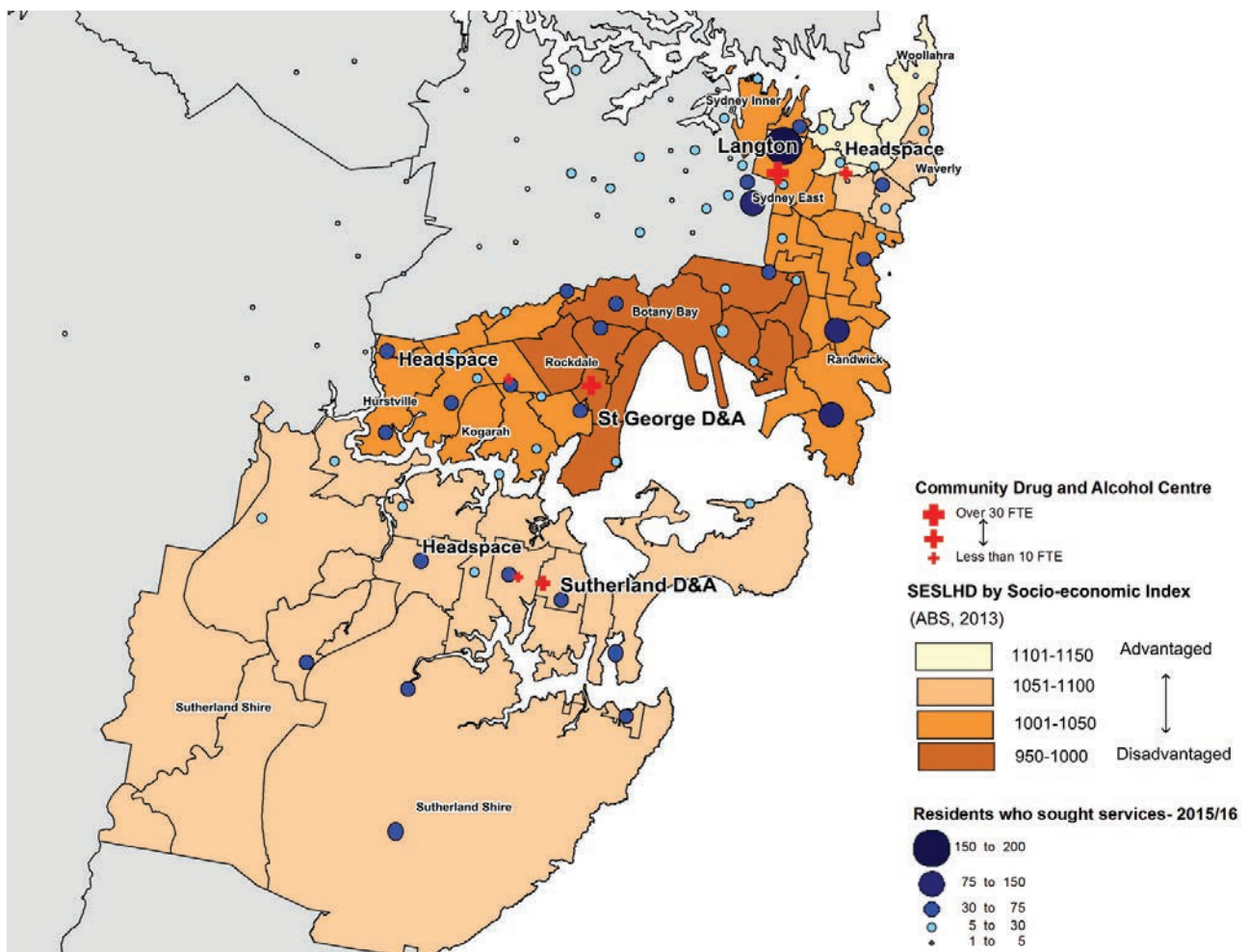
The largest clusters of clients accessing DAS reside in areas with lower socio-economic index for areas [SEIFA] scores.

Figure 7 details the geographical residence of all new clients in 2015/16 who sought services from DAS.

It is noted that a significant number of new clients have residential addresses in the SLHD. Within SESLHD, the largest numbers of new clients came from the south-eastern areas with significant numbers also residing in the Sutherland Shire. These areas are also the least well served by DAS facilities.

Figure 7 also displays LGAs by the socio-economic index. Residents of SESLHD are on average, less disadvantaged than the average NSW and Australian resident (i.e. a SEIFA² less than 1000) however there are pockets of disadvantage.

FIGURE 7:
Geographical residence of clients seeking services from DAS services 2015/16



Source:

Alcohol and other drug treatment services National Minimum Dataset [AODTS NMDS], Electronic Medical Records [eMR]). NB: includes clients from 14 years as this includes clients under the age of 18 years seeking Headspace services.

² Socio-Economic Indexes For Areas (SEIFA): is a suite of indexes which uses data from the Census of Population and Housing and summarises a number of variables associated with socioeconomic disadvantage. URL: [http://www.ausstats.abs.gov.au/ausstats/free.nsf/4ac2984dfb47af1eca2568a2008320b4/51714fc8ef605c0dca2571f70015a694/\\$FILE/Pramod%20Adhikari.pdf](http://www.ausstats.abs.gov.au/ausstats/free.nsf/4ac2984dfb47af1eca2568a2008320b4/51714fc8ef605c0dca2571f70015a694/$FILE/Pramod%20Adhikari.pdf)

6.4.2 Capital infrastructure – occupancy, space, buildings

There are significant issues to be addressed with capital infrastructure to ensure client access to and sustainability of DAS services.

DAS operates from three main locations:

- The Langton Centre, Surry Hills
- St George D&A, St George Hospital, Kogarah
- Sutherland D&A, Sutherland Hospital, Caringbah.

All locations provide office accommodation for staff, and clinical service spaces. In addition to these main locations, DAS has allocated office space at Sydney/ Sydney Eye and Prince of Wales Hospitals for staff providing HDA-CL services.

The Langton Centre

The Langton Centre [TLC] is a standalone dwelling occupied solely by the DAS.

TLC is the base for key executive management for the DAS and provides office accommodation for 60 clinical, management, administrative, and research staff. It is currently at capacity within the existing design and configuration.

The building was originally built as a general hospital. It has been modified over the years in an ad hoc manner, resulting in sub optimal use of the space for both staff accommodation and service delivery. In response to this, DAS completed a master planning process in 2015 which produced a framework and preliminary plans for remodeling the building to significantly improve the utilisation of the space for more effective client and staff flows and to enable increased staff and services accommodation.

St George D&A Service

The St George D&A Service shares occupancy of a two-story building located at 2 South Street on the St George Hospital campus, with the St George Hospital Immunology Department. Currently there is office accommodation for approximately 25 clinical, management, and administrative staff, and there are 7 clinical consultation rooms and an opioid substitution treatment / dosing space. Overall there is inadequate access to clinical space, and the configuration of offices and clinical space is sub-optimal. Significant remodeling and additional floor space would be required to meet the ongoing needs of the service. The building has been earmarked for decommissioning and redevelopment as part of the redevelopment of the St George Hospital campus.

The Sutherland D&A Service

The DAS Sutherland D&A Service is located in a separate annex of the Caringbah Community Health Centre [CCHC]. The office space comprises 9 offices and a reception/3 person waiting room. Offices accommodate 13 workstations for use by 18 full and part time staff.

Access to clinical space is significantly limited, with 2 consulting rooms located within the DAS accommodation. An additional 3 clinical /consultation rooms in the CCHC can be used by DAS, but these are often booked by other services and unavailable. Consideration of additional space for clinical services is required.

Addressing geographical inequities to access

There are implications for capital infrastructure in the proposed expansion of services to provide access to clients in the Botany, Maroubra and Malabar areas, as well as to support outreach and satellite services. In addition, there will be a need to consider co-location of some DAS services within SESLHD hospital and community health settings.

6.5 Issues identified through stakeholder consultations

The extensive consultation strategy for the Plan's development provided a comprehensive picture of the priority issues stakeholders considered should be addressed over the next 5-10 years (see Appendix 6).

In summary, those priorities are as follows:

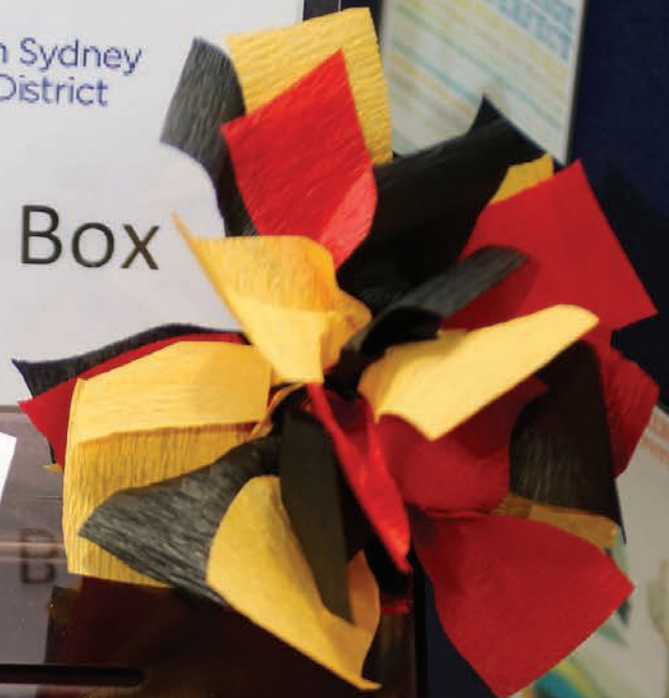
- **Improve access to D&A services**, including the Sutherland area and the Botany, Maroubra and Malabar areas; ambulatory services within the POWH/Randwick precinct; Aboriginal communities; young people; and aftercare services to support people to sustain health improvements after completing D&A treatment
- **Build capacity within health services**, including reducing the impact of D&A on Emergency Departments [EDs] and hospitals; increasing coverage of HDA-CL services; developing clearly defined clinical pathways; and increasing efforts to address issues related to frequent presenters to hospitals
- **Improve the health and wellbeing of D&A clients**, by developing care pathways for the ageing D&A population cohort and clients experiencing homelessness; collaborating with the Central and Eastern Sydney PHN to improve access to GPs for D&A clients
- **Improve the experience of D&A clients accessing specialist and other health services**, including increased involvement of D&A consumers and carers in planning for service improvement; reducing stigma for people with D&A issues attending SESLHD services; improving/refurbishing current sub-optimal DAS client facilities
- **Coordinate care for D&A clients**, improving the transfer of care and referral pathways between DAS and community-based providers of D&A inpatient withdrawal management and rehabilitation services; improving collaboration with mental health services; collaborating with SLHD and St Vincent's Health Network to improve referral pathways and communication
- **Work in partnership**, including with Central and Eastern Sydney PHN to explore opportunities for co-commissioning of D&A services in the community and encouraging uptake of D&A provision by GPs; with SESLHD Aboriginal Health; with consumer organisations in the development of a D&A peer workforce across SESLHD; with the Drug and Alcohol Multicultural Education Centre [DAMEC] and local CALD services; with relevant agencies to increase efforts to provide support for families and carers of people with D&A problems
- **Enhance the sustainability and quality of DAS services**, including better integration of DAS services within the four main hospital campuses; ensuring fit-for-purpose and client-friendly accommodation; strengthening governance and management arrangements within DAS; ensuring DAS is represented within hospital clinical governance mechanisms.



Health
South Eastern Sydney
Local Health District

SESLHD D&A Service

Feedback Box



STRATEGIC DIRECTION 1: IMPROVE ACCESS TO HIGH QUALITY D&A TREATMENT SERVICES ALIGNED WITH COMMUNITY AND INDIVIDUAL NEEDS**PRIORITY 1.1: IMPROVE EQUITY OF ACCESS, EXPERIENCE AND OUTCOMES FOR D&A CLIENTS ACROSS THE SESLHD CATCHMENT AREA**

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 1.1.1 Provide high quality D&A clinical services for clients with moderate to severe substance use disorders, and to prioritise services to individuals with complex treatment needs related to their substance use, health or social conditions</p>	<p>Other service providers involved in client care</p>	<p>People with moderate to severe substance use disorders and complex needs have improved health and wellbeing</p>
<p>Strategy 1.1.2 Work collaboratively with other specialist D&A providers to enhance the provision and co-ordination of services to clients with substance use disorders, enhance efficiencies, and minimise gaps in access to services for clients</p>	<ul style="list-style-type: none"> • NGO D&A providers • Primary care providers of D&A services • Private D&A providers • Kirketon Road Centre • Justice Health, SLHD, ISLHD, SVHN • Peak bodies including NADA, CESPHN 	<p>A systemic approach to building partnerships, active collaboration and ongoing communication between DAS and key D&A service providers</p>
<p>Strategy 1.1.3 Work with key partners to advocate for increased availability of specialist D&A services for clients in the SESLHD catchment area</p>	<ul style="list-style-type: none"> • MoH (CPH-DAP) • CESPHN • St Vincent's D&A Service • NGO D&A providers • NADA • Philanthropic funding sources 	<p>Identified service gaps in the community are addressed through collaborative approaches to commissioning of new services or enhancements to existing services</p>
<p>Strategy 1.1.4 Develop and implement a SESLHD Aboriginal D&A Strategy</p>	<ul style="list-style-type: none"> • SESLHD Aboriginal Health and Aboriginal Health workers • Aboriginal Communities in SESLHD • La Perouse Aboriginal Health Centre • Land Councils – La Perouse • Aboriginal Community Controlled Health services (Redfern AMS) • AH&MRC • Sydney LHD • Aboriginal Drug and Alcohol Network [ADAN] • Kurranulla Aboriginal Corporation • Narrangy-Booris Aboriginal Health Service 	<p>Aboriginal people have increased access to comprehensive, culturally appropriate D&A services</p> <p>Designated D&A Aboriginal Health Workers are involved in service provision</p>

STRATEGIC DIRECTION 1: IMPROVE ACCESS TO HIGH QUALITY D&A TREATMENT SERVICES ALIGNED WITH COMMUNITY AND INDIVIDUAL NEEDS

PRIORITY 1.1: IMPROVE EQUITY OF ACCESS, EXPERIENCE AND OUTCOMES FOR D&A CLIENTS ACROSS THE SESLHD CATCHMENT AREA

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 1.1.5 Implement specific approaches to improve access to D&A services for the following population groups, whilst continuing to monitor emerging issues and trends</p> <ul style="list-style-type: none"> • People with complex presentations and comorbidities • Young people • Older people • CALD populations • LGBTQI population • Clients referred from Justice Health or other Forensic and Corrections settings • Women experiencing domestic violence • Perinatal and early childhood 	<ul style="list-style-type: none"> • Young people: SCHN; Adolescent Services; Mental Health; headspaces; NGOs (e.g. Noffs, St George Youth Services, OASIS, WAYS, READY); CESPHN • Older people: Aged Care Services; SMHSOP; CESPHN; ACAT • CALD: DAMEC, CESPHN, SESLHD Multicultural Health • LGBTQI: DPPHE (HARP, Albion Centre, Sexual Health, Health Promotion), Kirketon Road Centre, ACON • People with complex presentations and/or comorbidities: Pregnancy and perinatal services: RHW, SGH, TSH, MHS; Homelessness: SESLHD Homelessness Health Coordinator, MHS, Mission Australia; Acquired brain injury: NDIS providers, FACS; Oral Health: SESLHD Oral Health Service • Forensic: Justice Health (e.g. Connections Project); MERIT; ADC • Women experiencing domestic violence: SESLHD Violence & Abuse Prevention Program Coordinator; Senior Health Clinician Safer Pathway; St George Domestic Violence Service; Mindset • Perinatal & early childhood: Perinatal services (O&G, Neonatal, MHS); Family and Childhood Services across RHW SGH, TSH, SCHN-Randwick campuses 	<p>Increased engagement of priority populations in DAS services</p> <p>Delivery of service models and effective models of care, tailored for priority populations</p> <p>Effective referral processes and streamlined transfer of care for clients with complex needs moving between DAS and other SESLHD specialist D&A providers</p>
<p>Strategy 1.1.6 Address geographic inequities in service access across the SESLHD catchment area through expansion of services for people</p> <ul style="list-style-type: none"> • Living in the areas of Botany, Maroubra and Malabar • Attending Randwick hospital campus • Living in the Sutherland catchment area 	<ul style="list-style-type: none"> • SESLHD <ul style="list-style-type: none"> ◦ Capital Planning ◦ Planning, Population Health and Equity ◦ General Managers of POWH, SGH, TSH, SSEH, ◦ Director of Operations MHS ◦ Medical and Nursing Workforce Managers ◦ Clinical Councils at each hospital • CESPHN 	<p>SESLHD residents across the catchment area can access 'core' D&A services that are easy to get to (i.e. close to home, work or transport), and have ready access to specialist services</p>
<p>Strategy 1.1.7 Explore options for extended operating hours for DAS services in some locations</p>		<p>Clients have increased access to services in hours that suit, e.g. for clients who work full time</p>

STRATEGIC DIRECTION 1: IMPROVE ACCESS TO HIGH QUALITY D&A TREATMENT SERVICES ALIGNED WITH COMMUNITY AND INDIVIDUAL NEEDS

PRIORITY 1.2: DELIVER COORDINATED, PERSON-CENTRED CARE TO CLIENTS WITHIN AN INTEGRATED CARE FRAMEWORK

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 1.2.1 Clinical services are provided within a quality framework incorporating comprehensive assessment, client-centred treatment planning and care coordination between service providers, delivery of evidence-based D&A treatment interventions, regular monitoring of treatment outcomes for clients, and processes for enhancing client engagement</p>	<p>Other service providers involved in client care</p>	<p>Improved quality of care, health outcomes and experiences for clients attending D&A Services</p>
<p>Strategy 1.2.2 DAS clinical services operate within the principles of integrated care, and address the range of substance use, physical and mental health, and psychosocial issues with clients, in collaboration with other health and welfare providers</p>	<ul style="list-style-type: none"> • Primary care providers • Specialist health providers from other sectors, e.g. mental health, pain, infectious diseases, O&G, gastroenterology, sexual health, oral health, FACS • Social Service providers, e.g. accommodation, aftercare services, vocational services • CESPNN, GP Networks • Integrated Care Program, SESLHD 	<p>Effective partnerships, active collaboration and ongoing communication between DAS and key primary health partners.</p> <p>DAS clients have an identified primary care provider.</p> <p>Referral pathways and transfer of care arrangements between DAS, primary care providers and other specialist services are documented and disseminated</p>
<p>Strategy 1.2.3 Expand approaches to the co-location and ‘shared care’ models between specialist D&A and other health and welfare services, including ‘in-reach’ (other services provided from DAS facilities) and ‘outreach’ (DAS services provided in other services)</p>	<ul style="list-style-type: none"> • Primary care providers • Other specialist health services, e.g. headspace, within Bright Alliance Building, La Perouse ACHC • Social Service providers, e.g. housing, legal aid 	<p>Clients have increased access to specialist D&A services within community-based services</p>
<p>Strategy 1.2.4 Utilise clinical information systems to support and strengthen clinical practice, co-ordination between service providers, and to implement processes for routinely using data to inform and enhance practice</p>	<ul style="list-style-type: none"> • SESLHD ICT, BIEU • COQI Project partners 	<p>The use of clinical Information systems to improve the quality of care, and co-ordination between service providers</p>

STRATEGIC DIRECTION 2: ENHANCE THE CAPACITY OF OTHER HEALTH SECTORS AND SERVICES (non-specialist D&A services) TO EFFECTIVELY ADDRESS D&A ISSUES IN THEIR CLIENT GROUPS

PRIORITY 2.1: TO ENHANCE RESPONSES TO CLIENTS WITH D&A RELATED PRESENTATIONS IN ACUTE HOSPITALS

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 2.1.1 Implement a funding and activity model that enables expansion of multidisciplinary Hospital D&A Consultation and Liaison [HDA-CL] services to address need/demand across SESLHD hospitals</p>	<ul style="list-style-type: none"> • General Managers of POWH, SGH, TSH, SSEH, RHW, Mental Health • BIEU • Program Management Office 	<p>All four major SESLHD hospitals have access to HDA-CL services in line with need and demand, supported by a sustainable funding model</p>
<p>Strategy 2.1.2 Establish or enhance capacity for D&A admissions across the major SESLHD hospitals</p>	<ul style="list-style-type: none"> • General Managers of POWH, SGH, TSH, SSEH • Clinical Councils at each Hospital 	<p>All major SESLHD hospitals have access to D&A admissions, resulting in improved client outcomes and enhanced continuity of care</p>
<p>Strategy 2.1.3 Enhance the capacity of the hospital workforce to provide appropriate screening, treatment and care for clients with D&A issues</p>	<ul style="list-style-type: none"> • General Managers POWH, SGH, TSH, SSEH • Medical Nursing & Allied Health Teaching co-ordinators • Clinical Councils at each Hospital • Clinical Streams 	<p>Effective referral processes and streamlined transfer of care for clients with complex needs moving between DAS and other SESLHD specialist D&A providers</p>
<p>Strategy 2.1.4 Strengthen clinical pathways between DAS and hospital based services (ED and admitted)</p>	<p>Clinical streams</p>	<p>Effective referral processes and streamlined transfer of care for clients with complex needs moving between DAS and other SESLHD specialist services</p>
<p>Strategy 2.1.5 Enhance continuity of care between hospital and community settings</p>	<ul style="list-style-type: none"> • General Managers POWH, SGH, TSH, SSEH, PI&CH, Mental Health • Clinical Councils at each Hospital 	<p>Improved client care and effective management of clients with D&A issues moving between the hospital and the community</p>

STRATEGIC DIRECTION 2: ENHANCE THE CAPACITY OF OTHER HEALTH SECTORS AND SERVICES (non-specialist D&A services) TO EFFECTIVELY ADDRESS D&A ISSUES IN THEIR CLIENT GROUPS

PRIORITY 2.2: TO ENHANCE RESPONSES TO CLIENTS WITH D&A RELATED PRESENTATIONS IN OTHER HEALTH & WELFARE SECTORS, INCLUDING PRIMARY CARE

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 2.2.1 Strengthen clinical pathways between DAS and other service sectors in the community, including primary care, mental health, chronic pain, homelessness, domestic violence, youth and older person's services</p>	<p>Other service sectors within SESLHD</p>	<p>Effective referral processes and streamlined transfer of care for clients moving between DAS and other health services</p>
<p>Strategy 2.2.2 Expand approaches to the co-location and 'shared care' models between specialist D&A and other health and welfare services, including 'in-reach' (other services provided from DAS facilities) and 'outreach' (DAS services provided in other services)</p>	<ul style="list-style-type: none"> • Primary care providers • Other specialist health services (e.g. headspace, Bright Alliance Building, La Perouse ACHC), • Welfare services (e.g. housing, legal aid) 	<p>Clients have increased access to specialist D&A services within community-based services</p>
<p>Strategy 2.2.3 Enhance options for health providers from other sectors to access specialist support and consultation services in the management of their clients, e.g. Addiction Medicine consultation clinics, shared care programs with primary care providers, specialist clinics (e.g. MH-DA co-morbidity clinics)</p>		<p>Improved access to specialist D&A Services for clients referred from other sectors</p>
<p>Strategy 2.2.4 Collaborate with key partners to contribute to building workforce capacity of health workers from other sectors, including primary health care providers, to address early to mild D&A issues for clients</p>	<ul style="list-style-type: none"> • CESPHN & partner LHD D&A services • ACI • RACGP, PSA, Pharmacy Guild, DANA • MoH (CPH-DAP) 	<p>Clinicians from other sectors, including mental health, pain, primary care providers [GPs, practice nurses, pharmacists and psychologists] have access to regular training and development opportunities in D&A issues based on identified need</p>

STRATEGIC DIRECTION 3: ENSURE THE SUSTAINABILITY AND CONTINUED DEVELOPMENT OF SESLHD D&A SERVICES

PRIORITY 3.1: STRENGTHEN CONSUMER AND CARER ENGAGEMENT

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 3.1.1 Enhance the involvement of Consumer Workers in DAS governance, quality improvement, research, planning and service provision activities</p>	<ul style="list-style-type: none"> • SESLHD Consumer and Community Advisory Committees • DAS consumers 	<p>Sustainable consumer engagement in DAS services</p> <p>Service improvements and enhanced consumer experience</p> <p>DAS consumer workers have access to timely and appropriate supervision to guide their role and develop their skills</p>
<p>Strategy 3.1.2 Improve the experiences of and outcomes for consumers accessing D&A services</p>	<ul style="list-style-type: none"> • SESLHD Consumer and Community Council • MH Consumer Program • D&A consumer & carer organisations (e.g. NUAA; Family Drug Support) • MoH (CPH-DAP) • ACI 	<p>Consumers report increased high levels of satisfaction with DAS services in terms of access, experience and health benefits</p>
<p>Strategy 3.1.3 Implement a framework for engaging and supporting carers and significant others of people with substance use problems</p>	<ul style="list-style-type: none"> • Mental Health carers' groups • Family Drug Support • MH Carer associations • SESLHD Consumer Council • Carers NSW 	<p>Carers of people with substance use problems are engaged in DAS services</p> <p>DAS has greater awareness of carers' needs</p> <p>Delivery of effective models of care tailored for carers</p>

STRATEGIC DIRECTION 3: ENSURE THE SUSTAINABILITY AND CONTINUED DEVELOPMENT OF SESLHD D&A SERVICES

PRIORITY 3.2: CONTINUE TO DEVELOP D&A WORKFORCE CAPACITY AND CULTURE

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 3.2.1 Ensure that DAS has an ongoing workforce strategy that supports the implementation of the D&A Clinical Services Plan and optimises staff engagement</p>	<ul style="list-style-type: none"> • SESLHD HR • HETI 	<p>DAS staff have access to workforce development opportunities aligned with the strategy</p>
<p>Strategy 3.2.2 Strengthen DAS professional leadership, particularly in the areas of nursing and allied health, including establishment of an allied health lead</p>	<ul style="list-style-type: none"> • SESLHD iiHub • HETI • SESLHD HR; Nursing Directorate; Allied Health Directorate 	<p>Active and effective leadership across all DAS professional groups (medical, nursing, allied health) and across SESLHD locations</p> <p>Mentorship and support for succession planning</p>
<p>Strategy 3.2.3 Collaborate with other specialist D&A service providers in the SESLHD catchment area to build workforce capacity through innovative learning development opportunities and access to clinical supervision</p>	<ul style="list-style-type: none"> • SLHD, ISLHD, SVHN D&A • NGO D&A providers • Private D&A Services • NADA • CESP HN • Professional Societies and Colleges • Addiction Doctors Education Program 	<p>Enhanced D&A capacity and competency within D&A services across the catchment area</p>

PRIORITY 3.3 ENSURE D&A SERVICES ARE PROVIDED FROM APPROPRIATE LOCATIONS, IN FIT-FOR-PURPOSE FACILITIES WITH CERTAINTY OF OCCUPANCY

<p>Strategy 3.3.1 Ensure access to appropriate facilities to provide ambulatory and inpatient D&A Services in main hospital campuses across the LHD</p>	<ul style="list-style-type: none"> • SESLHD Director PI&CH • SESLHD Hospital General Managers • SESLHD Director Capital Works and Design 	<p>Clients have access to a comprehensive range of D&A services at fit-for-purpose premises at all four major hospital campuses</p>
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STRATEGIC DIRECTION 3: ENSURE THE SUSTAINABILITY AND CONTINUED DEVELOPMENT OF SESLHD D&A SERVICES

PRIORITY 3.4: STRENGTHEN DAS CLINICAL, HOSPITAL AND CORPORATE GOVERNANCE MECHANISMS

STRATEGIES	KEY PARTNERS WITH DAS	INTENDED OUTCOMES
<p>Strategy 3.4.1 Ensure DAS governance and management structures are optimal for the safe, effective and efficient delivery of services</p>	<ul style="list-style-type: none"> • SESLHD D&A • SESLHD HR • SESLHD Director PI&CH 	<p>DAS management structure is aligned with service configuration and adaptable to accommodate changing needs</p> <p>Efficient and effective communication and decision-making processes</p>
<p>Strategy 3.4.2 Ensure appropriate representation of DAS across relevant SESLHD clinical and corporate governance structures (including clinical streams, nursing, allied health professional groups, consumer and carer governance structures, Business Intelligence Efficiency Unit [BIEU] and research governance)</p>	<ul style="list-style-type: none"> • Professional leads (Medicine, Nursing, Allied Health) • Research partners 	<p>Enhanced D&A profile and increased DAS influence within relevant LHD clinical and corporate governance mechanisms</p>

PRIORITY 3.5: STRENGTHEN RESEARCH, EVALUATION AND CONTINUOUS QUALITY IMPROVEMENT

<p>Strategy 3.5.1 Continue to engage, and strengthen our capacity to implement continuous quality improvement activities that enhance patient safety, outcomes and experiences, and service efficiencies</p>	<p>iiHub</p>	<p>Safe, caring, responsive and empowering Drug and Alcohol Services</p>
<p>Strategy 3.5.2 Continue to engage in translational research activities</p>	<ul style="list-style-type: none"> • SESLHD Director Research & Research Governance • UNSW & USYD • DAS professional leads • PHD students • ACI • iiHub 	<p>DAS services are informed and enhanced by research findings</p>
<p>Strategy 3.5.3 Develop a leading, innovative collaborative D&A research network with other D&A services and research centres</p>	<ul style="list-style-type: none"> • SESLHD Director Research & Research Governance • NDARC • UNSW and USYD • NSW DACRIN (D&A Clinical Research Improvement Network) • Burnet Institute 	<p>Enhanced research capacity and collaborative research endeavor</p> <p>Joint clinical appointments across SESLHD DAS and UNSW</p>
<p>Strategy 3.5.4 Improve clinical information systems, utilise information technologies and clinical data to improve patient and service outcomes (including to identify service and population needs, provide real time alerts to clinicians, support continuity of care, enhance research efforts and achieve workflow efficiencies)</p>	<ul style="list-style-type: none"> • ICT • MoH • InforMH • E-health • BIEU • Population health 	<p>Improvements in equity of access, patient experience and treatment outcomes</p> <p>A Clinical Outcome and Quality Indicator (COQI) Framework is implemented and data generated is routinely utilised for service improvement across DAS</p>

Planning Context

8.1 Commonwealth and State policy directions

The Plan is aligned with the directions outlined in relevant NSW and Commonwealth strategies.

Commonwealth Policy

The *National Drug Strategy 2016-2025* aims to contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.

The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019* (a sub-strategy of the National Drug Strategy 2010-2015), which aims to improve the health and wellbeing of Aboriginal and Torres Strait Islander people by preventing and reducing the harmful effects of alcohol and other drugs [AOD] on individuals, families, and their communities.

NSW Policy

The *NSW Health Alcohol & Other Drugs Strategic Plan- 2016-2025* aims to prevent and reduce the harm from alcohol and other drug use, increase access to treatment and improve health outcomes.

8.2 South Eastern Sydney strategic directions

SESLHD strategic directions

Planning within SESLHD is guided by the following internal strategic documents, which inform the development and delivery of services:



A Road Map to the delivery of excellence – 2014-2017 describes priority areas for action within an approach to optimising health system performance, characterised by the three dimensions of quality of care, health of the population and value and financial sustainability



The SESLHD Equity Strategy 2015 recognises equity in health and wellbeing as a priority for action across the entire organisation



The SESLHD Integrated Care Strategy 2015 outlines priorities and key strategies to transform current processes and delivery systems into a systemic and systematic approach to integrated care across the LHD.

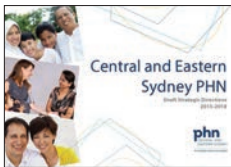
Related SESLHD clinical service and strategic plans

This Plan takes account of a number of other internal plans that play a critical role in achieving the goals for D&A across SESLHD, including:

- *Greater Randwick Integrated Health Services Plan (2016)*
- Sutherland Hospital Redevelopment Plan
- St George Hospital Redevelopment Plan
- *SESLHD Mental Health Clinical Services Plan*
- *Royal Hospital for Women's Strategic Plan*
- *Research Strategy*
- *Community Partnerships Strategy.*

Primary Health Network strategic directions

The Central and Eastern Sydney Primary Health Network is a key partner in improving the health of the population within the catchment area. It also has a particular role in improving the health of people with D&A issues and accordingly this Plan is informed by:



Central and Eastern Sydney Primary Health Network Strategic Plan 2015-18

and

Central and Eastern Sydney Primary Health Network AOD Operational Plan.

9

Implementation and Evaluation Plan

The strategies identified in this Plan will be monitored and evaluated rigorously over the next five years.

DAS will develop an implementation plan supported by DAS operational/business plans.

Progress will be monitored by:

- Annual Drug & Alcohol performance reports from DAS teams to the SESLHD Drug & Alcohol Executive Committee
- Key Performance Indicators through existing and discrete reporting forums.
- Formal and informal feedback from staff, consumers, carers and stakeholders
- Updates to the SESLHD Chief Executive, Board and other interested stakeholders.

In addition to the continuous monitoring outlined above, the effectiveness of this Plan in achieving its broader aims will be formally evaluated on its completion.



APPENDICES

APPENDIX 1

Aboriginal population

In 2016, more than 8,720 Aboriginal people lived in SESLHD, 0.9% of the total population. The highest proportions of Aboriginal residents were in the former Botany Bay LGA (1.6%) followed by Randwick LGA (1.4%).

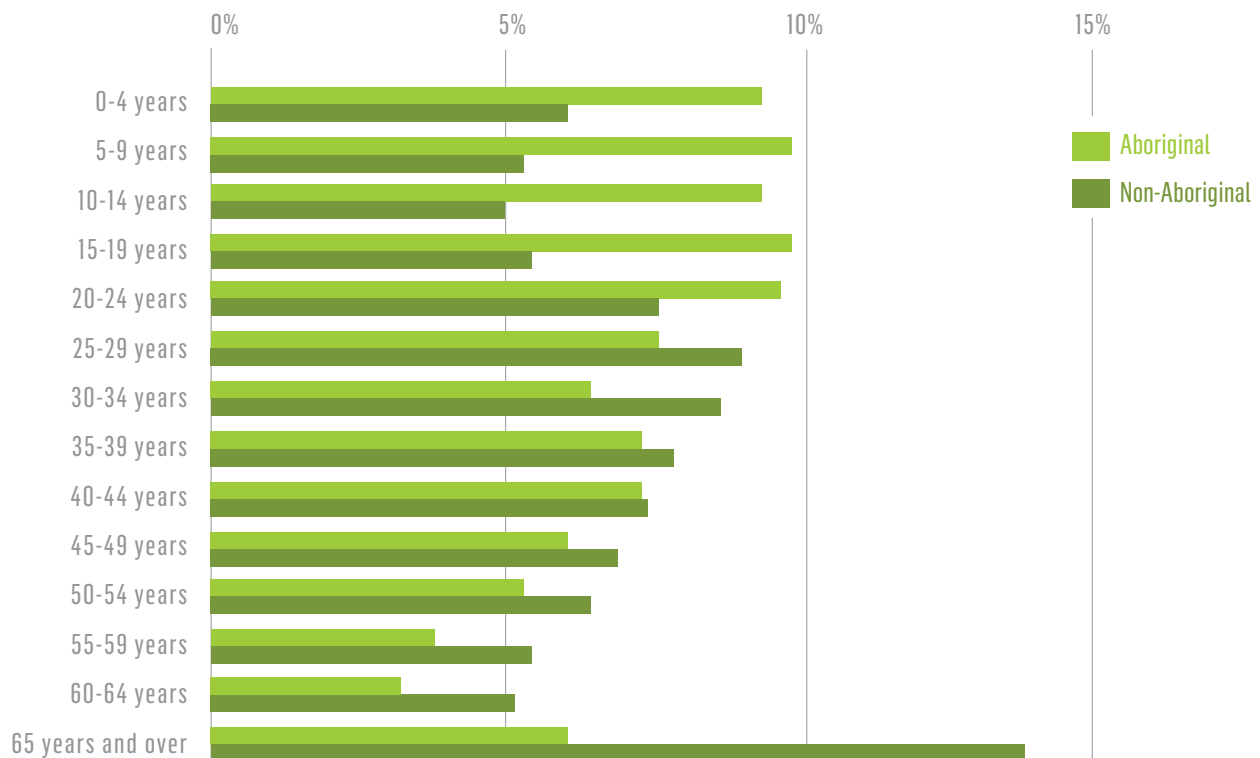
In 2015/16, 9.6% of the total individual clients of the SESLHD Drug and Alcohol Service (and 9.1% of all episodes) identified as Aboriginal or Torres Strait Islander.

As shown in Figure 8, the Aboriginal population is comparatively young in relation to the non-Aboriginal population. In 2011, 47% of the Aboriginal population in SESLHD was aged less than 25 years, as compared to 14% of non-Aboriginal residents; and 28% of the Aboriginal population was aged less than 15 years, compared to 16% of non-Aboriginal residents. Conversely only 6% of the Aboriginal population was aged 65 years and older, as compared to 13% of the non-Aboriginal population (Note that the age breakdown of the 2016 Census was not available at the time of production of this Plan).

While the highest proportions of Aboriginal residents were in the Botany area and Malabar - La Perouse - Chifley/Maroubra area, more than 400 Aboriginal people also lived in each of:

- Sydney East SLA
- Botany North area
- Cronulla - Miranda - Caringbah – West area and
- Oyster Bay/ Sutherland area.

FIGURE 8:
Percentage of Aboriginal and Non-Aboriginal people split by 5 year age groups, 2011.



Source: ABS 2011 Census of Population and Housing, Table: B07 Indigenous status by age and sex

Inclusions: LGAs: Botany Bay, Randwick, Sydney (part), Waverley and Woollahra

Exclusions: persons who did not state their Indigenous status.

NB: This data from 2016 Census was not available at time of publication.

APPENDIX 1 *(continued)*

The SESLHD Aboriginal Health Unit Manager notes that Aboriginal communities and Aboriginal researchers report:

- i) Younger age of engagement with drugs and alcohol. Many Indigenous Australians who become involved in drug use start using drugs from a young age, usually in their early to mid-teens, and generally at a younger age than other Australians
- ii) Intergenerational use of drugs
- iii) Increased use of methamphetamine/ice has been described as being on a “massive escalation” but observed more in regional/remote communities
<http://www.abc.net.au/news/2016-10-13/ice-use-in-aboriginal-communities-rising/7929786>
- iv) Whilst there are a multiplicity of factors which influence contact with the juvenile justice system, recent research indicates that for Aboriginals admitted to youth detention facilities, they are likely to commence their illicit drug use career at an earlier age, particularly with regard to the use of alcohol, tobacco, cannabis, inhalants and amphetamines (Doolan et al, 2015).

Across Australia, Aboriginal adults have high rates of abstinence or no consumption of alcohol in the last 12 months, with abstinence being 1.6 times more common among Aboriginal people than among non-Indigenous people. Across NSW, however, there is a significantly higher proportion of Aboriginal adults who consume alcohol at levels harmful to health (compared to rest of the NSW adult population).

ABORIGINAL IMPACT STATEMENT

An Aboriginal Impact Statement has been produced for this plan.

APPENDIX 2

Cultural diversity

In 2011, 42% of the SESLHD population was born overseas (NSW average 25%)¹, with the largest cohort being born in China.

6.7% of SESLHD residents were identified as non-English speaking (identified as having stated they do not speak any English, or do not speak English well); a further 7.6% did not respond to this particular question on the census. The highest proportions of Culturally and Linguistically Diverse populations were in Hurstville and Rockdale LGAs, which together represented 58% of the total non-English speaking population of SESLHD.

The majority of the non-English speaking population in SESLHD was aged between 45 and 69 years. Among older people, the top non-English languages spoken at home were Greek, Italian, Cantonese, Russian and Spanish.

At the time of publication of this document, data from 2016 Census had not been analysed.

¹ ABS, 2011, Census of Population and Housing

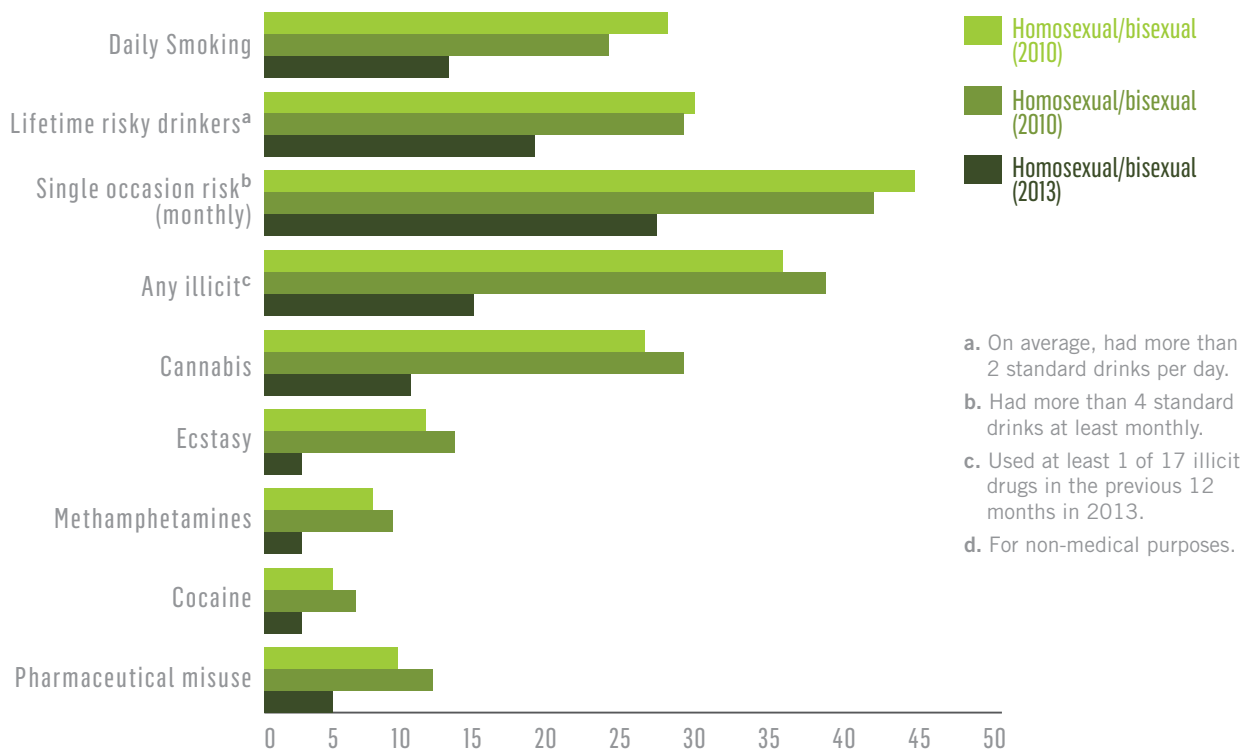
APPENDIX 3

D&A use in LGBTQI population

There is a growing body of evidence to suggest that people who identify as lesbian, gay, bisexual, transgender and intersex (LGBTQI) may be at a higher risk of developing mental health and substance use problems.

In the National Drug Strategy Household Survey 2013, people who identified as being homosexual or bisexual had higher rates of illicit drug use and were more likely to smoke daily and drink alcohol in risky quantities compared with those who identified as heterosexual. Use of illicit drugs in the last 12 months was more common among homosexual or bisexual people than heterosexual people. Homosexual/bisexual people were nearly 6 times more likely to use ecstasy than heterosexual people and over 4 times more likely to use meth/amphetamines (including ice). Illicit drug use was slightly more common than smoking tobacco and drinking in the homosexual and bisexual population.

FIGURE 9:
Drug use by sexual orientation, people aged 14 or older, 2010 and 2013 (per cent)



The Sydney Gay Community Periodic Survey (a cross-sectional survey of gay and homosexually active men: sample size 3,015 men in 2016) showed recreational drug use remained common within the sample, with 61.4% reporting any drug use in the six months prior to the survey. However, since 2012, the proportion of men saying they had used more than two drugs in the previous six months has fallen. In 2016, the most frequently used drugs were amyl/poppers (42.1%), marijuana (29.5%), ecstasy (22.9%), cocaine (21.7%), Viagra (19.5%) and GHB (10.8%). Since 2012 there have been significant declines in the use of ecstasy, amphetamine/speed, crystal methamphetamine, Viagra, ketamine, GHB, heroin and steroids with a small but significant increase in the use of cocaine. In general, HIV-positive men remained more likely to report drug use compared with HIV-negative men.

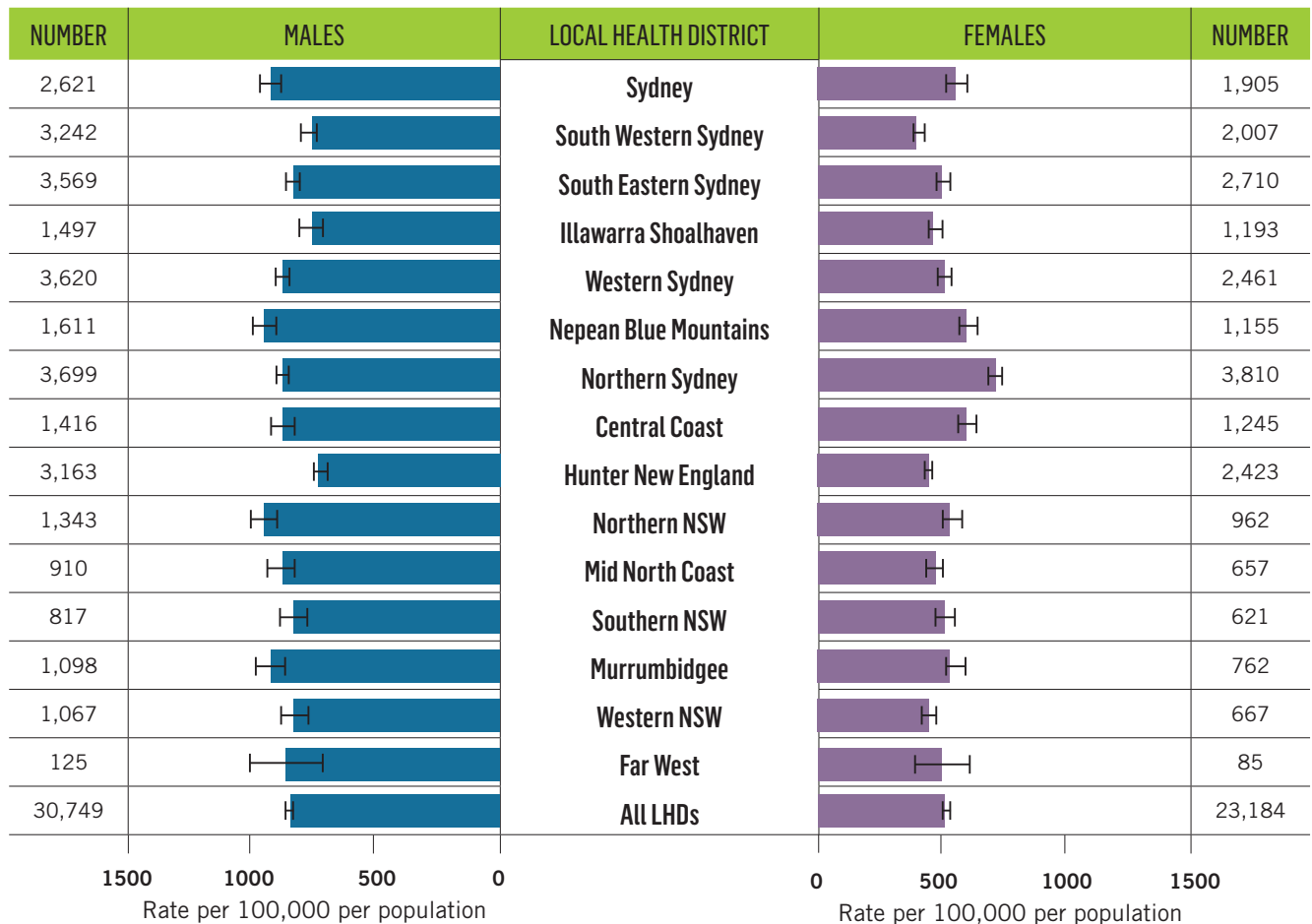
The Sydney Women and Sexual Health (SWASH) survey (a survey of health issues relevant to lesbian, bisexual and queer (LBQ) women: sample size 1,100 returned valid questionnaires in 2014) results showed 90% reported drinking alcohol; 62% of women who drank consumed more than the NHMRC guidelines recommend for reducing the lifetime risk of alcohol-related disease or injury. 28% of women drinkers (37% young women), drank 5+ more drinks weekly or more often in the past 6 months. 26% of drinkers indicated they would like to reduce or quit their alcohol consumption. In the preceding six months, 48% had used one or more illicit drugs including cannabis (34%), ecstasy (21%) and cocaine (19%). Rates of drug use were much higher than in the general community.

APPENDIX 4

SESLHD activity related to drug and alcohol Use

FIGURE 10:

Alcohol attributable hospitalisations by Local Health District and Sex, NSW 2014-15



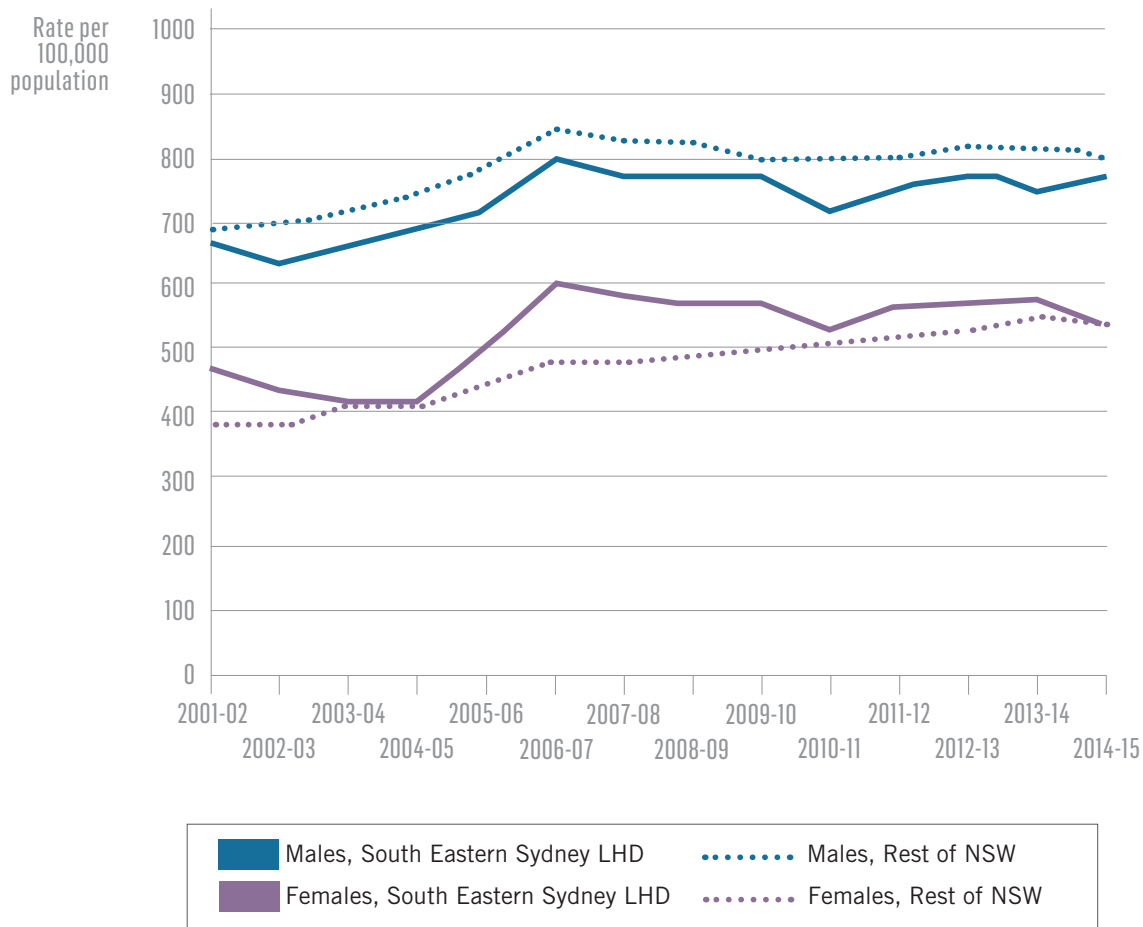
Source: NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI).
Centre for Epidemiology and Evidence, NSW Ministry of Health.

NB:

Excludes conditions where low to moderate alcohol consumption has an apparent overall protective effect. Calculated using age and sex-specific aetiological fractions from the School of Population Health, University of Queensland and AIHW, 2007. Only NSW residents are included.

Figure 10 shows rates per 100,000 population for all hospitalisations in SESLHD and in NSW where high alcohol consumption was a factor. The graph indicates an increasing rate for both sexes between 2002 and 2015, however, rates are much higher amongst males. This reflects the higher proportion of males accessing alcohol related services in SESLHD.

FIGURE 11:
Alcohol attributable hospitalisations by sex, SESLHD, NSW, 2001/02- 2014/2015



Source: NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI).
Centre for Epidemiology and Evidence, NSW Ministry of Health.
http://www.healthstats.nsw.gov.au/Indicator/beh_alcafhos/beh_alcafhos_lhn_trend?&topic=Alcohol&topic1=topic_alcohol&code=beh_alc

TABLE 2:
Clients admitted for drug withdrawal or overdose, SESLHD by admitting facility, 2010/11- 2014/15

HOSPITAL NAME	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
POWH	346	347	426	439	450
SGH	176	206	260	348	352
TSH	96	105	171	179	116
SSEH	126	159	149	146	177
GRAND TOTAL	745	817	1,006	1,112	1,097

Source: FlowInfo v15

Includes: ESRGs (v5): 812 - Drug & alcohol dependence and withdrawal &
813 - Poisoning/toxic effects of drugs and other substances

Excludes: ED only episodes, collaborative care services

TABLE 3:

Drug and alcohol inpatient separations (withdrawal or overdose) by principle diagnosis and secondary diagnosis in SESLHD in 2014/15

Facility	PRINCIPLE DIAGNOSIS (PD)			TOP 3 SECONDARY DIAGNOSIS (TOP 3 SD)			GRAND TOTAL 1 (PD + TOP 3 SD)		
	Seps	Bed days	Av LOS (o/n)	Seps	Bed days	Av LOS (o/n)	Seps	Bed days	Av LOS (o/n)
POWH	450	601	1.5	1,311	14,887	16.5	1,761	15,488	12.8
SGH	352	845	2.8	957	6,401	8.5	1,309	7,246	6.9
TSH	116	336	3.1	506	5,050	11.6	622	5,386	10.0
SSEH	177	719	4.1	294	1,287	5.1	471	2,006	4.7
TOTAL	1,095	2,501	2.7	3,068	27,625	11.8	4,163	30,126	9.3

Source: Flowinfo V15 (PD), HIE (SD)

Inclusions: Diagnosis codes F10 – F19, T41 –T43 Excludes: ED only episodes, collaborative care services

Note: the average length of stay above is calculated based on overnight episodes only, the separations and bed days above include all separations (day only and overnight episodes) and therefore do not result in the average length of stay which is presented. The average overnight length of stay has been calculated externally and inserted into the table.

TABLE 4:

The proportion of inpatient drug and alcohol separations (withdrawal or overdose) by principal diagnosis and secondary diagnosis in SESLHD in 2014/15

Facility	PRINCIPAL DIAGNOSIS (PD)		TOP 3 SECONDARY DIAGNOSIS (TOP 3 SD)		GRAND TOTAL (PD + TOP 3 SD)	
	Seps	Bed days	Seps	Bed days	Seps	Bed days
POWH	1.6%	0.5%	4.6%	13.4%	6.2%	13.9%
SGH	1.0%	0.5%	2.6%	4.0%	3.6%	4.6%
TSH	0.7%	0.5%	3.0%	7.7%	3.6%	8.2%
SSEH	1.7%	3.2%	2.9%	5.8%	4.6%	9.0%
TOTAL	1.2%	0.7%	3.3%	7.7%	4.5%	8.4%

Source: Flowinfo V15 (PD), HIE (SD)

Inclusions: Diagnosis codes F10 – F19, T41 –T43 Excludes: ED only episodes, collaborative care services

TABLE 5:

ED Presentations to ED for withdrawal or overdose from 2010/11 to 2014/15 in SESLHD

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	AAGR
POWH	304	305	485	482	537	15.3%
SGH	240	257	285	304	410	14.3%
TSH	231	255	309	332	317	8.2%
SSEH	916	978	875	865	932	0.4%
TOTAL	1,691	1,795	1,954	1,983	2,196	6.8%

Source: CaSPA (EDAA V1)

Inclusions: Diagnosis codes F10 – F19, T41 –T43

TABLE 6:
ED Presentations to ED for withdrawal or overdose in 2014/15 in SESLHD

	PRESENTATIONS	AV LOS (HOURS)	AV AGE	% LOCAL RESIDENTS	% INDIGENOUS	% ADMITTED	MOST FREQUENT TRIAGE CATEGORY	% ARRIVED BY AMBULANCE
POWH	537	4.5	40	74%	4.8%	45%	3	63%
SGH	410	5.2	40	73%	1.7%	39%	3	66%
TSH	317	3.9	39	88%	0.9%	10%	4	59%
SSEH	932	2.9	34	30%	3.5%	6%	4	85%
TOTAL	2,196	3.9	37	57%	3.1%	22%	4	72%

Source: CaSPA (EDAA V1)

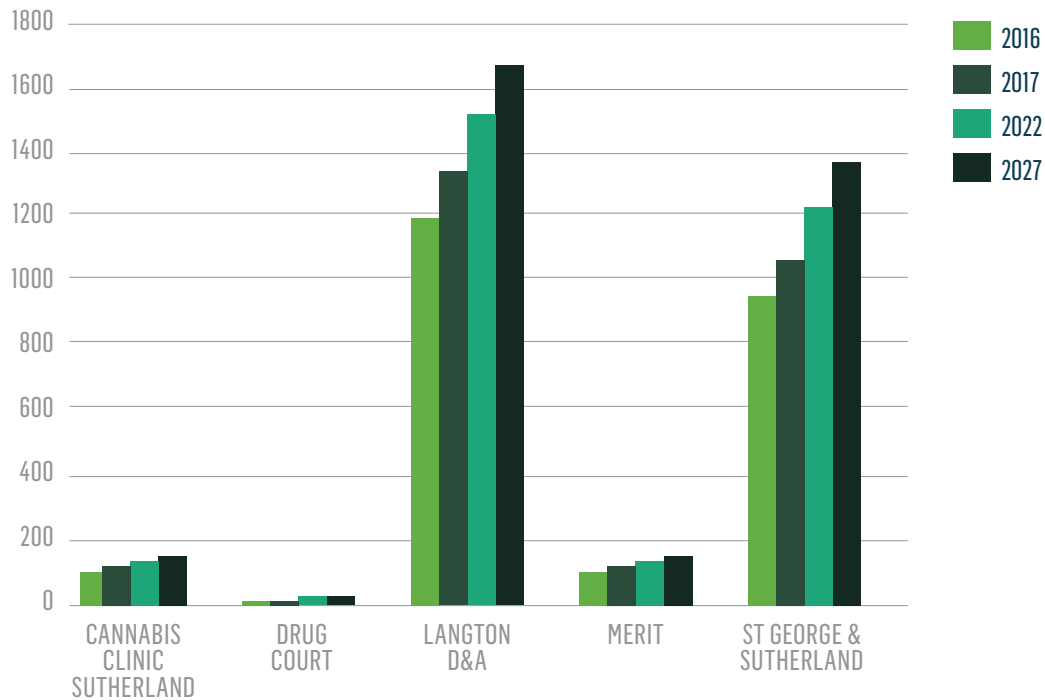
Inclusions: Diagnosis codes F10 – F19, T41 –T43

TABLE 7:
Consultation Liaison Service provided by Principal Drug of Concern, SESLHD, 2013/13- 2015/16

PRIMARY DRUG	2012/2013	2013/2014	2014/2015	2015/2016	TREND	% GROWTH	AGR
ALCOHOL	449	464	695	749		67%	19%
AMPHETAMINE TYPE SUBSTANCES	34	67	100	123		262%	54%
BENZODIAZEPINES	20	38	18	39		95%	25%
BUPRENORPHINE	3	4	11	22		633%	94%
CANNABIS	28	31	54	51		82%	22%
COCAINE	4	5	8	13		225%	48%
HEROIN	35	19	23	43		23%	7%
METHADONE	38	63	55	78		105%	27%
GRAND TOTAL	611	691	964	1,118		83%	22%

Source: SESLHD Drug & Alcohol Share-Point Consultation Liaison List

FIGURE 12:
Base Case projections for episode level activity by facility, SESLHD, 2015/16 – 2026/27



Source: SESLHD Drug & Alcohol Share-Point Consultation Liaison List

Assumptions

- Trend analysis between 2013 and 2016, segmented by PDoC where annual growth rate exceeded that of the aggregated service utilisation
- Applied the retrospective annual growth rate to the 2015/16 baseline data to presentation rate for each PDoC and facility

Assumes Prince of Wales Hospital’s models of care and patient flows remain largely unchanged.

Limitations

- The projections are to be used as a high level guide to estimating future service demand and do not take into account unforeseen changes in service delivery, implications of new technology or the implications of new drugs.
- Due to low activity levels, PDoCs have been rolled up into like categories: alcohol, Cannabinoids and related drugs, Heroin, Opioids and related drugs, sedatives/hypnotics and stimulants.
- SESLHD saw peaks in activity between 2012/13 and 2015/16 which are believed to be largely attributed to data reporting issues; as such they have been smoothed in the creation of these projections.
- Due to the unpredictable nature of new drugs and drug technologies, no scenario modelling was undertaken for Drug and Alcohol Services.

APPENDIX 5

Plan development process

The development process for the Clinical Services Plan included consultations with key stakeholders, data analysis and review of relevant Commonwealth, State and SESLHD policies.

Consultations

Stage 1 – February - April 2016

Consultations were undertaken as follows:

- A one-day planning forum was conducted with senior managers and clinicians from DAS to identify current and emerging D&A issues facing the community, current and future service gaps and service delivery challenges to be addressed through the Plan
- A series of face-to-face and telephone consultations were conducted with internal SESLHD stakeholders, including staff from DAS, Primary, Integrated and Community Health, Planning Population Health and Equity, Aboriginal Health, Emergency Departments and inpatient staff at Prince of Wales, St George, Sydney and Sutherland Hospitals and Joint Mental Health/D&A committees
- Two mixed service consultation forums were held bringing together SESLHD staff from relevant portfolio areas including Child, Youth, Women and Families, Homelessness Health, Youth Health Multicultural Health, Child Protection, Oral Health, Violence and Abuse Prevention team, Equity, Sexual Health and HIV and Related Programs [HARP].

Two technical papers have been produced documenting findings from the above processes:

- *Summary of Workshop Proceedings: D&A Service Planning Day*
- *SESLHD D&A Clinical Services Plan: Summary of Findings from Stage 1 Consultations.*

Both papers are available on request from the SESLHD Strategy and Planning Unit or DAS.

Stage 2 – May- June 2016

A second round of consultations was undertaken as follows:

- A half-day forum was conducted bringing together staff from a number of specialist D&A services, including community based D&A withdrawal management and residential rehabilitation services (largely NGO providers)
- A half-day forum was conducted bringing together staff working in SESLHD and other community youth services, including D&A services, general, health and mental health services for young people
- Face-to-face and/or telephone interviews were conducted with:
 - Central and Eastern Sydney Primary Health Network
 - Sydney Local Health District
 - St Vincent's Hospital Network
 - NSW Users and AIDS Association [NUAA]
 - The Drug and Alcohol Multicultural Education Centre [DAMEC]
 - SESLHD Homelessness Health Coordinator
 - Consultation with DAS clients via attendance at regular coffee morning events at St George and Langton.

A technical paper has been produced summarising findings from the above consultation process. *SESLHD D&A Clinical Services Plan: Summary of Findings from Stage 2 Consultations* is available as on request from SESLHD Strategy and Planning Unit or DAS.

Data analysis

Analysis was undertaken of population health and demographic data for the SESLHD catchment area, DAS activity data and inpatient and ED activity data by the SESLHD Strategy and Planning Unit in consultation with the SESLHD Drug and Alcohol Service Information Manager.

Governance

Oversight for the development of the Plan was provided by a Steering Committee chaired by the Director of Primary, Integrated and Community Health (PICH).

APPENDIX 6

Issues identified through stakeholder consultations

The extensive consultation strategy for the Plan's development provided a comprehensive picture of the priority issues stakeholders considered should be addressed over the next 5-10 years. In summary, those priorities are as follows:

Address current inequities in access to DAS services, particularly to ensure:

- Availability of comprehensive multidisciplinary D&A services to clients in the Sutherland area
- Delivery of an appropriate level of D&A services in the Botany, Maroubra and Malabar areas
- Provision of a greater range of D&A outpatient/ambulatory services within the POWH/Randwick precinct
- Improvement of D&A service access for Aboriginal communities across the District, including the employment of designated D&A Aboriginal health staff
- Improvement of the understanding of the D&A issues and service needs for people from CALD backgrounds
- Collaboration with community-based service providers to address gaps in D&A services:
 - For young people, inclusion of withdrawal and other treatment services
 - Access to residential rehabilitation services for women with dependent children
 - Access to aftercare services to support people to sustain health improvements.

Building capacity within health services

- Increase understanding amongst health service staff about the significant contribution of the DAS in reducing the impact of drug and alcohol on Emergency Departments and hospitals, evidenced by LOS, waiting lists, re-admissions, adverse events, and improved client outcomes.
- Increase HDA CL services to provide 7-day coverage, at levels aligned to the capacity of each of the four major hospitals
- Ensure access to adequate levels of addiction medicine staff (staff specialists, registrars) to support staff to manage D&A clients within EDs and inpatient settings
- Provide ongoing education of hospital staff to ensure they can adequately screen clients for D&A issues and can accurately interpret screening results to respond appropriately
- Develop clearly defined clinical pathways for common D&A presentations to assist hospital staff to manage effectively
- Increase efforts to address issues related to frequent presenters to hospitals, including more active case management.

Improve the health and wellbeing of D&A clients

- Develop care pathways to address the declining physical and cognitive health of the ageing D&A population cohort
- Improve referral pathways to health and welfare services for D&A clients experiencing homelessness
- Collaborate with the Central and Eastern Sydney PHN to improve access to GPs for D&A clients.

Improve the experience of D&A clients accessing specialist and other health services

- Strengthen the involvement of D&A consumers and carers in planning for service improvement
- Continue efforts to reduce stigma for people with D&A issues attending SESLHD services
- Improve/refurbish current sub-optimal D&A client facilities
- Enhance understanding of the impact of substance use in client presentations to facilitate more effective care for with clients with SUDs in EDs and hospital services.

Coordination of care for D&A clients

- Improve the transfer of care and referral pathways between DAS and community-based providers of D&A inpatient withdrawal management and rehabilitation services
- Improve collaboration with mental health services to facilitate more streamlined services for clients with co-morbid D&A and mental health issues
- Improve service and referral pathways to achieve integrated care between the hospital and the community for D&A clients
- Collaborate with SLHD and St Vincent's Hospital Network to improve referral pathways, improve communication about clients with complex needs who are frequent presenters across services, and negotiate the movement of clients between services.

Working in partnership

- Strengthen collaboration with Central and Eastern Sydney PHN, particularly to:
 - Address D&A service gaps and identify opportunities for co-commissioning of D&A services in the community
 - Encourage uptake of D&A service provision by GPs
 - Improve referral pathways between the Specialist D&A Service and the primary care sector
- Collaborate with SESLHD Aboriginal Health to develop tailored approaches to the provision of D&A services to Aboriginal communities in the catchment area
- Provide opportunities for cross-sector D&A workforce development within the catchment area (e.g. with NGOs, primary care and private providers)
- Collaborate with SLHD and SVHN in the management of D&A clients across service boundaries
- Strengthen DAS's commitment to involve consumers through partnership with consumer organisations, including the New South Wales Users and AIDS Association [NUAA], in the development of a drug and alcohol peer workforce across SESLHD
- Collaborate with the Drug and Alcohol Multicultural Education Centre [DAMEC] and local CALD services to improve engagement with CALD populations with D&A issues
- Collaborate with relevant agencies to increase efforts to provide support for families and carers of people with D&A problems.

Enhance the sustainability and quality of specialist D&A services

- Better integrate D&A services within the four main hospital campuses
- Refurbish and/or relocate some current DAS teams to ensure certainty of accommodation, which is fit-for-purpose and client-friendly
- Ensure adequate access to consultation rooms across D&A service locations to meet service demand
- Strengthen governance and management arrangements within the DAS, particularly to ensure alignment with service configuration and to streamline meeting and decision-making arrangements
- Further integrate the role of Consumer Workers into DAS service planning and core business
- Strengthen clinical governance, particularly:
 - Ensure DAS staff are represented within hospital clinical governance mechanisms
 - Establish mechanisms for allied health clinical governance and professional leadership.

APPENDIX 7

Clinical services role delineations

Role delineation is applied in NSW to inform strategic service, clinical and capital planning at the local and State level. When developing plans such as Clinical Service Plans, Business Cases for capital projects and other service plans, the *NSW Health Guide to the Role Delineation of Clinical Services* is used as a tool to describe the size, service profile, and roles of the facility applying to clinical services.

The role level of a service describes the complexity of the clinical activity undertaken by that service.

The Ministry of Health has recently finalised the Role Delineation for Drug and Alcohol Services.

SESLHD will be reviewing all role delineations in 2017, with reference to the revised guide produced by the Ministry of Health. This Plan should inform future role delineations to ensure alignment with population need and service roles.

APPENDIX 8

DAS clinical services FTE by location

TABLE 8: DAS clinical services FTE by location

	NON-ADMITTED PATIENT SERVICES	INPATIENT D&A ADMISSIONS	HOSPITALS D&A CONSULTATION LIAISON SERVICE	CHEMICAL USE IN PREGNANCY SERVICE (CUPS)	
TLC	36.6	NA	NA	NA	
STGH	15.6	0.3	2.2	0.6	
TSH	6.5	0	1.1	0.4	
POWH	0.5	0	3.8	0	
SSEH	0	0.5	0.4	0	
RHW	0	0	0	2	
TOTAL	59.2	0.8	7.5	3	70.5

Excludes Teaching/Training, Research, Administration, Corporate Support and Management FTE

APPENDIX 9

Relevant internal and external clinical guidelines and references

Individual DAS service streams have specific protocols guiding quality and safety, such as Model of Care for SESLHD Drug and Alcohol Service Cannabis and Smoking Clinics [CaSC].

At a statewide level there are a number of relevant guidelines governing clinical quality and safety standards for D&A treatment services, namely:

- NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines
http://www0.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf
- NSW Health Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment
http://www0.health.nsw.gov.au/policies/gl/2006/GL2006_019.html
- NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines
http://www0.health.nsw.gov.au/policies/gl/2008/pdf/gl2008_011.pdf
- NSW Health Hospital D&A Consultation Liaison Model of Care
<http://www.health.nsw.gov.au/mentalhealth/programs/da/Publications/Hosp-DA-consult-moc.pdf>
- NSW MERIT Operations Manual
<http://www.merit.justice.nsw.gov.au/Documents/meritprogramoperationalmanual.pdf>

OTHER REFERENCES

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“Episode of Care”

The unit of measurement for the NSW MDS DATS is a Service Episode. A Service Episode is defined as “a treatment process, with defined dates of commencement and cessation between a patient/client and a provider or team of providers, provided at the treatment agency or one of its service delivery outlets”.

Source:

Mental Health and Drug & Alcohol Office, 2012-2013 Data Dictionary and Collection Guidelines for the NSW Minimum Data Set for Drug and Alcohol Treatment Services. NSW Ministry of Health: Sydney 2012.

APPENDIX 10

Glossary

ACRONYM	MEANING
ABF	Activity Based Funding
ACAT	Aged Care Assessment Team
ACHAM	Australasian Chapter of Addiction Medicine [RACGP]
ACEM	Australasian College for Emergency Medicine (ACEM)
ACI	Agency for Clinical Innovation, NSW Ministry of Health
ACON	AIDS Council of NSW
ADC	Adult Drug Court
ADAN	Aboriginal Drug and Alcohol Network
ADIS	Alcohol and Drug Information Service
AFPHM	Australasian Faculty of Public Health Medicine
AH&MRC	Aboriginal Health and Medical Research Council
AIHW	Australian Institute of Health and Welfare
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
AoDP	Alcohol and Other Drugs Program, NSW Ministry of Health
ATOD	Alcohol, Tobacco and Other Drugs
CALD	Culturally and Linguistically Diverse
CCHC	Caringbah Community Health Centre
CDAN	Credentialed Drug and Alcohol Nurse - Drug and Alcohol Nurses Association
CESPHN	Central and Eastern Sydney Primary Health Network
ChAM	Chapter of Addiction Medicine
CHCs	Community Health Centres
CPP	Consumer Participation Project
COQI	Clinical Outcomes and Quality Indicators Framework
CUPS	Chemical Use in Pregnancy Service
D&A	Drug and Alcohol
DAMEC	Drug and Alcohol Multicultural Education
DANA	Drug and Alcohol Nurses Association
DAS	Drug and Alcohol Service, SESLHD
DET	District Executive Team, SESLHD
DPPHE	Directorate of Planning, Population Health and Equity, SESLHD
DRGs	Diagnostic Related Groups
ECCO	Enhanced Community Care Options Team
EDs	Emergency Departments
eMR	Electronic Medical Record
eMR CHOC	Electronic Medical Record Community and Health Outpatient Care
ESRGs	Enhanced Service Related Groupings
FACS	Family and Community Services
FACHAM	Fellowship of Australasian Chapter of Addiction Medicine
FDS	Family Drug Support
FoAP	Faculty of Addiction Psychiatry -a Faculty of the Royal Australian and New Zealand College of Psychiatrists
GPs	General Practitioners
HARP	HIV and Related Programs, DPPHE
HDA-CL	Hospital Drug and Alcohol - Consultation and Liaison Services
HETI	Health Education and Training Institute
HIE	Health Information Exchange

APPENDIX 10 (continued)

ACRONYM	MEANING
HITH	Hospital In The Home
ICT	Information Communication Technology and e-Health Ministry of Health
iiHub	SESLHD Improvement and Innovation Hub
InforMH	Health Informatics Unit for Mental Health statewide
ISLHD	Illawarra & Shoalhaven Local Health District
LGA	Local Government Area
LGBTQI	Lesbian, gay, bisexual, transgender, queer, intersex
LHDs	Local Health Districts
LHNs	Local Hospital Networks
LOS	Length of Stay
MERIT	Magistrates Early Referral Into Treatment
MH	Mental Health
MH-CCP	Mental Health Clinical Care and Prevention Model
MOH	Ministry of Health
MoH CPH-DAP	NSW Ministry of Health Centre for Population Health Drug and Alcohol Program
NADA	The Network of Alcohol and Other Drug Agencies
NDARC	National Drug and Alcohol Research Centre - UNSW
NDIS	National Disability Insurance Scheme
NGOs	Non-Government Organisations
NHMRC	National Health and Medical Research Council
NSW DACRN	D&A Clinical Research Improvement Network
NUAA	NSW Users and AIDS Association
OTP	Opioid Treatment Program
PDofC	Principal Drugs of Concern
PHN	Primary Health Network
PICH	Primary Integrated Community Health
PMO	Program Management Office Ministry of Health
POWH	Prince of Wales Hospital
PSA	Pharmacy Services Association or Public Sector Association
PWID	People who inject drugs
RACGP	Royal Australian College of General Practitioners
READY Program	St George Youth Service Resource - Resources & Education on Alcohol & Drugs for Youth
RHW	Royal Hospital for Women
SAPHaRI	Secure Analytics for Population Health Research and Intelligence
SCHN	Sydney Children's Hospital Network
SEIFA	Socio-economic index for services
SESLHD	South East Sydney Local Health District
SGH	St George Hospital
SLHD	Sydney Local Health District
SMHSOP	Specialist Mental Health Services for Older People
SSEH	Sydney Hospital and Sydney Eye Hospital
SVHN	St Vincent's Health Network
SUD	Substance Use Disorders
SYD LHD	Sydney Local Health District
TLC	The Langton Centre
TSH	The Sutherland Hospital
UNSW	University of NSW
USYD	University of Sydney



Health
South Eastern Sydney
Local Health District