Drug and Alcohol Plan

2000 – 2003

February 2001

(This Plan covers the period from July 2000 to June 2003)

South Western Sydney Area Health Service

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1 FOREWORD

The South Western Sydney Area Health Service Drug and Alcohol Plan 2000 – 2003 has been developed by a range of service providers from the Area Health Service, Non Government Organisations and the General Practice Unit.

The Plan recognises the importance of reducing the uptake of harmful drug use and preventing the harms arising from alcohol and other drug use. A number of population groups in South Western Sydney need improved access to a range of drug and alcohol services including ATSI, NESB and young people, women and the unemployed and people with both drug and alcohol and mental health problems. The Plan also recognises the special needs of the children and families of people who require treatment.

The Plan aims to increase access to a range of quality treatment and prevention services. Consulting and working with consumers, communities and key partnerships will be a key feature of the implementation of the plan. The Area Health Service will strengthen its key partnerships with General Practitioners, Community Pharmacies, Non Government Organisations and Local Government.

The Plan recognises the need for the health service as a whole to address problems arising from alcohol and other drug use. It will provide increased support to generalist health services to work with clients who have drug and alcohol problems. This will ensure early access to information on prevention and to an appropriate range of treatment services. The Area Health Service will work with key partners to improve the quality of services, increase access to services and build on opportunities for health gain.

The Plan is consistent with the NSW Drug Treatment Services Plan 2000 – 2005 and the implementation of the Plan will be greatly enhanced by funding from the NSW Drug Summit.

MR IAN SOUTHWELL
Chief Executive Officer

2 EXECUTIVE SUMMARY

The harmful and hazardous use of alcohol, illicit drugs and pharmaceutical drugs have been identified as the major causes of drug related harm, which require treatment and prevention in South Western Sydney.

Two frameworks have informed the development of the 2000/2003 Drug and Alcohol Plan. These are the "Framework and Scope for Prevention of Alcohol and Other Drug Related Harms" and the "Framework for Treatment" for people who have experienced those harms.

These Frameworks also reflect the principles of "an Australian approach to reducing the harm caused by drugs" outlined in the National Drug Strategic Framework (NDSF) and the SWSAHS principles of acceptability, equity, efficiency and effectiveness. These principles informed the prioritisation for service development and comprehensive strategies outlined in the Plan. The principles include evidence based practice, harm minimisation and an approach which is coordinated, integrated, balanced and based on partnerships and social justice.

A number of key issues have been identified for the implementation of the plan. These include

- Coordination, integration and quality improvement
- Implementation of the Drug Summit outcomes through key partnerships including the expansion of pharmacotherapy services and places, ambulatory detoxification services and improved information systems and coordination of access to treatment services
- Meeting the needs of children and families
- Improved services for people with substance abuse problems and mental health disorders
- Client payment fees for Drug Treatment Services
- Bankstown Sector Health Service
- Capital infrastructure costs
- Service viability for Non Government Organisations
- Attraction and retention of staff
- Research and evaluation

These issues will be addressed through the implementation of the comprehensive strategies for prevention and treatment and identified recommendations for resources required.

3 GLOSSARY OF TERMS

Ambulatory services are usually provided within a home setting.

Case Management services ensure clients of drug treatment services are managed in a holistic way including counselling, referral and other practical assistance.

Detoxification is the management of physical withdrawal from a drug of dependence so that the associated risks are minimised. This may be provided on an inpatient, ambulatory or outpatient basis.

Drug Action Teams have been formed within local government areas and include a number of government and non government agencies working together to address problems arising from the use of particular Drugs and Alcohol.

Drug Treatment Services provide a number of pharmacotherapies, counselling and case management.

Economic Harms relate to the financial burden of drug use on the individual and society, eg loss of productivity in the workplace, increased insurance premiums.

Harm minimisation is a policy framework which aims to minimise or reduce the harms resulting from drug use. The policy aims to reduce the harms to the user or people within the community in which they live.

Health Education Officer denotes an award not necessarily a common role. These officers generally provide health promotion services but are used in a range of other roles within Drug and alcohol services.

Health Harms include health risks associated with drug use, eg cirrhosis of the liver, lung cancer, accidents.

Illicit drugs are not legally available and include heroin, amphetamines, cannabis

Licit drugs are legally available drugs including tobacco, alcohol, pharmaceutical drugs and caffeine.

Pharmaco-therapies include methadone maintenance, naltrexone, buprenorphine and other therapies as they become available.

Prevention strategies aim to reduce the harms associated with alcohol and other drug use.

Primary prevention is aimed at forestalling the commencement or reducing the likelihood of using alcohol and other drugs.

Residential Rehabilitation this form of treatment is based on the principle that a structured drug free residential setting provides an appropriate context for clients to address the underlying causes of their addictive behaviour.

Secondary prevention aims to reduce the harms associated with the use of alcohol and other drugs.

Social Harms relate to the social impact of drug use on relationships, families, friends, eg alcohol related violence, family breakdown.

Tertiary prevention is aimed at reducing complications and includes any measures available to reduce impairments and disabilities and minimise suffering.

4 ABBREVIATIONS

ACHAC	Area Child Health Advisory Committee
AET	Area Executive Team
AHR	Area Human Resources
AIHW	Australian Institute of Health and Welfare
ALOS	Average Length of Stay
AOD	Alcohol and Other Drugs
ATSI	Aboriginal and Torres Strait Islander
CEO	Chief Executive Officer
CNS	Clinical Nurse Specialist
D&A	Drug and Alcohol
D&AAC	Area Drug and Alcohol Advisory Committee
DACIS	Drug and Alcohol Clinical Information System
DCP	Director, Community Paediatrics
DD&A	Director, Drug and Alcohol Services
DDP	Director, Division of Planning
DET	Department of Education and Training
DISC	Drug Intervention Service Cabramatta
DHP	Director, Health Promotion
DOH	Department of Health
DS	Drug Summit
FTE	Full Time Equivalent of a Staff position
GMs	General Managers
GPs	General Practitioners
HEO	Health Education Officer
HRDS	Human Resources Development Service
IDUs	Intravenous Drug Users
NDARC	National Drug and Alcohol Research Centre
NDSF	National Drug Strategic Framework
NDSHS	National Drug Strategy Household Survey
NESB	Non-English speaking background
NGO	Non Government Organisation
NHMRC	National Health and Medical Research Council
NSP	Needle Syringe Program
SWS	South Western Sydney
SWSAHS	South Western Sydney Area Health Service

5 INTRODUCTION AND OUTLINE TO THE PLAN

The South Western Sydney Area Health Service Drug and Alcohol Plan 2000 – 2003 provides clear directions for its drug and alcohol prevention and treatment services to the year 2003. The Plan provides a summary of the operating environment for Drug and Alcohol services in section 6. A summary of the current services available within the South Western Sydney area and the identified gaps in services are identified sections 7. Greater detail of sections 6 and 7 is provided in the Background papers

The Plan is based on two frameworks developed for South Western Sydney. These are the "Framework and Scope for Prevention of Alcohol and Other Drug Related Harms" and the "Framework for Treatment" for people who have experienced those harms. These Frameworks are attached in the Background Papers to this Plan and are briefly outlined in the Plan in section 8. The key issues for improved quality service provision and health outcomes are identified in section 9.

South Western Sydney Area Health Service (SWSAHS) has identified a comprehensive range of strategies to improve the coordination and integration between its treatment and prevention services. The treatment strategies will result in improved quality of service and increase clients' timely access to appropriate services. Strengthening partnerships with General Practitioners and Community Pharmacies will increase clients' access to treatment services. The prevention strategies will involve close partnerships at the local level to address a range of prevention concerns. The comprehensive strategies section of the Plan will provide a working document for Area and Sector business planning and implementation (Section 10). Consultation with consumers and community groups will inform the development of services. Effective partnerships between the Area Health Service and key stakeholders will be crucial for the implementation of the Plan. Key stakeholders include General Practitioners, Community Pharmacies, Non Government Organisations (NGOs) and other local and state government services. The resources required to implement these strategies are identified in section 11.

5.1 Background

The Area Health Service began a range of planning processes for improving services following the NSW Drug Summit in August 1999. A Planning Steering Committee was established with a reference group each for prevention and treatment services. Membership of the reference groups and the Steering Committee included Area and Sector representatives from SWSAHS, NGOs and the General Practice Unit based at Fairfield Hospital. The reference groups worked together to develop the Frameworks and related comprehensive strategies. The Steering Committee oversighted the development of the Plan and reported to the Area Drug and Alcohol Advisory Committee.

The 1999 Drug Summit provided an injection of funds to the Area Health Service over three years commencing in1999/2000. These funds will ensure the achievement of many of the planned strategies to improve drug treatment and

rehabilitation. Additional funding is expected following evaluation of the funded programs and confirmation of their efficacy.

The Area Health Service has a number of plans or projects related to the Area Drug and Alcohol Plan. The Tobacco Control Health Improvement Plan is being implemented as a specifically funded project, oversighted by the Director, Health Promotion Unit. Some strategies of this Plan relate to the Blood Borne Viruses planning and the Families First projects. The detailed planning for these strategies is the responsibility of the Director of Public Health and the Director of Community Paediatrics. The areas of overlap are mentioned in this Plan as appropriate.

5.2 Scope of the Plan

This Drug and Alcohol Plan identifies a comprehensive range of strategies for prevention and treatment of hazardous and harmful use of licit and illicit drugs and other substances. These strategies are based on a partnership approach and the principles of harm minimisation. The plan recognises the need for public health initiatives such as the provision of needle syringe service (NSP) and Drug Treatment Services to address the harms arising particularly from illicit drug use. This approach reflects the key features of success of the National Drug Strategy 1993 – 97 identified by Single and Rohl[1].

Licit drugs are legally available and include tobacco, alcohol and pharmaceutical drugs. This Drug and Alcohol Plan does not address tobacco related harms as these are covered by the Tobacco Control Health Improvement Plan. Illicit drugs are not legally available and include heroin, cannabis, amphetamines and cocaine. Other substances include inhalants and kava. Hazardous use of drugs exposes the user to the risk of some harm and harmful use of drugs results in harm to the individual or their family or the community. Hazardous and harmful use of drugs may relate to the amount consumed over time. However the harms arising from drug use may be social, economic or legal as well as physical. Those experiencing the harm may include the user, their family or friends and community members.

For the purpose of the 2000/2003 SWSAHS Drug and Alcohol Plan, the harmful and hazardous use of alcohol, illicit drugs and pharmaceutical drugs have been identified as the major causes of drug related harm, which require treatment and prevention in South Western Sydney.

5.3 Principles for service development

The frameworks for prevention and treatment of alcohol and other drug related harms have been developed on the basis of achieving maximum health gain for the South Western Sydney community as a whole and for individual clients, their families and friends. These Frameworks also reflect the principles of “an Australian approach to reducing the harm caused by drugs” outlined in the National Drug Strategic Framework[2] (NDSF) and the SWSAHS principles of acceptability, equity, efficiency and effectiveness. These principles informed the prioritisation for service development and comprehensive strategies outlined in the Plan and are described as follows:

5.3.1 Harm minimisation - This includes supply and demand reduction strategies for illicit and licit drugs and a range of harm reduction strategies for particular individuals and communities. Harm minimisation, as defined by the NDSF, "includes preventing anticipated harm as well as reducing actual harm";

5.3.2 A coordinated, integrated approach - This is essential to achieving ***efficiency*** and ***cost effectiveness*** in service provision. This approach needs to be implemented both within health related services and across related areas of law enforcement, criminal justice, education and other government, private and local community agencies and groups;

5.3.3 A partnership approach - There is a wide range of partners. This is essential as a basis for coordination and ensuring a balance between ***effectiveness*** and ***acceptability*** of strategies to the community as a whole. Partnerships are to be sought from the range of identified organisations and also from research organisations, business and industry affected communities such as drug users and those affected by drug related harm;

5.3.4 A balanced approach - Reducing drug related harm caused by both licit and illicit drugs is essential to achieving health gain. While most supply reduction strategies for illicit drugs fall within the realm of the police service to address, it will be important to ensure adequate communication between the police and health services to ensure an appropriate balance between ongoing public health initiatives and law enforcement;

5.3.5 Evidence based practice - This is crucial to ensure ***effectiveness*** of interventions in the achievement of positive health outcomes. This Plan recognises that funding for research and evaluation of health interventions has targeted particular interventions and that a range of accepted practice interventions have never had funding for evaluation. This Plan seeks to outline a planned development of services and programs which are evidence based. Where this evidence is not within the public realm, the Plan identifies the need for services to evaluate interventions in terms of the achievement of health gain;

5.3.6 Social Justice - This principle is fundamental to the achievement of ***equity*** of access to services and to maximise the equity of health gain. The NDSF states that "although drug related harm can affect any individual, family or community, patterns of such harm show that particular communities and population groups are more affected than others". Thus strategies must address the "needs of and problems facing the affected community".

Other factors taken into account when prioritising the comprehensive strategies included the need to ensure the:

- strategies identified support these principles and the Area Health Service's key principles and challenges identified in the Strategic Directions Statement and Implementation Plan 1998 – 2003; [3]

- implementation of the Drug Summit funding allocation; staffing and infrastructure is sufficient to implement the Plan; and quality of service through research, evaluation and training and development of staff.

Strategies were identified as high priority if they needed action in the short term, either as part of the Drug Summit funding or they were considered essential to the achievement of the overall direction of the Plan

6 OPERATING ENVIRONMENT

The need for a Drug and Alcohol Plan to address the harms arising from alcohol and other drug use is evident from an assessment of the South Western Sydney demographic profile, patterns of alcohol and other drug use and relevant indicators of harm arising from this use. This section identifies key target groups. Greater detail of the particular needs of these key target groups and the associated pattern of use is provided in the Background documents.

6.1 South Western Sydney's Demographic Profile

SWSAHS's population is projected to grow by 14.9% from 731,615 in 1996 to 840,680 in 2006. SWSAHS comprised 11.8% of the total 1996 NSW population and will be the most populous Health Service by 2006 with 12.5% of NSW's population. The demographic characteristics of SWS indicate the residents have more social disadvantage than other areas in NSW [4]:

- Young population (24.5% aged less than 15 years compared with 21.4% for Sydney);

- Aboriginal or Torres Strait Islander descent (1.2% compared with 0.57% for the rest of Sydney). SWSAHS also has 25% of Sydney's Aboriginal population;

- 34.4% of the SWS population was overseas-born compared to 23% for the rest of NSW, with even higher rates in Fairfield (53.5%), Liverpool (35.1%) and Bankstown (33.2%) LGAs;

- 28.5% of the SWSAHS population is from a non English speaking background compared to 15.7% for NSW. 36.5% of the population speak a language other than English at home compared to 18.1% for the rest of NSW);

- In relation to levels of education attained only 0.7% of the SWSAHS population had higher degree qualifications compared to 1.6% for NSW. 5.4% had post graduate diploma or bachelor degree qualifications compared to 9.3% in NSW;

- Unemployment (10.8% for SWSAHS compared with 8.8% for NSW);

- The SWSAHS population has a higher proportion of persons with incomes less than $31,200 (18.4% for SWSAHS compared to 16.9% for NSW) and a lower proportion of persons with incomes above $52,000 (2.6% for SWSAHS compared to 3.9% for NSW);

- Large population living in public housing with 10.1% for the SWSAHS population compared with 5.7% for NSW);

- 3.1% of the population received a disability support pension, 1.0% receive a carer's pension and 5.1% of the population are considered the Home and Community Care (HACC) target population.

6.2 Indicators of Drug Related Harm

The National Drug Strategic Framework outlines a range of indicators of drug related harm. It notes that:

- Tobacco smoking and alcohol are the primary and secondary preventable cause of death and hospitalisation. Alcohol is one of the most important risk factors in injury among adults and adolescents and is the major threat to public safety through violence, property loss or damage;

- Use of benzodiazepines among young people who inject drugs is a serious clinical problem with one third of injecting drug users using benzodiazepines;

- Since 1988 there has been a steady increase in the number of opioid overdose fatalities among people aged 15 to 54 years. There is a growing trend of poly drug use especially by people using heroin;

- Economic costs of over $18 billion per annum are associated with harmful drug use including prevention, treatment, loss of productivity in the workplace, property crime, theft, accidents and law enforcement activities; and

- In addition to economic and health costs of harmful drug use there are social costs for families and other relationships. Children over 14 years in families where a parent used the same drug were no more likely to smoke tobacco or consume alcohol. However, they were 27% more likely to use cannabis and 55% more likely to use other illicit drugs than young people whose parents did not use those drugs.

Drug related crime is a problem within SWSAHS. There has been a growth of 33% in the incidence of this crime between 1995 and 1997 attributable to possession and dealing in narcotics in the Fairfield local government area and Cabramatta in particular [5].

6.3 Key target groups for prevention and treatment services

When reviewing the patterns of alcohol and other drug use and the access to services a number of key target groups emerge who require a particular focus for prevention and treatment services. These include young people, people of Aboriginal and Torres Strait Islander background, people of Non English Speaking Background, women, children of people participating in the Drug Treatment Program, and the unemployed, people with substance use disorders and Mental Health problems. As indicated in 6.1 these are population groups of significant size in SWSAHS.

7 CURRENT SERVICES

The treatment and prevention services provided within South Western Sydney are fully described in the Background documents to this Plan. This identifies the service utilisation and types of prevention programs offered through South Western Sydney. Comparison between the services is difficult, as even same type services operate differently and data is recorded differently. Table 1 summarises the existing and Drug Summit funded services by Service Type and by Sector. An additional table (2) summarises the identified gaps in services and recommendations for service development.

Table 1: Summary of Current and Drug Summit funded Service Types by Sector

Service Type x Sector	Bankstown	Liverpool	Fairfield	Macarthur	Winge-carribee
Population					
1998	167,837	137,066	190,920	222,745	39,346
2006	166,291	171,303	197,042	249,687	46,363
TREATMENT SERVICES					
Counselling					
Designated Counsellors	2 FTE - CHC	1.5 FTE - CHC	2 FTE - CHC 2 FTE - DISC 1 FTE - Youth H	4 FTE - CHC 1 FTE - Youth H	1 FTE - CHC
Counselling Equivalents	.8 FTE Youth H		2 FTE - DISC		
ATSI counselling equivalent			.2 FTE - D&A/ mental health	1 FTE - Youth focus	
NGO Counselling Equivalents			1.35 FTE - SWAP .4 FTE - CCC		

Service Type x Sector	Bankstown	Liverpool	Fairfield	Macarthur	Winge-carribee
Drug Court Counselling Equivalents		4 FTE - Services the whole of SWSAHS			
Total counselling FTE	2.8 FTE	1.5 FTE & 4FTE for Area Drug Court Program	8.95 FTE	6 FTE	1 FTE
Needle exchange					
Outreach outlets	1	1	3	0	1
Secondary outlets	1	4	2	3	2
Syringe vending machines	0	1	0	3	1
Detoxification (Corella Lodge provides an Area wide inpatient service)					
Inpatient Detoxification	In hospital	In hospital	Corella Lodge	In hospital	In hospital
Ambulatory Detoxification	DS Funding 2000/01	DS Funding 2000/01	DS Funding 2000/01	DS Funding 2000/01	DS Funding 2000/01
Pharmacotherapies Methadone etc					
Existing places & services		281 - Jacaranda Early childhood nurse clinic Hepatitis B&C screening and vaccine program GP Shared Care (D&A Hospital & Mental Health Liaison Service & Drugs in Pregnancy Service are provided by the Area D&A Centre)		198 - Coopers Playgroup, Immunisation Drugs in Pregnancy Service Hepatitis B&C screening and vaccine program GP Shared Care D&A Hospital & Mental Health Liaison Service	

Service Type x Sector	Bankstown	Liverpool	Fairfield	Macarthur	Winge-carribee
Additional Places - funded by Drug Summit 2000/01	50 from Liverpool to be located at Bankstown when viable this will rise to 80 when further funds are available for 2001/2002	50	300	88	
Additional GP / Community Pharmacy places				61 across the area	
Residential Rehabilitation					
NGOs services		1 – Grow (targets people with mental health & substance abuse disorders)		1 - Odyssey House	
Specialist Drug & Alcohol Services and Related Services (Area Drug and Alcohol Centre and Corella Lodge provide Area wide services.)					
Medical Officers Specialist Nurses Treatment Services for people with Mental Health and substance abuse disorders	Mental Health funds an Area CNC for people with substance abuse and mental health disorders.	3 MO - D&AC Senior Nurses - 3 - D&AC 1 - Drug Court All area positions Adhoc Mental Health liaison mechanisms established	I MO - Corella 1 Nurse – DISC Adhoc Mental Health liaison mechanisms established	Adhoc Mental Health liaison mechanisms established	Adhoc Mental Health liaison mechanisms established
General Practitioners & Community Pharmacies					
Accredited General Practitioner	4	1	4	2	6
Community Pharmacies	12	9	11	11	7
Drug Court program					
Adult Program		See counselling & specialist services			

Service Type x Sector	Bankstown	Liverpool	Fairfield	Macarthur	Winge-carribee
Youth Drug court Program	Access to Area counselling & day programs	Residential service Access to Area counselling & day programs	Access to Area counselling & day programs	Access to Area counselling & day programs	Access to Area counselling & day programs
NGO Youth Drug Court counselling and day programs			1 – Open Family	1 - Tharawal	
Accommodation					
Proclaimed Places Refuges	1	1 1		1 1	
Other support agencies					
NGOs not funded by SWSAHS			Open Family	Burnside works with Coopers Cottage	
PREVENTION SERVICES					
Area Wide services					
Tobacco prevention positions (area wide) AOD Link Network		2.5 FTE (1 targets the Vietnamese community)		AOD Link is Coordinated by NGO	
Youth Services					
Prevention equivalents	1 FTE		1 FTE	1 FTE	
Sector Health Services					
Designated Prevention				1 FTE	
Prevention NGOs					
Designated Prevention			1.6 - CCC	3 - Mac D&AYP 2 - Syd City Mission	
Locality Prevention Partnerships					
Drug Action Teams - Premiers Dept	1		1		

Service Type x Sector	Bankstown	Liverpool	Fairfield	Macarthur	Winge-carribee
Place Management projects		Miller		Claymore Macquarie Fields	
NGO Sponsored Place / School Management				1 - Camden	1

7.2 Summary of identified gaps in services

Area and Sector Services and Non Government Organisations have identified a number of gaps in the provision of drug and alcohol treatment and prevention services. The Planning Steering Committee members reviewed these gaps and the priorities for resource requirements (outlined in Section 11) were based on consultation for the draft plan. The service gaps and recommendations are summarised in table 2 and include:

Table 2:

Program Area	Gaps in services - Assessment / Comment	Recommendation for funding
Counselling and Day programs	There is a need for a male and female ATSI D&A Counsellor in Macarthur and the northern sectors Liverpool and Bankstown Sectors are significantly disadvantaged in terms of the number of counsellors available. Bankstown Women's Health Centre has identified the need for women to access a female drug and alcohol counsellor. DISC has identified the need for additional counselling services in Stages 5 and 6	4 ATSI positions (unsourced) Liverpool 2.5 counsellors Bankstown 1.2 counsellors (unsourced) 1.6 counsellors (unsourced)
Needle Syringe Program	DISC has identified the need to expand their needle syringe program as part of their expanded (Stage 4) services	$60,000 goods and services (unsourced)
Detoxification Services	The need for ambulatory detoxification services was recognised by the Drug Summit There is a need for expanded inpatient detoxification services at Corella Lodge	Ambulatory Detox services to be funded by Drug Summit $211,360 (unsourced)
Pharmaco-Therapies	Additional methadone places and an expansion of services to the existing methadone clients including existing and future clients at all Sectors of GPs and Community Pharmacies. There is a need for new Drug Treatment Services to be established at Fairfield and Bankstown.	Expansion of services and methadone places and the establishment of new Drug Treatment Services in Fairfield and Bankstown (sourced - Drug Summit)

Program Area	Gaps in services - Assessment / Comment	Recommendation for funding
Residential Rehabilitation Services	There is a need for additional residential rehabilitation beds	5 beds for Odyssey House ($ 118,625 pa. sourced - Drug Summit)
Specialist Drug and Alcohol Clinical Services	There is a need to establish • treatment services for people with mental health and substance abuse disorders in 4 sectors • D&A Consultation and hospital/ GP liaison nursing services at Liverpool and Campbelltown • Treatment coordinator • D&A Consultation and hospital/ GP liaison nursing services at Bankstown and Bowral • An additional staff specialist • Medical training position (registrar) • Expanded medical and nursing services at DISC Stage 5& 6	$210,000 required for 3.5 Mental Health positions (possible source - Mental Health) Liv & Ct positions (sourced - Drug Summit) Treatment coord- inator - part sourced by DS 2 CNS positions (Bankstown high priority) - unsourced 1 Staff specialist position & 1 registrar - unsourced DISC - 1 nurse and .8 medical officer position - unsourced
General practitioners and Community Pharmacies	There is a need to establish better liaison with General Practitioners and Community Pharmacies	(sourced – within new services Drug Summit funds for hospital / GP liasion services)
Drug Courts Program	The Adult Drug Court program needs to continue operation to the end of the trial evaluation period. Future funding would be dependent on a positive evaluation. Funds are available to establish a Youth Drug Court residential and counselling program.	Continued operation for trial period (source not yet established - Drug Court funds and existing resources) Establish Youth Drug Court Program (sourced - Drug Summit, $60,000 for counsellor and residential funding to be established)
Other support services	There is a need to establish formalised links with other support services	Can occur within existing resources
Accommodation	There is a need to negotiate better access to refuge accommodation by young people There is a need for a proclaimed place for women	Can occur within existing resources Unsourced
Prevention services	There is a need to establish a number of prevention services including • a prevention coordinator • additional prevention positions to be established in sectors with no designated prevention resources eg Bankstown, Liverpool and Wingecarribee • Expansion of prevention services at DISC as part of the overall expansion of DISC services in stage 5	1 coordinator - unsourced Establish prevention positions at Bankstown, Liverpool and Wingecarribee - unsourced Establish 3 prevention positions at DISC - unsourced

8 PROPOSED SERVICES AND OPPORTUNITIES FOR HEALTH GAIN

As indicated, this Plan is based on two framework documents developed for South Western Sydney. These are the "Framework and Scope for Prevention of Alcohol and Other Drug Related Harms" and the "Framework for Treatment" for people who have experienced those harms. These documents are available separately to this Plan. However, the Frameworks and their proposed service strategies are briefly outlined below.

8.1 Framework & Scope For Prevention Of Alcohol And Other Drug Related Harms

8.1.1 Prevention

The aim of prevention is to improve health, social and economic outcomes by preventing and reducing drug use and its related harms. Drug related harms can occur to the individual or to the broader community and have health, social or economic impact.

The Prevention Framework incorporates all levels of prevention: primary, secondary and tertiary.

- **Primary prevention** is aimed at forestalling the commencement or reducing the likelihood of using alcohol and other drugs.

- **Secondary prevention** aims to reduce the harms associated with the use of alcohol and other drugs.

- **Tertiary prevention** is aimed at reducing complications and includes any measures available to reduce impairments and disabilities and minimise suffering.

8.1.2 Who Benefits from Prevention?

Everyone benefits from the prevention and reduction of alcohol and other drug use. Prevention can be primary targeting of the general public or a whole population that has not been identified on the basis of individual risk. National youth alcohol campaigns are examples of prevention strategies that address whole populations. Community development programs are examples of prevention strategies that address the general public in a particular area. Secondary prevention benefits individuals or subgroups of a population whose risk of developing drug related harm is higher than average, such as young males with a history of binge drinking. Finally, prevention can benefit high risk individuals who are identified as having an existing drug and alcohol use problem by reducing further harmful effects through, for example, needle exchange or smoking cessation programs.

8.1.3 The Prevention Focus – Using a Range of Strategies

In the past, prevention strategies have focused on school based drug education, mass media campaigns and so on and were largely information based. This focus on the individual ignored the larger impact that other influences, such as the environment, have upon an individual's choice to use or not use drugs. Consequently current prevention approaches include community development projects, targeted mass media campaigns, restrictions on advertising and packaging and other regulatory approaches such as reducing access to alcohol and other drugs, distribution of information, compulsory health warnings on tobacco products, as well as school based drug education.

Prevention approaches that address a combination of the principles will be more effective than those that address a principle in isolation. Approaches targeting the social, cultural, economic, natural and technical environments and which involve a relatively broad range of political, legislative and administrative strategies have been found to have a greater impact and be sustained.

Prevention initiatives should be designed to alter both risk and protective factors. Prevention strategies need to address the critical transitional periods for individuals or groups. These are identified in the Framework as early life / childhood, adolescence and adulthood. Working with the Community and through communication strategies was identified as providing effective strategies.

8.1.4 Recommended Prevention Strategies

The resources available for drug and alcohol prevention in South Western Sydney were initially expanded in the early nineties, but have declined over the last four years. Pressure to address treatment issues has resulted in a reallocation of resources away from prevention. In the last 12 months South Western Sydney Area Health Service has maintained or made commitments to prevention strategies which address harm arising from usage of tobacco and intravenous drugs and in the early childhood field.

This Plan recognises that many mainstream services and community development programs such as the Claymore and Miller "Place projects" provide an opportunity for interventions to address drug and alcohol problems. The Plan recommends a range of strategies identified as best practice, which target the community as a whole, adolescents and adults. This Plan also recognises the limited resources to address prevention at this level. Therefore the strategies identified are not prescriptive, but provide a framework for strategic action at the Area and Sector level and for Non Government Organisations funded through the Area Health Service.

There is a need to address prevention strategies at a number of levels. Forums within South Western Sydney such as the Chief Executive Officer's Forum and the Drug Action Teams initiated by the Premier's Department were identified as the major mechanism for setting appropriate policy and a strategic means of providing healthier environments within South Western Sydney. The Chief Executive Officer's Forum identified drug and alcohol issues as a priority for action, prior to the Drug Summit. This Forum will provide the high level support required for implementation of an intersectoral approach at the Sector or Drug Action team level. The proposed expansion of the Drug Action Team approach from Fairfield to Bankstown and across the Area Health Service will provide a momentum for cooperation within other Sectors to focus to prevention. Other community and school based initiatives such as the Wingecarribee and Camden projects provide another level on which to address prevention. This Plan recommends the establishment of a prevention coordination position and the adoption of a broad range of strategies.

8.2 Brief Outline of the Framework for Treatment and its infrastructure Requirements.

The Framework for treatment services across SWS proposes a network of client focused services. This recognises that clients may access treatment services through any one of a range of services and that they may enter and leave the network many times. The proposed Framework encourages clients to enter the network through a service, which suits their preference, their special needs, the extent and stage of their drug usage and their readiness to change that drug usage. The Framework is based on the range of services identified by the NSW Drug Treatment Services Plan[5]. These have been defined here as:

- Counselling, Welfare and Day Programs including Community Health, DISC and NGOs;
- Needle Syringe program;
- Detoxification services including designated residential detoxification services, within mainstream hospital beds, outpatient and home based services;
- Pharmacotherapies including Methadone Maintenance Services ;
- Residential Rehabilitation services;
- Specialist Drug and Alcohol Clinical services;
- General Practitioners and Community Pharmacies;
- Diversional programs such as the Drug Court Program.

In the last two years, South Western Sydney has initiated DISC, two designated detoxification programs, the Drug Court diversion program and increased collaboration with General Practitioners who are accrediated as Methadone prescribers and Community Pharmacies. The establishment of these services has increased SWS residents' access to a locally based, comprehensive range of services. The Area Health Service will form key partnerships with General Practitioners and Community Pharmacies to provide pharmacotherapy services to clients who have been stablised in the public clinics. The Framework for Treatment articulates opportunities for greater coordination and integration of services across the network of services. It identifies service principles for key services and the strategies identified are designed to improve the quality of all service provision.

The Framework recognises that a number of services not provided under the Health portfolio also provide essential support for clients participating in or seeking treatment. As such there needs to be improved coordination with support services such as:

- Accommodation, Hostels and proclaimed places;
- Other non government services and self help groups; and
- Interagency Networks.

In order for the Framework to operate effectively there are a number of infrastructure requirements, which are common across the model of service. These include:

- The establishment of an effective data base for monitoring and evaluation; and
- The development of an effective referral systems into drug and alcohol services and a generic assessment system between drug and alcohol services.

The Figures 1 and 2 provide a picture of how these services would interrelate. Figure 1 describes the Model of Care for Public Pharmacotherapy Clients in SWSAHS and Figure 2 describes the Model of Care for Drug and Alcohol Treatment Services in SWSAHS.

Figure 1

MODEL OF CARE FOR PUBLIC PHARMACOTHERAPY CLIENTS IN SWSAHS
Including four locally based public or not for profit Drug Treatment services

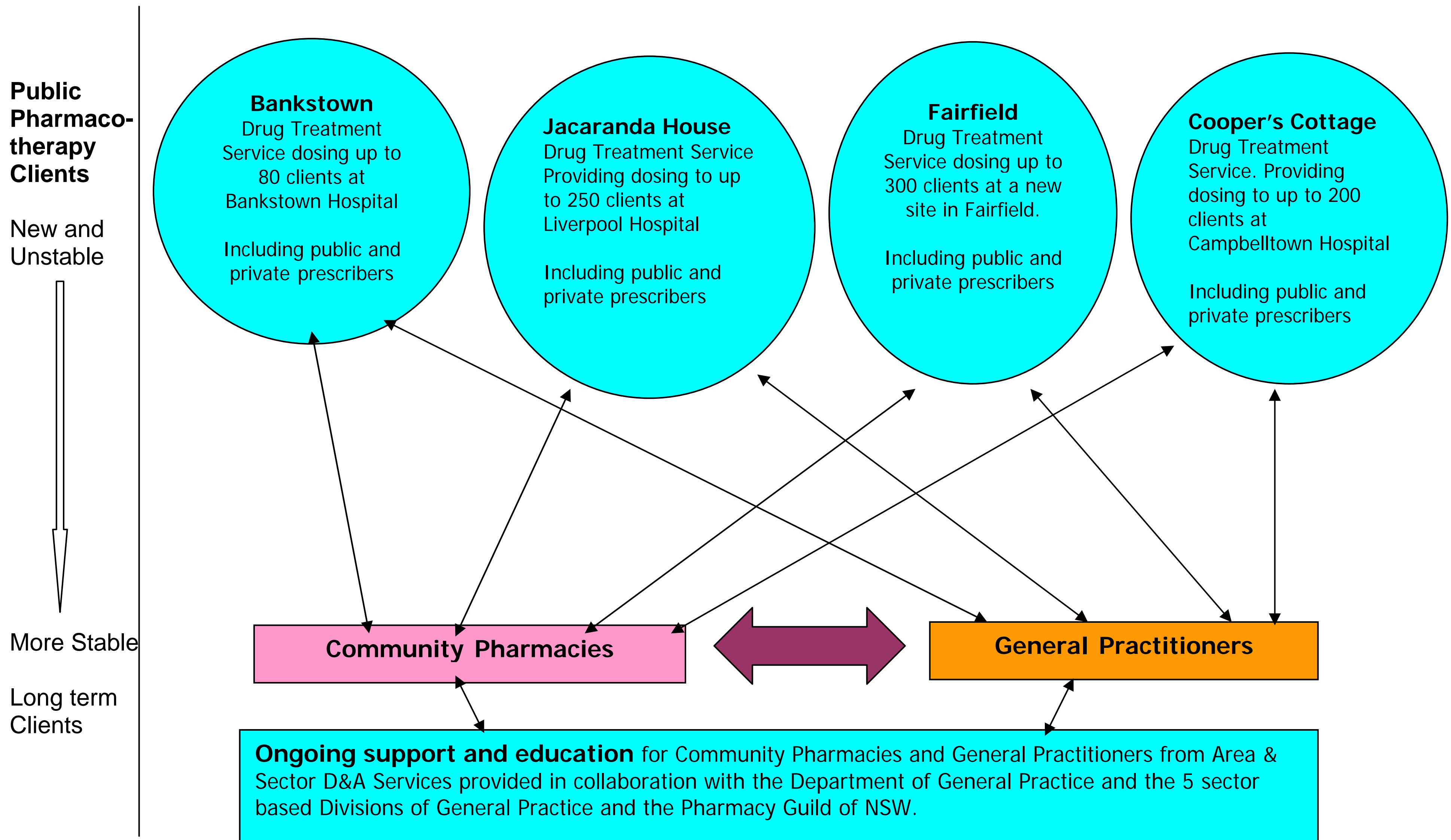
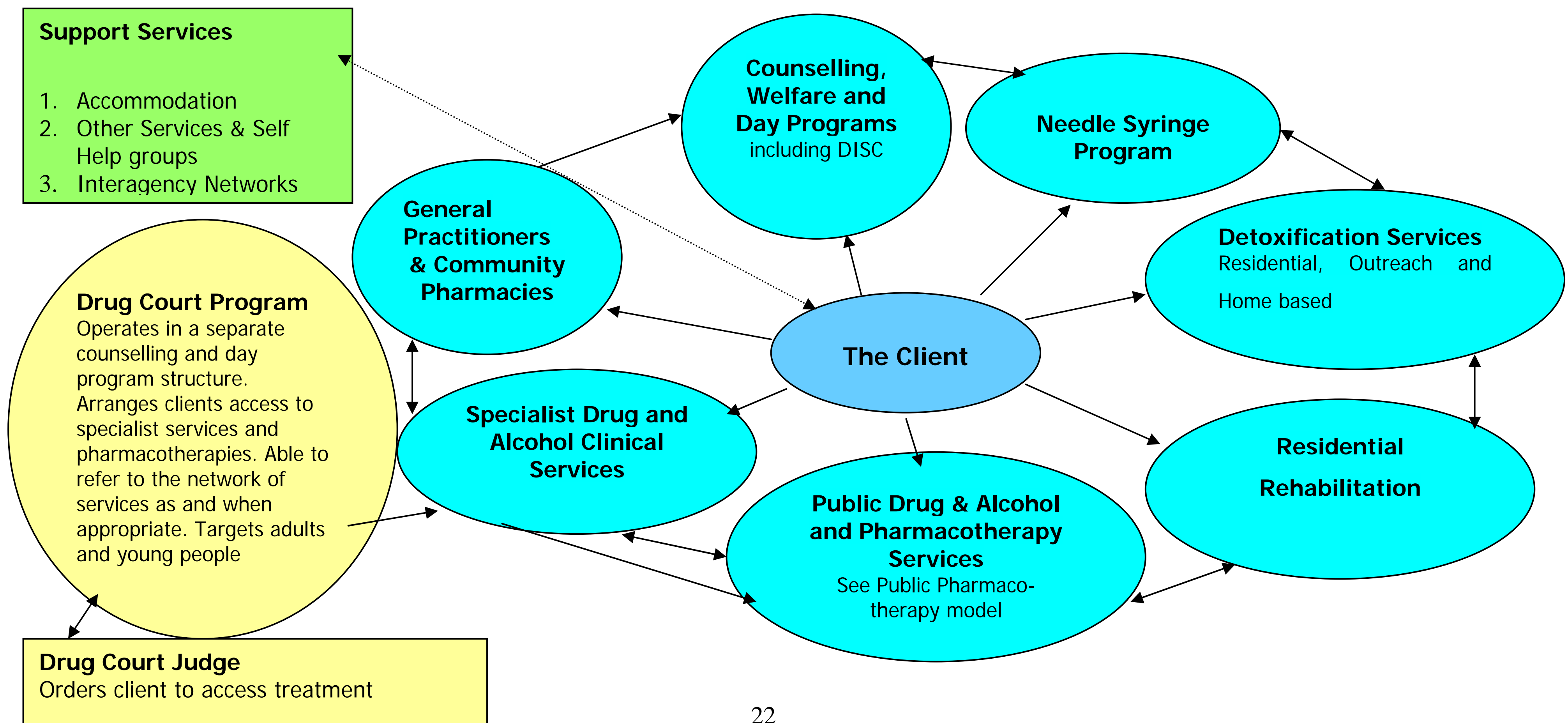


Figure 2

MODEL OF CARE FOR DRUG AND ALCOHOL TREATMENT SERVICES IN SWSAHS

Drug and alcohol treatment services will operate as a local network of services.

- The model recognises that clients may enter and leave the network many times
- This model encourages clients to enter the network through a service, which suits their preference, needs, drug usage and level of dependency and stage of readiness to change.
- Service providers should assess clients and facilitate clients' referral to other parts of the network by implementing strategies to improve coordination and integration between the services.
- Clients may access private methadone and rapid detoxification services independently of this model



9. KEY ISSUES FOR SERVICE DEVELOPMENT AND HEALTH GAIN

The planning process for the Drug and Alcohol Plan has been informed by consultation with service providers regarding the experience of their clients in accessing services. Two separate reference groups for treatment and prevention have had input to the Plan and the final result has been overseen by a Planning Steering Committee. The reference groups and Steering Committee have identified the following as key issues to be addressed by this Plan.

9.1 Coordination, Integration and Quality Improvement

Consultation with service providers identified the need for improved coordination and integration of treatment services. There is need to streamline clients' access to a continuum of care and ensure the achievement of better quality outcomes. The current system of intake and assessment means that clients' access to services may be ad-hoc. The Drug Summit recognised clients' need for information about services and to simplify their access to treatment services. A treatment access coordinator position has been funded to June 2001. This position will develop an effective triage and information system for services operating in South Western Sydney and facilitate referrals and other links between treatment services including Area services and NGOs.

This Plan identifies the need to establish two ongoing coordination positions, one to focus on treatment and the other to focus on prevention. A clinical Director manages the Area drug and alcohol services. As it has been difficult to attract sufficient clinicians to SWSAHS, the clinical demands on the Director's time leave little time for the coordination function of the Director's role. The coordination positions would have the responsibility to ensure greater integration between services and to facilitate quality improvement throughout treatment and prevention services.

9.2 The need for a balance between prevention and treatment services

The need for a prevention coordinator to ensure coordination of prevention services and additional positions to support prevention in three Sectors was also identified. The Area Health Service previously had a prevention position which fulfilled the coordination role but this position is now unfunded. The major focus of most health services is treatment or tertiary level prevention. The Drug Summit has identified the need for locally based Drug Action Teams to address a range of issues including prevention. This is difficult given the limited infrastructure for prevention services.

9.3 Implementation of the Drug Summit outcomes through key partnerships

The Drug Summit has provided $2,808,219 funding over three years for a range of services to be managed by the Area Health Service. Future funding is reliant on the achievement of performance outcomes. Improved case management and partnerships with General Practitioners and Community Pharmacies will provide the basis for achieving these outcomes. The services are listed below in 9.3.1, 9.3.2 and 9.3.3.

9.3.1 Expansion of Pharmacotherapy services and places

The Drug Summit identified the need for funding of additional Pharmacotherapy places and the expansion of services for clients receiving Drug Treatment Services to include case management and counselling. Service level targets have been set for the additional places and the expansion of services. These funds will enable the Area Health Service to address the need to take a more holistic approach to service provision for clients of the Drug Treatment Services. In particular the Fairfield area was noted by the Drug Summit as requiring a 'not for profit service". To date 450 additional places have been funded. Separate to this the Area Health Service has identified the need to establish a smaller Drug Treatment and counselling service in the Bankstown sector. This is in keeping with the SWSAHS Framework for Treatment that recognises the need to stabilise clients in the public sector and once stable facilitate clients' access to General Practitioners and Community Pharmacies. Funding is provided to support this partnership approach to care.

9.3.2 Ambulatory Detoxification Services

The Drug Summit also identified the need for ambulatory detoxification services and has set service level targets. The funding for this has been allocated until June 2001. This program will be trialed across the Area, targeting the general population and young Indo Chinese people in Cabramatta. This trial will be evaluated and used as the basis for future recommendations for funding and direction setting.

9.3.3 Improved Information Systems and Coordination of Access to Treatment Services

The need for improved information systems was identified in the planning process as a very high priority. None of the existing information systems provide readily collectable and accurate data either describing process information (ie which services are provided, to whom and why) or identifying the outcomes of treatment. As noted above, the Drug Summit has funded a new minimum data information system and the temporary provision of a coordinator to improve access to treatment services. The localised central access system will ensure potential clients access to a triage system and provide daily information about what services are available across the Area Health Services and NGO treatment services. This position will be used to improve coordination of treatment services.

The NSW Drug Treatment Data Set will provide both State and National Minimum data. It will include about 20 items of process information. This has been implemented from July 2000 using temporary manual or electronic systems. The software for this is being developed and will be implemented in 2001 as part of the core module of a Drug and Alcohol Clinical Information System (DACIS). DACIS will provide additional outcomes modules which will be used to monitor treatment outcomes such as reduced drug usage and impact on quality of life following methadone treatment, detoxification and

other treatment services. These modules may take up to eighteen months to be developed to implementation stage.

9.4 Meeting the Needs of Children and Families

The planning process recognised the needs of the children and families of people who are using substances in a manner which is harmful to their health or social wellbeing. There is a need for health services to address these needs and to provide a more holistic service for the whole family.

In particular the methadone services will strengthen their efforts to meet the needs of the children of their client group through provision of playgroups, access to immunisation and other child health and social services. Cooperation with Non Government Organisations and links to the Families First program is seen as a key factor in this process.

The planning process also recognises the needs of the adult family members and friends of people who are using substances to a harmful degree. This may include partners, parents, siblings and adult children. Family members and friends can potentially provide valuable support and a stable environment for the person, which can be enhanced if they have a better understanding of the problems and strategies for addressing drug and alcohol problems.

9.5 Improved Services for People with Substance Abuse Problems and Mental Disorders

The planning process recognised the need to establish stronger links between mental health and all levels of the drug and alcohol services. This would ensure improved outcomes for people with multiple problems, particularly substance abuse problems associated with mental disorders. Treatment of the mental disorder is likely to reduce the clients' motivation to abuse substances. This need is recognised by the Area Mental Health and Drug and Alcohol Services and the establishment of a link with the detoxification unit at Fairfield Hospital has been identified as a priority. However each of the Sector Health Services need designated positions to ensure improved liaison and the provision of specialised client services. These services may have a potential funding source through the new Mental Health enhancement-funding program.

9.6 Client payment fees for Drug Treatment Services

The NSW Drug Treatment Plan has identified the need for the NSW Department of Health to investigate the feasibility of introducing a client payment fee for Drug Treatment Services. This may facilitate the movement of clients from the public system to community pharmacies. It may also provide some additional funds to enhance services.

Many clinicians have concerns about charging. In particular the difficulty for new clients who need to stabilise their lives is an issue. Should charging be necessary, it is considered that a period of three months grace should be provided to new clients

in order to stabilise their lives before they are charged for their methadone. In terms of equity it would be more consistent to implement one charging policy across the Area. This would allow for cross subsidisation of newer and smaller services.

9.7 Bankstown Sector Health Service

Bankstown has been identified as a key Sector which lacks sufficient drug and alcohol infrastructure. The Bankstown Drug Treatment service will provide for relatively small numbers (up to 80 places). The Department of Health funding benchmark for the provision of methadone services is limited to $3098 for public clients and $610 for General Practice / Community Pharmacy clients. This will not provide sufficient funding to support the expanded range of services required including appropriate liaison services for the hospital, General Practitioners and Community Pharmacies. There is a need to provide a hospital liaison Clinical Nurse Specialist for this Sector.

9.8 Capital Infrastructure Costs

There is a need for two new Drug Treatment facilities in Fairfield and Bankstown and for refurbishment of the existing methadone clinics in Liverpool and Campbelltown. The Drug Summit funding will provide some funds towards the establishment of the new services, however funding for the Liverpool and Campbelltown refurbishment will need to be provided from the normal capital program.

9.9 Service Viability for NGOs

Four of the seven Drug and Alcohol NGOs funded through the Area Health Service are very small and have only two or three positions. In the last eighteen months, two NGOs identified problems with service viability. By definition service viability means that the cost of providing an existing service have risen and therefore the same level of service cannot be provided within the allocated budget. Both these funding problems have been resolved, but the potential for this to impact on the type and quality of service offered has been raised as a concern in the planning process. This issue needs ongoing monitoring through the Area's NGO management processes. However, there is a need to identify opportunities for outsourcing of drug and alcohol services to ensure sustainability of these services.

9.10 Attraction and Retention of Staff

A number of new Drug and Alcohol services have been established within the Area Health Service and by NGOs in South Western Sydney in the last few years. There has been difficulty in both attracting and retaining staff. The planning process identified the need for staff to expand their skills and to have access to development opportunities as one mechanism for attracting and retaining staff. The additional funds for the Drug Summit initiatives will provide greater employment opportunities for staff. However, there are likely to be difficulties in attracting staff to this field. There is a need to work cooperatively with the Area nursing marketing and

promotion project to attract nursing staff and to identify strategies to make this field of work more attractive.

9.11 Research and Evaluation

The planning process identified a number of areas in which there needs to be ongoing research and evaluation. Improved information systems and potentially single medical records will be the basis of improving the monitoring and evaluation of drug and alcohol services in South Western Sydney. This will provide the basis for both process and impact evaluation of health improvement.

Services within South Western Sydney will identify opportunities to improve services or expand services through specific funding grants. Evaluation of these programs will inform future development. In particular the Division of General Practice, the Division of Population Health and NDARC have received a Commonwealth Department of Health and Aged Care grant to research and evaluate a project on GP management of Illicit Drug problems. This will be conducted in SWSAHS and a rural area over a two-year period.

10 COMPREHENSIVE STRATEGIES FOR PREVENTION AND TREATMENT

The comprehensive strategies for prevention and treatment incorporate the strategies and performance indicators identified in the "Framework and Scope for Prevention of Alcohol and Other Drug Related Harms" and the "Framework for Treatment" for people who have experienced those harms. The strategies are linked to the objectives of the National Drug Strategic Framework (NDSF) and to the six key challenges of the South Western Sydney Area Health Service Strategic Direction Statement and Implementation Plan 1998 – 2003. The implementation and evaluation of the Drug and Alcohol Plan 2000 – 2003, is oversighted and monitored by the Area's Drug and Alcohol Advisory Committee

Key Challenge 1: Working with our community and staff to develop a shared sense of responsibility and direction

Ref	Objective	Strategies Key Challenge 1	Outcome / Performance Indicator - Working with community and staff	Resources	Respon- sibility	Time Frame / Priority
1.1	To increase community understanding of drug – related harm	1.1.1 Provide ongoing information and educational programs for key community groups	• Increased community understanding of drug –related harm and programs to address the harm eg methadone	Existing Resources	DD&A GMs D&AAC	June 01 Medium
		1.1.2 Sectors and Area Drug and Alcohol Service develop a comprehensive communication strategy regarding drug-related harm	• Increased community understanding of the benefits of various programs to reduce drug –related harm eg particularly in sectors establishing new Drug Treatment Services	Drug Summit Project Officer	DD&A GMs D&A AC	June 01 High
1.2	To ensure greater integration and coordination of services	1.2.1 Ongoing consultation and communication between Area / Sector Health Services and NGOs regarding the implementation and evaluation of the plan	• Clear communication, consultation and participation mechanisms established • Sector and NGO Performance Agreements reflect the implementation and evaluation of the Plan	Division of Planning Sector Managers	DD&A DDP GMs	June 01 Medium
			• Establish drug and alcohol area network which meets twice annually			Twice Annually Medium

Ref	Objective	Strategies Key Challenge 1	Outcome / Performance Indicator - Working with community and staff	Resources	Respon-sibility	Time Frame / Priority
1.2 cont	To ensure greater integration and coordination of services	1.2.2 Provide greater coordination between agencies within the Health Service at three levels by establishing 3 positions	• Three coordination positions established. See strategies 1.2.2.1, 1.2.2.2 and 1.2.2.3		DD&A	June 01 and ongoing High
		1.2.2.1 Establish Drug Summit Project Officer position to implement Drug Summit initiatives (Drug Summit funded to June 01)	• Position established and evidence of effective implementation of Drug Summit initiatives	Drug Summit Project Officer	DD&A	June 01 High
		1.2.2.2 Establish Treatment Coordination position to ensure improved integration across treatment services and establish a telephone triage system (Drug Summit funding to June 01) See also strategy 4.2.1	• Position established and evidence of improved integration and coordination across all drug and alcohol treatment services • Provision of daily telephone information and triage for referral to treatment	Treatment Coordinator	DD&A	Ongoing High
		1.2.2.3 Establish Prevention Coordination position (Unsourced) See also strategy 4.2.2	• Position established and evidence of improved integration and coordination of prevention services	Prevention Coordinator	DD&A	Ongoing High

Key Challenge 2: Working in partnership with other agencies to improve health

Ref	Objective	Strategies Key Challenge 2	Outcome / Performance Indicator - Working in Partnerships	Resources	Respon-sibility	Time Frame / Priority
2.1	To strengthen existing partnerships and build new partnerships to reduce drug- related harm	2.1.1 Sectors consult with key stakeholders and adapt models of care to community needs.	• Consultation completed • Model of care adopted and evaluated.	Existing resources and NGOs	GMs	June 01 Medium
		2.1.2 Establish memorandums of understanding between NGOs and SWS Area Health Service to address both prevention and treatment outcomes.	• Memorandums established	Treatment Coordinator and Prevention Coordinator	DD&A DDP	Dec 01 High
		2.1.3 Include NGOs in drug and alcohol planning within sector health services and develop agreed performance indicators.	• Performance indicators for prevention and treatment agreed upon which reflect a balanced approach to reduction of harm associated with licit and illicit drug usage including population health, prevention, early intervention, detoxification, treatment and rehabilitation, education and research.	Sector Managers	DDP GMs	Review Annually Medium
		2.1.4 Review and develop appropriate referral links between partnership agencies	• Evidence of improved referral links between agencies	Drug Summit Project Officer	DD&A	June 01 High

Ref	Objective	Strategies Key Challenge 2	Outcome / Performance Indicator - Working in Partnerships	Resources	Respon-sibility	Time Frame / Priority
2.1 cont	To strengthen existing partner-ships and build new partner-ships to reduce drug-related harm	2.1.5 Sectors and Area Drug and Alcohol Service identify opportunities for partnerships with ethnic specific doctors, religious leaders and organisations representing the interests of young people, people with NESB and ATSI backgrounds, women and other relevant groups.	• Evidence of improved access to prevention and treatment services by NESB and ATSI people, young people, women and other relevant groups.	Existing resources	GMs DD&A	Ongoing High
		2.1.6 Work with Department of Education and Training to identify an appropriate level of cooperation and support for school based prevention and education programs.	• Agreement with DET regarding the cooperation and support for school based prevention programs. • Sector Health Service Agreements developed with DET	Prevention Coordinator	DD&A	June 02 Medium
2.2	To develop and strengthen links with other related strategies	2.2.1 Identify & implement partnerships to address a range of health improvement issues	• Evidence of partnership approach to address health improvement strategies for mental health, infectious diseases, blood borne viruses, cardio vascular disease and stroke	Existing resources	GMs DD&A	Review Annually Medium
		2.2.2 Identify opportunities for partnerships at a range of levels, through mainstream programs such as the Miller and Claymore projects and through the Premier's Department supported Drug Action Teams and programs such as the Wingecarribee and Camden projects	• Evidence of cooperative development to "place improvement" • Evidence of a broad focus to cooperative actions addressing harms associated with licit as well as illicit drug use	NGOs, Sectors and Prevention coordinator	GMs DD&A	Review Annually High

Ref	Objective	Strategies Key Challenge 2	Outcome / Performance Indicator - Working in Partnerships	Resources	Respon-sibility	Time Frame / Priority
2.2 cont	To develop and strengthen links with other related strategies	2.2.3 Provide high level support for intersectorial initiatives 2.2.3 Identify opportunities to work with a range of accommodation services and other human support services to improve practical assistance for people experiencing drug and alcohol related harm.	• Support maintained at CEO Forum and evidence by broad approach to issues. • Evidence of partnerships with agencies which provide practical assistance to clients of the AHS or NGOs	 Existing resources Treatment Coordinator	CEO GMs DD&A	Ongoing High Review Annually Medium
3.1	To reduce the personal and social disruption, loss of quality of life, *loss of productivity and other economic costs* associated with the harmful use of drugs	3.1.1 Provision of a range of prevention and treatment programs which ensure reduction of personal and social disruption, loss of quality of life, *loss of productivity and other economic costs* associated with the harmful use of drugs	• Evidence of reduction of harm associated with usage of illicit drugs, Alcohol, Tobacco, prescribed drugs for clients of the Area Health service and NGOs • Evidence of reduction of harm associated with usage of illicit drugs, Alcohol, Tobacco, prescribed drugs within the community	Treatment Coordinator and Sector Mangers NGO Managers Epi Unit	DHP DD&A	Review Annually Medium As relevant surveys arise Medium

Key Challenge 3: Ensuring that people in SWS access health services according to need

Ref	Objective	Strategies Key Challenge 3	Outcome / Performance Indicator Access according to need	Resources	Respon-sibility	Time Frame / Priority
3.2	To increase access to a greater range of high-quality prevention and treatment services	3.2.1 Area and sector services will adopt prevention and treatment strategies based on appropriate needs assessments and community & client consultations	• Strategies implemented are based on evidence of need and are acceptable to the target population	Existing Resources	DD&A DDP GMs	Ongoing High
		3.2.2 Area and Sector prevention services will adopt a population health approach and implement comprehensive strategies based on the Ottawa Charter.	• Evidence that a comprehensive population health approach is the basis of prevention strategies	Existing Resources	DHP DD&A GMs	Review Annually High
		3.2.3 Area and sector health services in consultation with NGOs review the access to the range of treatment and prevention services and develop protocols for access for sector residents including employment of bilingual and ATSI staff	• Sectors identify and target key groups	Existing Resources	DD&A GMs DDP	June 01 Review Annually High
			• Evidence of improved access to culturally appropriate and innovative services by groups such as NESB, ATSI, Pregnant Women, Women, People with Dual Diagnosis, Unemployed, homeless, working poor and youth, children of drug users.	Drug Summit Project Officer		

Ref	Objective	Strategies Key Challenge 3	Outcome / Performance Indicator Access according to need	Resources	Respon-sibility	Time Frame / Priority
3.2 cont	To increase access to a greater range of high-quality prevention and treatment services (continued)	3.2.4 Sectors to implement the Drug Summit funding program to expand Methadone places within SWSAHS	• Public Drug Treatment Services established as key access point for new clients and clients with complex and unstable conditions	Drug Summit funding for 3.2.4 to 3.2.9	GMs DD&A	June 01 High
		3.2.5. Establish new public Drug Treatment Services at Fairfield and Bankstown	• Service Plans developed for Fairfield and Bankstown Services. • New Public Drug Treatment Services are established and provide expanded places in Fairfield and Bankstown.	Drug Summit Project Officer	GMs DD&A	June 02 High
		3.2.6 Sectors to implement strategies to improve residents access to holistic Drug Treatment Services through public clinics, GP and Community Pharmacies.	• Meet target numbers for expansion of places and expansion of services in the Drug Treatment Services • Sectors to improve counselling and other support services for clients receiving methadone through the public clinics and through the General Practitioners	Sector Managers	GMs DD&A	June 01 High
		3.2.7 Each sector establishes working relationship with GPs and Community Pharmacies to improve access to services by clients requiring Pharmacotherapy treatment.	• Increased numbers of GPs and Community Pharmacies in all sectors providing services to stable clients	Existing resources & GP / Pharmacy liaison CNC	DD&A GMs	June 01 High

Ref	Objective	Strategies Key Challenge 3	Outcome / Performance Indicator Access according to need	Resources	Respon-sibility	Time Frame / Priority
3.2 cont	To increase access to a greater range of high-quality prevention and treatment services (continued)	3.3.8 Each sector involve GPs and Community pharmacies in planning & development of new services	• GPs and Community Pharmacies are involved in planning and development of services	Sector Managers	GMs DD&A	June 01 High
		3.2.9 Sector implement the Drug Summit Funding for Ambulatory Detoxification	• Meet target for clients receiving ambulatory detoxification service	Sector Managers	GMs DD&A	June 01 High
		3.2.10 Area review of best practice models for provision of detoxification services to young people	• Review conducted and strategies recommended	Drug Summit Coordinator	DD&A	June 01 High
		3.2. 11 Sectors regularly review intake system to reduce time clients wait to be seen	• Review of waiting times conducted	Sector Managers	DD&A	Review annually Medium
		3.2.12 Sectors identify opportunities for shared care approaches with other agencies	• Clients of the Area Health Service are able to access more holistic services	Sector Staff Treatment Coordinator	GMs DD&A	Review annually Medium
		3.2.13 Sectors improve linkages with Mental health service and Allied Health Services and other human service agencies	• Improved access to holistic services within the Area Health Service and relevant external support services	Sector Staff Treatment Coordinator	GMs DD&A	June 01 High

Ref	Objective	Strategies Key Challenge 3	Outcome / Performance Indicator Access according to need	Resources	Respon-sibility	Time Frame / Priority
3.2 cont	To increase access to a greater range of high-quality prevention and treatment services (continued)	3.2.14 Establish a Generic Assessment and Triage system for the Area	• Generic assessment and Area Triage system developed • Consumers are able to obtain information and triage regarding their problems within one working day	Treatment Coordinator Sector Staff	DD&A	June 01 High
		3.2.15 Sectors establish day programs and groups if identified by needs assessment	• Day programs and groups provide education and support to targeted groups	Sector Staff	DD&A	Review annually Medium
		3.2.16 Review implications of Child Death review and best practice for neonatal care for children of people abusing substances	• Review conducted and recommendations for action identified • Recommendations for action implemented	Child Health Advisory Committee	DCP	June 01 High June 02
4.1	To improve information technology and shared data bases	4.1.1 Identification of information technology issues and shared data bases required to report provision of effective drug and alcohol services	• Evidence of improved reporting of provision of effective drug and alcohol services.	Treatment Coordinator	DD&A	June 01 High
		4.1.2 Establish planned program to improve data collection for health outcomes	• Implement DACIS information system throughout area health service and NGOs	Core module is funded by Drug Summit	DD&A	July 00 High

Key Challenge 4: Making the best use of and fairly allocating existing and incoming resources

Ref	Objective	Strategies Key Challenge 4	Outcome / Performance Indicator Best & fair use of resources	Resources	Respon-sibility	Time Frame / Priority
4.2	To ensure effective management structures and infrastructure for Drug and alcohol Services	4.2.1 Establish a permanent Treatment Coordinator position See also strategy 1.2.2.2	• Treatment Coordinator established and evaluated	Drug Summit funded to June 01 $60,000 required	DD&A	June 01 High
		4.2.2 Establish a permanent Prevention Coordinator position See also strategy 1.2.2.3	• Prevention Coordinator established	$60,000 required	DD&A	ASAP High
		4.2.3 Establish a Hospital / GP/ Community Pharmacy Liaison CNS position in Bankstown	• Liaison CNS position established • Effective infrastructure established for Bankstown sector	$60,000 required	GM / DD&A	ASAP High
		4.2.4 Establish appropriate infrastructure for implementation of plan	• Infrastructure established according to priority needs and resources available	$3,207,489 unsourced includes above positions	DD&A AET	June 03 High, medium & low

Ref	Objective	Strategies Key Challenge 4	Outcome / Performance Indicator Best & fair use of resources	Resources	Respon-sibility	Time Frame / Priority
4.3	Improve integration between drug and alcohol services	4.3.1 Implement the strategies of the Framework for Treatment including Counselling, Welfare and Day Programs; Drug Court Program; Detoxification Services; Pharmacotherapies; Residential Rehabilitation services, Specialist Drug and Alcohol Clinical Services, General Practitioners and Community Pharmacies; Other Support Services such as Accommodation, Hostels and Proclaimed places and relevant Non Government agencies	• Evidence that strategies were implemented and improved integration between each of the components of the Treatment Model of Care • Evidence of improved linkages with General Practice and Community Pharmacies	Drug Summit Project Officer Sector Managers GP and Pharmacy Liaison CNC and CNS	DD&A GMs	Ongoing Review June 01 June 03 High
4.4	To establish new drug treatment services	4.4.1 Develop procurement feasibility and project definition plans for new drug treatment services at Fairfield and Bankstown	• Procurement feasibility and project definition plans complete as required • Building / refurbishment complete	Division Planning	GM DD&A	Dec 00 High Not before June 02 High
4.5	To ensure a strategic approach to prevention	4.5.1 Sectors develop a strategic approach to prevention with NGOs, through Memorandums of Understanding	• Evidence of a balance approach between primary secondary and tertiary prevention programs.	Prevention Coordinator	GMs	Ongoing review June 01 and 03
5.1	To prevent the uptake of harmful drug use	5.1.1 Targeted prevention strategies to reduce uptake of tobacco, alcohol and illicit drugs	• A range of Prevention strategies are implemented including those targeted to reduce uptake of tobacco, alcohol and illicit drugs • Prevention strategies reduce uptake of more harmful method of illicit drug administration eg transition from smoking to injecting illicit drugs	Sector services & NGOs	DD&A DHP GMs	Review Annually High

Key Challenge 5: Developing effective and efficient health services, which focus on improved health outcomes.

Ref	Objective	Strategies Key Challenge 5	Outcome / Performance Indicator Effective & Efficient - Outcomes	Resources	Respon-sibility	Time Frame / Priority
5.2	To reduce drug related harm for individuals, families and communities	5.2.1 Review roles of counselling / clinical positions in relation to client need for practical assistance and advocacy	• Review completed • Guidelines development and links identified	Existing Resources Treatment Coordinator	GMs DD&A	June 02 Medium
		5.2.2 Ensure effective coordination with appropriate child development / child protection services for children of drug users	• Ensure early identification of Drug related problems and conditions • Evidence that Families First project addresses the needs of Families at Risk	Sector Managers	GMs	June 01 High
		5.2.3 Specialist hospital liaison services are reviewed and expanded to meet the identified needs and ensure opportunistic interventions	• Inpatients access early intervention and referral as appropriate.	Some Hospital liaison within Drug Summit funding	GMs	June 01 High
5.3	To reduce the level of risk behaviour associated with drug use	5.3.1 Provision of effective Needle Syringe program throughout mainstream and drug and alcohol services	• Drug and alcohol services maintain and develop key role in the reduction of the risks of blood borne viruses associated with drug use	Sector Staff	GMs DD&A PHU	Annual Review High
		5.3.2 Strategies implemented to achieve effective management and referral of clients with blood borne viruses	• Mainstream and drug and alcohol services implement the Blood Borne Virus Plan	Sector Staff	GMs DD&A PHU	Annual Review High
			• Hepatitis B immunisation available at all Public Methadone units	Sector Managers	GMs DD&A PHU	Annual Review June 01 High

Ref	Objective	Strategies Key Challenge 5	Outcome / Performance Indicator Effective & Efficient - Outcomes	Resources	Respon-sibility	Time Frame / Priority
5.4	To reduce the risks to the community of criminal drug offences and other drug related crime, violence and anti social behaviour (NDSF 8)	5.4.1 Implement the Adult Drug Court Trial programs through the provision of Drug Treatment, counselling and day programs 5.4.1 Implement the Youth Drug Court Trial programs through the provision of a residential program and counselling and day programs 5.4.2 Cooperate in appropriate partnerships with Police	• Evidence of reduced criminality and improved life skills among participants of Adult Drug Court Programs • Evidence of reduced criminality and improved life skills among participants of Youth Drug Court Programs • Evidence of cooperation on agreed programs	Drug Court Staff Drug Court funding Drug Summit funding Existing resources	GM s DD&A GM s DD&A GM s DD&A	June 01 High June 02 High Ongoing Medium
5.5	To increase evidence based practice throughout treatment and prevention services	5.5.1 Sectors and NGOs develop appropriate evaluation of strategies with reference to defined outcomes	• Evidence of Health Improvement & Evaluation of key programs	Sectors services and NGOs	GMs	Annual Review High

Key Challenge 6: Attracting, developing and retaining the best staff

Ref	Objective	Strategies Key Challenge 6	Outcome / Performance Indicator Attracting & retaining staff	Resources	Respon-sibility	Time Frame / Priority
6.1	To ensure appropriate attraction and retention of staff and Human Resource Development to meet the challenges of the plan	6.1.1 Work with the Area Nurse Marketing and Promotion program to promote nursing in the alcohol and other drug field.	• Improved attraction and retention of nursing staff	Manager, Area Nurse Marketing and Promotion	DD&A GMs	June 01 High
		6.1.2 Work with TAFE, universities and colleges to ensure opportunities for staff development and education.	• Staff have timely access to appropriate and affordable basic training	AD&A Nursing positions HRDU	GMs	Ongoing High
		6.1.3 Identify appropriate type and level of skills required for all positions, provide appropriate orientation and training to both permanent and temporary staff	• Improved profile of drug and alcohol services as a rewarding area of work.	Sector managers Treatment Coordinator	DD&A GMs	June 02 Medium
		6.1.4 Identify opportunities for NGOs to provide services / functions for the Area Health Service	• Opportunities for outsourcing identified	Existing resources	DD&A DD&A GMs	June 01 Medium
		6.1.5 Identify mechanism to financially recognise the skill level of Drug and Alcohol workers without degrees but extensive experience in the field	• Retention of experience and skilled Drug and Alcohol workers	Sector Managers/ HRDU	GMs/ Grading Committee	June 01 High

Ref	Objective	Strategies Key Challenge 6	Outcome / Performance Indicator Attracting & retaining staff	Resources	Respon-sibility	Time Frame / Priority
6.2	To ensure of staff have a range of formal and informal mechanisms available to broaden their skills to meet the challenges of the plan	6.2.1 Trial options such as voluntary rotation of staff between counselling and other treatment services or joint positions	• Nursing staff broaden skill capacity • All participating staff increase knowledge and skills	Sector Managers Area D&A Nursing Positions Treatment coordinator	GMs DD&A GMs DD&A	Ongoing High
		6.2.2 Develop links between counselling and other treatment services	• Improve continuity of care for clients			Ongoing High
		6.2.3 Identify opportunities for consultation and education of existing staff	• Improvement in attraction and development of staff		GMs DD&A	June 01 High
		6.2.4 Ongoing staff supervision and peer support	• Improvement in staff skills and perceived support		GMs DD&A	Ongoing High

Key Challenge 7: Becoming a learning and teaching organisation

Ref	Objective	Strategies Key Challenge 7	Outcome / Performance Indicator Learning and teaching organisation	Resources	Respon-sibility	Time Frame / Priority
7.1	To promote evidence based practice through research and professional education and training	7.1.1 Review treatment and prevention programs to ensure they are evidence based and establish baseline for evaluation of the Strategic Plan	• Baseline for evaluation of plan established	Drug Summit PO Treat & Prev Coords	DD&A GMs	June 01 High
		7.1.2 Support program evaluation and research by staff	• Identify opportunities for funding to meet the gaps in service	Existing resources	DD&A GMs All Staff	Review Annually Medium
		7.1.3 Develop joint research programs with NDARC and other appropriate agencies	• Evidence of evidence based practice • Evaluation of key programs	D&A Unit Sector Managers	DD&A GMs	Review Dec 01 June 03 High
		7.1.4 Work with Universities and colleges to ensure opportunities for appropriate professional education and training for staff.	• Joint research programs • Evidence of improved staff education	Drug Summit project officer	DD&A GMs	Review Dec 01 June 03 High
7.2	To promote mechanisms for the cooperative development, transfer and use of research among interested parties	7.2.1 Establish forum for research into drug and alcohol issues	• Evidence of research on drug and alcohol issues	Existing resources	DD&A GMs	Ongoing Medium

11 RESOURCES REQUIRED

A number of resources are required to implement the Plan. These are outlined below in 11.1, 11.2 and 11.3.

11.1 Drug Summit funding

The Drug Summit has provided a significant injection of funds for the establishment of new treatment services within South Western Sydney to be provided by the Area Health Service and Non Government Organisations. The Area Health Service's direct allocation has provided $2,808,219 funding over a three year period from 1999/2000. Table 3 outlines the funding allocated to date. The service outcomes and future Department priorities will form the basis for further funding following a review in June 2001.

Table 3 Funding allocated to date and client output required

Service	1999/2000	2000/01	2001/02	**Client Numbers	Notes
Fairfield Drug Treatment Services service	$350,000	$350,000	$538,000	300	$400,000 to be raised for full service
Minimum Data and Information Service	$25,000	$60,000			
Ambulatory Detoxification	$100,000	$200,000		500	Ongoing funding subject to future priorities
Expansion of Methadone services - case management	$257,810	$343,789		150	This includes service provision to clients of GPs and Community Pharmacies
Expansion of Methadone Places	$123,920	$464,700		150	Further funding expected in 2001/02

** Client numbers required are based on a full year of service in 2000/01 or 2001/02 for the Fairfield Service

The Drug Summit recognised the need for additional residential rehabilitation services which are illicit drug specific. Odyssey House has been provided $118,625 annually from 2000/01 to fund 5 additional beds through the NGO grant program. The Drug and Alcohol NGO administered by the Area Health Service were provided with $213,600 over four years to improve their information technology and infrastructure from 1999/2000. This will facilitate their participation in the Minimum Data and Information Service. The Drug Summit funding allocation to NGOs within SWS totals $569,475 over 4 years from 1999/2000

11.2 Additional Funding Requirements - Funding Sourced

The Area Health service has identified a number of additional funding requirements including additional Drug Treatment Services and places and ongoing participation in the Adult and Youth Drug Court Programs.

A second rollout of Drug Summit funding is expected in 2001/02. This will include approximately 50 to 80 additional Methadone places and further expansion of existing services. Only 50% of the existing Drug Treatment Services are funded for expanded services. A similar amount of funding would be expected to fund the expansion of services to the other 50% of existing methadone places.

The Adult Drug Court Program received funding of $650,000 per annum over a two year trial period. However the Department of Health is currently considering the future of the service and funding of this program. If ongoing funding is not made available through the Drug Court Program this program may need an alternative funding source if it is to continue. The Youth Drug Court program has been also funded by the Department of Health to provide a residential service located within Liverpool and a counselling and day program across South Western Sydney. The Area Health Service will manage the residential service and one position for the counselling and day program. The funding requirement for the residential service is to be established and $60,000 will be provided for the counselling position.

11.3 Unsourced funding requirements

In addition to funding for the services noted above, the Plan identifies the need for ongoing recurrent funding and capital funding of a number of services or positions, for which a funding source has not yet been established. These include

Item	Service / Position	Funds required	Priority	Comment
1	Fairfield Drug Treatment	$400,000	High	Recurrent funds to provide expanded services - charging policy is a potential source
2	Treatment Coordinator	$60,000	High	Recurrent – may be sourced from Drug Summit funding
3	Prevention Coordinator	$60,000	High	Recurrent
4	CNS for Bankstown Sector	$60,000	High	Recurrent
5	3.5 Mental Health/ D&A CNSs in 4 sectors	$210,000	High	Recurrent –may be sourced from Mental Health enhancements
6	Additional medical services - Staff specialist and registrar	$210,000	High	Recurrent
7	Fund Consortium contribution for outcomes modules of DACIS	$15,000	High	Recurrent
8	Adult Drug Court Program	$650,000	High	Recurrent
9	Male and female ATSI D&A Counsellors (4 positions) for Macarthur & northern Sectors	$240,000	Medium	Recurrent
10	Additional prevention positions for Bankstown, Liverpool and Wingecarribee	$135,000	Medium	Recurrent - it may be possible to fund through an NGO
11	Additional 3.7 counselling staff for Liverpool and Bankstown	$166,500	Medium	Recurrent
12	Expansion of DISC, Fairfield	$729,629	Medium	Recurrent - Stages 4, 5 & 6

Item	Service / Position	Funds required	Priority	Comment
13	Expansion of inpatient Detoxification Services	$211,360	Low	Recurrent - Includes improved night shift & outpatient staffing, relief medical and psychiatric staffing -medical staffing could be shared with DISC - Mental Health enhancement may fund psychiatrist
14	CNS for Bowral Sector	$60,000	Low	Recurrent
15	Refurbishment of Liverpool and Campbelltown Drug Treatment Services	$180,000	Low	Capital to be funded through normal capital program
	Total unsourced funds required	$3,387,489		$3,207,489 Recurrent $180,000 Capital

The ongoing source of funding for these positions and services is not clear. The Treatment Coordinator position may receive ongoing funding from the Drug Summit funds depending on the evaluation of the service and ongoing commitment to such a position from the Department of Health. The Adult Drug Court Program may also be funded separately.

12 REFERENCES

1. Single E, Rohl T. (1997) *The National Drug Strategy: Mapping the future. An Evaluation of the National Drug Strategy: Mapping the Future. An Evaluation of the National Drug Strategy 1993 – 97.* Canberra. Ministerial Council on Drug Strategy. Commonwealth of Australia.

2. Ministerial Council on Drug Strategy. (1998) *National Drug Strategic Framework 1998-99 to 2002-03.* Canberra. Ministerial Council on Drug Strategy. Commonwealth of Australia.

3. South Western Sydney Area Health Service. (1998) *Strategic Directions Statement and Implementation Plan 1998 – 2003*

4. South Western Sydney Area Health Service. (1999) *Area Operations Plan*

5. South Western Sydney Area Health Service. (2000) *Epidemiological Profile*

6. NSW Health. *The NSW Drug Treatment Services Plan 2000-2005.* 2000. NSW Health Department.

13 PLANNING TEAM MEMBERSHIP

Planning Steering committee:

- Dr Gilbert Whitton, Director of Drug and Alcohol Services (Chair person)
- Dr Wendy Wickes, Staff Specialist, Drug and Alcohol Services
- Ms Debbie Killian, Director of Community and Allied Health, Bankstown Health Service
- Ms Dianna Kenrick, Director of Community and Allied Health, Fairfield Health Service
- Ms Alison Beale, Senior Planner, Division of Planning
- Mr Mark Thornell, Business Manager, Population Health
- Mr James Pitts, General Manager, Odyssey House
- Ms Linda Goldspink- Lord, Manager, Macarthur Drug and Alcohol Youth Project
- Ms Carla Saunders, Quality Manager, Health Promotion Unit
- Mr James Mabbutt, HIV / AIDs Service
- Dr Nick Zwar, General Practitioner Unit

Treatment Reference Group:

- Dr Wendy Wickes, Staff Specialist, Drug and Alcohol Centre, (Chairperson)
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- Mr Tony Clifford, Manager, Coopers Cottage, Drug Treatment Service
- Ms Sue Heard, Manager, Drug Intervention Service Cabramatta, (DISC)
- Ms Alison Beale, Senior Planner, Division of Planning
- Mr Luat Nguyen Project Officer, Open Family
- Mr Stewart Stubbs, Project Officer, Youth Team, Cabramatta Community Centre
- Mr James Pitts, General Manager, Odyssey House
- Ms Leonie Stevens, General Practitioner Liaison Nursing Position, Drug and Alcohol Centre
- Ms Sandra Sunjic, Manager, Drug Courts Program
- Dr Peter McCaul, Corella Lodge, Detoxification Service

Prevention Reference Group:

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- Ms Carla Saunders, Quality Manager, Health Promotion Unit
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With special thanks to Ms Miriana Stamenic, Administrative Assistant, Drug and Alcohol Centre who provided the secretarial support to each of the groups.

Background Papers

Drug and Alcohol Plan 2000 – 2003

1 NEEDS ASSESSMENT

The NSW Drug Treatment Plan (2000)[1] notes the difficulty of planning for drug and alcohol services as the size of the problem or need is difficult to estimate at the local level. This section briefly summarises the costs and national patterns of alcohol and other drug use and the needs of the communities in South Western Sydney.

1.1 The Cost and Potential Harms of Alcohol and Other Drug Use

The Australian Institute of Health and Welfare (AIHW)[2] highlights both the social and economic cost of substance misuse. This indicates a need for the prevention and reduction of hazardous and harmful alcohol and other drug use. The AIHW notes that:

- In 1997, of total Australian deaths, 18,224 deaths were tobacco related, 3,668 deaths were alcohol related and 832 Australians died due to the effects of illicit drugs.

- Alcohol abuse was estimated to cost Australian Society $145 million in direct health care and $767 million in road accident costs in 1992.

- Work problems caused by alcohol including absenteeism, poor work performance and accidents are estimated to cost Australian industry over $1 billion each year.

The very high social, health and economic costs of alcohol and other drug use indicates the need for South Western Sydney Area Health Service (SWSAHS) to address the problems associated with this use.

1.2 Patterns of Alcohol Use

Single and Rohl in the National Drug Strategy: Mapping the Future[3] provide a thorough analysis of patterns and levels of alcohol use, the correlates and risk factors for high risk alcohol consumption and related harm. Single and Rohl note:

- Most Australians consume alcohol without any ill effect on their health and wellbeing.

- Though women are less likely than men to drink alcohol, those who do drink are more likely to be heavy or binge drinkers than men who drink.

- Low education and being unemployed are risk factors in drinking.

The 1998 National Drug Strategy Household Survey[4] (NDSHS) reports that

- People aged 60 years and over were more likely to drink every day than any other group (31% males and 18% females);
- Of the low number of indigenous people surveyed, alcohol was the most used substance with 81% using in the last 12 months;

- At least 8% of males and 4% of females (aged 14 years or more) are drinking at hazardous or harmful levels. For SWSAHS this indicates that approximately 34,500 people are drinking at harmful or hazardous levels. This is likely to rise to about 39,200 by 2006.

There is a need for prevention services to increase community awareness of the NHMRC low risk drinking recommendations for males and females and to work cooperatively with other agencies and alcohol retail outlets to increase this awareness. There is a need for treatment services to recognise the particular needs and patterns of alcohol use of women, indigenous people and the unemployed.

1.3 Patterns of Pharmaceutical use

Single and Rohl identify that

- Though only 1% of people aged 14 years or older had used tranquillisers or sleeping pills in the last year, of these nearly half 46% had consumed alcohol and 16% had consumed marijuana at the same time on at least one occasion

There is a need to raise awareness of the impact of combining medications with alcohol and marijuana and to address the needs of people experiencing affective disorders.

1.4 Patterns of Illicit Drug Use

The AIHW[4] reports

- Marijuana is the most widely used illicit drug in Australia with 44% of males and 35% of females reporting that they have used it at some time in their lives.

- Between the 1995 and 1998 NDSHS survey there was a marked increase in the number of people using marijuana in the last 12 months from 13% in 1995 to 18% in 1998. Use of amphetamines doubled from 1995 to 1998 from 2% to 4%. Use of other substances remained relatively constant.

A recent NDARC monograph[5] outlines the comparative drug use in three Australian States. The study surveyed a number of injecting drug users and interviewed key informants from Sydney, Adelaide and Melbourne. The trends in illicit drug use are outlined as follows:

- The study found heroin was easily available in the South Western Sydney (SWS) area. SWS had younger and more disadvantaged users with more criminal involvement and less contact with heroin treatment than users in other study areas

- The study indicated a general trend for Injecting Drug Users (IDUs) to begin injecting amphetamines and then to make the transition to injecting heroin. An increase in poly drug use associated with amphetamines was also evident.

Service providers identified a need for SWSAHS to provide improved treatment and prevention service to the younger more disadvantaged opioid users particularly those of Indo-Chinese background. There is also a need for prevention services to address the transition between drug usage. DISC has developed good working relationships with this community, but needs to expand it's services.

On 21 August 2000 the Pharmaceutical Service Branch, NSW Health Department identified a total of 1590 people receiving methadone maintenance therapy in South Western Sydney. Of the total people receiving their dose in South Western Sydney

- 1,329 people reside in SWSAHS
- 230 people reside outside SWSAHS
- There were 31 people whose AHS of residence is unknown

Between November 1998 and July 2000 the number of General Practitioner Prescribers has more than doubled going from 7 to 19 in that time. This is also reflected by a similar increase in the number of clients whose prescriber is a General Practitioner. The client numbers have increased from 162 in November 1998 to 310 in July 2000.

The NSW Drug Treatment Plan identifies the need to increase the proportion of heroin dependent people in treatment to 40 – 45% and to improve retention in treatment and improve treatment outcomes. General Practitioners are identified as having a key role to play in increasing clients access to replacement pharmacotherapy treatment such as methadone. This Area Health Service has a commitment to working with General Practioners to this end. Drug Summit funding will assist in this process.

1.5 Substance Use Disorders

The Mental Health of Australians Report[6] outlines the findings of the National Survey of Mental Health and Wellbeing. The report defines substance use disorders (including harmful use and dependence on alcohol or other drugs) as typically involving "impaired control over the use of alcohol or other drugs.

Obtaining, using and recovering from alcohol and drugs consumes a disproportionate amount of the user's time and the user continues to drink alcohol or take drugs in the face of problems that they know to be caused by them." The report indicates that in the previous 12 months

- 7.7% of people aged 18 years and older had a substance abuse disorder
- Males are twice as likely as females to have a substance use disorder with 11.1% of males and 4.5% of females fitting the definition.
- Alcohol use disorders are three times more common than drug use disorders. 6.5% of adults experience alcohol use disorders compared to 2.2% of adults with a drug use disorder.

The comparative disorders are outlined below

- 9.4% of males and 3.7% of females experienced alcohol use disorder
- 3.1% of males and 1.3% of females experienced drug use disorder
- 1.7% of adults had a cannabis use disorder
- 0.4% of adults had a sedative use disorder
- 0.3% of adults had a stimulant use disorder
- 0.2% of adults had an opioid use disorder

For South Western Sydney this would indicate that in 1998, 37,490 people experienced alcohol use disorder, 12,689 experienced some drug use disorder, 9804 experienced cannabis use disorder and 1154 experience opioid use disorder. The estimated number of people experiencing alcohol use disorder is slightly higher than the estimated number of the population consuming alcohol at hazardous and harmful levels (34,500). While this discrepancy needs further examination it provides a comparison for the substantially large number of people experiencing harm as a result of alcohol use compared to other drug use. This needs to be considered in the resourcing of the appropriate health services.

1.6 Acute Inpatient Presentations

It is difficult to monitor the number of acute inpatient separations for Drug and Alcohol related causes as many admissions may be the result of other disease or conditions with Drug and Alcohol as a complicating or secondary factor. In 1997/98 the total South Western Sydney resident demand for primarily Drug and Alcohol reasons represented 267 separations. Of these 155 were captured in SWSAHS hospitals and 112 residents were outflows to other hospitals with 29 residents of other areas attending SWSAHS hospitals.

Of the 155 residents treated locally, 103 separations were for Alcohol Intoxification and Withdrawal with an average length of stay of 1.6 days; 25 separations were for other drug use, disorder and dependence with1.08 ALOS. However the 27 separations for alcohol use disorder and dependence had a significantly longer length of stay 4.37 days.

15 of the 29 inflows were admitted to Bankstown Lidcombe Hospital for 2.26 days. 26 of the 29 inflows were for alcohol related illness with 22 of those separations for withdrawal.

Of the 112 residents flowing out of SWSAHS, 71 were for other drugs use disorder and dependence with a length of stay of 3.7 days. Mt Druitt hospital was the most referred to hospital with Sydney Hospital as second, though significantly less. Outflows for alcohol related illness comprised the rest of the outflows. More than half of these had day only admissions with some separations having an ALOS of between 3 and 26 days. The reason for these longer lengths of stay is not clear.

It may be that the patients were sicker or there were other health problems and difficulties in arranging appropriate accommodation.

There is a need to improve hospital liaison services throughout SWSAHS. This will increase the capacity of the health service as a whole to respond to clients needing Drug and Alcohol treatment services. The Drug Summit funding will contribute to this. However there is a need as yet unsourced to provide a Clinicial Nurse Specialist (CNS) at Bankstown and Wingecarribee.

1.7 Comparative Access to Health Services by People Experiencing Substance Use Disorders.

When reviewing the comparative access to health services by people experiencing different substance use disorders, it is evident that the greatest focus of the designated drug and alcohol health services is on providing services for people with illicit drug problems. The Director of Corella Lodge, the Area Detoxification service estimates that of the people presenting for detoxification 60% would be from heroin, 25% would be from alcohol and 15% would be from other drugs including speed, benzodiazepines, methadone, cannabis and poly drug use.

The Area Drug and Alcohol Centre provided services to 824 people presenting with a range of drug problems. A number of clients have problems with more than one drug. Of the total of 1,028 drugs which clients stated they used, heroin and other opioids make up 44.9% (461) of presenting drug problem and alcohol is the next largest at 21.6% (222).

The Drug Treatment Services provide replacement therapies for people who have used heroin, with methadone currently being the primary replacement therapy. The public Drug Treatment Services have operated at capacity for a number of years with key target groups only getting priority access to services. These groups include pregnant women, people with HIV or people with particular medical conditions and prisoners. The services get regular requests for access to the service from people who do not fit within these priority groups. The Drug Summit recognised the need to expand the number of methadone places in South Western Sydney and to expand the number of services available including improved case management to clients within the existing Drug Treatment Programs. This will go some way to increasing access to services by people with opioid use disorder.

The Community Health Drug and Alcohol Counsellors in SWSAHS reported for the NSW Drug Treatment Service Plan that they had seen a total of 1229 clients and provided 8382 occasions of service. A review of a sample of the client presentation statistics indicates that alcohol problems and dependency appear to be the primary reason for presentation to Community Health Counsellors.

This varies between 30% and 48% of all presentations depending on the Sector. This would indicate that somewhere between 400 and 590 people were seen as a result of alcohol problems which is only 1.7% of the estimated 34,500 people drinking at harmful or hazardous levels. As the major focus of most of SWSAHS's Drug and Alcohol Services is on illicit drug usage or replacement therapies, there is a case for enhancing these counselling services to address the problems related to alcohol consumption.

1.8 The need for Residential Rehabilitation Services

Odyssey House has operated at near or over capacity (95 places) for most of 1998/99. There has been limited space for clients with children, defacto couples and clients with dual diagnosis. The need for additional rehabilitation services has been recognised by the Drug Summit and $118,625 has been provided to Odyssey House annually in 2000/01 to fund an additional 5 residential rehabilitation beds which are illicit drug specific.

The need for rehabilitation services for Aboriginal people addressed in the Marrin Weejali Regional Plan[7] is noted below.

1.9 Alcohol Related Brain Damage

It is difficult to estimate the number of people within South Western Sydney Area who have alcohol related brain damage. Health workers report that people with mild brain damage are currently able to access sufficient services and supports. In the case of people with severe brain damage, placement in a nursing home environment has provided reasonable care. However, people with moderate damage are not adequately provided for within the current service mix available. There is a need to work with the Department of Housing, local government and Non Government Organisations to establish proclaimed places, refuges and long term accommodation. Links with Aged Care services and Mental Health Services would be important to achieve improved access to services by this group.

1.10 Poly Drug Use

The NSW Adult Alcohol Action Plan[8] cites considerable evidence that illicit drug users regularly use more than one drug and that alcohol is frequently used in combination. The plan notes research indicating that alcohol was found in 51% of fatal heroin overdoses compared to 1% of current heroin users. Thus indicating a need for harm reduction messages for heroin users regarding the effects of combined alcohol and heroin use.

1.11 Needs of Women

As may be seen above, the pattern of women's use of various substances is slightly lower but similar to the pattern of male useage. However as also noted above males are twice as likely as women to have a substance abuse disorder. This pattern appears to be reflected in access to the Drug Treatment Services (56% male: 38.6% female: 5% unstated - survey 1999)[14] and the Drug and Alcohol Centre (67% male:32.5% female). However, there needs to be recognition of the special issues for women accessing both prevention and treatment services. The Detoxification service has strategies in place to ensure women can safely detoxify in the inpatient unit. This needs ongoing monitoring and consumer feedback. The needs of pregnant women accessing Drug Treatment services has been a priority for the Area as has the need to support women who are mothers who wish to access the range of Drug Treatment services including rehabilitation. There is a recognition that partners of pregnant women also need priority access to Drug Treatment Services to assist the women maintain compliance with the program.

There is a need for all treatment and prevention services to recognise the impact of sexual assault and / or domestic violence on some women who abuse substances and the associated affective disorders which may arise from such experience. Access to female Drug and Alcohol counsellors has been raised as a need for women with this background. The needs of women who are family members of people who abuse substances also needs to be addressed as these women may carry a substantial burden in trying to assist their family member access services. The consultation with women's health services identified the need to provide a proclaimed place for women.

1.12 Needs of People with Substance Abuse Disorder and Mental Health problems

Regier et al[9] identify the most prevalent comorbid mental disorder among people with an alcohol disorder were:

- 19% anxiety disorders, 14% antisocial personality disorders, 13% affective disorders and 4% schizophrenia

For people with other drug disorders the most prevalent comorbid mental disorders were

- 28% anxiety disorders, 26% affective disorders, 18% antisocial personality disorders and 7% schizophrenia

Mental Health disorders with the highest rate of co-morbid substance disorder were antisocial personality disorder and schizophrenia.

- 84% of people with antisocial personality disorder and 47% of people with schizophrenia also had a substance abuse disorder

- only 32% of people with an affective disorder also had a substance abuse disorder. However as such disorders are more prevalent in the community their contribution is larger to the total prevalence of comorbidity.

Hall and Farrell[10] note poorer outcomes are predicted for clients if comorbid mental health disorders are not addressed in people with substance abuse disorders. They recommend staff in addiction services be trained to identify anxiety and affective disorders in their clients. The provision of mental health services which focus on clients with multiple problems will address these needs in each sector.

1.13 Needs of Unemployed people

As noted above by Single and Rohl low education and being unemployed are risk factors in drinking. Though unemployed people are most likely to abstain from alcohol, those who do drink are more likely to do so at hazardous and harmful levels. Morrow et al[11] note that people who are unemployed may present to General Practitioners with signs and symptoms of anxiety and depression and other physical problems of headaches and pains. Their consumption of cigarettes, alcohol and other substances may increase significantly and General Practitioners who have

regular contact with large numbers of unemployed people are in a position to impact positively on this group.

Of the 824 individuals seen by the Area Drug and Alcohol Staff in 1998, 733 provided details of their source of income. Of this group 44.8% were unemployed, 18.7% were receiving salaries and wages, 13.5% were receiving invalid pensions or sickness benefits and 11% were receiving aged or supporting parents pensions.

Though the survey of Drug Treatment Centres did not look at unemployment as a category, many clients of the Drug and Alcohol Centre are also clients of the Drug Treatment Centres, therefore the same high proportion of unemployment would be expected. A survey of Western Sydney clients of Drug Treatment Centres identified that most clients were interested in employment opportunities, training and literacy programs (Personal communication). There is a need to build partnerships with other government and non Government organisations to address these needs in South Western Sydney.

1.14 Needs of Young people

Data on Australian adolescents[2] indicates that their use of alcohol and drugs is high, with 25% of males and 30% of females aged 14-19 reporting harmful levels of alcohol consumption.

A survey of secondary school students in Victoria and New South Wales revealed that two weeks prior to the survey, one-third had engaged in heavy drinking sessions of 5 or more alcoholic drinks in a row. Further, a National Household Survey in 1993 revealed that the average age of respondents when they first tried substances other than alcohol or tobacco for the first time ranged

from 17 years (inhalants) to 22 years (ecstasy/designer drugs). This same survey reported that the average age of respondents when they first had an

alcoholic drink was 15.9 years. These data are significant in light of a substantial amount of research evidence which suggests that substance abuse may be an important factor in the development of aggressive, suicidal, criminal and other antisocial and harmful behaviours.

Qualitative research conducted in Western Australia identified four key factors that influence adolescent behaviour in relation to the misuse of alcohol and other drugs. These were parental and other significant relationships, peer group behaviour, personality types and observed experiences. In addition to this, large scale research in the United States has found that perceived risk and disapproval are important determinants of marijuana use. Evidence indicates early uptake of heroin use by people as young as 13 in the South Western Sydney area. The NSW Methadone Maintenance Treatment Clinical Practice Guidelines[12] requires court approval before a young person under the age of 16 can access treatment.

There is a need for prevention services to target young people and for treatment services to provide early intervention programs for young people who are initiating drug taking behaviour at earlier ages. There is a need to review young people's

access to appropriate detoxification or treatment services in the light of legal restrictions.

1.15 Needs of the Children and Families of Drug Users

Over the last few years public awareness of the needs of families of drug users has increased. This includes families need for information about the effects of drug usage and both prevention and treatment options. The families needs vary

according to the age of the drug user and the intensity and type of their drug use. Parents, siblings and friends of adolescents using drugs experimentally, may be more concerned about prevention options to ensure the adolescent does not take up hazardous drug usage. Parents and / or partners of users with hazardous drug use, particularly where the user has been involved in criminal activities may need assistance to support the behavioural change techniques involved in the users treatment program and to cope with the social impact on their own lives.

Currently the Drug and Alcohol counsellors provide limited services to family members of people misusing substances. The Adult Drug Court program aims to increase the likelihood of a positive outcomes for their clients, by supporting families who in turn support their substance abusing member. Consultation with service providers indicated there is a need for expanded services to family members. It is expected that some project funding may become available from the next round of Drug Summit funding. Additional counselling positions and a realignment of work practices will assist in meeting this need.

Children of drug users need access to adequate care, support and age appropriate education. For babies and preschoolers, this includes immunisation, access to play group experiences and a range of early intervention

opportunities. Some children of users attending school may need additional assistance through the school system or other support programs. The needs of children whose parents access the existing Drug Treatment Services within

SWSAHS are being met by Non Government Agencies, such as Burnside in Campbelltown and the Primary Health Nursing and Child and Family teams at Liverpool. The Families First initiative will also provide a mechanism to address the needs of these children.

The NSW Child Death Review Team 1998-1999 Report[13] estimates that "nearly 25% of child deaths reported to the coroner either directly or indirectly involved drugs and/or alcohol". The 1998 - 1999 report focused on child deaths involving parental substance dependence. The report identified a number of systemic issues for health service and made recommendations including the need to improve

- antenatal recognition, assessment and treatment of substance dependent parents
- perinatal assessment
- documentation in obstetric records,
- parental drug use, bed-sharing and infant deaths
- issues for Aboriginal children arising from parental drug and alcohol use

Consultation with the Director, Neonatology, Liverpool Health Service indicates that a number of hospitals provide services to substance abusing pregnant women at a tertiary level with positive outcomes. There is a need to review the recommendations of the Child Death report and to consider the best practice for provision of services to these parents and children. This would be the responsibility of the Child Health Advisory Committee.

1.16 Needs of Drug Users who have Children and Partners

Drug users access to and effective participation in a range of treatment services may be limited by their need to care for children and / or their partners access to treatment at the same time. Where both partners who are drug users are accepted into treatment together compliance with treatment is enhanced. A number of services have recently obtained additional resources or changed their practices and protocols to improve access to services by people with children and partners. Currently pregnant women and their partners have priority access to methadone services in order to improve compliance with the program by the pregnant woman and achieve better birth outcomes for the baby.

The change in the Maryfield's rehabilitation program from a residential service to a day program has resulted in an increase of women with children attending the programs. Odyssey House has recently been funded to improve their services to their residents who are parents and their children. This includes a new family building and the services of a developmental psychologist.

1.17 Needs of People Living with HIV

Of the total 201 SWSAHS HIV Notifications between 1990 and 1998 only 15 people or 7.5% were identified as intravenous drug users, though half of those had other risk factors. The low level of IDU in the HIV notifications indicates the positive achievement of the needle syringe program over the last decade. People living with HIV are a priority group for access to Drug Treatment Services and close cooperation in service provision occurs with relevant non government agencies.

1.18 Needs of Aboriginal and Torres Strait Islander People

Consultation for the SWSAHS Aboriginal Health Plan in 1998/99 identified substance misuse and mental health as priorities for the plan to address. The consultation process identified the need for more effective partnerships to tackle the problems, the need for more drug and alcohol and mental health workers and cultural awareness within drug and alcohol services. The Western Sydney Aboriginal Substance Misuse Regional Plan of the Marrin Weejali Aboriginal Corporation based in Western Sydney has consulted regarding the needs of Aboriginal people across the greater Western Sydney. Their plan identifies the need for halfway houses and rehabilitation places for Aboriginal people in the greater Western Sydney and identified the need for additional Aboriginal Drug and Alcohol workers in each of the Area Health Services.

Of the total individuals seen by the Area Drug and Alcohol Centre staff for the calendar year of 1998, 2.7% or 22 people were from an Aboriginal or Torres Strait Islander background. A survey of existing public methadone services indicates

comparatively high access of the services by people of Aboriginal and Torres Strait Islander background ie 7.7% indicating a substantial level of need for these communities. The ATSI Health planning group noted the need to provide adequate staffing and program resources to meet the differing needs of both genders and to address the complicated mental health issues associated with substance misuse in ATSI communities.

1.19 Needs of People from Non English Speaking background

The 1998 NDSHS on drug use of people from Non English Speaking background is not yet available. Instead the data for people born overseas is provided. This indicates the people born overseas are less likely to consume alcohol or use any illicit substance compared with Australian born non-Indigenous people

- 38% of people born overseas: 46% of Australian born non-Indigenous people had ever used any illicit substances
- 16% of people born overseas: 23% of Australian born non-Indigenous people had used illicit substances in the last 12 months
- 32% of people born overseas: 41% of Australian born non-Indigenous people had ever tried marijuana.

Though there is less alcohol or illicit substance useage by people of born overseas, there is real need for prevention and treatment services to meet the particular needs of people from non-English speaking backgrounds. As noted above, there is a real need for treatment services in SWSAHS to respond to the younger more disadvantaged opioid users particularly those of Indo-Chinese background. There is also a need for prevention services to address the transition between drug usage.

Currently about 21% of people accessing the Drug Treatment Services (1999 survey)[14] have a non-English speaking background. Access to DISC by people from non-English speaking backgrounds is relatively high. However, counselling services provide variable access to people from non-English speaking backgrounds with Liverpool about 23% and Macarthur slightly lower. There is a need to attract staff from non-English speaking backgrounds to improve access to services and to address the particular cultural issues for these groups.

1.20 Needs of Older People

Older people are more likely to consume alcohol on a daily basis than their younger counterparts. They also have a higher utilisation of hospital services. This provides opportunities for brief interventions on the potential risk of injury related to alcohol consumption and use of pharmaceutical drugs. It is also important that alcohol consumption is addressed when treating them for general health problems.

References

1. NSW Health. *The NSW Drug Treatment Services Plan 2000-2005.* 2000. NSW Health Department

2. AIHW *Statistics on Drug Use in Australia 1998* 1998 Commonwealth Department of Health and Aged Care.

3. National Drug Strategy Household Survey reported in AIHW *Statistics on Drug Use in Australia 1998* 1998 Commonwealth Department of Health and Aged Care.

4. Single E, Rohl T. (1997) *The National Drug Strategy: Mapping the Future. An Evaluation of the National Drug Strategy 1993 – 97.* Canberra. Ministerial Council on Drug Strategy. Commonwealth of Australia.

5. Hando J, Darke S, Degenhardt L, Cormack S, Rumbold G. 1998. *Drug Trends 1997. A comparison of Drug Use and Trends in Three National Australian States.* NDARC Monograph No. 38

6. Andrews G, Hall W, Teesson M, Henderson S. *Mental Health of Australians.* 1999. Commonwealth Department of Health and Aged Care

7. Marrin Weejali Aboriginal Corporation. *The Marrin Weejali Regional Plan* 1999.

8. NSW Health. *NSW Adult Alcohol Action Plan 1998 – 2002.* NSW Health Department.

9. Regier D, Farmer M, Rae D, et al *Comorbidity of Mental Disorders with Alcohol and other Drug Abuse: Results from the Epidemiologic Catchment Area Study.* 1990. Journal of the American Medical Association, 264, 2511-2518.

10. Hall W and Farrell M *Comorbidity between Substance Use and Other Mental Disorders.* 1997 Unpublished

11. Morrow M, Harris E & Harris M *Unemployment and Health : Can CBT Counselling Help?* December 1999: 10- 14. Current Therapeutics.

12. NSW Health. *The NSW Methadone Maintenance Treatment Clinical Practice Guidelines* 1999. NSW Department of Health.

13. NSW Child Death Review Team *The NSW Child Death Review Team 1998-1999 Report* 2000 Commissioner for Children and Young People.

14. A survey conducted for one week in October 1999 in the SWSAHS Drug Treatment Services to establish access to the service by special needs groups.

2 CURRENT TREATMENT AND PREVENTION SERVICES

This chapter documents the range of drug and alcohol treatment and prevention services available within South Western Sydney Area Health Service and includes the Non Government Organisations funded through the Area Health Service. The Services available within each sector are summarised at the end of the chapter. A number of other agencies provide support to people with drug and alcohol problems or provide prevention services to the broader population. Some of these agencies are also identified.

2.1 CURRENT TREATMENT SERVICES

The range of treatment services is outlined below in accordance with each of the components of the treatment model of care.

2.1.1 Counselling, Welfare and Day Programs

Drug and Alcohol Counselling services and Day programs within SWS are currently provided within Community Health Centres and some Non Government Organisations (NGOs) funded through the Drug and Alcohol Program.

There are 2 Drug and Alcohol (D&A) workers in the Bankstown Community Health Service; 2 D&A workers in the Fairfield Community Health Service; 1.5 full time equivalent (FTE) D&A workers in the Liverpool Community Health Service; 4 FTE D&A workers in the Macarthur Health Service (Campbelltown, Ingleburn, Rosemeadow, Narellan and Wollondilly Community Health Centres); and one D&A worker in the Wingecarribee Health Service. This makes a total of **10.5 FTE** D&A workers in the Community Health Services across the Area (this does not include the youth health services, DISC, Drug Courts and NGOs - see below).

In Bankstown Community Health during 1998/99 there were 3790 counselling occasions of service by the D&A Team (2 workers) in 1998/99. This represented 292 individual clients seen by the team. In Liverpool Community Health (1.5 D&A workers within the community counselling team) during 1998/99, occasions of service provided were 641. This does not include clients who received group therapy or those clients who received one–off sessions during Intake but were referred elsewhere, and this figure represents about 150 clients. In Fairfield Community Health during 1998/99 there were 820 individual occasions of service and 199 group occasions of service. During this period one of the two positions in Fairfield was vacant for approximately 8 months. 220 individual clients (new referrals) were seen in the Fairfield Community Health Service during this period, not including those who attended group programs. In Macarthur there were 2470 occasions of service with 390 clients seen. In the Wingecarribee Health Service, where there is only one D&A position, there were 661 occasions of service during 1998/99.

In SWSAHS there are also three Youth Health Services. These are the Corner Youth Health Service in Bankstown, the Fairfield Liverpool Youth Health Team (FLYHT) and Traxside (the Macarthur youth health service). Traxside has, and FLYHT has had, individual D&A Workers. The Corner Youth Health Service in

Bankstown estimates that approximately 0.8 FTE Youth Counsellor would currently

deal with D&A counselling issues. This totals approximately 2.8 FTE **D&A workers in the Youth Health Services across the Area.**

Another outpatient service, which provides counselling, is the new Drug Intervention Service Cabramatta (DISC). At DISC there are 2.0 FTE counsellors who both spend 50% of their time in rostered counselling/brief intervention (these rostered hours include brief intervention, referrals, assessments and provision of needle syringe services) and another 10-20% of time in booked appointments and consultancy to other staff. There are 5 HEOs who each spend 50% of their time in rostered brief intervention. There is a Registered Nurse who spends 20% of time in rostered brief intervention. This gives an approximate total of **4 FTE** for outpatient counselling at DISC. From when it opened in December 1998 to July 1999 there were 601 occasions of service at DISC for counselling and brief interventions. This involved 166 registered clients (i.e. those for whom a medical record was established).

Outpatient counselling is also provided to Drug Court referrals by the staff of the SWSAHS Drug Court team. This team is administratively located within the Bankstown Community Health Service. The team includes 2 outpatient counsellors and 2 staff members, who run the SWSAHS Drug Court Day Program. There are currently 35 patients receiving counselling through the SWSAHS Drug Court Program. These patients are seen twice weekly by their counsellor and also participate twice weekly for six weeks (sometimes longer) in the Day Program. This gives an approximate total of **3 FTE** for outpatient counselling by the SWSAHS Drug Court team.

Maryfields Day Recovery Centre in Campbelltown is a NGO funded by the NSW Health Department and administered by the St Vincent de Paul Society. NGO Counsellors (4 FTE) from Maryfields provide regular day programs. It reports that, for the period January 1999 to August 1999, 234 people were booked in for intake, of which 138 people attended and 90 received treatment.

The South West Alternative Project (SWAP) is a NGO in Cabramatta, which employs a manager who deals with crisis calls and intake only (35 hours per week), a counsellor/educator (35 hours per week) and a part-time counsellor/educator (10 hours per week). For an 18-month period to June 1999, SWAP was able to employ the third worker for 35 hours per week, using surplus accrued funds. These funds have run out now, so the third worker has been reduced to 10 hours per week. The manager of SWAP reports that the counsellor/educators each have a current caseload of 25 clients (individuals / couples / families) who attend weekly.

The Health Department NGO Grant program also funds the "Parents, Youth Drug and Alcohol Project" through 2 D&A youth worker positions within a youth team at Cabramatta Community Centre. Although counselling is not the focus of this project, some counselling and direct interventions occur. This accounts

for about 2 days per week of the workers time. For 1998/99, there were 103 occasions of service, not including 'drop-ins', without appointments. This represents 53 clients.

Taking all the SWSAHS and NGO outpatient D&A counselling services together, there are approximately 24 FTE positions in the Area. This does not include outpatient services provided by the specialist D&A doctors and nurses in the Area Drug and Alcohol Service or counselling performed by methadone clinic staff.

There is currently one ATSI Drug and Alcohol counsellor based in the Macarthur area and an ATSI mental health worker in Fairfield that has a focus on Drug and Alcohol issues. The ATSI Health Planning process has identified the need for additional male and female ATSI Drug and Alcohol counsellors to provide services for the Macarthur area and the northern Sectors. Drug and Alcohol counsellors are the primary source of help for people with alcohol problems and for family members who have a relative misusing substances. Liverpool and Bankstown sectors are poorly resourced compared to the size of their current and projected populations. DISC has identified the need to further expand their services at a total cost of $729,629 over three additional development stages ie 4, 5 and 6.

2.1.2 Needle Syringe Program

Twenty three Needle Syringe Programs (NSPs) are currently operated by SWSAHS, through a range of outreach, secondary and vending machines outlets. Many NSPs are situated at services that provide a range of Drug and Alcohol Services.

In 1999 approximately 51,000 clients accessed equipment from staff at SWSAHS NSP services and approximately 535,000 needles and syringes were distributed. Client numbers and equipment distributed have continued to increase each year. Currently 110 staff are authorised as NSP workers in SWSAHS.

NSPs play a key role in providing services to Drug and Alcohol clients. NSPs provide information to clients, brief / opportunistic interventions and referral to drug treatment services. Enhanced worker training and on going evaluation of current NSP practice ensures opportunities to connect clients to treatment and welfare services are a core component of NSP service operation.

The range of NSP services are coordinated at an Area level to address changing client needs and new drug use patterns.

2.1.3 Detoxification services

Until 1999 SWS residents had to travel out of the South Western Sydney area to receive residential detoxification services. Two new services opened in South Western Sydney in 1999, but were initially slow to function fully because of difficulties attracting staff.

Corella Lodge is a 20 bed unit in the grounds of Fairfield Hospital. The service provides primarily medicated inpatient detoxification services with sufficient medical and nursing backup to ensure medical, pharmaceutical and nursing services are

available. It has taken inpatients since July 1999 and was functioning fully by September 1999. Some outpatient services are provided.

Corella Lodge recognises the special needs of NESB and ATSI people and of women, young people and care givers of young children. The physical design facilitates the management of people with different needs, allowing some separate program areas based on age and accommodation closer to the nurses station for women. It has established protocols and strategies to address the needs of these people. Home and outpatient detoxification is to be offered as appropriate. The needs of young people under the age of 16 are an acknowledged gap in service, which may also require further medico legal work to ensure such young people find acceptable assistance for themselves.

Corella Lodge has identified the need for expanded services and improved staffing for night shift, outpatients, medical relief and a psychiatrist position.

Odyssey House provides a 6 bed unit within the rehabilitation service at Eaglevale. This service is a statewide service and has been fully operational since 1 March 1999. From that time to end June 1999 115 clients were inducted to the Detoxification program.

For a limited time, home detoxification was provided in the Fairfield area, by workers from a number of agencies. A position to support this program was advertised unsuccessfully a number of times. Currently the only home detoxification services provided within SWS are a shared care program operating in the Wingecarribee area. The Drug Summit funding will enable an ambulatory detoxification service to be provided across the area.

Limited detoxification services are provided within South Western Sydney Hospitals. In 1997/98 the total South Western Sydney resident inpatient demand for primarily Drug and Alcohol reasons represented 267 separations. Alcohol intoxification and withdrawal was the major reason for Drug and Alcohol inpatient admission in South Western Sydney Hospitals. Of the 155 residents treated locally, 103 separations were for alcohol intoxification and withdrawal with an average length of stay of 1.6 days. 26 of the 29 inflows were for alcohol related illness with 22 of those separations being for withdrawal from Alcohol.

2.1.4 Pharmacotherapies Including Replacement (Methadone) and Other Therapies

There are currently two public Drug Treatment Services operating in South Western Sydney based at Liverpool and Campbelltown Hospitals providing pharmacotherapy and case management services . Two Private Methadone Maintenance Services have operated in the South Western Sydney Area. One based at Scott Street, Liverpool and the other at Barbara Street, Fairfield. Following court action by the Department of Health, the Barbara Street Clinic is due to close in late 2000. This is currently subject to an appeal. A public or not for profit drug treatment service has been funded by the Drug Summit for the Fairfield area and is expected to be operational in early 2001.

The information systems to track clients in the public Drug Treatment Services are very poor. The numbers vary according to the time they were collected. In order to obtain some data for the two Public Drug Treatment Services at Liverpool and

Campbelltown a survey of all clients was conducted in late 1999. This has been the basis of the Drug Summit funding documentation.

According to the survey the two public methadone services manage 479 clients, 281 at Jacaranda House, Liverpool and 198 at Cooper's Cottage, Campbelltown. Of these clients 86% are aged between 20 and 45 years. Males outweigh females in access to methadone services by about 2 to 1 and of the total number of clients, NESB clients represent about 21% and ATSI clients represent about 7.7%. Liverpool has greater access by ATSI and NESB clients than Campbelltown. It is difficult to interpret these statistics in terms of equity of access as these statistics were a snapshot view of the service. The information systems to date have not been able to provide an accurate measure of the current level of usage for each target group. However, service providers have identified the need to improve access to NESB, ATSI and young people in particular.

While Campbelltown services primarily the Macarthur sector, Liverpool's clients come from Fairfield (22 %) and Bankstown (10%) with 8% from Macarthur. Of the Fairfield and Macarthur clients dosing at Liverpool, one third of Fairfield clients and 75% of Macarthur clients live within the Liverpool catchment area so are not likely to move to other public clinics should places become available. In addition 114 clients are dosed at Community Pharmacies. Private prescribers or general practitioners prescribe for 40 clients managed in the public system. These services currently offer Drugs and Pregnancy Services (DAPS) for methadone clients who are pregnant. Access to primary health nurse intervention for children and immunisation and other child development assessment services. Benzodiazapine reduction regimes have also been managed through the Drug Treatment Services.

2.1.5 Residential Rehabilitation Services

Two statewide residential rehabilitation services are located in South Western Sydney and managed by Non Government Organisations. These services assist clients develop living skills over a longer term period of 3 to 6 months.

Odyssey House provides a statewide rehabilitation service with 120 beds funded through the Non Government Organisation’s grant program. It operates with an abstinence philosophy. Odyssey House has recently received Commonwealth Illicit Drug Strategy funding, ($184,000 over a four year period) to provide assessment and treatment for children of parents involved in the Rehabilitation program. 305 Clients were inducted into the program in 1998/99. Approximately one third of Odyssey House residents (107) come from the South Western Sydney area. Odyssey House has operated at near or over capacity (95) for most of 1998/99. There has been limited space for clients with children, defacto couples and clients with dual diagnosis. The need for additional rehabilitation services has been recognised by the Drug Summit and $118,625 has been provided to Odyssey House annually in 2000/01 to fund an additional 5 residential rehabilitation beds which are illicit drug specific.

Grow also provides statewide rehabilitation service to people with Dual diagnosis. A 20 bed unit is funded through the Non Government Grant’s Program and the SWSAHS Mental Health Program. In 1998/99 Grow had 55 people enter their residential program. Of that number 53 had a dual diagnosis.

Of this group the three major diagnosis were schizophrenia (40%), depression (20%), Bipolar disorder (16%). Most people were poly drug users with over 40% using speed, alcohol and heroin and over 60% using cannabis. Of the 55 clients, one was ATSI and five were NESB, there were 38 males and 17 females, the average age was 28 with a range from 18 to 48 years and the average length of stay was 14 weeks. 87% of the residents smoked and 78% were on medication.

2.1.6 Specialist Drug and Alcohol Clinical Services and Related Services

The Area Drug and Alcohol Centre at Liverpool provides specialist medical and nursing clinical services including 3 Drug and Alcohol medical officers and 3 senior nurses. Clinical services include a cross-area outpatient clinic located at Liverpool Hospital for the management and referral of all drug dependencies and the management of chronic pain with drug dependency. This includes management of Naltrexone, severe alcohol dependence and poly drug users. The outpatient clinic also provides a psychiatric liaison service for clients with affective disorders or mental illness. Specialist consultancy services operate in Liverpool and Campbelltown Hospitals provided by the Drug and Alcohol Centre staff and Coopers Cottage staff respectively.

The Area Drug and Alcohol Service provides Drug and Alcohol outpatient clinics, inpatient consultations, telephone advice to health professionals (24 hour), a drugs and pregnancy service, a GP shared care program and support for non-English background communities (in particular the Vietnamese community) in dealing with Drug and Alcohol issues. The management of

patients with chronic pain and dependence is a significant aspect of the clinical work of the Area Drug and Alcohol Service. For the 1998 calendar year, there were 2659 clinical occasions of service provided by the doctors and nurses in the Area Drug and Alcohol service. This represented 824 patients seen by these staff. Corella Lodge, the Detoxification Unit at Fairfield will increasingly provide such drug and alcohol clinical support at Fairfield Hospital as the service develops. The Drug Court Program has a senior nurse, acting as the Coordinator. DISC has a nurse and shares a medical director of Drug and Alcohol services in the Fairfield sector with Corella Lodge.

Ad hoc Psychiatric liaison mechanisms have been established in Bankstown, Liverpool and Macarthur Sector Health Services however the establishment of links with the Fairfield Detoxification Service was identified as a priority. There is a need for these Psychiatric liaison mechanisms to be formalised and designated positions to be established in each sector to address the needs of people who have a mental health disorder and problems with substance abuse. Bankstown Health Service provides a mental health Clinical Nurse Consultant position for the Area to address the needs of this group. This position provides clinical support and services, education and policy development to ensure better integration, cross consultation and liaison between mental health services and all the various components of drug and alcohol treatment services. In addition the position works with service providers from mainstream health areas, other government and non government agencies and with carers and consumers to address health, welfare, accommodation and employment problems for this group.

Drug and Alcohol medical and nursing expertise needs to be enhanced, so that it is available and accessible Area wide. As a minimum, Drug and Alcohol consultation/liaison nursing positions need to be established at Bankstown, Campbelltown/Camden and Bowral Hospitals. There is a need for another Drug and Alcohol staff specialist in the Area, probably with psychiatric training to improve the interaction between Drug and Alcohol and Mental Health services. The Area would also like to establish a Drug and Alcohol medical registrar training position and would like to work with other Area Health Services to establish a formal accredited training program for medical practitioners in addiction medicine.

2.1.7 General Practitioners and Community Pharmacies

General Practitioner and Community Pharmacies operate throughout the South Western Sydney area. Shared care programs in Drug and Alcohol Treatment services have been developed in a number of sectors through collaboration with the Department of General Practice and the five Divisions of General Practice including Bankstown, Fairfield, Liverpool, Macarthur and Southern Highlands. This includes home detoxification in Wingecarribee and methadone prescription across the Area. A number of Community Pharmacies across South Western Sydney provide an outlet for methadone dosing. Liaison with the Pharmacies has been facilitated by the Pharmacy Guild of NSW.

2.1.8 Drug Courts Program

The Drug Court program started in March 1999 as a two-year trial treatment program, providing outreach counselling services and day programs to adult clients who have been diverted from the prison system to drug and alcohol treatment for drug related offences. The program also provides replacement pharmacotherapies (methadone and naltrexone) for opioid dependent individuals through collaboration with the Area Drug and Alcohol service, the two public drug treatment services and Liverpool Hospital Pharmacy department.

Once selected, clients are required by the court to participate in the complete program for a period of 12 months. Should clients fail to participate as required, their enrolment in the program is terminated by the court and they are required to serve their sentence or are sanctioned by the court for a period of time.

The Drug Court Program provides a twice weekly day program, which clients are required to attend for 6 weeks. Clients are assessed by the Service Manager and participate in one of four abstinence based treatment programs. These include complete abstinence, naltrexone, methadone or a three to six month residential rehabilitation program, followed by continued counselling. Two Psychologists administer psychological testing as part of the research base to the program and provide a cognitively based day program. The program focuses on stress management, and behavioural change and supports the rebuilding of relationships. Ongoing counselling is provided by two Drug and Alcohol Counselors and clients are monitored through twice weekly attendance at court and urine testing. The program aims to see up to 100 clients on an annual basis. Within the first six months of operation 46 clients have been attended the program. This program was funded $650,000 per annum for two years to June 2000.

The program is expected to continue. The Department of Health is currently considering whether additional funding will be provided to the Area Health Service.

A Youth Drug Court program is to be established in July 2000 involving residential accommodation and support through a house located in Liverpool. The Area Health service will manage this program for the Department of Health. The full funding of this service is to be established. Day programs and counselling services will be provided within the SWS by SWSAHS, Tharawal Aboriginal Health Service based at Airds and Open Family an NGO based in Cabramatta. Each of these services has been funded approximately $60,000 to employ a counsellor.

2.1.8 Other Support Services

A number of services not provided under the Health portfolio also provide essential support for clients participating in or seeking treatment including:

- Accommodation, Hostels and proclaimed places;
- Other services, such as Open Family and self help groups; and
- Interagency Networks.

2.1.9 Accommodation, Hostels and proclaimed places

The Drug Court program, DISC and the Clinical Nurse Consultant for people with Mental Health and substance abuse problems have identified accommodation as a priority need for their clients. A number of clients are living in situations, which do not support their treatment program. There is limited accommodation available for clients on methadone and people with both mental health and substance abuse problems experience discrimination in accessing refuge accommodation or the housing market. Many generalist refuges will not take people who are either users or ex users of illicit drugs or alcohol. This has been a particular problem for DISC when trying to access accommodation services though refuges for young people using illicit drugs.

The following accommodation services are provided in South Western Sydney to meet the needs of people effected by alcohol and other drugs. These services are primarily available to adult males:

DAWN (Drug and Alcohol Women's Network) located in Glenfield, Campbelltown. This service provides crisis and medium accommodation for women and their children. Clients must be alcohol/drug free. Women receive support from staff to remain abstinent from drugs and alcohol. This service does not accept women on methadone. There is room for 7 clients and their children. It provides a service to 10 women a year and their children and is usually able to accommodate all requests.

St Jude's Refuge. (Bankstown) St Vincent de Paul Society
Proclaimed place, providing accommodation for homeless males. 10 beds are available. This service is usually full and regularly turns potential clients away.

Vince's Place (Campbelltown) St Vincent de Paul Society Proclaimed Place
Provides accommodation, counselling, assessment &referral, work programs and living skills for homeless males over 18 years. 6 beds are available.

This service is always full and regularly turns 30 potential clients away per month. They provide a service to about 600 clients per annum.

Sydney City Mission (Liverpool) Proclaimed place and crisis accommodation for males. Provides counselling, assessment & referral, case management and support. 16 beds are available. This service is always full and regularly turns 60 - 100 potential clients away per month.

Serenity House (Ashcroft) Accommodation for men who have detoxified from alcohol. Provides 12 step program. 50 beds are available. The program is usually full and regularly turns potential clients away.

There is a need for refuge accommodation for young people who use illicit drugs and the women's health plan identifies the need for a proclaimed places for women

2.1.10 Other services and self help groups

A number of welfare based non Government Organisations provide services are an important point of contact to potential clients for Drug and Alcohol Treatment Programs. These include Burnside in the Macarthur area and Open Family in the Cabramatta area. A number of self help groups operate within the South Western Sydney area and provide support to people with Drug and Alcohol problems.

2.1.11 Interagency Networks

Interagency networks operate in the Macarthur and Fairfield area and Drug Action Teams have been established in Fairfield and Bankstown.

2.2 CURRENT PREVENTION SERVICES

2.2.1 Area Wide Services

The Area Health Service has limited designated resources to address the prevention of the harms arising from alcohol and other drug use. The Area Health Service funds two and a half designated drug and alcohol health promotion positions. The Vietnamese Smoking Prevention Officer is a permanent position and located at the Area Drug and Alcohol Centre. Two tobacco prevention positions have been funded as a project for two years. These include a Tobacco Control Coordinator and a part time smoking cessation coordinator located at the Area Health Promotion Unit.

2.2.2 Sector Youth Services

The Youth Health Services in Macarthur, Fairfield and Bankstown sectors provide a range of drug and alcohol prevention services targeting young people. The Macarthur and Bankstown services provide prevention services as a team. The services estimate that this effort would amount to one full time position for each

centre. Traxside at Macarthur has concentrated on research and secondary prevention associated with illicit drug use and provide a needle syringe program. They have also done some educational work through the schools and Reiby programs. The Corner Youth Health at Bankstown has concentrated on the

development of youth newsletter, developed by young people and on both school and group based programs targeting the harms relating to tobacco, cannabis and alcohol. They have also targeted young people who are identified as being at risk. FLYHT provides health education programs to young NESB and ATSI people.

2.2.3 Sector Health Promotion / Education

The Population Health service in the Macarthur area funds a full time designated Health promotion position. Most of the Drug and Alcohol counselling positions across the Area allocate a proportion of their time to Health Promotion activities or supporting the NSP program.

The DISC team provides a primary health service to young intravenous drug users. Their team members provide secondary and tertiary prevention services to those young people.

2.2.4 Non Government Organisations

Two Non Government Organisations are funded to provide prevention services to Young People in the Macarthur area. These are the Macarthur Drug and Alcohol Youth Project and Sydney City Mission. The Cabramatta Community Care Project is also funded to provide prevention services to young people in the Cabramatta area.

2.2.5 AOD (Alcohol and Other Drug) Link Project

The Macarthur Drug and Alcohol Youth Project has coordinated the AOD (Alcohol and Other Drug) Link Project. This project has documented the range of prevention strategies implemented by area health and non government staff over about 5 years. The project has the support of a number of the local government, health promotion staff. Projects documented include Youth Alcohol Forums and road safety programs involving councils and Police, a photo project as part of a statewide youth alcohol campaign, workshops in schools and smoking prevention programs with Koori people and young women. The project meets quarterly and provides a forum for prevention workers to exchange ideas and support for their work.

2.2.6 Locality Prevention Partnerships

A number of agency partnerships have been formed to work towards broad prevention goals and in some cases specific Drug and Alcohol prevention goals. These include the Drug Action Teams sponsored by the Premier's Department, various place management projects and two projects sponsored by the Macarthur Drug and Alcohol Youth Project

- **Drug Action Teams**
  The Premier's Department has sponsored two Drug Action Team involving partnerships between themselves, the Police, Education, Health, local government and relevant non government agencies and community groups. These teams have a broader focus than just prevention, but provide a powerful forum for prevention work.

- **Place Management Projects**
  A number of "Place Management Projects" such as Miller, Claymore and Macquarie Fields work in prevention and community development models to address a range of broad environmental, social and cultural factors which give rise to drug and alcohol issues

- **NGO Sponsored place projects**
  The Macarthur Drug and Alcohol Youth Project has worked with a number of other agencies and community groups to develop prevention projects in Wingecarribee and Camden schools.

3 FRAMEWORK & SCOPE FOR PREVENTION OF ALCOHOL AND OTHER DRUG RELATED HARMS

3.1 Introduction

This Framework outlines the broad agenda or scope of prevention services including the different levels of prevention and provides a general model or Framework for Prevention services. This Framework was developed following a thorough review of the literature. It identifies the elements to consider when planning and implementing prevention programs and the Ottawa Charter Principles provides examples of prevention programs at the individual and community level.

3.2 Prevention

The aim of prevention is to improve health, social and economic outcomes by preventing and reducing drug use and its related harms. Drug related harms can occur to the individual or to the broader community and can be categorised into three types:

- **Health Harms** include health risks associated with drug use, eg cirrhosis of the liver, lung cancer, accidents.
- **Social Harms** relate to the social impact of drug use on relationships, families, friends, etc, eg alcohol related violence, family breakdown.
- **Economic Harms** relate to the financial burden of drug use on the individual and society, eg loss of productivity in the workplace, increased insurance premiums.

This Framework incorporates all levels of prevention: primary, secondary and tertiary. Primary prevention is aimed at forestalling the commencement or reducing the likelihood of using alcohol and other drugs. Secondary prevention aims to reduce

the harms associated with the use of alcohol and other drugs. Tertiary prevention is aimed at reducing complications and includes any measures available to reduce impairments and disabilities and minimise suffering.

3.3 The Cost of Alcohol and other Drug Use

The following statistics released by The Australian Institute of Health and Welfare (AIHW)[1] highlight an immediate need for the prevention and reduction of alcohol and other drug use:

- In 1997, 3700 Australians died due to the effects of alcohol.
- It has been estimated that the economic cost of alcohol abuse in 1990 was $86.9 billion.
- Alcohol is a major factor in many social problems. About two in five divorces or separations are related to alcohol.
- Alcohol is involved in three out of four violent assaults and about half of all serious crime.
- Work problems caused by alcohol including absenteeism, poor work performance and accidents are estimated to cost Australian industry over $1 billion each year.
- About one in three serious road accidents and one in three drownings involve alcohol.
- In 1996 it was estimated that 6.5 % of all Australians aged 18 or over had an alcohol use disorder and 2.2 % abused other drugs, including cannabis, stimulants, sedatives and opiates.

Furthermore, the 1999 SWSAHS Epidemiological Profile has reported that in NSW, for the years 1992 – 1996, there were 1,135 recorded deaths (932 among males and 203 among females) from opiate related causes.

3.4 Who Benefits from Prevention?

Everyone benefits from the prevention and reduction of alcohol and other drug use. Prevention can be primary, targeting the general public or a whole population that has not been identified on the basis of individual risk. National youth alcohol campaigns are examples of prevention strategies that address whole populations. Community development programs are examples of prevention strategies that address the general public in a particular area. Prevention can be secondary, targeting of individuals or subgroups of a population whose risk of developing drug related harm is higher than average, such as young males with a history of binge drinking. Finally, prevention can target high risk individuals who are identified as having an existing drug and alcohol use problem by reducing further harmful effects through, for example, needle exchange or smoking cessation programs.

3.5 The Prevention Focus – Using a Range of Strategies

Prevention and reduction of alcohol and other drug use and related harms can be persuasively argued as involving a great deal more than interventions that target reductions in availability and access or which increase the severity of penalties. It will be evident from the complex nature and variation in the identified risk and protective factors associated with the prevention of drug and alcohol use that successful interventions will comprise more than single actions, isolated organisations or individual settings. In the past, prevention strategies have focused on school based drug education, mass media campaigns etc and

were largely information based. This focus on the individual ignored the larger impact that other influences, such as the environment, have upon an individual's choice to use or not use drugs. Consequently current prevention approaches include community development projects, targeted mass media campaigns, restrictions on advertising and packaging and other regulatory approaches such as reducing access to alcohol and other drugs, distribution of information, compulsory health warnings on tobacco products, as well as school based drug education.

Prevention approaches that address a combination of the principles will be more effective than those that address a principle in isolation. A substantial amount of research suggests that approaches that attempt to strengthen the individual's health potential so they will be able to cope more effectively with environmental demands, psychosocial stress and health problems or health risks greatly underestimate the cultural, social and economic influences on individuals. Syme[2] in his paper on mental

health problems states "about 60% of preventable morbidity and mortality are located not within the domains of individual behaviour or lifestyle but within social organisation". Approaches targeting the social, cultural, economic, natural and technical environments and which involve a relatively broad range of political, legislative and administrative strategies have been found to have a greater impact and be sustained [3]. Supporting this is the suggestion that changes in individual behaviours and lifestyle can only be expected if suitable changes also take place in the conditions of daily living. [4]

3.6 Understanding How to Prevent Harm - Factors Associated with Drug and Alcohol Use

The reasons underlying drug and alcohol use appear complex, interactive and cumulative. The literature indicates the problem reflects social circumstances, personal histories and psychological processes more than other genetic or biological contributors.

Prevention is often directed at those having the greatest potential to abuse. However, there is a wide range of mediating factors associated with either increased or decreased risk for drug and alcohol abuse. Prevention initiatives should be designed to alter both risk and protective factors. Many of these factors may be interrelated, interactive and operate cumulatively to cause the ill effects. Risk factors (such as peer influences and status seeking behaviours) may interact with protective factors (such as adequate parental supervision and guidance), effectively reducing potential risk [5]. The risk factors for drug and alcohol use should be considered dynamically. Individuals and their immediate environments are in a constant state of change, both in themselves and the way in which they influence one another.

Kadzin 1997 [6] highlights a number of 'critical transition' periods in a person's life including the transitions from home to school, primary to secondary school and from school to seeking entry into the paid workforce, making commitments to other people etc. What happens at each critical transition point depends not only on current circumstances but also on how the individual has coped with earlier transitions and developed the skills such as listening, taking advice and

identifying opportunities. The ‘critical transition’ periods can be demonstrated in the results of the ‘1996 Survey for NSW Secondary School Students on Smoking and Alcohol use’ that reported:

- The greatest increase in new recruits to smoking was before aged 16 years for males and before aged 15 years for females.
- 13% of twelve year olds and 55% of seventeen year olds reported recent drinking.
- An estimated 33,000 NSW students aged 16 and 17 years had engaged in hazardous drinking (5 or more standard drinks) two or more times in the fortnight preceding the survey.

3.7 Effective Intervention

Prevention programs include those targeting primary prevention, cessation and prevention of related harm. It is worth recognising that drugs are used in a continuum, from no current use to occasional use through to regular problematic use. Harm from drug use can occur anywhere along this continuum. The types of harm associated with alcohol and other drug use are death, injury, violence, mental health problems, unsafe sexual practice, unwanted pregnancies and unsafe injecting behaviour. Harm can result from a single isolated episode of drug use for example or from a one-off episode of adolescent binge drinking.

The levels of evidence used to assess the effectiveness of programs in the prevention of alcohol and other drug use or prevention of drug related harm are provided below. Level 1 evidence has the highest ranking[7].

Level 1 Quality assessed systematic reviews of randomised controlled trials
Level 2 Randomised controlled trials
Level 3 Well designed controlled trials without randomisation
Level 4 Well designed cohort or case – control trials
Level 5 Comparisons between times and places with or without intervention
Level 6 Opinions of respected authorities

There is a well recognised deficit of high level evidence for programs that stop alcohol or other drug use. Evidence for programs preventing alcohol and other drug use in Australia and other countries are from varied levels. In Australia, programs have been developed from a range of evidence with level 6 evidence at times being used to inform programs because of a lack of higher level evidence. Significantly more high level evidence is available for secondary prevention programs that reduce the harms associated with alcohol and other drug use. Included in these are methadone programs, community based prevention programs and the needle syringe program. Methadone and the needle syringe program are current practice in NSW. Community based programs are also current practice and address a range of issues besides alcohol and other drug related harm. For example they may target isolation, alienation and powerlessness. Community based programs are comprehensive in nature and are in keeping with the principles of the Ottawa Charter. This type of approach underpins current initiatives in the SWSAHS in Miller and Claymore Areas and with the Families First Program.

Evidence from interventions targeting the identified precursors to drug and alcohol abuse along with those directly addressing drug and alcohol problems is summarised below. A review of the literature will not necessarily provide the reader with an 'optimum intervention' nor will it necessarily permit an interpretation of which are the 'best' interventions. Each intervention needs to be judged on its ability to be successful within current circumstances and resources.

3.9 Early Life / Childhood

The aim of interventions targeting early life and childhood is to primarily help parents nurture their children. A systematic review of the effectiveness of parental training programs of early school age children conducted by Barlow 1997 [8] suggests that parenting programs can reverse both emotional and behavioural problems in children and more importantly, prevent their emergence. This is well supported in a meta-analysis and literature review conducted by Stanton and Shadish 1997 [9].

The following is an overview of the successful programs targeting early life and childhood:
Home Visiting. The provision of practical support to parents by lay volunteers and health professionals. Families are provided with baby healthcare requirements, assistance in the development of coping and parenting skills as well as establishment and maintenance of supportive relationships in their community, including effective use of community services. The unique characteristics and circumstances of individual families need to be considered in the planning of home visitation programs.

School / home based interventions. Improved school achievement and behaviour has been demonstrated in interventions that offered daily preschool programs and weekly home visits by teachers to coach children in the skills of effective decision making, self discipline, reasoning, recognising others views. The Health Promoting Schools concept developed by the WHO includes planned, sequential classroom learning complemented by policies, programs, practices, structures and procedures that schools adopt to encourage lifelong healthy practices in children and their families. [4, 6, 9, 10, 11]

3.10 Adolescence

Youth at risk for alcohol and other drug use often share mutual characteristics such as an inability to resist peer influence, poor self-esteem and decreased perceived risk of harm.

A review of controlled comparative studies and meta-analyses of prevention programs that have been successful in either reducing high risk behaviours, minimising the associated harms and delaying or preventing the initiation or uptake of alcohol and other drug use in youth has yielded several strategies [3, 5, 11, 12, 13, 14]:

- One to one individual attention. It appears that one of the most important interventions for preventing high-risk behaviours is the placement of an adult in a position of responsibility for consistent support and care. This can take the form of counselling, mentoring or case management.

- Involvement of parents / families. Programs that actively involve parents / families in decision-making or hire them as aides have been shown to be successful in delaying or preventing the initiation or uptake of alcohol and other drugs.

- Parental skills training. The provision of skills training for parents of adolescent drug users including instruction on how to set limits, supportive reinforcement and contracting between parents and children have been successful in reducing drug use in youth.

- School based interventions. Key features of successful classroom based interventions that showed significant reductions in both drug and polydrug use include; teaching a combination of social resistance and general life skills, peer programs, interactive (nondidactic) programs, proper implementation and sufficient length, as well as at least two years of booster sessions.

- Community wide multiagency approaches that are directed towards the antecedents of high risk behaviours such as unemployment, low self-esteem, lack of parental support and guidance etc. These approaches include the provision of vocational skills training, work, life and recreational opportunities, mass media components, community leaders highlighting the harms associated with drug use through ongoing and organised lobbying, school and parental involvement.

3.11 Adult

Included in the identified risk factors for alcohol and other drugs use in adults are social isolation and inappropriate use by spouse or significant other. Research evidence from randomised trials and population based studies suggest that successful intervention programs designed to reduce the harms associated with alcohol and other drug use in adults are multi-strategic programs in a variety of settings. The following strategies were found to have a positive impact [16, 17, 18, 19, 20, 21]:

- Physician delivered counselling sessions that include advice, education and contracting using a scripted workbook.

- Drug and alcohol policy development in tertiary education settings including 'no smoking' policies and procedures for dealing with non compliant staff, students and visitors, policies that restricted trading hours and advertisements for alcohol on campus, no 'happy hour' policy, responsible server training for employers and employees of licensed venues. A further successful strategy in tertiary settings is the provision of alternative venues for social gatherings such as alcohol free coffee shops.

- Standard drinks demonstrations by law enforcement agents at licensed venues including the operation of a breathalyser to demonstrate the difference in effects of light and full strength alcohol

- Involvement of community opinion leaders eg. religious leaders highlighting the harms associated with drug use through ongoing and organised lobbying

3.12 Community

Community interventions use coordinated, widespread, multicomponent programs to try and influence behaviour. The goals of most community interventions are to set in place structures that both support and reinforce efforts to improve health and well being. Community interventions are often conducted through community groups and organisations emphasising a principle of 'ownership' or 'partnership' in promoting health. Community members are involved in decisions about the implementation of various activities within the program, often building on existing structures. Many community interventions seek to generate a broad base of support by increasing coordination among existing prevention activities through the identification of ways in which the single agencies or organisations can collaborate-rather than compete- to attract new funds. Research findings in general suggest that to be effective, community intervention programs must support a diverse range of activities.

Examples of successful community based prevention activities and actions are as follows [22, 23, 24, 25, 26, 27]:

- Provision of alternative programs for youth eg. increase opportunities for recreation and leisure
- Media campaigns eg. Influencing coverage of local events by the mass media, to emphasise constructive rather than negative images of local life, raise community awareness over the threats posed by substance abuse etc.
- Employment programs.
- Workplace programs (eg. non-smoking policies in the workplace).
- Neighbourhood empowerment (citizen advocacy and lobbying for adequate public educational and recreational spending).
- Coordination of community organisations (embrace a broad variety of organisations including local governments, schools, faith communities, neighbourhood groups, parent groups, businesses, family, youth and other social service agencies, police, local colleges and universities).
- Empower residents to make decisions and take action (adult civic involvement on council, school and other agency boards addressing social and public health issues).
- Youth skills training.
- Parent training (programs that enhance parenting style and improve communication within the family)
- Local businesses deliver and encourage prevention messages and initiatives.
- Integration of social services which decreases competitiveness and duplication, and increases accountability and effectiveness.

3.13 Communication Strategies

Influential alliances or partnerships are essential in promoting health across sectors, across professional and lay boundaries and between public, private and non government agencies. Effective communication enhances existing alliances, and fosters collaboration between drug and alcohol, other health workers and agencies and communities. Avenues for communication that facilitate a sharing of decision making such as committees or coordinated groups and the development of written agreements or contracts between the collaborating parties have been found to be successful.

Effective dissemination of evidence based health information as well as its application to practice when appropriate, are important components of the prevention and reduction of alcohol and other drug use and related harms. The various channels of communication including radio, television, newspapers, magazines, calendars, leaflets, outdoor media (eg bridges, bus sides and billboards) posters and pamphlets have been found to be effective in communicating health information to the public, particularly in the area of prevention, risk reduction and drug information.

Research findings suggest that consideration needs to be given to the following areas when planning communication strategies [28, 29, 30]:

- Messages need to be appealing, relevant, non judgemental and credible to the particular target audience.
- The effect of a new message should be piloted on a sample of the particular target group before being disseminated widely.
- Messages should be developed within the literacy level of the target audience.
- Messages need to be culturally appropriate for the target audience.
- Message designs need to be research based eg. It has been found that the most effective alcohol education message for late adolescence is one that encourages moderate drinking and offers appropriate harm reduction strategies.
- Effective placement of a message to ensure adequate exposure for a particular target group needs to be identified eg. media habits, favourite leisure activities etc.
- Involve the target audience in the planning and development of educational messages wherever possible.

3.14 Planning and Implementing Prevention Programs

Research findings identify key elements to address in the planning and implementation of prevention programs:

- Drug and alcohol abuse occurs in a social, cultural, political or economic context. Interventions need to recognise the interaction between the agent (alcohol and other drugs), the user and the environment.
- A "mix and match" of different prevention approaches will be necessary until the right combination of activities for each community's unique needs is identified. Begin with identifying and building on the existing strengths of the community.
- Interventions are tailored to suit the needs of special populations. Some of these populations include ATSI, NESB, young people, the unemployed, women and older people.
- Interventions need to be based upon the values of the community being dealt with.
- Consider a range of social influences and organisations (schools, parents, media, police etc).
- Consider the age range of your target population and design interventions that will be developmentally appropriate.
- Interventions need to be informed by current research based best practice.
- Consultation and collaboration need to be fostered and maintained with all identified partners.
- Systems need to be available for monitoring progress, impact and outcomes.
- Sustained community effects are more likely when coupled with upstream interventions such as changes in the physical and economic availability of alcohol, restrictions on advertising etc.
- Effective prevention practice needs to be promoted to the community through the media and other key marketing activities.
- Interventions need to aim for lasting benefits (hold the gain).

3.15 Ottawa Charter Principles

Health promotion encourages a holistic approach to the prevention and reduction of alcohol and other drug use and related harms. Health promotion comprises all efforts directed at the protection, maintenance and improvement of health. The World Health Organisation's Ottawa Charter 1986 and the outcomes of the 4th International Conference on Health Promotion, Jakarta 1997 provide us with the principles currently underpinning health promotion action. Please see following page.

<table>
<tr><th rowspan="2">Ottawa Charter Principles</th><th colspan="2">Examples of Prevention Strategies</th></tr>
<tr><th>Individual Level</th><th>Community Level</th></tr>
<tr><td colspan="3">Build Healthy Public Policy</td></tr>
<tr><td>Public policy can contribute to positive health outcomes for the population as a whole and a range of specific target groups..</td><td>• Mandatory event management training for recreational officers
• Mandatory training in responsible alcohol serving practices for employers and employees of licensed venues
• Increase awareness amongst tobacco retailers of the sales to minors provisions of the Public Health Act 1991.</td><td>Changing public and corporate policies to make them more conducive to health eg.
• Formal regulation and enforcement in relation to managing, promoting, serving and supplying alcohol.
• Non smoking / alcohol policies in restaurants and workplaces,
• Elimination of “Happy Hour” incentives by licensed venues that encourage excessive drinking.
• Policies restricting drug and alcohol access and marketing tactics that target youth
• Needle & syringe programs reduce the incidence of blood borne viruses (BBV)
• Mechanisms in place to assist schools to develop smoking expulsion punishment policies and cessation practices</td></tr>
<tr><td colspan="3">Create Supportive Environments</td></tr>
<tr><td>Work, living and recreational environments, which are supportive contribute to quality of life and healthier outcomes for people within those environments.</td><td>The creation of safe, stimulating, satisfying and enjoyable living and working environments:
• Adequate opportunities for employment and leisure.
• Provision of smoking cessation programs in workplaces.
• Strengthening families through family support programs, parenting skills programs</td><td>• Public safety may be ensured by adequate lighting in public areas at night,
• Opportunities available for leisure and recreational activities in each community facilitate a more active lifestyle,
• Smoke free workplaces contribute to reduced incidences of smoking related asthma and bronchitis
• The number of enclosed public places and places where food is eaten in which are smoke free is increased.
• Social responsibility in drug use promoted through media, signage, and security</td></tr>
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<table>
<tr><th rowspan="2">Ottawa Charter Principles</th><th colspan="2">Examples of Prevention Strategies</th></tr>
<tr><th>Individual Level</th><th>Community Level</th></tr>
<tr><td colspan="3">Strengthen Community Action</td></tr>
<tr><td>Strengthening community action is the basis of empowering communities to take action which supports their health. -</td><td>Strengthen social networks, social support and empower community members:
• Decrease social isolation by providing opportunities for networking by community members.
• Community members use local media as a communication medium to voice concerns and promote available alternatives to drug and alcohol use.</td><td>• Community consultative processes around particular health issues facilitate communication between the community members and the health service providers
• Drug action teams in local areas can identify the range of community concerns and work together to respond to these concerns.</td></tr>
<tr><td colspan="3">Developing Personal Skills</td></tr>
<tr><td>Developing personal knowledge and skills enables people to exercise more control over their own health and environment and to make choices conducive to health.</td><td>The promotion of lifestyles conducive to health involves consideration a range of personal skills including personal coping strategies.
• Learning anger management and the skills for controlled drinking is important for people who become violent with Alcohol use to reduce the harms arising from their use.
• Learning the skills to manage their illness is important for the diabetic or asthmatic's long term health and quality of life
• Improving self esteem reduces vulnerability to peer group influence and status seeking behaviour</td><td>• Provision and ongoing reinforcement of information and education on health and life skills to the community to assist social adjustment and provide each individual with the ability to make informed life choices.
• Wide provision of vocational skills based training to allow successful access into the workforce.
• Mass media interventions that inform the public of the harms associated with the use of alcohol and other drugs eg. effects of alcohol on behaviour.
• Provision of information on passive smoking to all prenatal and postnatal services.</td></tr>
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<table>
<tr><th rowspan="2">Ottawa Charter Principles</th><th colspan="2">Examples of Prevention Strategies</th></tr>
<tr><th>Individual Level</th><th>Community Level</th></tr>
<tr><td colspan="3">Reorienting Health Services</td></tr>
<tr><td>The role of the health sector must move beyond its responsibility for the provision of clinical and curative services and use a health promotion approach to address the wider determinants of health.</td><td>• Health services encourage a participatory role for patients according to their health potential eg. Individual assessment for community rehabilitation requirements post cessation of methadone.</td><td>Health services work with local communities:
• Lobby council for an increase in the range of options for physical and recreational activity available to community members.
• Community participation in health service planning is actively encouraged.</td></tr>
<tr><td colspan="3">Participation</td></tr>
<tr><td>People need to be at the centre of all decision making around health promotion action to enable more enduring changes. Access to education and information is essential to achieving effective participation through the empowerment of people and communities.</td><td>Increase opportunities for individuals to access educational efforts that influence lifestyle in the interests of preventing ill health as well as efforts that encourage individual uptake of preventive services:
• Encourage GP's to inform clients of the need for as well as information on available drug and alcohol services.</td><td>• Develop communication channels to ensure appropriate (wanted) education opportunities in relation to alcohol and other drugs are developed and readily available to community members.
• Identify and act on opportunities for collaboration with community health and other services and agencies in relation to AOD problems.
• Consult with the Aboriginal community to determine their needs in relation to smoking cessation
• Establish networks and work with young people to reduce the attractiveness of smoking to young people</td></tr>
</table>

3.16 Recommended Prevention Strategies:

The resources available for Drug and Alcohol prevention in South Western Sydney were initially expanded in the early nineties, but have declined over the last four years. Pressure to address treatment issues has resulted in a reallocation of resources away from prevention. In the last 12 months South Western Sydney Area Health Service has maintained or made commitments to prevention strategies to address harm arising from usage of tobacco and intravenous drugs and in the early childhood field.

This Plan recognises that many mainstream services and community development programs such as the Claymore and Miller "Place projects" provide an opportunity for interventions to address Drug and Alcohol problems. The Plan recommends a range of strategies identified as best practice, which target the community as a whole, adolescents and adults. This Plan also recognises the limited resources to address prevention at this level. Therefore the strategies identified are not prescriptive, but provide a framework for strategic action at the Area and Sector level and for Non Government Organisations funded through the Area Health Service.

There is a need to address prevention strategies at a number of levels. Forums within South Western Sydney such as the CEO's Forum and the Drug Action Teams initiated by the Premiers Department were identified as the major mechanism for setting appropriate policy and a strategic means of providing healthier environments within South Western Sydney. The CEO's forum identified Drug and Alcohol issues as a priority for its action, prior to the Drug Summit. This forum will provide the high level support required for implementation of an intersectoral approach at the Sector or Drug Action team level. The proposed expansion of the Drug Action Team approach from Fairfield to Bankstown and across the Area Health Service will provide a momentum for cooperation within other sectors to focus to prevention. Other community and school based initiatives such as the Wingecarribee and Camden projects provide another level on which to address prevention.

This Framework recommends the establishment of a prevention coordination position and the adoption of a broad range of strategies.

3.16.1 Prevention Coordinator

The role of a prevention coordinator is essential to the effective implementation of prevention programs within South Western Sydney Area Health Services. This coordinator would aim to improve coordination and communication across the Area Health Service, the Non Government Organisations and other organisations. The Coordinator would support the implementation of many Drug Summit initiatives. The role would include:

1. Support Community Drug Action Teams
2. Establish links with the Families First program
3. Support existing place management projects in Miller, Claymore and Macquarie Fields

4. Support community development aspects of the expansion of services within Methadone services and other treatment settings to provide a more holistic service to clients.
5. Mapping the current prevention activities to ensure the Ottawa Charter principles are addressed.
6. Support national and state campaigns at the local level
7. Provide link with the relevant Advisory Committees for Mental Health, Sexually Transmitted Diseases and Blood Borne Viruses, Stroke and Cardiovascular Disease
8. Maintain and coordinate the AOD (Alcohol and Other Drug) Link
9. Advocate for prevention at all levels of the organisation
10. Advise on planning, implementation and evaluation of prevention programs
11. Provide training and support regarding prevention

3.16.2 General Prevention Strategies

A range of strategies to support prevention initiatives are recommended including:

1. The Health Service advocate that intersectoral forums broaden the focus of cooperative action to address the use of tobacco and alcohol and misuse of prescription drugs as well as illicit drug usage and to address the social determinants of drug and alcohol related harms.
2. Sector based memorandums of understanding be developed with the Health funded Non Government Organisations. This would identify an agreed strategic direction for prevention within the sector.
3. The Area and Sectors will work with a range of Non Government Organisations in addressing the harms associated with alcohol and other drug use.
4. The Area and Sectors will adopt evidence-based strategies to reduce the harms associated with licit and illicit drug usage.
5. The Area and Sectors will maintain a population approach to the extent possible within resources available. In particular, campaigns such as the Youth Alcohol Campaign and other related campaigns will be supported and coordinated.
6. The Area and Sectors will adopt strategies based on appropriate needs assessment and community / client consultation. This will be balance with the population health approach.
7. The Area and Sectors will work with the Department of Education and Training to identify an appropriate level of cooperation and support for the whole of school programs offered within the school settings.
8. The key mainstream sector Health Services will identify opportunities for prevention, referral and brief intervention to address Drug and Alcohol problems eg emergency, orthopaedics, perinatology and maternity. The Drug and Alcohol Services will support this work through the establishment of Hospital Liaison services linked with the Methadone services.
9. The Area and Sectors will advocate for and adopt an appropriate level of evaluation for the prevention programs implemented.

References

1. AIHW - *National Health Survey* - Summary of Results. 1997

2. Syme, S.L. (1996) *To Prevent Disease: The Need For a New Approach*. In: D. Blane E. Brunner & R. Wilkinson (Eds.) *Health and Social Organization: Towards a health policy for the 21st century.* London: Routledge.

3. Johnson C, Pentz M, Weber M *Relative Effectiveness Of Comprehensive Community Programming For Drug Abuse Prevention With High-Risk And Low-Risk Adolescents*. Journal Clinical Psychology 1990 58:447-456

4. National Crime Prevention (1999) *Pathways to Prevention: Developmental and early intervention approaches to crime in Australia*. Attorney-General's Department: Canberra. Commonwealth of Australia.

5. Weinburg, N. Rahdert, E. Colliver, J. & Glantz, M. *Adolescent Substance Abuse: a review of the past 10 years*. American Academy of Child & Adolescent Psychiatry 1998 Volume 37 pp 252-261.

6. Kazdin A.E. (1997) *'Conduct Disorder Across The Life Span'* in SS Luthar, J.A. Burack, D. Cicchetti & J.R. Weisz (eds) *Developmental Sychopathology: Perspectives on Adjustment, Risk & Disorder.* Cambridge University Press: Cambridge.

7. Stevens, A & Raftery J. *Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Review, Volume 1.* 1994. Oxford. Radcliffe Medical Press

8. Barlow, J. *Systematic Review of Effectiveness of Parent Training Programmes in Improving Behaviour Problems in Children Aged 3-10 yrs.* 1997. Oxford. Health Services Research Unit.

9. Stanton M.D., Shadish W.R. (1997) *Outcome, Attrition And Family/Couples Treatment For Drug Abuse: A Meta-Analysis And Review Of The Controlled, Comparative Studies.* Psychological Bulletin 122: 170-191.

10. NSW Health, Policy Division. *Achieving Health Outcomes for Children in NSW - Strengthening Families & Communities*. Draft Discussion Paper. Jan 1998.

11. Gutman, M. & Clayton, R. *Treatment & Prevention of Use & Abuse of Illegal Drugs: Progress on Interventions & Future Directions*. American Journal of Health Promotion. 1999; 14 (2): 92-97.

12. Pentz, M. Dwyer, J. Mackinnon, D. Flay, B. Hansen W. Yu, E. Wang & Johnson A. *A Multicommunity Trial For Primary Prevention Of Adolescent Drug Abuse*. JAMA, Volume 261, No 22 1989.

13. Botvin G.J., Bakere, Dusenbury L. *Long Term Follow Up Results Of A Randomised Drug Abuse Prevention Trial In A White Middle Class Population.* JAMA 1995; 273: 1106-12.

14. Dryfoos, J. *Preventing High Risk Behaviour* American Journal of Public Health.1991, Volume 81, No.2.

15. Tobler N.S., Stratton H.S. (1997), *Effectiveness Of School-Based Drug Prevention Programs: A Meta-Analysis Of The Research*. J Prim Prevent 18:71-128.

16. Alcohol, Tobacco & Other Drug Services, Queensland Health Information Network, *Support Resource to the Guide for Health Workers on Developing Partnerships* Dec 1997.

17. *Think Before You Drink Campaign 1998: Involve Your Worksite.* W.A. Health Department.

18. Blaze-Temple, D. Barney, J. Saxon, S. Cadsdon, D. Howat, P. Saunders, B. & O'Connor, J. (1991) *Policy Development for the Reduction of Alcohol & Other Drug Problems At An Australian University*. Australian Journal of Social Issues VOL 26 No.4.

19. Babor, T. Aguirre-Molina, M. Marlatt, A & Clayton, R. (1999*) Managing Alcohol Problems & Risky Drinking* American Journal of Health Promotion 14 (2): 98-103

20. O'Brien, T. Oxman, A. Haynes, R. Davis, D. Freemantle, N. & Harvey. *Local Opinion Leaders: Effects on Professional Practice & Health Care Outcomes*. Cochrane Collaboration1998.

21. Flemming M, Manwell L, Barry K, Adams W & Stauffacher, E (1999) *Brief Physician Advice for Alcohol Problems in Older Adults: A Randomised Community-Based Trial*. Journal of Family Practice 48 (5): 378-84.

22. Fawcett, S.B Lewis, R.K. Francisco, VT Richter KP, Williams EL, Copple B. *Evaluating Community Coalitions For Prevention Of Substance Abuse: The Case Of Project Freedom*. Health Education Behaviour 1997;24:812-828.

23. Vicary JR, Doebler MK, Bidger JC, Gurgevich EA. *A Community Systems Approach To Substance Abuse Prevention In A Rural Setting.* J Prim Prevent 1996;16:303-318.

24. CSAP. (1997). *National Evaluation of the Community Partnership Demonstration Grant Program: Fifth Annual Report.* Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

25. Kaftarian, S.J., & Yin, R.K. (Eds.). (1997). *Local and National Outcomes from Community Partnerships to Prevent Substance Abuse*. Evaluation and Program Planning, 20 (3).

26. Yin, R.K., Kaftarian, S.J., Yu, P.& Jansen, M.A. (1997). *Outcomes from CSAP's Community Partnership Program: Findings from the National Cross-Site Evaluation.* Evaluation and Program Planning, 20 (3), 345-355.

27. Manger, T. Hawkins, D. Haggerty, K & Catalano, R. *Mobilizing Communities to Reduce Risks for Drug Abuse: Lessons On Using Research To Guide Prevention Practice. Journal of Primary Prevention* VOL 13, No. 1 1992.

28. Grilli, R. Freemantle, N. Minozzi, S. Domenighetti, G & Finer,D, *1997 Mass Media Intervenitons: Effects on Health Services Utilization.* Cochrane Collaboration 1997.

29. Burns, S. & Thompson, C. 1998*. Developing a Youth Alcohol Education Message for School-aged Adolescents.* Health Promotion Journal of Australia; 8 (2): 109-114.

30. Alcohol, Tobacco & Other Drug Services, Queensland Health Information Network. *Guide for Health Workers on Developing Partnerships* December. 1997.

4 FRAMEWORK FOR DRUG AND ALCOHOL TREATMENT SERVICES - MODEL OF CARE

4.1 Outline of the Treatment Model of Care and its infrastructure requirements.

The model of care for treatment services across SWS proposes a network of client focused services. This recognises that clients may access treatment services through any one of a range of services and that they may enter and leave the network many times. The proposed model encourages clients to enter the network through a service, which suits their preference, their special needs, the extent and stage of their drug usage and their readiness to change that drug usage. The model is based on the range of services identified by the NSW Drug Treatment Services Plan. These have been defined here as including

- Counselling, Welfare and Day Programs including Community Health, DISC and NGOs;
- Needle Syringe program;
- Detoxification services including designated residential detoxification services, within mainstream hospital beds, outpatient and home based services;
- Pharmacotherapies including Methadone Maintenance Services;
- Residential Rehabilitation services;
- Specialist Drug and Alcohol Clinical services;
- General Practitioners and Community Pharmacies; and
- Diversional programs including the Drug Court Program.

In the last two years, South Western Sydney has initiated DISC, two designated detoxification programs, the Drug Court diversion program and increased collaboration with General Practitioners and Community Pharmacies. The establishment of services has increased SWS residents' access to a locally based, comprehensive range of services. This model of care articulates opportunities for greater coordination and integration of services across the network of services. It identifies service principles for services, which have been of key concern.

The model also recognises that a number of services not provided under the Health portfolio also provide essential support for clients participating in or seeking treatment. As such there needs to be improved coordination with support services such as:

- Accommodation, Hostels and proclaimed places;
- Other services, such as Open Family in Cabramatta and self help groups; and
- Interagency Networks

In order for the model to operate effectively there are a number of infrastructure requirements, which are common across the model. These include

- The establishment of an effective data base for monitoring and evaluation
- The development of an effective referral systems into Drug and Alcohol Services and a generic assessment system between Drug and Alcohol Services

Please find below detailed outlines of the common infrastructure requirements and the Treatment Model of Care.

4.2 INFRASTRUCTURE REQUIREMENTS FOR THE MODEL OF CARE FOR TREATMENT SERVICES

4.2.1 Establishment of an effective data base for treatment services

Location:

The Drug and Alcohol minimum data set and Drug and Alcohol Clinical Information System (DACIS) data base would be implemented across all Drug and Alcohol Treatment Services in the SWSAHS including the SWSAHS administered Treatment NGOs. This is part of a statewide initiative.

Who benefits:

The minimum data set and the DACIS data base would provide ongoing demographic and clinical data to services to facilitate referral and assessment of clients. The minimum data set and data base would also provide timely and accurate information for service planning, and for monitoring and evaluation of service activity and client access.

Issues:

Current data bases for clients treated within the SWSAHS Drug and Alcohol Treatment services are poor and information required to assess clients access to services is not readily available. SWSAHS has joined the Drug and Alcohol Clinical Information System (DACIS) Consortium. This consortium of Area Health Services will support the implementation of this information system across a number of area health services.

Strategies

Implementation of the DACIS system

4.2.2 Establishment of Effective Referral and Generic Assessment Systems for Drug and Alcohol Services.

Location:

All services referring clients to Drug and Alcohol Services for counselling and treatment would be included in the referral system. A generic assessment system would be developed for use among the SWSAHS managed services.

Who benefits:

A generic assessment and effective referral system to Drug and Alcohol Services would decrease the need for multiple assessments and enhance the relationship between workers and clients, for example, at a youth service, in a GP surgery or at a needle and syringe program.

Issues:

Referring to Drug and Alcohol Services can be complicated for clients and other Drug and Alcohol Services. Waiting lists and different referral procedures between agencies are common. This presents obstacles to clients who are not familiar with the systems or experience cultural or language barriers. The different models of treatment offered and different philosophical approaches can further complicate referral. Matching services to a client and their family is difficult without a central system that guides clients through an assessment procedure to the most appropriate service.

Strategies:

1. Review the options for a new referral system to Drug and Alcohol Services across the Area Health Service. The review should recommend whether this is best placed at a sector or area level and an appropriate implementation strategy. Establish an effective referral system;

2. Develop generic assessment processes and other linkages to facilitate support and referral between the various D&A Treatment Services; and

3. Provide appropriate training for workers in the referral and assessment systems.

4.3 TREATMENT MODEL OF CARE

4.3.1 Counselling, Welfare and Day Programs

Location:

Drug and Alcohol Counselling services and Day programs within SWS are currently provided within Community Health Centres and some Non Government Organisations (NGOs) funded through the Drug and Alcohol Program.

Who benefits:

Counselling services are available for people who self refer, or who are referred by other service providers such as Juvenile Justice. The self referrals are the major means of accessing the Community Health counselling. Juvenile Justice and Probation and Parole are a source of referrals for some NGOs.

It is proposed that Counselling and Day programs will be based on the cognitive behavioural therapy / social skills learning model. This is recommended as the best practice model for counselling services with demonstrated opportunities for health gain.[1]

Issues:

There is a need to maintain a balance between counselling, prevention work, group work and the flexibility to provide Day programs to meet specific needs.

Strategies:

There is a need to develop and improve

1. a shared care approach between Counselling services and the Departments of Community Services, Juvenile Justice and Probation and Parole, Non Government Organisations and hostels, refuges and others;
2. linkages between Counselling services with Mental Health and Allied Health Services and Area Gambling services;
3. linkages between counselling services and non D&A specific NGOs whom may have clients presenting to them with D&A problems;
4. welfare type services to clients and to assist with clients' access to leisure activities in a drug free environment, development of their living skills and job preparation; and
5. Day programs and groups may be required to provide opportunities for family support, prisoner support and peer support.

4.3.2 Needle Syringe Program

Location:

The Needle Syringe program operates throughout the South Western Sydney Area, through a number of primary and secondary outlets. Some secondary outlets are situated in specialist Drug and Alcohol Services.

Who benefits:

The Needle Syringe program in Australia has been demonstrated to be successful in controlling the transmission of HIV by injecting drug use.[2]

Issues:

The Needle Syringe program has a strong primary prevention role. However, there is also the opportunity to improve its role in brief intervention and referral.

Primary and secondary outlets are using the contact with intravenous drug users to offer brief treatment interventions and to provide referral information and advice.

Strategies:

1. Provide ongoing brief interventions and referrals to the various D&A Treatment Services and other health and welfare services.

4.3.3 Detoxification services

Location:

Detoxification services in SWS will be provided in a range of settings depending on the client's need.

Who Benefits:

The NSW Detoxification Guidelines[3] provide an outline of best practice service provision and all detoxification services should operate within these guidelines. The guidelines note the need for client's access to detoxification services regardless of their intention to maintain abstinence. They recommend that detoxification services negotiate with clients in order to provide the service which best meet the client's needs. Alcohol, heroin and benzodiazepines are the main drugs which clients wish to withdraw from. Some clients may wish to selectively withdraw from other drugs while maintaining their dose of methadone. Others may wish to withdraw from methadone.

Clients may require detoxification services for elective, crisis or incidental withdrawal. Clients who are basically well and have chosen elective withdrawal may be managed in a range of settings depending on their preference, special needs, family or other support environment, drug usage and associated level of dependence. These settings include a designated detoxification program such as Corella Lodge, a community based residential service such as Odyssey House and Outpatient and home settings.

A number of clients may be unsuitable for designated detoxification services due to other pre-existing medical or psychiatric conditions or illnesses. These clients will often present requiring a crisis withdrawal or end up withdrawing incidentally as a result of hospitalisation. For these clients, detoxification is better managed in a mainstream hospital setting.

Issues:

Research indicates early uptake of heroin use by young people in the South Western Sydney area.[4] The Children (Care and Protection) Act 1987 currently limits the type of service it is possible to provide to these young people under the age of 16. Therefore as an early intervention mechanism, youth specific detoxification services linked to broader youth specific counselling and rehabilitation services need to be developed within South Western Sydney. Corella Lodge's physical design allows the development of a youth service

within the 20 bed detoxification setting. However, this service would need to ensure the safety and protection of young people within the setting and operate on different protocols both to attract the young clients and to meet their particular needs. Young people will also require access to outpatient and home detoxification.

Other groups with special access needs for detoxification include homeless people and people who do not have Medicare cards, parents with children, pregnant women, dual diagnosis clients in the acute stage of psychosis and drug induced psychosis.

Service Principles:

- Clients may access services most appropriate to their special needs and their stage of readiness to change. Abstinence is not the only criteria for admission to detoxification services.

- Ensuring client, service provider and community safety are key components of any detoxification service.

Strategies:

1 Access to the range of detoxification settings will be improved and strengthened through General Practice shared care programs including counselling or clinical back up by designated drug and alcohol staff;

2 Hospital based services will be supported by strengthened specialist consultation and ongoing training of medical, nursing and allied health staff;

3 Options for improving access to detoxification services by young people, women, homeless people and those without Medicare cards will be investigated and recommended action identified; and

4 Policies and protocols for access to detoxification services will be improved and strengthened through memorandums of understanding between the relevant service providers.

5 Establish new home and ambulatory detoxification services based at DISC, Corella Lodge, Macarthur and Wingecarribee Health Services.

4.3.4 Pharmacotherapies

4.3.4.1 Replacement Pharmacotherapies such as Methadone

Location:

There are currently two public drug treatment services operating in South Western Sydney based at Liverpool and Campbelltown Hospitals. Two private clinics operate in the Liverpool and Fairfield town centres.

Who Benefits

There is a substantial body of evidence to indicate that the longer clients stay on the methadone maintenance program, the more likely they are to reduce their opioid use and reduce their criminal activity. Ward et al[5] state, that "there is reasonably strong evidence that methadone maintenance treatment reduces injection related HIV risk - taking behaviour and thereby reduces the risk of HIV infection among its recipients". Methadone maintenance treatment has a Cost benefit to the taxpayer and thus provides a long term benefit to the individual and the community in which they live and work. There is recognition that methadone services of the future need to develop a more comprehensive approach to meeting the holistic needs of their clients and children of the clients.

Issues

Pressure on the methadone services has resulted in public methadone services within SWS managing significantly higher numbers of clients than those initially approved by the NSW Department of Health. Access by new clients to the public methadone services has thus been restricted to Drug Court patients, pregnant women and their partners, recently released prisoners, patients with HIV or other medical conditions and referrals by General Practitioners.

Concerns regarding the provision of services in the Fairfield based private clinic has resulted in the NSW Department of Health taking legal action to close this service. This service is expected to close in 2000/ 2001.

Following consultation with affected local councils and communities and a review of public sector practices, an alternative proposal for four locally based public sector services is recommended. These would include the two existing public clinics and the establishment of two new clinics in Fairfield and Bankstown to meet the needs of the residents and those working in these local government areas. The public sector clinics would work in close partnership with a network of General Practitioners and Community Pharmacies.

The anticipated closure of the private methadone clinic in Fairfield is expected to have implications for both Fairfield and Bankstown residents. A number of these private clients are expected to make arrangements with their current private sector prescribers for alternative dosing outlets. However, there may be a number of clients who will need to be dosed through Jacaranda House, Liverpool or other alternative locations until the new Drug Treatment Service is commissioned. The establishment of these new services at Bankstown and Fairfield will address these clients needs in the short term and provide a valuable alternative access point for residents of those sectors in the longer term. The Fairfield service will be of sufficient size to warrant a new facility and the Bankstown Service can be established following some refurbishment at the hospital. Improved staff training will broaden and improve their skills and improve the overall quality of service. Staff will be involved in a range of services to be offered as part of the pharmacotherapy service including case management, “Drugs in Pregancy” services, hospital liaison, ambulatory detoxification and General Practitioner and Community Pharmacy shared care programs.

Principles for service delivery:

- Public clinics would be locally based and meet the holistic drug and alcohol treatment needs of their local residents. Improved case management would ensure this holistic approach and facilitate maintenance of clients in treatment;

- Public clinics would be located in an environment, which ensured client, staff and community safety. Services would be provided in a manner, which reduces the negative impact on the local community;

- The public clinics would continue to provide services to new clients and clients who are considered unstable or have complex needs. These services would continue to prioritise new clients who are recently released from prison, on the Drug Court program, women who are pregnant, people with HIV and referrals from General Practitioners; and

- Once stabilised clients would be encouraged to move to General Practitioner shared care and community pharmacies for prescription and dosing. As General Practitioner prescribing increases the public clinics would be able to provide access to a broader range of clients.

- Support services would be provided to General Practitioners and community pharmacies to assist in recruiting them to provide treatment and dosing for stable clients. Each medical practice or pharmacy would be asked to manage a small client load that, with support, should not substantially change the face of their business. These support services would be provided in collaboration with the Divisions of General Practice and the Pharmacy Guild of NSW. This service model is a key strategy in recruiting GPs and pharmacies.

Strategies

1 The holistic needs of clients include access to ongoing Blood Borne Virus (BBV) screening, improved links to other services such as psychiatry, social work and drug and alcohol counselling for those on methadone. Children of pharmacotherapy clients require improved access to immunisation, developmental assessment and other services such as the Families First program;

2 Develop more effective case management in keeping with the holistic approach;

3 Funding for a locally based comprehensive Drug Treatment service located in SWS has been identified as part of the Drug Summit. There is a need to establish two such services, one in Fairfield and the other in Bankstown;

4 Development and actively supported shared care programs with local General Practitioners and Community Pharmacies are essential for the success of each of these comprehensive and integrated replacement therapy services. These programs would be provided back up and support by the public methadone service and links to the community counselling and psychiatric services as appropriate; and

5 Other replacement therapies such as buprenorphine and levo-alpha-acetylmethadol (LAAM) would be included in the proposed clinics once there is evidence that they would produce better outcomes for some clients and they become legally available.

6 Staff will broaden their roles through the provision of case management and other services.

4.3.4.2 Strategies Relating to Other Drug Therapies eg Naltrexone:

There is a need for education on the use of naltrexone, its affects and potential difficulties following a rapid increase in prescribing.

1. Both General Practitioners and Pharmacists will require professional support and education provided through appropriate shared care programs;

2. This education needs to extend across the community including clients and families, but also hospital emergency departments and wards;

3. Naltrexone is not subsidised under the Commonwealth Pharmaceutical Benefits Scheme. There is a need for hospitals and services to develop policies and protocols on the appropriate allocation of cost for naltrexone; and

4. Clinical experience to date indicates that clients on Naltrexone require a substantial amount of support from Drug and Alcohol professionals and from their General Practitioners, Pharmacists and family and friends. Shared care strategies will be developed to improved support for families of people on Naltrexone.

4.3.5 Residential Rehabilitation services

Location:

Two statewide residential rehabilitation services are located in South Western Sydney and managed by the Non Government Organisations, Grow and Odyssey House. These services assist clients develop living skills over a longer term period of 3 to 6 months.

Issues:

There is a need for rehabilitation services to meet the needs of methadone clients, young people, women or parents with children, people who have been sexually assaulted, people with dual diagnosis or gambling problems.

Grow provides a service to people with dual diagnosis while Odyssey House meets the needs of a broad range of people, though tending to reach young people less.

Skills development is an essential aspect of this rehabilitation. Some services have recognised the importance of a certain level of schooling and have built this into their programs. The option for a half way house arrangement has ensured greater success in getting clients back into the community.

Strategies:

Odyssey House has identified the need for additional funding for additional rehabilitation beds and aftercare services. The Drug Summit will fund 5 additional rehabilitation beds.

4.3.6 Specialist Drug and Alcohol Clinical Services

Location:

The Area Drug and Alcohol Centre at Liverpool provides specialist medical and nursing clinical services. Specialist clinical support is also provided at Campbelltown Hospital through Coopers Cottage, which is also the local Methadone unit. Corella Lodge, the Detoxification Unit at Fairfield will increasingly provide such clinical support at Fairfield Hospital as the service develops. Psychiatric liaison mechanisms are established in Bankstown, Liverpool and Macarthur Sector Health Services.

Issues:

There is a need for clinical assessment and treatment to develop stronger links with psychiatric and social work services both in the hospital and community setting.

Stronger medical and nursing consultancy services need to be developed across all SWS hospitals, particularly Fairfield and Bankstown. There is also a need for improved links between the range of drug and alcohol services to ensure early intervention and greater continuity of care for drug affected clients and their families.

Strategies

1. Hospital based services need to be reviewed to improve opportunities for brief intervention and practical welfare assistance for drug affected clients;

2. Sectors need to investigate options for developing or improving drug and alcohol liaison services to hospital staff;

3. Improve and extend the Drugs and Pregnancy services operating in Sector Health Services

4. Improved clinical links with General Practitioners at the clinical level will form the basis for the development of ongoing shared care programs across the range of drug and alcohol settings and functions;

5. The Area and Sectors need to investigate options for providing ongoing support and education to community pharmacies and General Practitioners;

6. Establish a psychiatric liaison service for Fairfield. Funding has been made available through the Mental Health program.

4.3.7 General Practitioners and Community Pharmacies

Location:

General Practitioners and Community Pharmacies operate throughout the South Western Sydney area. Shared care programs in drug and alcohol treatment services have been developed in a number of sectors through collaboration with the Department of General Practice and the five Divisions of General Practice including Bankstown, Fairfield, Liverpool, Macarthur and Southern Highlands. This includes home detoxification in Wingecarribee and methadone prescription across the Area. A number of Community Pharmacies across South Western Sydney provide an outlet for methadone dosing. Liaison with the Pharmacies has been facilitated by the Pharmacy Guild of NSW.

Issues:

General Practitioners provide an important point of access for clients to drug and alcohol treatment services. The provision of methadone prescription from a General Practitioner surgery with dispensing through community pharmacies, increases clients local access to these services and addresses community concerns that such services be provided on a smaller scale than current private sector methadone clinics. The Pharmacy Guild is actively supporting increased recruitment of pharmacies for methadone dosing.

Strategies:

1. There is a need to recruit more General Practitioners into the a range of shared care programs and to provide ongoing education, through continuing collaboration with the Department of General Practice and the five Divisions of General Practice including Bankstown, Fairfield, Liverpool, Macarthur and Southern Highlands;

2. Ongoing recruitment of Community Pharmacies for dosing; and

3. The specialist Drug and Alcohol Clinical services will provide ongoing education and professional support to General Practitioners and Community Pharmacies as part of the range of drug and alcohol shared care programs.

4.3.8 Drug Courts Program

Location:

The Drug Court program is a two-year pilot program, which provides outreach counselling services and Day programs to clients who have been diverted from the prison system to drug and alcohol treatment for drug related offences. The program also provides replacement pharmacotherapies (methadone and naltrexone) for opioid dependent individuals through collaboration with the Area Drug and Alcohol Centre, the two public Drug Treatment Services and Liverpool Hospital Pharmacy department.

Who benefits:

The selection for the Drug Court Program is strictly limited and based on the Judge's decision and a thorough clinical assessment. Where possible or appropriate clients families are engaged and supported in the process. The Drug Court counselling and day programs are also based on the cognitive behavioural therapy / social skills learning model.

The Client's progress is monitored and non-compliance with the program results in legal penalties being enforced by the Court. The Bureau of Crime Statistics and Research is evaluating the program.

Though Drug Court participants, their friends or family members may be linked with generalist drug and alcohol services in SWSAHS, many of these individuals have not had previous intervention and may have been unaware of services available prior to the Drug Court program.

Issues:

There is a need to maintain a good working relationship with the Prisons and Probation and Parole system and other health based participants in the Drug Court program. Many clients have poor accommodation and family or peer support. A number have experiences of torture and trauma. There is a high proportion of clients with substance abuse disorder and mental illness (although not serious mental illness) and many other needs including health and welfare related needs.

Strategies:

The Strategies for the Drug Court Program are similar to those stated above. There is a need to develop and improve:

1. a shared care approach between the SWS Drug Court Team and the Departments of Corrective Services, Corrections Health, Probation and Parole, Non Government Organisations, and others;
2. linkages between counselling services with mental health, torture and trauma services and other specialist medical services;

3. welfare type services to clients and to assist with clients' access to leisure activities in a drug free environment, development of their living skills and job preparation; and
4. Day programs and groups may be required to provide opportunities for family support, prisoner support and peer support.

4.3.9 Other Support Services

4.3.9.1 Accommodation, Hostels and proclaimed places

Issues:

There is a need for a range of accommodation for clients who are using drugs of dependence, trying to stop using or who are at risk of using. This accommodation needs to be flexible to meet the differing needs of individual clients and their families. For example, crisis, short term up to 3 months and longer term of 6 to 12 months.

Strategies:

1. The Area drug and alcohol services will work closely with generalist refuges by providing education to workers who are reluctant or unwilling to accept drug dependent people. This includes providing professional support to the clients and refuge staff in order to maintain client access to supported accommodation; and

2. There is a further need to negotiate a policy change to provide greater access to these services by drug affected clients. The CEO's forum is considered the most appropriate forum to negotiate agreements between health, Department of Community Services as the funding body for refuges and Department of Housing.

4.3.9.2 Other services and self help groups

Issues:

A number of welfare based Non Government Organisations provide a range of services to potential clients for drug and alcohol treatment services. They also act as an important point of contact and referral for those clients. A number of self help groups operate within the South Western Sydney area and also provide support to people with drug and alcohol problems.

Strategies:

- Improve links between Area drug and alcohol services and welfare based NGOs that are not funded as specific drug and alcohol programs.

4.3.9.3 Interagency Networks

Interagency networks operate in the Macarthur and Fairfield area and Drug Action Teams have been established in Fairfield and Bankstown.

Issue:

Interagency networks have ensured good communication between drug and alcohol services and provide opportunities to work with the community at a broader level. The Drug Summit recognised the value of this approach in its recommendation to expand the number of Drug Action Teams across the State.

Strategy:

- The network of drug and alcohol services will work with existing and future interagency networks and Drug Action Teams.

4.3.10 Working with the Community

Issue:

There is a need to work with the Community to ensure broad access to drug and alcohol treatment services and that accurate information reaches specific community groups.

Strategy:

- Provide ongoing education and consultation to the community through small community groups and use focus groups to seek feedback on issues of priority.

4.3.11 Working with Staff

Issue:

Attraction and retention of staff has been identified as a major problem for drug and alcohol services. Improved training of staff is considered crucial to both the attraction and retention of staff and the implementation of this plan. Training will also help staff to improve the quality of services and equity of access to drug and alcohol services by people from diverse cultural backgrounds and with special needs. Employment of bilingual and ATSI staff in the network of drug and alcohol services will also facilitate access to these services by NESB and ATSI people.

Strategies:

The SWSAHS Human Resources Plan identifies the need to address a range of issues for staff. Strategies will be developed to address the following

- Recruitment and retention; work practice and health service delivery; skill development and learning needs; staff communication and consultation; staff well being.

References:

1. Jarvis P, Mattick R & Tebbitt J.*Teatment Approaches for Alcohol and Drug Dependencies, Introductory Guide.* 1992. John Wiley & Sons, New York.

2. National Centre in HIV Epidemiology and Clinical Research. 1998. *HIV / AIDS and Related Diseases in Australia: annual surveillance report.* Canberra. NCHECR.

3. NSW Health *The NSW Detoxification Clinical Practice Guidelines 1999.* 1999. NSW Health Department

4. Maher L, Dixon D, Lynskey M and Hall W. *Running the Risks, Heroin, Health and Harm in South West Sydney.* 1998. NDARC Monograph No. 38

5. Ward J, Mattick RP and Hall W, *Methadone Maintenance Treatment and Other Opioid Replacement Therapies.* 1998. Harwood Academic Publishers