

Drug and Alcohol Services Plan 2007-2011

August 2007



HNE Health Drug and Alcohol Services Plan 2007-2011

August 2007

Further copies may be obtained:

Via the Hunter New England Health website
http://intranet.hne.health.nsw.gov.au/planning_unit

Hunter New England Health
Planning Unit
Locked Bag 1
New Lambton NSW 2305

Or phoning: Healthlink 1800 063 635

TABLE OF CONTENTS

SECTION A

Executive Summary	5
--------------------------	----------

SECTION B

1. Introduction	8
1.1 Plan Aim	8
1.2 Plan Scope	8
1.3 Plan Goals	8
1.4 Plan Outcomes	8
1.5 Core Planning Group	9
1.6 Key Stakeholders	9
1.7 Consultation Strategies	9
1.8 Mental Health/Drug and Alcohol Clinical Network	10
1.9 Links to other Area Service Plans	10
2. Policy Context	12
2.1 The National Drug Strategy: Australia's integrated framework 2004-2009	12
2.2 National Drug Strategy Aboriginal and Torres Strait Islanders Peoples Complementary Action Plan 2003-2009	12
2.3 National Alcohol Strategy: Towards Safer Drinking Cultures 2006-2009	13
2.4 The State Plan 2006: A New Direction for NSW	13
2.5 The State Health Plan- Towards 2010	13
2.6 NSW Health Drug and Alcohol Plan 2006-2010	14
2.7 NSW Health Youth Alcohol Action Plan 2001-2005	15
2.8 NSW Tobacco Action Plan 2005-2009	15
2.9 The Management of People with a co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines	16
2.10 HNE Health Strategic Plan 2006-2010 and Healthcare Services Plan	16
2.11 Needle and Syringe Program policy and guidelines for NSW 2006	16
2.12 Interagency Guidelines for the early intervention, response and management of drug and alcohol misuse 2005	17
2.13 Amphetamine, Ecstasy and Cocaine: A Prevention and Treatment Plan 2005-2009	17
3. Drugs and Alcohol and the Burden of Disease	19
3.1 Introducing Hunter New England Health	19
3.2 The Hunter New England Population at a Glance	19
3.3 Burden of Disease	20
3.3.1 Tobacco	24
3.3.2 Alcohol	25
3.3.3 Cannabis	26
3.3.4 Psychostimulants	27
3.3.5 Ecstasy	27

3.3.6	<i>Heroin</i>	27
3.3.7	<i>Injecting drug use and communicable disease</i>	30
3.4	Vulnerable Population Groups	33
3.4.1	<i>Co-existing Mental Health and Substance Misuse Disorders</i>	33
3.4.2	<i>Aboriginal People and Communities</i>	34
3.4.3	<i>Sexual and Gender Diverse Groups</i>	36
3.4.4	<i>The Ageing Population</i>	37
3.4.5	<i>Drug-using Individuals in contact with the Criminal Justice System</i>	37
3.4.6	<i>People from Diverse Cultural and Linguistic Backgrounds</i>	38
3.4.7	<i>Rural Communities</i>	39
3.4.8	<i>Children in Developmental Stages</i>	39
3.4.9	<i>Young People</i>	40
4.	Current and Projected Service Delivery	42
4.1	HNE Health Drug and Alcohol Service Profile	43
4.2	Innovative Models of Care	45
4.3	Current Activity	50
4.4	Projected service requirements	58
5.	Strategic and Service Issues	61
5.1	Key Challenges	61
5.2	Workforce issues	60
5.3	Consumer Feedback and Analysis	62
5.4	Future Directions	66
6.	Aboriginal Health Impact Statement	69
7.	Ethnic Affairs Priority Statement	69
8.	References	70
SECTION C		
	Strategic Objectives and Strategic Action Plan	71
SECTION D		
	Appendices	92
	Appendix 1: Core Planning Group	90
	Appendix 2: Key Stakeholders List	91
	Appendix 3: Consumer Interview Form	92
	Appendix 4: Related Policies and other documents	102
	Appendix 5: HNE Health Drug and Alcohol Clinical Services Organ. Structure	104
	Appendix 6: Aboriginal Impact Statement	105
	Appendix 7: Corporate Risk Matrix	108

SECTION A: EXECUTIVE SUMMARY

The purpose of this plan is to outline the strategic directions for Hunter New England Health (HNE Health) Drug and Alcohol Clinical Services over the next five years and to identify strategies that will guide the development of a cohesive, integrated, area-wide approach to the provision of health care to people requiring these services.

The plan has been completed to inform Drug and Alcohol Clinical Services (DACS) of priority areas for action and guide the development of operational plans for each of the Services' streams e.g. MERIT, Detoxification. The outcomes of the Plan will be achieved by improving the quality of care provided to people affected by drug and alcohol misuse, by Drug and Alcohol Clinical Services and, in partnership with a range of other identified services.

This will be facilitated by ensuring that, on an ongoing basis: staff providing care to these clients have access to appropriate training and support; services are targeted to areas of need and consider alternate delivery models e.g. consultation liaison services, telehealth; services are provided in a planned and co-ordinated manner, and are accessed via an area wide centralised intake service; and, access to specialist services is streamlined. Whilst aiming to provide the most appropriate care as close as possible to where clients live, it is recognised that not all services can be provided at all locations.

In 2007/08, Drug and Alcohol Clinical Services will join with Area Mental Health Services to form a Mental Health/Drug and Alcohol Clinical Network. Area Clinical Networks link groups of health professionals from primary, secondary and tertiary care settings across the area to work together in a coordinated manner to provide integrated care for consumers of their services.

The plan is consistent with National, State and Area objectives. The issues that have been prioritised as significant challenges for the Area are addressed in this plan. It is recognised that unanticipated issues will emerge within the five-year period of the plan and those will be addressed accordingly.

Key Service Issues

The following are key challenges for drug and alcohol services development:

- The complexity of delivering comprehensive drug and alcohol clinical across multiple sites and large geographic distances
- Timely access to treatment services
- Recruitment and retention of staff (nursing, allied health and medical), to be able to offer a range of services with a quality standard of care in acceptable time frames and workloads
- Providing professional development opportunities to staff across the service
- Implementing new and enhancing existing culturally appropriate services for Aboriginal and socially disadvantaged communities
- Provision of adequate IT, support services and booking systems to support the provision of coordinated and integrated care
- Incorporating health promotion, early intervention and education services as

- standard practice across the clinical services
- Providing appropriate support for General practitioners.

Strategic Priorities for Implementation

Several high priority initiatives have been identified to ensure that HNE Health Drug and Alcohol Clinical Services are able to address the major issues facing communities over the next five years. These initiatives include:

- Ensuring consumer/community participation in all aspects of Drug and Alcohol service delivery
- Involving clients in the development of their individual treatment plans
- Expanding the use of alternate dosing modalities e.g. Take-safe
- Securing additional funding to address identified gaps in service delivery e.g. consultation and liaison services, Aboriginal Health Education Officers
- Work with HNE Health Aboriginal Health and Aboriginal Liaison Officers both internal and external to Drug and Alcohol Clinical Services to improve referral and consultation pathways
- Work with Children, Young People and Families services and Maternity and Women's Health Services to improve referral and consultation pathways
- Continuing to develop and maintain innovative and flexible strategies to provide services for people who are geographically disadvantaged e.g. teleconference, telehealth, email
- Working with public hospitals to encourage the development of consultation liaison services and engage them in pharmacotherapy service delivery
- Promoting and encouraging the development of a core set of Drug and Alcohol skills/competencies across all disciplines
- Develop and implement the Drug and Alcohol Services Workforce Plan
- Developing a Research Plan that:
 - Identifies opportunities for research funding, including a strategy for core research funding
 - Develops and strengthens links with Universities and other research bodies

SECTION B: INTRODUCTION AND BACKGROUND

1. Introduction

There is a substantial body of evidence that shows licit drugs (tobacco, alcohol and pharmaceuticals) are responsible for the most harm associated with drug use in our community. There are a substantial number of deaths (mortality), and considerable illness, disease and injury (morbidity) attributed to drug use and misuse¹.

Drug use also contributes to violence, crime, workplace concerns and breakdowns in families and relationships in Australia. Collins and Lapsley (2002) estimated that the economic costs associated with licit and illicit drug use in 1998-99 amounted to \$34.5 billion, of which tobacco accounted for 60%, alcohol 22%, and illicit drugs 17% of the estimated costs¹.

Drug and alcohol dependency affects people from all backgrounds and walks of life and is not simply a consequence of age, the social divide or geographic location. Development of this five-year plan provides the opportunity to initiate key strategies; partnerships and programs to ensure services have improved capacity and capability to respond to drug problems in the community¹.

The Hunter New England (HNE) Health Drug and Alcohol Services Plan is consistent with the policy and strategic directions at both National and State levels. The principles underpinning the Plan align with those of the NSW Health Drug and Alcohol Plan 2006-2010. These are:

- Provision of a policy framework for drug and alcohol services and health programs
- Ensuring that there are equitable and effective clinical services across the Area to assist people with drug and alcohol problems
- Setting directions that are based on high standards and the best scientific evidence to treat drug and alcohol related problems
- Increasing the capacity and competency of the drug and alcohol workforce².

In line with the NSW Health Drug and Alcohol Plan 2006 – 2010 and in consultation with a broad range of services and disciplines across HNE Health, consumers and key external stakeholders, the Plan focuses on identifying the key strategic and service issues and gaps, and initiating steps to guide the provision of services that ensure:

- Equitable access to services
- A healthier population
- Provision of quality healthcare
- Harm minimisation
- Assistance for Aboriginal communities

The Vision of HNE Health Drug and Alcohol services is:

- Healthier communities: Excellence in healthcare.

The Purpose is:

- Working with our communities to deliver quality Drug and Alcohol Services

When achieved, the vision, purpose and key strategic goals will contribute to improving the

health of the communities of the Hunter New England, through the provision of integrated and coordinated drug and alcohol services that are sustainable in the long term, increase access to services, reduce waiting times and provide innovative and flexible service delivery.

1.1 Plan Aim

The overall aim of the HNE Health Drug and Alcohol Services Plan is to guide the development of an integrated, efficient and cohesive Area-wide approach to the provision of drug and alcohol services across Hunter New England.

1.2 Plan Scope

The Plan:

- Provides direction for the delivery of an area wide drug and alcohol service that is flexible in approach and responsive to client/patient needs
- Identifies all services currently provided and highlight gaps in service provision
- Facilitates improved access to services
- Increases the focus on prevention, health promotion and early intervention
- Identifies strategies to advance training and ensure the maintenance of an adequate and skilled workforce
- Identifies opportunities for collaboration with other relative services and key stakeholders
- Outlines key infrastructure and governance strategies to improve the quality of services
- Identifies key information management strategies across the area

1.3 Plan Goals

The over-arching goal of the plan is to ensure that people requiring drug and alcohol services have access to a range of high quality services and best practice care irrespective of where they enter the health system.

Specifically, for HNE Health, the Plan aims to achieve:

- An area-wide strategic focus
- Community engagement
- Patient/client centred approach
- Equitable access
- Inter-sectorial collaboration
- Effective partnerships
- Alignment with relevant policies, plans, frameworks and strategies
- Cost effective use of available resources
- Evidenced based approach (where available)

1.4 Plan Outcomes

The Plan will contribute to preventing and minimising harm caused by licit drugs, illicit drugs and other substances by assisting in:

- Preventing the uptake of harmful drug use

- Reducing risk behaviours associated with drug use
- Reducing drug-related harm for individuals, families and communities
- Reducing the personal and social disruption, loss of life and poor quality of life, loss of productivity and other economic costs associated with harmful drug use
- Increasing access to a greater range of high-quality prevention and treatment services
- Increasing community understanding of drug-related harm
- Promoting evidence-informed practice through research, monitoring drug use trends, and developing workforce organisation and systems
- Strengthening existing partnerships to reduce drug related harm¹.

1.5 Core Planning Group

A Core Planning Group (CPG) was established to oversee the development of the plan and:

- Determine the strategic direction of HNE Drug and Alcohol Services
- Determine the scope of services to be offered
- Determine service development priorities including workforce priorities
- Determine minimum Service Standards for client care incorporating the standards in the NSW Drug Summit 1999 and the NSW Drug and Alcohol Plan 2006-2010.

Membership of the group is included as Appendix 1.

1.6 Key Stakeholders

The CPG identified key internal and external stakeholders that included:

- Rural/urban, acute/community, specialist/generalist service providers
- Health promotion, disease prevention, Aboriginal Health and Migrant Health service providers
- Health service managers, medical, nursing and allied health disciplines
- Consumers (clients, carers and community members)
- General practitioners, staff specialists and visiting medical officers
- External government and non-government agencies.

Membership of the Key Stakeholders Group is included as Appendix 2.

1.7 Consultation Strategies

Extensive consultations were undertaken as part of the development of the Plan. Identification of gaps and needs featured prominently in these consultations. A consumer questionnaire was developed and distributed via members of the Core Planning Group to ensure the views of the services' consumers informed the development of the Plan. The questionnaire is included as Appendix 3.

HNE Health Drug and Alcohol Services Managers provided feedback on staffing profiles, and consultation occurred with staff from area wide Drug and Alcohol Clinical Services (including a staff survey and face to face planning days), on workforce issues, service gaps and strategic directions.

1.8 Mental Health/Drug and Alcohol Clinical Network

HNE Health is introducing Area Clinical Networks to improve coordination of service delivery and build staff capacity across the area to ensure equitable provision of high quality, clinically effective care. Area Clinical Networks link groups of health professionals from primary, secondary and tertiary care settings across the area to work together in a coordinated manner. These networks shift the emphasis from separate institutions to a system of integrated care for the consumer.

Up to 80% of people with a drug and alcohol problem can have a co-existing mental illness. HNE Health will be developing a Mental Health/Drug and Alcohol Clinical Network that will facilitate Drug and Alcohol Services and the Area's Mental Health Services to work together on strategic initiatives. This new alliance reflects the recent NSW Health realignment of the separate Centres for Mental Health and Drug and Alcohol to a Mental Health and Drug and Alcohol Office.

The roles and responsibilities of the Mental Health/Drug and Alcohol Clinical Network include:

- Coordinating the development, review and use of appropriate clinical practice guidelines across relevant services
- Enhancing professional development and education for staff
- Facilitating the provision of information for service providers and consumers and their families to support access to appropriate care
- Enhancing service delivery through facilitation of integrated models of care
- Collecting, analysing and evaluating data in relation to service delivery and outcomes
- Promoting and using the quality framework (safe, effective, accessible, efficient, appropriate) in all activities
- Developing, implementing and monitoring of the Mental Health and Drug and Alcohol Service Plans
- Developing recommendations and facilitation of activities in relation to the retention, recruitment, succession of staff
- Developing recommendations for resource prioritisation and allocation
- Developing recommendations to Area Executive and others as appropriate on service delivery and planning priorities.
- Facilitating peer support and strong relationships across facilities, services, Area Clinical Networks and external partners to support service delivery.

This initiative will build on the work already occurring regarding joint initiatives between the two services. The development work for this Clinical Network will occur in the second half of 2007.

1.9 Links to other Area Service Plans

Service plans developed for all Area Clinical Networks must reflect the principles and practices of drug and alcohol services when appropriate to their strategies. Ongoing communication and collaboration between Area Clinical Networks is necessary to ensure the needs of people requiring drug and alcohol health services are constantly considered and addressed.

People with drug and alcohol problems may need links to Mental Health, Chronic Disease, Critical Care and Emergency, Maternity, Aged Care and Rehabilitation and, Child and Youth services to support and sustain their recovery, within the wider context of general health.

Most people with drug-related problems seek help initially from general medical and allied health workers rather than specialist drug services. Therefore it is essential that medical and allied health professionals have adequate information, resources and training systems to enable them to assess, manage and where necessary, refer patients with drug-related problems.

The HNE Health Drug and Alcohol services stream will play an integral part of the scoping and development of the Area Mental Health/Drug and Alcohol Clinical Network.

2. Policy Context

It is important that the strategies and initiatives included in the Plan align with relevant National and State policies, standards and frameworks. A list of relevant policies and other documents considered in the development of this Plan is included as Appendix 4.

Brief summaries of some of the key documents are included below.

2.1 The National Drug Strategy: Australia's Integrated Framework 2004 – 2009

The National Drug Strategy 2004-2009 provides a framework for a coordinated, integrated approach to drug issues in the Australian community. This document is a national policy framework that is complemented, supported and integrated with a range of national, state, territory, government and non-government strategies, plans and initiatives. It builds upon the experience and achievements of its policy predecessor, the National Drug Strategic Framework 1998-99 to 2003-04, and is overseen and guided by key advisory and decision making bodies.

The National Drug Strategy 2004-2009 seeks to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.

The following eight priorities have been identified in the National Drug Strategy 2004 –2009:

- Prevention
- Reduction of supply
- Reduction of drug use and related harms
- Improved access to quality treatment
- Development of the workforce, organisations and systems
- Strengthened partnerships
- Implementation of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006
- Identification and response to emerging trends.

2.2 National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2009.

During the development of other national action plans under the National Drug Strategic Framework 1998-99 to 2003-04, it was recognised that Aboriginal and Torres Strait Islander peoples' needs were not specifically addressed.

This action plan sets a national direction for reducing harm associated with use of alcohol, tobacco and other drugs amongst Aboriginal and Torres Strait Islander people. It provides an opportunity for communities, non-government organisations, Aboriginal and Torres Strait Islander community-controlled organisations and all levels of government to pursue strategies that are specifically relevant to Aboriginal and Torres Strait Islander peoples and their circumstances, needs and aspirations.

2.3 National Alcohol Strategy: Towards Safer Drinking Cultures 2006- 2009

This plan reflects the National Drug Strategy 2004-2009 and supports the key result areas of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2009.

The goal of the strategy is to prevent and minimise alcohol-related harm to individuals, families and communities in the context of developing safer and healthier drinking cultures in Australia.

To achieve this goal, the Strategy has four aims:

- Reduce the incidence of intoxication among drinkers
- Enhance public safety and amenity at times and in places where alcohol is consumed
- Improve health outcomes among all individuals and communities affected by alcohol consumption
- Facilitate safer and healthier drinking cultures by developing community understanding about the special properties of alcohol and through regulation of its availability.

2.4 The State Plan 2006 - A New Direction for NSW

The State Plan focuses on NSW Government priorities over the next ten years. Within the focus areas of 'rights, respect and responsibility' and 'delivering better services' there are specific priorities and targets relating to people suffering from alcohol and drug misuse. These include:

- Reducing rates of crime, particularly violent crime
- Reducing re-offending
- Reducing levels of antisocial behaviour
- Improving health through reduced obesity, smoking, illicit drug use and risk drinking

2.5 The State Health Plan - Towards 2010

The vision of the NSW public health system is *Healthy people – Now and in the future*. There are four goals:

- To keep people healthy
- To provide the health care that people need
- To deliver high quality services
- To manage health services well

Priority areas for future action are contained within the seven strategic directions:

- Make prevention everybody's business
- Create better experiences for people using the health system
- Strengthen primary health and continuing care in the community
- Build regional and other partnerships for health
- Make smart choices about the costs and benefits of health services
- Build a sustainable health workforce
- Be ready for new risks and opportunities

In regard to drug and alcohol misuse, NSW Health has committed to: continuing to implement social marketing campaigns, tobacco legislation, smoking cessation programs and other tobacco control measures particularly aimed at disadvantaged groups; reducing harm related to drug and alcohol use, particularly among young people, focusing on action to reduce underage drinking and encourage responsible drinking through implementation of the Youth Alcohol Action Plan; increase awareness and engagement of communities in effective ways to tackle drug and alcohol issues; continue working with the criminal justice system to ensure the early referral of suitable defendants into drug and alcohol treatment, through programs such as Magistrates Early Referral into Treatment (MERIT).

NSW Health will also: implement the Alcohol Disease Prevention Plan to deliver better health outcomes for people experiencing drug- and alcohol-related harm by enhancing design, availability and delivery of drug and alcohol services; improve emergency health responses and implement evidence-led preventative and treatment interventions.

2.6 NSW Health Drug and Alcohol Plan 2006-2010

The NSW Drug and Alcohol Plan 2006-2010 outlines the NSW Government's commitment to reduce the problems caused by drug and alcohol use, and builds on initiatives resulting from both the NSW Drug Summit 1999, the NSW Alcohol Abuse Summit 2003 and the National Drug Strategy 2004-2009. This is a particularly relevant document for the HNE Drug and Alcohol clinical services. The goals of the plan are to:

- Provide a policy framework for drug and alcohol services and health programs in NSW
- Set directions based on high standards and the best scientific evidence to treat drug and alcohol related problems
- Ensure that there are equitable and effective clinical services across NSW to assist people with drug and alcohol problems
- Increase the capacity and competency of the drug and alcohol workforce.

The Plan reports the current best practice and evidence-based approaches to the treatment of drug and alcohol problems. Three priority areas for future action have been identified in the plan:

- Prevention
- Brief and early intervention
- Treatment and extended care.

To support these three areas of future action the NSW Government will strengthen existing support structures, with particular emphasis on:

- Workforce development
- Infrastructure and governance
- Information management.

The Plan represents a shared commitment to continuously improve and build on the standard of care within the drug and alcohol field. The Plan will enhance the high quality of care already available through drug and alcohol services in NSW and will provide an opportunity to build on the achievements of the NSW Drug Treatment Services Plan 2000-2005.

The Plan adopts a population health approach and provides a systematic approach to drug

and alcohol treatment services aimed at improving access, quality and innovation in drug and alcohol treatment services across all regions of NSW.

2.7 NSW Health Youth Alcohol Action Plan 2001-2005

The NSW Youth Alcohol Action Plan outlines a commitment and approach to preventing and reducing alcohol use and associated harm by young people between 12 and 24 years.

Key outcomes for the Plan include:

- A reduction in premature death, illness and injury associated with alcohol use
- An increase in young people's knowledge of alcohol-related harms and strategies to reduce them
- A reduction in young people's access to alcohol and reduced incidence of underage drinking
- A reduction in alcohol-related violence, antisocial behaviour and crimes in which young people are involved
- A reduction in young people drinking at risky or dangerous levels
- A reduction in young people using alcohol with illicit drugs
- An increase in appropriate and accessible treatment services for young people who experience alcohol-related problems

An updated NSW Youth Alcohol Action Plan will be released in 2007.

2.8 NSW Tobacco Action Plan 2005-2009.

Tobacco smoking has been identified as the greatest principle cause of mortality and morbidity in NSW, particularly for cardiovascular disease, cancer and chronic obstructive pulmonary disease. There is also increasing evidence of harm to adults and children from exposure to environmental tobacco smoke in homes, workplaces and enclosed public spaces. Of all behavioural risk factors, tobacco use (including passive smoking) is responsible for the greatest burden of premature death and disability in NSW.

The goal of this Plan is to improve the health of the people of NSW and to eliminate or reduce their exposure to tobacco in all its forms.

Objectives of the Plan in the long term are:

- A decrease in the number of people in NSW who will die as a result of tobacco smoking
- A decrease in the level of disease and hardship caused by smoking in NSW
- A decrease in the economic and social costs of tobacco-related illness in NSW.

And in the short term:

- A reduction in the number of people who smoke tobacco
- A reduction in the number of children and young people who take up tobacco smoking
- A reduction in the NSW population's exposure to tobacco smoke.

Priority population groups within the plan are children, young people, Aboriginal and Torres Strait Islander people, and non-English speaking background communities with high smoking rates and people with mental illness.

2.9 The Management of People with a co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines, 2000.

These guidelines provide a framework for service providers to design, develop and deliver health care services for people with co-morbid mental health and substance use disorders. They are very relevant for specialist mental health and drug and alcohol services, primary care service providers e.g. General practitioners, as well as those working in tertiary care.

The aims and expected outcomes of the guidelines are to improve the health care and health outcomes for people with coexisting mental health and drug and alcohol problems (dual disorders) by:

- Developing and implementing a whole of life span approach encompassing the full spectrum and interventions from prevention through to early intervention treatment and maintenance
- Providing health care systems with a clearer direction, better understanding and greater capacity to deliver holistic health care
- Increasing the knowledge, skills and ability of all primary care providers to enable better identification, assessment, prevention, and management for this group
- Improving the links and partnerships between primary care, specialized services, non-government organizations and mainstream health care agencies to ensure continuum of care
- Promoting equitable access to a range of specialist and mainstream services
- Improving the clinical and management information systems that assist in the identification and management of this group
- Improving education and training for specialist and primary care providers
- Implementing and evaluating programs designed to meet the needs of individual consumers, their families and the communities in which they live
- Increasing community awareness of the risk factors associated with co-existing mental health and substance use disorders.

These guidelines are currently subject to review by NSW Health. NSW Health is currently in the process of finalising the NSW Health Comorbidity Mental Health/Illicit Substance Use Framework For Action 2007.

2.10 HNE Health Strategic Plan 2006-2010 and Healthcare Services Plan 2006- 2010

The Strategic Plan presents HNE Health's vision, purpose and values and strategic directions for health services. The Area Healthcare Services plan provides an overview of clinical service directions that support cardiac service directions over the coming five years. The HNE Drug and Alcohol Services Plan will reflect HNE Health Strategic directions.

2.11 Needle and Syringe Program Policy and Guidelines for NSW 2006

The Needle and Syringe Program (NSP) is an evidence-based public health program that aims to prevent the spread of infections such as of HIV and Hepatitis C among people who inject drugs.

The objective of the program is to minimize risk behaviours that have the potential to transmit blood borne viruses and the strategies of the program are:

- Distribution of sterile needles and syringes and safe sex equipment
- Promotion of safe disposal, including collection and disposal of used needles and syringes
- Development and delivery of early and brief education programs relevant to the aim of the program
- Provision of information/referrals to other health and welfare services.

2.12 Interagency Guidelines for the Early Intervention, Response and Management of Drug and Alcohol Misuse 2005

These guidelines are designed to assist justice and human services agencies to develop their drug and alcohol related policies and plan associated workforce needs.

The guidelines aim to:

- Strengthen the capacity of agencies to identify and respond appropriately to harmful drug and alcohol use among their service users
- Strengthen the co-ordination and collaboration between specialist and mainstream services to improve the effectiveness of responses to harmful drug and alcohol use among service users
- Assist justice and human service agencies to define their roles and responsibilities for *Interagency guidelines* among their service users
- Identify and describe the key practice areas that justice and human service agencies may engage in to respond to harmful drug and alcohol use among their service users
- Provide justice and human service agencies with guidance on when, how and who might respond to harmful drug and alcohol use among their service users
- Assist justice and human service agencies to review and develop drug and alcohol related policies, procedures and practices and plan workforce needs.

2.13 Amphetamine, Ecstasy and Cocaine: A Prevention and Treatment Plan 2005-2009

The NSW Health Amphetamine, Ecstasy and Cocaine Prevention and Treatment Plan 2005-2009 was developed in response to the changing patterns of drug use which will require innovative strategies to address. Of particular concern is the growing incidence of psychostimulant abuse and the need to reduce the associated harm. The aim of the Plan is to reduce the harms associated with the abuse of psychostimulants.

The objectives of the plan are to:

- Increase the range of effective interventions to reduce psychostimulant- related harms
- Interrupt transition to heavy, problematic use

- Increase the knowledge and skills levels of drug users, health and allied health professionals regarding the association between psychostimulant drug use and harm
- Increase the range and availability of effective, evidence-based treatment options and their appeal to psychostimulant users
- Increase understanding within the field of psychostimulant use and promote best practice through research, monitoring and evaluation of initiatives
- Increase the capacity of drug users to make decisions that reduce the harm associated with psychostimulant use
- Promote the development of targeted initiatives for special populations
- Encourage partnerships and collaborative approaches between health professionals and agencies, non-government organizations, communities and drug users to reduce psychostimulant-related harms.

3. Drugs and Alcohol and the Burden of Disease

3.1 Introducing Hunter New England Health

As at 1 January 2005 health services in NSW were restructured to form eight new Area Health Services. Hunter New England Health (HNE Health) was formed from the merging of the previous New England Area Health Service, Hunter Area Health Service and the lower portion of Mid North Coast Area Health Service.

HNE Health covers a significant geographic area of over 130,000 square kilometres or 16% of the area of NSW. Given such a vast area, with a major metropolitan and several regional population centres as well as small remote communities, HNE Health faces enormous challenges to ensure the provision of health services to meet the needs of such a widespread and diverse population. Major challenges include achieving improved health and wellbeing for all and improving equity of access to services across the area. The challenges faced are further compounded by the difficulties in attracting suitably qualified and skilled health professionals to rural and remote areas. In order to effectively manage a complex network of health services across such a vast area, HNE Health is divided into eight geographical clusters, which are based around Local Council Areas (see Table 1).

Table 1: Hunter New England Clusters by LCAs and LGAs

Cluster	Local Council Areas	Local Government Areas
Mehi	Moree Plains, Narrabri	Moree Plains, Narrabri
McIntyre	Inverell, Gwydir	Inverell, Bingara, Yallaroi, parts of the Guyra and Uralla shires
Tablelands	Tenterfield, Glen Innes, Severn, Guyra, Armidale-Dumaresq, Uralla	Tenterfield, Glen Innes, Severn, Armidale-Dumaresq, parts of the Guyra and Uralla shires
Peel	Tamworth, Walcha, Gunnedah	Tamworth, Walcha, Gunnedah, Parry, Barraba, Manilla, Nundle
Upper Hunter	Liverpool Plains, Upper Hunter, Muswellbrook	Scone, Murrurundi, Merriwa, Muswellbrook, Quirindi
Lower Hunter	Maitland, Dungog, Singleton, Cessnock	Maitland, Dungog, Singleton, Cessnock
Lower Mid North Coast	Greater Taree, Great Lakes, Gloucester	Greater Taree, Great Lakes, Gloucester
Greater Newcastle	Newcastle, Lake Macquarie, Port Stephens	Newcastle, Lake Macquarie, Port Stephens

3.2 The Hunter New England Population at a Glance

- The Hunter New England area currently has a population of 837,670 (DIPNR Dec 2004), which is approximately 12% of the population of NSW
- The population is widely distributed across the Area: from a densely populated coastal zone to small rural townships with declining populations
- Modest population growth is projected: 2.8% over the next five years (compared to 4.5% in NSW) reaching 856,870 in 2011 and 875,580 in 2016 (DIPNR Dec 2004). See Table 2.
- Population projections by age group show a declining birth rate (0-4 years), a decrease in the number of people aged 25-40 years and an increase in the

- number of people aged 55 years and over. See Table 3.
- The HNE Health area has the largest Aboriginal population of all Area Health Services: 21.6% of the State's Aboriginal population or 3.3% of the HNE population compared with 2.1% of the NSW population

Table 2: Projected Population growth across HNE Health 2001 to 2016

Cluster/Area	2001	2006	2011	2016
Mehi Cluster	30,790	30,130	29,540	29,040
McIntyre Cluster	21,140	20,710	20,180	19,950
Tablelands Cluster	51,260	50,870	50,670	50,600
Peel Cluster	72,530	73,090	73,990	74,920
Upper Hunter Cluster	34,810	34,340	33,690	33,100
Lower Hunter Cluster	133,380	140,020	145,600	150,970
Lower Mid North Coast Cluster	81,920	85,930	89,230	92,610
Greater Newcastle Cluster	388,970	402,580	414,060	424,390
Hunter New England Area	814,800	837,670	856,870	875,580

Source: DIPNR Dec 2004

Table 3: Hunter New England Population Estimates by Age groups 2001 to 2016

Age	2001	%	2006	%	2011	%	2016	%
0-4	53,680	6.6%	50,720	6.1%	47,580	5.6%	46,430	5.3%
5-9	58,630	7.2%	55,410	6.6%	52,560	6.1%	49,600	5.7%
10-14	59,560	7.3%	59,570	7.1%	56,450	6.6%	53,730	6.1%
15-19	57,050	7.0%	58,070	6.9%	58,020	6.8%	55,180	6.3%
20-24	48,460	5.9%	49,780	5.9%	50,570	5.9%	50,460	5.8%
25-29	49,830	6.1%	44,320	5.3%	45,450	5.3%	46,130	5.3%
30-34	53,180	6.5%	52,130	6.2%	47,280	5.5%	48,560	5.5%
35-39	57,790	7.1%	55,410	6.6%	54,560	6.4%	50,160	5.7%
40-44	60,290	7.4%	58,540	7.0%	56,500	6.6%	55,880	6.4%
45-49	56,020	6.9%	60,390	7.2%	59,050	6.9%	57,350	6.5%
50-54	54,380	6.7%	56,580	6.8%	60,920	7.1%	60,040	6.9%
55-59	45,640	5.6%	55,910	6.7%	58,100	6.8%	62,720	7.2%
60-64	39,020	4.8%	46,690	5.6%	57,350	6.7%	59,770	6.8%
65-69	33,780	4.1%	38,270	4.6%	45,870	5.4%	56,750	6.5%
70-74	32,290	4.0%	31,390	3.7%	35,980	4.2%	43,430	5.0%
75-79	26,050	3.2%	28,000	3.3%	27,610	3.2%	32,100	3.7%
80-84	16,550	2.0%	20,410	2.4%	22,400	2.6%	22,560	2.6%
85+	12,600	1.5%	16,080	1.9%	20,620	2.4%	24,730	2.8%
Total	814,800	100.0%	837,670	100.0%	856,870	100.0%	875,580	100.0%

Source: DIPNR Dec 2004

3.3 Burden of Disease

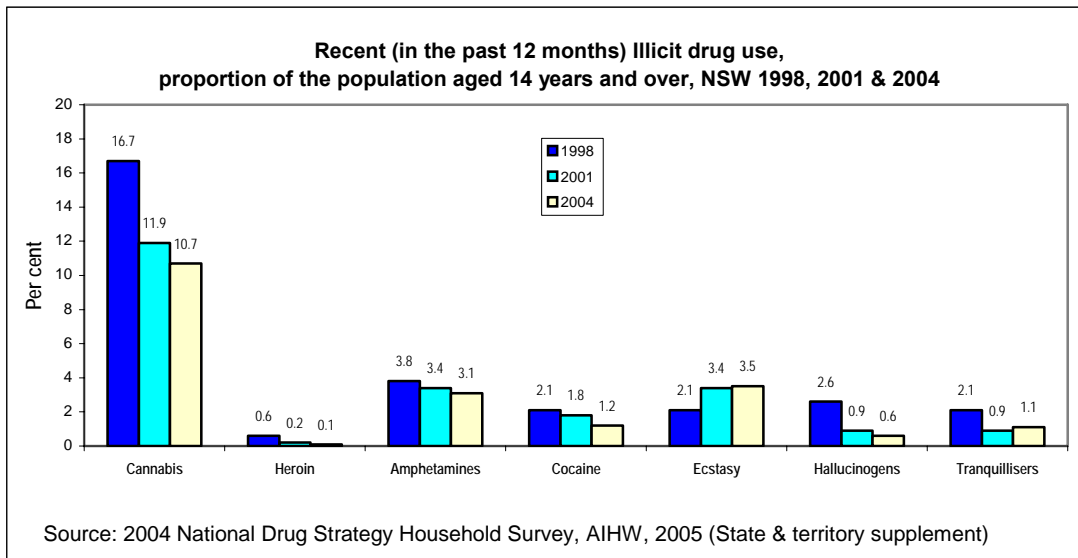
People may experience a range of problems as a result of drug and alcohol use – family, social, physical, psychological and legal. Some may seek assistance from one or more human service agencies, but may never come into contact with any drug and alcohol specialist services.

The need to continuously improve and coordinate services delivery is important, given that research suggests:

- Between 2-7% of the adult population of NSW would benefit from drug and alcohol treatment, particularly early and brief intervention
- Individuals who are unemployed and have low educational achievement are more at risk of developing drug and alcohol problems
- Low income and homelessness are risk factors for patterns of harmful drug and alcohol use
- Excessive drinking is likely to have contributed to presenting problems at welfare and general counselling services
- 30-80% of people with mental disorders also have a substance use disorder
- In NSW, 70% of prison inmates reported using drugs in the 24 hours preceding their offence and about half of the general prison population has a history of injecting drug use
- The Child Death Review Team estimates that drug and alcohol directly or indirectly contributes to nearly 25% of all child deaths reported to the Coroner
- Early and brief intervention offers substantial benefits when conducted by trained and resourced workers
- Drug treatment is effective in reducing harmful drug and alcohol use, hospital costs, drug-related harm, violence and welfare costs³.

Figure 1 shows findings from the NSW component of the 2004 National Drug Strategy Household Survey, which indicates that illicit drug use has, on average, decreased from 1998 to 2004. The only exception is with ecstasy use, which has increased from 2.1% to 3.5% of the population having used the drug in the past 12 months.

Figure 1: Recent illicit drug use, persons aged 14 years and over, NSW 1998, 2001 and 2004

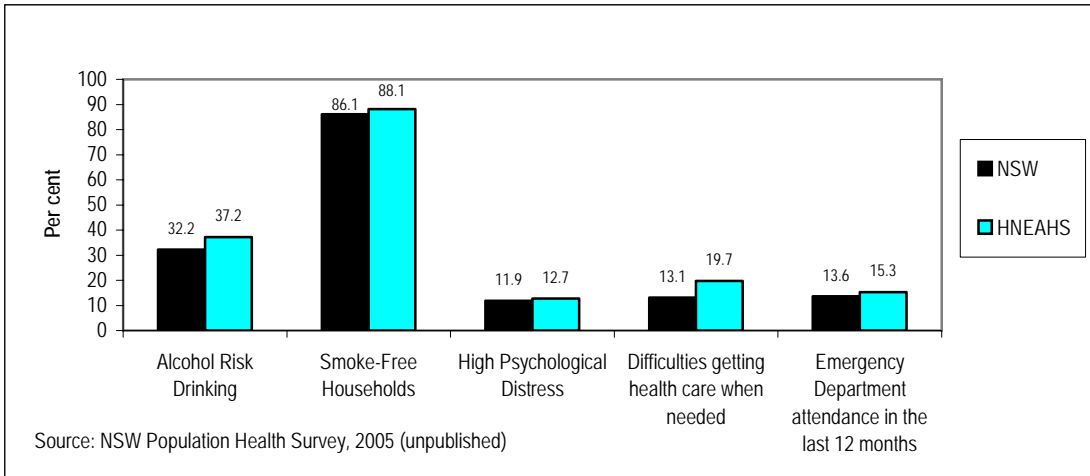


The NSW Health draft Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines (2007) states that, in 1992, Australia became the first country in the world to introduce harm reduction principles into drug policies, and a 'harm reduction' approach is recommended for all psychosocial interventions with drug and alcohol clients. Harm reduction approaches take a realistic and practical approach to the issues of problematic drug and alcohol use, and focus on reducing the harms (negative effects) associated with a client's drug and alcohol use, reinforcing any positive changes a client is able to make. It is important to note that harm reduction approaches to problematic drug and alcohol use recognises abstinence as the only safe goal for some severely substance dependent individuals. However, for many drug and alcohol clients, abstinence is not always a realistic goal. Instead, clients and professionals work together to build a hierarchy of goals for the client to work towards, which may or may not culminate in total abstinence. For a heroin user, this may include not sharing needles, participating in a needle/syringe program, engaging in safe sex, using methadone maintenance treatment, using other health services for relevant health issues, perhaps changing to oral or inhaled forms of heroin.

Harm reduction approaches are broadly grouped into three main categories: *prevalence reduction* (encouraging a reduction in problematic drug and alcohol use in society, e.g. through education about the harms of use); *quantity reduction* (reducing the frequency and amount of drug and alcohol used); and *harm reduction* (managing the other negative effects of problematic drug and alcohol use).

The 2005 NSW Health Survey included questions on a variety of health indicators. People who reside in the Hunter New England area were more likely to report risk drinking or having difficulty in obtaining health care when they needed it than the state average (Figure 2).

Figure 2: Health Indicators, NSW and HNE Health, 2005



Drug and alcohol treatment, excluding Opioid Treatment Pharmacotherapy (OTP), includes clients who attend treatment for counselling, detoxification, rehabilitation, information and education and a clinical assessment. Figure 3 indicates that clients from Hunter New England area are more likely to be Australian born than the NSW average. Clients from the Hunter New England area are less likely to be male, with more reported to be in employment than the NSW average. Figure 4 indicates that clients from Hunter New England area receiving treatment are similar in age groups to the NSW average.

Figure 3: Drug and alcohol treatment episodes (Minimum Data Set (MDS) excluding OTP) by client demographics, NSW and HNE Health, 2004 - 2005

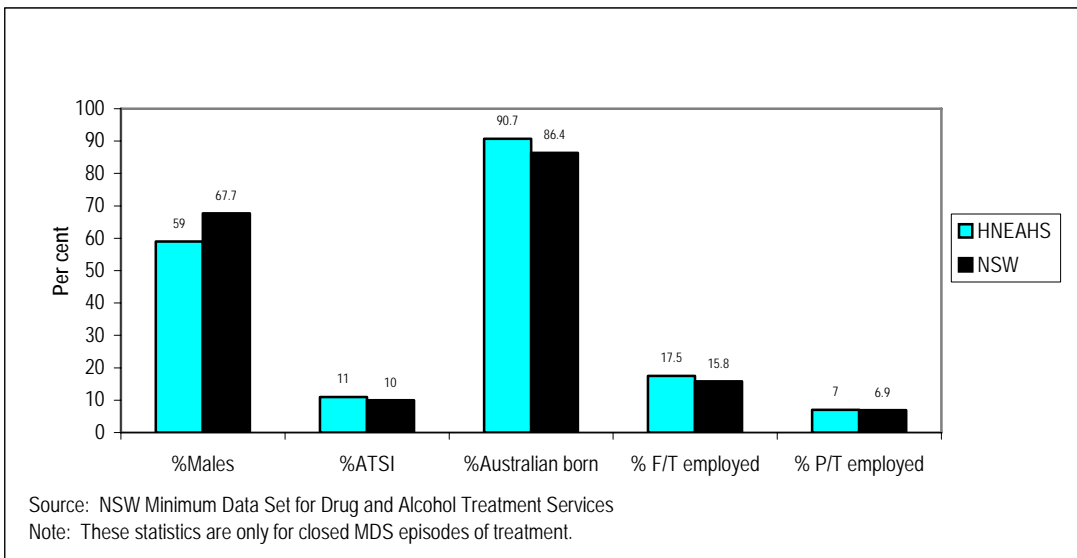
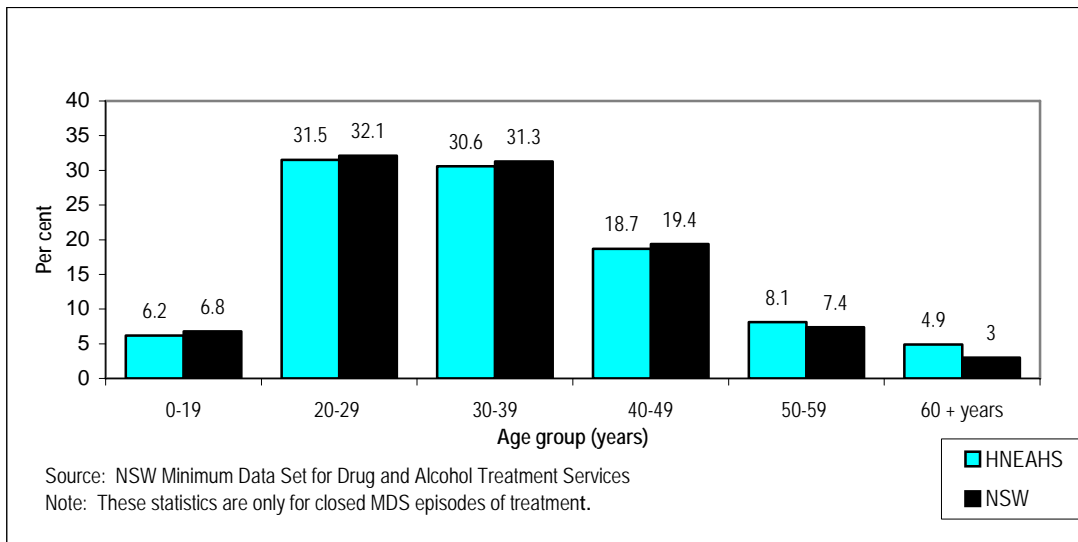


Figure 4: Drug and alcohol treatment episodes (MDS excluding OTP) by age group, NSW and HNE Health, 2004 - 2005



3.3.1 Tobacco

Tobacco remains a highly addictive and dangerous product and it is important that policy efforts are maintained to ensure that there is no upsurge in the use or acceleration in uptake by young people.

Tobacco smoking was responsible for 8% of the total burden of disease in Australia in 2003. It is the leading preventable cause of morbidity and premature mortality, particularly from cardiovascular disease, cancers of the lung, larynx, and mouth, and chronic obstructive pulmonary disease. Smoking also contributes to risk of sudden infant death syndrome (SIDS) and low birth-weight. The tangible social costs of tobacco use in Australia were estimated to be \$7.6 billion in 1998-99, or about 2.3% of the gross domestic product.

In NSW in 2004, smoking caused an estimated 6,507 deaths overall (4,244 males and 2,263 females). This represented 18% of all male and 10% of all female deaths. In 2004-05, it was estimated that smoking caused 55,591 hospitalisations (36,129 among males and 19,462 among females) representing 4% of all male and 2% of all female hospitalisations⁴.

Between 1985 and 2004, there was a 45% decline in the age-adjusted rate of deaths attributable to smoking in NSW, from 163 to 89 per 100,000 population. In 1985, smoking killed 282 men and 80 women per 100,000 population. By 2004, the rate had decreased to 135 men and 54 women per 100,000. The death rate attributable to smoking declined over this time by 52% among men, and by 33% among women⁴.

The age-adjusted rate of smoking-related hospitalisations for females in NSW increased by 13% between 1989-90 (461 per 100,000 population) and 2004-05 (520 per 100,000 population). In contrast, the age-adjusted rate of smoking-related hospitalisations for males, decreased by only 7% between 1989-90 (1,156 per 100,000 population) and 2004-05 (1,078 per 100,000 population)⁴.

In 2005, the New South Wales Population Health Survey found that for people aged 16 years and over, 20.1% of people reported current daily or occasional smoking (22.6% males; 17.6% females). In the Hunter New England area a significantly higher proportion, 23% of people, reported current daily or occasional smoking (26.1% males; 19.9% females)⁴.

In the Hunter New England area, during the period 1992 to 2003 there was a decline in the age standardised rate of death attributable to smoking. This decrease is quite significant for males from 243.0 to 151.3 deaths per 100,000. There was also a steady decrease in females deaths from 70.4 to 57.1 deaths per 100,000⁵.

In the Hunter New England area, during the period 1992/1993 to 2003/2004 change in age standardised rate of hospitalisations attributed to smoking differed between males and females. There has been a slight decline in the rate of hospitalisations for males from 1205.1 to 1128.5 per 100,000 and a slight increase for females from 503.0 to 540.9 per 100,000⁵.

A range of support services is available to assist smokers effectively and affordably make a quit attempt. In NSW, a telephone-based counselling service is available to all smokers who would like support for a quit attempt. The Quitline also provides assistance to the family and friends of smokers and others requesting information about smoking. Callers to the Quitline receive a free Quit Kit, along with 24-hour access to advice about quitting smoking, nicotine dependence, strategies on preparing to quit, preventing relapse and staying a non-smoker. Information on products and services to help with a quit attempt are also provided. Up to six follow-up phone calls can be scheduled throughout the most difficult period of quitting⁶.

3.3.2 Alcohol

For many people, alcohol forms part of an enjoyable and generally healthy lifestyle that includes good diet, avoidance of smoking, and exercise. Evidence suggests that there are health benefits in the regular consumption of a very small amount of alcohol for those aged over 45 years. This protective effect is observable in ischaemic heart disease and possibly stroke and gallstones.

However, these possible benefits must be balanced with the risks. Regular excessive alcohol consumption increases the risk over time of chronic ill health and premature death. Episodic heavy drinking places the drinker and others at risk of injury and death. A small amount of alcohol can lead to higher blood alcohol in older people as the body's total water content decreases and may increase the risk of injury from falls or driving.

In Australia in 2003, the burden of disease associated with alcohol was 10 times higher in males (6.5%) than in females (0.6%), with the greatest burden in males occurring in those aged 0-44 years (8% of the total disease burden in this age group). In Australia, the annual cost to the community of alcohol-related social problems was estimated to be \$7.6 billion (\$5.5 billion tangible) in 1998-99.

Excessive alcohol consumption is associated with cirrhosis of the liver, mental illness, several types of cancer, heart disease, stroke, gastritis, pancreatitis, foetal growth retardation, aggressive behaviour, dementia, family disruption, and reduced productivity. High rates of harm have been found among low-to-moderate drinkers when they drink to intoxication. Alcohol also contributes to injury from assaults, road trauma, domestic violence

and suicide. The distribution of hospitalisations that can be attributable to alcohol would be expected to reflect risk drinking or long-term drinking in the community. Increased use of alcohol has been associated with increased social disadvantage.

In NSW in 2004, alcohol use caused an estimated 1,416 deaths (1,021 males and 395 females). This represents 4.3% and 1.7% of all male and female deaths respectively. Between 1985 and 2004, the age-adjusted rate of deaths attributable to alcohol declined by 36% from 31 to 20 deaths per 100,000 population. The rate of decline was greater for males (39%) than females (29%) over this period⁴.

In 2004-05 alcohol caused an estimated 40,042 hospitalisations (25,680 among males and 14,362 among females). This represents 2.5% and 1.2% of all male and female hospitalisations respectively. The age-adjusted hospital separation rate increased between 1989-90 and 2004-05 by approximately 27%, from 460 to 583 hospitalisations per 100,000 population. The rate of increase in hospitalisations attributable to alcohol was greater for females (64%) than males (14%) over this period⁴.

In 2005, the New South Wales Population Health Survey found that 32.1% of people reported risk drinking (37.2% males; 27.3% females). The proportion was highest among those aged 16-25 years (47.5% males; 38.0% females). The proportion declined with age; however, 25.6% of males and 17.4% of females aged 75 years and over were still reporting risk drinking. A significantly higher proportion of people in the Hunter New England area, 37.1%, reported risk drinking (40% males; 34% females).

In Hunter New England in 2003, alcohol use caused an estimated 134 male deaths and 60 female deaths. Between 1992 and 2003, the age-adjusted rate of deaths attributable to alcohol declined from 26.2 to 21.4 deaths per 100,000 persons.

In 2003, alcohol caused an estimated 2,675 hospitalisations among males and 1,555 hospitalisations among females. The age-adjusted hospital separation rate between 1992 and 2003 increased from 435.4 to 497.8 hospitalisations per 100,000 persons in the Hunter New England area, with the rates increasing for both males and females⁵.

3.3.3 Cannabis

Cannabis is the most widely used illicit drug in Australia. It is estimated that of Australians aged 14 years and over in 2004, about one in three (34%) had used cannabis at some stage in their lifetime and one in nine (11%) had used it at least once in the previous 12 months. In NSW, 11% of people aged 14 years and over reported using cannabis in the previous 12 months⁷.

Use of cannabis can result in acute effects, including impairment of motor skills, reaction time and the ability to perform skilled activities. Psychotic illness and symptoms of schizophrenia may be exacerbated by cannabis use¹.

In 2004, most illicit drug use in the 12–15 years age group was of marijuana/cannabis. Between 1996 and 2005 in NSW, the NSW School Students Health Behaviour Survey showed a large fall in the reported use in cannabis among NSW secondary school students, with 15% of students reporting having ever used cannabis in 2005 compared to 34% in 1996. In males, usage rates dropped from 37.5% in 1996 to 17.6% in 2005 and in females, usage dropped from 30.7% in 1996 to 13.1% in 2005.

The proportion of students who have ever used cannabis increased with age across all

years. In 2005, 4.2% of students aged 12 years and 29% of those aged 17 years reported ever using cannabis. In 1996, the range was much greater (11.7% for those aged 12 years to 56.3% for those aged 17 years)⁴.

There are some concerns in the community about whether adolescents who use cannabis become dependent on it. Research indicates that young people who use cannabis regularly are at greater risk of using and abusing other substances and of criminal behaviour. They are also at risk of a range of mental health problems including: psychosis; depression; anxiety; suicidal thoughts and behaviours; impaired educational achievement, and, reduced life opportunities⁹.

3.3.4 Psychostimulants

The evolving nature of the psychostimulant market has seen the use of methamphetamine, including crystal methamphetamine and other related substances, increase over the past decade¹.

In 2001, amphetamines were the second most commonly used illicit drug in Australia after cannabis. The 20-29 year age group are the most likely to have ever used amphetamines. Amphetamine-type stimulants have particular appeal to young people and the 2001 NSW Health University Drug and Alcohol Survey of university students aged 18 – 24 years found that 10% of the sample reported having used amphetamines in the previous 12 months.

In Australia, the usual places recent users reported having used amphetamines were at home or at a friend's place, followed by private parties. Use in settings such as raves/dance parties and public establishments were also common. This lends credibility to anecdotal reports that amphetamines are mostly used as 'social drugs'.

In 2001, it was estimated that 1.3% of Australians aged 14 and over had used cocaine during the previous 12 month period. In terms of lifetime use the figure is 4.4%. Cocaine is used mostly by younger persons, with the highest prevalence in the 20-29 and 30-39 year age groups. The use of cocaine by young people is also supported by the 2001 NSW Health University Drug and Alcohol Survey, which found that 4.7% of the sample reported recent use and 6% reported lifetime use⁹.

Current data indicates that the prevalence of cocaine use is relatively low, however, injection of cocaine and methamphetamine has increased in recent years. The increase in cocaine and methamphetamine prevalence may be due to a reduction in the availability of heroin, with some heroin users moving from heroin to cocaine and methamphetamine use.

Harms associated with chronic and dependent use of cocaine and methamphetamine include hypertension, cardiac arrhythmias, myocardial infarction, profound mood swings, aggressive behaviour, psychosis, neurotoxicity and damage to the nasal mucosa⁹.

Benzodiazepines are a prescribed medication and are not illegal, however, they are often used illicitly. They have been included in reporting because of their high potential for harm among injecting drug users. In 2004, there were 61 deaths associated with benzodiazepines (70% in males with 64% in those aged 15-44 years); and 28 deaths were associated with psychostimulants (70% in males and 93% in those aged 15-44 years)⁴.

3.3.5 Ecstasy

Ecstasy is a psychostimulant and is the third most widely used illicit drug in Australia after cannabis and amphetamine. In 2001, it was reported that almost 456,000 people had used this drug in the last 12 months. This drug has social appeal, particularly for young people, and is consistently associated with party-going.

In NSW in 1998, the 20-29 year age group reported the highest prevalence of ecstasy use in regard to lifetime use (13.8%) and recent use (7%). Similarly, the 14-19 year old age group in NSW recorded the next highest prevalence of lifetime use (7.4%) and recent use (4.2%)⁸.

Research has revealed that ecstasy/designer drugs are popular amongst young people who are relatively well-educated and have little contact with the criminal justice system or drug treatment agencies. While the amount and frequency of drugs taken by ecstasy users can vary, heavy sessional use (using the drug continuously for more than 48 hours) and poly-drug use is common.

Unwanted effects associated with use include: mild perceptual distortions or hallucinations; increased jaw clenching and grinding of teeth; hot and cold flushes; sweaty palms; poor concentration; reduced urine flow; excessive thirst; anxiety; depression; mood swings; paranoia; panic attacks; sleep disturbances; and appetite disturbances. Fatal toxicity is low, but documented causes of death include: hyperthermia; cardiac arrhythmia; convulsion; stroke; and, liver necrosis⁸.

3.3.6 Heroin

Although heroin use in Australia is relatively low, it is a significant cause of death, injury and illness, particularly for younger people. Over the past decade, heroin overdose deaths represented the third greatest cause of death for the 25-35 year age group (behind motor vehicle accidents and suicide)¹.

In early adulthood, the burden of disease due to illicit drugs is dominated by mortality and morbidity associated with heroin use, but the long-term effects of blood-borne viruses (hepatitis B and C) contracted through injecting drug usage begin to manifest.

Opiate deaths from heroin, morphine or methadone, represent a large proportion of illicit drug deaths in Australia and are a source of public concern. Most opioid deaths are from heroin, however there has been an upsurge in the use of pharmaceutical opiates in the Hunter (10% of all opiates reported in the Illicit Drug Reporting System (IDRS) survey 2006).

Opiate overdose deaths peaked in NSW in 1999, and have declined in each year following. In late 2000 there was a heroin shortage in Sydney and other Australian capital cities, with severe drought in the 'Golden Triangle' region of Laos, Myanmar and Thailand affecting the Australian market. Policing operations have been cited as another contributing factor⁴. The Memorandum of Understanding between police and ambulance services which removed the necessity for police to accompany ambulances to overdose cases, and, the increase in health promotion intervention around overdose within drug-using networks may have also contributed.

HNE Health has a lower rate of ambulance attendances at opioid overdose than the NSW

average (Figure 5), whereas opioid related deaths are nearly 5% higher than the state average (Figure 6).

Figure 5: Ambulance attendances at overdose, NSW and HNE Health, January 2001- June 2005

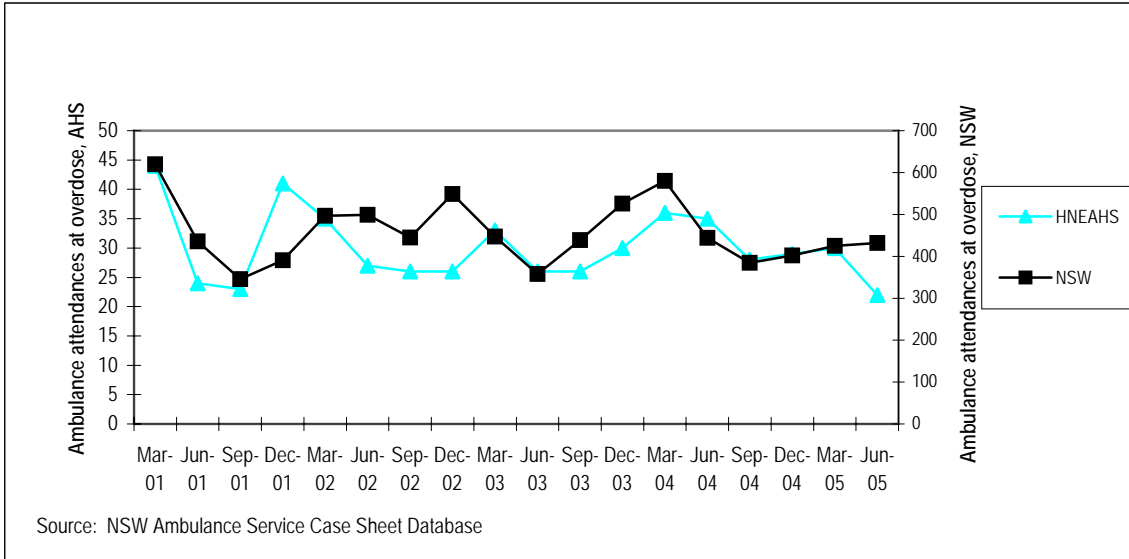


Figure 6: Opioid related deaths, rate per million population, persons aged 15-54, NSW and HNE Health, 2000 - 2004

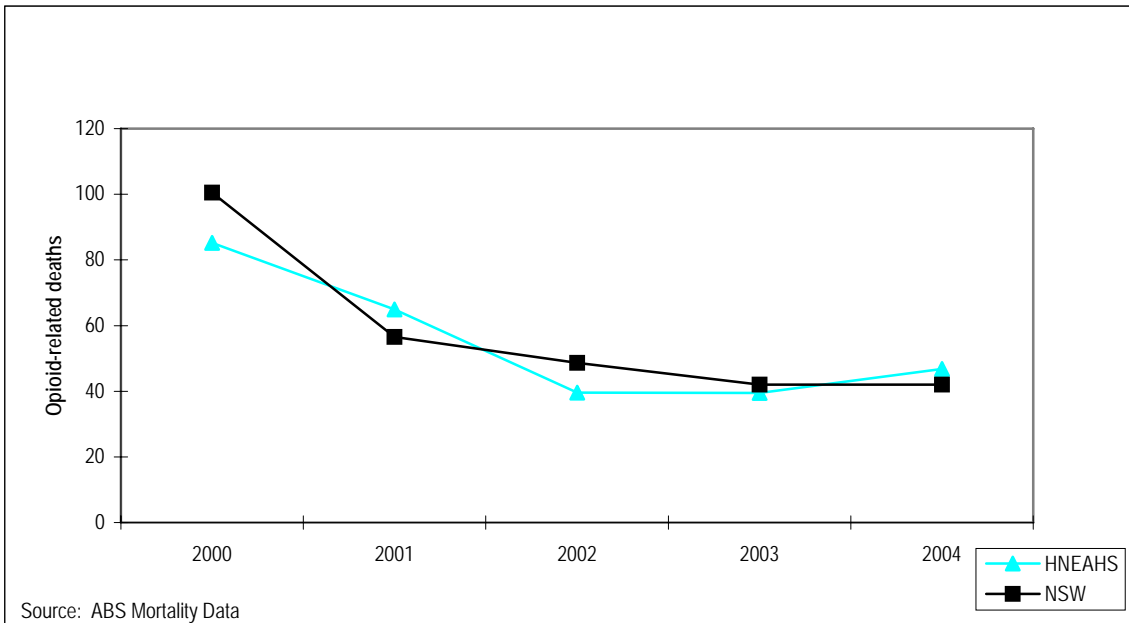


Table 4 indicates that OTP clients in the Hunter New England area are more likely to be born in Australia than the state average. Clients in the Hunter New England area are more likely to be of Aboriginal origin than NSW as a whole.

Table 4: OTP client demographics, NSW and HNE Health, 2004/2005

	HNE Health	NSW
% Male	59.9	65.0
Average age	37.3	37.1
% Aboriginal	11.3	10.8
% Australian born	97.6	90.6
Total number	1,084	16,469

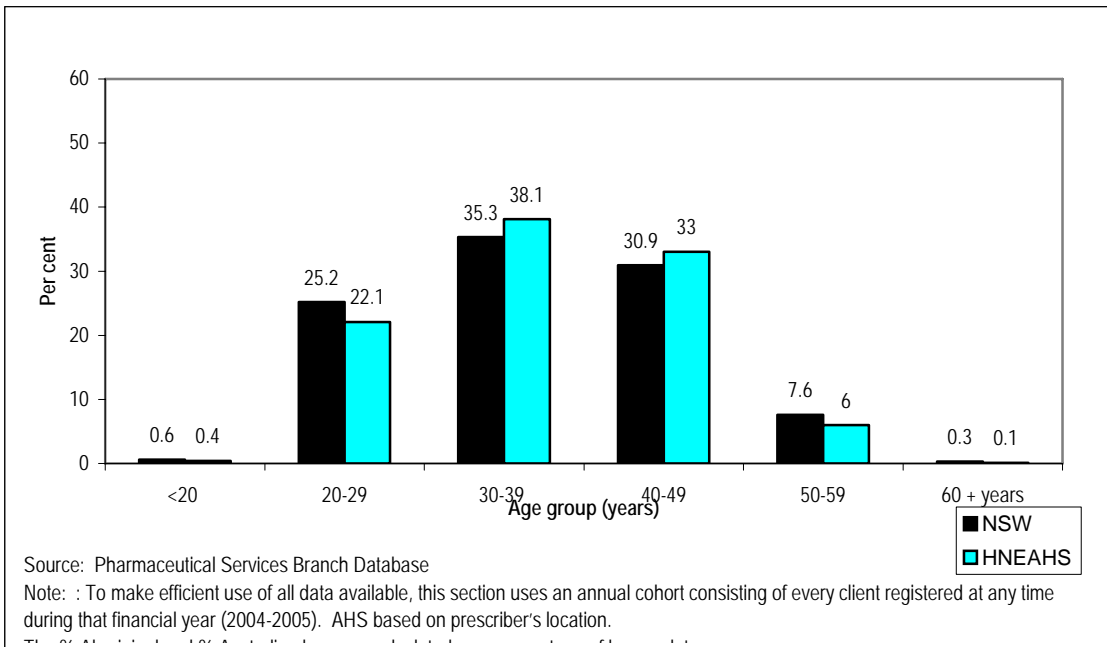
Source: Pharmaceutical Services Branch Database.

Note: To make efficient use of all data available, this section uses an annual cohort consisting of every client registered at any time during that financial year (2004-2005). AHS based on prescriber's location.

The % Aboriginal and % Australian born are calculated as a percentage of known data.

In Figure 7, OTP clients in the Hunter New England area are more likely to be in the age group 30-49 years than the state average.

Figure 7: OTP clients by age group, NSW and HNE Health 2004/2005



3.3.7 Injecting drug use and communicable disease

People who inject drugs are at highest risk of contracting hepatitis C. The proportion of people with hepatitis C virus (HCV) infection who inject drugs in NSW is thought to be in the range of 45% to 85%. Among this group, prevalent HCV infection has been found to be associated with duration of injecting and type of drug injected. The context or environment of injecting is also relevant as a risk factor.

For the spread of the disease to be contained, current users must be effectively targeted in any prevention campaign. There are difficulties in dealing with this target group because they are one of the most marginalised groups in the community, face high levels of discrimination, are difficult to engage and the illicit nature of the activity makes them difficult to access. A particularly difficult group to reach is former users, many of who now have professional careers or who simply wish to leave the past behind, but who may have to confront their previous drug use because they have hepatitis C¹⁰.

The Human Immunodeficiency Virus (HIV) spreads through infected body fluids such as blood and can pass from one person to another through shared needles. It attacks the human immune system, leaving infected individuals vulnerable to chronic, progressive illness, opportunistic infections and cancers.

The prevention of a major HIV epidemic among injecting drug users has been reliant on the capacity of the Needle and Syringe Program to provide sterile injecting equipment and health promotion¹¹. The Needle and Syringe Program has recently been renamed the Harm Minimisation Program (HMP).

The 2005 National Needle and Syringe Program (NSP) Survey found that:

- Self reported prevalence of hepatitis B appeared to be higher for long-term injecting drug users
- A larger proportion of people attending needle and syringe programs tested positive to hepatitis C than self-reported ever having hepatitis B
- The prevalence of hepatitis C generally increased with a longer duration of injecting drug use for both males and females
- Females tested positive to hepatitis C more frequently than males, particularly among those injecting for less than 3 years
- Hepatitis C prevalence among people attending needle and syringe programs remained high

For AIDS diagnoses and deaths the survey reported an increase in AIDS diagnoses among injecting drug users.

For injecting drug use and risky injecting behaviour it was reported that the proportion of males and females using a needle and syringe after someone else, was more stable for longer-term injecting drug users, but fluctuated for those with an injecting history of less than five years

In relation to overdoses, almost half those surveyed had overdosed on heroin at some time in their lifetime, and 9% of injecting drug users reported non-fatal heroin overdose on at least one occasion in the last 12 months.

The following information on prevalence of blood-borne viruses among injecting drug users was collected nationally, using sentinel HMP sites to perform annual blood spot checks on local injectors:

- HIV antibody prevalence remained low, nationally, at less than 2%, except among participants reporting male homosexual identity (21% in 2005)
- HCV antibody prevalence has remained high nationally, with some variation in the last five years (56% in 2002 to 61% in 2005)
- HCV antibody prevalence among participants reporting Aboriginal background

increased from 61% in 2001 to 71% in 2005.

In Hunter New England, the rate of new notifications of Hepatitis C infection has significantly reduced over the past six years, from 749 in 2001 to 437 in 2006 (Figure 8). Hepatitis B new notifications have also dropped over this time, from approximately 110 in 2001 to 80 in 2006 (Figure 9). For both diseases, there are more male notifications than female.

Figure 8: Number of Hepatitis C notifications for the Hunter New England 2001-2006

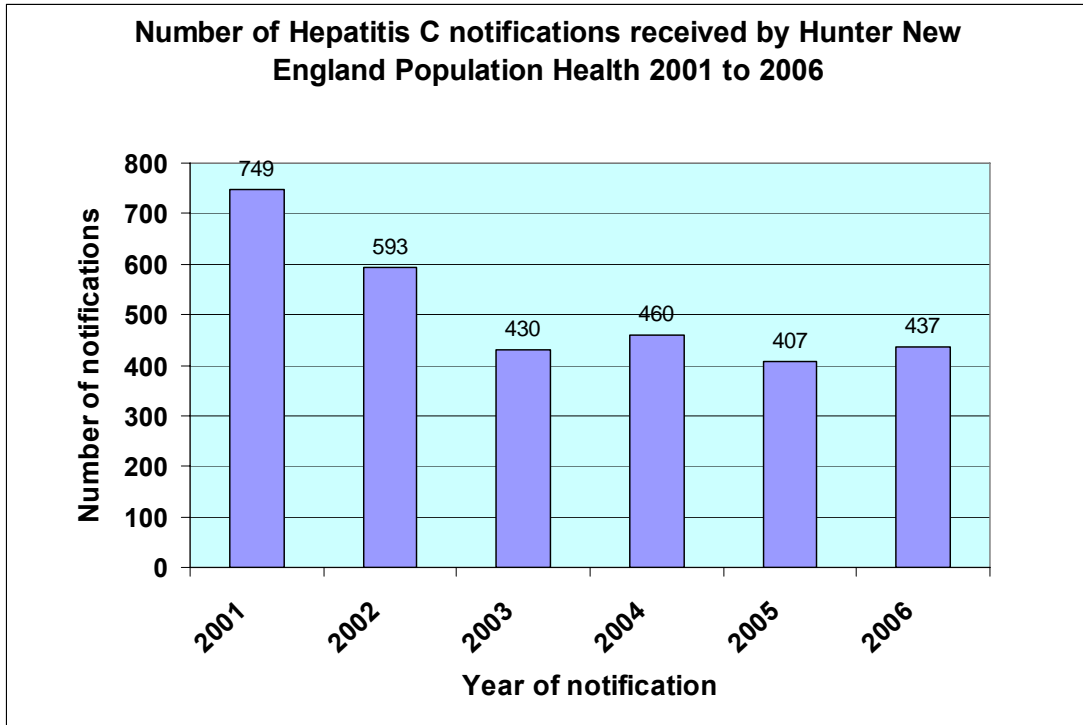
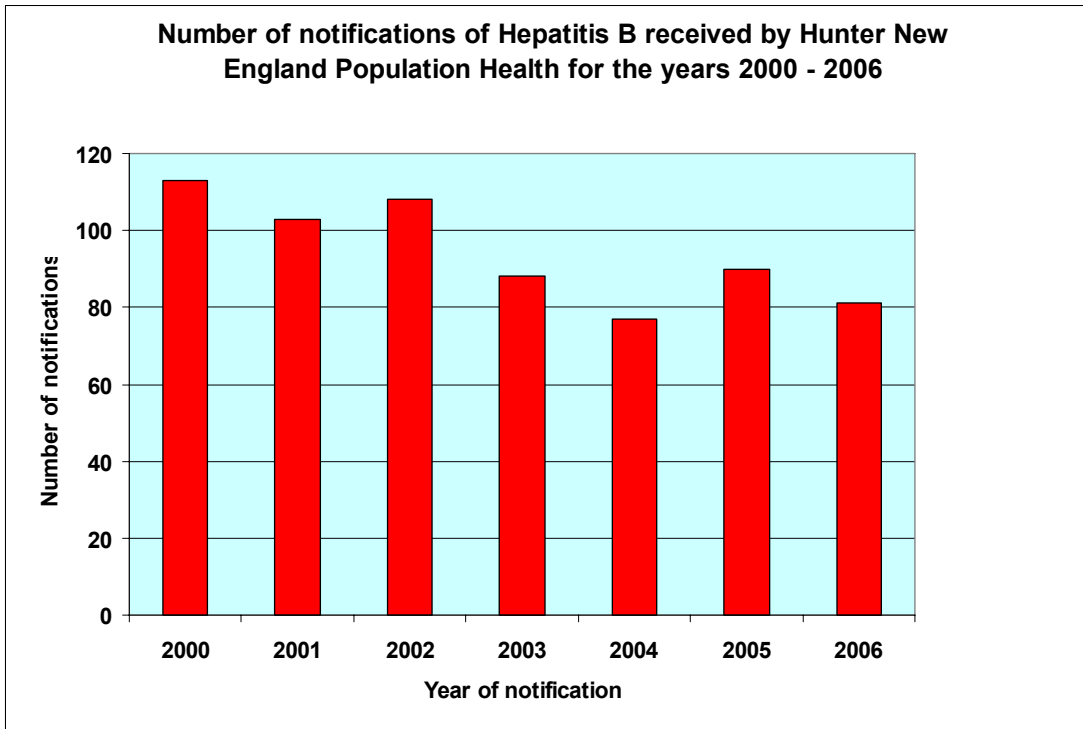


Figure 9: Number of notifications of Hepatitis B for the Hunter New England 2001-

2006



3.4 Vulnerable Population Groups

Certain groups within our population experience a greater risk of developing harmful alcohol and drug use behaviours or experiencing alcohol and drug related harm. As such, these groups may require a greater level of attention than that given to the general community in terms of education, treatment and prevention programs. These at risk population groups also experience barriers in accessing and receiving drug and alcohol services. Service delivery models for these groups need to be flexible, culturally specific and involve partners across many discipline's services to achieve their goals.

The HNE Health Drug and Alcohol Services Plan commits to equity of service delivery ensuring services are accessible geographically, and available to culturally diverse groups, and to people with complex and special needs².

3.4.1 *Co-existing Mental Health and Substance Misuse Disorders*

There are a considerable number of people with co-existing mental health and substance misuse problems and this prevalence may be increasing. It varies in severity and degree of impairment and cannot be defined in terms of a specific syndrome with a discrete treatment approach. People with such complex problems and disorders frequently challenge the capacity of health care systems to meet their needs¹².

People with a mental illness are at a very high risk of developing problematic alcohol or drug use. Between 30% and 80% of people with a mental illness have substance misuse problems. Tobacco, alcohol, benzodiazepines and cannabis misuse or often a combination of all of these are most common. Similarly up to 75 percent of clients with drug and alcohol

problems also experience mental health problems, most commonly anxiety or mood disorders such as depression¹³. Anecdotally psychostimulants are one of the most common drugs contributing to mental disorders.

Health service challenges include:

- Preventing, reducing and managing the negative effects associated with co-morbid substance use and mental illness for the individual, their family and the community
- Developing multiple strategies to promote health, reduce the risk of illness and respond to the health care needs of people across their lifespan
- Incorporating the physical, mental, social and cultural aspects of health care and providing equitable access to health services
- Developing collaborative partnerships with a diverse range of allied services to ensure specialised, coordinated treatment and continuity of care
- Improving the self-efficacy, confidence and self-esteem and wellbeing of the individual by involving them in their treatment and encouraging hopefulness¹¹.
- Developing integrated models of care across different services that address both alcohol and drug and mental health problems.

3.4.2 Aboriginal People and Communities

2006 ABS data shows that 138,506 Aboriginal people were estimated to be living in NSW, comprising just over 2.1% of the NSW population and approximately 30% of the total Aboriginal population in Australia, in comparison to the non-Aboriginal population. The Aboriginal population is younger, with around 40% under 15 years of age compared with 20% of the non-Aboriginal population. The percentage of the Aboriginal population over the age of 65 years is just under 3%, compared with around 13% in the non-Aboriginal population.

A significant proportion (21.6%) of the State's Aboriginal population reside in the Hunter New England area, comprising 3.3% of the Hunter New England population. Table 5 indicates that for the Hunter New England area the highest proportion of Aboriginal people are found in the Mehi Cluster (13.2% or 4645). However the highest numbers of Aboriginal people live in the Greater Newcastle Cluster (8,346 or 1.9%).

Table 5: Aboriginal Population totals by Cluster for 2004

Cluster	0-29 years	30-44 years	45+ years	Total	% of popn ¹
McIntyre	626	164	151	941	3.9
Mehi	2897	978	770	4645	13.2
Peel	3290	972	869	5131	6.4
Tablelands	2113	642	458	3213	5.6
Lower Mid North Coast	1996	568	495	3059	3.3
Upper Hunter	190	319	190	699	3.6
Lower Hunter	2373	702	514	3589	2.4
Greater Newcastle	5367	1675	1305	8347	1.9
HNE Totals	18852	6020	4752	29624	

Source: Australian Bureau of Statistics estimated residential populations as at 30 June 2004.

1. Figures based on 2001 population statistics. HNE Health Strategic Plan 2005–2010 Vol 4.

Aboriginal people experience lower life expectancy, higher rates of chronic disease risk factors and deaths, higher rates of hospitalisations and deaths from injuries and assaults,

higher rates of sexually transmitted diseases and lower *per capita* rates of expenditure on health promotion and primary health care. Aboriginal people also report lower incomes, higher unemployment rates, poorer education and lower rates of home ownership¹⁴.

According to the 2004-05 National Aboriginal and Torres Strait Islander Social Survey (NATSISS):

- Sixteen percent of Aboriginal people aged 18 years or over had a level of alcohol consumption that is classified as risky/high risk
- The rate of risky/high risk alcohol consumption was higher for males than females and was highest in the 35-44 year age group
- Aboriginal people are also at risk of ill health through the use of substances such as marijuana, heroin, amphetamines and inhalants
- Twenty eight percent of Aboriginal people aged 18 years and over in non-remote areas had recently used an illicit substance
- Fifty percent had tried at least one illicit substance in their lifetime
- There is no reliable national data on petrol sniffing, but case studies indicate that the practice continues to be a major problem in some Aboriginal communities
- Fifty percent of the Aboriginal population aged over 18 years were daily cigarette smokers
- A similar proportion of the males (51%) and females (49%) were daily smokers with the highest rates reported by those aged 25-44 years
- Smoking is much more prevalent among Aboriginal people than non-Aboriginal people¹⁵.

In addition, the National Aboriginal and Torres Strait Islander Health Survey 2004-05 shows:

- The rate of hospitalisation for trauma due to alcohol in the Aboriginal population was twice as high than the non-Aboriginal population
- The rate of involvement of Aboriginal people in drug and alcohol treatment was over three times that of non-Aboriginal people
- The rate of hospitalisation attributable to alcohol was over three times higher compared to non-Aboriginal people¹⁶.

Treatment episodes involving clients who identified as being of Aboriginal origin in NSW were most likely to involve alcohol (42%), opioids (23%, with heroin accounting for 20%), cannabis (19%) and amphetamines (12%).

In NSW, the proportion of treatment episodes involving Aboriginal people reporting alcohol as their principal drug of concern was similar to other Australian clients (42% and 41% of treatment episodes respectively). By comparison, national figures place Aboriginals 5% above non-Aboriginal clients in treatment episodes for alcohol¹⁷.

Drug and alcohol prevention strategies in Aboriginal and Torres Strait Islander communities should be community based and community owned. These strategies may be achieved by:

- Developing and using local Aboriginal and Torres Strait Islander leadership and workers at all stages of programs
- Implementing programs which build capacity within local communities to work on their own solutions

- Ensuring the accessibility and appropriateness of mainstream services to these communities through consultation with local Aboriginal and Torres Strait Islander groups
- Researching local Aboriginal and Torres Strait Islander issues to inform the direction and suitability of local strategies
- Ensuring a sustainable framework which reflects the impact of drugs and alcohol on Aboriginal and Torres Strait Islander communities through skill building and workforce development, continuous evaluation and funding
- Recognising that these are complex problems that do not have simple solutions
- Proactively targeting recruitment strategies to increase the number of Aboriginal community liaison officers
- Establishing specialist drug and alcohol resource units to support community based action.

3.4.3 Sexual and Gender Diverse Groups

The 2006 *'Private Lives Report'* notes that there is a significant body of research which links same-sex attraction with elevated levels of drug use. Also noted in this report are the findings from the Longitudinal Study of the Health of Australian Women 2004, which states that same sex attracted women in the 22-27 year age group were significantly more likely to report risky alcohol use (7% compared to 3.9%), marijuana use (58.2% compared to 21.5%), other illicit drugs (40.7% compared to 10.2%) and injecting drug use (10.8% compared to 1.2%) than their heterosexual counterparts. Higher rates of tobacco use amongst gay, lesbian, bisexual, transsexual and intersex (GLBTI) people are also well documented with lesbians' rates of use of particular concern¹⁸.

Patterns of drug use in this population group again appear somewhat higher than in the Australian population as a whole. Tobacco use is higher for all groups surveyed for the *Private Lives Report* than in the National Health Survey (ABS), where the comparable percentage was 24%. Overall, more than a third of respondents reported using tobacco more than five times in the previous month (37.3%) and one in six (15.7%) reported using marijuana at the same level. No other drug was used that frequently by the entire sample. Ecstasy (9.1%), speed (5.1%) and crystal methamphetamine (3.1%) were the next more often used drugs¹⁸.

The most marked variations in drug use with respect to gender included more men than women using LSD, ecstasy, speed and crystal methamphetamine more than five times in the previous month. This would appear to reflect cultural patterns of drug use. Intersex males, intersex females, transgender males and transgender females appear to be more likely to report frequent use of steroids¹⁸.

Considerations for health services include:

- Information about alcohol and other drugs needs to be sensitive to issues of gender, sexuality and lifestyle
- Need to work in partnership with appropriate services to target same sex attracted young people to drug and alcohol services
- The need for professional training on issues of sexuality, lifestyle and appropriately sensitive service provision for health service providers²⁰.

3.4.4 The Ageing Population

Elderly people with drug and alcohol issues have a greater need for support services than other groups in the community. The health effects of long-term alcohol misuse are only likely to emerge over a period of time, and therefore older people are likely to be over-represented amongst people suffering chronic health damage from alcohol misuse.

Although a sizable majority of older people are either non-drinkers or very light drinkers, a small but significant proportion drinks in the hazardous to harmful range. This may be as a result of social factors such as isolation, loneliness, lack of access to recreational or social outlets, reduced mobility or grief at the loss of a partner. Whilst this combination of circumstances is not unique to older people, there are indications that they are much more likely to experience them, turn to alcohol and therefore experience a greater risk of alcohol-related harm than other sectors of the community. Strategies to reduce the risk of alcohol-related harm for this group of older people will need to focus not on the drinking behaviours, but on the set of social and personal circumstances that are contributing to the high-risk consumption²¹.

The prescription and use of benzodiazepines and other pharmaceutical drugs is of particular concern amongst older people, especially older women. Benzodiazepines are a group of drugs used mainly as sedatives and muscle relaxants. Almost a quarter of those over 75 years of age report the use of sleeping pills. In more recent years the Australian Institute of Health and Welfare reported in 1999 a large increase in the reported illicit use of tranquillisers and other prescription drugs by women over the age of 50 years increasing from 3.9% to 13.4% in the 50 to 59 age group and 3.7% to 6.3% in the sixty and over range. People can become physically dependent on benzodiazepines at normal therapeutic doses so when they stop or reduce their use they experience withdrawal symptoms. Benzodiazepine and other tranquilliser use can lead to excessive sedation, which can greatly reduce their quality of life and may contribute to incontinence, lack of mobility, falls, instability and a range of other problems.

In most cases the satisfactory management of anxiety and insomnia can be achieved without the need to prescribe medication. Clarifying the problem, providing counselling and specific advice and follow-up support can assist the majority of people. In some cases referral will need to be arranged where the nature of the condition is uncertain or further assistance with management of the issues is required²⁰.

3.4.5 Drug-using individuals in contact with the Criminal Justice system

Over 60% of prisoners in the NSW Correctional System are estimated to have been under the influence of drugs or alcohol at the time of offending; 80% have committed drug related crimes; 60% have a history of injecting drug use; and 40% are current injectors².

While in custody many inmates undergo severe alcohol and other drug withdrawal. This can complicate their management from a custodial point of view and lead to poor psychological and health outcomes, including self-harm.

People released from NSW prisons are at much higher risk of mortality from all causes,

especially drug related overdose, compared with the general population. For men released from prison, the risk of death is 3.7 times higher than the general population, and in women 7.8 times higher. The risks of mortality for Aboriginal clients released from custody are further elevated by specific causes of death e.g. cardio-vascular disease.

Table 6 shows that convictions for driving under the influence of alcohol or drugs are higher than the state rate across Hunter New England, convictions for the possession/use of cannabis are higher in the Northern area of Hunter New England than the state rate but convictions for possession/use of narcotics are significantly below the state rate across the Area. Convictions for possession/use of amphetamines are also consistently lower than the state rate in Northern area.

There remains an overwhelming need for enhanced responses to mental health and drug problems for people who have been in prison. This includes priority access to services upon release to manage mental health and drug and alcohol problems and regular reviews by medical practitioners, including soon after release for clients in Opioid Treatment Programs and those with mental health concerns²².

Table 6: Drug and alcohol-related crime, NSW and HNE Health (Northern and Hunter Statistical Division, Newcastle Subdivision) 2004-2006

	Hunter Statistical Division	Northern Statistical Division	Newcastle Subdivision	NSW
Driving under the influence of Alcohol or Drugs (rate per 1,000 population)				
2004	26.2	28.0	27.9	18.8
2005	18.0	31.3	17.6	17.4
2006	18.0	24.0	16.4	14.5
Possession and/or use of narcotics (rate per 1,000 population)				
2004	4.0	0.6	4.4	13.8
2005	5.1	0.0	5.7	12.7
2006	1.5	0.6	1.4	8.7
Possession and/or use of cannabis (rate per 1,000 population)				
2004	145.6	190.7	137.1	180.2
2005	127.6	178.7	115.9	172.0
2006	126.6	198.8	115.3	177.0
Possession and/or use of amphetamines (rate per 1,000 population)				
2004	30.8	21.2	26.6	29.5
2005	24.7	25.1	21.5	30.4
2006	34.1	19.0	33.9	34.6

Source: Recorded Crime Statistics, NSW Bureau of Crime Statistics and Research

3.4.6 People from diverse Cultural and Linguistic Backgrounds

Migrants face difficulties associated with such a major life change and all struggle to some extent with adapting to life in a new country. Refugees are no exception. However, they must also confront the additional burden of coming to terms with the circumstances that forced their relocation²³.

Different cultural values and attitudes to alcohol and other drugs, as well as differing levels of competency in English will determine the extent to which general education and

information campaigns reach and affect culturally diverse communities. The diversity of these values will also affect the extent to which treatment services are accessible and appropriate to people of these communities²³.

Access to health services generally, and alcohol and other drug services specifically, is often difficult for people of non-English speaking background because of language and cultural factors and a lack of information amongst ethnic communities about the services available to them²⁴.

3.4.7 Rural Communities

Rural and remote populations have specific challenges in accessing comprehensive health care including distance, travelling times, availability of clinicians and dispersal of the population. These factors also impact on our capacity to deliver integrated drug and alcohol services in rural and remote areas.

In NSW in 2005, 11% of people living in outer regional and remote areas reported high risk drinking (16.7% males; 5.5% females) compared to 10% of the total NSW population; 82% of 14-19 year olds in rural communities regularly consumed alcohol compared to 71% in metropolitan areas; and 22% of rural road fatalities are alcohol related compared to 14% in metropolitan areas⁴. Anecdotally, the long-term drought has also had a significant affect on income and employment in rural areas of NSW leading to increased levels of stress, family unit disruption and depression with subsequent increased abuse of alcohol and other drugs.

3.4.8 Children in Developmental Stages

Drinking alcohol while pregnant increases the risk of problems in foetal development, but the level of drinking which causes significant foetal problems is not known. No completely safe level of alcohol consumption has been determined for the foetus. Prenatal alcohol exposure is linked to a pattern of birth defects, known as foetal alcohol syndrome. It includes central nervous system problems, low birth weight, mental retardation and abnormal facial features. Children with foetal alcohol syndrome may have physical disabilities, problems with learning, memory, attention and problem solving, and, social and behavioural problems.

Foetal alcohol syndrome is found in babies born to mothers who drink four to five drinks every day, or who binge drink large amounts of alcohol. The risks increase with the amount of alcohol consumed. Further research has shown that the effects of alcohol exposure vary widely. Some babies seem to escape harm, even when their mothers drink heavily, while others are severely damaged due to the effects of even small amounts of alcohol²⁵.

Smoking during pregnancy doubles the risk of having a low-birthweight baby and significantly increases the risk of perinatal mortality, sudden infant death syndrome and other adverse pregnancy outcomes including placenta praevia, abruptio placentae, ectopic pregnancy and preterm premature rupture of the membranes.

In the three-year period 2002 to 2004, an average of 15.4% of NSW mothers reported smoking during pregnancy. Smoking rates in NSW are highest among young adults, people in the lowest socioeconomic groups and Aboriginal people (CER, 2006). In 2004, around 57% of Aboriginal mothers reported smoking at some time during pregnancy, compared to

14% of non-Aboriginal mothers (CER, 2005)⁴.

Most of the studies that have been carried out on smoking in pregnancy have examined the effect of cigarette smoke rather than smoke from marijuana. However, it is clear that, whether a pregnant woman smokes tobacco or marijuana, it is the smoke itself that puts such a tremendous strain on a developing baby.

The first report to link the use of ecstasy to birth defects came from the UK Teratology Information Service. Half the women in their study used other drugs in addition to ecstasy, although the majority only took the drugs in the first trimester of pregnancy. Birth defects, mainly limb and heart defects, were higher than was expected.

The effect of cocaine is also potentially serious, as the drug reduces the supply of nutrients and oxygen to the developing baby, resulting in a low birth weight baby, even if carried full term. Low-birthweight babies are more likely to die in their first month than normal-weight babies. Women who stop using cocaine early in pregnancy reduce their risk of having premature or low-birthweight babies²⁵.

Amphetamines can also have adverse effects on the developing baby. Low birth weight, and increased foetal loss in the second trimester are features of pregnancies where amphetamine use is constant.

3.4.9 Young People

One of the primary concerns of any community must be the safety, health and wellbeing of its children and young people. Drug and Alcohol services clearly have a role to play in identifying and supporting children and young people who may be at risk of harm as a result of their parents or carers having substance abuse problems.

Child abuse and neglect is associated with a number of risk factors, including poor parental mental health, substance misuse, economic stress and social disadvantage, and family disruption. These factors may also compound the negative effects of abuse²⁶.

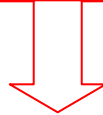
While many young people do not use drugs and alcohol at dangerously high levels, there are known harms associated with all levels of misuse. It is also recognised that some young people will develop chronic patterns of drug use and engage in frequent harmful binge use².

The New South Wales School Students Health Behaviours Survey (2005) collected information on students' use of a variety of substances. In NSW in 2005 the most frequently reported substance used in the last four weeks was painkillers (67%) followed by alcohol (39%), tobacco (11%), inhalants (9%), cannabis (6%) and tranquillisers (3%). A higher rate of alcohol and cannabis use was reported in older students (64% and 22% respectively in 17 year olds) whereas a higher rate of use of inhalants were reported in younger students (12% in 12 year-old students).

Generally, male and female students reported similar levels of using substances in the last four weeks. Male students were more likely to report using cannabis (8% in males and 4% in females). While low levels of recent use of amphetamines, ecstasy, hallucinogens, cocaine, steroids or heroin were reported by both sexes, recent use of any drug was more often reported by male students than female students⁴.

Key Considerations

- Several identified vulnerable groups in the Hunter New England require ongoing support and/or treatment from Drug and Alcohol Services
- Drug and alcohol services must be culturally sensitive and provide easy access to consultation liaison with Aboriginal Health workers
- Increase in the demand for drug and alcohol services by people aged 55 years and over as this population group increases
- Collaborating with, reinforcing links to and developing new partnerships with both internal and external services is essential to ensure appropriate services are in place for identified vulnerable groups
- Increase access to clean injecting equipment to support reduced incidences of equipment sharing, and, provide referral for testing and immunisation for blood borne viruses
- Increase consultation and liaison services across HNE Health to provide early and brief intervention



Strategic Directions

- Objective 1.3: Improved flexibility and diversity of service delivery particularly to groups exposed to high risk
- Objective 2.1: Improved collaboration and partnerships designed to enhance drug and alcohol service delivery and outcomes
- Objective 3.2: Promotion, prevention and early intervention

4. Current and Projected Service Provision

The following activities are core to the Drug and Alcohol services:

- Outpatient/community services (including assessment, case management, counselling, early intervention, referral to services)
- Detoxification (patient and community)
- Consultation and liaison
- Pharmacotherapy
- Residential Rehabilitation provided through NGO networks
- Workforce support training and infrastructure.

The merger of Area Health Services in 2005 provided an opportunity to improve the range, capacity, consistency and quality of Drug and Alcohol Clinical Services across HNE Health. The following points describe the realignment of sections of the service structure following the merger of the Drug and Alcohol Clinical Services across HNE Health:

Medical Leadership

- Drug and Alcohol is becoming more medically focused and recognised as a medical specialty. The medical leadership model has already proven successful in recruiting GPs who are a vital link in providing Drug and Alcohol services
- The Staff Specialists are active leaders in regular structured clinical review process, which ensures consistent and quality service delivery
- Staff have access to high-level medical input to ensure optimum patient safety and assistance with analysis and management of patient safety
- Specialist medical staff are clinical leaders not managers.

Line management of all staff within the stream

- Consistent service delivery across the whole of the new Drug and Alcohol Clinical Service
- There are now highly specialised programs, treatments and clinical interventions within the Drug and Alcohol field. These need to be driven by managers who understand and are trained in contemporary Drug and Alcohol treatment modalities
- Direct line management has increased ability to direct and achieve better clinical outcomes within a highly specialised field.

Clinical Governance Learning and Information Improvement

Clinical Governance is responsible for coordinating clinical risk management activities, undertaking training activities and coordinating clinical reviews. This is done in conjunction with the services to promote accountability and continuously improve the quality of services as well as safe-guarding high standards of care by creating an environment in which clinical excellence will flourish.

Good clinical information management is paramount to effective client care. A clinical information improvement and support team, facilitates new and innovative clinical interactions such as Telehealth, web based training, electronic medical records etc.

Aboriginal Drug and Alcohol Service Coordination

An Aboriginal manager position located at Tamworth will co-ordinate an Aboriginal Drug and Alcohol Team and service delivery area wide. The rationale for this is:

- Creation of a specific Aboriginal team to promote staff retention, development and support
- Ensuring that services are culturally appropriate
- Ensuring vertical and horizontal integration of service delivery and planning
- Providing a structured and coordinated approach to drug and alcohol and health initiatives in the Aboriginal community.

Research

There is a need to provide a whole of service focus that is leading the field in research. The rationale behind this is:

- Some streams are at capacity and new, more effective and cost efficient ways of treating drug and alcohol problems are needed. Examples of these are the Stimulant Treatment Trial, the Suboxone trial and evaluation of the Take-safe device
- Research will be led by the Director and supported by the medical service delivery model, the Clinical Governance and Learning and Information Improvement Unit
- Continued audit of current practices will support improving access, reducing wait times and improving treatment quality
- Opportunities for multicentre studies across health services can be assessed and progressed.

4.1 HNE Health Drug and Alcohol Services Profile

See Appendix 5 for HNE Health Drug and Alcohol Services Organisational Chart

Management Unit

The Management Unit consists of the following positions: Area Director, Area Manager, Manager Drug and Alcohol Clinical Governance and Information Improvement and Area CNC. The unit is responsible for the planning, strategic direction and overall management of HNE Health Drug and Alcohol Clinical Services.

Central Telephone Intake Service

The Central Telephone Intake Service is the first point of contact for and referral to HNE Health Drug and Alcohol Services. The service is open to all members of the community. It provides:

- Drug and Alcohol Information
- Brief assessments
- Brief interventions
- Drug and Alcohol community counselling appointments
- Assessment appointments for detoxification
- Referral to appropriate services (government and non-government) for people requiring assistance with drug and alcohol issues.

Harm Minimisation Program (HMP)

The Harm Minimisation Program operates from Newcastle and through a network of secondary outlets across HNE Health, incorporating health facilities and non-government organisations. These secondary outlets provide HMP services in addition to their core operating business activities. Vending machines are located on selected health sites and dispense injecting equipment and safe-sex packs and thereby reduce the sharing of injecting equipment and unsafe sex.

The Harm Minimisation Program aims to prevent the spread of blood-borne infectious diseases such as HIV/AIDS, hepatitis B and hepatitis C by providing sterile injecting equipment, safe-sex packs and health information to those who inject drugs. A core component of HMP services includes brief intervention and referral into treatment programs. Clients are provided with a range of information on relevant health issues such as hepatitis C transmission, vein care, nutrition, mental health and treatment services. Referrals are provided to community counsellors and other health and welfare agencies, as well as to pharmacotherapy and detoxification services.

Drug and Alcohol Community Counselling

This service seeks to provide supportive interventions to clients in varying levels of dependency. The approach to counselling is based on minimising the harm associated with drug and alcohol use. The service provides:

- A free confidential service
- Individual, adolescent, family and couple counselling where alcohol and/or other drugs are involved
- Phone counselling
- Referral to alternate or specialist services
- Consultation, education and skills training for health and welfare providers
- Information and educational resources eg. pamphlets, fact sheets etc to clients

Detoxification Services (Withdrawal Management)

Lakeview Inpatient Unit

The Lakeview Detoxification Service is a stand-alone twelve bed residential facility at Belmont Hospital, offering a supportive, safe environment for people 16 years and over who wish to detoxify from alcohol and other drugs.

The service provides:

- 8 beds for non-medical detoxification. This is an appropriate intervention for people who have no concurrent medical conditions.
- 4 beds for medicated detoxification. This involves supportive withdrawal management with the use of medication and regular review by a Drug and Alcohol Medical Staff Specialist.

Community Detoxification Service

This involves withdrawal-supported management by Registered Nurses and the client/patient's general practitioner (GP). Community detoxification can occur within the client/patient's home or at a hospital as an outpatient.

Pharmacotherapy Services

Pharmacotherapy is a voluntary treatment program for opiate dependant people. Treatment options include Methadone, Biodone, Buprenorphine and Suboxone. The approach involves the prescriber, case manager and a pharmacist. In geographically isolated areas clients/patients treatment may even be commenced in a pharmacy setting.

Magistrates Early Referral Into Treatment (MERIT) Services

MERIT is a Local Court based diversion program that targets adult defendants with illicit drug use problems who are motivated to undertake drug rehabilitation. A MERIT treatment program is typically three months in duration, reflecting the average Local Court bail period.

Aboriginal Drug and Alcohol Co-ordination

There is an increased need for Aboriginal clinical services to access drug and alcohol treatment facilitated by Aboriginal staff. Northern drug and alcohol services have been operating under this philosophy. It is proposed to develop this model area wide. The intention is to provide a structured and co-ordinated approach to drug and alcohol health initiatives in the Aboriginal community.

Drug and Alcohol Services also have key partnerships with a number of non-government service providers who provide the following services:

- Youth Services
- Residential Rehabilitation Services for men and women with or without children
- Parenting services
- Community based services that provide a range of treatment options in rural areas.

4.2 Innovative Models of Care

HNE Health Drug and Alcohol Services is involved in developing, assessing and trialling a number of new initiatives with NSW Health.

Initiatives include:

The Co-Morbidity Package (COMP) evaluation of methamphetamine treatments in South Eastern Sydney/Illawarra and Hunter/New England Area Health Services

HNE Health is one of two Area Health Services selected to evaluate the Co-Morbidity Package (COMP). This package involves the establishment and evaluation of methamphetamine treatments, using a collaborative approach to treatment with both mental health and drug and alcohol assessments and interventions.

In the Hunter New England COMP provides the following:

- The Stimulant Treatment Program (STP) Clinic commenced operations from the Royal Newcastle Hospital premises in November 2006 and relocated to Wesley Mission site in Newcastle West in July 2007. The aim of the service is to attract people with self-identified stimulant problems into treatment, and to ensure the most effective treatments are provided to these people. The service operates on a shop-front model, where services include a stepped care approach to service delivery with access to counselling, referral and support, detoxification, psychosocial and pharmacotherapy interventions.
- An outreach Drug and Alcohol Clinical Liaison service to Taree and Tamworth Mental Health inpatient units to facilitate identification, assessment, brief intervention, and referral/linking to drug and alcohol services.
- Strong linkages and referral pathways from Emergency Departments, Mental Health facilities, Police, and General Practitioners to the STP Clinic via the development of agreed protocols and possibly memorandums of understanding.

- Clinical interventions for patients identified with both a mental health and methamphetamine related condition.
- Clinical support networks for staff treating patients presenting to mental health and emergency services.

Buprenorphine-naloxone (Suboxone™) Trial – A new pharmacotherapy for the treatment of Opioid Dependence

In February 2005, Newcastle Pharmacotherapy Service, the Langton Centre in Sydney and Turning Point in Melbourne were involved in the buprenorphine-naloxone randomised controlled trial. The trial involved three sites. The trial was completed in December 2005. Subsequently buprenorphine-naloxone has been rolled out across the state to public and community dosing points. Buprenorphine-naloxone is a new pharmacotherapy that is a combination of both Buprenorphine and naloxone in one tablet. The aim of this combination is to deter people from injecting buprenorphine-naloxone as the naloxone can precipitate an unpleasant withdrawal reaction when injected. It has the potential for unsupervised dosing (i.e. all doses do not have to be supervised by a pharmacist). For very stable clients in treatment, buprenorphine-naloxone can be scripted to allow greater freedom from clinic/pharmacy settings with those clients able to collect doses on a fortnightly or monthly basis.

Since April 2006, this new pharmacotherapy treatment for opioid dependency has been available across the State. It is used for maintenance therapy in community settings for stabilised patients. A thorough clinical assessment and consultation with other health care providers (e.g. pharmacists) involved in patient care is undertaken to determine a patient's suitability for unsupervised doses of buprenorphine plus naloxone. In all cases where unsupervised dosing is being considered, the stability of the patient's clinical condition is the critical factor to be considered. A stepped approach to receiving take-away doses is adopted.

Take-Safe Device Evaluation

HNE Health was chosen by NSW Health as the single trial site for the Take-Safe Device Evaluation. The trial started in Newcastle in March 2006, extended to Cessnock and Tamworth over the following weeks, and continued for a period of six months. Thirty-three participants were recruited from community and public clinic sites. Twenty-seven completed the evaluation period.

The Take-Safe device is a hardened plastic container with a microprocessor which can only be locked or unlocked by the dispensing pharmacist, and is designed to deliver a single take-away dose every 24 hours for up to six days. The Take-Safe trial aimed to see if this device helped to make the use of methadone safer, by reducing the risk of it being misused or diverted to other users. Methadone treatment comes with high levels of support from a case worker and the doctor prescribing the methadone. The use of the Take-Safe device does not decrease this contact.

Dispensing pharmacists expressed a high level of satisfaction with the device and indicated they would like to see all patients on methadone in the Hunter New England having access to this dosing option. Trial participants also reported a high satisfaction with the device. One patient, who had an infant requiring regular physiotherapy, as a single parent depending on public transport, said the device had been invaluable. One of the participants who began a TAFE course felt that "he had been given a chance to get his life back", he has since

completed Year 10 with excellent results and been offered an apprenticeship. One participant's child began school and Take-safe enabled her to volunteer for canteen and reading classes.

The Take-Safe trial was very much in keeping with the aims of HNE Health Drug and Alcohol Clinical Services, which are to continually improve safety for its patients and assist patients with achieving long-term outcomes. Having one dose a day in a controlled way and not having to travel to a dosing point each day has helped to normalise people's lives. The benefit of normalising lives means that people are more able to gain employment, take up studies or job training, care for their family, and move their lives away from the drug scene. Use of the Take-safe device is an important mechanism to improve access for rural clients.

MERIT and NGO Collaboration – Vocational Skills Training

The Salvation Army Ark Program received funding from the Illicit Drug Diversion Program for 2006/2007. This program provides 28 places for Hunter MERIT clients in the Arks accredited Vocational/Work Skills training program. Suitable MERIT clients participate in a 10 week accredited vocational training/ skill development course. Accredited training is available in Hospitality Operations, Retail Operations, Information Technology and Furniture Manufacturing. This enhances employment and training opportunities for MERIT clients.

Other Achievements of HNE Health Drug and Alcohol Clinical Services include:

The Supported Housing Project:

In 2002 an agreement between Mission Australia, Department of Housing and HNE Health Drug and Alcohol Clinical Services resulted in a joint venture to provide temporary housing to clients on Drug and Alcohol Programs. The service provides short term, supported, stable and affordable accommodation to people who are receiving treatment from Drug and Alcohol Clinical Services (or require stable accommodation in order to access treatment from Drug and Alcohol Clinical Services) and who have a problem with homelessness or are at risk of becoming homeless.

Following a planning, consultation, and risk assessment process, protocols and referral pathways were established. Involved parties have since signed a Memorandum of Understanding and developed intake processes and a License Agreement.

Clients are jointly case managed by HNE Health Drug and Alcohol Clinical Services and Mission Australia, which allow for clients who have complex needs to be cared for in a holistic manner. Since its inception the program has been expanded to across the Newcastle metropolitan area, resulting in increased capacity to manage people who have complex problems and allowing the treating agencies to continue offering this care to even more people in need of services.

The project won a Commonwealth Bank Quality Award and was mentioned at the NSW Summit on Alcohol Abuse in 2003 as an example of a model to be adopted state-wide to facilitate interagency service agreements and delivery of services.

In-reach Project

HNE Health Drug and Alcohol Clinical Services initiated the In-Reach Project in 2001 in response to the large numbers of clients being released to Hunter Pharmacotherapy services from correctional facilities without support networks in place. A joint collaborative agreement between Corrections Health, HNE Health, Probation and Parole and the Community Restorative Centre was developed. It was seen as an opportunity to engage clients prior to release and to identify issues that may become problematic for the client post release.

Pre-release assessments were conducted on inmates discharging from Cessnock Correctional Centre. The assessment included all case management domains and involved identifying appropriate post release support strategies. Issues addressed included housing, finances, identification, referral mechanisms between services and medical history of clients referred from Cessnock Correctional Centre to Pharmacotherapy Services in the Hunter.

In 2002, a State-wide In-Reach project was implemented based on this project. All Area Health Services with Correctional Centres providing pharmacotherapy treatment participated in the trial. The trial established a network of In-Reach workers who conducted pre-release assessments for Justice Health pharmacotherapy clients. The service continues with the main focus on strengthening the established processes and further developing strategies to engage clients prior to release.

Outcomes from the project highlighted issues relating to meeting the mental health needs of this client group. To address those issues a trial commenced in 2005 with the Mental Health Clinical Nurse Specialist at Cessnock Correctional Centre clinic developing discharge summaries, medication and pre-release referrals to the community mental health teams. This collaboration has given the local community mental health teams a reference point for ongoing treatment and created a continuity of care for the client post release.

The In-reach Project in its current form ceased in June 2007. In August 2007, a new project called Connections commenced. This project team is managed by Justice Health and has 1.6 FTE Clinical Support Workers allocated to cover the Hunter New England area.

This project aims to improve continuity of care for clients of the correctional centers with drug and alcohol problems, who are being released into the community. The Connections Project is a linkage model project that aims to link clients with relevant health and welfare service providers post release. The Connections Project team utilises a broad array of contacts, both in the correctional environment and the community, and link clients into services appropriate to their individual needs post release.

The Clinical Support Worker's will:

- Assess the individual's post release needs prior to release and develop a post release care plan
- Provide co-ordination between correctional centre care and community based health and welfare services in order to support former clients to stay in the community
- Ensure that clients on OTP have appropriate arrangements in place to continue treatment in the community post release and that their care is taken over by the external service provider in a timely manner.

- Ensure that where these clients have other ongoing health related needs, these are identified and supported appropriately post release.
- Where there are problems with the client having difficulty initially engaging with the external service provider, the Clinical Support Worker will assist the client with the engagement process.

Pharmacotherapy Outreach Service

An outreach service was established in 2000 to support GPs and Pharmacists, and, improve access to pharmacotherapy treatment. Outreach workers visit participating pharmacies offering support, education and advice on management issues with complex clients. Issues arising during treatment are identified resulting in improved co-ordination of care, enabling clients and GPs to reach more satisfactory treatment outcomes and reduce adverse incidents in the community.

The service also engages GPs in shared care arrangements with Pharmacotherapy services. Caseworkers negotiate with individual GPs to attend individual surgeries regularly (once a week to once a month).

This level of support has encouraged more GPs to become accredited prescribers of opiate replacement therapy. There has also been a significant increase in non-accredited GPs, resulting in more people receiving treatment (250 people in 2000 to 850 people in 2007). Telephone consultations by GPs have increased dramatically with staff specialists providing mentoring and support to GP prescribers. The service enables clients to access drug treatment in a community setting, rather than having to attend a clinic each day. Positive impacts of this strategy include improved access and the ability of clients to distance themselves from their former drug-using networks.

The relationship between Drug and Alcohol Clinical Services and primary care providers continues to be an important focus. Drug and Alcohol Clinical Services recognises the important role of general practitioners and community pharmacists play in treating more stable patients and those who find it difficult accessing specialist services due to distance.

Telehealth and Videoconferencing

Drug and Alcohol in the Northern part of the Area use of video/teleconferencing to rural areas to provide prescribing services and support local GPs. This service is being progressively rolled out across the remainder of the Hunter New England following a successful funding submission to improve service delivery utilising Telehealth. New Telehealth sites have been established at Taree, Belmont and the Upper Hunter Drug and Alcohol Service.

Aboriginal Needs Analysis

An Aboriginal Needs Analysis was undertaken in 2003 through the Hunter Aboriginal Health Partnership. The project was commissioned by the then Hunter Health Drug and Alcohol Clinical Services, and managed by the Hunter Centre for Health Advancement.

An Aboriginal and Torres Strait Islander advisory group, service providers and the Aboriginal and Torres Strait Islander peoples of the Hunter contributed to the project. The needs analysis confirmed the optimum service delivery model for Aboriginal people involving Aboriginal Drug and Alcohol workers liaising between communities and services to support Aboriginal people to access the drug and alcohol services they need.

4.3 Current Activity

Emergency department (ED) presentations

Drug and alcohol related presentations to Emergency Departments in the Hunter New England area are generally lower than the state average, except for 'alcohol' and 'other drug' related presentations, which are slightly higher than the state average (see Table 7). As noted in Figure 2 on page 21, HNE residents report engaging in higher levels of risk drinking than the state average, which in turn may contribute to an increased number of ED presentations due to alcohol related accident, injury and/or illness.

Table 7: ED presentations for drug and alcohol, NSW and selected AHS 2005

ED presentations	HNE Health	NSW
Alcohol (N)	1,040	8,267
Rate per 100,000 population	(124.7)	(121.5)
Opioid (N)	30	1362
Rate per 100,000 population	(3.6)	(20)
Cannabis (N)	2	56
Rate per 100,000 population	(0.2)	(0.8)
Psychostimulants (N)	18	430
Rate per 100,000 population	(2.2)	(6.3)
Other drug (N)	266	1,602
Rate per 100,000 population	(31.9)	(23.5)
Total (drug and alcohol) (N)	1,070	9,629
Rate per 100,000 population	(128.3)	(141.5)

Source: NSW Emergency Department Data Collection.

Note: As not all Emergency Departments supply data to the EDDC, it is not technically appropriate to do a rate per 100,000 population. Hence, the rate given above are estimates only.

Drug and alcohol-related hospital admissions are generally lower in the Hunter New England area than the NSW state average (Figures 10, 11).

Figure 10: Hospital inpatient presentations for drugs, NSW and HNE Health, January 2000-June 2005

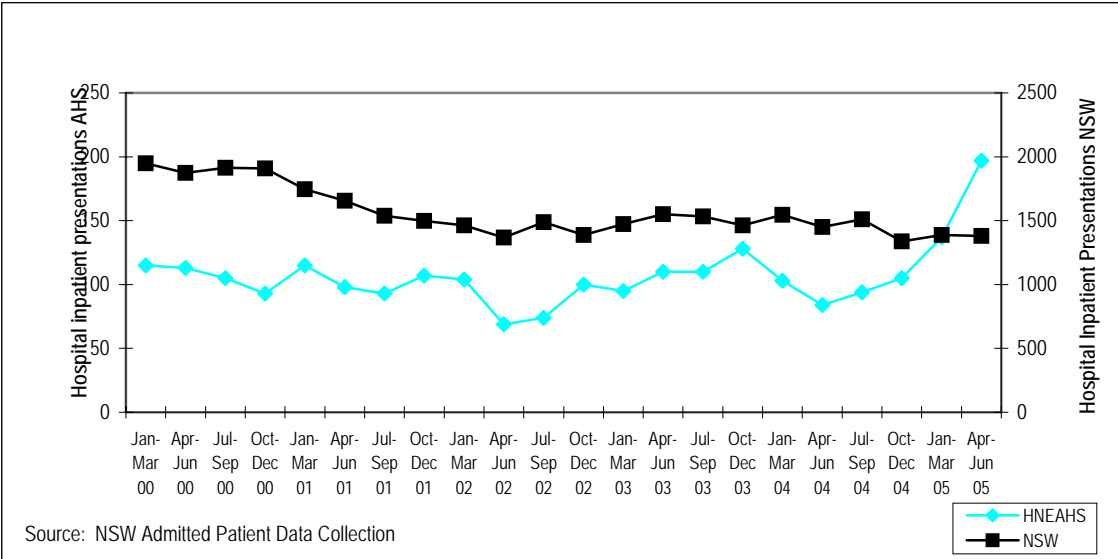
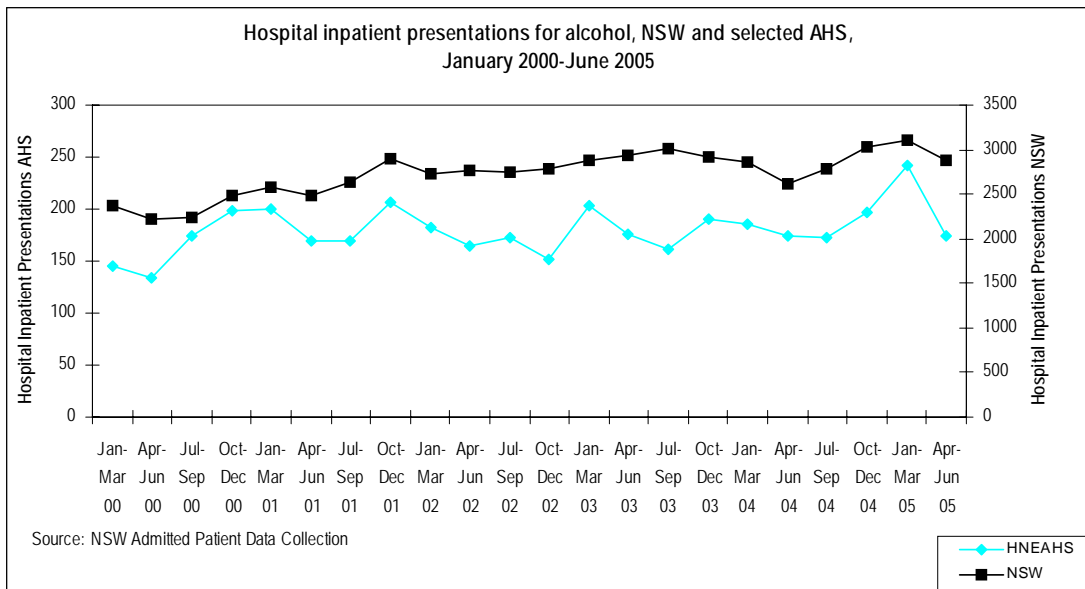


Figure 11: Hospital inpatient presentations for alcohol, NSW and HNE Health, January 2000-June 2005



The Hunter New England area also has a slightly higher rate of presentations for drug intoxication and withdrawal with and without complications, and a significantly lower rate for alcohol use disorder and dependence (same day) than NSW as a whole.

Table 8 shows that for the period 2002 – 2006, acute inpatient separations have risen significantly in all drug and alcohol DRGs except alcohol use disorder and dependence, which has remained static. A comprehensive assessment and early intervention to identify and treat D&A issues could decrease inpatient activity for this cohort of clients.

**Table 8: HNE Health Drug and Alcohol Inpatient Acute separations by DRG
2002-2006**

DRG	2002/03	2003/04	2004/05	2005/06	Total
Alcohol Intoxication and Withdrawal	456	512	529	607	2104
Alcohol Use Disorder and Dependence	201	161	205	206	773
Alcohol Use Disorder and Dependence, Sameday	8	13	13	16	50
Drug Intoxication and Withdrawal W CC	37	61	62	142	302
Drug Intoxication and Withdrawal WO CC	136	195	189	375	895
Opioid Use Disorder and Dependence	33	25	58	60	176
Other Drug Use Disorder and Dependence	141	142	189	210	682
Total	1012	1109	1245	1616	4982

Source: Flowinfo v.8

The inpatient detoxification unit at Belmont Hospital (Lakeview) has 12 designated beds. There were 433 admissions in 2004/05 (unit closed for refurbishment for 6 weeks), 509 in 2005/06 and 560 in 2006/07. Referrals from this unit for further treatment include pharmacotherapy programs, community counselling programs, dual diagnosis and residential rehabilitation. In 2004/05 referrals were 353, 2005/06 was 455 and 2006/07 were 490.

Table 9 shows that non-admitted patient occasions of service (NAPOOS) are increasing for all Drug and Alcohol service streams Area wide.

Table 9: HNE Health Drug and Alcohol Clinical Services NAPOOS 2004-2007 (YTD)

	04/05	05/06	06/07(YTD) To March '07
Pharmacotherapy			
Southern	92903	96602	70267
Northern	10817	10941	7953
Lower Mid North Coast	0	10329	10814
Total	103720	117872	89034
Inpatient Detox/Outpatient assessment			
Lakeview*	5899*	109	160
Total	5899	109	160
Community Detox			
Southern	1398	1737	2835
Northern	83	84	61
Lower Mid North Coast	0	79	83
Total	1481	1900	2979
Other NAPOOS			
Southern	15305	19429	22625
Northern	5741	5807	4221
Lower Mid North Coast	0	5482	5739
Total	21046	30718	32585
Other NAPOOS includes: Central Intake, Community Counselling, Clinical Liaison			
Totals			
Southern	115505	117877	95887
Northern	16643	16833	12236
Lower Mid North Coast (stats not available for 2004-05)	0	15891	16637
Totals	132148	150601	124760

Source: HIE 2007

Note: Lakeview inpatient stats were counted as NAPOOS until November 2004. However pre-assessments are done by the staff and are therefore counted as NAPOOS

Presentations for alcohol are more common in the Hunter New England area than the NSW state average. Amphetamine and opiate related presentations are also more common in Hunter New England than NSW as a whole (see Table 10). This is evidenced by the waiting times for OTP for individuals other than priority groups i.e. pregnant women, people released from correctional institutions, people with HIV and their opioid using partners, hepatitis B carriers and their opioid using partners, and people on a diversion program from the criminal justice system.

Table 10: Drug and alcohol treatment episodes (MDS excluding OTP) by principal drug of concern, NSW and HNE Health, 2004-2005

Principal Drug	HNE Health	NSW*
	Per cent	
Alcohol	43.2	40.9
Amphetamines	15.4	11.7
Benzodiazepines	1.7	2.2
Cannabis	17.1	17.6
Cocaine	0.1	0.6
Ecstasy	0.1	0.3
Heroin	12.7	18.2
Methadone	1.4	2.2
Nicotine	1.8	1.3
Other (non-opiates)	4.4	3.2
Other opiates	2.0	1.8
Total (Number)	5,190	43,253

Source: NSW Minimum Data Set for Drug and Alcohol Treatment Services.

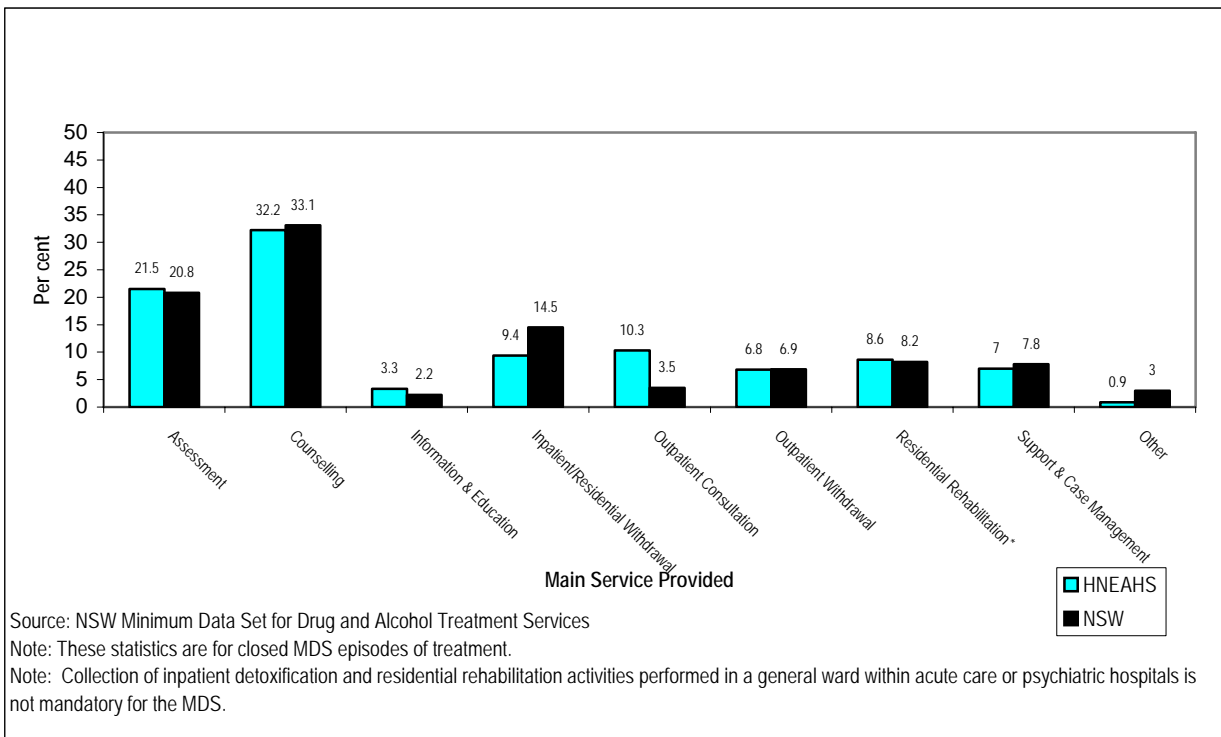
Note: These statistics are for closed MDS episodes of treatment only.

This table excludes clients under age 10 and records pertaining to non-funded NGO's.

* Excludes treatment episodes for clients seeking treatment for the drug use of others.

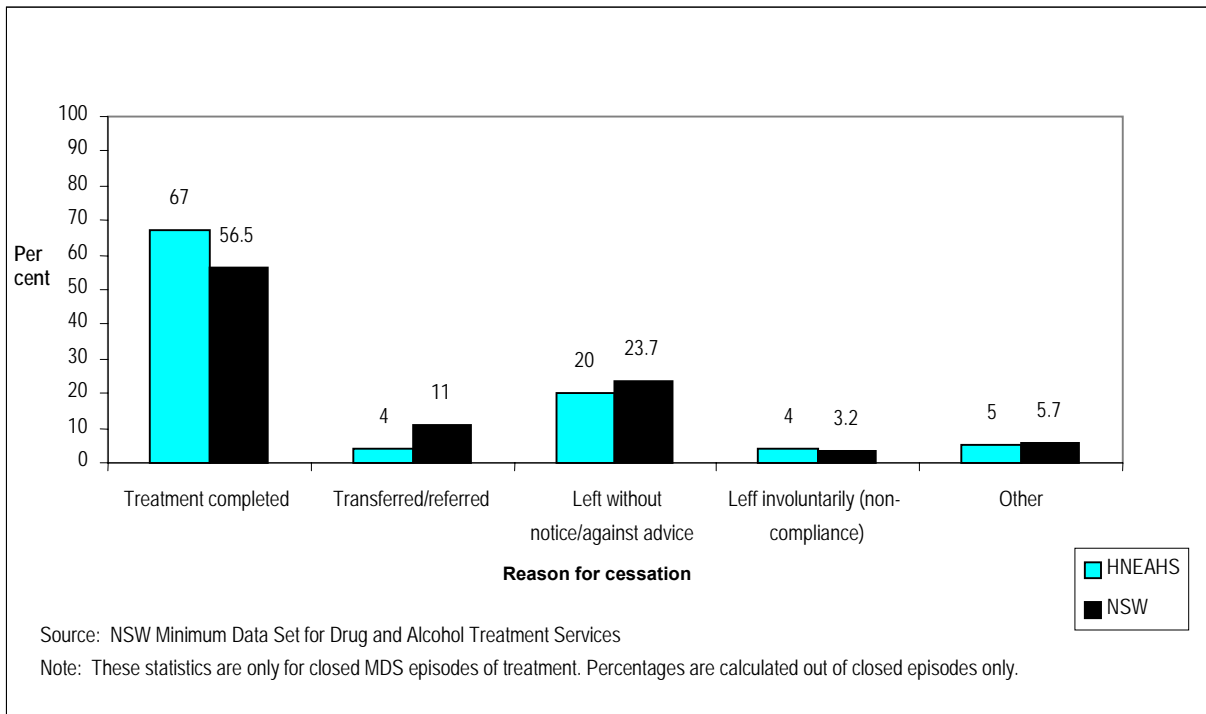
HNE Health has nearly twice as many episodes of outpatient consultation than the NSW state average (Figure 12).

Figure 12: Drug and alcohol treatment episodes (MDS excluding OTP) by main service provided, NSW and HNE Health, 2003-2004



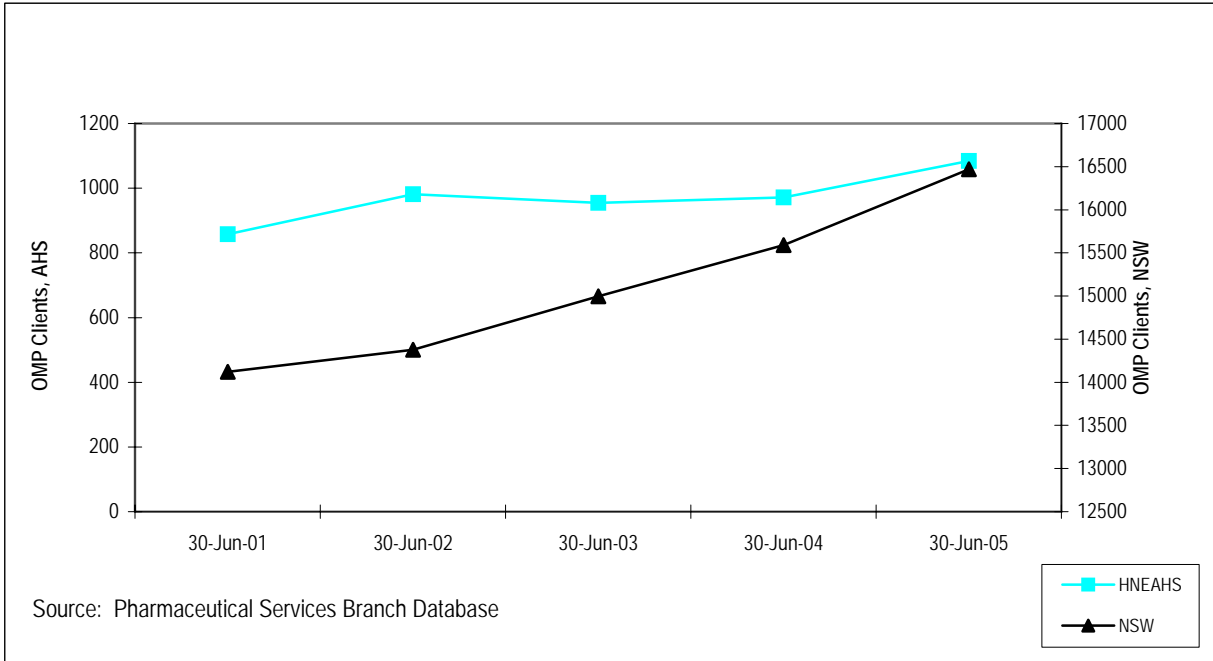
As shown in Figure 13, HNE Health reported high levels of clients completing their treatment episodes as the reason for cessation for their treatment. When compared to NSW as a whole, HNE Health reported less than half of their clients were transferred/referred to another service.

Figure 13: Drug and alcohol treatment episodes (MDS excluding OTP) by reason for cessation, NSW and HNE Health, 2004-2005



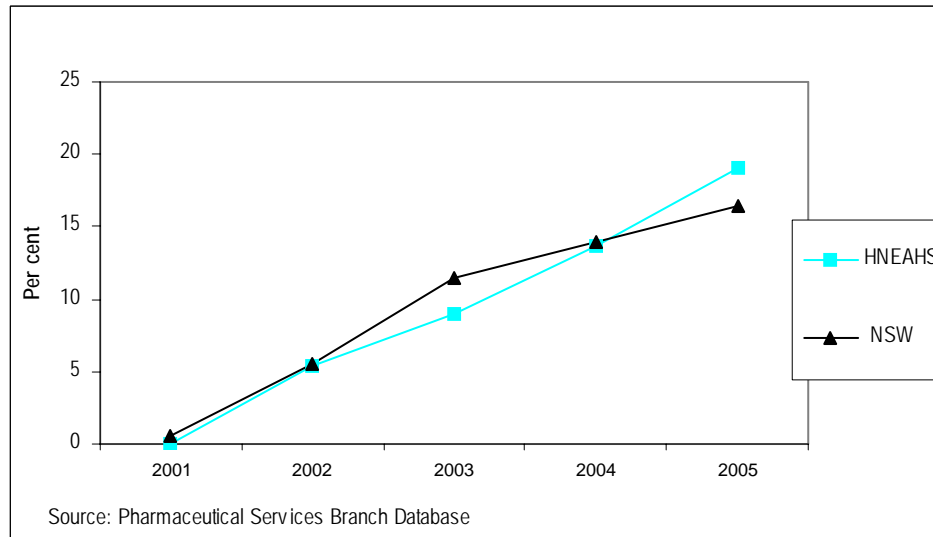
Numbers of OTP clients increased for NSW as a whole between 30 June 2001 and 30 June 2005 (Figure 14).

Figure 14: OTP clients, NSW and HNE Health, as at 30 June 2001- 2005



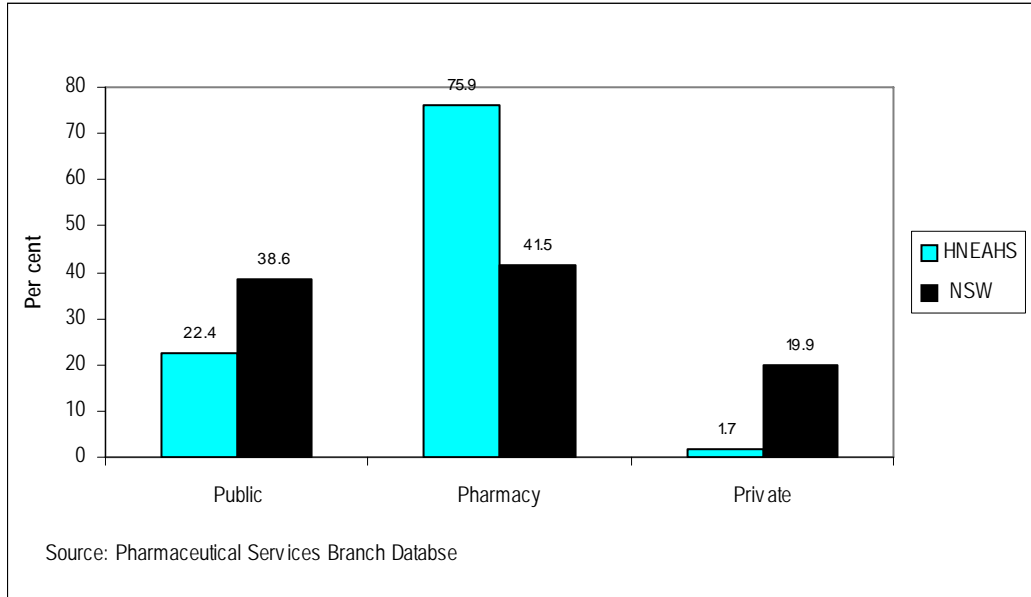
Uptake of buprenorphine by Hunter New England clients has been about the same as the state average (Figure 15).

Figure 15: OTP clients by buprenorphine, NSW and HNE Health, as at 30 June 2001-2005



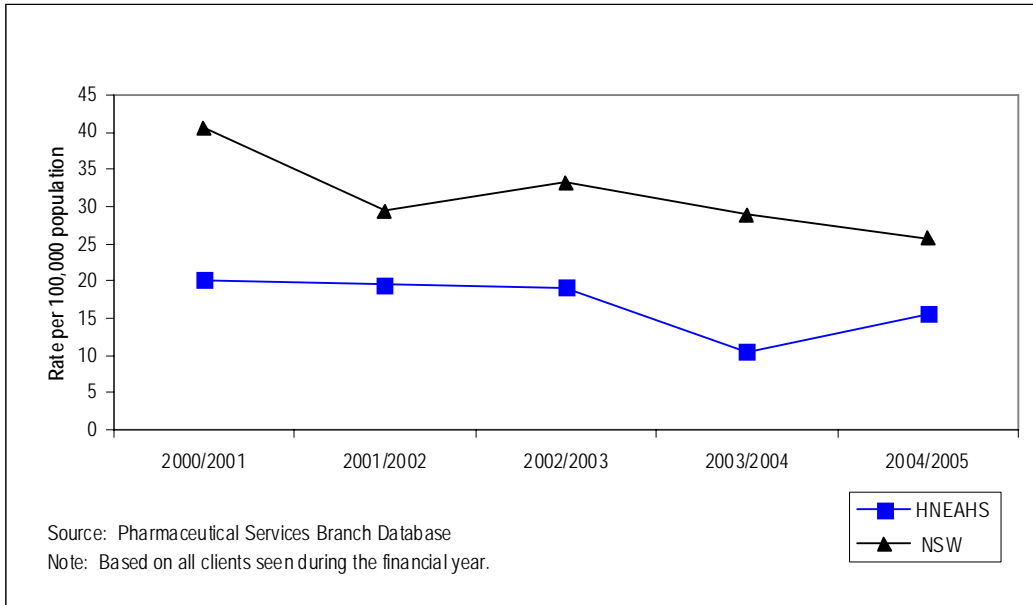
The percent of clients being dosed in public sector, private clinics or the pharmacy sector has remained mostly consistent for NSW as a whole. In figure 16, we see that trends in the Hunter New England area for client dosing have remained stable over the past five years with a much higher proportion of clients being dosed in pharmacies than across NSW as a whole.

Figure 16: OTP clients by dosing point, NSW and HNE Health, as at 30 June 2005



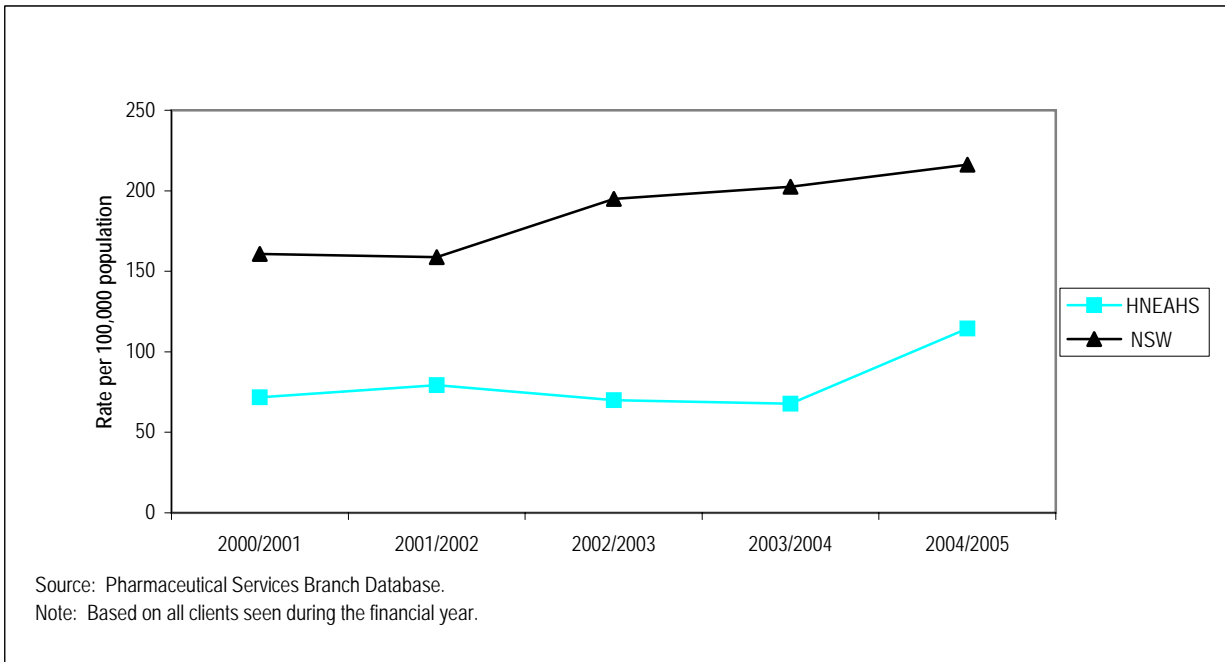
Hunter New England Drug and Alcohol Services have a lower rate of new clients than NSW as a whole. The rate of new clients has fluctuated over the past five years, with decreasing numbers in the past 2 years for both the Hunter New England and NSW (Figure 17).

Figure 17: OTP clients by brand new clients, NSW and HNE Health, 1999/2000-2004/2005



In comparison to new clients, the rate of re-registered clients has been steadily increasing across NSW since 1999/2000. Figure 18 shows that HNE Health has lower rates of re-registered clients than NSW as a whole.

Figure 18: OTP clients by re-registered clients, NSW and HNE Health, 2000/2001-2004/2005



4.4 Projected service requirements

The majority of Drug and Alcohol services in HNE Health are provided in the community setting. At present there is only one inpatient facility available, Lakeview Detoxification Unit, located at Belmont Hospital. However, across the area patients are admitted to acute facilities with primary Drug and Alcohol diagnoses.

Table 11 presents projections for acute drug and alcohol inpatient beds for HNE Health until 2017. The baseline for 2003/04 suggests a need for 14 beds (the 12 beds at Lakeview plus 2 across the area). Whilst beddays and separation numbers show increases, the number of beds is only projected to increase by 1 by 2016/17.

Table 11: Projected Acute Drug and Alcohol Inpatient beds 2003-2017

	2003/04	2011/2012	2016/2017
Beds	14	15	15
Separations	1884	1988	2063
Beddays	3973	4291	4444

Source: aIM2005

Across the Area, Drug and Alcohol Non-Admitted Patient Occasions of Service are currently increasing at approximately 12.25% per annum. Table 12 shows the projections to 2017 based on the annual percentage increase remaining constant.

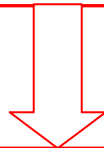
Table 12: Projected Drug & Alcohol NAPOOS 2005-2017

	2005/06	2011/2012	2016/2017
NAPOOS	150,601	272,593	439,556

Source: aIM2005

Key Considerations

- Inadequate identification of Drug and Alcohol related conditions on admission to hospitals leads to complications and co-morbidities
- Lack of alternate dosing modalities for pharmacotherapy services and service delivery options such as prescribing and support using Telehealth decreases treatment outcomes and increases adverse incidents in the community
- Inadequate health promotion of and access to appropriate Drug and Alcohol treatments for Aboriginal People



Strategic Directions

- Objective 1.2: Improved equity of access to services
- Objective 1.3: Improved flexibility and diversity of service delivery particularly to groups exposed to high risk

5. Strategic and Service Issues

5.1 Key Challenges

Particular barriers and challenges to achieving and maintaining good health that face people who misuse drugs and alcohol have been identified and discussed throughout this plan. Population groups who are particularly vulnerable to a whole range of health issues throughout childhood and adolescence, and, into adult life have also been described.

A review of existing service structures and service delivery models across HNE Health identified the following issues as key challenges for the development of drug and alcohol services:

- The complexity of delivering comprehensive drug and alcohol clinical across multiple sites and large geographic distances
- Timely access to treatment services
- Recruitment and retention of staff (nursing, allied health and medical), to be able to offer a range of services with a quality standard of care in acceptable time frames and workloads
- Providing professional development opportunities to staff across the service
- Implementing new and enhancing existing culturally appropriate services for Aboriginal and socially disadvantaged communities
- Provision of adequate IT, support services and booking systems to support the provision of coordinated and integrated care
- Incorporating Health promotion, early intervention and education services as standard practice across the clinical services
- Providing appropriate support for general practitioners

5.2 Workforce issues

As part of the planning process a survey was circulated to service units and clusters across the Area to identify workforce issues. In addition, workforce issues were identified at the two-day planning workshop involving all drug and alcohol staff from across the Area. Fifty-four completed surveys were returned. Table 13 summaries the key workforce issues identified by the staff and the strategies developed to address them.

Table 13: Workforce Strategy Summary

Issues	Strategy	Responsibility
Access to professional development, inclusive of rural workers (cost, relief, distance, modality, program appropriateness)	Implement D&A capability framework Explore different modalities for delivery of training and education programs Identify the capacity of D&A to deliver programs	D&A Organisational Capability and Learning Workforce planning and development
Misalignment between clinical models of care and workforce competencies	Align service delivery requirements with workforce capability and capacity Optimise workforce utilisation Review strategic relevance of current workforce demand to projected service and workforce demand	D&A Organisational Capability and Learning Workforce planning and development Service planning
Availability of workforce to mainstream D&A education across sectors and agencies (early and brief intervention)	Identify D&A service responsibilities between ED/inpatient services and specialist D&A services Develop partnerships to support the shared responsibilities of D&A service intervention	Human Resources D&A Organisational Capability and Learning Workforce planning and development Appropriate service directors Service planning
Availability of experienced and specialist staff	Develop Talent management (mentoring), Succession planning and Career planning strategies	Human Resources D&A Organisational Capability and Learning Workforce planning and development
Limited availability of workforce to service demands in all disciplines	Review level of workforce supply and utilisation based on current service delivery models Review workplace effectiveness strategies Review strategic relevance of current workforce to projected service intervention models Optimise workforce to meet projected service delivery models Develop a behavioural engagement framework	Human Resources D&A Organisational Capability and Learning Workforce planning and development Service planning
Ageing workforce and intergenerational relationships	Increase participation rate of experienced workers (>45 age) Develop positive workplace relationships across age spectrums	Workforce planning and development D&A
Increase profile and	Identify positive marketing	Communication Unit

Issues	Strategy	Responsibility
marketing of D&A as a career option	strategies Develop a behavioural engagement framework	Human Resources D&A Workforce planning and development
Work-Life Balance: Changing Attitudes to Work Child/elder care	Develop a behavioural engagement framework to meet service delivery requirements	Human Resources D&A Workforce planning and development
Access and availability of a goal based professional development system that aligns with strategic action plan	Develop and align a goal based professional development system to align with D&A workforce capability framework including leadership and technical capability	D&A Workforce planning and development
Industrial Relations: Workforce instability (short term contracts) External IR environment Positions funded by non-recurrent funding	Create stability strategies to capitalise workforce to maintain service supply for long term service delivery	D&A Workforce planning and development Human Resources Finance
Loss of workforce talent and knowledge in clinical services Limited succession planning framework in place to support career paths and competitive advantage	Develop Talent management strategies (mentoring), Succession planning and Career planning Develop a behavioural engagement framework	D&A Workforce planning and development Human Resources

5.3 Consumer Feedback and Analysis

To inform the development of the plan, a consumer questionnaire was developed and distributed across the Area. Questionnaires were distributed at each of the clinical services sites and via the NSW Users and AIDS (NUUA) representative. Aboriginal and Torres Strait Islanders and those from a culturally diverse background were invited to provide further information regarding the appropriateness of Drug and Alcohol services. The questionnaire is included as Appendix 3.

Fifty-five completed questionnaires were returned. Thirty-seven were interviewer- assisted and 18 were self-administered. Sixty two percent were male and 38% female. There were seven responses from Aboriginal people and three responses from people from CALD backgrounds. Responses were received from Newcastle, Lake Macquarie, Port Stephens, Lower Hunter, Upper Hunter and Taree LGAs. No responses were received from the northern part of the Area.

Results of Consumer Questionnaire

Services Accessed

The main service accessed by respondents was counselling (29%), followed by pharmacotherapy (20%), NSP and Detoxification (19%) and MERIT (11%). 79% of respondents were currently engaged in treatment with DACS, 19% with the Harm Minimisation Program services and 1% with other agencies or none.

Drugs of choice

Primary main drug of choice for respondents was Alcohol (21%), then Amphetamines (19%), Cannabis (17%) and Tobacco (17%). Secondary drug of choice was Tobacco (29%), followed by Cannabis (21%), Alcohol (16%) and Amphetamines (15%).

Aim of Treatment

The aim of going into treatment was to achieve abstinence (57%), followed by control use (25%) and reduce use (18%). This is quite a significant finding as severe drug use disorders are disabling and often relapsing conditions²⁸. The primary goals of treatment for such problematic drug and alcohol use should be concerned with reducing harms associated with the use of substances, if not actually reducing or ceasing the use of drugs and or alcohol altogether²⁸.

About the Service

With regard to interacting with the staff of Drug and Alcohol services, clients overwhelmingly agreed that staff attitudes and values (93%); staff communication (91%); support for complaints (94%) and confidentiality (100%) was highly important or important.

As well, clients want to be involved in developing their treatment plans (98%) and have the capacity to give feedback (96%). Keeping travel costs (83%) and costs of being on the program low (82%) were concerns. Where the service is located (81%), waiting times (89%) and access to Mental Health services (75%) were also seen as important.

27 people provided written comments regarding what is important about this service. Seven (25%) of these stated that the services were supportive, five (18%) commented on the strict guidelines that can block access to services i.e. 'there is no treatment for people like me I have nowhere to live'. Four people (15%) commented on the long waiting times and that services need to be more prompt in responding to people needs i.e. 'a response group should be organised for different and immediate help'. Three people (11%) were concerned about confidentiality and trust, and, commented that it was hard for mothers to trust the service. People also commented on client equality and respect, having access to local services and not having to travel out of area and wanting more surveys like this.

Accessing Services

In response to the question, "Where would you send somebody with a drug and alcohol problem for help?", seventeen respondents (31%) would refer people to detoxification services, eight (15%) to pharmacotherapy, five (9%) to AIDS Council of Australia and MERIT, three (5%) to other users or friends, two to rehabilitation and mental health. Other responses included GP, Narcotics Anonymous, Alcohol Drug Information Service and NSP. Twenty-nine (54%) of total responses stated they would send people to this service because they had access to caseworkers or the service was helpful. Seven (13%) people stated it was the main service they knew and six (11%) that the service was recommended. Other comments included dosing at public clinics because of the cost of pharmacy, long waiting lists and flexible, discreet service delivery.

Service Gaps

Forty-five people identified Drug and Alcohol service gaps. Twenty-four percent suggested that Methadone and Subutex services were needed in the Newcastle/Cessnock area. Twenty-four percent identified the need for Detoxification services including adult, teenager and medicated home detoxifications across all areas. 9% suggested access to Naltrexone in the Newcastle area. Nine percent suggested community counselling in rural areas and 7% wanted access to programs for stimulants in rural areas. Seven percent requested more rehabilitation services and 5% identified the need for access to mental health services and NSP services in rural areas. Other comments identified the need for a community liaison officer to assist with complaints, case managers, program follow-up, hepatitis C screening and testing, mobile services, take-a-ways everywhere, 24 hour contact person and, alternatives to Alcoholics Anonymous and Narcotics Anonymous such as SMART Recovery.

Models of Service Delivery

The majority of clients agreed they would utilise Telehealth (61%) and Teleconference (62%) facilities if available and that they would participate whether conducted by a Doctor (68%) or other worker (63%). Eighteen people provided feedback on why they would not use the service. Of these 72% stated they wanted face-to-face contact and 27% stated confidentiality as the main barrier.

Barriers to Accessing Services

When asked to identify major barriers that stop people turning to Drug and Alcohol services for assistance, respondents identified the following: unwilling or afraid to admit they have a problem (75%); have had or heard of someone having a bad experience when using Drug and Alcohol services (69%); other commitments like child care getting in the way (67%); afraid of losing their children (66%); not knowing where to go (65%); long waiting lists (64%); not having transport to get to services (49%); not being able to afford to pay (31%); and, 33% felt that lacking English language skills was not a problem.

As well there were 50 written comments regarding barriers. 20% felt discrimination was the most important reason for not accessing services. The majority of these responses came from rural areas. 12% stated confidentiality, people unwilling to admit they have a problem or not knowing where services are available. Being told of some one else's bad experience (12%) or having had a bad experience (6%) was also given as a barrier to accessing services. Waiting lists, childcare, no other supports, respect, shame and other commitments were other issues raised.

General comments

People were asked if there was anything else they wanted to say. There were 16 responses.

55% (10) included a thank you for the quality of service given.

16% (3) said they had had a bad experience

11% (2) said waiting times needs to be addressed.

Other comments included the need for assistance with housing and dental health, client delegates to speak on behalf of clients and being flexible in service delivery.

Aboriginal and Torres Strait Islander Cultural Appropriateness of Service

Seven of the fifty-five respondents (13%) to the survey answered the questions designed specifically for Aboriginal or Torres Strait Islanders on cultural appropriateness of Drug and Alcohol services. Four were interview assisted and three were self-answered.

When interacting with Drug and Alcohol staff, respondents found the following to be important in ensuring the cultural appropriateness of services: having an Aboriginal or Torres Strait Islander staff member to help them (86%); staff having a holistic care approach; thinking about social, financial, emotional and spiritual issues as well as the client's health (86%); and staff having cultural awareness training (72%).

The respondents also wanted flexible service delivery (100%), the Drug and Alcohol services working in partnership with Aboriginal organisations to ensure community involvement in planning services (100%), making services welcoming with appropriate indigenous decoration (72%) and identifying all Aboriginal or Torres Strait Islander clients and ensuring their cultural needs are met (71%).

Multicultural Appropriateness of Services

Three of the fifty-five respondents (5%) to the survey answered the questions designed specifically for people from a culturally and linguistically diverse background. The questions were very similar to the questions for Aboriginal or Torres Strait Islander people. One response was interview assisted and 2 were self-answered.

Responses were similar to those given by the Aboriginal and Torres Strait Islanders for all questions. There was strong agreement for the need for professional health care interpreters to facilitate communication between staff and client.

Implications for Service Planning

The main areas of need identified from the consumer survey and considered in the planning exercise include:

- Monitoring of waiting lists
- Location of services aligned with client demand
- Improving links with partners in care e.g. Mental Health services
- Maintaining and providing ongoing staff training in communication, confidentiality and cultural awareness
- Addressing the real and perceived barriers for clients to access services
- Involving client/consumer participation in service planning, feedback and development of their treatment plans.

Addressing the real and perceived barriers

The survey found that people are often reluctant or afraid to admit that they have problems with alcohol and/or other drugs, and can therefore be apprehensive about accessing services. Participants in the survey also spoke of people's fears concerning confidentiality, when engaged in treatment services and when utilising new technologies to deliver services. Discrimination also featured especially for clients seeking help in rural communities. Fears were expressed about issues related to having children and trust in authorities when seeking help. For Aboriginal/multicultural communities access to Aboriginal/multicultural staff, whom they were familiar with, trust and feel able to contact is very important.

Providing a service that is holistic and flexible in its approach, endeavouring to make people

more comfortable and therefore likely to seek support from drug and alcohol services and addressing the need for cultural competence will help resolve these issues.

Strategies

- Involve mainstream services in developing their services to deliver a patient-centred approach to care
- Include information and discussion regarding trust, confidentiality and respect
- Ensure all clients receive information and explanations regarding service and client expectations when entering into treatment, release of information, continuity of care and involvement of other services to assist with improved outcomes for people engaged in treatment e.g. DoCs.
- Enhance links with Aboriginal and multicultural services across HNE Health Drug and Alcohol Clinical Services to inform service delivery and to provide assistance/guidance with culturally appropriate interventions
- Provide avenues for greater consumer participation in the delivery and planning of care by establishing consumer representation forums, regular surveys and reviewing participation rates in care planning. There are limited opportunities to do elective inpatient detoxification in public hospital settings due to difficulties in accessing beds.

Monitoring waiting lists, and location of services

People from rural and remote areas can have limited access to health services within their own LGAs. Most people, regardless of where they live, expect to be able to access services within a timely manner. This has obvious implications for both rural and remote service delivery. Exploring ways to deliver more flexible drug and alcohol services to rural and remote communities will be important in reducing access barriers and promoting interdisciplinary delivery of care.

Strategies

- Utilise Telehealth and videoconferencing for prescribing and counselling interventions across the area.
- Develop evidence based care through the ongoing identification of submissions for and participation in clinical trials and research projects (in both rural and remote settings) that utilise flexible models of service delivery across multiple sites. Such projects will increase access, improve outcomes and provide a quality delivery of service for people engaged in treatment.
- Develop strategic local plans involving relevant Non-Government Organisations, other health and allied health services to develop ways to work together more effectively and share available resources.

5.4 Future Directions

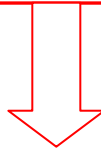
The following strategies have been identified during the planning process:

- Streamline the Central Intake Line Service so there is one contact point for DACS area wide.
- Work in partnership with Mental Health to implement improved integrated care approaches and collaborative relationships to improve the transition of care between services
- Facilitate and promote shared care opportunities with other service providers
- Implementation of relevant health promotion/prevention programs across the service

- Expansion of access to telehealth consultations.
- Establish an avenue for an Area Wide Consumer Representative Group meeting
- Consult and involve Aboriginal communities in the planning processes and provision of services.
- Consult and involve CALD communities in the planning processes and provision of services.
- Involvement and planning with the following agencies to improve health outcomes for clients of DACS:
 - Divisions of General Practice
 - Department of Community Services (DoCS)
 - NSW Police
 - Department of Ageing, Disability and Home Care (DADHC)
 - Ambulance services
 - Emergency Departments
 - Relevant NGO's
 - Aboriginal Medical Services
 - Probation and Parole
 - Justice Health
- Roll out core curriculum education program across DACS to ensure staff have knowledge of evidence based and standardised practice.
- Expansion of infrastructure of Information and Technology in consultation with HNE Health IT services.
- Standardise processes for electronic medical record across DACS
- Implement clinical governance processes across service

Key Considerations

- Provide avenues for greater consumer participation in the delivery and planning of care by establishing consumer representation forums, regular surveys and reviewing participation rates in care planning
- Recruitment and retention of staff (nursing, allied health and medical), to be able to offer a range of services with a quality standard of care in acceptable time frames and workloads
- Providing professional development opportunities to staff across the service



Strategic Directions

- Objective 1.1: Improved consumer/ community understanding of health and social effects of drug and alcohol use and the role of harm minimisation and treatment
- Objective 5.1: Attracting and retaining the required high quality staff
- Objective 5.2: Developing competence, capability, capacity, professionalism, individual accountability and performance

6. Aboriginal Health Impact Statement

In the development of the HNE Health Drug and Alcohol Services Plan, the health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed.

See Appendix 6 for the completed Aboriginal Health Impact Statement checklist.

7. Ethnic Affairs Priority Statement

In the development of the HNE Health Drug and Alcohol Services Plan, the health needs and interests of people from culturally and linguistically diverse groups have been considered. HNE Health is committed to delivering services that best meet their needs and there are specific strategies included in the Strategic Action Plan demonstrating that commitment.

9. References

1. The National Drug Strategy: Australia's integrated framework 2004 –2009
2. NSW Health Drug and Alcohol Plan 2006-2010
3. Statistics on drug use in Australia 2006, April 2007, AIHW
4. The Health of the people of New South Wales. Report of the Chief Health Officer 2006.
5. Interagency guidelines for the early intervention, response and management of drug and alcohol misuse, NSW Health 2005
6. Cancer Institute NSW, Quitline Program, 2007
7. Health in Hunter New England, Hunter new England Population Health, HNE Health 2005
8. Alcohol and other drug treatment services in New South Wales 2004 –05, AIHW
9. Mental Health and adolescent cannabis use, NSW Department of Education and Training, 2005
10. NSW Hepatitis C Strategy 2000-2003 NSW Health
11. NSW HIV/AIDS Strategy 2006-2009 NSW Health
12. The management of People with a co-existing Mental Health and Substance Use Disorder. Service Delivery Guidelines. NSW Health 2000
13. Dual Diagnosis. A Resource for Caseworkers, Australian Government Department of Family and Community Services 2005
14. Australian Institute of Health and Welfare – Aboriginal and Torres Strait Islander Health and Welfare Unit 2006
15. Australia's Health 2006, AIHW
16. Australian Bureau of Statistics (ABS) 2006 – National Aboriginal and Torres Strait Islander Health Survey 2004-05
17. Alcohol and Other Drug Treatment Services in Australia 2004 – 05: Report on the National Minimum Data Set, AIHW 2006
18. *Private Lives Report. A report on the health and wellbeing of GLBTI Australians*, Australian Research Centre in Sex, Health and Society, March 2006
19. *Beyond Perceptions: a report on alcohol and other drug use among gay, lesbian, bisexual and queer communities in Victoria*, Australian Drug Foundation 2000
20. NSW Adult Alcohol Action Plan 1998-2002, NSW Health
21. The Alcohol and Other Drug Council of Australia Policy 2000: A new agenda for harm reduction
22. Extreme cause-specific mortality in a cohort of adult prisoners 1998 – 2002. Karaminia A, Butler TG, Corben SP, Levy MH, Grant L, Kaldor JM, Law MG.
23. *Are Refugees at Increased Risk of Substance Misuse?* Drug and Alcohol Multicultural Education Centre, 2005
24. *Drug and Alcohol* Drug & Alcohol Services South Australia 2007
25. *Illegal drugs in Pregnancy*, Babycentre UK 2007
26. Australian Institute of Health and Welfare 2007. *Young Australians: their health and wellbeing 2007*. Cat. No. PHE 87. Canberra. AIHW.

SECTION C: STRATEGIC OBJECTIVES AND STRATEGIC ACTION PLAN

The following pages present HNE Health's Drug and Alcohol Services Strategic Objectives and Strategic Action Plan for the next five years. The Plan details the strategic initiatives that will be implemented to achieve the Strategic Objectives.

Drug and Alcohol Services' Strategic Objectives

The Services' Vision, Purpose, Key Focus Areas and Strategic Objectives are presented as a one-page summary.

The Key Focus Areas are those areas that are considered critical to achieving the Services' Vision. For each Key Focus Area, Strategic Objectives are identified to ensure the Services remain focussed on the most important issues and needs.

Drug and Alcohol Services' Strategic Action Plan

The Strategic Action Plan identifies performance measure/s for each of the strategic objectives and presents the strategic initiatives (the actions, activities or projects) that will be implemented over the next five years to improve performance, reach targets and achieve the strategic objectives.

Each Objective is risk-rated using the HNE Health Risk Matrix (see page 88), which is based on the NSW Health Severity Assessment Code (SAC). In rating the strategic objectives the consequences and likelihood of not achieving an objective and the impact on service provision and outcomes for the community were considered. The risk ratings identified for each strategic objective signify the priority placed on achieving each objective and indicate where the Services want to be in relation to each objective in five years time. A current risk rating (based on what we are doing now) and a target risk rating (what the risk will be once we have implemented the strategic initiatives) have been assessed for each objective.

Drug and Alcohol Services

VISION: Healthier communities: Excellence in healthcare
PURPOSE: Working with our communities to deliver quality Drug And Alcohol services

OUR VALUES

- TEAMWORK
- HONESTY
- RESPECT
- ETHICS
- EXCELLENCE
- CARING
- COURAGE
- COMMITMENT

Focus Area: 1: Individuals Families and Communities
 To achieve our vision, the key outcomes we must deliver are:

- ❖ 1.1 Improved consumer/ community understanding of health and social effects of drug and alcohol use and the role of harm minimisation and treatment
- ❖ 1.2 Improved equity of access to services
- ❖ 1.3 Improved flexibility and diversity of service delivery particularly to groups exposed to high risk

Focus Area: 2: External Partners
 To deliver the required community outcomes, we need to excel in:

- ❖ 2.1 Improved collaboration and partnerships designed to enhance drug and alcohol service delivery and outcomes

Focus Area: 3: Internal Networking and Processes
 To deliver the required community outcomes, we need to excel in:

- ❖ 3.1 Safe, evidence-based healthcare within a quality framework that is person centered and aims to reduce drug related harm
- ❖ 3.2 Promotion, prevention and early intervention
- ❖ 3.3 Better integration and cooperation with our internal partners

Focus Area: 4: Resource Accountability
 To deliver the required community outcomes, we need to excel in:

- ❖ 4.1 Effective management of resources and assets for maximum health benefit

Focus Area: 5: Our People, Culture and Capability
 (Employees and Contracted)
 To achieve the desired community outcomes and sustain our ability to change and improve, we need to excel in:

- ❖ 5.1 Attracting and retaining high quality staff
- ❖ 5.2 Developing competence, capability, capacity, professionalism, individual accountability and performance
- ❖ 5.3 Effective consultation and communication
- ❖ 5.4 Ensuring a safe working environment
- ❖ 5.5 Demonstrating innovative healthcare and a culture of excellent practice

ABBREVIATIONS TABLE:

APSAD	Australasian Professional Society on Alcohol and other Drugs
BBV	Blood Borne Virus
CALD	Culturally and Linguistically Diverse
CGU	Clinical Governance Unit
CHIME	Community Health Information Management Enterprise
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
Comms	Communication
DACS	Drug and Alcohol Clinical Services
DAMEC	Drug and Alcohol Multicultural Education Centre
D&A	Drug and Alcohol
Detox	Detoxification
Dir	Director
DV	Domestic Violence
Exec	Executive
GP	General Practitioner
HCV	Hepatitis C Virus
HMP	Harm Minimisation Program
IT	Information Technology
Man	Manager
MHDAO	Mental Health Drug and Alcohol Office
MOU	Memorandum of Understanding
NGO	Non-government Organisation
NUAA	NSW Users and AIDS Association
OTP	Opioid Treatment Program
PIT	Psychologist in training
TAFE	Technical and Further Education
TBD	To be decided
WP&G	Workforce Planning and Development

When reviewing the strategic action plan, please refer to the following keys:

- ◆ **Funding Key:** 1. Initiative/Action to be implemented without funding 2. Initiative/Action to be implemented with funding from existing resources 3. Enhancement funding required
- ★ **Priority Key:** Strategic Initiatives/Actions that require “Enhancement Funding” (3) are to be prioritised as either **Low**, **Medium** or **High**, based on their contribution to achieving the objective

FOCUS AREA:	INDIVIDUALS FAMILIES AND COMMUNITIES						
OBJECTIVE:	To achieve our vision, a key outcome we must delivery is: 1.1 Improved consumer/ community understanding of health and social effects of drug and alcohol use and the role of harm minimization and treatment					Risk Rating	
						Current	Target
						K	K
DESTINATION STATEMENT:	<i>There are processes in place for consumer/community participation in all aspects of service delivery, resulting in an increased understanding of the benefits and expected outcomes of drug and alcohol service delivery</i>						
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H
Consumer participation rate at agreed forums	Baseline 75%	Annually	<ul style="list-style-type: none"> • Encourage consumer/community participation through: <ul style="list-style-type: none"> - Representation on project and planning groups - Client forums • Development of consumer/client survey feedback • Establishment of a consumer steering committee • Increased involvement with Aboriginal and CALD communities • Incorporating the above strategies in a Communication Plan • In conjunction with Communication and Stakeholder Engagement Unit, develop a strategy to disseminate positive media releases and enhance service image • Identify opportunities to promote positive attitudes to people with drug and alcohol issues • Increase opportunities to inform/increase information for future clinical care • Ensure the information provided is both culturally appropriate and addresses literacy levels • Involve clients in the development and review of their individual treatment plans and review client participation rates • Develop a web based medium to enable prospective clients to be better informed of services e.g. a 'virtual' tour of services such as Lakeview 	D&A CGU	Jun 08	2	H
Consumer participation rate in feedback survey	Baseline +5%	Annually		Area Manager, Comms unit	Jun 08	1	M
				Managers, All staff	Jun 08	1	L
				Managers, All staff	Jun 08	1	M
				D&A CGU	Jun 08	1	L
				Managers	Jun 08	1	H
				D&A CGU, Comms Unit	Jun 08	2	L

FOCUS AREA:		INDIVIDUALS FAMILIES AND COMMUNITIES							
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: 1.2 Improved equity of access to services					Risk Rating			
						Current	Target		
DESTINATION STATEMENT:		<i>Within our Area, people with the same clinical need, can access an appropriate range of treatment options as close to where they live as possible</i>							
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H		
Number of clients given an assessment appointment with in five working days from Intake. Number telehealth/teleconference clinical interventions	80%	Annually	<ul style="list-style-type: none"> Identify and prioritise access blocks and develop strategies for improvement i.e.: <ul style="list-style-type: none"> Expand Pharmacotherapy access to hospitals for dosing points. Expand the use of alternate dosing modalities e.g. Take safe and alternative treatment options such as buprenorphine-naloxone, unsupervised dosing Centralise waiting list for access to DACS services Ensure services are delivered by the right staff with the right skills Submit funding applications as appropriate for identified gaps in service delivery e.g. consultation and liaison services, Aboriginal Health Education officers Establish an Area wide working party to review and support implementation of relevant guidelines e.g. detoxification, psychosocial, OTP, in line with NSW Health guidelines Develop and implement operational plans for DACS streams Area wide e.g. HMT, Pharmacotherapy, Community Counselling Continue to develop and maintain innovative and flexible strategies to provide services for people who are geographically disadvantaged e.g. teleconference, telehealth, email Review and streamline central intake processes Develop a working party to explore DACS role delineation in relation to service provision in rural areas 	Area Manager	Jun 09	1	L		
	Baseline +2%	Annually					1	H	
							1	M	
							1	M	
							3	H	
						Dir Detox, D&A CGU	Mar 09	1	L
						D&A Exec	Jun 08	1	H
						D&A Exec	Jun 08	3	M
				Area Manager	Jun 08	1	M		
				D&A Exec	Jun 08	1	M		

FOCUS AREA:	INDIVIDUALS FAMILIES AND COMMUNITIES						
OBJECTIVE:	To achieve our vision, a key outcome we must deliver is: 1.3 Improved flexibility and diversity of service delivery particularly to groups exposed to high risk					Risk Rating	
						Current	Target
DESTINATION STATEMENT:	<i>Services are provided that are innovative and responsive to complex and changing needs.</i>						
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H
Number flexible service delivery options offered	Baseline + 2%	Annually	<ul style="list-style-type: none"> • Adopt a multidisciplinary and multi service model of care 	D&A Exec	Ongoing	1	H
			<ul style="list-style-type: none"> • Implement options to increase availability of service delivery, such as 24 hour HMP services 	D&A Area Man	Ongoing	2	H
			<ul style="list-style-type: none"> • Participate in the roll out of the HNEH centralised intake service Contact Centre 	D&A Area Man	Jun 2011	1	L
			<ul style="list-style-type: none"> • Expand existing services such as community detoxification, within funding and according to NSW Health guidelines. 	D&A Exec	Jun 2011	1	M
			<ul style="list-style-type: none"> • Participate in the expanded statewide Take-safe Trial 	D&A Area Man	Jun 2011	1	H
			<ul style="list-style-type: none"> • Explore options for buprenorphine-naxone rollout 	D&A Exec	Jun 2011	1	L
			<ul style="list-style-type: none"> • Establish links with other key agencies/services to continually identify and develop responses to clients e.g. Mental Health, Aboriginal, Population Health Units, Residential Aged Care Facility providers 	Network Exec Teams	Sep 08 Jun 08, ongoing	1	M
			<ul style="list-style-type: none"> • Co-existing mental health and substance misuse disorders <ul style="list-style-type: none"> - Improve links with Mental Health Services via the Clinical Network development 	D&A Exec	Jun 08, ongoing	1	M
			<ul style="list-style-type: none"> - Identify and develop resource staff for consultation within DACS 	Managers	Ongoing	1	L
			<ul style="list-style-type: none"> - Train staff in use of computer based tools for mental health interventions 	D&A Exec	Ongoing	1	H
<ul style="list-style-type: none"> • Aboriginal Community <ul style="list-style-type: none"> - Work with HNEHealth Aboriginal Health and Aboriginal Liaison Officers both internal and external to DACS to improve referral and consultation pathways 	Managers	Ongoing	1	H			
<ul style="list-style-type: none"> - Improve referral pathways between Aboriginal specific services such as Aboriginal Medical Services and DACS 	D&A Exec	Ongoing	1	M			

OBJECTIVE:	To achieve our vision, a key outcome we must deliver is:					Risk Rating	
	1.3 Improved flexibility and diversity of service delivery particularly to groups exposed to high risk <i>Continued</i>					Current	Target
						A	C
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H
<i>Continued</i>			<ul style="list-style-type: none"> • Sexual and gender diverse groups <ul style="list-style-type: none"> - Establish links with groups/services to improve referral opportunities • Ageing population <ul style="list-style-type: none"> - Provide input to and participate in Aged Care Services planning • Drug-using individuals in contact with the Criminal Justice System <ul style="list-style-type: none"> - Liaise closely with Justice Health to ensure post release care- planning is appropriate - Work with Probation and Parole to ensure referral pathways are appropriate and collaborative arrangements are in place for service delivery • CALD <ul style="list-style-type: none"> - Involve leaders of cultural groups to disseminate information - Educate staff to identify those clients who are CALD to improve use of interpreter services - Increase capacity to provide Drug and Alcohol information in other languages e.g. DAMEC (Drug and Alcohol Multicultural Education Centre) • Rural area <ul style="list-style-type: none"> - Review approaches to providing services to clients in rural areas 	D&A Exec Managers Managers D&A Exec Managers D&A Exec D&A Exec	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	1 1 1 1 1 2 1	L L L L L L M

OBJECTIVE:	To achieve our vision, a key outcome we must deliver is:					Risk Rating	
	1.3 Improved flexibility and diversity of service delivery particularly to groups exposed to high risk <i>Continued</i>					Current	Target
						A	C
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H
<i>Continued</i>			<ul style="list-style-type: none"> • Children of clients with substance use problems e.g. pregnant women, parents of methadone <ul style="list-style-type: none"> - Work with Children, Young People and Families services and Maternity and Women's Health Services to improve referral and consultation pathways - Provide facilitated access to treatment of clients with high needs - In collaboration with Maternity Services and Child and Family services, develop Area wide clinical pathways for high risk antenatal and post natal clients - Work with MHDAAO to develop treatment initiatives for at risk clients with children 16 years old and younger - Encourage and support DACS staff to expand skills in the management of high risk ante-natal and post-natal clients - Collaborate with Mental Health and Child and Family services to roll out the Safe Start program • Young people with emerging problems <ul style="list-style-type: none"> - Increase capacity to provide Drug and Alcohol information in appropriate formats for young people - Work with government funded NGO youth groups to deliver services to address identified gaps • Consumer groups Liaise with consumer groups to address other key high risk groups such as sex workers e.g. NUAA 	<p>Managers</p> <p>Managers Managers</p> <p>Area Dir</p> <p>GCU / Managers</p> <p>D&A Exec</p> <p>NGO Policy Officer</p> <p>D&A Exec</p>	<p>Ongoing</p> <p>Ongoing Ongoing</p> <p>Jun 08</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>	<p>1</p> <p>1 1</p> <p>2</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p>	<p>H</p> <p>L M</p> <p>M</p> <p>M</p> <p>L</p> <p>L</p> <p>M</p>

FOCUS AREA:		EXTERNAL PARTNERS						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in:						Risk Rating	
	2.1 Improved collaboration and partnerships designed to enhance drug and alcohol service delivery and outcomes						Current	Target
							D	K
DESTINATION STATEMENT:	<i>Our partnerships consistently deliver benefits to Hunter New England people through shared goals, clearly agreed responsibilities and the achievement of optimal outcomes</i>							
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H	
Participation rate in Consumer Satisfaction Surveys	Baseline + 2%	Annual	<ul style="list-style-type: none"> • Review current partnership status and update Performance Agreements • Continue participation in key stakeholder Interagency meetings and relationships • Disseminate information for D&A funding opportunities to appropriate services. • Develop a better understanding, alignment and linkages with the Violence Prevention Program • GP and pharmacy Liaison- <ul style="list-style-type: none"> - Work with MHDOA to redevelop the role of pharmacotherapy services to provide support to general practitioners/community pharmacies within resources - Continue support for outreach model within funding allocation - Explore opportunities to expand role of community detoxification services - Review alternate approaches to pharmacotherapy dosing - Review opportunities for Drug and Alcohol training for GP practice nurses/GP registrars • Develop standardised processes for consultation in rural and regional areas e.g. Skilling up rural GPs using telehealth • Identify resource or contact persons for specific partnerships • Explore the exchange of staff from other area and NGOs and DOCs etc (MOU) • Clarify and communicate key DACS service deliverables with external partners and agencies 	NGO Pol Officers	Jun 08	1	L	
				D&A Exec	Jun 08	1	L	
					ongoing	1	L	
				D&A Area Manager	Jun 08	1	M	
				D&A Area Manager	Jun 08,	1	H	
				D&A Exec	ongoing			
					Mar 08			
				D&A Area Director	Jun 08	2	M	
					Jun 09			
				Managers	Jun 09	1	L	
D&A CGU		1	L					
D&A Area Manager		1	L					

FOCUS AREA:		INTERNAL NETWORKING AND PROCESSES						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in:						Risk Rating	
	3.1 Safe, evidence-based healthcare within a quality framework that is person centered and aims to reduce drug related harm						Current	Target
							L	R
DESTINATION STATEMENT:	<i>We ensure our care is evidence based, of a high standard and committed to continuous improvement, thereby minimising harm and optimising outcomes</i>							
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H	
Percent people accessing clinical service	Baseline + 2%	Annually	<ul style="list-style-type: none"> Implement a review of D&A clinical governance structure to process of policies / procedures / guidelines / protocols / tools to standardise service delivery 	D&A CGU	Jun 2011	1	M	
Number IIMS notifications for adverse events	Baseline - 2%	Annually	<ul style="list-style-type: none"> Review and implement a process to ensure quality clinical practice including: <ul style="list-style-type: none"> Clinical supervision Practicing at clinical skill level Provision of services that are culturally aware Continuous clinical review through different forums e.g. area wide clinical review, peer review utilising a range of modalities such as telehealth, video, phone etc. 	D&A CGU, Managers	Jun 08	1	M	
			<ul style="list-style-type: none"> Promote strategies to manage violence and aggression within services such as: <ul style="list-style-type: none"> DV screening tool completed and monitored Directory for and referral pathways to anger management services 	D&A GCU, Managers	Jun 09 Ongoing	1	M	
			<ul style="list-style-type: none"> Train staff and implement a process for benchmarking and using measurable outcomes 	D&A CGU Managers	Jun 2010	1	M	
			<ul style="list-style-type: none"> Continuous monitoring of services to promote a safe environment for staff and clients Develop clinical structures to promote the developing evidence base for interventions 	D&A GCU	Dec 07 Jun 2011	1	M	

FOCUS AREA:	INTERNAL NETWORKING AND PROCESSES						
OBJECTIVE:	To deliver the required community outcomes, we need to excel in: 3.2 Promotion, prevention and early intervention					Risk Rating	
						Current	Target
						K	Q
DESTINATION STATEMENT:	<i>We embrace opportunities to promote lifestyle choices that minimise risks associated with drug and alcohol use.</i>						
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H
Number of activities related to Health Promotion Strategies	Four	Annually	<ul style="list-style-type: none"> • Promote access to current information through a range of modalities e.g. brochures, internet, DVDs, TV • Identify opportunities to promote drug and alcohol education and if appropriate referral to services through: <ul style="list-style-type: none"> - Drug action week - Working with Community Drug Action Teams - Through partnerships with other service providers to provide brief interventions and opportunistic service delivery e.g. BBV vaccinations - Promotional information on vending machines and in fit-packs - Work with Population Health staff to identify health promotion activities 	Area Manager D&A Exec & Managers	Jun 08 Ongoing Jun 10	1 1	L L

FOCUS AREA:		INTERNAL NETWORKING AND PROCESSES							
OBJECTIVE:	To deliver the required community outcomes, we need to excel in:						Risk Rating		
	3.3 Better integration and cooperation with our internal partners						Current	Target	
DESTINATION STATEMENT:		Our internal partnerships deliver benefits to Hunter New England people through our team approach and commitment to providing a seamless service						K	V
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H		
Number shared care activities	Bench Mark + 5%	Annually	<ul style="list-style-type: none"> • Complete implementation and integration of electronic medical record (CHIME) including: <ul style="list-style-type: none"> - Implement standard confidentiality - All staff to be trained in the use of the system - CHIME to be standard agenda items at all team meetings - Representation of Frontline staff at CHIME user group meetings and at Area wide working party meetings - Standardise CHIME processes and tools used within the system • Work with public hospitals to: <ul style="list-style-type: none"> - To engage them in pharmacotherapy service delivery - Encourage the development of consultation liaison services • Work with IT services to promote / provide flexible service delivery <ul style="list-style-type: none"> - Install a comprehensive Area wide service information/directory on the Intranet website with current information • Implement processes that deliver accurate and effective data collection <ul style="list-style-type: none"> - Review of data - Feedback to staff - Data collected reflects reporting requirements as determined by funding allocations • Provide ongoing support and training in all clinical applications/databases • Participate in the implementation of the Area wide centralised intake service • Identify and participate in key stakeholders meetings • Support appropriate teambuilding processes 	D&A CGU, CHIME, Managers	Jun 09, ongoing	1	H		
Number of initiatives developed via the D&A/MH HNE Clinical Network	Baseline + 5%	Annually		Area Manager, Area Director	Jun 08, ongoing	1 3	M H		
				D&A CGU, Managers	Ongoing	2	H		
				D&A CGU	Dec 08	1	L		
				D&A CGU	Jun 08, ongoing	1	M		
				D&A CGU	Jun 08, ongoing	2	L		
				Area Manager	Jun 2011	2	M		
				Managers	Jun 08	2	L		

OBJECTIVE:	To deliver the required community outcomes, we need to excel in:					Risk Rating	
	3.3 Better integration and cooperation with our internal partners					Current	Target
						K	V
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H
<i>Continued</i>			<ul style="list-style-type: none"> Develop care pathways for the management of Drug and Alcohol issues within healthcare settings, in accordance with NSW Health guidelines, especially mental health, oral health, sexual health, Obstetrics, HCV Expand treatment interventions and referral pathways for blood borne virus disease management within general D&A services Standardise processes for internal referrals and discharge processes / planning to promote continuity of care 	Managers D&A CGU, Managers	Jun 08 Jun 2011 ongoing	1 1	L L
				Managers	Jun 2011 Ongoing	1	
				D&A CGU, Managers	Dec 09	1	M

FOCUS AREA:		OUR PEOPLE, CULTURE AND CAPABILITY						
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in:						Risk Rating	
	5.1 Attracting and retaining the required high quality staff						Current	Target
DESTINATION STATEMENT:		<i>We have the right people with the right skills, in the right place, at the right time</i>						
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H	
Number clinical staff receiving clinical supervision	Baseline 50% Increase to 100% at end of plan	Annually	<ul style="list-style-type: none"> Target internal advertising for psychologists/social workers <ul style="list-style-type: none"> Review the role of psychologists in Drug and Alcohol services Review the possibility of recruiting existing private psychologist to accept Drug and Alcohol referrals Offer mentoring and clinical supervision to new psychology graduates 	Area Manager, D&A Exec	Jun 09	2	H	
Staff turnover rate		Annually	<ul style="list-style-type: none"> Review different options for clinical supervision and rotation across the Area Optimise opportunities for graduate programs – PIT program Support HNEH Workforce Development strategies for incentives for employment, especially in rural services Develop and implement the Drug and Alcohol Services Workforce Plan to include: <ul style="list-style-type: none"> Management of staff positions Safe workload etc Implement a rotation option of team members as clinical liaison succession planning. Identify staff training needs in relation to succession planning Staff exchange / secondment between services Identification of staff minimal standards Develop a workforce strategy for all key disciplines working in drug and alcohol <ul style="list-style-type: none"> Allied Health Medical Nursing Pharmacy Review the utilisation of staff with welfare backgrounds/TAFE qualifications in some areas of work practices. View to permanent placement to avoid relocating to NGO services Provide opportunities to improve training /support for DACS Aboriginal health workers 	D&A CGU Managers D&A Exec D&A Exec, D&A CGU, Managers, WP&D D&A Exec, WP&D Area Manager D&A CGU, DACS Man, Aborig Serv	Jun 08 Jun 08 Jun 08 Jun 09 Jun 09 Jun 08 Jun 08, ongoing	1 1 2 2 2 2 2 2	M L H H H M L M	

FOCUS AREA:		OUR PEOPLE, CULTURE AND CAPABILITY					
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in: 5.2 Developing competence, capability, capacity, professionalism, individual accountability and performance					Risk Rating	
						Current	Target
DESTINATION STATEMENT:		<i>Our staff develop their knowledge base and skills, accept responsibility for their decisions and actions, and are supported to optimise their performance</i>					
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H
Percent staff with current performance management plans	Baseline 50% 100% end of plan	Annual	<ul style="list-style-type: none"> • Review and implement orientation for Drug and Alcohol Services • Review Area wide availability for Drug and Alcohol training • Explore opportunities to disseminate training/education using electronic medium • Explore funding options to develop a core set of skills/competencies for all Drug and Alcohol staff. Incorporate into individual performance management plans/appraisals. • Provide incentives for staff to continuously develop their skills e.g. conference attendance • Utilise information from staff appraisals for professional development by identifying <ul style="list-style-type: none"> - Recurrent themes from staff appraisals and implement appropriate strategies/training to address themes • Promote and encourage the development of a core curriculum across all disciplines • Develop standards of entry requirements (online Drug and Alcohol training, orientation package, certificate) • Develop and review a process for Drug and Alcohol services peer review using the NSW Health Clinicians Tool Kit to include: <ul style="list-style-type: none"> - Formalised feedback systems - Honest evaluation - Competency based mentoring - Supervision across the Area 	D&A CGU	Jun 08	2	M
				D&A CGU	Jun 09	2	M
				D&A CGU	Jun 2011	2	M
				Managers	Jun 08, ongoing	2	M
				D&A CGU, Managers	Jun 09	1	H
				D&A CGU, D&A Exec, WP&D	Jun 09	3	H
				D&A Exec, WP&D	Jun 09	1	M
				D&A CGU, WP&D	Jun 2010	2	M

OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in:						Risk Rating	
	5.2 Developing competence, capability, capacity, professionalism, individual accountability and performance <i>continued</i>						Current	Target
							J	Q
Measure:	Target	Reporting Timeframe	Initiatives/Actions: <i>Continued</i>	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H	
<i>continued</i>			<ul style="list-style-type: none"> • Develop and rollout across all Drug and Alcohol Services a database of skill sets e.g. Proact, CHIME • Prioritise staff skills to increase better outcomes for patients. Match skills to areas working in • Interchange staff into different programs e.g. innovative programs • Investigate funding opportunities to create a Nurse Practitioner position and review of current unfilled Nurse Practitioner positions across the Area • Enhance Drug and Alcohol professional image to both the community and other health professionals through: <ul style="list-style-type: none"> - Informed representation on services related meetings and forums - Promotion of Drug and Alcohol services to other professional bodies - Drug And Alcohol services having shared values across HNE Health - Working together capacity building 	D&A CGU, WP&D Managers	Dec 10	1	L	
				Managers	Jun 08, ongoing Jun 08	2	L	
				D&A Exec	Jun08	2	M	
				D&A Exec, Managers	Jun 08, ongoing	1	M	

FOCUS AREA:	OUR PEOPLE, CULTURE AND CAPABILITY							
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in:						Risk Rating	
	5.4 Ensuring a safe working environment						Current	Target
DESTINATION STATEMENT:	<i>We actively maintain a safe workplace</i>							
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	* Priority L,M,H	
Lost time injury frequency rate		Monthly	<ul style="list-style-type: none"> Review all Drug and Alcohol guidelines and procedures regarding health and safety to ensure adherence and compliance with Area and NSW Health policies Ensure all policies and procedures are easily accessible, to increase opportunity for understanding and adherence to by all staff Review all areas for access and use of security services and duress alarm systems and their adequacy. Identify areas without adequate access and update Review available aggression management courses and provide on a regular basis to all staff, incorporate behaviour management practices into treatment (involving psychology input) Examine consistency between Zero Tolerance, violence/abuse policy and actual patient care Provide comprehensive behavioural expectations at induction of client Clarify Zero Tolerance using evidence based practice e.g. Clients to attend office, visiting in pairs (e.g. with police) Provide appropriate facilities, including outreach and community services 	D&A CGU, Managers Managers Area Manager, Managers D&A CGU, Managers Managers Managers Area Manager, Managers	Jun 08 Jun 08, Ongoing Jun 08, Ongoing Jun 08 Ongoing Ongoing Jun 08, ongoing Jun 08	1 1 2 2 2 2 2	M L L M L M M	

FOCUS AREA:		OUR PEOPLE, CULTURE AND CAPABILITY						
OBJECTIVE:	To achieved the desired outcomes and sustain our ability to change and improve, we need to excel in:						Risk Rating	
	5.5 Demonstrating innovative healthcare and a culture of excellent practice						Current	Target
DESTINATION STATEMENT:		<i>We actively pursue opportunities to participate in research and evidence based activities that promote innovation in service delivery, setting directions based on high standards and evidence based practices</i>						
Measure:	Target	Reporting Timeframe	Initiatives/Actions:	Responsibility	Time frame	◆ Funding 1,2,3	★ Priority L,M,H	
Number of staff providing information to service regarding content of conference / education proceedings	Baseline 50% to 100% at end of plan	Annually	<ul style="list-style-type: none"> • Provide feedback to staff on any conferences, seminars, clinical presentations etc to allow greater access by all staff e.g. Concorde seminars, NSW Health, APSAD conferences • Participate in keeping abreast of current trends in diagnosis and treatment through involvement of key staff (staff specialists, nurse practitioners, CNC/CNS, psychologists and others) • Identify cutting edge authorities, leaders in relevant areas • Provide education to develop research skills via Clinical Nurse Consultant/clinical leaders by: <ul style="list-style-type: none"> - Developing a manual on Evidence Based Practice - Promoting peer review and exchange of ideas about what actually works - Reviewing clients survey data consultations • Develop a Research Plan that includes investigation of: <ul style="list-style-type: none"> - Opportunities for research funding, including a strategy for core research funding - Business case for a dedicated Research Officer - Strengthening links with Universities and other research bodies 	Managers	Jun 08, ongoing	1	L	
				Managers	Jun 08, ongoing	1	H	
				Area Director	Jun 08	1	M	
				D&A CGU	Dec 07	2	M	
				Area Director, Area Manager,	Jun 09, ongoing	3	H	

BSC No.	Focus Area: Objectives	Focus Area	Current Rating	Target Rating
1.4	Improved flexibility and diversity of service delivery particularly to groups exposed to high risk	IF&C	A	C
1.2	Improved equity of access to services	IF&C	B	K
2.1	Improved collaboration and partnerships designed to enhance drug and alcohol service delivery and outcomes	EP	D	K
5.4	Ensuring a safe working environment	OPC&C	J	K
5.2	Developing competence, capability, capacity, professionalism, individual accountability and performance	OPC&C	J	Q
3.1	Continuous service review to ensure person centred care	IN&P	J	R
1.1	Improved community understanding of the health and social impacts associated with Drug and Alcohol use and the benefits of treatment options	IF&C	K	K
5.1	Attracting and retaining high quality staff	OPC&C	K	L
3.3	Promotion, prevention and early Intervention	IN&P	K	Q
1.3	Enhanced delivery of effective services within a quality framework	IF&C	K	R
1.5	Facilitation and support of the participation of individuals, families and communities in the planning process for service delivery and treatment	IF&C	K	R
3.4	Better integration and cooperation with our internal partners	IN&P	K	V
3.2	Safe and evidence-based healthcare	IN&P	L	R
5.5	Setting directions based on high standards and evidence based practices	OPC&C	L	R
4.1	Effective management of resources and assets for maximum health benefit	RA	P	V
4.2	Prioritisation and allocation of resources to best meet health needs in the rural, regional and metropolitan areas	RA	P	V
5.3	Effective consultation and communication	OPC&C	R	U
5.5	Demonstrating innovative healthcare and a culture of excellent practice	OPC&C	R	V

SECTION D: APPENDICES

Appendix 1

Core Planning Group

1. *Scott McLachlan, Director Operations, Primary and Community Networks - Executive Sponsor
2. *Sylvia Myers, Nurse Manager DACS Clinical Governance Learning and Information Improvement- Plan Leader
3. *Gillian Osborn/ Anne MacKenzie - Planning Officer
4. Dr Adrian Dunlop, Area Director Drug and Alcohol Clinical Services (Chair)
5. Vi Hunt - Area Manager Drug and Alcohol Clinical Services
6. Craig Sadler - Staff Specialist Drug and Alcohol Services
7. Martin Nean, Senior Aboriginal Health Education Officer - Aboriginal Health Services
8. Kerri Shying, NSW Users and AIDS Association (NUAA) - Consumer Rep
9. Lyn Gardner, NUM Northern Drug and Alcohol Clinical Services -
10. Bill Robertson, Manager Drug and Alcohol Services LMNC - Allied Health Rep
11. Marcia Sherring, CNC - Justice Health Rep
12. Paul Gorrick, General Manager, Peel Cluster - Cluster Manager Rep
13. Liaison through Delys Brady, Director Integration and Partnerships, will establish consultation processes with NGOs and GPs.
14. Mental Health – Margaret Terry
15. Hunter Population Health – Karen Nairn
16. Dr. Debbie Jagers – Area Coordinator – Clinical Networks

* Also comprise the Plan Development Team

Appendix 2

Key Stakeholders List

Acute Service Providers

Tertiary and rural referral hospitals
District health services
Community hospitals/MPS
Community Health Services
HNE Health Emergency Departments
HNE Health Disability Services
HNE Health Allied Health Forum
HNE Health Senior Nurses Forum
Child, Young People and Families Area Clinical Network
Mental Health Services
Newcastle Mater Misericordiae Hospital
HNE Health Maternity Services
Universities and other education providers
Pharmacists Hospital based and community
HNE Population Health
Department for Mental Health and Drug and Alcohol, NSW Health
Department of Community Services
Probation and Parole Services
Justice Health
Ambulance Service of NSW
HNE Migrant Health Unit

Consumers

Community Forums on Health
Health Advisory Council
Community Drug Action Team
NUAA

General Practitioners

General Practice Advisory Committee and Divisions of GPs (through Director, Integration and Partnerships)

Committees

Collaborative Mental Health
Aboriginal Mothers and Babies
HNE Health D&A Executive
AOD NGO Forum and relevant support groups

Other

Area Executive Team
Aboriginal Community Controlled Health Services
NSW Police
Aboriginal Partnership Group

Appendix 3

**Hunter New England Area Health Service
Drug and Alcohol Clinical Services
Consumer Interview Form**

Date interview conducted

___ / ___ / _____ (DD / MM / YYYY)

Interviewer: _____

Responder

- 1 = An individual community member
- 2 = Representative of an Aboriginal organisation
- 3 = Representative of a Multicultural organisation

Responder gender

- 1 = Male
- 2 = Female
- 3 = Other

Town where you live? Include postcode

Thank-you for agreeing to participate in this survey. This will be used to assist in the planning process for Drug and Alcohol Services across HNE Health. Your views are important to us. However, we will not be able to deliver everything that people request and must deliver services within our funding guidelines. In circumstances where the results indicate a need, this information could be used to support requests for funds.

Please circle appropriate answers

What Drug and Alcohol Clinical Services are you engaged with?

1. Needle Syringe Program
2. Detoxification
3. Counselling
4. Pharmacotherapy
5. MERIT
6. Other
7. None

What was / would be your aim of going into treatment for Drug and Alcohol problems

1. Abstinence
2. Control use
3. Reduce use

Please circle the appropriate rating:
What is important about this service?

Staff attitudes and values

- | | | | | |
|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Staff Communication

- | | | | | |
|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Involvement in developing your treatment plans

- | | | | | |
|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Capacity to give feedback to service

- | | | | | |
|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Keeping costs low in regards to
 Travelling to get to the program

- | | | | | |
|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Cost of being on the program

- | | | | | |
|--------------------------|-----------------|----------------------------------|--------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Waiting times

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Where the service is located

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Access to Mental health Services

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Support for complaints

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Confidentiality

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Comments

Accessing services

Imagine that you knew somebody that you thought might have a drug or alcohol problem. Where would you send them for help? **(Record just one answer)**

Why did you choose this particular service (or other contact)?

Are there any kinds of Drug and Alcohol services missing in the Hunter New England Area – things that we need, but don't have?

- 1 = Yes
- 2 = No

If yes: record in the following table.

Describe the type of service that is needed
 Specify WHERE this is geographically – in one Local Government Area, all Hunter New England, etc?
 Record any other relevant comments

Type of service	Where is this service needed (geographically)?	Any other comments

Drug and Alcohol Services will be utilising different ways to deliver services to remote areas. These include

- i. Telehealth - This service is provided by using a videoconference screen to review a client's /patient's ongoing health care needs. A worker will be present with the client throughout the interview and the doctor or another clinician will dial in from another site.
- ii. Teleconference - This service involves counselling/case-management over the telephone.

Would you use these services, if they were available? (Please circle one)

- i. Telehealth - Yes = 1 No = 2
- ii. Teleconference - Yes = 1 No = 2

If no: please explain the barriers to using this service.

Would you participate in videoconference or telehealth if delivered by the following health workers:

- iii. Doctor - Yes = 1 No = 2
- iv. Other worker - Yes = 1 No = 2

Barriers to accessing services

Some people do NOT turn to the services for help. If we want to do something about that, we need to understand why. Below is a list of possible reasons. Can you tell me which ones YOU think may apply?

Because they are unwilling or afraid to admit they have a problem

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because they don't have transport to get to the services

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because they can't afford to pay for it

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because the services have long waiting lists

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because they have had a bad experience with service (like discrimination), or have heard of someone else who did

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because they don't know where to go

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because they are afraid of losing their kids

- 1 Strongly disagree**
- 2 Disagree**
- 3 Neither agree or disagree**
- 4 Agree**
- 5 Strongly agree**

Because other commitments make it difficult to go (eg. no child care)

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Because they are afraid that other people in their community will find out about their problem if they go to a local service

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Because they lack effective English language skills

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Which one do you think is the MOST important and why?

Is there anything missing from this list?

- 1 = Yes
- 2 = No

If yes: what?

Anything else you want to tell us.

THANK-YOU FOR YOUR TIME

If you are Aboriginal or Torres Strait Islander could you please answer the questions on the following two pages. (Pages 8 and 9)

If you have a multicultural or linguistically diverse background could you please answer the questions on the next two pages. (Pages 10 and 11) Aboriginal or Torres Strait Islander Cultural appropriateness of services

The following questions have been developed in consultation with Awabakal Aboriginal Medical Service (AMS) and Aboriginal Health Coordinator, NUUA and members of the Core Planning Group for the Drug and Alcohol Plan. Question to be answered only by Aboriginal or Torres Strait Islander people.

Most people agree that services need to be “culturally appropriate” – but it isn’t always clear what that means they should actually DO. I’m going to read out some ideas. Which ones do YOU think would make a service “culturally appropriate”?

Having an Aboriginal or Torres Strait Islander staff member to help clients (either on site or available to be contacted for advice or to come out)

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Teaching staff about Aboriginal issues (“cultural awareness training”)

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Putting up local Aboriginal art or posters in the reception area

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Asking every client that comes in if they are Aboriginal or Torres Strait Islander, then making sure that their cultural needs are met

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Being flexible in the way that services are provided – such as going out into the community or into homes

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Working in Partnership with Aboriginal organisations to make sure that the community is involved in planning services

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Making sure that services think about the whole person – thinking about social, financial, emotional and spiritual issues as well as health

1
Strongly
disagree

2
Disagree

3
Neither agree
or disagree

4
Agree

5
Strongly
agree

Anything else you want to tell us.

THANK-YOU FOR YOUR TIME

Multicultural appropriateness of services

The following questions have been developed in consultation with Multicultural Service, NUUA and members of the Core Planning Group for the Drug and Alcohol Plan. Questions to be answered only by people with a multicultural background.

Most people agree that services need to be “culturally and linguistically appropriate” – but it isn’t always clear what that means they should actually DO. I’m going to read out some ideas. Which ones do YOU think would make a service “culturally appropriate”?

(NB CALD Cultural And Linguistic Diversity – culturally and linguistically diverse background)

Having a staff member from a CALD background or MHLO (Multicultural Health Liaison Officer) to help clients (either on site or available to be contacted for advice or to come out)

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Providing staff with cultural awareness or cultural sensitivity training

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Providing professional health care interpreters to facilitate communication between yourself and the CALD client

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Asking every client that comes in if they are from a CALD background, then making sure that their cultural needs are met

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Being flexible in the way that services are provided – such as going out into the community or into homes

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Working in Partnership with ethnic (culturally and linguistically diverse) organisations to make sure that the community is involved in planning services

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Making sure that services think about the whole person – thinking about social, financial, emotional and spiritual issues as well as health

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Anything else you want to tell us.

THANK-YOU FOR YOUR TIME

Appendix 4

Related Policies and other Documents

- 1 NSW Policy for the Use of Buprenorphine in the Treatment of Opioid Dependence, Circular 2001/84
- 2 National Clinical Guidelines and Procedures for the Use of Buprenorphine in the treatment of Heroin Dependence
- 3 Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment of Opioid Dependence, National Drug Strategy
- 4 Methadone Maintenance Treatment Clinical Practice Guidelines, NSW Health
- 5 NSW Health Dosing Facilities in Public Hospitals for Patients on Opioid Treatments
- 6 NSW Health Opioid Dependent Persons Admitted to Hospitals in NSW – Management
- 7 NSW Health Availability of Dosing Places for Released Inmates on Substitution Pharmacotherapies
- 8 NSW Health Methadone Clinic Accreditation Standards
- 9 Detoxification Clinical Practice Guidelines, NSW Health
- 10 NSW Health Withdrawal Management Guidelines
- 11 The Needle and Syringe Program Guidelines for Police
- 12 The Management of People with a Co-Existing Mental Health and Substance Use Disorder NSW Health
- 13 NSW Heroin Overdose Prevention and Management Strategy
- 14 NSW Health Psychostimulants Strategy 2003-2007
- 15 Alcohol and Other Drugs Policy for Nursing Practice in NSW Clinical Guidelines 2000-2003, NSW Health
- 16 Clinical Guidelines for Nursing and Midwifery Practice in NSW – Identifying and Responding to Drug and Alcohol Issues (Draft)
- 17 Alcohol and Other Drugs Policy for Nursing Practice in NSW A Framework for Progress, 2000-2003 NSW Health
- 18 Policy for Identifying and Responding to Domestic Violence (Amended) 2006
- 19 Interagency Guidelines for Child Protection Intervention 2000
- 20 NSW Health Frontline Procedures for the Protection of Children and Young People
- 21 HNE Mental Health Services Plan (Draft)
- 22 Clinical Management of Patients with Possible Suicidal Behaviour or who are at Risk of Suicide (HAHS)
- 23 Parenting Services Plan (Southern Sector) Kaleidoscope HNE Health 2006 – 2010
- 24 Families First Plan (HAHS) 2005 - 2008
- 25 NSW Health Perinatal Aboriginal Health Report (2003)
- 26 Aboriginal Affairs Plan 2003 – 2012: Two Ways Together (2002)
- 27 D&A Parenting Guidelines (2006) National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn
- 28 Hepatitis C Strategy 2006-2009, NSW Health
- 29 National Hepatitis C Strategy 2005 - 2008
- 30 HIV/AIDS Strategy 2006-2009: Overview and Action Plan NSW Health
- 31 Operational Guidelines – Non Government Organisations Grant Program NSW

Health

- 32 Report of Reviewable Deaths in 2005 Volume 2: Child Deaths November 2006
- 33 NSW HIV/AIDS, STI and Hepatitis C Strategies: Implementation Plan for Aboriginal people 2006-2009.
- 34 National Guidelines for the use of Naltrexone
- 35 Amphetamine, Ecstasy and Cocaine: a prevention and treatment plan 2005-2009
- 36 Child Protection Service Plan 2004-2007 NSW Health 2004

Appendix 5

HNEH DRUG & ALCOHOL CLINICAL SERVICES (DACs)

ORGANISATIONAL STRUCTURE

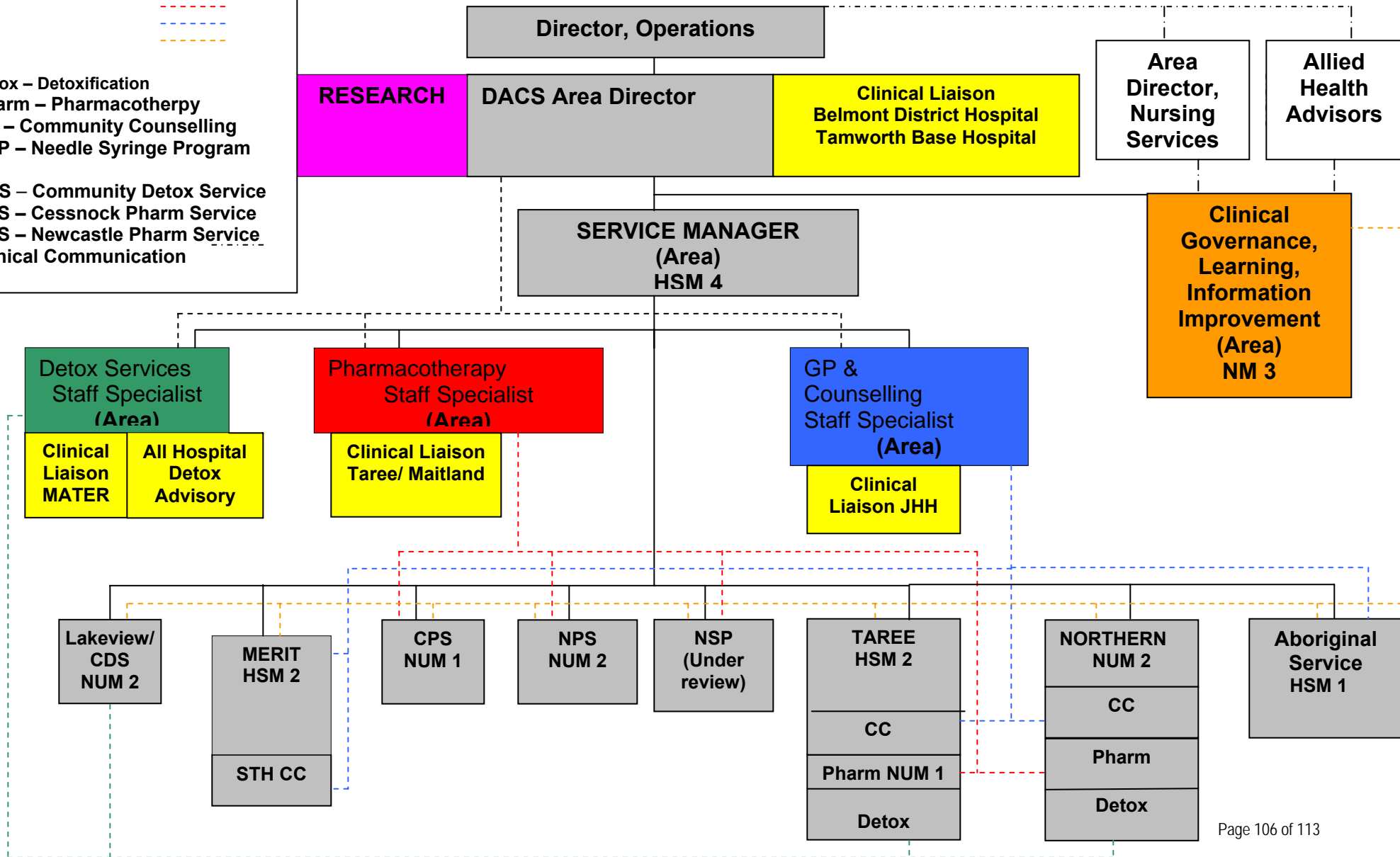
LEGEND

Operational Management ———

Clinical Leadership - - - - -

Detox – Detoxification
 Pharm – Pharmacotherapy
 CC – Community Counselling
 NSP – Needle Syringe Program

CDS – Community Detox Service
 CPS – Cessnock Pharm Service
 NPS – Newcastle Pharm Service
 Clinical Communication



Appendix 6

Aboriginal Health Impact Statement

HNE HEALTH DRUG AND ALCOHOL SERVICES PLAN

Have all items of the checklist been reviewed and answered?

Yes

Will this policy, program or strategy significantly affect the health* of Aboriginal people?

Yes

Is this policy, program or strategy likely to lead to a change in the nature or level of resources or health services available for Aboriginal Health?

Yes.

Drug and Alcohol Clinical Services will employ an Aboriginal Manager who will be located at Tamworth and co-ordinate an Aboriginal Drug and Alcohol Team and service delivery area wide. The rationale for this is

- Creation of a specific Aboriginal team to promote staff retention, development and support
- Ensuring that services are culturally appropriate
- Ensuring vertical and horizontal integration of service delivery and planning
- Providing a structured and coordinated approach to drug and alcohol and health initiatives in the Aboriginal community.

Statement

The health needs and interests of Aboriginal people have been considered, and where relevant, incorporated and appropriately addressed in the development of the Hunter New England Health, Drug and Alcohol Clinical Services Area Wide Plan

Head of Unit Name: Scott McLachlan

Unit Name: Director of Operations, Primary and Community Networks

For Aboriginal people, health is defined as not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.

Development of the Policy, Program or Strategy

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy?

Yes. There has been appropriate broad representation in the Plan development from the HNE Director of Aboriginal Health and, Drug and Alcohol Clinical Services Aboriginal Health Education Officers, to Aboriginal Medical Services across the area.

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development?

Yes

- An Aboriginal health representative is a member on the core planning group
- Director of Aboriginal Health has distributed document to Aboriginal Medical Services and Hunter New Health Strategic partners
- Consumer survey contained Aborigine specific questions and feedback
- Representation from staff of Aboriginal descent in Drug and Alcohol Clinical Services at two day staff planning workshop, staff workforce surveys and feedback on the draft plan.

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders?

Yes

4. Have these processes been effective?

Yes

- Recommendations from Aboriginal health staff and the core planning group representative have been incorporated into the plan as well as results and feedback from the consumer survey. Specific strategies include:
 - o Work with Hunter New England Health Aboriginal Health and Aboriginal Liaison Officers both internal and external to DACS
 - o Improve referral pathways between Aboriginal specific services such as Aboriginal Medical Services and DACS
 - o Submit funding applications as appropriate for identified gaps in service delivery e.g. consultation and liaison services, Aboriginal Health Education officers

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies?

Yes. Links have been made to:

- National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009
- National Aboriginal and Torres Strait Islander Social Survey 2004-2005
- NSW Aboriginal and Torres Strait Islander Agreement
- Aboriginal Health: Strategic Plan, NSW Health 1999
- Two Ways Together Families and Communities Action Plan 2005-2007
- Overcoming Indigenous Disadvantage: Key Indicators Report 2003
- National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003
- Aboriginal Mental Health Policy: A Strategy for delivering Mental Health Policy 2005
- Aboriginal Chronic Conditions Area Health Service Standards 2005
- Participation of Aboriginal people in the MERIT program, NSW Attorney General's Dept., Dec. 2006.

6. Has the policy, program or strategy been endorsed by the NSW Aboriginal Health Partnership/Local Aboriginal Health Partnership where required?

N/A

Contents of the Policy, Program or Strategy

7. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services?

Yes. The Drug and Alcohol Services Plan recognises the need for improved referral pathways to specific services and for services to be developed and delivered in partnership with Aboriginal Health Services in a culturally appropriate way.

8. Have these effects been adequately addressed in the policy, program or strategy?

Yes

9. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy?

Yes. The Aboriginal Manager for Drug and Alcohol Services will be involved in the development of annual operational plans for each of the streams within Drug and Alcohol Clinical Services

Implementation and Evaluation of the Policy, Program or Strategy

10. Will implementation of the policy, program or strategy be support by an adequate allocation of resources specifically for its Aboriginal health aspects?

Yes. The plan identifies the need for additional resources to implement initiatives to meet the needs of the Aboriginal population of the Hunter New England. Most of the initiatives will be implemented using existing resources and a business case will be developed for those requiring enhancement funding.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders?

Yes

12. Does an evaluation plan exist for this policy, program or strategy?

No. This will be developed as annual operational plans for service streams are developed.

13. Has it been developed in conjunction with Aboriginal stakeholders?

No. This will occur in consultation with the development of the annual operational plans.

Appendix 7

HNE HEALTH RISK MATRIX

CORPORATE CONSEQUENCE	Serious	Major	Moderate	Minor	Minimum
	<p>Patients with Death unrelated to the natural course of the illness of the illness and differing from the immediate expected outcome of the patient management or:</p> <p>Suspected suicide Suspected homicide National Sentinel Events</p> <ul style="list-style-type: none"> -Procedures involving the wrong patient or body part -Suspected suicide in hospital -Retained instruments -Unintended material requiring surgical removal -Medication error involving patient death -Intravascular gas embolism -Haemolytic blood transfusion -Maternal death associated with labour and delivery -Infant discharged to the wrong family 	<p>Patients suffering a major permanent loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following:</p> <ul style="list-style-type: none"> • Suffering significant disfigurement as a result of the incident • Patient at significant risk due to being absent against medical advice • Threatened or actual physical or verbal assault of patient requiring external or police intervention 	<p>Patients with Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following:</p> <ul style="list-style-type: none"> • Increased length of stay as a result of the incident • Surgical intervention required as a result of the incident 	<p>Patients requiring Increased level of care including:</p> <ul style="list-style-type: none"> • Review and evaluation • Additional investigations • Referral to another clinician 	<p>Patients with No injury or increased level of care or length of stay</p>
	<p>Community: Childhood vaccination coverage of target groups fall below levels where epidemics can occur. Inadequate planning and preparation for the Avian Influenza Pandemic. Failure to reduce the risk of Chlamydia transmission in the community. Failure to reduce the gap in health and well being between Aboriginal and Non-Aboriginal people.</p>	<p>Community: Failure to reduce childhood obesity rates. Inadequate compliance with Smoke Free Environment Act and Tobacco Regulations in terms of Public Health Act. Failure to use Population Health information in agency decision making . Breakdown in organisational capacity to identify, assess and respond to Aboriginal Health priorities.</p>	<p>Community: Failure to influence main stream managers to take responsibility for integrated service delivery to the Aboriginal Population which results in core business issues not being incorporated into appropriate operational committees and expert working groups.</p>	<p>Community: Heightened Community Concern, Cluster Manager review leading to service improvement.</p>	<p>Community: Community inconvenience not related to safety, quality or clinical outcomes</p>
	<p>Reputation and Partnerships: Loss of Reputation or Image. External Investigation or Ministerial Inquiry</p>	<p>Reputation and Partnerships: Public Outrage, Media Outcry. NSW Health Inquiry. Failure to meet health service standards and loss of accreditation.</p>	<p>Reputation and Partnerships: Loss of Consumer Confidence. CE Internal audit or review. Regulatory Breach or High Priority Improvement Notice.</p>	<p>Reputation and Partnerships: Heightened Consumer Concern, Review or assessment that identifies system deficits that need /rectification.</p>	<p>Community and Partnerships: Consumer annoyance or not related to safety, quality or clinical outcomes</p>
	<p>Staff: Death of staff member related to work incident, or suicide, or hospitalisation of 3 or more staff</p>	<p>Staff: Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention</p>	<p>Staff: Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff</p>	<p>Staff: First aid treatment only with no lost time or restricted duties</p>	<p>Staff: No injury or review required</p>
	<p>Visitors: Death of visitor or hospitalisation of 3 or more visitors</p>	<p>Visitors: Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution</p>	<p>Visitors: medical expenses incurred or treatment up to 2 visitors not requiring hospitalisation</p>	<p>Visitors: Evaluation and treatment with no expenses</p>	<p>Visitors: No treatment required or refused treatment</p>
	<p>Services, Equipment and Products: Complete loss of service or output. Unserviceable equipment or products that could lead to patient death. Loss of essential services.</p>	<p>Services, Equipment and Products: Prolonged reduction in full scope of service provision. Unserviceable or poorly design equipment or products that could lead to patient injury.</p>	<p>Services, Equipment and Products: Interrupted reduction in service provision. Unserviceable equipment or products that could lead to inappropriate therapy, misdiagnosis, surgical intervention or increased length of stay.</p>	<p>Services, Equipment and Products: Minor disruption in service provision. Unserviceable equipment or products that could lead to additional patient investigations, compromised sterility, incomplete or unclear instructions</p>	<p>Services, Equipment and Products: No loss of service. Unserviceable equipment or products that pose no risk to patients, staff, visitors or the health service.</p>
	<p>Financial: loss of or damage to assets or investments with replacement value Greater than \$1M</p>	<p>Financial: damage to assets or loss of investments with replacement value \$100 – \$1M</p>	<p>Financial: damage to assets or loss of investments with replacement value \$10K – \$100K</p>	<p>Financial: damage to assets or loss of investments with replacement value \$5- Less than \$10K</p>	<p>Financial: damage to assets or loss of investments with replacement value No cost.</p>
	<p>Environmental and Disaster Management: Toxic release off-site with detrimental effect. Fire requiring evacuation</p>	<p>Environmental and Disaster Management: Off-site release with no detrimental effects or fire that grows larger than an incipient stage</p>	<p>Environmental and Disaster Management: Off-site release contained with outside assistance or fire incipient stage or less</p>	<p>Environmental and Disaster Management: Off-site release contained without outside assistance</p>	<p>Environmental and Disaster Management: Nuisance releases</p>

CONSEQUENCES TABLE

CONSEQUENCE

LIKELIHOOD TABLE

PROBABILITY	DEFINITION
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

ACTION REQUIRED TABLE

RISK ESCALATOR/ACTION REQUIRED
<p>Extreme Risk Escalate risk to Chief Executive SAC1 immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.</p> <p>High Risk Escalate risk to Director SAC2 need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.</p> <p>Medium Risk Escalate risk to Service or Hospital Manager SAC3 management responsibility must be specified – Aggregate data then undertake a practice improvement project. Exception – all financial losses must be reported to senior management</p> <p>Low Risk Escalate risk to immediate supervisor SAC4 manage by routine procedures – Aggregate data then undertake a practice improvement project</p> <p>NB: RIB reports are completed for SAC 2, 3 or 4 incidents if there is the potential for media interest or they require direct notification under legislative reporting or policy directives.</p>

CORPORATE RISK MATRIX

Determine the consequences before the likelihood of an event occurring

CONSEQUENCE \ LIKELIHOOD	Serious	Major	Moderate	Minor	Minimum
Frequent	A	B	J	P	S
Likely	C	D	K	Q	T
Possible	E	H	L	R	U
Unlikely	F	I	N	V	X
Rare	G	M	O	W	Y

